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The Effect of Participative Leadership on Organizational Citizenship Behavior: An Applied Study at Al-Sadr Teaching Hospital, Maysan Health Directorate

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Abstract: Organizational citizenship behavior (OCB) has become increasingly important in healthcare organizations because of its contribution to service quality, employee collaboration, and organizational effectiveness. Despite extensive research linking leadership styles to OCB, empirical evidence regarding the influence of participative leadership remains inconsistent across organizational contexts, while evidence from Iraqi public healthcare institutions remains particularly limited. Addressing this gap, this study investigates the impact of participative leadership on organizational citizenship behavior among employees at Al-Sadr Teaching Hospital, one of the hospitals affiliated with the Maysan Health Directorate. Grounded in Somech's multidimensional model of participative leadership and Organ's organizational citizenship behavior framework, the study adopts a descriptive-analytical design. Data were collected through a structured questionnaire administered to a stratified random sample of 274 hospital employees and analyzed using correlation and multiple regression techniques. The findings revealed that participative leadership exerts a statistically significant positive effect on organizational citizenship behavior. Collectively, the five dimensions of participative leadership accounted for a substantial proportion of the variance in organizational citizenship behavior. Among these dimensions, the degree of participation emerged as the strongest predictor, followed by the objective of participation, decision domain, and rationale, whereas the structure dimension exhibited the weakest unique contribution after controlling for the remaining dimensions. The study concludes that strengthening employees' genuine involvement in organizational decision-making represents an effective managerial strategy for promoting organizational citizenship behavior in public healthcare organizations. The findings extend the empirical applicability of Somech's multidimensional participative leadership model within an under-researched Iraqi healthcare context and provide practical implications for enhancing employee engagement and organizational effectiveness.

Keywords: Participative Leadership; Organizational Citizenship Behavior; Healthcare Leadership; Public Hospitals; Iraq

1. Introduction

Healthcare organizations operate within highly complex and dynamic environments characterized by continuous operational change, mounting workforce pressures, and increasing demands for high-quality patient care. These conditions require leadership approaches capable of sustaining organizational performance while promoting effective

collaboration among healthcare professionals [1]. Within this context, organizational citizenship behavior (OCB) has emerged as a critical behavioral resource that enables healthcare organizations to function beyond the limitations of formal job requirements. Rather than reflecting simple compliance with prescribed duties, OCB encompasses discretionary behaviors through which employees voluntarily assist colleagues, respond constructively to organizational challenges, and actively contribute to organizational effectiveness, ultimately enhancing both service quality and patient safety [2], [3], [4]. Recent evidence further indicates that the development of OCB among healthcare professionals is shaped by a wide range of organizational and individual factors, making it an important managerial priority for healthcare institutions seeking to improve employee engagement and organizational performance [5].

Among the organizational factors associated with OCB, leadership style has consistently received considerable scholarly attention. Unlike directive leadership, where decision-making authority remains concentrated in the hands of supervisors, participative leadership emphasizes the distribution of influence by involving employees in organizational decision-making processes. From the perspective of Social Exchange Theory, such involvement signals trust, respect, and organizational support, encouraging employees to reciprocate through voluntary behaviors that benefit both colleagues and the organization [6], [7]. The relevance of participative leadership is particularly pronounced within healthcare settings, where multidisciplinary collaboration, rapid coordination, and continuous interaction among physicians, nurses, and administrative personnel are essential for delivering effective healthcare services [8].

The Iraqi public healthcare sector provides a particularly important context for examining this relationship. Persistent shortages of financial resources and specialized healthcare professionals, together with the long-term effects of professional migration and institutional constraints, have intensified the need for management practices capable of maximizing the contribution of existing employees [9]. Under such circumstances, participative leadership represents more than a desirable managerial approach; it constitutes a strategic mechanism for encouraging employees to extend their efforts beyond formal role requirements despite severe organizational constraints.

Despite extensive international research examining the relationship between participative leadership and organizational citizenship behavior, existing evidence remains inconclusive. While numerous studies have reported positive associations across educational, hospitality, and service organizations [10], [11], other investigations have demonstrated that both the magnitude and direction of this relationship vary according to contextual conditions, including organizational complexity and employees' psychological characteristics [8]. These inconsistent findings suggest that the relationship cannot be assumed to operate uniformly across organizational environments.

This inconsistency becomes particularly important when considering Iraqi public hospitals, whose institutional structures, administrative practices, and cultural characteristics differ substantially from those in which most previous evidence has been generated. Moreover, although Somech's [12] multidimensional model of participative leadership and Organ's [2] multidimensional model of organizational citizenship behavior have each received extensive empirical support independently, their theoretical integration has rarely been examined within Arab healthcare settings and, to the best of the researcher's knowledge, has not previously been investigated in Iraqi public hospitals. Consequently, the central research problem is not whether participative leadership influences organizational citizenship behavior per se, but whether this relationship retains its explanatory power within the distinctive organizational environment of Iraqi public healthcare institutions.

Accordingly, this study investigates the extent to which the five dimensions of participative leadership decision domain, degree of participation, structure, rationale, and participation target contribute to explaining variations in organizational citizenship behavior among employees at Al-Sadr Teaching Hospital. By integrating Somech's multidimensional framework of participative leadership with Organ's multidimensional model of organizational citizenship behavior, the study seeks to provide empirical evidence from a context that remains largely underrepresented in the international literature while offering practical implications for strengthening employee engagement and organizational effectiveness within public healthcare organizations.

Research Hypotheses

Main Hypothesis: Participative leadership has a statistically significant effect on organizational citizenship behavior among employees at Al-Sadr Teaching Hospital.

Sub-Hypotheses:

1. The decision domain has a statistically significant effect on organizational citizenship behavior.
2. The degree of participation has a statistically significant effect on organizational citizenship behavior.
3. The structure dimension has a statistically significant effect on organizational citizenship behavior.
4. The rationale dimension has a statistically significant effect on organizational citizenship behavior.
5. The objective of participation has a statistically significant effect on organizational citizenship behavior.

Theoretical Framework

Participative Leadership

Participative leadership has been conceptualized from multiple theoretical perspectives, reflecting different assumptions regarding the distribution of authority and influence within organizations. Vroom and Yetton [13] approached the concept from a normative decision-making perspective, emphasizing the conditions under which leaders should involve subordinates in organizational decisions. Locke and Schweiger [14] focused instead on the consequences of employee participation for individual autonomy and control, whereas Pearce and Conger [15] broadened the discussion through the concept of shared leadership, conceptualizing leadership as a dynamic process of reciprocal influence among team members rather than a purely hierarchical relationship between leaders and followers. These different perspectives explain why participative leadership has been alternatively viewed as either a leader-driven behavioral practice or an emergent collective property of work teams.

Among the available conceptualizations, Somech's [12] multidimensional framework provides one of the most comprehensive explanations of participative leadership within formal organizations. Challenging the traditional treatment of participative leadership as a unidimensional construct, Somech argued that inconsistent empirical findings largely resulted from conceptual oversimplification. Accordingly, participative leadership was reconceptualized as a multidimensional construct comprising five interrelated dimensions: decision domain, degree of participation, structure, rationale, and objective of participation [16]. This framework recognizes that employee participation differs according to the type of decision involved, the extent of influence granted to employees, the formal mechanisms through which participation occurs, the underlying managerial rationale, and the criteria governing employee involvement.

Although alternative theoretical models remain influential, their suitability for the present study is comparatively limited. The Vroom Yetton model primarily functions as a normative decision-support framework designed to guide managers in selecting appropriate decision-making styles across specific situations rather than measuring participative leadership as a multidimensional organizational construct. Likewise, Pearce and Conger's shared leadership model focuses on horizontal influence processes within self-managing teams and therefore differs conceptually from the traditional vertical leader–subordinate relationships that characterize public healthcare organizations. Consequently, Somech's multidimensional framework offers a more appropriate theoretical foundation for investigating participative leadership within hierarchical hospital settings.

Somech [7] further defined participative leadership as a process of shared decision-making and mutual influence between supervisors and subordinates rather than unilateral managerial control. Importantly, participative and directive leadership should not be viewed as mutually exclusive approaches. Instead, effective leaders may combine both styles according to the characteristics of the decision context, employing directive leadership during highly critical situations while encouraging employee participation in routine administrative decisions. Subsequent research [17] extended this perspective by demonstrating that participative decision-making influences not only employees' observable behaviors but also their underlying work attitudes and psychological attachment to the organization.

Recent evidence from healthcare organizations further supports this contingency

perspective. Leadership effectiveness varies according to the urgency, complexity, and uncertainty of the decision environment. Highly time-sensitive situations, such as emergency medical crises, often require greater directive coordination to ensure rapid decision implementation and patient safety, whereas routine organizational activities provide broader opportunities for employee participation and consultation [18]. Longitudinal evidence from the COVID-19 pandemic likewise indicates that directive leadership tends to increase substantially during the initial stages of organizational crises before gradually declining as organizations adapt to a more stable operational environment. Participative leadership, however, remains relevant throughout prolonged crises because leaders continue to involve employees in decisions requiring collaboration, organizational learning, and mutual support [19]. Similarly, Usman et al. [20] demonstrated that employee participation in decision-making continued to promote discretionary helping behaviors among healthcare professionals even during the sustained pressures associated with the pandemic. Collectively, these findings suggest that the effectiveness of participative leadership is contingent upon the characteristics of the decision context rather than representing a universally superior leadership style.

Overall, participative leadership has evolved from a procedural decision-making technique into a multidimensional organizational construct supported by substantial theoretical and empirical evidence. Nevertheless, important questions remain regarding the contextual conditions under which its various dimensions exert the greatest influence on employee behavior, particularly within healthcare organizations characterized by hierarchical authority structures and complex decision-making processes. Accordingly, the present study adopts Somech's [12] multidimensional framework as the theoretical foundation for examining participative leadership within Iraqi public hospitals.

Dimensions of Participative Leadership According to Somech’s [12] Model

Somech’s [12] model conceptualizes participative leadership as a multidimensional construct comprising five interrelated dimensions that collectively determine the nature of participative leadership practice. Unlike earlier approaches that reduced participation to a single continuum, this model recognizes that participation varies according to the decision context, the depth of employee involvement, the structure through which participation occurs, the rationale behind leaders' participative practices, and the criteria used to determine who participates in decision-making.

The first dimension is the (decision domain), which distinguishes between technical decisions associated with employees' daily work activities and managerial decisions concerning broader organizational issues, including policies, planning, and resource allocation. Somech [12] found that leaders were generally more willing to involve employees in technical decisions than in managerial ones, largely because technical issues pose fewer challenges to formal authority. This distinction is particularly relevant in healthcare organizations, where routine clinical decisions coexist with strategic administrative decisions requiring different degrees of participation. Recent healthcare evidence similarly indicates that involving nursing staff in technical aspects of care is associated with greater professional satisfaction and stronger perceptions of effectiveness, whereas strategic managerial decisions largely remain centralized within senior management [21].

The second dimension is the (degree of participation), which reflects the extent to which employees genuinely influence the final decision. Participation may range from limited consultation, where employees merely provide opinions, to full partnership in generating alternatives and making decisions. The significance of this dimension extends beyond decision quality. Employees who perceive that their contributions meaningfully influence organizational decisions tend to report stronger procedural justice, greater organizational trust, and higher levels of commitment, thereby increasing their willingness to engage in discretionary behaviors that benefit the organization [22].

The third dimension concerns the (structure of participation), referring to whether participative practices are institutionalized through formal mechanisms, such as committees and scheduled meetings, or occur informally according to situational demands. Formal participative structures are especially important in healthcare organizations because they ensure continuity, consistency, and transparency while allowing sufficient flexibility to respond to rapidly changing clinical situations. Shared governance models widely implemented in healthcare institutions illustrate this dimension, as formal councils and

interdisciplinary committees strengthen employees' perceptions of meaningful participation in organizational decisions [21]. These findings suggest that stable participative structures represent an important organizational mechanism through which participative intentions are translated into everyday managerial practice.

The fourth dimension is the (rationale for participation), referring to the underlying reason why leaders choose to involve employees in decision-making. Participation may be motivated by pragmatic considerations, such as improving decision quality and organizational effectiveness, or by normative values emphasizing employees' intrinsic right to participate regardless of organizational outcomes. Somech [12] reported that pragmatic motives were more frequently observed among participating leaders. However, employees who perceive participation as being driven solely by instrumental objectives may respond less positively than those who perceive participation as reflecting genuine organizational values.

The fifth dimension is the)objective of participation(, which concerns the criteria leaders use when selecting employees to participate in decision-making. Leaders may prioritize either employees' technical expertise or their willingness and motivation to contribute. Somech [12] observed that leaders often favored motivated employees over technically experienced individuals. Although this approach may enhance engagement, excessive reliance on motivation may unintentionally exclude highly competent professionals whose expertise is substantial but whose communication style is less visible. Such a concern is particularly relevant within healthcare organizations, where specialized clinical expertise constitutes a critical organizational resource.

Collectively, these five dimensions create an organizational environment that encourages employees to exceed formal job requirements through discretionary behaviors benefiting both colleagues and the organization. Nevertheless, empirical evidence suggests that the effectiveness of these dimensions depends on the broader organizational context. For instance, research conducted within complex institutional settings indicates that participative leadership alone may not be sufficient to offset the negative consequences of role conflict and unfavorable working conditions, with the explanatory benefits of participation narrowing considerably as institutional complexity increases [8]. Accordingly, the present study assumes that the influence of participative leadership on organizational citizenship behavior should be interpreted within the institutional characteristics of Iraqi public hospitals rather than as a universally constant relationship.

Organizational Citizenship Behavior

The concept of Organizational Citizenship Behavior (OCB) originated from the early observations of Bateman and Organ [23], who found that job satisfaction was associated with employees' willingness to perform discretionary behaviors beyond formal job requirements. Smith, Organ, and Near [24] subsequently proposed a two-dimensional conceptualization consisting of altruism and generalized compliance. The concept reached its conceptual maturity through Organ's [2] multidimensional framework, which defined OCB as discretionary individual behavior that is neither formally prescribed nor directly rewarded, yet collectively contributes to organizational effectiveness. This conceptual evolution reflected growing recognition that extra-role behaviors differ substantially in both their orientation and underlying motivation.

The principal theoretical explanation for OCB is provided by Social Exchange Theory [6], which argues that organizational relationships are governed by reciprocal social obligations rather than strictly contractual exchanges. Employees who perceive supportive treatment from their organization or supervisors tend to reciprocate through voluntary behaviors that extend beyond formal role expectations. Building on this theoretical foundation, Podsakoff, MacKenzie, Moorman, and Fetter [25] developed a multidimensional measurement scale that empirically confirmed the distinctiveness of the five dimensions of OCB. Nevertheless, Podsakoff, MacKenzie, Paine, and Bachrach [26]cautioned that research had devoted considerably more attention to identifying antecedents and outcomes of OCB than to critically examining the construct itself. This concern continues to be reflected in contemporary literature [27].

Within healthcare organizations, distinguishing between discretionary and implicitly expected behaviors is particularly challenging. Assisting colleagues, sharing knowledge, and voluntarily covering additional responsibilities often become embedded within professional norms rather than remaining purely voluntary actions [3]. Consequently, measuring OCB in

hospital settings requires greater conceptual and methodological caution than in many other organizational contexts.

Taken together, OCB has evolved from an empirical observation associated with job satisfaction into a well-established multidimensional construct grounded in Social Exchange Theory. Nevertheless, debate continues regarding the boundaries separating truly discretionary behavior from professional norms, particularly within highly collaborative environments such as healthcare organizations.

Dimensions of Organizational Citizenship Behavior

The first dimension, (altruism), refers to voluntary behaviors through which employees assist colleagues in completing work-related tasks without expecting direct rewards. Such behaviors include helping newly appointed employees, supporting coworkers experiencing excessive workloads, and voluntarily providing professional assistance. Altruism contributes substantially to cooperation and team effectiveness and has been positively associated with patient safety culture in healthcare organizations [2], [26], [28].

The second dimension,)courtesy(, encompasses preventive behaviors intended to minimize interpersonal conflict through information sharing, mutual respect, and consideration of how individual actions may affect colleagues. Although courtesy promotes organizational harmony, evidence suggests that it may decline under conditions of excessive workload despite its positive contribution to patient safety and collaborative practice.

The third dimension,)sportsmanship(, reflects employees' willingness to tolerate unfavorable organizational conditions without unnecessary complaints while maintaining positive attitudes toward both their work and their organization. Research indicates that sportsmanship may be particularly vulnerable to deterioration in demanding healthcare environments characterized by sustained work pressure [2], [26].

The fourth dimension, (conscientiousness), refers to employees' commitment to exceeding minimum formal job requirements through punctuality, efficient use of organizational resources, adherence to organizational rules, and consistent self-discipline. Together with altruism, conscientiousness is frequently reported as one of the strongest manifestations of OCB among healthcare professionals due to the disciplined nature of clinical work [29].

The fifth dimension,)civic virtue), reflects employees' active interest in organizational affairs and their voluntary participation in meetings, committees, and improvement initiatives that contribute to organizational development [30], [2]. Compared with other dimensions, civic virtue is more explicitly directed toward the organization itself rather than toward individual colleagues. Evidence indicates that this dimension is strongly associated with work engagement, supervisory support, and patient safety culture within healthcare organizations [31], [28].

Although these five dimensions collectively represent employees' overall willingness to perform discretionary behaviors beyond formal job requirements, they do not necessarily develop to the same extent. Behaviors closely linked to daily professional responsibilities, such as altruism and conscientiousness, generally appear more frequently than broader organizational behaviors, including civic virtue, courtesy, and sportsmanship. This variation is expected to be influenced by the extent to which leaders genuinely involve employees in organizational decision-making, an issue examined empirically in the present study.

2. Materials and Methods

Research Method

This study employed a descriptive-analytical research design, as it was considered the most appropriate approach for addressing the research problem and achieving the study objectives. This design facilitates the systematic examination of participative leadership practices across their five dimensions among employees at Al-Sadr Teaching Hospital, enables the analysis of the relationships between these dimensions and the five dimensions of organizational citizenship behavior (OCB), and allows the direct effects of participative leadership on organizational citizenship behavior to be empirically tested.

Research Population and Sample

The study population comprised all employees of Al-Sadr Teaching Hospital, which operates under the Maysan Health Directorate, totaling 940 employees distributed across medical, nursing, administrative, and technical occupations. This population was considered

appropriate because its members are directly exposed to participative leadership practices and are therefore well positioned to evaluate their influence on organizational citizenship behavior within the hospital.

The study sample consisted of 274 employees, selected using proportionate stratified random sampling to ensure proportional representation of all occupational categories within the target population. The sample size was determined according to the Krejcie and Morgan [32] sample size table, which recommends an appropriate sample for a population of this size at a 95% confidence level and a 5% margin of error. Table 1 presents the demographic characteristics of the respondents according to gender, age, length of service, and educational qualification.

Table 1. Demographic Characteristics of the Study Sample

Variable	Category	Frequency	Percentage
Gender	Male	174	63.5%
	Female	100	36.5%
	Total	274	100%
Age	30 years or younger	57	20.8%
	31–40 years	93	33.9%
	41 years and above	124	45.3%
	Total	274	100%
Length of Service	Less than 5 years	42	15.3%
	5–10 years	91	33.2%
	11–15 years	78	28.5%
	More than 15 years	63	23.0%
	Total	274	100%
Educational Qualification	High School or below	18	6.6%
	Diploma	96	35.0%
	Bachelor's Degree	122	44.5%
	Master's Degree	26	9.5%
	Doctoral Degree (PhD)	12	4.4%
	Total	274	100%

Research Instrument

A structured questionnaire was used as the primary data collection instrument. The questionnaire was developed from established measures reported in the peer-reviewed literature reviewed in the theoretical framework. It comprised three sections. The first section collected respondents' demographic information, including gender, age, length of service, and educational qualification. The second section measured participative leadership using Somech's [12] five-dimensional model, encompassing the decision domain, degree of participation, structure, rationale, and objective of participation. The third section measured organizational citizenship behavior based on Organ's [2] conceptualization and the measurement scale developed by Podsakoff et al. [25], covering the five dimensions of altruism, courtesy, sportsmanship, conscientiousness, and civic virtue. All measurement items were assessed using a five-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). The questionnaires were distributed in paper format to the selected respondents at Al-Sadr Teaching Hospital.

Instrument Validity and Reliability

The validity and reliability of the research instrument were evaluated before conducting the statistical analyses. To establish face validity and content validity, the questionnaire was reviewed by a panel of academic experts specializing in human resource management and organizational behavior. The panel evaluated the clarity, relevance, and representativeness of the questionnaire items to ensure that they adequately reflected the theoretical constructs and dimensions of the study.

Internal consistency reliability was assessed using Cronbach's alpha coefficients for each dimension as well as for the two overall study variables. Following the recommendation of Nunnally [33], a minimum coefficient of 0.70 was adopted as the acceptable threshold for reliability. The results of the reliability analysis are presented in Table 2.

Table 2. Cronbach's Alpha Coefficients for the Study Variables and Their Dimensions

Variables	Dimensions	Number of Items	Cronbach's Alpha
Participative Leadership	Decision Domain	4	0.847
	Degree of Participation	4	0.873
	Structure	4	0.825
	Rationale	4	0.856
	Objective of Participation	4	0.838
	Overall Reliability of Participative Leadership	20	0.928
Organizational Citizenship Behavior	Altruism	4	0.884
	Courtesy	4	0.851
	Sportsmanship	4	0.832
	Conscientiousness	4	0.891
	Civic Virtue	4	0.865
	Overall Reliability of Organizational Citizenship Behavior	20	0.941
Overall Reliability of the Questionnaire	—	40	0.952

Reliability Analysis

The reliability analysis based on Cronbach's alpha coefficients demonstrated that all dimensions of the study variables exhibited high levels of internal consistency, confirming the quality of the measurement instrument and its suitability for the objectives of the present study. The reliability coefficients for the dimensions of participative leadership ranged from 0.825 for the Structure dimension to 0.873 for the Degree of Participation dimension. All coefficients exceeded the recommended threshold of 0.70 [33], indicating good internal consistency and a high degree of homogeneity among the items measuring the five dimensions of participative leadership—decision domain, degree of participation, structure, rationale, and objective of participation. These results confirm that the scale provides reliable measurement of employees' perceptions of participative leadership practices.

Similarly, the dimensions of organizational citizenship behavior demonstrated strong internal consistency, with Cronbach's alpha coefficients ranging from 0.832 for Sportsmanship to 0.891 for Conscientiousness. These values indicate that the items consistently captured employees' discretionary workplace behaviors, with the conscientiousness dimension exhibiting the highest level of reliability among all measured dimensions.

At the construct level, the overall reliability coefficient reached 0.928 for participative leadership and 0.941 for organizational citizenship behavior, both of which indicate excellent reliability. Furthermore, the complete questionnaire, consisting of 40 items, achieved an overall Cronbach's alpha coefficient of 0.952, reflecting an exceptionally high level of internal consistency. Collectively, these findings demonstrate that the measurement instrument is highly reliable and that the collected data are suitable for subsequent statistical analyses and hypothesis testing with a high degree of confidence.

3. Results

Descriptive Statistics of the Study Variables

This section presents a descriptive analysis of respondents' perceptions of the two study variables participative leadership and organizational citizenship behavior together with their respective dimensions. Descriptive statistics were calculated using arithmetic means and standard deviations based on a five-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree). To facilitate interpretation, mean scores were classified into four levels: low (1.00–2.33), moderate (2.34–3.00), high (3.01–4.20), and very high.(5.00–4.21)

Table 3 presents the arithmetic means and standard deviations for all dimensions of the two study variables, arranged in descending order according to their mean scores within each construct.

Table 3. Means and Standard Deviations of the Dimensions of Participative Leadership and Organizational Citizenship Behavior

Variable	Dimensions	Mean	Standard Deviation
Participative Leadership	Objective of Participation	4.24	0.55
	Decision Domain	4.18	0.58
	Degree of Participation	4.10	0.61
	Rationale	4.06	0.63
	Structure	3.95	0.67
	Overall Mean of Participative Leadership	**4.11**	**0.49**
Organizational Citizenship Behavior	Altruism	4.27	0.53
	Conscientiousness	4.21	0.54
	Courtesy	4.14	0.57
	Civic Virtue	4.08	0.60
	Sportsmanship	4.02	0.66
	Overall Mean of Organizational Citizenship Behavior	**4.14**	**0.47**

The descriptive statistics presented in Table 3 indicate that the overall mean score for participative leadership was 4.11 (SD = 0.49), corresponding to a high level of respondents' agreement. This finding suggests that employees at Al-Sadr Teaching Hospital generally perceive participative leadership practices to be well established within their workplace.

Among the five dimensions of participative leadership, Objective of Participation recorded the highest mean (M = 4.24, SD = 0.55), representing the only dimension that reached a very high response level. This finding indicates that employees clearly recognize the criteria used by their supervisors when selecting staff members to participate in decision-making processes. It was followed by Decision Domain (M = 4.18), Degree of Participation (M = 4.10), and Rationale (M = 4.06), all of which achieved high response levels.

In contrast, Structure recorded the lowest mean (M = 3.95) and the largest standard deviation (SD = 0.67) among the participative leadership dimensions. The relatively larger dispersion suggests greater variability in employees' perceptions regarding the formalization and consistency of participatory mechanisms across the hospital's administrative and clinical units.

With respect to organizational citizenship behavior, the overall mean reached 4.14 (SD = 0.47), indicating a high level of organizational citizenship behavior among employees. This result suggests that discretionary behaviors extending beyond formal job requirements are commonly practiced within the hospital.

At the dimensional level, Altruism achieved the highest mean (M = 4.27, SD = 0.53), corresponding to a very high response level, reflecting employees' strong willingness to voluntarily assist their colleagues. This was followed by Conscientiousness (M = 4.21), which also reached a very high level, whereas Courtesy (M = 4.14) and Civic Virtue (M = 4.08) were both rated as high. Sportsmanship recorded the lowest mean (M = 4.02) and the highest standard deviation (SD = 0.66) among the organizational citizenship behavior dimensions, indicating greater variation in employees' willingness to tolerate unfavorable working conditions without complaint.

A comparison of the overall means shows that organizational citizenship behavior (M = 4.14) was marginally higher than participative leadership (M = 4.11). Both variables exhibited relatively low standard deviations, indicating a high degree of consistency in respondents' evaluations. Collectively, these descriptive findings provide preliminary support for a positive association between participative leadership and organizational citizenship behavior. The nature and magnitude of this relationship are examined more rigorously in the following section through regression analysis and hypothesis testing.

Hypothesis Testing

Testing the Main Hypothesis: Simple Regression Analysis

The main hypothesis proposes that participative leadership has a statistically significant effect on organizational citizenship behavior among employees at Al-Sadr Teaching Hospital at the significance level of $\alpha \leq 0.05$. To test this hypothesis, a simple linear regression analysis was performed. The results are presented in Table 4.

Table 4. Results of the Simple Linear Regression Analysis Examining the Effect of Participative Leadership on Organizational Citizenship Behavior

Independent Variable	Dependent Variable	R	R^2	Adjusted R^2	Std. Error of the Estimate	F	Degrees of Freedom (df)	Sig.	B	Constant	T	Sig.	Hypothesis Result
Participative Leadership	Organizational Citizenship Behavior	0.719	0.517	0.515	0.438	291.31	(1, 272)	0.000	0.786	0.841	17.07	0.000	Accepted

Table 4 presents the results of the simple linear regression analysis examining the effect of participative leadership on organizational citizenship behavior. The correlation coefficient (R) was 0.719, indicating a strong positive association between the two variables. The coefficient of determination (R^2) reached 0.517, indicating that participative leadership accounted for 51.7% of the variance in organizational citizenship behavior, whereas the remaining 48.3% may be attributed to factors beyond the scope of the present study. The adjusted coefficient of determination (Adjusted $R^2 = 0.515$) was nearly identical to the original R^2 value, confirming the stability and explanatory adequacy of the regression model.

The regression model was statistically significant, with an F-value of 291.31 at (1, 272) degrees of freedom ($p < 0.001$), demonstrating that participative leadership significantly predicts organizational citizenship behavior. The unstandardized regression coefficient (B) was 0.786, indicating that a one-unit increase in participative leadership is associated with a 0.786-unit increase in organizational citizenship behavior. The regression coefficient was also statistically significant ($t = 17.07$, $p < 0.001$), exceeding the criterion for statistical significance ($\alpha \leq 0.05$). Accordingly, the main hypothesis is supported, confirming that participative leadership exerts a statistically significant positive effect on organizational citizenship behavior among employees at Al-Sadr Teaching Hospital.

Testing the Sub-Hypotheses: Multiple Regression Analysis

The five sub-hypotheses propose that each dimension of participative leadership—Decision Domain, Degree of Participation, Structure, Rationale, and Objective of Participation—has a statistically significant effect on organizational citizenship behavior at the significance level of $\alpha \leq 0.05$, after controlling for the influence of the remaining dimensions. To examine these hypotheses, a multiple linear regression analysis was conducted. The results, together with the overall model summary, are presented in Table 5.

Table 5. Results of the Multiple Linear Regression Analysis Examining the Effects of the Dimensions of Participative Leadership on Organizational Citizenship Behavior

Independent Dimensions	B	Standard Error	Standardized Coefficient (β)	t-value	Sig.	Sub-Hypothesis
Decision Domain	0.193	0.054	0.207	3.57	< 0.001	Supported
Degree of Participation	0.271	0.058	0.314	4.67	< 0.001	Supported
Structure	0.109	0.050	0.124	2.18	0.030	Supported
Rationale	0.164	0.056	0.173	2.93	0.004	Supported
Objective of Participation	0.236	0.055	0.254	4.29	< 0.001	Supported

Constant (Intercept)	0.718	0.229	—	3.14	0.002	—

Statistic	Value
R	0.779
R^2	0.607
Adjusted R^2	0.600
Standard Error of the Estimate	0.396
F-value	82.86
Degrees of Freedom (df)	(5, 268)
Sig.	< 0.001

The results of the multiple regression analysis demonstrate a clear improvement in the explanatory power of the model compared with the simple regression analysis. Whereas the simple regression model produced a correlation coefficient of R = 0.719 and explained 51.7% of the variance in organizational citizenship behavior, the multiple regression model yielded a higher multiple correlation coefficient (R = 0.779) and an increased coefficient of determination (R^2 = 0.607). This indicates that the five dimensions of participative leadership jointly explained 60.7% of the variance in organizational citizenship behavior. Moreover, the adjusted coefficient of determination (Adjusted R^2 = 0.600) was very close to the original R^2 value, indicating that the model retained its explanatory power after adjusting for the number of predictors and providing no evidence of overfitting. The overall regression model was statistically significant ($F = 82.86$, $df = 5, 268$, $p < 0.001$), confirming that the set of participative leadership dimensions collectively provides a significant explanation of organizational citizenship behavior and justifying interpretation of the individual regression coefficients.

Examination of the standardized regression coefficients revealed that Degree of Participation was the strongest predictor of organizational citizenship behavior ($\beta = 0.314$, $t = 4.67$, $p < 0.001$), providing support for the second sub-hypothesis. The second strongest predictor was Objective of Participation ($\beta = 0.254$, $t = 4.29$, $p < 0.001$), supporting the fifth sub-hypothesis. Decision Domain also made a significant positive contribution ($\beta = 0.207$, $t = 3.57$, $p < 0.001$), supporting the first sub-hypothesis, followed by Rationale ($\beta = 0.173$, $t = 2.93$, $p = 0.004$), which supported the fourth sub-hypothesis.

In contrast, Structure exhibited the weakest unique contribution to organizational citizenship behavior ($\beta = 0.124$, $t = 2.18$, $p = 0.030$). Although its effect was comparatively modest, the probability value remained below the predetermined significance level ($\alpha \leq 0.05$), indicating that the relationship remained statistically significant. Accordingly, the third sub-hypothesis was also supported.

Overall, the findings support all five sub-hypotheses while demonstrating noticeable variation in the relative contribution of the individual dimensions. Degree of Participation and Objective of Participation emerged as the most influential predictors of organizational citizenship behavior, whereas Structure contributed the smallest unique effect despite retaining statistical significance. These differences warrant further theoretical interpretation in light of the conceptual characteristics of each dimension and their differential capacity to stimulate discretionary employee behaviors.

The regression intercept (Constant = 0.718) was also statistically significant ($t = 3.14$, $p = 0.002$), suggesting the existence of a baseline level of organizational citizenship behavior that is not explained by the participative leadership dimensions included in the model. This residual effect may reflect the influence of additional organizational or individual factors beyond the scope of the present study, such as organizational culture, perceived organizational support, or employees' intrinsic motivation.

Finally, the increase in the coefficient of determination from the simple regression model (R^2 = 0.517) to the multiple regression model (R^2 = 0.607) indicates that analyzing participative leadership through its individual dimensions provides greater explanatory precision than treating it as a single composite construct. This finding suggests that each dimension contributes unique explanatory variance beyond that captured by the overall participative leadership score, thereby reinforcing the theoretical rationale for adopting Somech's [12] multidimensional framework in the present study.

4. Discussion

The findings of the present study demonstrate that participative leadership exerts a strong and statistically significant positive effect on organizational citizenship behavior (OCB) among employees at Al-Sadr Teaching Hospital. The simple regression analysis yielded a correlation coefficient of R = 0.719, a result that closely corresponds to the findings of Bhatti et al. [10], who reported a correlation of r = 0.782 between the same variables. who argued that participative leaders encourage employees to exceed formal job requirements by enhancing their intrinsic motivation and sense of involvement.

Beyond confirming the existence of this relationship, the findings provide additional insight into its explanatory structure. Participative leadership, when treated as a single composite construct, explained 51.7% of the variance in organizational citizenship behavior. However, decomposing the construct into its five constituent dimensions increased the explained variance to 60.7%. This nine-percentage-point improvement is theoretically meaningful rather than merely statistical. More than two decades ago, Somech [12] criticized the widespread tendency to conceptualize participative leadership as a unidimensional construct, arguing that such simplification obscures important sources of explanatory variance. The present findings provide direct empirical support for this argument. Had participative leadership been examined only as an overall construct, approximately 9% of the explainable variance in organizational citizenship behavior would have remained undetected. This finding reinforces the value of adopting multidimensional conceptualizations of participative leadership in future organizational research.

Among the individual dimensions, Degree of Participation emerged as the strongest predictor of organizational citizenship behavior (β = 0.314), exceeding the predictive contribution of Decision Domain (β = 0.207). This finding suggests that employees respond more positively to the depth of influence they are granted than to the number of decision areas in which they are invited to participate. In practical terms, employees appear more willing to exhibit organizational citizenship behaviors when they possess genuine influence over a limited number of decisions than when they are merely consulted across a broader range of issues without meaningful influence over final outcomes. This interpretation is consistent with Vroom and Yetton's [13] continuum of participation, which distinguishes different levels of employee influence in decision-making. The findings therefore imply that the quality of participation is more influential than its breadth in stimulating discretionary employee behaviors.

The Objective of Participation dimension ranked second in predictive importance (β = 0.254), highlighting the practical significance of transparent participation criteria within healthcare organizations. Somech [12] argued that leaders frequently select participants based on motivation rather than technical competence. The present findings indicate that employees respond positively when the criteria governing participation are perceived as fair and transparent, regardless of whether those criteria emphasize competence, motivation, or other legitimate considerations. This interpretation is fully consistent with the principles of procedural justice and Social Exchange Theory [6], both of which emphasize fairness as a key antecedent of reciprocal employee behavior.

In contrast, Structure produced the smallest unique contribution to organizational citizenship behavior (β = 0.124), although its effect remained statistically significant (p = 0.030). This result deserves particular attention because it departs, at least partially, from the expectations derived from Somech's [12] framework, which emphasizes the importance of formal participatory mechanisms in establishing enduring organizational trust. One possible explanation lies in the characteristics of the Iraqi public healthcare context examined in this study. Employees may value actual opportunities to participate more highly than the formal mechanisms through which participation occurs. In such settings, spontaneous involvement during operational challenges may carry psychological significance comparable to formally institutionalized participation. This interpretation appears particularly plausible in healthcare organizations operating under persistent resource constraints and continuous operational pressure, where flexibility often becomes more valuable than procedural formality.

This interpretation is further supported by the contingency perspective discussed in the theoretical framework. Post et al. [34] demonstrated that the effectiveness of participative leadership depends largely on the urgency and nature of the decision-making context. The relatively limited contribution of Structure may therefore reflect the coexistence of routine

administrative decisions and emergency clinical situations within Al-Sadr Teaching Hospital. Under such conditions, the availability of timely participation may be more influential than the formal organizational procedures through which participation is implemented.

Regarding organizational citizenship behavior itself, Altruism recorded the highest descriptive mean among all measured dimensions (M = 4.27). This finding is consistent with Sun et al. [5], who argued that healthcare environments naturally foster altruistic behaviors because effective patient care depends heavily on continuous teamwork and mutual assistance among healthcare professionals. Consequently, helping colleagues during periods of high workload is often perceived not merely as an optional discretionary behavior but as an implicit professional expectation embedded within healthcare culture. This observation also supports the theoretical argument advanced by Bolino et al. [3], who highlighted the increasingly blurred distinction between voluntary and implicitly expected behaviors within healthcare organizations.

Overall, the findings provide strong empirical support for the theoretical framework underpinning the present study. Consistent with Social Exchange Theory, participative leadership appears to promote organizational citizenship behavior by strengthening employees' perceptions of trust, fairness, and reciprocal obligation. Furthermore, the study contributes to addressing the theoretical, empirical, and contextual gaps identified in the introduction by providing evidence from an Iraqi public healthcare institution that supports the applicability of Somech's [12] multidimensional model of participative leadership and Organ's [2] framework of organizational citizenship behavior beyond the Western contexts in which these models were originally developed. Nevertheless, the relatively modest contribution of the Structure dimension suggests that contextual factors may influence the effectiveness of specific participative leadership practices. Future studies should therefore replicate the model across different Iraqi healthcare organizations and other public-sector institutions to determine the generalizability of the present findings.

5. Conclusion

In light of the theoretical framework and empirical findings, this study confirms that participative leadership exerts a statistically significant positive effect on organizational citizenship behavior (OCB) among employees at Al-Sadr Teaching Hospital. As a composite construct, participative leadership explained 51.7% of the variance in OCB, providing further evidence that this relationship is robust and extends beyond the specific organizational context examined in the present study.

The explanatory power of the model increased substantially when participative leadership was examined as a multidimensional construct. Incorporating the five dimensions proposed by Somech [12] into a multiple regression model increased the explained variance to 60.7%, demonstrating the additional explanatory value of analyzing participative leadership through its individual dimensions rather than treating it as a single aggregate variable. These findings provide empirical support for the multidimensional conceptualization adopted in this research.

The results also confirmed all five sub-hypotheses, although the dimensions differed in the magnitude of their independent effects. Degree of Participation emerged as the strongest predictor of organizational citizenship behavior, followed by Objective of Participation, Decision Domain, and Rationale. Structure exhibited the weakest, yet still statistically significant, independent effect. These findings suggest that employees respond more positively to meaningful participation in decision-making and transparent participation criteria than to the formal institutionalization of participatory procedures.

Descriptive analysis further revealed high levels of both participative leadership (M = 4.11) and organizational citizenship behavior (M = 4.14). Objective of Participation and Altruism recorded the highest mean scores within their respective constructs, indicating a generally supportive organizational environment that can be further strengthened through targeted managerial interventions rather than fundamental organizational restructuring.

Overall, the findings provide empirical support for Social Exchange Theory [6], suggesting that participative leadership encourages employees to reciprocate fair and inclusive managerial practices through discretionary behaviors that benefit the organization. Moreover, this study contributes to addressing an important gap in the Arabic management literature by providing empirical evidence from an Iraqi public healthcare institution and by

validating the applicability of Somech's [12] participative leadership model and Organ's [2] organizational citizenship behavior framework within this context.

Recommendations

Based on the findings of this study, hospital management should place greater emphasis on enhancing the quality and depth of employee participation in decision-making rather than merely expanding opportunities for consultation. Employees should be granted meaningful influence over decisions that directly affect their work, as the Degree of Participation dimension demonstrated the strongest predictive effect on organizational citizenship behavior.

Leaders should clearly communicate the criteria used to select employees for participation in decision-making processes. Transparent selection procedures based on professional competence, experience, or motivation are likely to strengthen employees' perceptions of fairness and encourage greater organizational citizenship behavior.

The hospital should review its existing participatory mechanisms to determine whether current formal structures, including committees and scheduled meetings, adequately support participation within the dynamic healthcare environment. More flexible participation mechanisms that accommodate operational demands and emergency situations may enhance the effectiveness of participative leadership practices.

Because Sportsmanship recorded the lowest mean among the dimensions of organizational citizenship behavior, training and developmental initiatives should be implemented to strengthen employees' resilience, constructive coping strategies, and ability to manage organizational pressures without unnecessary complaints.

Leadership development programs should be designed around the multidimensional framework proposed by Somech [12], with particular emphasis on developing managers' competencies in facilitating genuine employee participation rather than symbolic or procedural involvement.

Finally, hospital leaders should develop greater situational flexibility by adapting their leadership style to the nature of the decision being made. Participative approaches appear most beneficial for routine administrative decisions, whereas urgent clinical situations may require more directive leadership to ensure timely and effective responses.

Limitations and Directions for Future Research

Several limitations should be considered when interpreting the findings of this study. First, the cross-sectional research design limits the ability to establish causal relationships or examine how participative leadership and organizational citizenship behavior evolve over time. Longitudinal studies would provide stronger evidence regarding causal dynamics.

Second, the exclusive reliance on self-reported questionnaire data may have introduced common method variance and social desirability bias. Future research should combine multiple data sources, including supervisor evaluations and observational measures, to improve measurement validity.

Third, the study was conducted within a single public hospital affiliated with the Maysan Health Directorate. Consequently, the findings should be generalized with caution to other healthcare organizations that differ in organizational structure, size, or administrative context. Comparative studies involving public and private hospitals across different Iraqi governorates would provide stronger external validity.

Fourth, although Somech's [12] instrument has been widely employed in healthcare research, it was originally developed outside the healthcare sector. Future studies may consider refining or adapting the measurement scale to better capture leadership practices specific to hospital environments.

Finally, the present model examined only the direct relationship between participative leadership and organizational citizenship behavior. Future research should investigate potential mediating variables such as organizational trust, perceived organizational support, psychological empowerment, and organizational commitment, as well as moderating variables including decision type, organizational climate, and departmental characteristics. Qualitative approaches, particularly interviews and focus groups, may also provide deeper insights into why the Structure dimension exhibited the weakest independent effect despite remaining statistically significant.

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