

The Performance Blueprint: Mapping Leadership's Journey Through Cultural and Structural Pathway

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Abstract:

Healthcare organizations in post-conflict and transitional economies face profound operational challenges, struggling to balance rigid bureaucratic compliance with the need for adaptive, supportive work environments. Conceptualizing leadership not merely as a supervisory function, but as a systemic Organization Development (OD) intervention, this study tests a dual-mediation model of how organizational culture and structure channel leadership behaviors into hospital performance. Structural Equation Modeling (SEM) with bias-corrected bootstrapping analyzed cross-sectional data from 391 healthcare professionals in Iraqi hospitals. The findings challenge traditional direct-effect paradigms: transformational leadership has no direct effect on performance, remaining latent unless channeled through a psychologically safe culture along with a decentralized structure. The study also discovers a “transactional paradox” in which punitive oversight undermines intrinsic motivation directly but indirectly benefits organizational performance by enforcing structural boundaries. Finally, laissez-faire leadership activates “bureaucratic substitution,” an involuntary institutional defense mechanism in which rigid standard operating procedures compensate for executive voids to avoid systemic collapse. Such results demand a strategic paradigm shift for OD and HR executives. Navigating complex institutional environments requires moving beyond clinical seniority in talent acquisition, pivoting instead toward recruiting strategic environmental architects capable of leveraging culture and structure as integrated OD interventions to drive sustainable healthcare performance.

Keywords: transformational leadership, organizational culture, organizational structure, hospital performance, transactional paradox.

Introduction

In contemporary Organization Development (OD) and strategic management, enhancing institutional performance positions leadership as a central focus of inquiry. Historically, theories considered a direct and linear correlation between the behavior of the executives and the success of the organization, where the leaders independently decided the stability of their institutions (Alrowwad et al., 2020; Yukl, 2013). Modern administrative science, however, has shifted definitely away from this provincial view. The existing empirical evidence indicates that leadership operates mainly as a systemic catalyst. The strategic vision of a leader remains operationally latent unless it systematically transforms the internal organizational environment, especially its culture and structural architecture (Ali et al., 2022; Nguyen et al., 2023). Effective leaders do more than just manage tasks. They are strategic architects who align internal organizational development activities to improve engagement and ensure sustainable performance (Almahasneh et al., 2023).

In health care, the interaction between leadership, culture and structure is of paramount importance. Medical institutions are different from traditional business environments because they are high reliability organizations that are unpredictable and have zero tolerance for error. Healthcare

administrators have a dual, conflicting mandate. Patient safety and operational efficiency are achieved by strict adherence to clinical pathways and SOPs. They also need to build a collaborative and psychologically healthy corporate culture to support medical professionals who work in stressful conditions (Al-Yassiri et al., 2021; Specchia et al., 2021). For sustainable operations, it is important to understand how leadership affects this dual internal environment.

The Iraqi healthcare system provides a complex, transitional environment for analyzing these administrative dynamics. The sector faces challenges in sustaining essential service delivery after decades of macroeconomic instability and a constrained health workforce (WHO, 2024). A rapid demographic growth (around 45 million) has been a heavy burden on public resources, accelerating the growth of private facilities (EUAA, 2024). Within this setting of needs, the ongoing crisis of administration does not permit efficiency in the institutions: the elevation of leading physicians to directorial hospital positions is determined solely by clinical competence, and not by a rigorous education in organizational development (WHO, 2024). The gap between clinical seniority and administrative competency worsens structural problems, such as the crises in human resource management and physician “dual practice” (Ali et al., 2025; Al-Rubaie & Al-Shammari, 2021).

The severe governance crises and administrative difficulties in Iraqi hospitals indicate that the sector's vulnerabilities are both structural and cultural (Ali et al., 2025; WHO, 2024). Consequently, conventional direct-effect leadership methodologies are inherently insufficient in inflexible, high-pressure settings (Almahasneh et al., 2023). Institutional friction arises from bureaucratic centralization and insufficient psychological safety, which renders executive vision operationally inactive unless actively conveyed through internal processes. Nevertheless, the existing literature addresses organizational culture (Nguyen et al., 2023) independently from formal structure (Abu Rassa & Emeagwali, 2020). The authors argue that dealing with these twin crises requires a “dual-mediation” strategy that simultaneously builds structural agility and cultural cohesion; however, until such mechanisms are integrated, healthcare facilities will continue to suffer from unmitigated operational and systemic weaknesses.

These vulnerabilities call for urgent organizational development interventions. There is a glaring theoretical gap in the literature of organizational behavior. Current studies often examine the mediating functions of organizational culture (Nguyen et al. 2023) or organizational structure (Abu Rassa & Emeagwali, 2020) in isolation. The fragmented, single-mediator approach fails to adequately capture the complex interconnectedness of institutional transformation, providing little empirically grounded guidance to administrators (Almahasneh et al., 2023). This study empirically investigates a dual mediation model to understand the degree to which culture and structure together mediate the relationship between the full-range leadership model and multidimensional performance in Iraqi hospitals. This study contributes to the contingency theory by providing evidence that visionary leadership requires supporting culture and structure simultaneously (Ali et al., 2022; Zhao et al., 2024). It introduces the “transactional paradox”. It shows that punitive supervision decreases intrinsic motivation, but it still supports needed structural compliance (Specchia et al., 2021). It further reinforces “bureaucratic substitution,” showing how rigid protocols provide institutional protection in times of laissez-faire (Ali et al., 2025; Al-Yassiri et al., 2021). Such results offer HR directors a basis to shift talent acquisition from clinical seniority to the recruitment of strategic “environmental architects” who can facilitate all-around organizational development transitions (Mousa & Al-Hassani, 2022; WHO, 2024).

Literature Review and Hypotheses

Leadership Styles and Organizational Performance

Leadership is a dynamic and systemic intervention that can radically transform institutional directions in change management (Almahasneh et al., 2023; Yukl, 2013). The study conceptualised leadership as a multidimensional continuum and explored its function as a catalyst for systemic transformation using the Full-Range Leadership Model (FRLM) (Bass & Avolio, 1994; Northouse, 2021). Many studies have shown that transformational leadership is an important contributor to increasing employee engagement, aligning clinical priorities and improving organizational performance (Bass & Riggio, 2006; Judge & Piccolo, 2004; Wang et al., 2011). Transactional leadership revolves around the use of contingent rewards and management-by-exception that focuses

on maintaining the operational status quo. This compliance-oriented style is important in high-stakes healthcare settings to ensure protocols are followed (Antonakis & House, 2014; Specchia et al., 2021). Laissez-faire leadership, which is marked by the abdication of executive responsibility, is often linked to role ambiguity and reduced performance, highlighting institutional weaknesses that require systemic buffering (Ali et al., 2025; Skogstad et al., 2007). Based on these behavioral links, the primary direct relationships between leadership styles and organizational performance are hypothesized as follows:

Hypothesis 1 (H1): There is a significant relationship between leadership styles and organizational performance.

H1a: There is a positive significant relation between transformational leadership and organizational performance.

H1b: There is a positive significant relation between transactional leadership and organizational performance.

H1c: There is a negative significant relation between Laissez-faire leadership and organizational performance.

The Role of Leadership in Shaping Organizational Culture

Organizational culture is the psychological base of an institution (Schein, 2010). Modern organizational development theory also understands culture as a flexible and dynamic tool and can be undertaken through engagement, consistency, adaptation, and alignment with mission to translate executive purpose into measurable effectiveness (Denison & Mishra, 1995; Denison, Haaland, & Goelzer, 2003). These environments are primarily shaped by transformational leaders, who influence psychologically safe, adaptive cultures to improve workforce results in uncertain healthcare environments (Lu, 2026; Nguyen et al., 2023; Ogbonna & Harris, 2000). In contrast, transactional leaders who focus on stability create cultures of rigid conformity and laissez-faire leadership breaks down shared values, resulting in chaotic subcultures and mission misalignment (Al-Sawai, 2013; Bass & Riggio, 2006). These dynamics lead to the following hypotheses:

Hypothesis 2 (H2): There is a significant relationship between leadership styles and organizational culture.

H2a: There is a positive significant relation between transformational leadership and organizational culture.

H2b: There is a positive significant relation between transactional leadership and organizational culture.

H2c: There is a negative significant relation between Laissez-faire leadership and organizational culture.

The Role of Leadership in Shaping Organizational Structure

Organizational culture is the psychological foundation of an organization, while organizational structure is the operational structure within which an organization functions, coordinating institutional activities through formalization, centralization, and complexity (Daft, 2015; Pugh et al., 1968). Skilled OD practitioners design these structures intentionally to support strategic goals (Avolio, Walumbwa, & Weber, 2009). Transformational leaders tend to cut rigid bureaucratic constraints in favor of decentralized, organic structures that improve clinical responsiveness (Damanpour & Aravind, 2012). Transactional leaders are more likely to lean towards mechanistic structures and thus promote centralization and formalization to a greater degree in order to facilitate regulatory compliance (Burns & Stalker, 1961). In the laissez-faire leadership setting, the structure is a compensatory mechanism, buffering the organization from the disorderliness of executive evasion (Abu Rassa & Emeagwali, 2020). The assumed relationship between leadership styles and organizational structure is:

Hypothesis 3 (H3): There is a significant relationship between leadership styles and organizational structure.

H3a: There is a positive significant relation between transformational leadership and organizational structure.

H3b: There is a positive significant relation between transactional leadership and organizational structure.

H3c: There is a negative significant relation between Laissez-faire leadership and organizational structure.

The Simultaneous Dual-Mediation Framework

Synthesizing the FRLM with organizational contingency theory reveals a major methodological blind spot. The tendency to view culture and structure as mutually exclusive paths does not reflect the interdependent reality of systemic institutional transformation (Almahasneh et al., 2023; Donaldson, 2001). Without formal procedures to enforce clinical safety, a collaborative, patient-centered culture will fail, and a rigid structural hierarchy will not be resilient without an adaptive cultural mindset (Zhao et al., 2024).

This study uses a conceptual model based on simultaneous dual-mediation that combines these two realities. Organizational culture is the main social mechanism for translating leadership intent into performance (Nguyen et al., 2023). Simultaneously, formal structure is the necessary operational bridge (Chen & Huang, 2007). This structural mediation brings in the theory mechanism for the “transactional paradox” whereby the punitive oversight not only directly lowers morale but also indirectly sustains the institution through enforcing critical bureaucratic boundaries. The “bureaucratic substitution” effect shows how rigid SOPs inadvertently sustain the operations in the leadership vacuums under laissez-faire leadership (Ali et al., 2025). Thus, these structural and cultural pathways together provide the theoretical basis for the dual-mediation mechanisms described below:

Hypothesis 4 (H4): organizational culture mediates the relationship between leadership style and performance.

H4a: Organizational culture mediates the relationship between transformational leadership and organizational performance.

H4b: Organizational culture mediates the relationship between transactional leadership and organizational performance.

H4c: Organizational culture mediates the relationship between laissez-faire leadership and organizational performance.

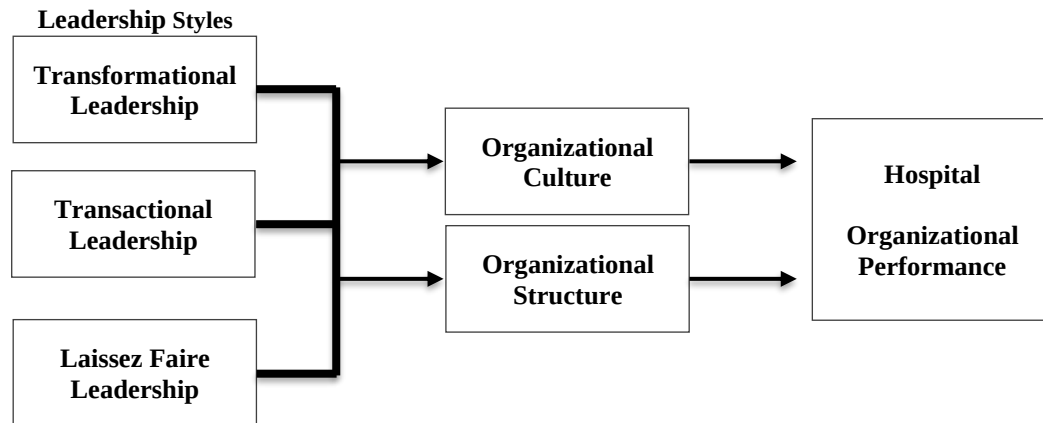
Hypothesis 5 (H5): organizational structure mediates the relationship between leadership style and performance.

H5a: Organizational structure mediates the relationship between transformational leadership and organizational performance.

H5b: Organizational structure mediates the relationship between transactional leadership and organizational performance.

H5c: Organizational structure mediates the relationship between laissez-faire leadership and organizational performance.

Figure 1: The Proposed Conceptual Framework



Note. Developed based on the literature review

Methodology

Sample and Data Collection

The current study employed a quantitative, cross-sectional, and correlational research design to test the hypothesized dual-mediation model empirically (Creswell & Creswell, 2018; Saunders et al., 2019). This deductive approach was chosen deliberately to investigate complex, theory-based hypotheses of the dual-mediation of organizational culture and organizational structure without disturbing the critical, high-stakes operational realities of the Iraqi healthcare environment (Setia, 2016).

The targeted population was the clinical and administrative health-care professionals in Iraqi hospitals. Due to the natural access limitations and the lack of a centralized national sampling frame, a purposive sampling strategy was adopted (Etikan, Musa, & Alkassim, 2016). Data were collected using a self-administered bilingual (Arabic/English) online survey hosted by Microsoft Forms. The survey was distributed through professional LinkedIn networks and official staff WhatsApp groups, once formal permission was obtained from the relevant authorities, which included the Authority of Health and Medical Education and hospital HR departments.

Data collection took place over a seven-week field opening (July 20 to September 5, 2025). The final valid sample size was $n=391$. Rigorous data cleaning procedures were undertaken to remove incomplete submissions and responses from outside the region. The sample size used in this study is far above the minimum statistical requirement for complex Structural Equation Modeling (SEM) (Hair et al., 2019; Kline, 2016). The demographic and professional profiles of the respondents are described in detail below.

Table 1: Demographic Characteristics of the Respondents ($n = 391$)

Variable	Category	Frequenc y	Percentage (%)
Age	Under 20	0	0
	20 – less than 35	290	74.2
	35 – less than 50	91	23.3
	50 – less than 65	10	2.6
	65 and above	0	0
	Total	391	100
Gender	Male	236	60.4
	Female	155	39.6
	Total	391	100
Education Level	High School or less	52	13.3
	Diploma	65	16.6
	Bachelor's Degree	213	54.5

Variable	Category	Frequency	Percentage (%)
Job Category	Master's Degree	45	11.5
	Doctorate	16	4.1
	Total	391	100
	Medical staff (e.g., doctor, nurse, technician, pharmacist)	208	53.2
	Administrative staff (e.g., Manager, Team leader, HR, finance, secretarial, general administration)	183	46.8
Job Level	Total	391	100
	Senior Manager (e.g., Hospital Director, Department Head)	58	14.8
	Supervisor or Team Leader (e.g., Head Nurse, Unit Coordinator)	36	9.2
	Regular Staff (e.g., Doctor, Nurse, Technician, Admin Staff)	297	76.0
	Total	391	100
Years of Experience in Healthcare	Less than 1 year	41	10.5
	1–5 years	167	42.7
	6–10 years	85	21.7
	More than 10 years	98	25.1
	Total	391	100
Monthly Salary Range (in USD)	Less than \$300	16	4.1
	\$300 – \$499	94	24
	\$500 – \$699	101	25.8
	\$700 – \$999	102	26.1
	\$1,000 – \$1499	37	9.5
What is the approximate size of your hospital?	\$1,500 or more	41	10.5
	Total	391	100
	Small (under 100 beds)	65	16.6
	Medium (100–300 beds)	290	74.2
	Large (more than 300 beds)	36	9.2
Hospital Type	Total	391	100
	Public	48	12.3
	Private	280	71.6
	Charity/ non-profit	63	16.1
	University-affiliated	0	0
Which hospital do you work in?	Total	391	100
	Al-Farahidi Medical Center	1	.3
	Al-Hadi (PBUH) Center for Muscle and Nerve Disorders	10	2.6
	Al-Hindiya General Teaching Hospital	1	.3
	Al-Imamain Al-Kadhmain Medical Teaching Hospital	8	2
	Al-Shifa Hospital	1	.3
	Al-Thaqalayn Cancer Hospital	19	4.9
	Almojtaba Center for Hematology and Bone Marrow Transplant	31	7.9
	Alshaab hospital	1	.3
	Baghdad Medical City	2	.5
	Gastroenterology and Hepatology Center	1	.3
	Imam Al-Hasan Al-Mujtaba Teaching Hospital	6	1.5
	Imam Al-Hussain General Medical Hospital	4	1
	Imam Zain Al-Abidin Hospital	157	40.2
	Karbala Cardiac Diseases and Surgery Center	1	.3
	Najaf Cardiac Center	1	.3
	Salamatek Center for Home Health Care	4	1
	Sayyeda Khadija Al-Kubra Women's Specialized Hospital	30	7.7
	Warith International Cancer Institute	25	6.4
	Other	88	22.5
	Total	391	100

Note. N = 391. The data represent the consolidated socio-demographic and professional characteristics of the sampled healthcare professionals across Iraqi hospitals.

Measures

The survey instrument was constructed utilizing established, standardized scales, deliberately adapted from prominent organizational behavior literature to ensure robust psychometric validity.

All substantive variables were measured by 5-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

Leadership Styles:

The exogenous construct was operationalized by 12 items from the Multifactor Leadership Questionnaire (MLQ 5X) (Bass & Avolio, 1995). In this study three different exogenous variables are evaluated to capture different behavioral dimensions, instead of a single composite construct. These are transformational leadership (measured by four items), transactional leadership (measured by four items) and laissez-faire leadership (measured by four items). Each style was tested separately to chart its own structural path in the mediation model.

Organizational Culture:

The cultural environment, the main social mediator, was measured with 12 items from the Denison Organizational Culture Survey (Denison & Mishra, 1995; Denison et al., 2003). This scale measured four key features that determine institutional effectiveness, including involvement, consistency, adaptability, and mission fit (three items per characteristic).

Organizational Structure:

The operational mediating variable was measured by nine items based on the classical structural dimensions identified by Pugh et al (1968). The scale measured three defined dimensions of institutional design: formalization, centralization and complexity (three items for each).

Organizational Performance:

An eight-item scale adapted from the Balanced Scorecard framework tailored for healthcare was used to assess the final endogenous outcome (Kaplan & Norton, 1992; Wu & Chen, 2014). It measured multidimensional success across four domains: operational excellence, customer (patient) intimacy, product/clinical leadership, and financial achievement (two items per domain).

Data Analysis Strategy

A rigorous two-step statistical approach was used to model the complex dual mediation pathways. IBM SPSS (Version 26.0) was used to conduct preliminary data screening, missing value analysis, descriptive statistics, and assessment of statistical assumptions including multicollinearity using Variance Inflation Factors (VIF) and common method bias using Harman's single-factor test.

Subsequent inferential and structural analyses were performed utilizing JASP (Version 0.17). The measurement model was tested using a Confirmatory Factor Analysis (CFA), which assessed the global goodness-of-fit, internal consistency, and both convergent and discriminant validity. Next, the proposed structural relationships were examined using Structural Equation Modeling (SEM) with a maximum likelihood (ML) estimate method. To provide a full evaluation of the systemic OD mediation mechanisms and to avoid probable deviations from multivariate normality, the indirect effects were assessed through a bias-corrected percentile bootstrapping method with 5,000 resamples.

Declaration of Generative AI in the Writing Process

The author discloses that this manuscript has been prepared with the use of Generative Artificial Intelligence (AI) and Large Language Model (LLM) technology in strict accordance with present standards of academic publishing and institutional integrity. These tools were used only as administrative, linguistic and editorial assistants. They were limited to improving overall readability, refining flow of the structure, and enforcing the formatting rules of the APA 7th Edition Style manual. The generative AI was not a contributing author. All empirical calculations, statistical data analyses, theoretical syntheses and conceptual conclusions in this study are the sole and original intellectual property of the human researcher.

Results

Data Screening and Measurement Model Evaluation

Preliminary data screening evaluated the dataset ($N = 391$) for normality and common method bias (CMB). While formal normality assessments (Kolmogorov-Smirnov and Shapiro-Wilk) yielded significant results ($p < .001$), skewness (-0.935 to 0.548) and kurtosis (-0.102 to 2.457) remained strictly within acceptable thresholds. Consequently, a non-parametric bootstrapping procedure with 5,000 resamples was deployed to generate robust standard errors. Furthermore, Harman's single-factor test extracted a principal factor explaining only 38.9% of the total variance, confirming that CMB did not systematically inflate the modeled relationships.

Confirmatory factor analysis (CFA) was employed to measure internal consistency and construct validity of the measurement model. Psychometric integrity was ensured through a rigorous item purification protocol. Items q3 (transformational leadership) and q29 (organizational structure) were deleted because of negligible squared multiple correlations and non-substantial factor loadings (0.449 and 0.142 respectively). Similarly, item q5 (transactional leadership) was removed to avoid misspecification and significant cross loading.

The refined measurement model demonstrated excellent internal consistency. Both Cronbach's alpha (α) and McDonald's omega (ω) coefficients easily surpassed the 0.70 benchmark: transformational leadership ($\alpha = 0.869$, $\omega = 0.825$), transactional leadership ($\alpha = 0.857$, $\omega = 0.859$), laissez-faire leadership ($\alpha = 0.837$, $\omega = 0.809$), organizational culture ($\alpha = 0.934$, $\omega = 0.930$), organizational structure ($\alpha = 0.792$, $\omega = 0.794$), and organizational performance ($\alpha = 0.913$, $\omega = 0.847$).

Convergent validity was established via the Average Variance Extracted (AVE). All constructs solidly surpassed the 0.50 cutoff, except for organizational structure (AVE = 0.350). In strict adherence to the Fornell-Larcker criterion, this construct was retained because its robust composite reliability ($\omega = 0.794$) adequately compensated for the lower variance extracted. This statistical compression is a manifestation of the dimensional drag within the Pugh-derived scale, where high institutional formalization (e.g., rigid adherence to rules) coexists with highly volatile operational complexity and fluid centralization lines in transitional hospital settings. Operationally, keeping this heterogeneous construct intact is critical to safeguarding content validity, ensuring the model captures authentic administrative frictions rather than an artificially sanitized monolith. Finally, discriminant validity was assessed via the Heterotrait-Monotrait (HTMT) ratio. The correlation between transformational and transactional styles (0.915) slightly exceeded conservative thresholds; however, this overlap is theoretically anticipated as the "augmentation effect" of hybrid leadership in high-stakes environments.

Table 2: Measurement Model Reliability and Convergent Validity

Construct	Items	Standardized Factor Loadings	Cronbach's α	McDonald's ω	Average Variance Extracted (AVE)
Transformational Leadership	q1, q2, q4	0.771 - 0.904	0.869	0.825	0.655
Transactional Leadership	q6, q7, q8	0.766 - 0.853	0.857	0.859	0.669
Laissez-faire Leadership	q9 - q12	0.651 - 0.930	0.837	0.809	0.553
Organizational Culture	q13 - q24	0.564 - 0.869	0.934	0.930	0.552
Organizational Structure	q25 - q28, q30 - q33	0.210 - 0.710	0.792	0.794	0.350

Construct	Items	Standardized Factor Loadings	Cronbach's α	McDonald's ω	Average Variance Extracted (AVE)
Organizational Performance	q34 - q41	0.488 - 0.752	0.913	0.847	0.533

Note. Items q3, q5, and q29 were excluded during the item purification process due to low factor loadings and cross-loadings. All retained factor loadings are significant at $p < .001$.

Structural Model Fit

The structural equation model (SEM) was estimated by maximum likelihood estimation (MLE). The absolute fit indices indicated a good fit with the empirical data. The Root Mean Square Error of Approximation (RMSEA) was 0.065 and the Standardized Root Mean Square Residual (SRMR) was 0.074. The overall model yielded a χ^2 of 1715.458 (df = 647, $p < .001$).

The measured Comparative Fit Index (CFI) of 0.893 is slightly below the conventional threshold of 0.90, although it remains statistically justifiable considering the significant complexity of the model. The analysis employed JASP's sophisticated dynamic fit index (T-size equivalent) to establish precision thresholds specifically designed for this 41-item, dual-mediator framework (N = 391). The tailored T-size equivalent criterion for an acceptable ("fair") fit was precisely calculated as 0.881 ($\alpha = .05$). The attained CFI (0.893) significantly surpasses the dynamic threshold, indicating that the structural framework is a mathematically accurate representation of the intended Iraqi healthcare ecosystem.

Structural Model Assessment and Hypotheses Testing

The hypothesized model showed phenomenal explanatory power (R^2). The overall systemic OD model explained 73.9% of the variance in organizational performance ($R^2 = 0.739$). Furthermore, leadership behaviors accounted for 56.8% of the variance in organizational culture ($R^2 = 0.568$) and 51.1% of the variance in organizational structure ($R^2 = 0.511$). For OD practitioners, such metrics underscore an actionable operational reality – nearly three-quarters of a hospital performance trajectory can be deliberately engineered by bringing leadership behaviors and internal cultural and structural interventions into alignment.

The examination of direct effects produced surprising and paradoxical outcomes that contest conventional leadership models. Transformational leadership exhibited a statistically insignificant direct influence on organizational performance ($\beta = 0.141$, $p = 0.332$), leading to the rejection of H1a. The direct impact of laissez-faire leadership on performance was found to be non-significant ($\beta = -0.089$, $p = 0.129$; H1c not supported). Transactional leadership exerted a notable yet negative direct impact on performance ($\beta = -0.337$, $p = 0.019$; H1b supported). This suppression effect indicates that an exclusive emphasis on punitive, rule-based control diminishes baseline hospital performance by eroding intrinsic motivation. Leadership was highly effective in shaping the internal environment. Transformational leadership was determined to influence both organizational culture ($\beta = 0.575$, $p < .001$; supporting H2a) and organizational structure ($\beta = 0.406$, $p = 0.022$; supporting H3a). Transactional leadership strengthened structural rigidities ($\beta = 0.459$, $p = 0.010$; H3b supported) but did not significantly affect culture ($\beta = 0.272$, $p = 0.076$; H2b not supported). Laissez-faire conduct had significant positive correlations with both culture ($\beta = 0.121$, $p = 0.049$; H2c supported) and structure ($\beta = 0.218$, $p = 0.003$; H3c supported).

To evaluate the core OD thesis, mediation pathways were tested using bias-corrected bootstrapping. Crucially, the empirical data explicitly demonstrates that transformational leadership is the only style that successfully triggered parallel full mediation through both organizational culture and organizational structure simultaneously. Because its direct path to performance was non-significant, its entire impact relies on this dual framework. Transformational leadership successfully routed through culture to impact performance ($\beta = .358$, $p < .001$; H4a Supported) while concurrently driving performance through structure ($\beta = .192$, $p = .021$; H5a Supported).

Conversely, the alternative leadership styles were rigidly confined to distinctly defined, singular-mediator pathways: The findings validated the presence of the "transactional paradox. Transactional

leadership did not effectively leverage the cultural pathway to influence performance ($\beta = .170$, $p = .086$; H4b Not Supported). Nonetheless, despite its immediate adverse effect on performance, it produced a markedly significant favorable indirect effect through stringent enforcement of structural compliance ($\beta = .216$, $p = .020$; H5b Supported).

Finally, the data provided empirical support for the “bureaucratic substitution” effect. No effect of laissez-faire leadership on performance through organizational culture ($\beta = .075$, $p = .052$; H4c Not Supported). However, the indirect effect of laissez-faire leadership on performance through structural scaffolding only was significant ($\beta = .103$, $p = .006$; H5c Supported).

These particular statistical evidences substantiate that dependence exclusively on leadership charisma is functionally outdated. Sustainable performance in intricate healthcare systems necessitates systemic organizational development interventions, wherein executives deliberately shape both the cultural essence and the structural framework of the organization to effectively realize their objectives.

Table 3: Summary of Hypotheses Testing Results

Hypothesis Path	Beta (β)	Standard Error (SE)	z-Value	p-Value	Result
Leadership Styles → Performance					
H1a: Transformational → Performance	0.141	0.111	0.971	.332	Not Supported
H1b: Transactional → Performance	-0.337	0.108	-2.346	.019	Supported (-)
H1c: Laissez-Faire → Performance	-0.089	0.054	-1.517	.129	Not Supported
Leadership Styles → Org. Culture					
H2a: Transformational → Org. Culture	0.575	0.117	3.600	< .001	Supported
H2b: Transactional → Org. Culture	0.272	0.110	1.774	.076	Not Supported
H2c: Laissez-Faire → Org. Culture	0.121	0.053	1.967	.049	Supported
Leadership Styles → Org. Structure					
H3a: Transformational → Org. Structure	0.406	0.112	2.295	.022	Supported
H3b: Transactional → Org. Structure	0.459	0.111	2.568	.010	Supported
H3c: Laissez-Faire → Org. Structure	0.218	0.055	2.998	.003	Supported
Org. Culture mediates Lead → Prf					
H4a: Transformational → Culture → Performance	0.358	0.075	3.667	< .001	Supported
H4b: Transactional → Culture → Performance	0.170	0.074	1.718	.086	Not Supported
H4c: Laissez-Faire → Culture → Performance	0.075	0.035	1.940	.052	Not Supported
Org. Structure mediates Lead → Prf					
H5a: Transformational → Structure → Performance	0.192	0.064	2.310	.021	Supported
H5b: Transactional → Structure → Performance	0.216	0.070	2.323	.020	Supported
H5c: Laissez-Faire → Structure → Performance	0.103	0.034	2.760	.006	Supported

Note. The standardized coefficient (β) reported for H4a–H5c represents the bootstrapped indirect effect. Confidence intervals (LLCI, ULCI) were omitted for brevity as they align with the significance levels reported.

Discussion and Conclusion

Discussion of Main Findings

The main aim of this study was to simplify the traditional “black box” of leadership effectiveness through an evaluation of organizational culture and structure as systematic OD interventions. The empirical results criticize the traditional linear management paradigms in significant ways. In the highly regulated and error-sensitive environment of Iraqi hospitals, leadership actions exert an indirect influence, requiring the concurrent dual-mediation of the internal organizational environment.

This study's primary finding is that transformational leadership, despite its aspirational qualities, has no substantial direct impact on institutional performance. In a specialized healthcare environment, charisma and intellectual engagement alone do not heal patients or optimize clinical routes. A leader's

strategic goal remains dormant until it is manifested through the concurrent development of a psychologically secure corporate culture and a decentralized, agile structure. This is consistent with Ogbonna and Harris (2000), affirming that the impact of leadership is entirely mediated by the leader's environmental construct. Recent extensive assessments support this systemic viewpoint, illustrating that the genuine effectiveness of transformative leadership in unstable healthcare environments resides in its ability to proactively influence corporate culture and cultivate institutional resilience (Lu, 2026). Through the application of visionary leadership as an organizational development catalyst, administrators can effectively enhance workforce motivation and mitigate burnout, hence fostering sustainable organizational performance (Lu, 2026).

Moreover, the data indicates a significant “transactional paradox”. Without structural mediators, transactional leadership has a significant, negative impact on the organizational performance. This strategy severely undermines the intrinsic motivation and psychological autonomy of health care workers through punitive management-by-exception and strict surveillance (Ryan & Deci, 2000). The contradiction, however, is in its indirect utility: transactional leadership indirectly sustains organizational performance through the rigid enforcement of formal structural boundaries and clinical SOPs (standard operating protocols). Analysis of laissez-faire leadership shows an unintentional institutional defensive mechanism “bureaucratic substitution” (Kerr & Jermier, 1978). When leaders fail to do their job, the hospital is able to prevent near systemic collapse by relying on its established, rigid bureaucratic institutions to maintain basic operational continuity.

Theoretical Contributions

This Study addresses a significant gap in current OD literature by advancing beyond the fragmented, single-mediator models that presently prevail in the discipline. Historically, change management research has focused on either cultural routes (Almahasneh et al., 2023) or structural frameworks (Abu Rassa & Emeagwali, 2020) to elucidate executive efficacy. This work empirically verifies a multi-path dual-mediation model by synthesizing Schein's (2010) cultural theories with Burns and Stalker's (1961) structural dynamics. It demonstrates that institutional success is a composite outcome of harmonizing the psychological "soul" (culture) and the operational "skeleton" (structure) of an organization.

This study further extends the applicability of Western-centric administrative theories by evaluating them in a post-conflict, transitional healthcare context (Alkhadra et al., 2023). The investigation empirically delineates the transactional paradox and bureaucratic substitution in Iraq, so enhancing the theoretical nuance of the full-range leadership model. It necessitates a reconceptualization of transactional and laissez-faire approaches, transforming them from simple indicators of managerial failure to contingent, structure-dependent catalysts that initiate critical systemic compensations.

Managerial and Practical Implications

The validity of this dual-mediation concept for HR directors, OD practitioners, and hospital administrators calls for a radical change in institutional governance and talent acquisition. Healthcare organizations need to fundamentally change the standards of how leaders are chosen. The historical reliance on promotion practices based solely on clinical seniority often leads to administrative bottlenecks (Ali et al., 2025). Without appropriate environmental design, visionary leadership remains dormant; therefore, HR executives must change their focus to recruit “environmental architects”—leaders with the strategic organizational development expertise necessary to cultivate psychological safety while navigating complex, formal operational frameworks.

Secondly, hospital administrators must make active efforts at addressing the transactional paradox by implementing a “Just Culture. While adherence to clinical SOPs is critical for patient safety, overreliance on punitive transactional surveillance results in workforce fatigue and limits error reporting (Specchia et al., 2021). Frontline managers should restrict rigorous transactional compliance monitoring to high-risk, non-negotiable clinical practices (e.g. medicine administration, infection control) and use transformational organizational development interventions to encourage autonomous problem-solving in broader hospital operations.

Finally, Hospital boards need to be deliberate about creating flexible structural buffers. OD practitioners should recognize the bureaucratic substitution effect and extensively digitize clinical

pathways and automate standard audits. By proactively building structural resilience, the quality of patient care can be protected during periods of significant executive turnover, crises, or ineffective leadership.

Limitations and Directions for Future Research

The empirical results are robust but should be interpreted within specific methodological limitations. The study used a cross-sectional approach which, despite robust structural equation modelling, provides a snapshot in time and constrains the ability to identify clear causal relationships (Abu Rassa & Emeagwali, 2020). The geographical scope is intrinsically linked to the socio-economic and legal context of the Iraqi healthcare sector, so care should be taken when extrapolating directly to highly individualistic Western economies or to quite different businesses. In addition, performance was measured using subjective, self-reported opinions, rather than objective clinical or financial metrics.

Future research on organizational development should employ longitudinal designs to examine the temporal evolution of cultural and structural changes, particularly to explore the long-term sustainability of the bureaucratic substitution effect. Researchers are encouraged to incorporate objective institutional data such as patient mortality rates, readmission data, or specific financial return on investment to allow for a more definitive assessment of systemic change projects. In the end, it will be only in cross-comparisons of public and private health care institutions that the different operational contexts will be shown to shield the negative effects of transactional regulation.

Conclusion

Enhancing organizational performance in intricate, crisis-prone healthcare industries necessitates a shift beyond isolated, direct-management approaches. This paper systematically illustrates that a leader's authentic influence on hospital results is realized through a complex dual-mediation process. Transformational vision remains inactive unless CEOs simultaneously cultivate a psychologically secure organizational culture and a robust, adaptable organizational structure. This Study offers OD practitioners an evidence-based framework for systemic transformation by elucidating the transactional paradox and bureaucratic substitution. To achieve high-reliability performance and enduring institutional excellence, contemporary healthcare governance must shift from emphasizing clinical oversight to mastering strategic environmental design.

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