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Self-esteem and Extroversion as Predictors of Clinical Leadership Competency among Clinicians in Nigeria

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Abstract

A number of writers have referred to the particular issues surrounding doctors and healthcare professionals, both on team leadership and leadership in general. The purpose of the study is to examine the relationship between self-esteem, and extroversion on clinical leadership competency among Clinicians in Lagos and Ondo States Nigeria. This phase of this study was conducted using, Ex-Post facto factorial design since it attempted to explain consequence based on antecedent condition. Employees in the health industry in Lagos and Ondo states metropolis constitute the population of the study. Principal component analysis was used for factor analysis in the pilot study. In order to determine the extent and direction of associations among the study variables, Pearson Product Moment Correlation (PPMC) analysis was conducted. Multiple regression analysis was then used to test hypothesis 1, 2 and 3. The analyses were conducted using SPSS 17.0 Wizard. Result indicated that age, gender, job position, job tenure and academic qualification had no significant relationship on clinical leadership. However, marital status depicted significant relationship with clinical leadership. Results show that self esteem did not have a significant relationship with clinical leadership [r (410) = -0.017; p > 0.05]. This implies that self esteem does not have any relationship with clinical leadership. Extroversion had significant negative relationship with clinical leadership [r (410) = -0.198; p < 0.01]. This imply that clinicians who reported high extroversion show low clinical leadership competency. Based on the findings, the study has empirically demonstrated that clinicians who perceived a diminish sense of self esteem, and extroversion showed higher tendency to demonstrate clinical leadership competence than their counterparts in healthcare management.

Keywords:

Introduction

Background of the study

There have been growing awareness and recognition for the input that clinicians can provide in meeting the demands for a better health care delivery system around the world including Nigeria [1-3]. Mountford and Webb [4] reported that healthcare organizations world over that have incorporated the clinical leadership practices have witnessed tremendous growth.

Mountford and Webb [4] suggest that there is an increasing need for healthcare providers with a diverse and specific set of competencies to meet the current challenges facing the health care sector [5]. The politicization of healthcare policies has been a major issue inhibiting the development of health care delivery in Africa (World Health Organization Regional Office for Africa, 2011).

Clinical leadership is a readily used term to describe doctors and other health care mavens as leaders within the health service but has thus far not been empirically and extensively researched in Nigeria [6-8]. Clinical leadership can be perceived as positioning clinicians at the core of determining and overseeing clinical services, so as to deliver first-rate outcomes for patients and populations, not as a one-off task or project, but as a core part of clinicians' professional identity and concern [4,7,9].

The Millennium Development Goals (MDG) and need for an effective and efficient healthcare delivery system in Nigeria cannot be over emphasized. This has led to various healthcare activities, reforms, and programmers in the healthcare sector geared towards developing and re-structuring clinical practices and training of hospital employees or clinicians [5,10].

The National Leadership and Innovation Agency for Healthcare suggest that effective clinical leadership is pivotal because healthcare based leadership incorporates both improvement in healthcare administration and it also assist in synergizing the agenda of all national health schemes making them become part of the working structure.

Transforming healthcare is everyone's business with the provision of high quality care being at the heart of everything [11]. Creating a culture of visible commitment to patient safety and quality requires clinical and professional leaders to work together so that health care systems can meet the healthcare challenges of the future [12].

Clinical leadership involves influencing and motivating others to deliver clinically effective care by demonstrating clinical excellence, and providing support, and guidance to colleagues through mentorship, supervision and inspiration [13]. Clinical Leadership is about more than simply appointing people to particular positions [4]. Rather it is about recognizing the diffuse nature of leadership in health care organizations, and the importance of the influence of personality as well as formal authority in clinical leadership positions [14].

There were several strong values described as absolute prerequisites for clinical leadership. Doctors and other healthcare practitioners expect integrity, honesty, self-esteem, sociability (extroversion) and accountability for decisions made by clinical leaders [4]. These were conveyed as 'non-negotiable' assets to providing good care to patients and positive leadership to doctors [15]. These core values were clearly deeply held by all who spoke about them and reveal much about the factors that guide and motivate doctors in their daily work [5,16]

Statement of the problem

A number of writers have referred to the particular issues surrounding doctors and healthcare professionals, both on team leadership and leadership in general [1,17-23]. Health care systems across the world are feeling the impact of change and reform therefore; clinicians have historically been somewhat difficult to engage in leadership development and team-working programmes and do require some special consideration [24].

Mottram [25] also found that clinicians often use the term management to describe leadership and that clinicians have five different constructs in mind when they use the word "management", namely: Administration and support to clinical activity, being "in charge" of a service, management processes, personality and whether someone is "likeable" and has good judgment, and team working.

Simpson and Smith [26] reported that in time past medical practitioners have always been of the opinion that issues of budgets, staff operations and strategy are for non-medical personnel or that management is for doctors who are too old and burnt out for anything better [1].

Burgoyne and Lorbiecki [19] found a widespread opinion that doctors are often poor team players and this was reinforced in interviews, particularly around the extent to which multi-disciplinary meetings can become solely focused on doctor related matters. There is often a lack of common understanding about exactly what a team is and what good team working should be as little medical training focuses on communication, teamwork and this is not required for promotion into senior medical roles [27].

Some studies also suggests that (unlike most other professions) in medicine a doctor is often given a medical leadership role and will have the support of his colleagues if he or she is clinically credible and has served some form of apprenticeship which creates a degree of trust and that this is much more important than their skills or attributes [28,25].

Healthcare practitioners often need evidence of the effectiveness of a programme before committing time and energy [29,30] as such the doctors who are involved in team development try hard to engage medical colleagues and are delighted whenever this happens. Hence, this informed the interest of the present study.

Purpose of the study

The purpose of the study is to examine the relationship between self-esteem, and extroversion on clinical leadership competency among Clinicians in Lagos and Ondo States Nigeria. However, the specific major purpose of this study is to:

Examine whether self-esteem and extroversion would jointly or independently predict clinical leadership competency among Clinicians in Ondo and Lagos States.

Relevance of study

The outcomes of this study would have some pragmatic relevance for healthcare institutions, ministries and health departments of various organizations in Nigeria through the results of this study would shed more light to the current paradigm shift in health process and practice. This is because clinical leadership does suggest a multi-disciplinary approach in which clinicians from various healthcare backgrounds who demonstrate clinical leadership competence are adequately suited for current and future leadership demands.

In addition, this study has a real-life application helping with learning and educational processes which also will be useful in Nigerian medical colleges and teaching hospitals including universities, in training medical students on clinical leadership competence would be included as a core part of curricula for postgraduate trainees, or for clinicians in substantive posts.

Finally, findings of this study would have some practical relevance for other researchers as the study has ecological validity, as it was conducted in a real clinical setting. The findings from this study will serve as a reference point and stimulate more research in this direction among researchers in clinical psychology and other researchers that are interested in similar studies. This study will be of huge benefit for academic purposes. The findings of this study will also broaden the knowledge of other researchers interested in this kind of study because it will help them realize reasons why undergraduates need to develop and maintain clinical leadership qualities needed for successful leadership in clinics, medical center's and hospitals.

Self-esteem and clinical leadership competency

Firth-Cozens and Mowbray [30] and Ciarrochi et al. [31] asserted that self-esteem has become a household word in clinical circles. Doctors, Nurses, Social Workers, Psychiatrists, Psychiatric nurses, therapists, and others have focused efforts on boosting self-esteem, on the assumption that high self-esteem will cause many positive outcomes and benefits this is no different in the healthcare sector. However, this assumption have been critically evaluated in some literatures [32-34,10].

But is self-esteem a cause of important consequences in clinical leadership? The results of a survey of major research findings bearing on this question have provided some thorough review of empirical findings emphasizing the most methodologically rigorous research studies to ascertain whether high self-esteem is in fact a cause of positive or negative outcomes [35,36]. Researches have revealed that self-esteem has positive value for bringing about clinical practice benefits [34].

Such a pattern would presumably allow an accurate and nuanced understanding of just what high self-esteem is good for. This would be beneficial both for theory (in that it would promote a better understanding of self-esteem as well as the outcomes it predicts) and for practical applications and even for determining whether efforts at boosting self-esteem are worth undertaking in order to solve particular social problems [36,37].

Method

Research design

This chapter explains the various research methods used to generate the data in this study. A cross-sectional survey design was adopted in the study. Moreover, variables of this study were not actively manipulated. The dependent variable is clinical leadership. The predictor variables are self esteem and extroversion.

Research setting

This phase of this study was conducted using, Ex-Post facto factorial design since it attempted to explain consequence based on antecedent condition. Employees in the health industry in Lagos and Ondo states metropolis, Nigeria constitute the population of this study because healthcare workers in Lagos and Ondo State are strategically located in the hub of the most populous nation in Africa and are more saddled and in critical need to engage in building, structuring and developing clinical leadership among nascent and experienced clinicians. The pluralistic, commercial, and strategic nature of Lagos and Ondo states informed the choice of hospitals used in the study.

Participants

A total of 412 employees across 3 federal and 2 state hospitals, including 4 general hospitals and health centers in Lagos and Ondo metropolis, Nigeria were sampled using accidental sampling technique. The federal and state hospitals, including general hospitals and health centres were also selected. The hospitals selected were; National Orthopedic Hospital, Igbobi, Onipanu, Lagos, Lagos University Teaching Hospital, Idi-Araba, Mushin Lagos (LUTH), Federal Neuro-Psychiatric Hospital, Harvey Road, Yaba, Lagos, Adekunle Ajasin University Health Centre, Akungba-Akoko, Ondo State, Federal Medical Centre, Owo, Ondo State (FMC), Iwaro General Hospital, Iwaro-Oka, Ondo State, Ikare General Hospital, Ikare, Ondo State, Isolo General Hospital, Osolo way, Lagos and Gbagada General Hospital, Soluyi, Lagos (LUTH Annex). The participants comprised of 212 (51.5%) males and 200 (48.5%) females. The ages ranged from 20 to 59 with a mean of 38.19 years and SD of 9.52. Also, 106 (25.7 %) of the participants were single, 255 (61.9%) were married, 29 (7.0%) were widowed, and 19 (4.6%) were divorced. Their qualification also varied; 5 (1.2%) had WAEC/GCE, 30 (7.3%) had NCE/OND, 137 (33.3%) HND/B.Sc., Masters 207 (50.2%) and PhD 28 (6.8%). Their job position revealed that 161 (39.1%) were of junior cadre and 245 (59.5%) were of senior cadre. In addition, their job tenure ranged from 1 year to 33 years with a mean of 8.58 years and SD of 6.345.

Pilot study location and participants

The pilot phase was conducted in Ondo and Lagos State among clinicians in the Akoko North-West local government area which included the Adekunle Ajasin University Heath Centre, Federal Medical Centre, Owo, Iwaro general Hospital, and Ikare general Hospital including clinicians in Lagos at Federal Neuro-Psychiatric Hospital, Lagos State University Teaching Hospital and National Orthopedic Hospital, Igbobi, Onipanu, Lagos. These vicinities were selected because of easy access and large number of clinicians in these areas. Selection of participants was based on accidental sampling also because of the shift nature of the jobs of these professionals.

Pilot study objectives

The purpose of the pilot study was four fold, namely:

- To gain in-depth understanding of the psychosocial factors influencing clinical leadership, in particular specific issues including the reliability coefficients of the instruments that impact on clinical leadership and practice.
- To use the information above to identify key variables impacting on clinical leadership
- To adapt clinical leadership instrument in measuring psychosocial variables, and to pilot test the different data collection instrument.

Instrument

Relevant data were gathered through the use of validated questionnaire which comprises of four sections (A-D).

Section A: Socio-demographic information. These include age, gender, marital status, job position, job tenure and academic qualification.

Section B: The rosenberg self esteem scale (self esteem): The Rosenberg self esteem scale, is a widely used self-report instrument for evaluating individual self esteem, 10-item scale that measures global self-worth by measuring both positive and negative feelings about the self. The scale is uni-dimensional. All items are answered using a 4-point Likert type scale format ranging from strongly agree to strongly disagree. Scoring: Items 2, 5, 6, 8, and 9 are reverse scored. Give "Strongly Disagree" 1 point, "Disagree" 2 points, "Agree" 3 points, and "Strongly Agree" 4 points. The scores are on a continuous scale. Higher scores indicate higher self esteem. Samples items included: "I am able to do things as well as most other people" showed that the RSES had adequate internal reliability, and test retest correlation of 0.61 over a 7-month period in Ontario, reported a Cronbach's Alpha coefficient of 0.79. Baumeister et al. [35] reported a Cronbach's Alpha coefficient of 0.86 and Cronbach's Alpha of 0.86 among health workers. Among Nigerian samples of the Rosenberg scale coefficient of 0.92 showing good internal consistency using Nigerian Sample. In the present study, a Cronbach's Alpha of 0.410 was obtained for the scale. Scores above the mean reflect high self esteem while score below the mean indicate low self esteem. Higher score on the scale implies high self esteem.

Pilot study item development for key variables

Principal component analysis was used for factor analysis in the pilot study. The pilot phase was consisted of developing and selecting items for each of the variables used in the study. The variables include:

- Self esteem (predictor variable)
- Interpersonal relationship (predictor variable)
- Extroversion (predictor variable)
- Clinical leadership (dependent variable).

The items were generated by combining questions from existing scales (Clinical Leadership Competency Framework, Rosenberg Self Esteem Scale, Relationship Assessment Scale and the Big Five Personality Inventory) with the items generated on the basis of the variables under focus. Using principal component analysis the items in the questionnaire were tested and a selection of questions to be included in the final questionnaire which was administered in the final data collection phase, on the basis of internal consistency and reliability. It is imperative to note here that, certain items were removed in the final selection. The initial Rosenberg scale which was a

10 item Likert instrument but upon factor analysis it was revealed that item 8 had low coefficients and hence was removed. The Cronbach Alpha reliability coefficient of the Rosenberg Self Esteem Scale after factor analysis using principal component analysis was 0.920.

Section A: Extroversion (The big five personality inventory): Extroversion is the personality trait of seeking fulfillment from sources outside the self or in community. The instrument used for collection of data for extroversion was the big five personality traits questionnaire 44-item inventory that measures an individual on the Big Five Factors (dimensions) of personality. Each of the factors is then further divided into personality facets which consists of openness (8 items), conscientiousness (10 items), Extraversion and Introversion (9 items), Agreeableness (11 items) and Neuroticism (10 items).However, only the section measuring extroversion was used in the study and not the composite sections of the instrument. The instrument measured facets of (and correlated trait adjective) extraversion including gregariousness (sociable), assertiveness (forceful), activity (energetic), excitement-seeking (adventurous), positive emotions (enthusiastic), and warmth (outgoing).

The reliability of the Big Five Personality trait Questionnaire was determined by the use of test-retest reliability and internal consistency reliability. The reliability coefficients are adequate and the correlation gave a reliability coefficient of 0.78 when correlated by using Pearson's Product Moment Correlation Formula. Samples items included "I like to start most conversations". "I talk to a lot of different people at gatherings and events". Cronbach's Alpha coefficients were between 0.66 and 0.87 and the inventory was validated through criterion-related validity with coefficients between 0.65 and 0.76. Among Nigerian samples represented the Cronbach's Alpha of 0.57.

However, other Nigerian studies that have used the Big Five Inventory among Nigeria subjects reported valid and not culturally biased study using the Big Five Personality Inventory found coefficient alpha of 0.69. Cronbach's alpha of for extraversion, agreeableness, conscientiousness, neuroticism, and openness to experience respectively. The coefficient alpha reliability are 0.67, 0.74, 0.73, 0.74, 0.72 respectively. In the present study, a Cronbach's Alpha of 0.623 was obtained for the Big Five Inventory. Items were scored on a 5-point Likert format ranging from 1-rarely or none of the time to 5 most or all of the time. The data were collected through administration of the questionnaire to 412 participants.

Pilot study

Using the Big Five Personality Inventory was a 9 item Likert type scale which was later reduced to 3 items due to the negative component analysis revealed in items 18, 20, 21, 23, 25 and 26 by the factor analysis. The Big Five Personality Inventory was adapted distinctly by inferring from only the items assessing extroversion without using the composite scale. Table 1 below shows the reliability coefficient of the extroversion item of the Big Five Personality Inventory after factor analysis was 0.525.

Section A: Clinical leadership competency framework (CLFC): The Clinical Leadership Competency Framework was created with the agreement of the NHS Institute for Innovation and Improvement and the Academy of Medical Royal Colleges. The Clinical Leadership Competency Framework which was created developed and is owned jointly by the NHS Institute for Innovation and Improvement and Academy of Medical Royal Colleges [38]. The scale originally was a 39 item Likert type scale, divided into 5 distinct but interrelated domains.

In line with the provisions of the CLCF, hospital employees will exhibit a range of leadership behaviours across these seven domains dependent on the context in which they operate. It is essential that all staff is competent in each of the five core leadership domains: demonstrating personal qualities, working with others, managing services, improving services and setting direction. On the scale next to each statement, the individual is allowed to choose a rating that reflects how frequently it applies to him or her. For example, response could be a lot of the time, some of the time, very little or none of the time. Total of the scores reflect on what the individual have indicated. If the clinician has mainly very little or none of the time and some of the time in any particular domain, these domains may be areas which the clinician wish to develop further. Sample item include: "I apply my learning to practical work", "I take action to improve performance", "I take responsibility for embedding new approaches into working practices". However, there are no studies yet in Nigeria that has empirically studied the concept of clinical leadership competency.

CLCF was assessed with the Clinical Leadership Competency Framework (CLFC) which originally is a 39 item Likert type scale but was later reduced to a 24 item scale because item 28, 29, 31, 35, 36, 38, 43, 46, 49, 51, 53, 57, 58, 63 and 65of the preliminary or pilot questionnaire used for the pilot study revealed negative inconsistent component analysis. The CLCF was divided into 5 distinct but interrelated domains i.e. Demonstrating Personal Qualities (DPQ), Working with Others (WWO), Managing Services (MS), Improving Services (IS) and Setting Direction (SD). Table 1 below shows the co-efficient scores were as follows; (DPQ) 0.642, (WWO) 0.681, (MS) 0.661, (I.S) 0.744, and (SD) 0.612 respectively. However, the overall reliability of the pilot study for the entire CLCF upon factor analysis was 0.898.

Procedure

In order to get the clinicians that participated, permission and ethical approval was sought and obtained from the ethical review committee of the Federal Neuro-Psychiatric Hospital, Lagos. In a bid to get clinicians to participate in the study, approval was sought and obtained in form of informed consent before they were selected for the assessment. The respondents were adequately informed about the nature of the study and its benefits. The purpose of the study was explained to the participants as they were also given assurance of confidentiality and anonymity of their identities and responses. In addition, the respondents were told that there was no right or wrong answers, and as such should try to be honest as possible in their responses.

The choice of hospitals was arrived at after the researcher sought and obtained permission and was granted by the authorities of these hospitals which included a letter from the Ethic Review Board, Federal Neuro-Psychiatric Hospital, in Lagos. Using accidental sampling technique, the researcher administered four hundred and thirty questionnaires to clinicians across various disciplines that consented in such a way that averages of 45 copies of questionnaire were administered per hospital. The reason for using accidental sampling technique and not randomization was because most hospital employees are always busy and their job-schedule (shift rotation) situations in most hospitals and clinics did not allow for a more rigorous sampling technique. So, the only way to get sustainable participants is by using this non-probabilistic method. Although, four hundred and thirty (430) copies of questionnaire were administered

but only four hundred and twelve (412) copies of questionnaire were found usable for the analysis. This yielded a response rate of 95.8%.

Inclusion criteria

Eligibility to participate in the study included all qualified employed resident/consultant clinicians which comprises of Psychiatrists, General Practitioners, Surgeons, Neuro-surgeons, Orthopedics, Ophthalmologists, Pharmacist, Occupational Therapists, Clinical Psychologists, Psychiatric Nurses, Laboratory Analysts, Social workers and Interns (Medicine, Pharmacy and Psychology) who have spent not less than 6 months and who are in direct contact with patient or who provide healthcare for inpatients and outpatients in managed care institutions.

Exclusion criteria

The respondents that were ineligible or excluded from the study comprised those classified as outliers who include retired healthcare practitioners, healthcare artisans and those chronologically less than 18 years of age, clinicians with less than six-month experience, laboratory workers, ambulance drivers, administrative staffs, hospital domestic workers and all non-practicing healthcare professionals.

Data analysis

In order to determine the extent and direction of associations among the study variables, Pearson Product Moment Correlation (PPMC) analysis was conducted. Multiple regression analysis was then used to test hypothesis 1, 2 and 3.

Some of the socio-demographic variables were codified. For example, gender was coded male 0, female 1. Marital status was coded single 0, married 1, widow 2 and divorce 3. Job position was coded junior 0, senior 1. All analyses were conducted using SPSS 17.0 Wizard.

Result

Test of relationship among the study variables

The first analysis involved inter-correlations of all the variables of the study. The result presented in Table 1.

Variables	Mean	SD	1	2	3	4	5	6	7	8	9	10
1. Age	38.19	9.53	1									
2. Gender	-	-	.158**	1								
3. Marital Stat	-	-	.614**	.040	1							
4. Job Position	-	-	.646**	-.079	.496**	1						
5. Job Tenure	8.58	6.35	.769**	-.088	.543**	.635**	1					
6. Academic Q	-	-	.606**	-.038	.494**	.766**	.596**	1				
7. Self Esteem	31.92	3.14	-.021	.123*	-.025	.069	.012	.062	1			
8. Extroversion	12.15	2.22	.119*	.114*	.138**	.055	.076	.074	.022	. **	1	
9. Clinical L.	37.75	6.45	-.097	.057	.111*	-.027	-.061	.047	-.017	-.159**	-.198**	1

Table 1: Correlation matrix showing the mean, sd and inter-variable relationships among variables of the study.

Note: ** $p < 0.01$, * $p < 0.05$, N = 412. Key: Marital Stat. = Marital Status, Academic Q. = Academic Qualification, Clinical L. = Clinical leadership.

Results in Table 1 indicated that age, gender, job position, job tenure and academic qualification had no significant relationship on clinical leadership. However, marital status depicted significant relationship with clinical leadership.

Table 1 show that self esteem did not have a significant relationship with clinical leadership [r (410) = -0.017; p > 0.05]. This implies that self esteem does not have any relationship with clinical leadership. Similarly, extroversion had significant negative relationship with clinical leadership [r (410) = -0.198; p < 0.01]. This imply that clinicians who reported high extroversion show low clinical leadership competency.

Test of hypotheses 1, 2 and 3: In order to test hypothesis 1, 2 and 3, multiple regression analysis was conducted (Table 2).

Variables	B	t	R	R2	df	F
Self Esteem	.000	.006	.238	.057	3, 408	8.195**
Extroversion	-.179	-3.690**				

Table 2: Summary of Multiple Regression Analysis Showing the Contributions of Self Esteem and Extroversion to Clinical Leadership.

Note: *** $p < 0.01$ N = 412.

Results in Table 2 showed that self esteem did not significantly predict clinical leadership (β = -0.000; t = 0.006; p > 0.05). This means that self esteem of clinicians will not determine clinical leadership competence. Therefore, hypothesis 1 was rejected. The result confirmed hypothesis two. Therefore, hypothesis 2 was confirmed. Extroversion significantly negatively predicted clinical leadership (β = -0.179; t = -3.690; p < 0.01). This implies that clinicians who reported high on extroversion showed lower clinical leadership competency compared to clinicians who scored low on extroversion. This result did confirmed hypothesis 2. Therefore the hypothesis was accepted.

On the contribution of all the independent variables (self esteem and extroversion) to the prediction of clinical leadership, the outcome of the summary in Table 2 signify that all the independent variables

when pulled together yield a multiple R of 0.239 and R2 of 0.057 [$F_{(3, 408)}$ = 8.195, p < 0.01]. This is an indication that all the independent variables contributed 5.7% of the variance in clinical leadership. Meanwhile, other variables not considered in this study therefore accounts for 94.3%.

Discussion

The study examined the influence of self esteem, and extroversion on clinical leadership among clinicians in Ondo and Lagos State, Nigeria. In hypothesis 1, the result showed that self esteem did not significantly predict clinical leadership. Therefore the hypothesis was rejected [36,39]. According to these authors self-efficacy, self-confidence and self esteem does not directly contribute to leader success.

Rather, they suggested that it is the individual's belief regarding his or her capabilities to successfully perform the leadership task that is the key causal factor [36]. An explanation for this is that leadership does not stem directly from self esteem, but self esteem may have indirect effects [37].

Clinicians with high self esteem show stronger in-group favoritism that may lead to or increase prejudice and discrimination that are detrimental to healthcare management. Also, self esteem is heavily invested with feelings about the self, as specific facets of self esteem include a variety of self related thoughts whereas, clinicians are trained to work as unit where competence is commended and personal identity is consigned to the background [40].

Leadership competence leads to high self esteem rather than the reverse [4,41]. For decades it had been assumed that leaders with high self esteem are more liked than others, but researches have failed to confirm this and an explanation could be that most highly self esteemed leaders are seen as egocentric and insensitive, people with high self esteem are actually disliked more than others [36].

There are some weak simple correlations between self esteem and leadership, but analyses that control for other factors have found that self esteem has little in the way of direct and unique causal impact. The possibility remains, however, that self esteem perhaps have indirect effects that are mediated by other factors, such as leadership efficacy [24,42,43]

The focus of the relationship is on the client's ideas, experiences, and feelings. Inherent in a therapeutic (restorative) relationship is the clinician's focus on significant personal issues introduced by the client during the clinical interview [44]. The clinician and the client identify areas that need exploration and periodically evaluate the degree of change in the client. Although the nurse may assume a variety of roles (e.g., teacher, counselor, socializing agent, liaison), the relationship is consistently focused on the client's problem and needs.

Clinicians must get their needs met outside the relationship. When clinicians begin to want the client to "like them," "do as they suggest," or "give them recognition," the needs of the client cannot be adequately met and the interaction could be detrimental (non-therapeutic) to the client [5,24,45].

The relationship is usually centered on facilitating communication of distressing thoughts and feelings assisting clients with problem solving to help facilitate activities of daily living, self care needs by helping clients examine self-defeating behaviors and test alternatives promoting self-care and independence [46,47]. The results of the current study revealed that extroversion negatively predicted clinical leadership which corroborated with the findings of significant negative association between extroversion and clinical leadership. Research on the "dark sides" of extraverted behaviors finds that with experience working together, peers interpret extraverts as poor listeners who are unreceptive to input from others [39]. In respect to extroversion several researches has shown that personality plays an important role in shaping who earns status in work groups in healthcare management [48] by signaling competence and shaping performance expectations. In particular, extraverted members are attributed with high status and frequently selected for leadership positions [49,50]. Although extraverts dominance and forcefulness generate positive performance expectations at the outset, extraverts are often poor listeners and unreceptive to others' input which can limit their effectiveness at interdependent group tasks [51].

An explanation for self esteem is that leadership does not stem directly from self esteem, but self esteem may have [52-55] found that highly extroverted leaders were considered ineffective because they overemphasized instrumental outcomes. These behaviors may be particularly detrimental to medical team performance on interdependent tasks, because the other group members do not feel that their input is appropriately valued [56-60]. Research has indicated that extroverts low receptivity to others input may signal that extroverts have self-interested objectives, thus making peers interpret extroverts behaviors as attempts to self-aggrandize through a work group's task rather than to truly benefit the group [56,61-65]. Thus, it is possible that the behaviors of extroverted members that signal high status may be interpreted as self-interested and self-aggrandizing in the context of collective duty interactions as is the case with healthcare medical teams [66-71].

Lastly, self esteem, and extroversion jointly significantly predicted clinical leadership. This is indicative that the combined influence of self esteem and extroversion together has stronger association with clinical leadership. An explanation for this finding is that clinicians with a diminished sense of personal worth, low coupled with low extroverted-ness will develop and predict clinical leadership competence. In other words, clinicians with high self esteem and extroversion are less likely to predict leadership competence [71-76].

Conclusion

Based on the findings, the study has empirically demonstrated that clinicians who perceived a diminish sense of self esteem, and extroversion showed higher tendency to demonstrate clinical leadership competence than their counterparts. Moreover, the results revealed that hospital employees who have high self esteem showed lower tendency to exhibit clinical leadership competence [76-81].

The result of this study also showed that all the independent variables (self esteem, , and extroversion) jointly predicted clinical leadership. Conclusively, findings of this study established that self esteem and extroversion jointly exert significant influences on clinical leadership competence among clinicians [82,83].

Implications of the findings

Findings of the study have some direct practical implications for management and boards of directors in ministries of health in government owned hospitals in Nigeria and Africa. The findings from this study implicate the need for hospital and healthcare management as well as personnel departments to design and develop intervention

programmers that can help increase effective clinical leadership structure and personnel development within the healthcare sector.

The findings of this study also have practical implications for reviewing and updating Nigerian hospital reforms and training manual, specifically in relations to teaching, training of hospital employees. It is therefore suggested that hospital management should include measure of clinical leadership as part of assessment tools, and academic course during training. Clinical leadership training should also form an important area of concentration in colleges of medicine, and schools of nursing.

Lastly, findings from the study would serve as a reference point and stimulate more research in this direction among healthcare leadership and governance clinical psychologists' researchers and other researchers that are interested in clinical leadership among clinicians.

Recommendations

Based on the findings of this study, the researcher recommends as follows:

1. Colleges of medicine and various schools of Nursing under the Ministry of Health in Nigeria should take adequate steps to inculcate clinical leadership structures that suit and encourages the cultural and environmental demands of clinical leadership competencies. In other words, clinicians who work in healthcare environments in Nigeria shall acquire career development possibilities and leadership training like those in the United Kingdom (UK), and central Europe who are already reaping the dividends of clinical leadership competency.

2. Since clinicians interact and work directly with patients and hold the interest of the patient the most. The researcher therefore recommends that the Nigeria healthcare reforms and policies should be reviewed, specifying issues relating to enrollment, conscription, and training of clinicians. It is therefore recommended, that hospital management in Nigeria should include measure of clinical leadership competency as part of their training and assessment tools during enrolling in medical colleges, and schools of nursing. This may help hospital employee's deal with work pressures, physician-nurse relationship, medical team structure and functional responsibility.

3. Healthcare practice needs evidences that are proved by research outcomes. Integration of research evidence into clinical leadership performance is essential for the delivery of high-quality clinical care. Leadership behaviors of doctors, psychologists, nurses, especially, managers and administrators have been identified as important to support research use and evidence-based practice. Yet, minimal evidence exists indicating what constitutes effective clinical leadership competency for this purpose or what kinds of interventions help clinical leaders to successfully influence research-based care. It is recommended that research centered on these areas should be intensified.

Limitations of the study and direction for future research

Like other studies, this present study has some limitations as well. The limitations noted were: One, findings in this study should be generalized with caution due to the following reasons; (1) data might be open to response set because data were collected using self-report questionnaires, (2) the study only made use of 462 participants (including the pilot study) which may not be enough for generalization, and (3) participants were drawn form only hospitals in Lagos and Ondo states, Nigeria. Also, this study considered only three

(self esteem, and extroversion) predictor variables on clinical leadership. The influence of other variables such as communication relationship, ethical policies, and emotional intelligence on clinical leadership of clinicians should be considered in future research.

Using more clinicians across hospital in Nigeria, future research should, therefore, test the extent to which medical, therapeutic and psycho-socio variables moderate the relationship between the scopes of clinical leadership. Future researchers should also embark on comparative study as this will tell if the independent variables are truly responsible for effective leadership, in other part of Nigeria. The interactive role of the various psycho-socio factors on clinical leadership should also be examined.

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