Leadership Styles of Nurse Managers and Employees’ Organizational Commitment during the COVID-19 Pandemic

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Keywords
COVID-19 · Leadership styles · Nurse managers · Organizational commitment · Nurses

Abstract
Objective: The aim of this study was to determine the leadership styles of nurse managers and then determine the relationship of the respective styles with the organizational commitment of the nurse managers during the COVID-19 pandemic. Methods: A quantitative correlational study design was employed in this investigation. Simple random sampling yielded 259 nurses who participated in this study. It was conducted between October and November 2021 at the government hospitals of the Hail Region, Kingdom of Saudi Arabia. Results: The nurses’ perceived that their nurse managers employed an idealized influence leadership style (9.15). Age, years of experience, and ward assignment were found to have no statistically significant difference on organizational commitment; however, a significant difference was found with nationality. No significant difference was found regarding age with idealized influence, inspirational motivation, intellectual stimulation, individual consideration, or management by exception; however, it was found significantly different with the contingent reward and laissez-faire leadership. Concerning nationality, a significant difference was found with idealized influence and inspirational motivation. However, no significant difference was found between nationality and intellectual stimulation, individual consideration, contingent reward, management by exception, or laissez-faire leadership. With the ward assignment, a significant difference was found with individual consideration and laissez-faire leadership. Conclusion: During the pandemic, nurse managers employed idealized influence leadership styles. Age, years of experience, and ward assignment were found to be of no significant difference to organizational commitment, but they did have a significant difference to nationality. Age differed significantly with individualized consideration, contingent reward, and laissez-faire leadership. Years of experience was found to be significantly different with contingent reward and laissez-faire leadership. Concerning nationality, a significant difference was found with idealized influence and inspirational motivation. With the ward assignment, a significant difference was found with individual consideration and laissez-faire leadership.

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Introduction

Amid the challenges brought about by the COVID-19 pandemic, managers and leaders must learn from a variety of leadership styles to create a work environment that fosters the commitment of nursing staff to the patients as well as the organization [1]. Due to both the nature of their profession and because they are directly exposed to vulnerabilities, frontline workers, especially nurses, are at risk of developing psychological distress and other mental health symptoms. Among nurses, this has resulted in feelings of inefficiency, worry, weariness, a dilemma over provided care, and issues using protective gear [2]. Nonetheless, it is imperative to keep frontline healthcare professionals healthy. Emphasizing the importance of a reassuring leadership style among the managers is paramount to improving the work culture and preserving nurses’ resilience during an outbreak or pandemic. Unquestionably, strong leadership is required to improve and enhance the efficacy and efficiencies of healthcare systems [3] while promoting employees’ psychological, physical, and social well-being [4], leading to better organizational commitment.

Leadership styles are critical in defining the culture of a healthcare facility, creating an organization that promotes work independence, job fulfillment, and growth in one’s profession [5], and directing the actions of a group toward a common goal [4]. Such leadership styles influence how organizations operate [6]. Understanding the styles of existing nursing leadership, as well as any connections to organizational commitment and nursing retention, will aid in the development of the knowledge of effective leadership [7]. It has long been understood that styles in leadership can help organizations respond to crises by improving both staff morale [8] and commitment to that organization. Consistent with other investigations, leadership styles can preserve employee well-being [9] and improve nurses’ performance by enhancing their human resources. Indeed, the health of nurses is influenced by their perceptions of their superiors’ leadership styles [10]. Robbins [11] defined organizational commitment as the condition, whereby an employee identifies with the aims of an organization and wishes to remain a part of it. Earlier studies revealed a significant link connecting leadership styles and organizational commitment. Studies by both Al-Yami et al. [12] and May-Chiun et al. [13] claimed that leadership style has an impact on organizational commitment. In contrast, autocratic leadership has a strong beneficial effect on organizational commitment [14]. These inconsistencies demonstrate the need to explore and understand the connection between styles of leading and employee commitment, especially during this pandemic. In this time of pandemic, leaders should not simply assume that everything would go smoothly. It is envisaged that this leader’s attitude of empathy, kindness, and compassion will be reflected in the organization’s attitude during the COVID-19 pandemic crisis. As concluded by earlier study, in order to carefully manage the COVID-19 epidemic, a leader in an organizational environment must be coherent, be flexible, account for his emotions, be involved, and listen to all employee viewpoints [15].

This current study is significant because it illuminates the type leadership that is best suited to maintaining nurses’ well-being and improving their healthcare conditions during a pandemic. It will help managers to adjust their leadership styles during pandemics when frontline nurses are at risk of developing psychological distress and other mental health symptoms. Such leadership styles may be able to influence and instigate beneficial support for the frontline nurses. In return, organizations can improve their performance and value by enhancing their human resources. With these considerations, this study aimed to determine both the leadership styles of nurse managers during the surge of the pandemic and the relationship of those leadership styles with the organizational commitment of the nurses.

Materials and Methods

Research Design

This investigation used a quantitative correlational study design to determine both the leadership style of nurse managers during the COVID-19 pandemic and the relationship of those leadership styles to organizational commitment.

Participants

This study was conducted in Hail City, Kingdom of Saudi Arabia. The participants were hospital nurses from King Salman Specialist Hospital, Convalescent Hospital, King Khalid Hospital, and Hail General Hospital. Nurses who could write and understand English and had direct contact with patients were included in the study. Of the 800 participants who surpassed the criteria, 259 were invited with the help of the head nurses and other nurses in the participating hospitals to identify those nurses fitting the inclusion and exclusion criteria. The Raosoft calculator was used to identify the numbers needed to participate. The participants were chosen through a simple random sampling technique employing the simple random computer generator. This study was conducted between October and November 2021.

Data Collection and Analysis

The researcher used a Google Forms Survey Questionnaire, which was distributed to the invited staff nurses over WhatsApp.
Prior to data collection, the researcher conducted an orientation with the staff nurses. It provided the participants with information about the study, including such things as study objectives, scope of participation, and participant rights.

**Instrument**

The researchers used two questionnaires. The first, known as the Multifactor Leadership Questionnaire (MLQ), was developed by Bass and Avolio [16]. The MLQ-6S contains 21 items that are used to assess leadership on seven factors associated with transformational leadership. The sum of three specific items on the questionnaire determines the score for each factor. For example, add the responses to items 1, 8, and 15 to get the score for factor 1 (idealized influence). This approach is carried out for each of the seven factors [16].

The second questionnaire was the Organizational Commitment Questionnaire (OCQ) which is defined by three criteria that are used to assess organizational commitment: readiness to put forth effort, desire to remain a member of the organization, and recognition of organizational principles [17]. It has 15 items with a response format following the 7-point Likert scale. The ratings in this questionnaire are strongly agree (7), moderately agree (6), slightly agree (5), neither agree nor disagree (4), slightly disagree (3), moderately disagree (2), and strongly disagree (1). The scores were summed and divided by 15 to get a summary indication of employee commitment. Negative words and reverse-scored items were denoted by an “R.” The higher the mean, the better the employee commitment.

**Data Analysis**

The data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 26. The demographic profiles of the participants were treated with frequency and percentage. To check for data distribution, the data were tested with Shapiro-Wilk test, using the hypothesis that the data were normally distributed. The Shapiro-Wilk test result (0.83) was higher, with a p value of 0.05, indicating that the data were normally distributed. Therefore, tests of difference, such as the t test and one-way ANOVA, were used. The relationship between leadership styles and organizational commitment was treated with Pearson’s correlation (bivariate r).

### Results

Table 1 presents the sociodemographics of the 259 participants. Nurses aged above 32 years dominated the workforce (51.9%), followed by those aged 29–31 years old (30%). More nurses had 6–10 years of experience (41.9%), and most were non-Saudi (89.6%). Almost all of the nurses (96.2%) were in the non-COVID or clean ward.

The organizational commitment of the nursing workforce is 4.6 out of 7. They perceived that their nurse managers employed an idealized influence (9.15) leadership style, followed by management by exception (8.63), and

| Variables                  | Mean       | Std        | Interpretation | Highest possible range score |
|----------------------------|------------|------------|----------------|-----------------------------|
| Organizational commitment  | 4.6355     | 0.72061    |                | 7                           |
| Factor 1 (idealized influence) | 9.1583     | 1.89911    | High           | 12                          |
| Factor 2 (inspirational motivation) | 7.9961     | 1.86668    | Moderate       | 12                          |
| Factor 3 (intellectual stimulation) | 7.7375     | 1.97675    | Moderate       | 12                          |
| Factor 4 (individual consideration) | 8.5753     | 1.66506    | Moderate       | 12                          |
| Factor 5 (contingent reward) | 8.0270     | 1.78800    | Moderate       | 12                          |
| Factor 6 (management by exception) | 8.6371     | 1.69116    | Moderate       | 12                          |
| Factor 7 (laissez-faire leadership) | 7.7336     | 1.68511    | Moderate       | 12                          |

Score range: high = 9–12, moderate = 5–8, low = 0–4.
**Table 3. Differences between sociodemographics, organizational commitment, and leadership styles**

| Indicator                                      | Group            | Mean ± SD | Sig. |
|------------------------------------------------|------------------|-----------|------|
| **Age group**                                  |                  |           |      |
| Organizational commitment                      | <25 years old    | 4.72±0.634| 0.297|
|                                               | 26–28 years old  | 4.62±0.506|      |
|                                               | 29–31 years old  | 4.57±0.753|      |
|                                               | >32 years old    | 4.61±0.753|      |
| Factor 1 (idealized influence)                 | <25 years old    | 10.42±0.975| 0.061|
|                                               | 26–28 years old  | 9.41±1.96 |      |
|                                               | 29–31 years old  | 9.41±1.97 |      |
|                                               | >32 years old    | 8.87±1.82 |      |
| Factor 2 (inspirational motivation)            | <25 years old    | 8.42±2.29 |      |
|                                               | 26–28 years old  | 8.00±1.93 | 0.063|
|                                               | 29–31 years old  | 7.88±1.87 |      |
|                                               | Above 32 years old| 8.42±2.29 |      |
| Factor 3 (intellectual stimulation)            | <25 years old    | 10.0±1.52 |      |
|                                               | 26–28 years old  | 7.79±2.49 |      |
|                                               | 29–31 years old  | 7.39±1.66 | 0.068|
|                                               | >32 years old    | 7.80±1.92 |      |
| Factor 4 (individual consideration)            | <25 years old    | 10.28±1.25|      |
|                                               | 26–28 years old  | 9.66±1.40 | 0.008|
|                                               | 29–31 years old  | 8.24±1.58 |      |
|                                               | >32 years old    | 8.36±1.62 |      |
| Factor 5 (contingent reward)                   | <25 years old    | 10.28±1.25|      |
|                                               | 26–28 years old  | 8.58±2.02 | 0.001|
|                                               | 29–31 years old  | 7.70±1.92 |      |
|                                               | >32 years old    | 7.93±1.53 |      |
| Factor 6 (management by exception)             | <25 years old    | 10.14±0.690| 0.095|
|                                               | 26–28 years old  | 8.79±1.74 |      |
|                                               | 29–31 years old  | 8.56±1.86 |      |
|                                               | >32 years old    | 8.55±1.57 |      |
| Factor 7 (laissez-faire leadership)            | <25 years old    | 9.71±0.487|      |
|                                               | 26–28 years old  | 7.84±2.27 | 0.001|
|                                               | 29–31 years old  | 8.10±1.46 |      |
|                                               | >32 years old    | 7.38±1.53 |      |
| **Years of experience**                        |                  |           |      |
| Organizational commitment                      | 1–5 years        | 4.74±0.672| 0.009|
|                                               | 6–10 years       | 4.67±0.706|      |
|                                               | Above 11 years   | 4.38±0.773|      |
| Factor 1 (idealized influence)                 | 1–5 years        | 9.40±1.56 |      |
|                                               | 6–10 years       | 9.21±2.07 | 0.067|
|                                               | Above 11 years   | 8.67±1.97 |      |
| Factor 2 (inspirational motivation)            | 1–5 years        | 8.14±1.74 |      |
|                                               | 6–10 years       | 8.00±2.09 | 0.475|
|                                               | Above 11 years   | 7.75±1.58 |      |
| Factor 3 (intellectual stimulation)            | 1–5 years        | 7.72±2.14 |      |
|                                               | 6–10 years       | 7.73±1.87 | 0.996|
|                                               | Above 11 years   | 7.75±1.91 |      |
| Factor 4 (individual consideration)            | 1–5 years        | 9.17±1.56 |      |
|                                               | 6–10 years       | 8.20±1.55 | 0.091|
|                                               | Above 11 years   | 8.32±1.77 |      |
| Factor 5 (contingent reward)                   | 1–5 years        | 8.43±1.80 |      |
|                                               | 6–10 years       | 7.44±1.61 | 0.001|
|                                               | Above 11 years   | 8.46±1.79 |      |
| Factor 6 (management by exception)             | 1–5 years        | 9.45±1.39 |      |
|                                               | 6–10 years       | 8.09±1.88 | 0.95 |
|                                               | Above 11 years   | 8.36±1.18 |      |
| Factor 7 (laissez-faire leadership)            | 1–5 years        | 8.17±1.68 |      |
|                                               | 6–10 years       | 7.18±1.56 | 0.001|
|                                               | Above 11 years   | 8.06±1.63 |      |
individual consideration (8.57). The intellectual simulation (7.73) and laissez-faire leadership styles (7.73) were employed the least (Table 2).

Table 3 displays the differences between the sociodemographic variables, organizational commitment, and leadership styles. No significant difference was found with age to organizational commitment ($F = 1.23; p > 0.297$). There was also no significant difference with age to idealized influence ($F = 2.79; p > 0.061$), inspirational motivation ($F = 8.03; p > 0.183$), intellectual stimulation ($F = 4.01; p > 0.068$), or management by exception ($F = 2.14; p > 0.095$). However, there was statistically significant difference in the “individual consideration” between the age groups. The mean and the SD are 10.28 ± 1.25, 9.66 ± 1.4, 8.24 ± 1.58, and 8.36 ± 1.62 for groups less than 25 years, 26–28 years, 29–31 years, and 32 years or more, respectively ($p$ value = 0.008). Also, there was a significant difference in the contingent reward with the mean and SD of 10.28 ± 1.25, 8.58 ± 2.02, 7.70 ± 1.92, and 7.93 ± 1.53 for groups less than 25 years, 26–28 years, 29–31 years, and 32 years or more, respectively ($p$ value <0.001). Moreover, a significant difference was found in the “laissez-faire leadership” with a mean and SD of 9.71 ± 0.487, 7.84 ± 2.27, 8.10 ± 1.46, and 7.38 ± 1.53 for groups less than 25 years, 26–28 years, 29–31 years, and 32 years or more, respectively ($p$ value <0.001).

A significant difference was found with years of experience and organizational commitment. The mean and

| Indicator                                | Group                | Mean ± SD         | $p$ (2-tailed) |
|-------------------------------------------|----------------------|-------------------|----------------|
| **Nationality**                           |                      |                   |                |
| Organizational commitment                 | Saudi                | 4.36±1.07         | 0.033          |
|                                           | Non-Saudi            | 4.66±0.665        |                |
| Factor 1 (idealized influence)            | Saudi                | 8.38±1.98         | 0.028          |
|                                           | Non-Saudi            | 9.24±1.87         |                |
| Factor 2 (inspirational motivation)       | Saudi                | 6.15±1.75         | 0.001          |
|                                           | Non-Saudi            | 8.20±1.76         |                |
| Factor 3 (intellectual stimulation)       | Saudi                | 6.76±1.98         | 0.098          |
|                                           | Non-Saudi            | 7.84±1.95         |                |
| Factor 4 (individual consideration)       | Saudi                | 8.50±2.37         | 0.808          |
|                                           | Non-Saudi            | 8.58±1.57         |                |
| Factor 5 (contingent reward)              | Saudi                | 7.76±1.75         | 0.439          |
|                                           | Non-Saudi            | 8.05±1.79         |                |
| Factor 6 (management by exception)        | Saudi                | 8.84±1.84         | 0.507          |
|                                           | Non-Saudi            | 8.61±1.67         |                |
| Factor 7 (laissez-faire leadership)       | Saudi                | 7.23±1.60         | 0.109          |
|                                           | Non-Saudi            | 7.78±1.68         |                |
| **Ward assignment**                       |                      |                   |                |
| Organizational commitment                 | COVID ward           | 4.96±0.605        | 0.166          |
|                                           | Non-COVID/clean ward | 4.62±0.722        |                |
| Factor 1 (idealized influence)            | COVID ward           | 10.0±0.866        | 0.176          |
|                                           | Non-COVID/clean ward | 9.12±1.91         |                |
| Factor 2 (inspirational motivation)       | COVID ward           | 7.33±1.87         | 0.279          |
|                                           | Non-COVID/clean ward | 8.02±1.86         |                |
| Factor 3 (intellectual stimulation)       | COVID ward           | 7.44±1.23         | 0.652          |
|                                           | Non-COVID/clean ward | 7.74±1.99         |                |
| Factor 4 (individual consideration)       | COVID ward           | 7.44±1.74         | 0.038          |
|                                           | Non-COVID/clean ward | 8.61±1.65         |                |
| Factor 5 (contingent reward)              | COVID ward           | 8.55±1.42         | 0.368          |
|                                           | Non-COVID/clean ward | 8.00±1.79         |                |
| Factor 6 (management by exception)        | COVID ward           | 9.00±1.00         | 0.513          |
|                                           | Non-COVID/clean ward | 8.62±1.71         |                |
| Factor 7 (laissez-faire leadership)       | COVID ward           | 9.00±1.11         | 0.021          |
|                                           | Non-COVID/clean ward | 7.68±1.68         |                |
Leadership Styles of Nurse Managers

the SD are 4.74 ± 0.672, 4.67 ± 0.706, and 4.38 ± 0.773 for groups 1–5 years, 6–10 years, and 11 years and above, respectively (p value = 0.009). Meanwhile, no significant differences were found with idealized influence (F = 2.73; p > 0.067), inspirational motivation (F = 0.746; p > 0.475), intellectual stimulation (F = 4.01; p > 0.068), individual consideration (F = 10.9; p > 0.081), or management by exception (F = 2.14; p > 0.95). Conversely, years of experience was found significantly different with the contingent reward having a mean and SD of 8.43 ± 1.80, 7.44 ± 1.61, and 8.46 ± 1.79 for groups 1–5 years, 6–10 years, and 11 years and above, respectively (p value < 0.001). Also, there was a significant difference with laissez-faire leadership with the mean and SD of 8.17 ± 1.68, 8.17 ± 1.68, 7.18 ± 1.56, and 8.06 ± 1.63 for groups 1–5 years, 6–10 years, and 11 years and above, respectively (p value < 0.001).

There was a statistically significant difference in the “organizational commitment” between the nationality groups. The mean and the SD are 4.36 ± 1.07 for Saudi compared with 4.66 ± 0.664 for non-Saudi (p value = 0.033). Further, there was a significant difference in the idealized influence having a mean and SD of 8.38 ± 1.98 for Saudi compared with 9.24 ± 1.87 for non-Saudi (p value = 0.028). Also, there was a significant difference in the inspirational motivation with a mean and SD of 6.15 ± 1.75 for Saudi compared with 8.20 ± 1.76 for non-Saudi (p value < 0.001). Conversely, with nationality, no significant difference was found with intellectual stimulation (t = −2.664; p > 0.998), individual consideration (t = −0.243; p > 0.808), contingent reward (t = −0.775; p > 0.439), management by exception (t = 0.664; p > 0.507), or laissez-faire leadership (t = −1.609; p > 0.109).

No significant difference was found with the ward assignment of the nurses or their organizational commitment (t = 1.39; p > 0.166). Meanwhile, the ward assignment found no significant difference on idealized influence (t = 1.35; p > 0.176), inspirational motivation (t = −1.085; p > 0.279), intellectual stimulation (t = −0.452; p > 0.652), contingent reward (t = 0.902; p > 0.368), or management by exception (t = 0.655; p > 0.513). In contrast, there was a statistically significant difference in the “individual consideration” between the COVID ward nurses 7.44 ± 1.74 compared with non-COVID ward nurses 8.61 ± 1.64 (p value = 0.038). Lastly, there was a significant difference in the laissez-faire leadership with a mean and SD of 9.00 ± 1.11 for COVID ward nurses compared with non-COVID ward nurses 7.68 ± 1.68 (p value = 0.021).

Table 4 shows the relationship between the organizational commitment and leadership styles. No significant relationship was found between the organizational commitment and idealized influence (r = 0.71; p > 0.256), inspirational motivation (r = 0.085; p > 0.172), intellectual stimulation (r = 0.58; p > 0.356), individual consideration (r = 0.069; p > 0.268), contingent reward (r = 0.051; p > 0.410), management by exception (r = 0.076; p > 0.225), or laissez-faire leadership (r = 0.18; p > 0.778) styles.

**Discussion/Conclusion**

The nursing workforce current organizational commitment may be due to the surge of COVID-19. This implies that, in the face of pandemic diseases such as COVID-19, nurses found themselves in a state of unrelenting work that they could not abandon, ensuing in their bravery and selflessness. This finding corroborates a study in Israel [18] that indicated that nurses’ perceptions of their organization’s commitment were revealed as the most important element in their own professional commitment. Despite the fact that delivering care at this time is incredibly stressful and includes personal risk, nurses do not regret choosing nursing as a profession [19]. Such findings demonstrate that most nurses do not believe that they have the authority to refuse to treat specific patients. Indeed, they appear to be highly driven and influenced primarily by their commitment to treat patients, as well as, perhaps more interestingly, by their obligation to assist the society of the Kingdom. The nurses’ perceived that their nurse managers employed idealized influence and management by exception, which, according to the nurses, implies that the nurse managers are able to apply both transformational and transactional leadership styles. This present finding indicates that an increase in additional effort, contentment, and perceived leader effectiveness among nurses was attributed to a combination of

### Table 4. Relationship between organizational commitment and leadership styles

| Variables                        | r   | Sig.  |
|----------------------------------|-----|-------|
|                                  |     | (2-tailed) |
| Organizational commitment        |     |       |
| Factor 1 (idealized influence)   | 0.071 | 0.256 |
| Factor 2 (inspirational motivation) | 0.085 | 0.172 |
| Factor 3 (intellectual stimulation) | 0.058 | 0.356 |
| Factor 4 (individual consideration) | 0.069 | 0.268 |
| Factor 5 (contingent reward)     | 0.051 | 0.410 |
| Factor 6 (management by exception)| 0.076 | 0.225 |
| Factor 7 (laissez-faire leadership) | 0.018 | 0.778 |
transformational and transactional leadership styles. As reported by studies [20–22], transformational leadership approaches increase employee happiness, effectiveness, and additional effort. As a result, the more the transformational and transactional their leaders were regarded to be, the more driven the nurses were [23], and higher commitment was obtained from them through enabling tactics and evocative contributions of their ideas [24].

The age of the nurses was found not significant to organizational commitment, which means that, regardless of age, there was no adjustment in the organizational commitment. In the study by Ghiyasvandian et al. [25], nurses of various generations demonstrated similar degrees of organizational commitment. There were no significant variations in age to idealized influence, motivation, intellectual stimulation, or management by exception, which implies that, regardless of the nurses’ age, it makes no difference whether the nurses’ managers use a transformational leadership style. These findings support the study of Hito and colleagues [26], which determined that age had no impact on the leadership style. Conversely, age differs significantly with individualized consideration, contingent reward, and laissez-faire leadership. This demonstrates that, as nurses age, their attitudes regarding laissez-faire and transactional leadership styles change. Without a doubt, all of the transactional subscales followed a similar trend, with the youngest participants receiving the lowest scores and the oldest receiving the highest [12]. The significant findings with age to individualized consideration, contingent reward, and laissez-faire recommend that, in stressful settings where nurses are at high risk of infection, the managers’ level of support appears to be critical in keeping the nurses engaged. Trust and respect appear to be essential for providing the best possible care to COVID-19 patients, and transformational leadership creates mutual understanding between nurses and their managers. Such findings recommend that nurse managers can play a critical role in bringing the team together to solve the obstacles.

Meanwhile, a significant difference was found with the years of experience and organizational commitment. This implies that the nurses’ tenure was associated with organizational commitment. Accordingly, nurses with more work experience felt that their healthcare organization appreciated their job decisions more than did the nurses with less work experience [19]. As a result, more experienced nurses are more committed to their institution. In fact, one study found employees with more years of experience (6–15 years) have a high level of affective commitment [20].

This finding indicates that nurses’ organizational commitment is influenced by the fact that they have received COVID-19 training, have equivalent prior experience, or have worked in units with pandemic-related policy requirements. No significant differences were found regarding the years of experience to inspirational motivation, idealized influence, intellectual stimulation, individual consideration, or management by exception. This indicates that, regardless of the nurses’ tenure, it makes no difference whether their managers use transformational or transactional leadership styles. This finding corroborates a study by Vesterinen et al. [27], which showed that, while nurse managers had just joined the organization, they were more familiar with the organization’s strategy and vision, and may have even contributed to its advancement. However, the years of experience was found to be significantly different with the contingent reward and laissez-faire leadership, and this means that tenure is linked with laissez-faire leadership. The prior finding maintained that age predicts experience; hence, the younger nurses are more likely to be less experienced [12]. These findings demonstrate that nurses’ organizational commitment is influenced by their previous work experience caring for patients with infectious illnesses. Nurses’ self-protection and coping methods to deal with psychological discomfort may improve with tenure [28]. Such a finding recommends that managers be offered continuous professional development considering COVID-19 training plans to increase their expertise.

The nationality of a nurse has some influence on organizational commitment [29]. This could be due to cultural differences, where Saudi nurses may perceive the lifestyle and work environment in Saudi Arabia to be similar to their home countries, resulting in a high level of commitment. This has been affirmed that culture significantly affects employee’s commitment, which increases the productivity level [30]. Such a context explains the significant difference between nationality and organizational commitment in this current study. Further, idealized influence and inspirational motivation were found to have significant differences with nationality, which implies that the nationality of the respondents is allied to the application of transformational leadership by the nurses’ managers. Conversely, nationality was found to have no significant difference with intellectual stimulation, individual consideration, contingent reward, management by exception, or laissez-faire leadership, which implies that, irrespective of their nationality, it makes no difference whether the nurses’ managers utilize transformational, transactional, or laissez-faire leadership styles. These
findings corroborate those of the study of Al-Yami et al. [12]; demographic variables such as nationality explain 28% of the diversity in organizational commitment, with nurse managers adopting transformational, transactional, and laissez-faire leadership styles. Therefore, it can be recommended that nursing managers in Saudi Arabia should help with cultural issues such as religion’s supportive role in Saudi society.

No significant difference was found between the ward assignment of the nurses and their organizational commitment, which means that, regardless of the ward assignment whether nurses are in the COVID ward or non-clean ward, there is no change in their organizational commitment. Being committed to the organization, whether assigned in a COVID or non-COVID ward, can be attributed to the fact that the nurse workforce is cognizant of clinical management and public safety, both of which necessitate robust nursing staff engagement. The study by Saleh et al. [31] corroborates the present finding, which established that the nurses in different wards had the same level of organizational commitment. This finding recommends that, in the event of a pandemic, health organizations must continue to do what they are practicing, including providing dedicated pandemic training and proactive emotional support for nurses. Meanwhile, no significant difference was found regarding the ward assignment on idealized influence, inspirational motivation, intellectual stimulation, contingent reward, or management by exception. This means that, irrespective of their ward assignment, it makes no difference whether the nurses’ managers utilized transformational or transactional leadership styles. This supports the study of Ahmad and Oranye [32], which indicated that the leadership style of nurse managers has little bearing on the nurses’ ward assignment. However, the ward assignment of nurses was found to have a significant difference with individual consideration and laissez-faire leadership, which means that ward assignment is related to laissez-faire leadership. Research by Wang et al. [33] revealed that a nurse’s leadership style may be influenced by the nature of their work environment. Such a finding recommends that, during the COVID-19 pandemic, nurse managers exercise control in numerous ways that are dependent on the need of care provided in the wards. Nurse managers must empower and assist nurses so that they can make their own decisions, which will have a positive impact on their perceptions of leadership.

With organizational commitment, no significant relationship was found with idealized influence, inspirational motivation, intellectual stimulation, individual consideration, contingent reward management by exception, or laissez-faire leadership. These findings imply that, regardless of the leadership style of their nurse managers, nurses’ organizational commitment does not change. According to several studies [3, 16, 33], nurses claimed that their managers displayed different styles of leadership (such as transformational, transactional, or laissez-faire) while remaining committed to their institution. In this current study, nurse managers also exhibited contingent reward behaviors in which they communicated clearly defined roles and rewarded nurses when such tasks were completed. As a result, managers focused more on greater motivation growth and improved followers’ motivation and positive emotions by providing compelling future visions [33]. These findings recommend that nurse managers must grasp the position of dominance, task structure and competence, and leader member relationship to adopt a strong leadership style in an organization. Since the outcome of institutions is frequently connected to it, having effective leadership is critical to organizational commitment. During the COVID-19 pandemic, various approaches were required for different situations, and each nurse manager needs to know when to use which one.

This study had limitations that are worth further interrogation. One was in the noninclusion of the nurses who cannot speak and understand English. This can be addressed with the translation of the questionnaire to the Arabic language. Moreover, the use of a self-administered questionnaire is a risk for biases. This can be addressed by employing a mixed methods approach. In addition, there were only nine participants from COVID-19 ward and this affects the result and conclusion. Thus, one must be cautious in interpreting the result and conclusion.

**Conclusion**

During the surge of the pandemic, nurse managers employed idealized influence leadership styles. The age, years of experience, and ward assignment were found to be no significant difference to organizational commitment, but they did have a significant difference with nationality. Age differs significantly with individualized consideration, contingent reward, and laissez-faire leadership. Years of experience was found significantly different with the contingent reward and laissez-faire leadership. Concerning nationality, no significant difference was found to idealized influence and inspirational motivation. The ward assignment found a significant difference with individual consideration and laissez-faire leadership.
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Statement of Ethics

The author followed the guidelines accorded by World Medical Association Declaration of Helsinki. The researcher assured that the participants understood their rights before participating in the study. This study protocol was reviewed and approved by Institutional Review Board of the University of Hail, approval number [H-2021-001] dated September 5, 2021. The participants had given their written informed consent before their participation.

Conflict of Interest Statement

The authors have no conflicts of interest to declare.

References

1. Asiri SA, Rohrer WW, Al-Surimi K, Da’ar OO, Ahmed A. The association of leadership styles and empowerment with nurses’ organizational commitment in an acute health care setting: a cross-sectional study. BMC Nurs. 2016;15(38).
2. Galedar N, Toulabi T, Kamran A, Heydari H. Exploring nurses’ perception of taking care of patients with coronavirus disease (COVID-19): a qualitative study. Nursing Open. 2020;8(1):171–79.
3. Jin GAM, Yuh AS, Roy DP. Leadership style of nurse managers as perceived by registered nurses: a cross-sectional survey (short communication). Proc Singapore Healthc. 2018; 27(3):205–10.
4. Van De Voorde K, Paauwe J, Van Veldhoven M. Employee well-being and the HRM–organization relationship: A review of quantitative studies. Int J Manag Rev. 2012;14(4):391–407.
5. Marquis BL, Huston CJ. Leadership roles and management functions in nursing: Theory and application. 9th ed. Philadelphia: Lippincott Williams & Wilkins; 2017.
6. Nguni S, Sleegers P, Denessen E. Transformational and transactional leadership effects on teachers’ job satisfaction, organizational commitment, and organizational citizenship behavior in primary schools: the Tanzanian case. Sch Eff Sch Improv. 2006;17(2):145–77.
7. Lavoie-Tremblay M, Fernet C, Lavigne GL, Austin S. Transformational and abusive leadership practices: impacts on novice nurses, quality of care and intention to leave. J Adv Nurs. 2016;72(3):582–92.
8. Dirani KM, Abadi M, Alizadeh A, Barhate B, Garza RC, Gunasekara N, et al. Leadership competencies and the essential role of human resource development in times of crisis: a response to Covid-19 pandemic. Human Res Dev Int. 2020;23(4):380–94.
9. Kelloway EK, Turner N, Barling J, Loughlin C. Transformational leadership and employee psychological well-being: The mediating role of employee trust in leadership. Work Stress. 2012;26(1):39–55.
10. Franke F, Felle J, Pundt A. The impact of health-oriented leadership on follower health: development and test of a new instrument measuring health-promoting leadership. GHRM. 2014;28(1–2):139–61.
11. Robbins SP. Organizational behavior. 10th ed. New Jersey: Pearson Education; 2006.
12. Al-Yami M, Galdas P, Watson R. Leadership style and organisational commitment among nursing staff in Saudi Arabia. J Nurs Manag. 2018;26(5):531–9.
13. May-Chiun L, Ramayah T, Hii WM. Leadership style and organizational commitment: a test on Malaysia manufacturing industry. Afr J Mark Manag. 2009;1(6):133–9.
14. Alkreedy B. Leadership styles and their impact on organizational commitment: a field study in the faculty of management and economics at Qadisiyah University. Qadisiyah J Admin Econ Sci. 2010;12(3):22–43.
15. Talu S, Nazarov AD. Challenges and competencies of leadership in Covid-19 pandemic. Adv Soc Sci Educ Hum Anat Res. 2020;486:518–24.
16. Bass B, Avolio B. Multifactor leadership questionnaire: Short form 6S. NY, USA: Center for Leadership Studies: Binghamton; 1992.
17. Mowday RT, Steers RM, Porter LW. The measurement of organizational commitment. J Vocat Behav. 1979;14(2):224–47.
18. Goldfarb N, Grinstein-Cohen O, Shamian J, Schwartz D, Zilber R, Hazan-Hazorof R, et al. Nurses’ perceptions of the role of health organisations in building professional commitment: insights from an Israeli cross-sectional study during the COVID-19 pandemic. J Nurs Manag. 2021;29(5):1102–10.
19. Sperling D. Ethical dilemmas, perceived risk, and motivation among nurses during the COVID-19 pandemic. Nurs Ethics. 2021;28(1):9–22.
20. Sujatha S, Swathi M, Seema A. Impact of term experience on organizational commitment of employees. Int J Comput Sci Manag Stud. 2012;12:2231–5268.
21. Ali HM, Abood SA, Thabet M. Relation between leadership styles and behaviors of nurse managers’ and organizational commitment of staff nurses. Minia Scientific Nurs J. 2020; 7(1):54–62.
22. Ahmed AK, Ata AA, Abd-Elhamid ZN. Relationship between the leadership behaviors, organizational climate, and innovative work behavior among nurses. Am J Nurs. 2019; 7(5):870–8.
23. Sabbah IM, Ibrahim TT, Khamis RH, Bakhour HAM, Sabbah SM, Droubi NS, et al. The association of leadership styles and nurses well-being: A cross-sectional study in health-care settings. Pan Afr Med J. 2020;36:328.
24. Musinguzi C, Namale L, Rutebemberwa E, Dahal A, Nahiriya-Ngue P, Kekitiinwa A. The relationship between leadership style and health worker motivation, job satisfaction and teamwork in Uganda. J Healthc Leadership. 2018;10:21–32.

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Author Contributions

This is a sole authorship of the researcher.

Data Availability Statement

The data that support the findings of this study are available from the corresponding author (M.A.) upon reasonable request.

Author’s Note

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25 Ghiyasvandian S, Sedighiyani A, Kazemnejad A, Iranshahi I. Relationship between organizational communication satisfaction and organizational commitment in nurses. *Iranian J Med Ethics Hist Med*. 2017;9(6):20–33.

26 Jodar I Solà G, Gené I Badia J, Hito PD, Osaba MAC, Del Val Garcia JL. Self-perception of leadership styles and behaviour in primary health care. *BMC Health Serv Res*. 2016;16(1):572.

27 Vesterinen S, Suhonen M, Isola A, Paasivaara L, Laukkala H. Nurse managers’ perceptions related to their leadership styles, knowledge, and skills in these areas: a viewpoint: case of health centre wards in Finland. *Int Sch Res Notices*. 2013;2013(5):951456.

28 Fernandez R, Lord H, Halcomb E, Moxham L, Middleton R, Alananzeh I, et al. Implications for COVID-19: a systematic review of nurses’ experiences of working in acute care hospital settings during a respiratory pandemic. *Int J Nurs Stud*. 2020;111:103637.

29 Al-Haroon HI, Al-Qahtani MF. Assessment of organizational commitment among nurses in a major public hospital in Saudi Arabia. *J Multidiscip Healthc*. 2020;13:519–26.

30 Yuniawan A, Djastuti I, Hidayati R, Udin U. Investigating the effect of national culture and affective commitment on employee performance: An empirical study in Indonesian banking sector. *Revista Espacios*. 2020;41:6.

31 Saleh AM, Darawad MW, Al-Hussami M. Organizational commitment and work satisfaction among Jordanian nurses: a comparative study. *Life Sci*. 2014;11(2):31–6.

32 Ahmad N, Oranye NO. Empowerment, job satisfaction and organizational commitment: A comparative analysis of nurses working in Malaysia and England. *J Nurs Manag*. 2010;18(5):582–91.

33 Wang G, Oh IS, Courtright SH, Colbert AE. Transformational leadership and performance across criteria and levels: a meta-analytic review of 25 years of research. *Group Organ Manag*. 2011;36(2):223–70.