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ARTICLE

Leaders' individualized consideration, team commitment and patient loyalty: The role of social and task-related contexts

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Abstract

Drawing from transformational leadership (TFL) theory and research on contextual leadership, we examined a conditional process model of leadership in nursing teams to predict patient loyalty. Using TFL's individualized consideration dimension as a salient facet of the construct in care services, we first posited that nurses' team affective commitment would partially mediate the impact of nurse leadership. We further conceptualized nurse–physician collaboration, organizational formalization and task feedback as discrete contexts that may curb the influence of head nurses' individualized consideration. In a three-wave, multisource and multilevel study, we surveyed 654 nurses and 1770 patients from 91 hospital units. We found that team-level head nurses' individualized consideration positively and partially related to patient loyalty through nurses' team commitment and that higher levels of nurse–physician collaboration, organizational formalization and task feedback were associated with reduced influence of individualized consideration on team commitment and patient loyalty. We discuss the implications of these findings for advancing theory and research on TFL and contextual factors of leadership.

KEYWORDS

affective commitment, patient loyalty, social context, task context, transformational leadership

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Practitioner points

- Leaders' individualized consideration positively relates to patient loyalty.
- Team commitment partly mediates the relationship between individualized consideration and patient loyalty.
- Social and task contexts are contingencies that alter the effects of leaders' individualized consideration on team commitment and patient loyalty.

BACKGROUND

Transformational leadership (TFL) theory posits that a transformational leader inspires followers with vision, provides meaning to their work, arouses their enthusiasm and stimulates them to be innovative (Bass et al., 2003). A key feature of TFL theory is that TFL involves a process by which leaders 'generate awareness and acceptance of the purposes and mission of the group' (Bass, 1990, p. 21), suggesting that it can be conceptualized as a group-level concept (Bono & Judge, 2003; Li et al., 2015; Siangchokyoo et al., 2020). Indeed, by encouraging employees to perform beyond expectations (Bass, 1985), transformational leaders put the promotion of collective action and mission at the forefront of their influence on followers (van Knippenberg & Sitkin, 2013). At the team level, TFL would embody an 'ambient stimulus' that imbues the work group (Liao & Chuang, 2007, p. 1007). Research has reported team-level TFL to be positively associated with group identification (Wang & Howell, 2012), team potency (Schaubroeck et al., 2007), team support for innovation (Eisenbeiss et al., 2008), group performance (e.g., Banks et al., 2016, 2018; Bass et al., 2003; Wang et al., 2011) and team innovation (Li et al., 2016).

Despite the wealth of studies conducted to examine the effects of TFL, researchers have identified several limitations to this literature. First, based on a review of empirical evidence, Siangchokyoo et al. (2020) highlighted that little research has addressed the transformation of followers' motivational base as a mechanism that conveys the effects of TFL. Delving into this process is warranted because, as asserted by TFL theory (Bass & Riggio, 2006), TFL refers to 'a process whereby the leader builds followers' commitment to organizational objectives and develops followers to be able to accomplish organizational goals' (Siangchokyoo et al., 2020, p. 3). This approach is also consistent with defining leadership as 'the act of leading', hence as a process of social influence towards a common goal (Carton, 2022, p. 62). The present study heeds this call for examining processual models of TFL and aims at exploring the influence of TFL behaviours at the team level. There is indeed evidence that TFL may operate using distinct processes at the team level compared with the individual level (e.g., Chun et al., 2016; Li et al., 2016; Liao & Chuang, 2007; Wang & Howell, 2012). We posit that commitment to the team's goals as an aggregate, team-level psychological state represents a partial pathway through which TFL helps achieve team outcomes.

Second, critiques regarding the validity of the TFL model have emerged during the past decade (Antonakis et al., 2016; Fischer & Sitkin, 2023; van Knippenberg & Sitkin, 2013), which pointed out a deficient conceptualization where TFL is defined by its effects and unclear inclusion criteria to describe how the dimensions map onto the overall TFL construct. These critiques have led scholars to suggest that to revive the study of TFL, researchers should 'deconflate' the construct (Fischer & Sitkin, 2023) and focus on specific TFL dimensions where a family of related behaviours is used as part of a process model (Carton, 2022; van Knippenberg & Sitkin, 2013). This approach would allow departing from the use of a too broad construct that is liable to halo effects (Antonakis et al., 2016). The present study focuses on TFL's individualized consideration dimension because the context of the study, that is, nursing teams, makes it a relevant leadership behaviour (Johns, 2006, 2018). Individualized consideration refers to the extent to which a leader 'attends to each follower's needs, acts as a mentor or coach to the follower, and listens to the follower's concerns and needs' (Judge & Piccolo, 2004, p. 755).

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This study is conducted within the service sector (i.e., nursing teams), which provides the background, and general or *omnibus context* (Johns, 2006) where TFL's individualized consideration takes place. TFL research in service context remains scarce, however (e.g., see Liao & Chuang, 2007; Schaubroeck et al., 2016). A pending and unanswered question is how TFL, or its dimensions, may (a) foster service quality and (b) shape teams' motivational base to attend to customers' needs and meet their expectations. First, while team outcomes such as performance (e.g., Banks et al., 2018; Wang et al., 2011) and innovation (e.g., Eisenbeiss et al., 2008; Li et al., 2016) have been studied in connection to TFL, the perspective of the customer has been neglected (for an exception, see Weller et al., 2020). Scholars have generally argued and shown that TFL may benefit customer outcomes by fostering service climate and employee service performance (Liao & Chuang, 2007; Schaubroeck et al., 2016). More generally, service linkage research suggests that service climate and employee service behaviours may convey the effects of leadership on customer experiences (Bowen & Schneider, 2014). Second, this research however did not address how team-level TFL behaviours (e.g., individualized consideration) may build the team's motivation base towards serving customers. This study digs into both (a) the direct effect of TFL's individualized consideration on customer loyalty and (b) its indirect effect on customer loyalty through team commitment. This issue is particularly warranted given that leadership has been shown to wield a stronger impact on employees' customer orientation when they hold customer-contact positions (Liao & Subramony, 2008). This endeavour is also in line with evidence indicating that TFL is more effective at motivating employees when they are in contact with the beneficiaries of their actions (Grant, 2012). We posit that customer (patient) loyalty is a specific outcome of this process.

This study further aimed at exploring the role of *discrete context* variables on the influence of TFL's individualized consideration. Discrete context refers to situational factors that may influence behaviour or act as moderators of relationships between variables (Johns, 2006). While the role of situations has been explored for a while in leadership research (Howell et al., 1986), as illustrated by Fiedler's (1978) contingency model, House's (1971) path-goal theory, and Kerr and Jermier's (1978) substitutes for leadership theory, concerns about the validity of these models (e.g., Dionne et al., 2002; Podsakoff et al., 1996b; Podsakoff, Niehoff, et al., 1993; Zaccaro et al., 2018) have led leadership researchers to propose new approaches to situations (Ayman & Lauritsen, 2018; Oc, 2018). Following Johns (2006), discrete situations fall into three categories: task, social and physical aspects of the context. Oc (2018) extended this nomenclature by adding a temporal aspect, leading to four categories of discrete situations that may moderate the impact of leadership. Several scholars have called for a closer examination of the role of context in leadership (e.g., Anderson & Sun, 2023; Day, 2012; Zaccaro et al., 2018).

We suggest that Johns's (2006; see also Oc, 2018) task and social categories of discrete context are particularly relevant to the influence of the leader in nursing teams. First, as the delivery of quality care service is dependent on nurses' behaviour (Almarwani & Alzahrani, 2023), task-related features that provide information useful to helping nurses accomplish their jobs may mitigate the influence of the head nurse's acting as a coach or mentor (i.e., individualized consideration). We argue that organizational formalization (Contandriopoulos et al., 2018) and task feedback (Ilangakoon et al., 2022) are such task-related attributes of the nursing context that render individualized consideration by the leader less influential. Second, social aspects of the context may matter too. Studies have documented the importance of interprofessional collaboration (e.g., with physicians) (Karam et al., 2018; Tschannen & Kalisch, 2009) for achieving care quality. Therefore, we posit that nurse–physician collaboration is a salient social aspect that may facilitate the flow of information from physicians to nurses and help the latter achieve their tasks efficiently. Such collaboration may thus render the head nurse's behaviour (i.e., individualized consideration) less consequential.

The present study makes several contributions. First, taking stock of the recent critiques of the TFL model (e.g., Antonakis et al., 2016; Banks et al., 2018; van Knippenberg & Sitkin, 2013), we selected TFL's individualized consideration as a key leadership dimension predicting work outcomes among nursing teams. A focus on individualized consideration affords departing from a holistic perspective on TFL, known to be liable to halo effects in measurement (Fischer & Sitkin, 2023), to examine a specific set of related behaviours. This approach helps get TFL research out of its recent stagnation (Siangchokyoo

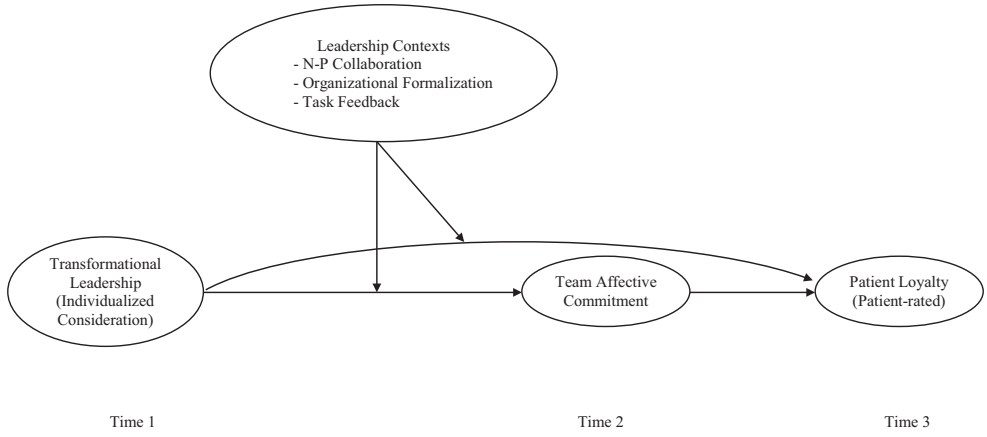


FIGURE 1 Theoretical model.
Note: N-P = Nurse-physician. Age, gender, unit tenure, and professional tenure are used as controls.

et al., 2020) by looking at TFL under the lens of leader behaviour (Anderson & Sun, 2023; Carton, 2022). Second, we explore both the direct effect of TFL's individualized consideration on service outcomes (patient loyalty) and its indirect effect through team commitment. This allows us to both consider the mechanism by which leaders *transform followers* (Bass, 1985; Bass & Riggio, 2006; Siangchokyoo et al., 2020) for the benefit of service quality and to examine individualized consideration's direct influence on patient loyalty by embodying an ambient stimulus for service quality (Liao & Chuang, 2007).

Third, we introduce an outcome that has been overlooked in the TFL literature, customer (i.e., patient) loyalty, which has strong relevance to the context of TFL among nursing teams. As an indicator of the customer experience (Bowen & Schneider, 2014), customer loyalty derives from customers experiencing need fulfilment during service interactions (Liao & Chuang, 2007), which resonates to TFL's individualized consideration attending to employees' needs and concerns (Judge & Piccolo, 2004). Finally, this study explores the role of task and social characteristics as boundary conditions associated with head nurses' individual consideration. In so doing, we contribute to elucidate how discrete contexts may alter the effect of leader behaviour, an under-explored area (Ayman & Lauritsen, 2018; Oc, 2018). Figure 1 presents our research model.

THEORY AND HYPOTHESES

TFL's individualized consideration and patient loyalty

The TFL model comprises three core dimensions: idealized influence, intellectual stimulation and individualized consideration (Bass & Riggio, 2006). Idealized influence refers to the leader behaving as a role model for followers and promoting shared values in the group; intellectual stimulation involves encouraging followers to innovate by challenging the status quo; and individualized consideration refers to the leader coaching followers and caring for their growth. By engaging in these behaviours, the transformational leader sparks members' sense of belonging to their team (Kark et al., 2003) and promotes team functioning (Hoffman et al., 2011). Several reviews and meta-analyses of the TFL literature have been conducted over the years that have reported positive relationships between TFL and individual (e.g., job satisfaction, affective commitment, job performance and OCB) and team (e.g., performance and innovation) outcomes (e.g., Abbas & Ali, 2023; Banks et al., 2016; Hoch et al., 2018; Koh et al., 2019; Lowe et al., 1996; Peng et al., 2021;

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Rockstuhl et al., 2023; Wang et al., 2011; Watts et al., 2020), including in nursing context (e.g., Alanazi et al., 2023).

However, TFL has been mostly treated as a unidimensional construct by averaging scores across dimensions in empirical research (e.g., Bass et al., 2003; Bono & Anderson, 2005; Eisenbeiss et al., 2008; Hannah et al., 2016; Lin et al., 2019), thereby hampering any consolidated knowledge regarding the contribution of the dimensions to work outcomes. This issue echoes recent critiques over the validity of the TFL construct. For example, van Knippenberg and Sitkin (2013) argued that TFL is unclearly defined, and that no logical basis is provided to justify the inclusion of the dimensions within the TFL umbrella, leading to conceptual ambiguities. Carton (2022) further suggested that TFL theory is a *lumped* theory of leading that combines multiple leader behaviours into a single concept, which may lead to halo effects when perceivers evaluate TFL dimensions (see also Antonakis et al., 2016; Fischer & Sitkin, 2023). Countering this holistic approach, research has however demonstrated that TFL dimensions exhibit differential effects on leader performance (Deinert et al., 2015) and employee identification to multiple targets (Horstmeier et al., 2017).

Focusing on specific TFL dimensions would help avoid the conceptual ambiguities raised by the critiques of the model by turning the spotlight on a family of coherent behaviours at the facet level. At the same time, this would obviate the atomistic fragmentation that results when too narrow leader behaviours are examined. We posit that the *omnibus context* of research (Johns, 2006) should dictate which TFL dimension is most relevant. The omnibus context 'refers to an entity that comprises many features or particulars' (Johns, 2006, p. 391). Johns posits that such context can be grasped through five questions, which for the purpose of this study can be answered as follows: *who* (nurses interacting with patients), *what* (care delivery), *when* (during patients' stay), *where* (within the nursing unit) and *why* (to improve patient health status). We contend that such omnibus context renders individualized consideration the most salient TFL facet as the work process involves human beings interacting during, and participating to, service delivery. Thus, how nurses feel their leader attends to their needs and concerns and promotes their growth and development (individualized consideration; Bass & Riggio, 2006; Judge & Piccolo, 2004; Rockstuhl et al., 2023) should be in sync with how patients derive their sense of loyalty to the nursing team. Indeed, the service linkage model (Bowen & Schneider, 2014) and relationship marketing principles (Liao & Chuang, 2007) suggest that the degree of need fulfilment and relational benefits are at the centre of the customer experience. We argue that when nurse leaders engage in individualized consideration towards nurses, the fulfilment of human needs will pervade the work unit and encourage nurses to take care of the needs of the beneficiaries of their work. This may happen because interactions with patients bring a sense of prosocial impact and meaning to their contributions (Grant, 2012).

While individualized consideration addresses each follower's needs and concerns individually (Schriesheim et al., 2009), our study is conducted at the nursing team level. Research indicates that TFL comprises dimensions that focus on either the individual or the group level (Li et al., 2016; Wang & Howell, 2010, 2012). For example, Wu et al. (2010) found differentiated individual-focused TFL (i.e., differentiated individualized consideration and intellectual stimulation) to sequentially induce leader identification divergence and self-efficacy divergence, which ultimately detracted from group effectiveness, while group-focused TFL dimensions (i.e., idealized influence and inspirational motivation) fostered group effectiveness via group identification and collective efficacy. This has brought the attention of researchers to better specify the level at which leadership behaviours, particularly TFL behaviours (Wang et al., 2011), and processes hold (Fischer et al., 2017). In the *omnibus* context of nursing teams, we submit that TFL's individualized consideration can be aggregated to reflect an 'ambient stimulus' (Liao & Chuang, 2007) pervading the whole team (Avolio & Bass, 1995). By attending the needs of all ward nurses individually, the head nurse ensures that all nurses self-actualize, resulting in the whole team being imbued by a service and caring mindset that fosters the delivery of quality services. A particularity of nursing teams is indeed that patient care cannot be delivered otherwise than through the concerted effort by the whole nursing team. Therefore, the following hypothesis is proposed.

Hypothesis 1. Team-level TFL's individualized consideration is positively related to patient loyalty.

TFL's individualized consideration, team affective commitment and patient loyalty

Individualized consideration also likely relates to patient loyalty through mediating mechanisms. Scholars have recently called for more research on addressing the processes by which TFL is assumed to influence work outcomes (Carton, 2022; Fischer et al., 2017; Gottfredson & Aguinis, 2017; Siangchokyoo et al., 2020; van Knippenberg & Sitkin, 2013). Since its inception, TLF theory has proposed three intervening processes through which TFL wields influence on followers (Bass, 1985; van Knippenberg & Sitkin, 2013; see also Shamir et al., 1993): collective identification, value internalization and self-efficacy. These processes involve developing or leveraging individual or team resources for the benefit of performance-related outcomes (Fischer et al., 2017) and reflect 'particular transformation in followers' (Siangchokyoo et al., 2020, p. 3). However, little research has examined how these processes can be activated by specific TFL dimensions to influence team outcomes. At the individual level though, Deinert et al.'s (2015) meta-analysis revealed that individualized consideration was positively related to leader, team and organizational identification.

This study focuses on the first mechanism (i.e., collective identification) specified by TFL theory as driving the effects of leader behaviour. Per Bass's (1985) theory, TFL is viewed as fostering commitment to shared goals among followers (Eisenbeiss et al., 2008; Ng, 2017; Rockstuhl et al., 2023). We surmise that team affective commitment adequately reflects such mechanism. Such commitment is based on the internalization of the team's goals and values (Kukenberger et al., 2015) and acts as a motivational force to produce high-quality service and performance (Johnson et al., 2010; Neininger et al., 2010). Moreover, team affective commitment has been found to aggregate at the team level because the emotional significance of members' attachment to their team tends to be shared through social interactions while members work at achieving the team's goals (Kearney et al., 2009; Kearney & Gebert, 2009). We suggest that TFL's individualized consideration indirectly helps improve customer service through team affective commitment. When attending to members' needs and concerns and acting as coaches for followers' development, leaders ignite the team's motivation to excel in delivering quality service to customers (patients). That is, nurses who benefit from such individualized consideration from their leader will feel supported in thriving at pursuing the goal of service quality endorsed by the team (Zaghini et al., 2020), hence team commitment will be enhanced. This would then have downstream consequences on customer (patient) loyalty. Thus, team commitment would be a linchpin that conveys the impact of TFL's individualized consideration on service delivery.

Hypothesis 2. At the team level, team affective commitment mediates a positive relationship between TFL's individualized consideration and patient loyalty.

The role of discrete contexts

Early on, Bass (1997) and Bass and Riggio (2006) conceded that context matters when examining the applicability of leadership models—including TFL. Various conceptualizations of contexts or situations have been proposed in the literature. For example, based on subjective perceptions of laypeople, Rauthmann et al. (2014) proposed and validated a taxonomy of psychologically meaningful dimensions of situation characteristics which they named DIAMONDS, an acronym to refer to eight types of situations ('Duty, Intellect, Adversity, Mating, pOsitivity, Negativity, Deception, and Sociality;' p. 677) that act as cues for behaviours and actions. While this taxonomy could be used to determine which type of leader behaviour is activated in a given (perceived) work situation (Anderson & Sun, 2023), other

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models have been proposed that are more specific to leadership in workplaces. For example, Ayman and Lauritsen (2018) suggested that leadership contingencies can be split into two categories: the *interpersonal context* (e.g., culture, organization, nature of the task and group composition) and the *intrapersonal context* (e.g., personality traits and gender role). Similarly, Zaccaro et al. (2018) distinguished objective situations such as demographic characteristics and physical distance with the leader, and subjective situations, which reflect how situational characteristics are filtered and socially constructed by individuals.

We contend that Johns's (2006) categorical framework, which has been extended and applied to leader behaviour by Oc (2018), offers a valuable approach to understanding the role of contextual factors in nursing leadership. This is because the omnibus context, which relates to the 'who, what, when, where, and why' (Johns, 2006, p. 391) of the context, as discussed above, provides the higher-order situation or environment within which discrete contexts are nested. 'Nurses and patients interacting in nursing wards during service delivery in hospitals for purpose of health improvement' describes the omnibus context of the present study. Among discrete contexts, task, social, physical and temporal contexts would be the major characteristics that may influence the effectiveness of leader behaviour (Oc, 2018). Among these characteristics, the task and social contexts have been mostly investigated, essentially because task characteristics have natural relevance to contingency models of leadership while social characteristics have been abundantly treated in the team effectiveness literature (Beal et al., 2003; Mathieu et al., 2008; Oc, 2018).

This study examines three types of discrete situations that are conceived as moderators of TFL's individualized consideration: *nurse–physician collaboration* (i.e., a social characteristic) and *organizational formalization* and *task feedback* (i.e., task characteristics). In contrast to past research that has often examined discrete situations at the individual level, particularly substitutes for leadership (e.g., Podsakoff et al., 1996a), we examine these discrete contexts as moderators that affect the influence of leaders at the team level (Tosi & Banning, 1998) due to likely shared subjective perceptions of such contexts within teams (Oc, 2018). We submit that all three contexts have the unique property of partly neutralizing (a) the direct effect of head nurses' individualized consideration on customer loyalty and (b) its indirect effect on it through team commitment.

Social context: Nurse–physician collaboration

Coordination with other professionals such as physicians is a social context characteristic that may alter how nurse leaders can influence patient loyalty and team commitment. Nurse–physician collaboration reflects a situation where nurses and physicians work together to accomplish shared objectives related to patient care (Tang et al., 2013). Such collaboration involves nurses and physicians sharing responsibilities about patient care (Ushiro, 2009). Studies reported nurse–physician collaboration to be critical for nurses (e.g., job satisfaction and low turnover intention; Anderson, 1996; Caricati et al., 2016; Zhang et al., 2016) and patients (e.g., hospital stay, patient satisfaction and loyalty; Tschannen & Kalisch, 2009; Wang et al., 2018). Meta-analysis (Zangaro & Soeken, 2007) confirmed that nurse–physician collaboration may enhance health care professionals' working relationships and patient outcomes. It has also been shown that a stronger nurse–physician collaboration is related to lower odds of patients reporting inconsistency in communication between staff (von Knorring et al., 2020) and that interdisciplinary teamwork improves team functioning and care delivery (Karam et al., 2018) as well as better understanding by patients of the plans of care (O'Leary et al., 2012).

We suggest that the social context of nurse–physician collaboration provides cues that alter the effect of TFL's individualized consideration in two ways. First, nursing teams that enjoy close collaboration with physicians are more likely to feel autonomous and find opportunities to learn (Laschinger & Wong, 1999). Moreover, such collaboration offers an empowering environment that helps nurses develop self-governance (Laschinger, 2004). This is because this context provides nurses with care instructions from physicians which may guide the nursing team in completing their tasks. This social context makes head nurses' assistance through coaching or mentoring activities (individualized consideration) less needed. This may happen because the empowerment benefits instilled by a close

collaboration with physicians may partly substitute for the service ambiance (Liao & Chuang, 2007) that leaders' individualized consideration generates to foster the quality of the service experience among patients. Conversely, when collaboration with physicians is low, nursing teams may feel less empowered by their interactions with physicians to attend to patient needs (Keenan et al., 1998), thereby making the service ambiance instilled by the leader's individualized consideration more critical for gaining patients' loyalty. To summarize, a stronger nurse–physician collaboration should curb the positive relationship between leader individualized consideration and patient loyalty.

> **Hypothesis 3a.** At the team level, nurse–physician collaboration moderates the relationship between TFL's individualized consideration and patient loyalty such that this relationship is weaker when nurse–physician collaboration is higher.

Second, a stronger nurse–physician collaboration should also reduce the indirect effect of TFL's individualized consideration on patient loyalty through team commitment. As individualized consideration helps build the team's motivation at delivering care quality (i.e., team commitment) by supporting nurses at doing so, one may expect that a climate of close cooperation with physicians will act as a substitute for nurses' identification to team goals. That is, a close collaboration with physicians may reduce the ability of head nurses to use individualized consideration (e.g., coaching activities) to leverage nurses' identification to team goals, because nurses would not consider such activities as important (due to the role of physicians in this endeavour) for internalizing the team's goal of quality care. Ultimately, team commitment would be less efficient at conveying the effect of the leader's individualized consideration actions on patient loyalty. Conversely, a context of reduced collaboration with physicians would provide a broader opportunity for head nurses to influence team commitment by addressing nurses' needs. In such context, mentoring and coaching activities by the head nurse may foster the emotional significance of the team's goals as nurses would understand how such activities help achieve the team's goals, leading to stronger team commitment and ultimately to enhanced customer loyalty. The above discussion leads to the following hypothesis.

> **Hypothesis 3b.** At the team level, nurse–physician collaboration moderates the relationship between TFL's individualized consideration and team commitment and the indirect relationship between TFL's individualized consideration and patient loyalty via team commitment such that these relationships are weaker when nurse–physician collaboration is higher.

Task characteristics: Organizational formalization and task feedback

The task-related context has a long tradition of research as a contingency of leadership (Ayman & Lauritsen, 2018; Oc, 2018). We argue that two task characteristics, that is, organizational formalization and task feedback, may engender situational cues that can moderate the leader's influence in nursing teams.

Organizational formalization

As a device that produces a standardization of care processes and operations (Contandriopoulos et al., 2018), organizational formalization refers to the degree to which work procedures and guidelines are explicitly communicated (Kerr & Jermier, 1978; Podsakoff, MacKenzie, & Fetter, 1993). As such, formalization provides nurses with ground rules that forestall unclear expectations about task completion. As professionals, nurses are inclined to attend to information and seek resources that help improve knowledge and nursing practice (Hakvoort et al., 2022). The formalization of care processes fills this need by providing guidelines regarding how nursing acts should be accomplished. We posit that such formalization affects the influence of leader individualized consideration in two ways. First, a context where care processes are standardized makes the completion of tasks related to patient care less dependent on the service mindset initiated by head nurses' individualized

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consideration. That is, the standardized rules can to some extent replace nurses' attention to patient needs. As such, patients may want to remain loyal, not because they benefit from a positive service climate but because the tasks of patient care are nicely standardized and work smoothly. Such context makes head nurses' individualized consideration less critical to patient loyalty. The reverse may happen when organizational formalization is reduced. Such situation would make the completion of tasks more uncertain, thereby requiring that head nurses coach team members to enable them to manage work-related ambiguity. By providing appropriate coaching to ward nurses, head nurses would work at maintaining a keen sense of customer service, which should contribute to patient loyalty. Therefore, the following hypothesis is proposed.

> **Hypothesis 4a.** At the team level, organizational formalization moderates the relationship between TFL's individualized consideration and patient loyalty such that this relationship is weaker when organizational formalization is higher.

Second, formalization may also affect the indirect relationship between TFL's individualized consideration and patient loyalty through team commitment. As formalization is aimed at standardizing work procedures, the power of nurse leaders as coaches of nurses' needs and concerns (i.e., individualized consideration) to foster the team's commitment to health care goals may be undermined. In other words, as ward nurses can refer to standard procedures for delivering patient care, they will be less dependent on the head nurse's attention to their needs to experience an emotional attachment to the team's goals (i.e., team commitment; Kearney & Gebert, 2009). Thus, organizational formalization renders TFL's individualized consideration a less salient driver of team commitment, ultimately resulting in a weaker downstream effect on customer loyalty. Conversely, when work procedures are less standardized, the effect of TFL's individualized consideration on building a collective identity would be stronger because ward nurses would see the head nurse's mentoring as a useful support for attaining team goals, which should foster team commitment, leading to improved patient experience (i.e., patient loyalty). This leads to the following hypothesis.

> **Hypothesis 4b.** At the team level, organizational formalization moderates the relationship between TFL's individualized consideration and team commitment and the indirect relationship between TFL's individualized consideration and patient loyalty via team commitment such that these relationships are weaker when organizational formalization is higher.

Task feedback

A variety of task characteristics have been considered as contextual moderators of leadership, such as task complexity (e.g., D'Innocenzo et al., 2016), task interdependence (e.g., Burke et al., 2006; Li et al., 2016) and job autonomy (e.g., Den Hartog & Belschak, 2012). This study focuses on task feedback, which refers to the performance assessment that is provided by the task itself regarding how well one has performed at work (Hackman & Oldham, 1975; Kerr & Jermier, 1978; Wegman et al., 2018). As such, task feedback is a mechanism that contributes to develop nurses' competencies (Ilangakoon et al., 2022), particularly as it informs about patients' status and reaction to medical treatments, and contributes to motivation and effectiveness (Sansone, 1986). Contrary to other task characteristics (complexity, interdependence and autonomy), task feedback may function 'in place of the formal leader' (Kerr & Jermier, 1978, p. 379) because it provides 'direct and clear information about the effectiveness of task performance' (Morgeson & Humphrey, 2006, p. 1323). For example, a nurse may attend to the patient's physical status (e.g., blood pressure and body temperature) after administering a medication, thereby being informed about how well she did. Unlike prior studies that treated task feedback as an individual-level variable, our study examines task feedback at the team level. As nurses perform similar job roles and accomplish their tasks complementarily, task feedback

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likely aggregates and is incorporated into the team's overall functioning, particularly by facilitating team decisions about patients' treatment.

As it provides cues that help ward nurses improve their performance, task feedback represents a context that may influence leadership. First, the head nurse's mentoring activities, which are helpful to instil a sense of customer service within the team, may be less needed when nurses receive performance feedback from their tasks. This is because such feedback would provide the impetus for quality service to patients without the need for a leader instilling a sense of service. Therefore, the TFL's climate of individualized consideration would not contribute as much to the patient experience (customer loyalty) than when task feedback is high. In contrast, when task feedback is low, the coaching activities of the head nurse would contribute to the emergence of a collective sense of service that secures a positive patient experience. This would happen because the sense of service brought by the leader would substitute for the service that naturally flows when task feedback is high. We thus suggest the following hypothesis.

> **Hypothesis 5a.** At the team level, task feedback moderates the relationship between TFL's individualized consideration and patient loyalty such that this relationship is weaker when task feedback is higher.

Second, the motivational effect of TFL's individualized consideration on patient loyalty through team commitment would also be lessened within an environment of strong task feedback. Indeed, when nurses benefit from feedback related to their tasks, they may perceive the coaching activities of the head nurse as less inspiring, supportive and needed for their commitment to the team's goals. Task feedback would blur ward nurses' need to be supported and mentored by the head nurse, which would curtail the benefits of TFL's individualized consideration for building a collective sense of identity (i.e., team commitment) and indirectly the patient experience. The reverse would happen when task feedback is low. In the absence of task feedback, nurses may turn to the head nurse to feel emotionally engaged in patient care, which is the basis of team commitment. Indeed, looking after nurses' needs and concerns would meet their expectations of support, thereby enhancing team commitment, which in turn would convey a better patient experience. Thus, the following hypothesis is proposed.

> **Hypothesis 5b.** At the team level, task feedback moderates the relationship between TFL's individualized consideration and team commitment and the indirect relationship between TFL's individualized consideration and patient loyalty via team commitment such that these relationships are weaker when task feedback is higher.

METHOD

Sample and procedure

We conducted this study among the nursing units of six general hospitals in Western Europe. At each hospital, we obtained the agreement of the nursing director, the medical director and the ethics committee for surveying nurses and inpatients. Informed consent was also obtained from participants. The leadership structure of nursing departments included (a) a nursing director, (b) several nursing heads supervising services that combine units pertaining to the various medical disciplines (e.g., internal medicine, surgery and paediatrics) and (c) head nurses who act as supervisors of a nursing team/unit. Head nurses namely oversee nursing practice in their unit, plan work schedules, evaluate unit nurses' acts and coordinate activities with other professional groups. Unit nurses are collectively responsible for nursing care to all patients in their unit, meaning that patients are not assigned to specific nurses. This makes the coordination of activities across nurses a linchpin for

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delivering high-quality patient care. Unit nurses' work schedules (morning, afternoon and night shifts) are organized such that all nurses successively work on the different shifts and maintain frequent contacts with their head nurse.

To be eligible, inpatients were to stay at least 48 h (except for day care), be aged 18 years or more and display no altered consciousness. Based on these criteria, units of paediatrics, neonatology, psychiatry, emergency and medico-technical services were excluded. In total, 91 head nurses agreed that their units—nurses and inpatients—would participate. These units represented a variety of medical disciplines, including surgery ($n = 30$), internal medicine ($n = 28$), maternity ($n = 6$), intensive care ($n = 10$), geriatrics ($n = 6$), rehabilitation ($n = 6$) and day care ($n = 5$). At Time 1, nurses were surveyed about TFL's individualized consideration of the head nurse and the three leadership contextual factors. A cover letter accompanied questionnaires, explaining the purpose of the study and assuring the confidentiality of responses. Two months later, Time 1 respondents were surveyed about team affective commitment. Finally, inpatients were surveyed about patient loyalty 2 months after Time 2. For each unit, a random sample of 20 to 25 patients was selected from the list of inpatients.[1] Eight students who were unaware of nurses' responses contacted patients, explained the research objectives, assured response confidentiality and asked patients for their participation. Patients filled out their questionnaire privately and sealed it in an envelope. At the end of the day, students collected the envelopes with the completed questionnaires.

Among 1300 nurses, 830 (63.85%) responded at Time 1 and 654 (50.31%) responded at Time 2 (M per unit = 7.19; range = 3–19). Average age was 35.77 years ($SD = 8.35$), average unit tenure was 8.65 years ($SD = 6.91$), average professional tenure was 13.51 years ($SD = 8.28$), and 92.66% were female. Moreover, 1770 patients provided usable responses (M per unit = 19.67; range = 13 to 23). To assess attrition bias over time, we tested whether participating at T2 ($N = 654$) among T1 participants ($N = 830$) could be predicted by Time 1 variables. The logistic regression was significant: $\chi^2(8) = 28.15$, $p < .001$: nurses with lower scores on TFL's individualized consideration and nurse–physician collaboration and higher scores on organizational formalization at Time 1 were more likely to respond at Time 2. We discuss this attrition bias in the limitations section.

Measures

Unless otherwise stated, a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*) was used.

Transformational leadership: Individualized consideration

We measured TFL's individualized consideration ($\alpha = .96$) using Bass and Avolio's (1991) 8-item scale (e.g., 'Treats each of us as individuals with different needs, abilities and aspirations').

Nurse–physician collaboration

We measured nurse–physician collaboration ($\alpha = .95$) as a team climate using Anderson's (1996) 10-item scale (e.g., 'The physicians trust nurses' assessments'). This scale captures aspects such as co-operation, communication, mutual respect, and recognition between physicians and nurses. As a social characteristic, nurse–physician collaboration is captured through a referent-shift consensus approach (Chan, 1998).

[1]We opted for 20 to 25 patients per unit out of practical considerations, for it was not always possible to reach a constant number of patients. So, it was more feasible to collect patient data by a flexible range.

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Organizational formalization

We measured organizational formalization ($\alpha = .85$) using Podsakoff and MacKenzie's (1994) 3-item scale (e.g., 'My job responsibilities are clearly specified in writing'). Organizational formalization is assessed through a direct consensus approach (Chan, 1998) and aggregated to the team level because nurses interchangeably complete the same tasks to achieve patient care.

Task feedback

We measured task feedback ($\alpha = .66$) using Podsakoff and MacKenzie's (1994) 3-item scale (e.g., 'My job provides me with the opportunity to find out how well I am performing'). Task feedback is assessed through direct consensus among nurses (Chan, 1998).

Team affective commitment

We measured team affective commitment ($\alpha = .83$) using Meyer et al.'s (1993) 6-item scale. As this scale was developed for measuring organizational commitment, we replaced 'organization' with 'unit' (e.g., 'I really feel a sense of belonging to my unit').

Patient loyalty

We measured patient loyalty ($\alpha = .96$) using three items (i.e., 'If you were to be hospitalized again, would you choose this unit?' 'Overall, to what extent are you satisfied with your stay at this unit?' 'After your stay, would you recommend the unit where you have been hospitalized to your family or a friend?') on a 5-point scale ranging from 1 (*definitely not*) to 5 (*definitely yes*). An exploratory factor analysis of these three items revealed a single-factor solution (eigenvalue = 2.80), with factor loadings ranging from .92 to .98. Our 3-item measure of patient loyalty is an application to the hospital context of the construct of customer loyalty, defined as 'a deeply held commitment to rebuy or repatronize a preferred product/service consistently in the future' (Oliver, 1997, p. 392), which captures commitment to repurchasing a product/service central to customer loyalty (Maxham III et al., 2008).

Control variables

We controlled for age, gender, unit tenure and professional tenure, as these variables have been reported to be associated with job attitudes and performance (Bommer et al., 2007; Eldor, 2021).

RESULTS

Confirmatory factor analyses

Confirmatory factor analysis (CFA) with MLM estimation was used to examine the data at the unit level ($n = 91$). For modelling efficiency (cf. Little et al., 2013), we parcelled items into three indicators per construct for individualized consideration, nurse–physician collaboration and team commitment, using balancing approach (i.e., the high-to-low loadings procedure). The six-factor model yielded a good fit: $\chi^2(120) = 155.98$, CFI = .97, TLI = .96, RMSEA = .06 and SRMR = .05 (see Appendix 1). This model was superior to (a) a five-factor model (organizational formalization and task feedback:

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one factor): $\Delta\chi^2$ (5) = 14.49, $p < .05$; (b) a four-factor model (the three leadership contexts: one factor): $\Delta\chi^2(9) = 142.70$, $p < .001$; (c) a three-factor model (the three leadership contexts and team commitment: one factor): $\Delta\chi^2(12) = 220.97$, $p < .001$; and (d) a two-factor model (nurse-reported items: one factor): $\Delta\chi^2(14) = 471.18$, $p < .001$. Our constructs were thus distinguishable.

Data aggregation and levels of analysis

We assessed the appropriateness of aggregating the individual-level scores to the team level by calculating within-group agreement ($r_{WG[J]}$; James et al., 1984) and intraclass correlations (ICC[1] and ICC[K]; LeBreton & Senter, 2008). The results (see Appendix 2) provided justification for aggregating variables to the team level (e.g., individualized consideration: mean $r_{WG[J]} = .84$, median $r_{WG(J)} = .90$, ICC[1] = .37, ICC[K] = .78).

Analyses

We used multilevel structural equation modelling (MSEM) with unconflated technique (Preacher et al., 2011) to examine the data. We mean centred team-level variables by the hospital mean to control for hospital effects and mean centred the individual-level variables by the unit mean. This allowed testing the moderating effects of the contextual factors of TFL's individualized consideration at the team level. We used latent moderated structural equations (LMS) with Mplus 8.3 (Muthén & Muthén, 1998–2017) to test hypotheses involving interactions (Hayes & Preacher, 2013). We tested our hypotheses in two steps: Step 1 tested Hypotheses 1–2 (partial mediation); Step 2 examined Hypotheses 3–5 (two-way moderations combined with partial mediation).

Hypothesis tests

Descriptive statistics and correlations are reported in Table 1. Hypothesis 1 predicted that individualized consideration positively relates to patient loyalty and Hypothesis 2 that team commitment mediates this relationship. Using MSEM, the partial-mediation model (M2) fitted the data well, $\chi^2(133) = 96.15$, CFI = 1.00, TLI = 1.01, RMSEA = .00, SRMR = .05, and outperformed the full-mediation model (M1), $\Delta\chi^2(1) = 5.41$, $p < .05$. In this model, TFL's individualized consideration positively related to patient loyalty ($\beta = .14$, $p < .05$), yielding support for Hypothesis 1.[2] Moreover, TFL's individualized consideration was positively associated with team commitment ($\beta = .36$, $p < .001$), and the latter was positively related to patient loyalty ($\beta = .31$ $p < .05$). Using the Monte Carlo method with 20,000 replications (Selig & Preacher, 2008) to create 95% confidence intervals (CIs), we found TFL's individualized consideration to indirectly and significantly relate to patient loyalty through team commitment (.11, 95% CI = [.02, .20]). Hypothesis 2 is thus supported.

Hypotheses 3–5 specified a moderating role of nurse–physician collaboration, organizational formalization, and task feedback in the effects of TFL's individualized consideration on team commitment and patient loyalty. To test these hypotheses, we added the alternative moderators to M2, thereby building three moderated mediation models: M3 to M5. M3 through M5 yielded a better fit than M2 (*p*s < .001): M3 (nurse–physician collaboration): $\Delta\chi^2(6) = 154.90$; M4 (organizational formalization): $\Delta\chi^2(6) = 315.78$; and M5 (task feedback): $\Delta\chi^2(6) = 141.69$ (see Figure 2 for all model coefficients).[3] Table 2 reports the tests of simple-slope differences between high and low levels of the

[2]We examined whether patient loyalty could be influenced by (a) degree of care acuteness (internal medicine, surgery and intensive care units are rated as 'acute' while maternity, geriatrics and rehabilitation units are rated as 'sub-acute'), (b) patients' average length of stay (1 = <3 days; 2 = 3–6 days; 3 = 7–12 days; 4 = 12+ days), (c) number of hospital beds and (d) number of nurses per unit. Using multiple regression at the unit level, none of these variables predicted patient loyalty.

[3]For model comparisons, we followed Bryant and Satorra (2012) suggestion and estimated the $\Delta\chi^2$ using log-likelihood difference values (i.e., Δ-2LL) and scaling correction factors obtained from Mplus 8.3 (see http://www.statmodel.com/chidiff.shtml; cf. Dimitruk et al., 2007).

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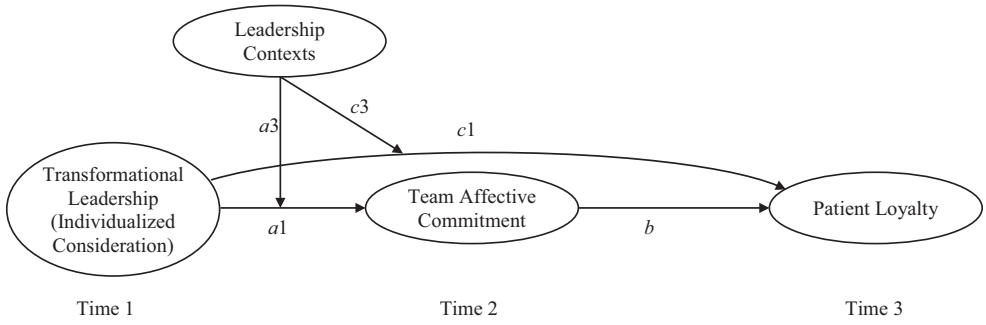
TABLE 1 Descriptive statistics and correlations among variables.

Variable	1	2	3	4	5	6	7	8	9	10	*M*	*SD*
1. Age	–	−.18**	.55**	.94**	−.04	.06	.11**	.18**	.01	−.11**	35.59	4.86
2. Gender		–	−.06	−.17**	−.07	−.00	−.17**	−.19**	−.10**	−.02	.06	.11
3. Team tenure			–	.57**	−.06	.13**	.18**	.13**	.08	.18**	8.40	3.47
4. Professional tenure				–	−.09*	.07	.03	.16**	.00	−.11**	13.34	4.79
5. TFL's individualized consideration					(.96)	.33**	.49**	.43**	.53**	.37**	3.18	.75
6. Nurse–physician collaboration						(.95)	.38**	.42**	.29**	.28**	3.21	.62
7. Organizational formalization							(.85)	.62**	.36**	.37**	3.37	.71
8. Task feedback								(.66)	.29**	.14*	3.93	.41
9. Team affective commitment									(.83)	.36**	3.74	.47
10. Patient loyalty										(.96)	4.19	.41

Note: *N* (teams) = 91. For gender: 0 = female, 1 = male. TFL = transformational leadership. Alpha coefficients are reported on the diagonal in parentheses.

*$p < .05$; **$p < .01$.

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Models	Leadership Contexts	*a*1	*a*3	*b*	*c*1	*c*3
Model 3	Nurse-physician collaboration	.30***	-.22**	.25*	.11#	-.08
Model 4	Organizational formalization	.33***	-.22***	.19*	.11*	-.23***
Model 5	Task feedback	.33***	-.39	.19#	.12#	-.47*

Note. $N = 91$ teams. Entries are coefficient estimates.
#$p < .10$; *$p < .05$; **$p < .01$; ***$p < .001$.

FIGURE 2 Model path coefficients for interaction tests.

moderators. The direct effect of TFL's individualized consideration on patient loyalty was negatively moderated by organizational formalization (−.29, 95% CI = [−.43, −.15]) and task feedback (−.29, 95% CI = [−.49, −.10]), but not by nurse–physician collaboration (−.09, 90% CI = [−.20, .03]). Figure 3 depicts the significant two-way interactions. TFL's individualized consideration had stronger positive relationships with patient loyalty (Panels D and E) when the contextual moderators were low (vs. high) (*simple slope* '*s*' and *slope comparison* 'Δ*s*'): Panel D (organizational formalization): +1*SD*: $s = -.04$, *ns*, −1*SD*: $s = .25$, $p < .001$, $\Delta s = -.29$, $p < .001$; and Panel E (task feedback): +1*SD*: $s = -.03$, *ns*, −1*SD*: $s = .27$, $p < .01$, $\Delta s = -.29$, $p < .01$. Therefore, Hypotheses 4a and 5a are supported while Hypothesis 3a is rejected.

Similarly, the relationship between TFL's individualized consideration and team commitment was negatively moderated by nurse–physician collaboration (−.26, 95% CI = [−.43, −.09]), organizational formalization (−.28, 95% CI = [−.43, −.15]) and task feedback (−.24, 90% CI = [−.45, −.04]). As shown in Figure 3, TFL's individualized consideration had stronger positive relationships with team commitment at low levels of the contextual moderators (*simple slope* '*s*' and *slope comparison* 'Δ*s*'): Panel A (nurse–physician collaboration): +1*SD*: $s = .17$, $p < .05$, −1*SD*: $s = .43$, $p < .001$, $\Delta s = -.26$, $p < .01$; Panel B (organizational formalization): +1*SD*: $s = .19$, $p < .01$, −1*SD*: $s = .46$, $p < .001$, $\Delta s = -.28$, $p < .001$; and Panel C (task feedback): +1*SD*: $s = .21$, $p < .05$, −1*SD*: $s = .46$, $p < .001$, $\Delta s = -.24$, $p = .05$. Finally, the indirect effect of TFL's individualized consideration on patient loyalty through team commitment was negatively moderated by nurse–physician collaboration (−.07, 90% CI = [−.13, −.004]), organizational formalization (−.05, 90% CI = [−.10, −.002]) and task feedback (−.05, 90% CI = [−.09, −.002]). Hypotheses 3b, 4b and 5b are thus supported.[4]

DISCUSSION

This study used a disaggregated approach to the study of TFL by focusing on its dimension of individualized consideration as a driver of nurse team commitment and customer loyalty. Based on Johns's (2006) categorical framework as applied to leadership (Oc, 2018), we specified nursing teams as the *omnibus context* in which nurse–physician collaboration, organizational formalization and task

[4]The results related to hypothesis tests remained similar when the control variables were dropped.

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TABLE 2 Tests of simple-slope differences for moderated direct and indirect effects.

Model	Leadership contexts	Contextual levels	Estimates $X \rightarrow M$ $\theta a = a1 + a3{*}W$	Estimates $X \rightarrow Y$ $\theta b = c1 + c3{*}W$	Estimates $X \rightarrow M \rightarrow Y$ $\theta c = (a1 + a3{*}W) \times b$
M3	Nurse–physician collaboration	High	.17 [.03, .31]	.07 /−.07, .20/	.04 /.002, .08/
		Low	.43 [.31, .55]	.16 [.01, .30]	.11 [.01, .21]
		High vs. Low	−.26 [−.43, −.09]	−.09 /−.20, .03/	−.07 /−.13, −.004/
M4	Organizational formalization	High	.19 [.06, .32]	−.04 [−.14, .07]	.04 /.001, .07/
		Low	.46 [.32, .60]	.25 [.13, .37]	.09 /.01, .16/
		High vs. Low	−.28 [−.43, −.15]	−.29 [−.43, −.15]	−.05 /−.10, −.002/
M5	Task feedback	High	.21 [.03, .40]	−.03 /−.15, .10/	.04 /−.01, .09/
		Low	.46 [.27, .64]	.27 [.10, .44]	.09 [.003, .17]
		High vs. Low	−.24 /−.45, −.04/	−.29 [−.49, −.10]	−.05 /−.09, −.002/

Note: Estimates reflect tests of simple-slope differences for high (+1*SD* above the mean) vs. low (−1*SD* below the mean) value of leadership contexts. Values within / / reflect 90% confidence interval while values within [] reflect 95% confidence interval.

Abbreviations: M, team affective commitment; W, leadership context; X, transformational leadership (individualized consideration); Y, patient loyalty.

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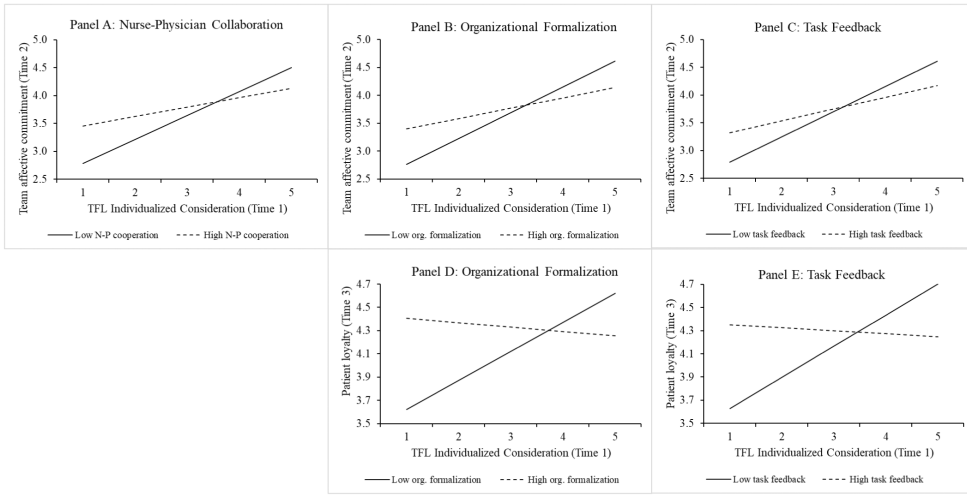


FIGURE 3 Plots for interactions between transformational leadership (TFL) (individualized consideration) and leadership contexts.

feedback were nested as *discrete contexts*. Using this contextual perspective at the team level, we found that TFL's individualized consideration by head nurses was both directly related to enhanced patient loyalty and indirectly related to it through stronger team affective commitment. Moreover, the discrete contexts of nurse leadership were found to qualify these relationships such that nurse–physician collaboration, organizational formalization and task feedback mitigated the positive effects of TFL's individualized consideration. These findings have implications for TFL research and the role of context in the study of leadership, as we now discuss.

Theoretical contributions

During the past decade, several critiques of the TFL model have spread in the leadership literature (e.g., Anderson & Sun, 2017; Antonakis et al., 2016; Banks et al., 2018; Carton, 2022; Fischer & Sitkin, 2023; van Knippenberg & Sitkin, 2013). Critiques underscored that TFL is a broad construct, ill-conceived, which comprises dimensions whose relationship to the higher-order TFL concept is not clearly defined (e.g., van Knippenberg & Sitkin, 2013). Moreover, the description of the behaviours associated with TFL, or its dimensions, has been judged to be susceptible to conflation. Basically, the description of the leader's behaviours may be confounded with the behavioural intentions of the leader, the quality of execution of the behaviours, and/or with their effects, resulting in construct redundancy and amalgamation (Fischer & Sitkin, 2023). To circumvent these issues, scholars have suggested that a path forward in TFL research might be to focus on specific dimensions of the construct depending on the nature of the context (e.g., Siangchokyoo et al., 2020; van Knippenberg & Sitkin, 2013). This approach would involve abandoning the study of leadership styles to undertake the examination of specific categories of leader behaviours (i.e., Banks et al., 2018; Carton, 2022).

This study focused on TFL's individualized consideration because it involves behaviours that have high relevance in a context where care for human beings is the core activity and prosocial impact is thus salient (Grant, 2012). As it refers to a set of related behaviours (e.g., paying attention to followers' needs, coaching them and providing feedback; Antonakis et al., 2003), instead of a leadership style, individualized consideration can be compared with dimensions from other leadership models. For example, it has similarities with the consideration factor from the Ohio State studies (Fleishman, 1973; Judge et al., 2004) and the 'helping subordinates grow and succeed'

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dimension from the servant leadership model (Liden et al., 2008). Although rather scarce research has examined TFL's individualized consideration as a predictor of leadership outcomes (e.g., Deinert et al., 2015; Horstmeier et al., 2017), the present findings suggest that at the team level, individualized consideration by head nurses positively relates to patient loyalty, both directly and through team commitment. To break down the barriers across leadership models, it might be worth exploring whether similar results could be obtained using the relational dimensions of other leadership models (Rowold et al., 2015).

The present study counts among the few attempts at testing a process model of TFL targeting one of its specific dimensions. This endeavour was conducted using a time-lagged design with a temporal separation of 2 months between measures and an outcome reflecting the perspective of the beneficiaries of service providers' work, thereby ensuring robustness to the findings (Siangchokyoo et al., 2020). First, TFL's individualized consideration was associated with improved customer loyalty, which is an important indicator of the service experience (Bowen & Schneider, 2014). This finding extends research showing that TFL predicts team performance (e.g., Banks et al., 2018; Bass et al., 2003; Keller, 2006; Mach et al., 2022; Mitchell et al., 2014; Wang et al., 2011) and work indicating that at the individual level, TFL fosters follower service performance, ultimately resulting in customers' willing to maintain the service relationship (Liao & Chuang, 2007), as well as sales and revenue by call centre employees (Grant, 2012). This study uniquely demonstrates that in the context of care service at the team level, customers (patients) appraise positively the climate of head nurses caring for nurses' needs to a point that they are willing to stay loyal to the nursing team. We argue that such association might be attributable to the isomorphism between attention paid to nurses' concerns and care provided to patients. That is, nurses' evaluation of head nurses' individualized consideration may reflect an assessment of human service orientation that matches the perspective of customers evaluating care service. This result is in line with the principles of service linkage research (e.g., Bowen & Schneider, 2014; Hong et al., 2013; Schneider et al., 2005).

Second, we addressed a key mediating mechanism by which TFL's individualized consideration prompted the customer experience, that is, team commitment, which was found to partly channel the effect of individualized consideration onto patient loyalty. Team commitment corresponds to what early TFL theory labelled collective identification (Bass, 1985; Kark et al., 2003; Shamir et al., 1993) in that it is based on the internalization of the team's goals and values (Kukenberger et al., 2015) and can be shared through social interactions among followers (Kearney & Gebert, 2009). Our finding underscores the importance of head nurses' attention to nurses' needs and concerns as a specific motivational mechanism that helps nurses internalize the goals of their team. Such mechanism differs from head nurses being role models (i.e., idealized influence), providing a vision (i.e., inspirational motivation) and encouraging followers to find creative solutions (i.e., intellectual stimulation) (Banks et al., 2018; Bass & Riggio, 2006) as alternative TFL dimensions. As competence development is a central concern for nurses (Hakvoort et al., 2022), head nurses who attend to this need may create the ideal conditions for them being committed to achieving the team's goal (i.e., presumptively delivering care quality) and to share this mindset with the other teammates. This process logically results in improved customer experience.

Another set of contributions relates to the contextualization of TFL's individualized consideration. Findings indicate that specific social and task contexts can make leader behaviours less consequential in influencing followers' commitment and patient loyalty. First, we found that nurse–physician collaboration negatively moderated the effect of TFL's individualized consideration on team commitment and its indirect effect on patient loyalty. Such moderating effect may occur because a responsibility of head nurses is to coordinate activities with other professional groups (e.g., physicians); close nurse–physician collaboration may reduce the utility of head nurses' coaching activities as a basis for nurses' collective identity. Indeed, when physicians collaborate closely with nursing teams, nurses feel empowered (Galletta et al., 2016; Zangaro & Soeken, 2007)—hence less in need of head nurses' attention. Second, organizational formalization negatively moderated the direct and indirect effect of TFL's individualized consideration on patient loyalty. While formalization may constrain employees by enforcing standard procedures (Hirst et al., 2011), it also renders nurses' responsibilities less ambiguous (Adler, 2012). Formalization is thus an important contingency that brings relevant guidance for nurses' work. In such context, the attention of head nurses to nurses' concerns

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as a driver of a service mindset and of a source of identification to team goals may be less effective because the standardization of work procedures reduces the value of head nurses' leadership. Finally, we also found task feedback to negatively moderate the direct and indirect effects of TFL's individualized consideration on team commitment and patient loyalty. Task feedback provides performance information readily available to nursing teams that they can use to complete their tasks. Therefore, task feedback by itself encourages nurses to provide the service behaviour that otherwise would need head nurses' coaching to be achieved. Relatedly, task feedback may diminish the motivational power of leaders' individualized consideration for building the team's commitment to perform service quality.

The discrete contexts examined in this study should be seen as 'constraints that affect … [the] "functional relationships between variables"' (Johns, 2006, p. 386). That is, they were modelled as situational factors that alter the strength of the relationship between TFL's individualized consideration and follower and patient outcomes (Siangchokyoo et al., 2020). As such, nurse–physician collaboration, organizational formalization, and task feedback represent the aggregate and subjective perception of situations as processed by individuals (Zaccaro et al., 2018) and reflecting their psychological meaning to them (Rauthmann et al., 2014). Therefore, the present findings highlight how the collective perception of the psychological meaning of such situations influences the importance that nurses attribute to head nurses' coaching activities for their ability to collectively commit to the goal of quality care delivery. While the current findings are rooted in the collective assessment by ward nurses of discrete contexts, they also reveal that patients themselves react in a manner that is consistent with how ward nurses value head nurses' attention to their needs and concerns.

Strengths, limitations and future research directions

A significant strength of this paper is that we used a disaggregated approach to TFL by selecting individualized consideration as a factor whose saliency is determined by the context of nursing teams, thereby heeding the call for more research on specific TFL dimensions based on their relevance to context (Anderson & Sun, 2023; Carton, 2022; van Knippenberg & Sitkin, 2013). Moreover, we adopted a temporally lagged, multisource and multilevel design, thereby not only minimizing common method bias, but also exploring a process model where the transformation of followers is directly addressed as an intervening mechanism (Siangchokyoo et al., 2020). Finally, we used the customer's perspective as the outcome to be predicted by our model, which has significance in contexts where social impact is high (Grant, 2012).

Despite these strengths, this study has limitations. First, we sampled only nurses and patients in hospital units. Although this focus helps control for industry and occupation variations, it might limit the generalizability of the findings. Second, our sample was subject to range restriction due to attrition bias, for nurses reporting lower scores on TFL's individualized consideration and nurse–physician collaboration and higher scores on organizational formalization at Time 1 were more likely to participate at Time 2. This may have reduced the statistical power to detect moderating effects (Aguinis et al., 2017). Third, task feedback had a low reliability, suggesting that there might be variability across nurses and tasks regarding the opportunity for receiving feedback. Fourth, while we focused on specific discrete contexts, other variables such as leaders' and nurses' personality, human resource practices and service climate (Liao & Chuang, 2004) may be relevant personal (Gottfredson & Reina, 2020) or contextual (Ayman & Lauritsen, 2018; Oc, 2018) moderators.

This study also provides opportunities for future research. First, scholars stressed that individualized consideration speaks to each follower separately (Schriesheim et al., 2009; Wang & Howell, 2010, 2012). We contend however that actions dedicated to attend to the specific needs of all individuals can aggregate at the team level by raising the skills of the whole team. As nurses work collectively at producing care services to same patients, TFL's individualized consideration would create a sense of service that pervades the team. However, it might still be interesting to explore whether team-focused consideration that targets the development of skills linked to teamwork such as coordination, problem-solving or conflict management

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competencies would have similar effects than those reported in the present study. Second, we addressed only one of the three processes assumed to be associated with TFL, that is, collective identification, leaving aside value internalization and self-efficacy (Bass, 1985; Shamir et al., 1993). As research addressing all three processes in the same study is rare (Siangchokyoo et al., 2020), it would be worth examining whether the effects of TFL's individualized consideration could be channelled by value internalization and self-efficacy as well. Moreover, as our study revealed a main effect of individualized consideration on patient loyalty, the possibility exists that it could be explained by self-efficacy, particularly because individualized consideration may facilitate nurses' growth and development. Finally, as pointed out by Fischer and Sitkin (2023), the scale of individualized consideration partly refers to the effect of leader behaviour (e.g., typical item: 'helps me to develop my strengths'), which may cause behaviour-effect conflation. Therefore, further refinement of the scale is warranted to improve its construct validity.

Practical implications

The results of this study offer implications for health care organizations. Our study shows that TFL's individualized consideration matters, particularly when the work context provides nurses with little cues about appropriate attitudes and behaviours. Research has shown that TFL behaviours can be learned (Dvir et al., 2002) as it involves a set of skills that can be mastered through training, education, and professional development (Fischer, 2016). Organizations are advised to train head nurses to develop the skills related to individualized consideration such as mentoring nurses and coaching them. Training sessions can be provided to head nurses on a regular basis. Nurses could also be invited to offer feedback on head nurses' performance in these skills. Moreover, our results suggest that team commitment is a key mechanism through which individualized consideration promotes patient loyalty. So, organizations may need to help nurses develop a strong commitment to their team. For example, they may implement team support programmes (e.g., funding team-building activities and rewarding team performance) to increase nurses' perceived team support, thereby strengthening team commitment (Bishop et al., 2005). Finally, a formal leader cannot carry out all leadership functions, and many leadership contexts amount to formal leadership being transferred to informal leaders (Yukl, 2008). From this perspective, health care organizations are advised to train nursing directors to be mindful of head nurses' limits so that when exerting their leadership, head nurses can proactively seek the desirable contexts, thereby maintaining team effectiveness when their formal leadership is unnecessary.

CONCLUSION

For a long time, scholars have been calling for more studies to situate TFL in team contexts (Avolio & Bass, 1995; Day, 2012; Kozlowski et al., 2016). Moreover, researchers have called for reviving the construct by looking at the behaviours of leading associated with TFL dimensions (Carton, 2022; Siangchokyoo et al., 2020). This study contextualized TFL's individualized consideration in nursing team environments, accentuating the essential role of work situations in affecting its relation to team affective commitment and patient loyalty, thus contributing to the understanding of how and when head nurses' individualized consideration may function for the benefit of patients' expectations. We hope the present findings will inspire other research that explores the contextual boundaries and mechanisms associated with TFL dimensions and extends its application to various industries.

AUTHOR CONTRIBUTIONS

Wei-Gang Tang: Methodology; formal analysis; conceptualization; writing – original draft. **Sabine Stordeur:** Conceptualization; investigation; project administration. **Christian Vandenberghe:** Conceptualization; supervision; funding acquisition; writing – review and editing. **William D'hoore:** Conceptualization; supervision.

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CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interests/competing interests to disclose.

DATA AVAILABILITY STATEMENT

Data available on reasonable request due privacy/ethical restrictions.

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APPENDIX 1

CONFIRMATORY FACTOR ANALYSES: FIT INDICES

Measurement models	χ^2 (df)	CFI	TLI	RMSEA	SRMR	$\Delta\chi^2$ (Δdf)[a,b]
1. Hypothesized six-factor model[c]	155.98 (120)	.97	.96	.06	.05	
2. Two-factor model	609.41 (134)	.62	.57	.20	.15	471.18 (14)***
3. Three-factor model	401.40 (132)	.79	.75	.15	.14	220.97 (12)***
4. Four-factor model	296.96 (129)	.87	.84	.12	.11	142.70 (9)***
5. Five-factor model	168.52 (125)	.97	.96	.06	.06	14.49 (5)*

Note: $N = 91$.

Abbreviations: CFI, comparative fit index; RMSEA, root-mean-square error of approximation; SRMR, standardized root-mean-square residual; TLI, Tucker-Lewis fit index.

[a]The hypothesized six-factor model is the baseline model, with which alternative models are compared.

[b]When model comparison is based on MLM estimation, it is inappropriate to compute $\Delta\chi^2$ in the conventional way by direct subtraction (Byrne, 2012). To calculate the correct $\Delta\chi^2$, we applied Satorra and Bentler's (2001) formula, which is also available on the Mplus website (http://www.statmodel.com/chidiff.shtml).

[c]Items are parcelled into three indicators for the following constructs: transformational leadership (individualized consideration), nurse–physician collaboration and team affective commitment. This is because the sample size ($N = 91$) is small, rendering the ratio between sample size and number of parameters too low at the unit level (for technical details, see Little et al., 2013).

*$p < .05$; ***$p < .001$.

APPENDIX 2

WITHIN-GROUP AGREEMENT AND INTRACLASS CORRELATIONS FOR STUDY VARIABLES

Variable	$r_{WG(J)}$ mean	$r_{WG(J)}$ median	ICC (1)	ICC (K)
Transformational leadership (individualized consideration)	.84	.90	.37	.78
Nurse–physician collaboration	.92	.94	.30	.71
Organizational formalization	.63	.68	.24	.66
Task feedback	.85	.88	.14	.47
Team affective commitment	.88	.93	.24	.64
Patient loyalty	.80	.86	.15	.77

Note: $N = 91$ teams.

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