JOURNAL OF MANAGEMENT AND BUSINESS SOLUTIONS

Exploring the Impact of Leadership Communication on Employee Trust and Organizational Citizenship Behavior in Healthcare Organizations

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ABSTRACT

This study aims to explore how leadership communication influences employee trust and organizational citizenship behavior (OCB) in healthcare organizations. A qualitative research design was employed using semi-structured, in-depth interviews with 20 healthcare professionals from public and private hospitals in Tehran, Iran. Participants were selected through purposive sampling to ensure diversity in roles, experiences, and hierarchical levels. Data collection continued until theoretical saturation was reached. The interviews were transcribed verbatim and analyzed using thematic analysis following Braun and Clarke's six-phase framework. NVivo software was utilized to support systematic coding and theme development. Ethical protocols, including informed consent, confidentiality, and voluntary participation, were strictly followed throughout the study. Three main themes emerged: (1) Dimensions of Leadership Communication, which included clarity, empathy, feedback, accessibility, and consistency; (2) Development of Employee Trust, shaped by leader integrity, fairness, competence, psychological safety, and long-term relationship orientation; and (3) Organizational Citizenship Behavior, encompassing altruism, conscientiousness, civic virtue, sportsmanship, and organizational loyalty. Participants emphasized that transparent and empathic leadership communication fostered a supportive atmosphere, strengthened relational trust, and encouraged voluntary, prosocial behaviors that exceeded formal job requirements. Trust was reported to be particularly influenced by how leaders handled feedback, admitted mistakes, and communicated during crises. The findings highlight the crucial role of leadership communication in shaping trust and promoting OCB in healthcare settings. Effective communication practices—especially those grounded in empathy, fairness, and transparency—can foster positive relational climates and enhance organizational functioning. The results offer practical insights for healthcare administrators aiming to build resilient, trust-based teams and underscore the need for culturally responsive leadership development.

Keywords: Leadership communication; employee trust; organizational citizenship behavior; healthcare management; qualitative research; Iranian hospitals; organizational behavior.

Introduction

In the context of healthcare organizations, where the stakes are high and the environment is often characterized by rapid change, uncertainty, and stress, effective leadership communication plays a pivotal role in shaping employee experiences, trust, and performance. Communication is not merely a vehicle for conveying information in such settings—it serves as a strategic function that defines the nature of relationships, structures expectations, and fosters emotional and behavioral responses among organizational members (Clampitt, 2016). In particular,

Article history:
Received 11 August 2024
Revised 16 September 2024
Accepted 28 September 2024
Published online 01 October 2024

How to cite this article:
Nabizadeh, P., Hedayati, K., & Daneshmehr, S. (2024). Exploring the Impact of Leadership Communication on Employee Trust and Organizational Citizenship Behavior in Healthcare Organizations. *Journal of Management and Business Solutions, 2*(4), 1-9. https://doi.org/10.61838/jmbs.2.4.1

leadership communication has been increasingly recognized as a foundational factor in cultivating employee trust and encouraging organizational citizenship behavior (OCB), both of which are essential for the sustainable success of healthcare institutions (Men & Stacks, 2013).

Employee trust in leadership has emerged as a critical component of organizational functioning, especially in complex and high-stress environments like healthcare, where coordination, collaboration, and emotional resilience are fundamental. Trust in leadership is generally defined as the willingness of employees to be vulnerable to the actions of their leaders based on the expectation that these leaders will act competently, fairly, and with integrity (Dirks & Ferrin, 2002). Numerous studies have confirmed the association between leadership communication and trust, showing that transparent, empathetic, and consistent communication styles foster greater psychological safety and relational confidence among employees (Norman, Avolio, & Luthans, 2010; Karssiens, Van der Velde, & Wilderom, 2014). When healthcare leaders communicate openly about challenges, clarify expectations, and acknowledge the emotional realities of frontline work, they enhance not only trust but also staff morale and organizational commitment (Bromley & Powell, 2012).

The link between leadership communication and organizational citizenship behavior is equally compelling. OCB refers to discretionary behaviors by employees that go beyond formal job requirements and contribute to the overall effectiveness of the organization (Organ, 1988). These behaviors include helping coworkers, being punctual, advocating for the organization, and showing initiative. In healthcare settings, where teamwork and patient-centered care are core values, such behaviors can significantly affect clinical outcomes and service quality (Podsakoff et al., 2009). Research has demonstrated that supportive leadership communication fosters a sense of inclusion, recognition, and psychological engagement, all of which are antecedents to OCB (Walumbwa et al., 2011). Leaders who express genuine concern, offer constructive feedback, and model ethical behavior are more likely to inspire employees to contribute voluntarily to collective goals.

Despite the theoretical importance of leadership communication, empirical research focusing specifically on how it influences employee trust and OCB in the healthcare sector—particularly in non-Western contexts—is still developing. Much of the literature has focused on business, education, and public administration domains, leaving a gap in our understanding of these dynamics in clinical and hospital environments (Tourish & Robson, 2006; Welch, 2011). Given the unique challenges of healthcare, including shift work, emotional labor, resource constraints, and hierarchical decision-making, it is crucial to explore how communication behaviors by leaders are interpreted and internalized by staff. Furthermore, trust and OCB are not static traits; they are continuously shaped by situational cues, emotional climates, and interpersonal exchanges—factors that are heavily mediated through communication (Mishra & Mishra, 2008).

Healthcare organizations also differ in terms of culture, regulation, and governance across regions. In Iran, for example, healthcare systems are marked by centralized management, rigid hierarchies, and strong cultural expectations surrounding authority and professionalism (Roudbari, 2020). These contextual factors can profoundly affect the way leadership communication is enacted and received. Leaders in Iranian hospitals may face cultural and institutional constraints that influence their communication choices, and employees may interpret messages through the lens of collectivist norms and role expectations. Consequently, a locally grounded, qualitative approach is necessary to unravel the nuanced ways in which leadership communication fosters trust and discretionary behaviors in Iranian healthcare organizations.

Moreover, there is growing interest in moving beyond the “what” of leadership communication to the “how” and “why.” While quantitative studies have shown correlational links between leadership style and employee outcomes, fewer studies have examined the mechanisms through which communication actually builds trust or elicits citizenship behaviors. Qualitative research, especially through in-depth interviews, can shed light on these mechanisms by capturing the lived experiences of employees and the meanings they attach to leadership interactions (Braun & Clarke, 2006). Such an approach allows for a richer understanding of the interpersonal and emotional dimensions of workplace communication and its consequences.

The COVID-19 pandemic has further underscored the urgency of effective leadership communication in healthcare. During the crisis, healthcare workers were often required to operate under rapidly changing protocols, emotional exhaustion, and heightened personal risk (Shanafelt et al., 2020). Leaders who maintained clear, compassionate, and consistent communication were instrumental in preserving trust and minimizing burnout. Conversely, communication breakdowns—such as misinformation, ambiguity, or perceived neglect—contributed to demoralization and disengagement. These developments have prompted renewed scholarly interest in the communicative behaviors of healthcare leaders, particularly their role in shaping organizational resilience and employee well-being.

The present study seeks to contribute to this evolving field by exploring how leadership communication impacts employee trust and organizational citizenship behavior in healthcare organizations in Tehran, Iran. Using a qualitative research design grounded in thematic analysis, the study captures the subjective experiences of healthcare professionals as they interpret and evaluate the communication behaviors of their leaders. Through this lens, the study addresses several critical questions: What dimensions of leadership communication are most salient to employees? How does communication shape their perceptions of trustworthiness and fairness? In what ways does it motivate them to engage in behaviors that benefit the organization beyond their formal roles?

By focusing on a healthcare-specific context and drawing on rich, narrative data, this study not only enhances theoretical understandings of communication-trust-OCB linkages but also offers practical insights for hospital managers and policymakers seeking to improve workplace relationships and performance outcomes. The findings aim to inform leadership development programs, communication training, and organizational culture interventions that can strengthen employee engagement and institutional effectiveness in healthcare settings.

Methods and Materials

Study Design and Participants

This qualitative study employed an exploratory design to investigate how leadership communication influences employee trust and organizational citizenship behavior (OCB) within healthcare organizations. The approach was chosen to gain in-depth insights into the lived experiences and subjective interpretations of healthcare professionals regarding communication dynamics and their behavioral outcomes. Participants were selected using purposive sampling to ensure maximum relevance to the research objectives.

A total of 20 participants were interviewed, all of whom were healthcare professionals including nurses, physicians, administrative staff, and middle managers from public and private hospitals in Tehran. The inclusion criteria required participants to have a minimum of three years of experience working within healthcare organizations and to have direct or indirect communication with their organizational leaders. Efforts were made to

ensure diversity in gender, age, professional role, and organizational hierarchy to capture a broad range of perspectives.

Data Collection

Data were collected through semi-structured, in-depth interviews conducted face-to-face over a period of six weeks. An interview guide was developed to ensure consistency across interviews while allowing flexibility for participants to express their unique experiences. Key topics included perceptions of leadership communication styles, the quality of communication between employees and leaders, trust in leadership, and manifestations of organizational citizenship behaviors.

Each interview lasted approximately 45 to 60 minutes and was audio-recorded with the consent of participants. Interviews were conducted in Persian and later transcribed verbatim. Data collection continued until theoretical saturation was reached—that is, no new concepts or themes emerged from the data, confirming the sufficiency of the sample size for the qualitative inquiry.

Data analysis

Thematic analysis was used to analyze the interview transcripts, following the six-phase framework proposed by Braun and Clarke (2006). This involved familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the final report. NVivo qualitative data analysis software was utilized to manage and code the data systematically.

Coding was conducted in Persian to preserve linguistic nuances and avoid loss of meaning during interpretation. Initial open codes were developed, followed by axial coding to identify relationships among the codes. Themes were derived inductively based on patterns in the data and refined through iterative comparison. To enhance the credibility and trustworthiness of the findings, member checking was conducted with a subset of participants, and peer debriefing sessions were held with qualitative research experts.

Findings and Results

Theme 1: Dimensions of Leadership Communication

Clarity and Transparency:

Participants emphasized the importance of receiving clear, transparent messages from leaders. Ambiguity in communication was frequently associated with confusion and decreased trust. One nurse noted, "Sometimes we receive conflicting instructions from different departments, and it creates stress. I value when our supervisor gives direct and clear messages." Clarity helped staff align with organizational goals and understand role expectations, especially in high-stakes situations.

Active Listening:

Many respondents highlighted how leadership’s ability to actively listen enhanced their sense of being respected and valued. Active listening was perceived not just as hearing but truly understanding staff concerns. A participant stated, "When my manager listens carefully and repeats what I said to clarify, it makes me feel heard and supported." This practice fostered psychological safety and encouraged open dialogue.

Consistency in Messaging:

Consistency between what leaders say and what they do significantly affected employee trust. Inconsistent messaging was seen as a red flag, especially during organizational changes. One participant explained, "If a leader says patient care is the priority but pushes us to discharge quickly, it sends mixed signals. That inconsistency creates doubt." Regular and reliable communication was associated with credibility.

Emotional Tone and Empathy:

Respondents discussed how the emotional tone of communication—especially in times of crisis—affected their morale. Empathetic communication made staff feel understood and emotionally supported. A physician shared, "When our director expressed appreciation and recognized our burnout, it meant a lot. It wasn't just about work—it was human." Empathy conveyed through tone was considered essential in the emotionally intense healthcare environment.

Feedback Practices:

Constructive, timely feedback emerged as a vital aspect of leadership communication. Participants appreciated two-way feedback, which included both evaluation and encouragement. A participant said, "I appreciate when feedback isn't just criticism but includes how I can grow or improve." This practice was linked to higher motivation and role clarity.

Accessibility of Leaders:

The perceived approachability and availability of leaders influenced the quality of communication. Participants mentioned that when leaders were visible and available—either physically or virtually—it promoted a culture of openness. As one administrative staff member mentioned, "Even a quick hallway chat with our manager makes a difference. It shows they're present and care."

Use of Digital Communication Tools:

The increasing reliance on digital tools brought both convenience and challenges. While emails and group messaging apps enabled faster dissemination, some felt they lacked emotional nuance. One respondent reflected, "An email doesn't always capture the urgency or empathy you get in a face-to-face talk." Nevertheless, well-managed digital communication was seen as efficient and inclusive.

Theme 2: Development of Employee Trust

Integrity and Honesty of Leadership:

Participants emphasized that truthfulness and moral behavior were critical for cultivating trust. Leaders who acknowledged mistakes and communicated honestly—especially during crises—were perceived more favorably. A nurse commented, "When a manager admits they don't have all the answers but will find out, I respect that more than fake confidence."

Competence and Decision-Making:

Trust was also deeply linked to the perceived competence of leaders. Staff trusted leaders who demonstrated sound judgment and clinical knowledge. A participant stated, "I trust our chief because she's been on the front lines. Her decisions reflect both experience and logic." Competence was particularly critical in emergency and high-pressure contexts.

Fairness and Equity:

Perceived fairness in promotions, workload distribution, and recognition significantly influenced trust. Instances of favoritism or unequal treatment eroded trust quickly. One respondent shared, "When leadership favors certain

staff regardless of performance, it demotivates the rest of us." Transparency in decisions was viewed as a remedy for perceived inequities.

Psychological Safety:

Respondents reported that environments where they could speak up without fear of retaliation were more likely to foster trust. Psychological safety enabled them to report errors, express dissent, and suggest improvements. A participant noted, "I once pointed out a safety issue. My supervisor thanked me instead of blaming me—that built real trust."

Long-term Relationship Orientation:

Employees valued leaders who showed investment in their growth and well-being over time. Trust deepened when staff felt leaders were committed beyond transactional interactions. As one physician mentioned, "It's not just about this week's shift. Leaders who care about your career and life—that builds lasting trust."

Reputation of Leadership:

The historical behavior and reputation of a leader shaped initial trust perceptions. New leaders with known track records were more easily accepted. One participant noted, "I had heard positive things about our new supervisor before she joined. That made me more open to her leadership from day one."

Theme 3: Organizational Citizenship Behavior

Altruism Among Employees:

Participants described various prosocial behaviors they performed voluntarily, often motivated by leadership modeling or trust. These included helping colleagues without being asked or covering shifts during emergencies. A nurse stated, "When I see our supervisor going the extra mile, I feel like doing the same for my team."

Conscientiousness:

Many respondents showed a high degree of diligence and self-discipline, often exceeding formal job requirements. They attributed this to internal motivation reinforced by supportive leadership. One participant remarked, "Our head nurse is very organized—it motivates us to be punctual and thorough, even when no one's watching."

Civic Virtue:

Engagement in organizational governance and policy-related discussions was also observed. Staff described voluntarily attending meetings or participating in improvement projects. A staff member noted, "We don't get paid extra to join those sessions, but I do it because I care about the hospital's future."

Sportsmanship:

Despite work stressors, employees maintained positive attitudes and refrained from unnecessary complaints. Leaders who acknowledged challenges while encouraging resilience were especially effective. One employee shared, "We're tired, but we try not to complain because our manager handles pressure with such grace."

Organizational Loyalty:

Participants expressed strong identification with and defense of their organizations. This loyalty was often rooted in their trust in leadership and the organization's values. A respondent mentioned, "Even during hard times, I've stayed because I believe in our mission and how our leadership treats us."

Discussion and Conclusion

The findings of this study underscore the critical role of leadership communication in fostering both employee trust and organizational citizenship behavior (OCB) within healthcare organizations. Through thematic analysis of interviews with healthcare professionals in Tehran, three overarching themes emerged: **Dimensions of Leadership Communication**, **Development of Employee Trust**, and **Organizational Citizenship Behavior**. These categories reveal how specific communication behaviors—such as clarity, empathy, feedback, accessibility, and consistency—translate into trust-building and discretionary behaviors among staff. The results are consistent with and extend the current literature on organizational behavior and healthcare leadership.

First, the theme of **Dimensions of Leadership Communication** revealed that clarity, transparency, and active listening are fundamental to effective leadership in healthcare contexts. These elements were repeatedly cited by participants as mechanisms that reduce uncertainty, enhance understanding, and foster a sense of mutual respect. This finding aligns with Clampitt's (2016) argument that communication clarity is foundational to effective managerial practice and builds cognitive trust. Similarly, Tourish and Robson (2006) noted that leaders who engage in upward and downward communication—particularly through active listening—are more likely to be perceived as responsive and inclusive. Moreover, the finding that accessibility and informal presence of leaders (e.g., hallway conversations, virtual check-ins) boost perceptions of approachability echoes Welch's (2011) conclusion that communication frequency and informality are strongly associated with employee engagement and connection.

Furthermore, the subtheme of emotional tone and empathy was particularly salient among participants, reflecting a recognition that communication is not merely informational but also emotional. This reinforces the findings of Shanafelt et al. (2020), who demonstrated that compassionate communication during the COVID-19 crisis significantly buffered against burnout and psychological distress among medical staff. Our participants similarly described how leadership expressions of concern, acknowledgment of workload, and empathic tone created a supportive atmosphere, thereby improving emotional resilience and collective morale.

The second major theme, **Development of Employee Trust**, captures how leadership communication behaviors cultivate affective and cognitive trust. Trust in leadership was tied not only to the content of communication but also to the perceived integrity, competence, and fairness of the communicator. These insights are in strong agreement with Dirks and Ferrin's (2002) meta-analysis, which emphasized that consistent, ethical, and transparent communication enhances employee perceptions of leadership trustworthiness. In our study, participants identified psychological safety as a trust-building factor, particularly when leaders welcomed dissenting voices, allowed for mistake reporting, and responded supportively to concerns. This supports Edmondson's (1999) research on team learning, where psychological safety was shown to be integral to effective and innovative performance.

Moreover, the importance of fairness and equity in communication resonates with previous findings that justice perceptions in leadership interactions influence both trust and motivation (Colquitt et al., 2013). Our participants emphasized the negative impact of perceived favoritism and opaque decision-making processes on their willingness to trust and collaborate. These experiences parallel the work of Norman, Avolio, and Luthans (2010), who found that ethical and fair leadership communication promotes authentic trust and psychological empowerment.

The final theme, **Organizational Citizenship Behavior**, provides evidence of the behavioral consequences of trust and effective communication. Participants described a wide range of OCBs—such as helping colleagues, working beyond contractual duties, and participating in voluntary initiatives—as being directly influenced by the way leaders communicated with them. These behaviors were frequently described as responses to perceived fairness, empathy, and recognition from leadership. Such findings are consistent with the research of Podsakoff et al. (2009),

who established that leader support and fairness are key antecedents of OCB. In particular, participants linked their willingness to demonstrate sportsmanship (e.g., avoiding complaints, maintaining a positive attitude during stress) to how leaders modeled resilience and positivity in their own communications.

Additionally, the role of conscientiousness and civic virtue—attending extra meetings, staying informed about policies, and promoting organizational reputation—was linked to the perceived credibility and openness of leaders. These insights align with Walumbwa et al. (2011), who found that ethical leadership enhances collective voice and conscientiousness within teams. In our context, when leaders shared strategic goals transparently and allowed staff to contribute, participants felt more responsible for organizational success, thus engaging in OCB voluntarily.

The findings of this study contribute to a more nuanced understanding of how leadership communication operates within the unique sociocultural environment of Iranian healthcare institutions. The results show that leadership behaviors that may seem universal—such as transparency and feedback—are still interpreted through local norms related to hierarchy, collectivism, and professional identity. For example, while upward communication was welcomed, it had to be exercised with deference and respect. This observation is supported by Roudbari (2020), who emphasized that Iranian healthcare leadership is embedded within cultural expectations of authority and interpersonal decorum. Therefore, culturally contextualized leadership communication strategies are essential for fostering trust and eliciting high levels of OCB in such settings.

While prior studies have offered models linking communication to trust and behavior in corporate or educational settings, this study adds to the limited empirical evidence specific to healthcare. It illustrates that in high-pressure clinical environments, leadership communication serves not only operational purposes but also emotional, relational, and symbolic functions that influence employee behavior. The insights offered here are particularly relevant in the post-pandemic context, where healthcare institutions are reassessing how to build resilient, trust-based teams through non-financial and relational strategies.

Acknowledgments

We would like to express our appreciation and gratitude to all those who helped us carrying out this study.

Authors' Contributions

All authors equally contributed to this study.

Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

All ethical principles were adheried in conducting and writing this article.

Transparency of Data

In accordance with the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

Funding

This research was carried out independently with personal funding and without the financial support of any governmental or private institution or organization.

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