Nursing Leadership in the Eastern Province of Saudi Arabia

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Declaration

I certify that except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

Nourah Abdalaziz Alsadaan

Signed: _____ Date: 13/06/2018

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List of Abbreviations

ANOVA: Analysis of Variance

BSN: Bachelor of Science in Nursing

CCC: Culturally Competent Care

CEO: Chief Executive Officer

CR: Contingent Reward

II: Idealised Influence

IC: Individualised Consideration

IM: Inspirational Motivation

IS: Intellectual Stimulation

IRB: Institutional Review Board

KFU: King Faisal University

KSA: Kingdom of Saudi Arabia

LF: Laissez-faire

M: Mean

MBE-A: Management-by-Exception Active

MBE-P: Management-by-Exception Passive

MOE: Ministry of Education

MOH: Ministry of Health

MLQ: Multifactor Leadership Questionnaire

MLQ 5X-Short: Multifactor Leadership Questionnaire Short Version

NGHA: National Guard Health Affairs

NUOC: Nursing Unit Organisational Culture

PBUH: Peace be Upon Him

PHC: Primary Healthcare

PCA: Principal Components Analysis

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analysis

RMIT: Royal Melbourne Institute of Technology

SCFHC: Saudi Commission for Health Specialties

SD: Standard Deviation

SNB: Scientific Nursing Board

SPSS: Statistical Package for the Social Sciences

UAE: United Arab Emirates

UK: United Kingdom

USA: United States of America

UWS: University of Western Sydney

WHO: World Health Organisation

Definition of Significant Terms

Contingent reward:

The provision of contingent rewards emphasises a particular exchange system that relies on a clear agreement between the leader and the followers to accomplish organisational goals. As the workers provide their effort and time, the leader is then expected to provide rewards founded on the agreement that was established (Riaz & Haider, 2010).

Exert extra effort:

Extra effort signifies the ability of the leader to encourage followers to exert more effort towards the accomplishment of work (Abualrub & Alghamdi, 2012).

Expatriate:

An employee who immigrates to another country in search of work, mainly as a professional (Almalki, Fitzgerald, & Clark, 2011).

Full range leadership model:

The full range leadership model is one of the leadership theories developed by Bass (1985), which incorporates elements from transformational leadership as well as elements from transactional leadership and laissez-faire leadership.

Idealised influence:

Idealised influence is one of the factors of transformational leadership where leaders become role models who are respected and imitated by followers. Charismatic leaders have the ability to build on the followers' needs and values through dramatic words and actions (Bass & Riggi, 2006).

Individualised consideration:

Individualised consideration is the final factor of transformational leadership where leaders support their followers by listening to each follower's needs and concerns. Each member of the team will be treated differently according to their needs and capabilities (Bass & Riggi, 2006).

Inspirational motivation:

Inspirational motivation is when leaders inspire and motivate followers which often depend on the leader's ability to articulate a vision (Bass & Riggi, 2006).

Intellectual stimulation:

Intellectual stimulation occurs when leaders stimulate their followers to look at problems, beliefs and values from a new perspective (Nwoke, 2010). When transformational leaders provide intellectual stimulation, this will encourage followers to think outside the box and engage in a generative thinking process (Sosik, Avolio, & Kahai, 1997).

Job satisfaction:

Satisfaction can be linked to the leaders' contentment with their own performance as well as the followers' satisfaction in terms of the leaders' decisions, actions and behaviours (Atmojo, 2012).

Laissez-faire leadership style:

It is an avoidance or absence of leadership where leader believes that the best leadership is the least leadership (Bass & Avolio, 1995).

Leaders' effectiveness:

Effectiveness has been associated with the efficiency of leaders to accomplish tasks, achieve goals and respond towards the needs and expectations of their followers, which can be a highly relevant factor that can contribute to long-term outcomes (Limsila & Ogunlana, 2008).

Leadership:

The ability of the leader to influence others to enable achievement of the organisational outcomes through motivation and guidance and direction (Bennis & Nanus, 1985).

Leadership style:

The characteristics and traits shown by leaders in directing and influencing their followers (Abualrub & Alghamdi, 2012).

Management-by-exception active:

The active approach to management by exception is when leaders use punitive action when followers are unable to adhere to the set standards therefore, this increases the monitoring of performance and corrective action of followers (Jamaludin, Rahman, Makhbul, & Idris, 2011).

Management-by-exception passive:

Passive management by exception is demonstrated by leaders who choose not to provide information and articulate tasks, goals and expectations in spite of their leadership role. They cannot be expected therefore, to create effective solutions and timely responses to critical situations (Jamaludin et al., 2011).

Multifactor Leadership Questionnaire (MLQ):

A questionnaire based on the full range leadership model. It consists of nine elements that enables the assessment of leadership styles (Andrews et al., 2012).

Nurse:

Registered nurses in the hospitals settings who are charged with the responsibility of delivering healthcare to patients whilst working under the supervision of a nurse manager (Abualrub & Alghamdi, 2012).

Nurse manager:

This term refer to the professional nurses in nursing organisation in Saudi Arabian hospitals who are responsible for supervising nurses, planning and organising nursing services (Abualrub & Alghamdi, 2012).

Perception:

Perception is the view of an individual about themselves or others (Andrews, Richard, Robinson, Celano, & Hallaron, 2012).

Transactional leadership style:

Transactional leadership is an exchange between the leader and follower. Followers receive certain rewards when they act according to the leader's wishes, resulting in a transactional leader motivating the followers to work as expected (Hartog, Muijen, & Koopman, 1997).

Transformational leadership style:

Transformational leader is one who motivates followers to do more than they originally expected to do (Bass, 1985). Transformational leaders have a mission and vision for their organisation which help in achieving outcomes and the development of the followers (Bass & Riggi, 2006). Transformational leadership included four factors: idealised influence, inspirational motivation, intellectual stimulation and individualised consideration.

Abstract

Aim: The aim of this study was to identify the leadership styles of nurse managers working at Saudi Arabian hospitals located in the Eastern province and also to assess the relationship between the perceived leadership style and organisational outcomes including: leaders' effectiveness, nurses' job satisfaction and nurses' willingness to exert extra effort.

Method: This study adopted a mixed-methods research design. A mixed-methods design which included quantitative data (questionnaire; for nurses and nurse managers) and qualitative data (interviews; for nurse managers) was used to accomplish the aims of this study. The study was undertaken at six hospitals within the Eastern province of Saudi Arabia. It was based on the full range leadership model developed by Bass (1985) which incorporates transformational (five factors), transactional (three factors) and laissez-faire (one factor) leadership styles. The Multifactor Leadership Questionnaire MLQ 5X-Short (Avolio, Bass & Jung, 1995) was used to obtain data from nurse and nurse manager participants and additionally, all participants completed a demographic data survey. A convenience sample of 825 (600 nurses and 225 nurse managers) from the six hospitals were invited to participate in the study. The sample consisted of nurses and nurse managers who had a minimum experience of one year in nursing. From two of the hospitals included in the study, 50 nurse managers were also invited to be interviewed for the qualitative research component. Themes from the qualitative data analysis were developed by identifying recurrent patterns from the data and then organising them into groups through a process of inductive reasoning.

Results: A sample size of 404 (nurses n = 283, nurse managers n = 121) participated in the study. The results indicated that the majority of the participants were female, with a range in age of 20 to 40 years for nurses and a range in age of 30-39 years for nurse managers, with the majority of participants holding a diploma qualification. A majority of nurses had 1-2

years of experience with nurse managers having 3-10 years of experience. Overwhelmingly, most participants were expatriate who were mainly from India and the Philippines. The quantitative analysis of this study indicated that nurse managers and nurses perceived that the leadership style of nurse managers was a mix of transformational and transactional leadership styles. Furthermore, the results revealed that nurse managers utilised the five transformational leadership factors and the contingent reward transactional leadership factor. Both nurses and nurse managers rated transformational higher than transactional leadership factors. Nurses rated the nurse managers lower on the average than the nurse managers rated themselves on nine leadership factors with the exception of laissez-faire leadership and the management-by-exception passive transactional leadership factor. In regard to the relationship between leadership styles and organisational outcomes, results for both nurses and nurse managers demonstrated a significant positive correlation with each of the five transformational leadership factors and two of the transactional leadership factors. However, there was a negative correlation between laissez-faire leadership and management-by-exception passive with each of the three organisational outcomes.

The themes identified from the qualitative data analysis included the following: ensure good patient care and safety, leadership according to the situation, be a role model, maintain good working relationship, caring about staff, know how to motivate staff, be a good communicator, challenges and need to go through all the steps.

Conclusion: This study provides an evidence base for nursing leadership in Saudi Arabia. It presents insights into current leadership styles practiced in Saudi Arabian hospitals and in particular, the Eastern province. In addition, this study helped to identify the predominant and the most effective leadership model which is expected to improve the nursing workforce and overall healthcare services in Saudi Arabian hospitals. Nursing administrators should consider providing training and development of nurse managers, particularly in transformational

leadership. Nurse educators should also encourage nurse managers to utilise the transformational leadership style to enhance learning and organisational outcomes in healthcare services in Saudi Arabian hospitals. For future research, there is a need to expand this study to incorporate other regions in Saudi Arabia, including teaching hospitals and the private healthcare sector to facilitate generalisability of findings and for improving educational programs for future nursing leaders.

Keywords

Nursing leadership, transformational leadership, transactional leadership, leadership styles, nurse manager, organisational outcomes.

Chapter 1: Introduction

1.1 Introduction

Globally, the importance of nursing workforce issues is being identified, including the need for addressing the important role of nurse managers (Alshammari, 2014). A nurse manager is defined as a professional registered nurse who is responsible for planning and organising nursing services, supervision of nurses and the quality of work done by nurses in a ward (Abualrub & Alghamdi, 2012). The Ministry of Health (MOH) in Saudi Arabia has recognised the importance of nurse managers and has focused on this role in the improvement of healthcare services (Ministry of Health, 2016). The purpose of this study was to identify the leadership style of nurse managers (including head nurses, charge nurses and supervisors) working at Saudi Arabian hospitals located in the Eastern Province of Saudi Arabia. This study was also designed to assess the correlation between the perceived leadership style of nurse managers and nurses to three organisational outcomes including: leader effectiveness, job satisfaction and staff willingness to exert extra effort. This chapter provides an introduction to the thesis, as well as providing a background to the study, a statement of the problem, the research aim, specific objectives, research questions and study design. Finally, the organisation of the thesis is discussed.

1.2 Background

Several key issues are important for providing a background and context to this study. In particular there are a number of challenges for the nursing profession and for nursing leaders in Saudi Arabia. The motivation for this study came from this PhD candidate's clinical experience in various healthcare settings in Saudi Arabia and her observation of the

influence of these challenges on leadership styles and outcomes. The following is a discussion of some of these key issues facing nursing leaders in Saudi Arabia.

1.2.1 Challenges of nursing in Saudi Arabia

There are a number of challenges for the nursing profession and leaders of the profession in Saudi Arabia. In 2016, it was reported that hospitals in Saudi Arabia were staffed by only 36.5% of local nurses, while the remaining 63.5% of nurses were expatriate (Ministry of Health, 2016). The majority of nurses in Saudi Arabia are, therefore, expatriates from other countries whose values, norms and beliefs are vastly different from those of the Saudi culture (Oulton, 2006). The Islamic way of life is practised by most of the population in Saudi Arabia (Mebrouk, 2008). One of the issues with such a large expatriate workforce is that inadequate knowledge and cultural incompetency may cause nurses to overlook the relevance of Islamic principles in the healthcare system and patient care quality. Furthermore, it is important for foreign nurses to recognise the importance of strong extended family ties, the protection of women, the belief in an omnipotent deity, honour and egalitarianism (Aboul-Enein, 2002). Mebrouk (2008) asserts that the values and beliefs of the patients and their families should be strongly taken into consideration when providing patient care.

Another complexity relating to the advancement of nursing practice in Saudi Arabia is the information exchange that is carried out in healthcare facilities (Almalki, 2017). The level and type of communication are key aspects of nursing practice and patient care outcomes (Albagawi & Jones, 2017). A study conducted by Aldossary, While and Barriball (2008) highlighted the language differences between Saudi Arabian and expatriate nurses. More specifically, the use of Arabic as the native language between patients and English as the common form of language between nurses and other healthcare professionals was identified (Aldossary et al., 2008). Many expatriate nurses, however, are not necessarily competent in the English language nor are they familiar with the Arabic language. This creates a

significant issue in terms of interaction with the nurses as well as the patients they are caring for (Simpson, Butler, Al-Somali, & Courtney, 2006).

Another challenge for nursing in Saudi Arabia is the high turnover of expatriate nurses as a result of many factors that will be discussed further in Chapter 2 (Al-Dossary, Vail, & Macfarlane, 2012). One of these factors is that Saudi Arabia is seen as a place where nurses can gain experience and then use this to gain a position in a Western country, such as Canada or Australia (Al-Ahmadi, 2002; Almalki et al., 2011). According to Falatah and Salem (2018), the high turnover of expatriate nurses in Saudi Arabia exacerbates the shortage of nurses. As a result, this shortage can lead to losing experienced nurses and which could affect patient outcomes as well. Nurse managers in Saudi Arabia should develop a retention strategy, therefore, that could help in decreasing the turnover rate for both new and expert nurses (Falatah & Salem, 2018).

In Saudi Arabia, healthcare organisations are making serious attempts to deal with diverse issues pertaining to culture and education, as well as the employee experience. For effective management of the complexities in the Saudi Arabian healthcare system, administrators need to work towards the development of a nursing leadership who can manage these intricacies by applying appropriate methods and strategies that focus on people and solving problems (Tumulty, 2001). Proper leadership strategies should be aimed at enhancing the nursing workforce in Saudi Arabia. Recent research in Saudi Arabia has highlighted the concept of nursing leaders facilitating positive changes and improvements in nursing as a profession (Abdelhafiz, Mah'd Alloubani, Klaledeh, Mutari, & Almukhtar, 2015; Alshammari, 2014). This is not a new concept as Brooks and Anderson (2004) have suggested that nursing leaders should be capable of addressing the needs and issues of a strongly culturally diverse workforce comprised of a large number of expatriate nurses.

1.3 Challenges of nursing leadership in Saudi Arabia

Leadership is a process of influencing people to achieve goals. According to Winston and Patterson (2006, p. 7):

> A leader is one or more people who selects, equips, trains, and influences one or more followers who have diverse gifts, abilities, and skills and focuses the followers to the organization's mission and objectives causing the followers to willingly and enthusiastically expend spiritual, emotional, and physical energy in a concerted coordinated effort to achieve the organizational mission and objectives.

Effective leaders are known to have a well-planned vision for articulating values and beliefs as well as satisfying and motivating employees (Bass & Riggio, 2006). In the process of leading to meet an organisation's goals, a leader allows followers to be creative and self-directed as well as helping them to learn from their mistakes and others' mistakes and success (Winston & Patterson, 2006).

The global nursing shortage and the other healthcare challenges faced by the Saudi Arabian healthcare system alerted the nursing leadership to address these challenges and rebuild the nursing workforce (Cummings, MacGregor, Davey, Wong, et al., 2010). This call for leadership is also to implement a new model of care. According to Cummings et al. (2010) effective leadership style is associated with positive outcomes for the nursing workforce and health care organisation. Furthermore, Cummings et al. (2010) claimed that leaders who practice dissonant leadership that focuses on task completion alone, are not focusing on developing or building relationships with staff. In contrast, transformational leaders mainly focus on understanding what individual employees are feeling during difficult times, thereby building trust through listening, empathy, and responding to staff concerns

(Bass & Riggio, 2006). This leads to completion of the tasks required to achieve goals, and in the case of healthcare, ultimately the provision of excellence in patient care.

Healthcare in Saudi Arabia faces a looming shortage of nurse leaders. This could be because the Saudi Arabian healthcare system is managed by physicians who give the impression of being authoritative rather than collaborative (Brown & Busman, 2003). Changes over the last two decades have identified that there is a positive trend in nursing engagement however, entrenched power relationships may indirectly influence nurse managers on how they should implement their managerial strategies (Brown & Busman, 2003). Physicians who work as hospital directors in Saudi Arabia have been known for their bureaucratic and hierarchical style of management (Tumulty, 2001). In most healthcare facilities in Saudi Arabia, the director of nursing reports to the hospital directors which mean that allocative efficiency, autonomy, and creativity are limited. There is a need therefore, for implementing strategies to ensure effective leadership is paramount. By developing and promoting viable nursing leadership for the future, organisations can achieve the goal of providing high quality healthcare.

1.4 Statement of the problem

The nursing workforce in Saudi Arabia currently faces the challenges of dealing with increasing change and uncertainty within a complex geopolitical environment (Abdalla et al., 2016). In light of the rapid changes taking place in healthcare organisations, effective leadership and the identification of an appropriate leadership style will be crucial in transforming the healthcare sector in Saudi Arabia. Having a positive work environment is highly associated with the leadership style of nurse managers. Additionally, the workplace is influenced by the relationship between leaders and their followers (Alshammari, 2014). In order to prepare nurse leaders in Saudi Arabia, there is a need to identify the predominant

nursing leadership style and its relationship with organisational outcomes, including effectiveness, satisfaction and staff willingness to exert extra effort.

Many nursing leadership style studies have been conducted in a variety of countries where the culture is different to Saudi Arabia, for example, Finland (Vesterinen, Suhonen, Isola, & Paasivaara, 2012), the United States of America (Casida & Parker, 2011) and Italy (Zampieron, Spanio, Bernardi, Milan, & Buja, 2013). This difference makes the generalisation of data difficult as the leader-subordinate relationship is affected by culture (Alshammari, 2014). In addition, the level of individuality and the type of healthcare organisation may impact the nursing workforce. Even though a number of studies have been conducted in Saudi Arabia on identifying leadership styles (for example, Aboshaiqah, Hamdan-Mansour, Sherrod, Alkhaibary, & Alkhaibary, 2014; Abualrub & Alghamdi, 2012; Alshammari, 2014; Suliman, 2009), no such studies have been conducted in the Eastern province of Saudi Arabia. The population in the Eastern Province are more liberal and more likely to choose the nursing profession (Personal communication, 24 October, 2017). Studies in Saudi Arabia of nursing leadership have been conducted in regions such as Riyadh (Aboshaiqah et al., 2014; Alyami, Galdas, & Watson, 2017; Asiri, Rohrer, Al-Surimi, Da'ar, & Ahmed, 2016), the three largest cities in the Western region of Saudi Arabia including Jeddah, Makah and Taif (Abualrub & Alghamdi, 2012), the western region in general (Suliman, 2009), the northern region (Alshammari, 2014) and the southern region of Saudi Arabia (Alshahrani & Baig, 2016).

For the various studies conducted in Saudi Arabia there are a variety of findings about the leadership style practiced by nurse managers. Alshammari (2014) conducted a quantitative study to assess the leadership styles of nurse managers working at Saudi Arabian MOH hospitals located in the Northern area of Saudi Arabia (Hail region) using the Multifactor Leadership Questionnaire (MLQ) 5X-Short (Bass & Avolio et al., 1995) and

found that the dominant leadership style was laissez-faire. In contrast, a study conducted by Suliman (2009) to examine the leadership styles of nurse managers in a National Guard Health Affairs hospital located in the Western part of Saudi Arabia and utilising the MLQ 5X-Short tool (Avolio et al., 1995), demonstrated that both participants (nurse managers and nurses) reported transformational leadership as the predominant leadership style. In another study conducted in two referral tertiary hospitals in Riyadh the findings were that nurses rated their nurse managers as more frequently using the transformational and transactional leadership styles (Aboshaiqah et al., 2014). These findings were supported by critical care nurses in Aseer in the Southern region of Saudi Arabia (Alshahrani & Baig, 2016). In a more recent study of nursing leadership styles in Saudi Arabia, transformational leadership was the most dominant leadership style for nurses working at two hospitals located in the largest MOH medical cities in Riyadh (Alyami et al., 2017). Given this variability in findings across the various areas of Saudi Arabia, this study provides an opportunity to explore nurse managers' leadership styles in a region not studied previously. It also highlights the need for further research to include other Saudi Arabian regions for comparison of results and an opportunity to consolidate the research findings.

Upon review of the studies of nurse managers' leadership styles in Saudi Arabia there is also a paucity of qualitative data collected. All studies to date have been quantitative studies (Abdelhafiz et al., 2015; Abualrub & Alghamdi, 2012; Aboshaiqah et al., 2014; Alshahrani & Baig, 2016; Alshammari, 2014); Al-Yami et al., 2017; Asiri et al., 2016; Dahshan et al., 2017; Moussa, Absohaiqah & Alotaibi, 2016; Musaed et al., 2016; Suliman, 2009), commonly utilising the MLQ 5X-Short (Avolio et al., 1995) as the research tool and few have included qualitative data (Omer, 2005; Saleh et al., 2018). A mixed-methods approach was included in this research project to address this gap in the literature. Thus, this

thesis will be providing new and an original contribution to the literature and enable understanding of the nursing leadership styles in Saudi Arabia.

It is predicted that outcomes from this research will be useful for developing tailored and targeted leadership training for nurses working in Saudi Arabian hospitals. Accordingly, identifying the current leadership styles will establish baseline information for identifying the most effective leadership styles best suited for the nursing workforce in Saudi Arabia. Moreover, it will contribute to the knowledge base that will allow nurses as well as nurse managers to be educated and trained to become more effective and efficient leaders.

1.5 Rationale of the study

Despite the findings from numerous studies conducted in Saudi Arabia (Suliman, 2009; Abualrub & Alghamdi, 2012; Aboshaiqah et al., 2014; Alshammari, 2014; Alshahrani & Baig, 2016; Asiri et al., 2016; Al-Yami, Galdas & Watson, 2018), there is a gap in the literature regarding leadership styles because of the narrow focus on quantitative data collection. Quantitative research does not allow the topic to be explored in depth and is confirmatory (Creswell, Plano Clark, Gutmann, & Hanson, 2003). Recommendations have been made that future research should extend quantitative methods to more fully explore leadership theories beyond survey assessment (Antonakis, Avolio & Sivasubramaniam, 2003). The findings have provided some understanding of the leadership styles being applied by nurse managers in Saudi Arabia but there has been no further exploration of this data by qualitative research methods. This study will help to fill that gap and provide information on these nursing leadership styles.

Another incentive for pursuing this study was that no research had been completed investigating nursing leadership styles in the Eastern Province of Saudi Arabia. As previously identified, the population in the Eastern Province is more liberal and more likely to choose

the nursing profession (Personal communication, 24 October, 2017). There is therefore, a cultural difference in the population in this province which could affect perceptions of nursing leadership styles. In combination with studies completed in other regions of Saudi Arabia, this study will contribute to the knowledge base of leadership styles of nurse managers in healthcare institutions in Saudi Arabia. This knowledge is important as it will help in assessing whether the required nursing leadership exists in hospitals in Saudi Arabia.

An understanding of the leadership styles of nurses is valuable information for policymakers and administrators given the impact the various leadership types may have in the working environment of a hospital. Knowledge of the characteristics of the leadership styles can help determine the level of leadership training required to enhance the effectiveness of nurse managers. Further, it is expected that this study will provide pertinent information on nurse managers' perceptions of their leadership styles and their critical role in motivating nurses and their performance. Moreover, it is expected that the results of this study will promote the importance of nurse managers' and the influence they may have on the healthcare sector in general in Saudi Arabia. Given this, the results of this study may be used to improve the quality of care for patients in Saudi Arabian hospitals.

1.6 Aim of the study

The purpose of this study was to examine the leadership styles of nurse managers working in Saudi Arabian hospitals in the Eastern Province of Saudi Arabia. The study also assessed the relationship between nurses' and nurse managers' perceived leadership style to three organisational outcomes: effectiveness, job satisfaction, and willingness to exert extra effort.

1.7 Objectives of the study

The overall objectives of the study were to examine in hospitals in the Eastern Province of Saudi Arabia on the following:

1. To examine how nurses perceive their nurse managers' leadership styles.
2. To examine how nurse managers perceive their own leadership styles.
3. To investigate the difference between nurses' perceptions of their nurse manager leadership styles and nurse managers' perceptions of their own leadership styles.
4. To identify the association between nurse managers' leadership styles and nurses' willingness to exert extra effort.
5. To identify the relationship between nurse managers' leadership styles and staff job satisfaction.
6. To identify the association between nurse managers' leadership styles and staff effectiveness.

1.8 Research questions

The research questions for this study in relation to hospitals in the Eastern Province of Saudi Arabia were:

1. What are the self-reported leadership styles of nurse managers?
2. What are nurses' reported perceptions of leadership styles of nurse managers?
3. Is there a relationship between leadership styles of nurse managers and nurses' job satisfaction and willingness to exert extra effort?
4. Is there a correlation between nurse managers' leadership styles and their effectiveness?
5. Is there a significant difference between how nurse managers perceive their leadership styles to that of nurses' perception of their managers' leadership styles?

6. Is there a significant difference between demographic characteristics and the leadership styles of nurse managers?

1.9 Study design and method

This study used a mixed-method approach (concurrent nested strategy). The concurrent nested strategy is a process of collecting and analysing both quantitative and qualitative data at the same time with one embedded within the other. In this study, priority was given to the quantitative data to guide the research, whilst the qualitative data was embedded to seek more information from different levels. The quantitative part of this study was based on the full range leadership model. This model was measured using a questionnaire called the MLQ 5X-Short (Avolio et al., 1995). The qualitative section of the study included semi-structured face-to-face interviews. As discussed, the target population of this mixed-method research study was nurse managers and nurses working at Saudi Arabian hospitals located in the Eastern Province.

1.10 Organisation of the thesis

The thesis is composed of nine chapters. This first chapter has included an introduction to the study and includes the research background which provides a brief overview of healthcare, nursing practice and leadership in Saudi Arabia. It delineates the study aims and design, the rationale for the study and the research methods used.

Chapter 2 provides an overview of the country and culture of Saudi Arabia, as well as the healthcare system and nursing profession. Chapter 3 presents a literature review of the research area following a systematic literature review of previous studies of nursing leadership styles and the development of leadership theories. The aim of the literature review was to identify the gap in the literature which this study investigated.

Chapter 4 presents the conceptual framework of the study based on a leadership model. Chapter 5 presents the methodology of the study. This includes the study's overall aim and the research questions as well the study design and the significance of using a mixed-methods approach. This presents the study setting, sample and sampling techniques, data collection and analysis techniques. This is followed by an outline of the ethical considerations.

In Chapter 6, the results of the quantitative data for this study are presented with important information arising from the data analysis highlighted.

Chapter 7 presents the qualitative results and discusses the various themes that were identified.

Chapter 8 discusses the results of the study with comparison of findings to relevant literature for the research topic. The aim of this chapter is to illustrate how the findings from this study are contributing to knowledge in this area of nursing practice.

Finally, Chapter 9 is a summary of the research and includes the strengths, limitations, recommendations and conclusions of the research study. This chapter provides recommendations for nursing leadership, health and hospital policy and ongoing healthcare services in Saudi Arabia.

1.11 Summary

This chapter has provided an introduction to this study including a description of the healthcare system and nursing in Saudi Arabia and nursing leadership. A statement of the problem was also provided, as well as the study aims, objectives, research questions and research design. It is expected that this study will contribute to the knowledge base of nursing leadership styles and outcomes in Saudi Arabia. This will help inform the ongoing development of nursing leadership education and practice across the healthcare sector in Saudi Arabia. Moreover, this topic has been studied in Saudi Arabia in various regions of the

country but none to date in the Eastern Province and with few studies including qualitative research methods. In consideration of this, the results of this study are significant in emphasising the leadership styles of nurses and the critical role this can have in motivating nurses and their performance in clinical practice. The following chapter includes an overview of the context of Saudi Arabia and the healthcare system where this research was conducted.

Chapter 2: Saudi Arabian Context

2.1 Introduction

This chapter presents the Saudi Arabian context for the study in three sections, highlighting the system of healthcare and the unique position the nursing profession is situated in this arrangement. The chapter begins with an overview of the cultural perspectives in Saudi Arabia. This is followed by a description of the MOH and its role in governing healthcare services in Saudi Arabia. A description of the organisation of the nursing workforce and education is presented as well as challenges facing the nursing profession in Saudi Arabia.

2.2 The Kingdom of Saudi Arabia

Saudi Arabia is a recognised geographical region of south-western Asia, positioned in the Middle East and covering an area of 2.2 million km^2. In 1932 (1352 H), King Abdulaziz established and unified a country consisting of 80% of the Arabian Peninsula, encompassing mountain and deserts with some scrub and grasslands and named it the Kingdom of Saudi Arabia (KSA) (Al-Rasheed, 2010). The national day of Saudi Arabia is on the 23rd of September which happens to correspond with the first day of Libra. This date marks the unification of the Kingdom and its establishment by His Majesty King Abdulaziz bin Abdulrahman Al Saud. In 1983, in the eastern part of Saudi Arabia, the discovery of oil was a good omen for the young nation (Al-Rasheed, 2010). With the discovery of oil King Abdulaziz supported the creation of a modern social network and infrastructure to invest in this scare resource.

Sharia is the legal system in Saudi Arabia (Al-Rasheed, 2010). It is an Islamic law derived from the Quran and the Sunnah (the traditions) of the Islamic prophet Mohammed peace be upon him (PBUH). Sharia is the primary source of law in many areas including

criminal, family, commercial, and contract law; the Quran and the Sunnah are declared to be the country's constitution (Al-Rasheed, 2010). Islamic jurisprudence consists of ijmaa which comprises the fundamental elements of consensus, as well as qiyas, which is a deductive analogy using the Quran and the teaching of the Hadith to create a new injunction by applying a known injunction to a new circumstance (Almutairi & McCarthy, 2012). To make decisions regarding any new events associated with Islamic culture, society and technology, additional elements called ijtehad (logical thinking) are used by Islamic scholars. Thus, it is ensured that laws regarding these new events are congruent with Islam.

For the Saudi Arabian population, this has reached 31,742,308 in 2016 with 24.8% under the age of 15, 73.9% between 15 and 64 years old, and 1.3% at the age of 65 years or older (Ministry of Health, 2016) (see Figure 2.1). Hence, the population of Saudi Arabia largely consists of a younger demographic with a life expectancy for both genders of 75 years (Ministry of Health, 2016).

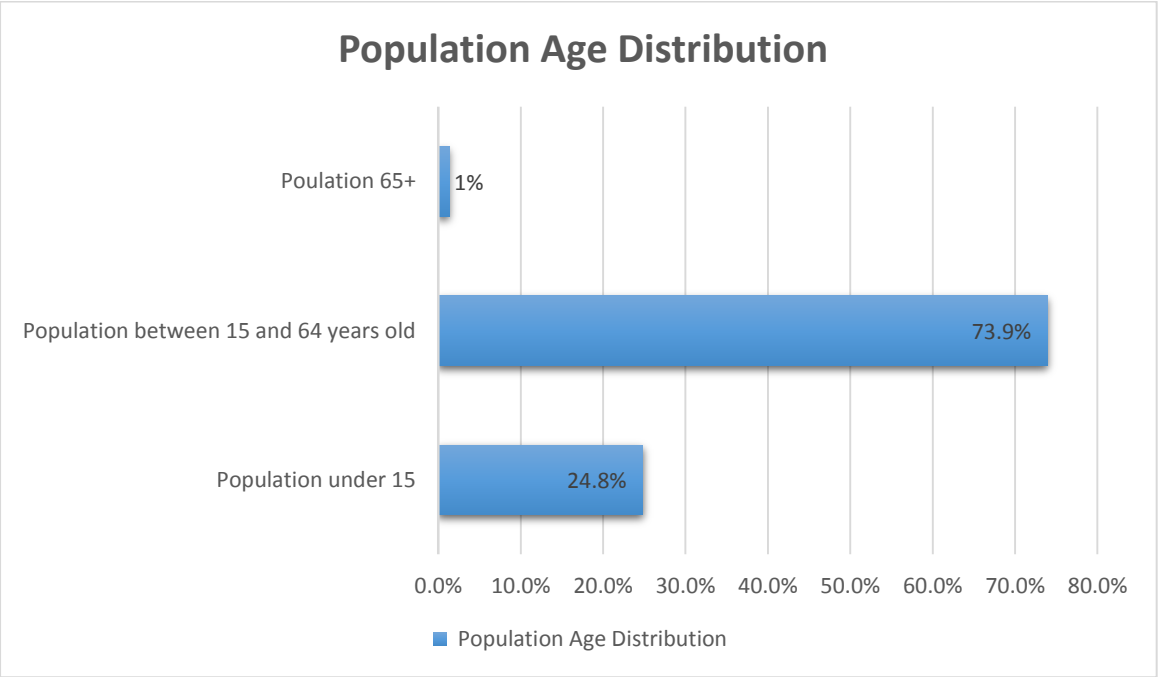


Figure 2.1 Saudi Arabia population age distribution.

(Source: MOH Statistical Book for the Year, 2016 p. 29)

2.3 Eastern Province of Saudi Arabia

The Eastern Province of Saudi Arabia is home to most of the oil production of Saudi Arabia with more than 20% of the world's total 1.3 trillion barrels of proven oil reserves. The Eastern Province has a population of 4 million of which 78% are Saudi nationals (Salam, Elsegaey, Khraif, & Al-Mutairi, 2014). Dammam is the regional capital of the Eastern Province of Saudi Arabia. This is a favourite destination for tourists from different parts of the Kingdom of Saudi Arabia. The Eastern Province, with more than 36% of Saudi Arabia's total area, is the largest province in the Kingdom. It extends from the borders of Kuwait and Iraq in the north, to the desert of Al-Rub Al-Khali (The Empty Quarter: the largest sand desert occupying the Southern part of the Kingdom) where the country borders Yemen and Oman. The Eastern Province also has land and/or sea borders with Bahrain, Qatar, United Arab Emirates (UAE) and Oman in the east. The administrative and territorial division of the Eastern Province includes ten districts. The largest towns include Dammam, Alhasa, Al-Jubail, Ras Tanura, Dhahran, Al-Khobar and Alqatif (Salam et al., 2014).

The government does not conduct a census on religion in Saudi Arabia. Sunni Islam however, is the predominant religion overall in the country although Shia Muslims are predominant only in Alqatif and Alhasa. Furthermore, people from all over the Saudi Arabian provinces move to the Eastern Province whereas other provinces on Saudi Arabia tend to have only their original native population. This indicates that the Eastern Province has people from many different backgrounds and religious beliefs. In contrast, Sunni Muslims are predominately located in the rest of Saudi Arabia (Salam et al., 2014).

The people who live in the Eastern Province are more liberal and open minded and more likely to choose the nursing profession especially in the cities of Alahsa and Alqatif. Whereas in other provinces of Saudi Arabia such as the Qassim, it is rare for local Saudi

Arabians and especially females, to work in hospitals as they are more conservative in their approach (Personal communication, 24 October, 2017).

In relation to the migration of people to the Eastern Province of Saudi Arabia, this is often determined by employment opportunities. As a consequence, this can contribute to the diversity of nationalities who reside in the Eastern Province as well as religions practiced in this region of Saudi Arabia (Personal communication, 24 October, 2017).

2.4 Overview of the culture of Saudi Arabia

Culture is considered as the attitudes, customs, beliefs, ideas and social behaviours of a society (Cortis, 2004). Culture is transmitted between one generation to the next through art, language and ritual (Havenaar, 1990). Although Saudi Arabia is a young country in that it was unified in 1932, Saudi culture has an Islamic Arabic influence spanning more than 1400 years since the first emergence of Islam (Aba-Namay, 1993). The Saudi Arabian culture is a mix of Islamic Arabic traditions and customs that shapes the mindset and behaviours of the people. For this chapter, discussion of the culture of Saudi Arabia will be presented in more detail under the following headings: families in Saudi Arabia, language, fasting month (Ramadan), traditional belief and cultural attitudes.

2.4.1 Families in Saudi Arabia

Families in Saudi Arabia are considered as an important component of society and the framework of the identity of individuals (Al-Saggaf, 2004). Families have an extended network with each individual being part of a family which includes grandparents, cousins, parents, aunts, uncles and siblings. Saudi families tend to live near each other which facilitates family interaction and socialisation and helps to preserve and strengthen family linkage. According to Al-Saggaf (2004), in Islam Muslims should maintain good relations with their family by supporting them, visiting them, celebrating with them and showing

respect for every member of the family. The fertility rate in Saudi Arabia is 2.7 births per woman compared to 1.8 births per woman in countries such as Australia (World Bank, 2015).

Family support during illness has a unique meaning in Saudi Arabian culture which helps maintain the integrity within the extended family. It is considered a moral responsibility for family members to be at a patient's bedside when in hospital and provide care (Harle et al., 2007; Searle & McInerney, 2008). Furthermore, members of the family are encouraged to stay with the patient to support and to hear the patient's last words prior to and during the time of the patient's death. Hence, nurses have opportunities to actively engage family members in offering care to their relatives.

In Saudi Arabian culture grandparents and parents are highly respected and have authority especially for their children's health. Furthermore, the extent of this authority can impact on how healthcare is provided to their family members (Felemban, O'Connor & McKenna, 2014). For Saudi Arabian elderly patients whilst spending time in hospital, they expect to be treated as they would be treated by their family members. Consequently, this means that they are expecting the nurses to be gentle, humble and patient with them. Patients view nurses as being outsiders, especially when comparing them to their close friends and family (Felemban et al., 2014). Felemban et al. (2014) reported that there are many challenges for the relationship between nurses and patients. However, Felemban et al. (2014) suggested these challenges may be overcome if the nurse is included as a family member or close friend. Consequently, this approval will help nurses to associate their authority and expertise with individual warmth as she/he attends to the patients. This will assist nurses in gaining more trust from their patients compared to being purely professional in their role (Felemban et al., 2014).

In addition, nurses will gain the trust of the Saudi Arabian people if they display competence when delivering healthcare for family members. Furthermore, nurses must show respect of diverse beliefs and cultural sensitivity and must understand that cultural differences might alter the way healthcare services are provided (Miller-Rosser, Chapman, & Francis, 2006).

2.4.2 Language

Arabic Language is considered as the official language in Saudi Arabia. Most of the Saudi Arabian people who have completed a tertiary education are able to speak English. Expatriate nurses speak English and minimal if any, Arabic. This makes it difficult for these nurses to communicate with the patients who may not speak or understand English (Vcencio, Albagawi, Alshammari, & Elsheikh, 2017). Consequently, some hospitals in Saudi Arabia provide interpretation services to surmount language barriers between expatriate healthcare providers and patients. Communication issues have been identified as one of the challenges within the healthcare system (Albagawi & Jones, 2017).

2.4.3 Fasting month (Ramadan)

In the Ramadan month all adult Muslims must fast. This occurs during the ninth month on the Lunar calendar, based on the sighting of the moon. Fasting starts from sunrise until sunset. During the day Muslims must abstain from eating, drinking, smoking and sexual intercourse. Travellers, patients, pregnant and lactating mothers are temporary concessions from fasting. However, they must resume fasting once their situation has changed (Kadri et al., 2000). After Ramadan, Muslims celebrate Eid Alfeter by visiting relatives and greeting each other with the words ‘Happy Eid’ which nurses are expected to greet their patients with as well.

2.4.4 Traditional beliefs

In the Saudi Arabian society, many people are practicing spiritual healing to cure diseases that cannot be cured by modern medicine such as poisonous stings, Jinn possession (possession by an alien spirit or other parahuman force), and the negative effect of evil-eye (al-Shahri, 2002). The treatments include reading the Quran and following the sayings of Prophet Mohammed (PBUH), eating black seeds and honey, and drinking Zamzam water. Zamzam water is obtained from the well in the Holy mosque in Mecca in Saudi Arabia (al-Shahri, 2002). This water is believed to possess special qualities because as narrated by Jabir, Prophet Mohammed (PBUH) said: "Water of Zamazm is good for whatever purpose it has been drunk". Prophet Mohammed also said "Water of Zamzam is a healer of every disease" (Memish & Ahmed, 2002). Muslims all over the world believe in these spiritual healings (Memish & Ahmed, 2002). Furthermore, some Saudi Arabian people believe their illness is atonement for sins and as a consequence, they may refuse medications or pain relief. This is because they believe that they deserve to suffer despite the teaching of Islam encouraging people to seek medical treatment (Memish & Ahmed, 2002). Hence, it is important that nurses show respect to such beliefs to build strong relationships with patients and their families in Saudi Arabian societies.

2.4.5 Cultural attitude

Shyness is considered one of the main characteristics of Saudi Arabian people (Al-Saggaf & Williamson, 2004). Shyness refers to a behavioural trait that is demonstrated by practicing modesty and decency in personal appearance and using appropriate language. This is more commonly expressed by women (Al-Saggaf & Williamson, 2004). Honour and shame are two characteristics that are correlated to each other and influence Saudi society and culture (Johnson & Lipsett-Rivera, 1998; Maisel & Shoup, 2009). If the honour of an

individual is tarnished by some factors such as meanness and immoral sexual conduct of a female family member, the whole family will be shamed (Gannon & Pillai, 2010). A clear understanding of these concepts and characteristics of the Saudi culture, therefore, will help expatriate nurses in the comprehension and appreciation of Saudi behaviours.

According to anthropology, culture is either high or low-context in nature (Hall, 1989). High context culture is defined as:

> One in which people are deeply involved with each other. As a result of intimate relationships among people, a structure of social hierarchy exists, individual inner feelings are kept under strong self-control, and information is widely shared through simple messages with deep meaning (Hall, 1976, p.39).

In contrast, a low-context (LC) culture is:

> One in which people are highly individualised, somewhat alienated, and fragmented, and there is relatively little involvement with others (Hall, 1976, p.39).

The low-context culture is common in countries such as the USA, Germany, Switzerland and Scandinavian countries, whereas the high-context culture is common in countries such as the Middle East (including Saudi Arabia), Africa, and South America (Richardson & Smith, 2007).

In a high-context culture, people are indirect in their personal communication using a combination of verbal and non-verbal messages to convey meaning with the verbal component conveying only a part of the meaning (Samovar, Porter, & McDaniel, 2009). Importantly, people who tend to be indirect in their communication style will avoid any interactions that cause conflict. In some societies, this conflict is dealt by discussing any issues privately or using a third party (Gupta, 2010; Schein, 2010). For people who use an

indirect communication style they will avoid anything that may embarrass them publicly and will try to resolve problems in a way that avoids loss of respect with others (Gupta, 2010). In contrast, in the low-context culture people will be direct in their interaction with others by using explicit communication styles. Thus, any problem is restored through face to face encounters. In Saudi Arabia where nursing includes a multicultural workforce an understanding of high and low-context cultures has some relevance in explaining the cultural differences that may exist among the local community and the healthcare workforce in Saudi Arabia.

2.5 Saudi Arabian Ministry of Health

The origins of the Saudi Arabian healthcare system started in 1926 with the opening of the Ajyed hospital in the Mecca region and Bab Shareef hospital in the Jeddah region, with both hospitals located in Western Saudi Arabia (Al-Rabeeah, 2003). This was followed by the establishment of the Health Directorate in Jeddah, which was renamed in 1927 to the Directorate of General Health and Ambulances (Al-Rabeeah, 2003). In 1951, the Directorate of General Health and Ambulances was renamed the MOH and operated 11 hospitals in various parts of the country (Al Yousuf, Akerele, & Al Mazrou, 2002). The establishment of the MOH in 1950 was under royal decree (Almalki et al., 2011). Twenty years later, the five-year development plans were introduced by the Saudi Arabian government to improve the healthcare system (Almalki et al., 2011). Between 1966 and 1976, oil revenues led to a huge investment in healthcare infrastructure (Brown & Busman, 2003). By 1970 Saudi Arabia had 74 hospitals with a total of 9039 beds and 331 hospitals which had grown to a total of 47242 beds in 2002 (Aldossary et al., 2008).

Healthcare in Saudi Arabia is provided free of charge for all Saudi Arabian citizens and expatriates working in the public sector, primarily through the Ministry of Health. In Saudi Arabia the healthcare system is made up of three main sectors: the MOH (public

sector), other government sectors such as the National Guard and teaching hospitals, and the private sector. In the public sector, the MOH provides primary, secondary and specialised care services. The MOH provides 63% of the total healthcare services in Saudi Arabia and is considered as the main government provider with a total of 218 hospitals (30489 beds) and 1905 primary healthcare (PHC) centres (Jannadi, Alshammari, Khan, & Hussain, 2008).

Based on statistics for 2016, physical resources in Saudi Arabia include 462 hospitals (70844 beds) and 2838 primary healthcare centres and hospitals which were staffed by a ratio of 24 physicians and 57 nursing and midwifery personnel per 10000 of the population (Ministry of Health, 2016). In Saudi Arabia, 7% of GDP was the total expenditure on healthcare services in 2016 (Ministry of Health, 2016).

The Saudi Arabian MOH has developed a 10-year strategy to address access issues to healthcare facilities. Over the previous five years this has resulted in the number of health facilities increasing by 10% (World Health Organisation, 2012). As part of this strategy, the MOH aims to pursue quality assurance by enhancing standard operating procedures and the accreditation of healthcare facilities. This is important because Saudi Arabia relies mostly on expatriate nurses and there is a high turnover among them (Alshammari, 2014). In 2016, Saudi nurses were only 36.5% of the nursing population in Saudi Arabia, while the remaining 63.5% of nurses were expatriates (Ministry of Health, 2016). An indigenous healthcare workforce plan, therefore, has been developed to help address these issues. As a result, the MOH has been aided by new nursing facilities and training and scholarship programs to educate healthcare staff abroad in known international institutions (World Health Organization, 2012).

The KSA introduced a new vision, called the 2030 vision (Investment Jadwa, 2016). This vision is based on three themes: a vibrant society, a thriving economy and an ambitious nation. The first theme is important to the achievement of the vision as the country believes

in the vital role of a vibrant society, which includes supporting the nation by establishing an empowering healthcare system. The second theme is also important as a thriving economy will help to grow the Saudi Arabian economy, which as a result will improve the quality of the healthcare system. For any future decisions, this vision will serve as a reference, to ensure that all projects are aligned with its content. In terms of healthcare services, the country aims to develop private medical services in order to improve access to healthcare services and reduce waiting times for appointments with specialists and consultants (Investment Jadwa, 2016). Currently, the Kingdom is ranked 26 out of 190 in relation to healthcare services (Almalki et al., 2011). Saudi Arabia is aiming to raise its position from 26^{th} to 10^{th} in the rankings. To accomplish this Saudi will introduce corporatisation into the sector by transferring the responsibility for healthcare provision to a network of public companies that operate both within the public and private sectors. This will provide the Saudi people with the highest quality of healthcare and enable them to choose their preferred service provider, as well as allowing the government to focus on its legislative, regulatory and supervisory roles (Almalki et al., 2011).

The population of Saudi Arabia is growing rapidly as according to the United Nations (2013), by 2025 the population is expected to reach 37 million. With the rapid growth of the Saudi population, the recruitment, retention, training and performance of nurses has become widely recognised as a critical issue in shaping healthcare delivery (Al Hosis, Plummer, & O'Connor, 2012). Associated with this, a national nursing workforce planning strategy has been called for to address the challenges in the nursing profession. These challenges include a shortage of nurses, impacts on the quality of patient care, language differences, communication gaps and difficulties such as the increasing need for nurses with work experience that is relevant to the nursing setting they are working in (Khani, Jaafarpour, & Dyrekvandmogadam, 2008).

2.6 Saudi Commission for Health Specialties

In 1992 (1403 AH) the Saudi Commission for Health Specialties (SCFHC) was established by a royal decree. This is a non-profit government authority located in the Diplomatic Quarter of the Riyadh city with several branches across Saudi Arabia. The SCFHC is responsible for assessing and evaluating healthcare professional training programs, administering the required examinations and setting standards for the practice of health professionals. Additionally, SCFHC is responsible for evaluating the qualifications of overseas qualified health care professions and issuing registration of healthcare professions to ensure safe and high quality practice. All healthcare practitioners in Saudi Arabia must have a valid registration to be entitled to work in the nation (SCFHS, 2012).

Included in the SCFHC organisation is the Nursing Council of Saudi Arabia. The SCFHC is the sole body tasked with establishing standards for all healthcare professions, registration of healthcare professionals, accreditation of healthcare programs and management of continuing professional development for all health professions. Given this, the SCFHC encourages development of professional skills including innovative and evidence-based practice (SCFHS, 2012).

The principal responsibilities of the SCFHS are in:

- Developing, assessing and approving healthcare professional programs, and creating sustained medical education programs.
- Evaluating health institutions responsible for training and specialisation of healthcare professionals.
- Specialist scientific committees and boards responsible for approving results of specialised examinations.
- Issuing professional certificates.

- Coordinating with other health commissions and schools outside Saudi Arabia.
- Developing the principles and standards governing the practice of healthcare professions, including the Code of Ethics.
- Developing the standards governing healthcare practice.
- Evaluating and approving healthcare certificates.
- Foster scientific research, publishing papers and issuing its own journals.
- Organising conferences to discuss local health problems, suggestion solutions and checking the implementation of suggestions (SCFHS, 2012).

2.7 History of nursing in Saudi Arabia

Nursing in Saudi Arabia began under the guidance of Rufaida Al-Aslmiya during periods of war in the time of Prophet Mohammed, peace be upon him (PBUH) (Miller-Rosser et al., 2006; Tumulty, 2001). Rufaida learnt nursing skills from her father who was a prominent healer. Together, Rufaida and a group of both men and women provided first aid and protection from the desert and heat for armies wounded (Aldossary et al., 2008). This group also continued to provide nursing care for the wounded and dying members of armies by erecting a tent in a mosque with the permission of Prophet Mohammed, (PBUH). As a result of her endeavours, Rufaida has been known as the first nurse and the founder of nursing in the Islamic era (Miller-Rosser et al., 2006). Female nurses in the early period of Islam were known as Al-Asiyah which means curing the wounds. Nowadays, female nurses are known as maumarrida which is the Arabic translation of nurse (Al Osimy, 1994). In terms of formalisation of healthcare in Saudi Arabia, the MOH was created in 1954 and the construction of health care centres and hospitals began. In order to expand the health care facilities, there was a need for development of nursing and programs of training of nurses.

In 1987 to recruit more national nurses and improve the quality of nursing care, the Central Nursing Committee was established at the MOH (Aboul-Enein, 2002). Following from this in 1994 the Saudi Arabian MOH established the General Directorate of Nursing to advance the quality of nursing care (AlYami & Watson, 2014). Prior to 1960, there were no nursing schools and as a consequence, there was little or no opportunity for Saudi Arabian people to join the nursing profession.

2.8 Nursing education in Saudi Arabia

In 1958 four years after the MOH was established, the first Health Institute program (Nursing) for males was initiated in Riyadh, with collaboration between the MOH and the World Health Organization (WHO) (Al Osimy, 1994). Fifteen students with elementary school qualifications enrolled in a one year nursing program (Aldossary et al., 2008; Alhusaini, 2006). In 1961, another two Health Institute programmes opened and were specifically for Saudi Arabian women to undertake nursing training with one located in Riyadh and the other in Jeddah (Tumulty, 2001). Subsequently, the one year nursing program extended to three years to recruit students with secondary school qualifications (Miller-Rosser et al., 2006). In 1990, the total number of Health Institutes offering nursing education for females was 17 and 16 for males. In 1992, the MOH upgraded the training level by establishing a Junior College for high school students (Abu-Zinadah, 2006).

Currently in Saudi Arabia there are 24 health institutes and 19 junior health colleges which award diplomas in various fields including nursing. In addition, Saudi Arabia has a range of specialist nursing fields available including medical, surgical, paediatric, psychiatry and midwifery as well as opportunities to practise in subspecialties such as critical care, orthopaedic and ophthalmic. The only postgraduate courses offered are in midwifery, possibly due to the lack of suitably qualified staff to teach other areas of clinical studies (Almalki et al., 2011).

In 1976, the Bachelor of Science in Nursing (BSN) program was initiated by the Ministry of Education (MOE) at King Saud University in Riyadh (Abu-Zinadah, 2006). This program of study was followed by a Bachelor degree at King Abdulaziz University in Jeddah in 1977 and another at King Faisal University (KFU) in Dammam in 1978 (Tumulty, 2001). All of these BSN programs have been limited to female students and it was only in 2004 that a BSN degree was established for males in Riyadh (AlYami & Watson, 2014). These Bachelor programs are five years of study plus one year as a full-time intern. In parallel, the MOE introduced the Master of Science in Nursing in 1987 at King Saud University in Riyadh (Almalki et al., 2011).

To improve nursing education in Saudi Arabia, there was a need for financial resources and academic experience. As a result, in 2008 all of the nursing programs of study were transferred from the MOH to the MOE. The Master of Science was commenced in 1987 with graduates from this program referred to as Senior Specialists (Aldossary et al., 2008). Saudi Arabia also has in-country scholarship programs such as the collaboration between King Faisal Specialist Hospital and Monash University in Australia for postgraduate studies for Saudi Arabian nurses (Abu-Zinadah, 2006; Miller-Rosser et al., 2006). In particular, doctoral scholarships are available to facilitate nurse managers obtaining a doctorate at an overseas university (Miller-Rosser et al., 2006; Aldossary et al., 2008).

In terms of the different levels of nursing qualifications in Saudi Arabia, nurses who graduate with diplomas from health institutes or junior colleges are categorised as technical nurses or senior technical nurses, respectively. Bachelor of Nursing graduates are referred to as Specialists whilst Master of Nursing Science or PhD graduates are referred to as Senior Specialists. For nurses with three years of clinical nursing plus a PhD are referred to as Nursing Consultants. To become a manager, nurses usually work at the beside for a number

of years consolidating their practice. Nurses then become leaders often without formal education on leadership or management (Millward & Bryan, 2005).

2.9 Nursing regulation

Under the direction of the SCFHS, the Scientific Nursing Board (SNB) was established in 2002 as the regulatory authority for the nursing profession in Saudi Arabia (Miller-Rosser et al., 2006). Prior to the establishment of the SNB, there was no formal registration of nurses and continuing education programs were not accredited or standardised. At present, nurses in Saudi Arabia are required to undertake continuing education programs for renewal of their registration (Abu-Zinadah, 2006).

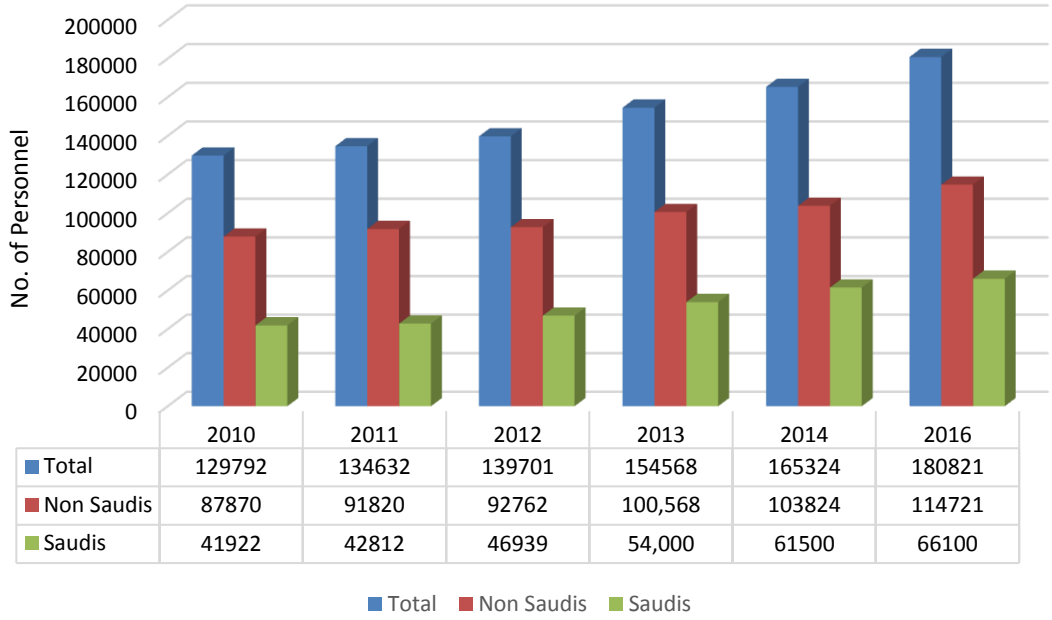
The functions of the SNB are similar to regulatory bodies in other countries such as the Nursing and Midwifery Board of Australia (NMBA, 2018), the Nursing and Midwifery Council (NMC, 2018) in the United Kingdom, and those in neighbouring Arabic countries (Ministry of Health, 2013). The SNB roles not only include registration of nurses but also development of standards of practice and accreditation of nursing education institutions and post-qualifications programs. A constraint of the SNB however, is that it is under the authority of the SCFHS which has general oversight of all health related professions. This may limit the roles and influence of the SNB. There have been suggestions that an independent nursing board should be created given that the current board whose role is to support nurses, mainly concentrates on the medical profession (Almalki et al., 2011).

In 2003 the Saudi Nursing Society was established at the King Abdulaziz University in Jeddah (Almalki et al., 2011). The aims of this society are to develop scientific thought in the nursing profession whilst providing scientific advice to its members. Other objectives include the enhancement of clinical and theoretical competencies of nurses and improvement

in the working conditions of nurses. The Council of the Saudi Nursing Society includes Saudi Arabia's most highly educated and experienced nurses (Almalki et al., 2011).

2.10 Challenges of nursing in Saudi Arabia

There are a number of challenges that have been associated with nursing practice advancement in Saudi Arabia. Firstly, the shortage being experienced in human resources for healthcare is a worldwide phenomenon and many countries around the globe are seeking to address this challenge (Liu, Goryakin, Maeda, Bruckner, & Scheffler, 2017). One of the development goals of the Saudi government was to establish a healthcare system for the benefit of all people in the country. However, Saudi Arabia is experiencing an immense national nursing workforce shortage. Saudi Arabia depends on an international nurse supply from more than 40 countries, with most nurses coming from the Philippines and India in numbers far beyond what was planned (Mebrouk, 2008). According to the Saudi Arabian MOH Statistics (2016) the majority of nurses in Saudi Arabia are expatriates with a total of 66100 Saudi nurses and 114721 nurses from other countries (see Figure 2.2).



	2010	2011	2012	2013	2014	2016
Total	129792	134632	139701	154568	165324	180821
Non Saudis	87870	91820	92762	100,568	103824	114721
Saudis	41922	42812	46939	54,000	61500	66100

Figure 2.2 Nurses working in Saudi Arabia 2010-2016

(Source: MOH statistical book for the year 2016 p. 48)

Reliance on such a large proportion of expatriate nurses contributes to a number of issues in itself, specifically, how they are recruited. These nurses are usually recruited through agencies based in countries like India and Philippines, with few systems or controls in place to ensure standards are followed (Tumulty, 2001). Contracts for recruitment are usually awarded for three years, followed by a bidding process for the next contract. This can result in a lack of continuity of contract providers and potentially contracts that are so poor that maintaining quality of personnel is difficult (Tumulty, 2001). Teams of staff from Saudi Arabia consisting of predominantly doctors and administrators go to these countries to recruit nurses. Usually nurses are not part of this recruiting team which may result in ineffective screening issues. This can result in recruits lacking the necessary experience and being poorly matched to the positions they are recruited for (Tumulty, 2001). A further complication to this recruitment process is that it is not necessarily undertaken on a regular basis. The last

recruitment cycle for one hospital, for instance, occurred in 2014 (Personal communication, 24 October, 2017).

A further issue is that once expatriate nurses working in Saudi Arabia obtain training and experience they are often then move to developed countries such as the United States of America, the United Kingdom, Australia and Canada (Almalki et al., 2011). Expatriates turnover is considered to be a major concern for leaders of healthcare facilities as this results in failure to have a return on the investment made in their training and it constitutes a loss of corporate memory (Almalki et al., 2011). Furthermore, the high turnover rate of expatriate nurses in Saudi Arabia has led to losing well-qualified nurses (Al-Ahmadi, 2002).

According to Tumulty (2001) the expatriate turnover has been associated with a number of factors including: work-related issues, personal characteristics or external environmental factors. One of these factors is the high workload because of a shortage of staff as outlined above. Another factor attributing to the high workload is due to nurses having to undertake non-nursing duties. This is because there are inadequate levels of ancillary and management personnel in most hospitals to undertake these non-nursing duties (Almalki et al., 2011; Tumulty, 2001). As a consequence, nurses are compelled to undertake these duties on top of their normal nursing tasks.

Another contributing factor to the high turnover of expatriate nurses relates to their accommodation and living expenses provided on site by the MOH. In the past this provision for accommodation was extended to include family members such as children. Of recent years, this provision has been ceased and so expatriate nurses either leave their family in their home country or pay for their accommodation themselves. The result is that the expatriate nurses tend not to stay and contributes to their high turnover rate. There are a number of other contributing factors to this high turnover of expatriate nurses that have been identified by Van

Rooyen, Telford-Smith and Strümpher (2010). These include the stressful experience of nurses leaving their families, the culture shock of being in a Muslim country which entails strict adherence to orthodox tenets and traditions, working 12 hour shifts and 44 hours per week (in contrast Australian nurses do 8 hour shifts and 38 hours per week), the physical constraints of a hot climate (for example, dehydration, headaches and exhaustion) and communication barriers (Van Rooyen et al., 2010).

In order to minimise the effect of a nursing shortage in Saudi Arabia, there is an urgent need for a local nursing workforce planning strategy to recruit more national nurses and retain the current expatriate workforce. The problem with this however, is that many of the Saudi Arabian people are not interested in joining the nursing profession (Aboul-Enein, 2002; Al-Ahmadi, 2002). There are a number of reasons why the Saudi Arabian people are not attracted to the nursing profession, both cultural and social. Firstly, Gazzaz (2009) found that Saudi Arabian nurses of both genders are found to be more satisfied with their job if they have been accepted culturally and socially especially if accepted by their families and relatives. According to Tumulty (2001) nursing as an appropriate job for women was ranked last in Saudi Arabia. Strict social traditions in Saudi Arabia make it hard for Saudi Arabian female nurses to practice their job due to the high workload, long working hours, night shifts and working over the weekends. As discussed previously, nurses in Saudi Arabia work 12 hour shifts and 44 hours per week in a number of hospitals. All these factors contribute to Saudi Arabian nurses having little time to spend taking care of their families and homes (Almalki et al., 2011). Moreover, many Saudi Arabian people consider nurses as maids who follow the physician's orders and so have very low status (Miller-Rosser et al., 2006). Furthermore, most Saudi Arabian females do not feel comfortable working with members of the opposite gender. Saudi Arabian men also face a challenge when choosing nursing as a job because of the poor image of the profession in Saudi Arabian society, including among their

family and friends (Miller-Rosser et al., 2006). According to Almalki (2011) cooperation with the media is important to increase community awareness of the importance of nursing and it plays a vital role in the advancement of community health. In contrast to the factors that discourage people from taking up nursing in Saudi Arabia, salary, benefits, flexibility and job security are considered to be motivations for choosing a nursing job elsewhere (Duffield, Diers, O'Brien-Pallas, Aisbett, Roche, King, & Aisbett, 2011; Spouse, 2000).

2.11 Saudisation

In order to overcome many of the issues with having a predominately expatriate nursing workforce as identified above, the Saudisation policy was introduced. The Saudisation policy was introduced about 24 years ago which aims to increase the number of Saudi Arabian nationals in the workforce (Al-Mahmoud, Mullen, & Spurgeon, 2012). In 1992, a royal decree was issued by the Saudi Arabian government to promote the Saudisation policy of the nursing workforce in order to gradually replace expatriate nurses with national nurses. The Saudisation policy arose out of the realisation that a continued heavy reliance on an expatriate workforce has associated risks and could precipitate a major crisis in the workforce if large numbers of expatriate nurses withdrew from the country (Sadi & Al-Buraey, 2009). For example, during the Gulf War many expatriates left Saudi Arabian hospitals. This exodus of expatriates resulted in a critical shortage of healthcare professionals due to the potential dangers at that time with Saudi Arabia sharing a border with both Kuwait and Iraq (Al Hosis et al., 2012). The Saudisation policy is intended, therefore, to ensure that the nursing profession in Saudi Arabia takes an active and useful role in restructuring the healthcare system.

Saudisation was also aimed at addressing the high unemployment rate in Saudi Arabia. The aim of the program was to force the private sector to employ more Saudi Arabian

nationals as well as reduce the number of expatriates in the workforce generally (Torofdar, 2011). This was, however, seen more as an ideology rather than a policy. There was a tendency to prioritise professions differently for example, professions such as engineering were given a higher priority than nursing (Alshammari, 2014). One of the reasons for this decision was the influence of culture and gender in attracting Saudi Arabian nationals to nursing. Engineering being a predominantly male profession compared to nursing being predominantly female contributed to this different priority. Engineering was therefore, a more achievable profession for success with Saudisation as a more male dominated profession (Alshammari, 2014; Torofdar, 2011).

In Saudi Arabia, there is a need to enhance the public image of nursing in order to motivate the younger Saudi Arabian population to become involved in the nursing profession by providing suitable educational and employment incentives. As pointed out by Takase, Maude, and Manias (2006), the negative image of nursing remains a strong factor in contributing to the international shortage of nurses. According to Al-Thagafi (2006), the negative social image of nursing is a barrier to joining the nursing profession for young individuals.

In recent years, the number of Saudi Arabian nurses has slowly increased due to foreign nurses leaving the country because of many of the issues identified in the previous section. These issues include the Saudisation policy as discussed, and other factors in particular, geopolitical instability (Miller-Rosser et al., 2006). Table 2.1 demonstrates the past and projected percentages of Saudi Arabians in the nursing workforce in five-year intervals for the current nurse to population ratio of 1:300 and for other lesser ratios. Despite the remarkable progress that has been made to increase the number of Saudi Arabian nurses, this progress is not readily visible because of the continuing reliance on expatriate nurses. According to Brown and Busman (2003, p. 347):

This reliance on foreign workers can be problematic for the healthcare sector, from recruitment and retention to more fundamental issues in service delivery that may result from differences in culture, language and professional skills.

Table 2.1 Saudisation in nursing from 2002 to 2025

Nurse to total population ratio			
Year	**1/300% (current)**	**1/400%**	**1/500%**
2002	21	28	35
2005	27	36	45
2010	33	44	55
2015	3 8	51	64
2020	44	59	73
2025	50	66	83

(Source: Mufti (2000) p.41. Healthcare development strategies in the Kingdom of Saudi Arabia)

2.12 Summary

This chapter provided an overview of the Saudi Arabian context including discussion of the role of the Ministry of Health, the nursing workforce and nursing education in Saudi Arabia. The chapter has also provided an insight into the constitution of Saudi Arabia, the language, cultural attitudes and the Ramadan Month. Understanding these cultural facets can assist healthcare providers in establishing good relationships with their patients and avoid any cultural conflicts in Saudi Arabia. This chapter also presented the Saudi Commission for Health Specialties and the Saudisation program. The contextual foundation as provided by this chapter creates a groundwork upon which the study results may be presented and interpreted. The following chapter presents a literature review in relation to nursing leadership styles and identifies the gap in the literature that justifies this research.

Chapter 3: Literature Review

3.1 Introduction

In any workforce, the leadership style practised by managers is considered to be an important factor for achieving organisational outcomes. The aim of this study was to explore the leadership styles practised by nurse managers working in Saudi Arabian hospitals located in the Eastern Province, as well as identifying the correlation between the perceived leadership styles and organisational outcomes (effectiveness, satisfaction and extra effort). This chapter presents a literature review discussing the leadership styles of nurse managers to identify the research gap and justify this research.

3.2 Definition of leadership

There are many different definitions of leadership identified in the literature (Stodgill, 1974). To define the concept of leadership over the past 60 years, as many as 65 classification systems have been developed (Fleishman et al., 1992). In trying to categorise these systems, Bass and Riggio (2006) asserted that there are many views on the definition of leadership. One definition views leadership as the focus of a group process where the leader is at the centre of the group activity (Bass & Riggio, 2006). Another view conceptualises leadership from a personality perspective (Bass & Riggio, 2006). Leadership can also be defined as a power relationship as well as an instrument of goal achievement. Bass (1990) and Burns (1978) define leadership as the degree to which the leader creates a vision for the future for the organisation and articulates new ways for the followers to accomplish the organisational goals. To accept leadership as a complex and multifaceted phenomenon, it is necessary to be familiar with a variety of perspectives from theorists and researchers (Marriner-Tomey, 1993). According to Northouse (2012) some conceptualise leadership from a relation standpoint, and others view leadership as a trait or behaviours.

All in all, the conceptualisation of leadership has been associated with references to individual attributes and traits, leadership behaviours, role relationships, patterns of interaction, exertion of influence over others, or having influence over tasks (Davidson, Dennison-Himmelfarb, & Alsadaan, 2015). Although leadership has been conceptualised in different ways, Northouse (2012) argues that there are four components to leadership including: leadership is a process; involves influence; occurs in groups; and involves the achievement of goals. Therefore, looking into these various conceptualisations, it remains important to explore the various leadership traits, behaviours and styles as well as to look into their strengths and weaknesses.

3.3 Leadership theories

A leadership theory defines the set of principles on which the leadership activities are based or a system of ideas defined to explain the concept of leadership in various dimensions by considering various attributes (Northouse, 2012). Leadership reflects the process by which an individual influences others in achieving organisational/collective goals. In doing so, the leaders have to adopt different traits that can motivate others to achieve the defined goals. Prior to the 1900s, the evolution of leadership theories (see Figure 3.1) started with the great man theory which was one of the first systematic attempts to study leadership based on a theory popularised by the Scottish writer Thomas Carlyle in the 1840s that great leaders are born and not made (Casida, 2007). Between 1900 and 1948, the great man theory was extended and developed and became known as the traits theory. The trait theory adopted the same concept but focused on understanding and analysing the social, mental and physical characteristics (which can be considered as the qualities) that are common among the leaders (Bass, Avolio, Jung, & Berson, 2003). Some of the major criticisms of the trait theories include that it does not consider environmental factors that build and nurture the qualities

possessed by leaders, and it does not consider that qualities can be nurtured from experiences (DeRue, Nahrgang, Wellman, & Humphrey, 2011).

Later, the trend slowly moved towards considering behavioural aspects as the important elements that define leadership. This gave rise to a new notion that leaders are made not born (Bass et al., 2003). The behavioural theories focused on the behaviours of the leaders rather than the characteristics, which helped the researchers to analyse the leadership using cause and effect relationships (Bass et al., 2003). Following the great man theory and its extentions, the contingency theory emerged between 1948 and 1980 (Casida, 2007). Furthermore, Casida (2007) has identified other leadership theories such as the servant leadership theory and the transformational leadership theory which are still in current usage. These theories focused on the leadership styles which considered situational factors along with the traits and behavioural elements in analysing the leadership theory. These theories are explained in detail in the following sections.

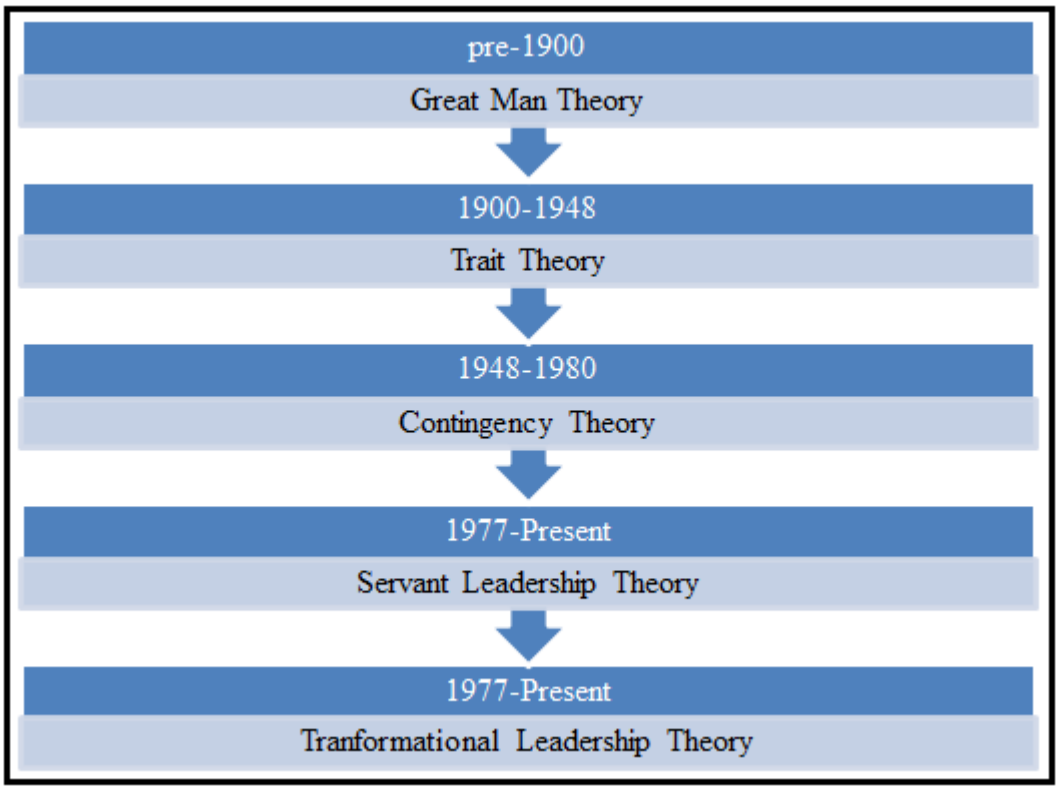


Figure 3.1 Evolution of leadership theories (Source: Casida, 2007)

3.3.1 The traits approach

The trait theory, as identified earlier, was one of the first systematic attempts to study leadership (Northouse, 2012). The trait theory focused on the leader's characteristics through identifying unique qualities possessed by great leaders. In relation to this theory, Stogdill (1948) undertook research and identified ten characteristics that were associated with leadership which included: achievement, initiative, persistence, insight, responsibility, self-confidence, influence, tolerance, cooperativeness and sociability. It was believed that great leaders were born with these traits, and they are the only ones who can possess these traits (Northouse, 2012). Although Stogdill identified characteristics that could differentiate leaders from non-leaders however, he could not establish a particular set of traits (Stodgill, 1974). This led Stogdill (1974) to conclude that it is difficult to focus on a set of traits without factoring in situational effects. Research also asserted that the trait theory failed to look at

traits in relation to leadership outcomes (Northouse, 2012). Moreover, it has been identified that this is not a useful theory for the training and development of leaders because individuals' personal characteristics are stable and as a result their traits cannot be changed (Northouse, 2012). Consequently, researchers began to look at the relationship between traits and situational factors.

3.3.2 The style approach

The style approach is distinct from the trait approach because it emphasises leaders' behaviours while the trait approach focuses on certain leaders' personality characteristics (Northouse, 2012). Leadership in the style approach is conceptualised as a function of the style of behaviour that a leader can bring to a situation (Rubenstein, 2005). Researchers who studied the style approach identified two types of behaviours: task behaviours and relationship behaviours (Northouse, 2012). Task behaviours help followers to accomplish their goals. On the other hand, relationship behaviours help followers to feel comfortable with themselves, with others and with the situation (Northouse, 2012). The main point of the style approach is to help explain how leaders combine these two types of behaviours to influence followers in their attempts to achieve their goal (Northouse, 2012).

Based on the finding of Stogdill's (1948) work, a study was conducted at the Ohio State University to investigate the style approach using the Leader Behaviour Description Questionnaire (LBDQ) (Stogdill, 1965). In a later study, Stogdill (1974) found that responses were clustered around two different types of leader behaviours: initiating structure and consideration. Initiating structure refers to task behaviours such as organising work. On the other hand, consideration refers to relationship behaviours such as respect and trust between leaders and followers (Stodgill, 1974). According to Northouse (2012), by acting on both task and relationship, leaders form the core of the leadership process. However, research on the

style approach failed to show how the leaders' styles are associated with performance outcomes (Bryman, 1999; Yukl, 1994). The style approach also failed to introduce universal behaviours that could be associated with effective leadership.

3.3.3 The situational approach

The situational approach was developed by Blanchard, Zigarmi, and Nelson (1993) when researchers found traits and behaviours failed to explain leadership effectiveness. This situational approach was based on the 3-D management style theory (Northouse, 2012). After this approach had been revised and refined several times, it was used for leadership training and development (Northouse, 2012). The central point of the situational approach is that different situations require different kinds of leadership (Northouse, 2012). This approach posits that effective leadership comprises both supportive and directive factors that should be applied in a certain situation. The situational approach is classified into four leadership styles: high directive-low supportive, high directive-high supportive, high supportive-low directive and low supportive-low directive (Northouse, 2012). The situational leadership model concerns the development of the subordinates which refers to the subordinates' competence and commitment to accomplish certain tasks (Blanchard, 1985). However, the author failed to explain how commitment is combined with competence to form the four distinct levels of development (Northouse, 2012).

3.3.4 The contingency approach

The contingency approach is also called leader-match because it attempts to match leaders to appropriate situations (Fiedler & Garcia, 1987). The contingency approach is focused on styles and situations. Fiedler and Chemers (1967) was the first to introduce the contingency theory. They developed the Least Preferred Coworker (LPG) scale to measure effective leadership styles by distinguishing between three factors that characterised situations: task structure, position power and relationship (Fiedler & Chemers, 1967). The

contingency approach has broadened the understanding of the type of leader that is more likely to be effective in certain situations however, it failed to explain why certain leadership styles are more effective in some situations than others (Northouse, 2012). This leadership approach also failed to explain the role of the organisation when there is a mismatch between the leader and the situation in the workplace. Many theories were developed from the contingency theory such as the path-goal theory, which refers to how leaders motivate followers to achieve certain goals (House, 1971), and the leader-member exchange theory which concentrated on interaction between leaders and followers (Dansereau, Cashman, & Graen, 1973; Dansereau, Graen, & Haga, 1975).

3.3.5 The servant leadership theory

The servant leadership theory was developed by Robert Greenleaf in the 1970s and according to Casida (2007), has been in active use since 1977. This theory describes the fact that a leader is considered as a servant of followers. The main role of the servant-leader is to help followers achieve a shared vision (Greenleaf & Spears, 2002). This results in the leader becoming a servant to the organisation and its followers. Spears (2004) identified ten critical characteristics of the servant-leader which included listening, empathy, healing, awareness, persuasion, conceptualisation, foresight, stewardship, commitment to the growth of people and building community. This concept can be applied in any organisational structure, for example, nurse managers who practice servant leadership should understand his/her nurses' needs. Once the nurse managers help in fulfilling the nurse's needs, nurses will be motivated to achieve the organisational outcomes. Graham (1991) claimed that servant leadership theory is similar to transformational leadership as both approaches encourage leaders and followers to raise each other to higher levels of motivation.

3.3.6 The transformational leadership theory

The transformational leadership theory was first proposed by Burns (1978) and then advanced by Bass (1985). This term 'transformational' was used for political leaders but later it was used in reference to other organisations (Bass & Riggio, 2006). Transformational leadership is defined as a process of cooperation between a leader and followers by raising one another to create a vision that guides the required change through motivation (Burns, 1978). In order to measure transformational leadership and identify its impact on followers' motivation and performance, Bass (1985) advanced the work of Burns (1978) and used the term 'transformational' instead of 'transforming'. Bass (1985) identified four transformational leadership behaviours that leaders practising this style used to transform, inspire and motivate followers including: idealised influence, inspirational motivation, intellectual stimulation and individual consideration. These will be discussed in more detail in Chapter 4 of this thesis. Furthermore, the transformational leader motivates the followers to use critical thinking which in return will promote change in the work environment and improve performance (Alshammari, 2014). Due to the fact that transformational leadership is associated with the establishment of a vision and adaptation to change, it has gained favour in health related areas such as nursing and also teaching. For instance, Welford (2002) and Thyer (2003) claimed that the transformational leadership style is the preferred style for clinical nursing and is the most suitable style for empowering nurses.

Transformational and transactional leadership in the field of healthcare have been previously examined to determine the link between these leadership styles and organisational outcomes. The study findings indicated that transformational leadership style had a stronger and more positive relationship with organisational outcomes (Spinelli, 2006). Stanley (2006) speculated as to why this may be so and stated that the transactional form of leadership focuses more on control. In contrast, transformational leadership focuses on setting directions

and creating opportunities for both the professional and personal development of healthcare professionals. Wilgeng (2004) also posited that the transactional leader is more likely to focus on personal interests and leadership through mandates and directives. Comparatively, motivation can be developed through transformational leaders who tend to take on a proactive approach towards problem solving, decision making and team functioning. In addition, Kerfoot (2006) asserted that such leadership styles significantly differ in terms of directing and partnering. The establishment of partnerships across healthcare leaders and members is facilitated through the exchange of information, coaching and mentoring among others. This is supported by leadership research in the field of nursing. The interactions that occur within the workplace are crucial for the effectiveness of leaders. Hence, the need for transformational leadership in improving healthcare systems and practices (Spillane, 2005).

3.4 Types of leadership necessary in a multicultural workforce

It is well recognised that leaders play an important role in improving the quality of performance and satisfaction as well as the quality and nature of hospital care (Abdelhafiz et al., 2015). Transformational leadership is considered as the most appropriate leadership style to meet the needs of a diverse and culturally pluralistic workforce, like the one in Saudi Arabia, and to improve the leadership process (Abualrub & Alghamdi, 2012). It has been found that nurse managers and nurses working in Saudi Arabian hospitals prefer transformational leader behaviours over transactional ones (Suliman, 2009). As mentioned earlier in Chapter 2, nurse managers working in Saudi Arabian hospitals face the challenges of working within the context of cultural diversity because of the high number of expatriate nurses. Leadership in the provision of cultural competence care therefore, is a major requirement. According to Brown and Busman (2003, p. 347), “This reliance on foreign workers can be problematic for the healthcare sector, from recruitment and retention to more

fundamental issues in service delivery that may result from differences in culture, language and professional skills". This mix of the nursing workforce from different cultures, religions and educational backgrounds requires outstanding leaders to lead nurses to meet the requirements of quality care, as well as delivering a positive work environment for nurses and achieving the organisation's outcomes. This puts great pressure on nurse managers to help expatriate nurses to address Saudi Arabian values, attitudes, and behaviours towards health-related issues (Al-Khathami, Kojan, Aljumah, Alqahtani, & Alrwaili, 2010). The MOH plays an important role in this issue by providing orientation programmes for expatriate nurses in order to promote cultural awareness and improve their communication skills. Nurse managers however, must develop strategies to maximise the efficiency of expatriate nurses and to integrate them into the community as well as the work environment, which in turn might help to increase job satisfaction and improve overall performance.

Culture has a significant impact on leadership as many researchers have studied the multicultural workforce to gain knowledge about the correlation between a multicultural workforce and the most effective leadership styles (Casida & Pinto-Zipp, 2008; Holt, Bjorklund, & Green, 2009; Tohidi & Jabbari, 2012). For instance, Holt, Bjorklund and Green (2009) reported that comparing leadership models and cultural frameworks to examine the relationship between multicultural workforce and leadership can contribute to understanding nurses' diversity and their different cultures. Furthermore, comparing leadership models and cultural frameworks might provide opportunities for cross-cultural communication. The importance of this was highlighted in a study undertaken by Holt et al. (2009). This was an exploratory study on culture using a structured questionnaire gathered from 91 countries and 91 participants investigating the characteristics of an effective leader. After analysing the results of this study, the researchers were able to identify the main characteristics of the ideal leader and their values within discrete cultural settings. Interestingly, the results indicated that

the participants' responses were contingent on their cultural background, education and age (Holt et al., 2009). Culture was one of the major determinants of the rating of a leader by junior staff (Holt et al., 2009). Hence, it is important that nurse managers understand the importance of culture and the methods of diversity management. Based on the study findings of Holt et al. (2009), it is clear that there is a need for leaders to have cultural competence to manage staff and patients in multicultural environments.

Cultural competence refers to traits and behaviours that enable someone to coordinate and interact with other people from different backgrounds. According to Giger et al. (2007), cultural competence is essential in management because even care, suffering and illness indicate a variety of things to people from different backgrounds. Hence, knowledge of multicultural customs can enable nurses to offer better healthcare services. In fact, culturally competent nurses are able to work effectively with a multicultural workforce and to recognise challenges to cultural understanding between patients and staff (Leavitt, 2002).

Many researchers have conducted studies relating to leadership and culture in the nursing workforce (Casida & Pinto-Zipp, 2008; Suliman, 2009). For instance, Casida and Pinto-Zipp (2008) conducted a study to assess the relationship between the leadership styles of nurse managers and the workplace culture in New Jersey, USA. These authors reported on the significance of nurse managers gaining skills and knowledge related to cultural competence. The nurse managers who participated in the study recognised the importance of workplace culture and leadership in determining organisational performance. In relation to the leadership styles reported by the study, most nurse managers chose transformational and transactional as the preferred styles of leadership. Moreover, nurse managers using a transformational leadership style were found to produce the best organisational outcomes in such an environment (Casida & Pinto-Zipp, 2008).

In addition, when working with a multicultural nursing workforce, nurse managers should follow a strategy to ensure that they can accomplish different goals with diverse and limited resources (Casida & Pinto-Zipp, 2008). Adopting an effective strategy would simplify the process of defining, adopting and managing a workplace culture. Worryingly, because of the nursing shortage, nurse managers also have the responsibility of creating a long lasting nursing workforce that can cope with the retirement of experienced nurses (Bally, 2007).

Nurse managers working with a multicultural workforce, such as the nursing workforce in Saudi Arabian hospitals, should adopt an appropriate and effective leadership style that generates a positive outcome with regard to managing a diverse workforce environment (Suliman, 2009). According to Harrison (2011), transformational leadership is considered to be the most common and effective style that best suits the mixed workforce. Transformational leaders exhibit certain traits including determination, self-confidence, freedom from inner conflicts and an understanding of their subordinate's needs (Harrison, 2011). Hence, transformational leaders are found to increase nurses' motivation and satisfaction by uniting them (Nyberg, Bernin, & Theorell, 2005). Transformational leaders working in a multicultural workforce are foresighted, and transform staff's thoughts from expectations to reality, with a drive towards success (Suliman, 2009). Furthermore, nurse managers who use transformational leadership are providing personalised attention and individualised mentoring which inspire trust, awareness of challenges, confidence and solutions among their staff (Suliman, 2009).

In addition, and as mentioned earlier, transformational leadership has been found to improve job satisfaction and reduce staff turnover (Suliman, 2009). Bally (2007) identified practices in transformational leadership as being salient in the attainment of sustainability of the mentoring programmes, which have deep roots in an organisation's culture. In a study

discussed earlier that involved 278 participants, transformational and transactional leadership styles were found to be associated with organisational culture in many nursing units in New Jersey (Casida & Pinto-Zipp, 2008). Nurse managers using transformational leadership were able to achieve balance between flexibility dynamics and stability in the units, an aspect central to the maintenance of organisational effectiveness (Casida & Pinto-Zipp, 2008). However, according to Bally (2007), nurse managers who practice transformational leadership style need to use Bass's transformational leadership behaviours to understand this style in depth. These behaviours include inspirational motivation, idealised influence, intellectual stimulation and individualised consideration, as previously discussed.

In a multicultural working environment transformational leadership styles can enhance the organisational effectiveness by using a combination of various initiatives (Alshammari, 2014). The Saudi Arabian MOH seeks to improve the nation's health sector. Consequently, transformational leadership among nurse managers will play a major role, in part due to the continued ethnic and national diversity of nursing unit workforces in Saudi Arabia

Research has reported however, that culture may affect transformational leadership because cultural groups tend to vary in the way they conceive different leadership styles (Spreitzer, Perttula, & Xin, 2005). A study was conducted by Spreitzer et al. (2005) to examine variances in transformational leadership's effectiveness in different cultures specifically, leaders from North America and Asia. These authors found that transformational leadership may be effective or ineffective in different cultures because of the way different cultures value the various leadership styles. However, the majority of staff in this study did find transformational leadership to be one of the best leadership styles (Spreitzer et al., 2005).

3.5 Transformational leadership and organisational outcomes

One of the advantages of transformational leadership is that it has been positively correlated with some organisational outcomes including effectiveness, extra effort and job satisfaction (Alshammari, 2014). According to transformational leadership theory, the dimensions of such a form of leadership can generate a wide range of positive outcomes at an individual and organisational level (Avolio & Bass, 2002). This is because according to Bass (1985) a transformational leader is one who encourages followers to go beyond what they initially expect to be possible. Once transformational leaders lay down the organisation's crucial vision and mission, the understanding of the followers regarding the significance of the expected outcomes, as well as their performance expectations, is enhanced (Bennis & Nanus, 1985; Conger & Kanungo, 1998; House, Spangler, & Woycke, 1991). According to Alharbi and Yosoff (2012), the transformational leadership style has a positive impact on quality management practices.

A transformational style of leadership has been shown to bring about favourable outcomes including job satisfaction, performance, and intention to stay which are important considerations in a population like Saudi Arabia (Abualrub & Alghamdi, 2012). Taking these factors into consideration, effective nursing leadership is expected to increase nurses' job satisfaction, productivity, effectiveness, and retention rates, as well as increase the quality of care for patients and their satisfaction (AbuAlRub, Omari, & Al-Zaru, 2009). In the following sections, the positive impact of transformational leadership on organisational outcomes including effectiveness, job satisfaction and exerting extra effort will be discussed in more detail.

3.5.1 Effectiveness

Effectiveness is defined as the efficiency of leaders to accomplish tasks, achieve goals and respond to the needs and expectations of their followers (Limsila & Ogunlana, 2008). Effectiveness has been found to be positively associated with the transformational leadership style (Limsila & Ogunlana, 2008). It is through the transformational leadership behaviours identified earlier, that leaders can increase effectiveness. Idealised influence is one of the ways to increase the effectiveness, whereby leaders instil a feeling of pride among the followers to be associated with the leader. This in turn builds confidence among the leaders and as a result the leaders display a sense of power and confidence for assuring others that they can overcome obstacles and meet their goals (Negussie & Demissie, 2013). Nurse managers using idealised influence behaviour are respected by their staff to the extent that they consider their manager to be a role model for them (Negussie & Demissie, 2013). Furthermore, through the application of an idealised influence transformational leadership style, leaders inspire their staff and the needs of the staff come first. Secondly, nurse managers utilising intellectual stimulation motivate staff creativity and innovation and encourage them to be involved in problem solving. Another transformational leadership style is individualised consideration which relates to the degree to which the leaders attend to the followers needs. This process links the priorities of the followers to the development of the organisation (Ogola, Sikalieh, & Linge, 2017). In addition, individualised consideration behaviour helps staff to achieve professional growth by considering the differences in individuals' needs and by mentoring them (Ahmad, Adi, Noor, Rahman, & Yushuang, 2013).

For all these reasons, therefore, nurse managers implementing transformational leadership style are in line with high-level performance and organisational effectiveness. Utilising this leadership style will help to shape the environment of nursing units or wards by

building trust, organisational commitment and shared governance (Vesterinen et al., 2012). With effective nursing leadership, nurses will feel that their ideas are being taken into consideration and that they are valued and considered an important resource in the process of developing organisation (Alshammari, 2014). In order to enhance the role of leaders, nurse managers should use open communication to build a relationship with their staff and develop their autonomy (Germain & Cummings, 2010).

The behaviours of the leaders in terms of effectiveness are one of the important factors that need to be assessed along with the impact of leadership behaviours on organisations. Erkutlu (2008) conducted a quantitative study to examine leadership styles of managers and the satisfaction and commitment of subordinates working in 60 boutique hotels in Turkey. The findings of the study showed that there was a significant relationship between transformational leadership behaviours and both organisational and leadership effectiveness (Erkutlu, 2008). This result is supported in the literature with the influence of leadership behaviours on stimulation satisfaction and organisational commitment (Failla & Stichler, 2008; Kleinman, 2004; McGuire & Kennerly, 2006).

With the intention of assessing the effect of leadership style on productivity, Voon, Lo, Ngui, and Ayob (2011) conducted a study in Malaysia and which found that employees very much affected by their manager's behaviours. This study also found that managers' behaviours might influence staff effectiveness (Voon et al., 2011). Leaders must therefore, serve as a role model by providing a clear guiding vision and direct actions. Voon et al. (2011) also suggested that managers could achieve this by acting as an example and inspiring shared visions by collecting staff's visions and values. Similarly, Malik (2013) conducted a descriptive study to examine the relationship between leader behaviours and job satisfaction and found that staffs' job satisfaction depends upon the managers' behaviours.

Leader behaviour is considered therefore, as a key factor for effectiveness as well as high job satisfaction (Akdol & Arikboga, 2015; Kleinman, 2004; Shader, Broome, Broome, West, & Nash, 2001). These findings are supported in the literature in relation to the influence of transformational leadership behaviours of nurse managers on organisational effectiveness. In a study by McGuire and Kennerly (2006), it was demonstrated that nurse managers demonstrating transformational leadership are more likely to have committed nurses who contribute to an organisation's performance and competitive edge. Similarly, Lin, MacLennan, Hunt and Cox (2015) conducted a cross-sectional quantitative study of 807 nurses across 12 hospitals in Taiwan and found that transformational leadership behaviour contributed to organisational commitment and job satisfaction of nursing staff.

3.5.2 Job satisfaction

Job satisfaction can be linked to the leaders' contentment with their own performance as well as the followers' satisfaction in terms of the leaders' decisions, actions and behaviours (Bogler, 2001). As such, the level of satisfaction indicates whether leaders have been able to implement and utilise favourable approaches in the workplace. Job satisfaction is considered an outcome of the interactions in the work environment. Also, it is a function of the relationship between what an individual seeks from their job and what the individual perceives the job is offering (Locke, 1969; Lund, 2003). Nurses with higher levels of job satisfaction tend to demonstrate greater productivity and intentions to stay (Abualrub & Alghamdi, 2012; Lu, While, & Barriball, 2005). This is supported by the findings from a general study undertaken by Al-Ahmadi (2009) which highlighted the importance of job motivation and meaningful work as well as knowledge of work outcomes, expectations, pay, opportunities for advancement and security in ensuring nurse satisfaction.

Recently, Lapeña, Tuppal, Loo and Abe (2018) conducted a pilot study in Philippines to investigate the relationship between leadership styles and job satisfaction. The result of this

study revealed that participants agreed that their nurse managers were utilising both transformational and transactional leadership styles and both were related to job satisfaction. Another similar study was conducted by i Solà, i Badia, Hito, Osaba and García (2016) in Barcelona to determine the influence of leadership styles on job satisfaction. This study found that nurse managers rated themselves as equally displaying both transformational and transactional leadership styles. In addition, the result of this study revealed that both transformational and transactional positively correlated with job satisfaction (i Solà et al., 2016).

In contrast, Robbins and Davidhizar (2007) found that transformational leadership is more strongly correlated than transactional leadership with lower turnover rates, higher job satisfaction and higher productivity. This is supported by Alshahrani and Baig (2016) who conducted research in Saudi Arabia to evaluate the impact of transformational and transactional leadership styles on job satisfaction. The study found that nurse managers demonstrating both transactional and transformational and nurses who worked under transformational leaders had a high job satisfaction rate. Similarly, Abualrub and Alghamdi (2012) reported that transactional leadership style is considered as the weakest indicator of job satisfaction among nurses. These authors suggested that nurse managers should be equipped with transformational leadership skills.

Likewise, Nebiat and Demmisie (2013) conducted a study using a non-experimental correlation design to examine the relationship between leadership styles and job satisfaction among nurses in Ethiopia. These authors found that nurses were more satisfied with transformational leadership compared to transactional leadership. Based on these findings, Nebiat and Demmisie (2013) highlighted the importance of utilising the transformational leadership styles to increase job satisfaction.

3.5.3 Extra effort

Extra effort signifies the ability of the leader to encourage followers to exert more effort towards the accomplishment of work (Bass, 1990). In relation to the work environment, Barbuto (2005) asserts that extra effort can be considered as an outcome of individual motivation. Workers who demonstrated extra effort in carrying out tasks have been associated with leaders who have been effective in motivating workers to go beyond the original expectations (Barbuto, 2005).

To highlight the impact factors correlating leadership to staff effort, Salanova, Lorente, Chambel, and Martinez (2011) claim that social cognitive theory is considered as one of the predictors of staff behaviours. This theory predicates self-efficacy through intrinsic motivation that stimulates engagement and performance in the workplace. Additionally, Salanova et al. (2001) reported that one of the most important sources of self-efficacy is transformational leadership, which is directly associated with motivational processes. Therefore, to mediate the relationship between transformational leadership, extra effort and self-efficacy, there is a need for work engagement (Salanova et al., 2011). Moreover, staff-leader relationships and transformational leadership can directly benefit the organisation by catalysing additional workplace effort. According to Cummings et al. (2010), leadership that focuses on task completion is not adequate to achieve organisational outcomes for the nursing workforce. Leaders therefore, need to encourage and develop transformational and relational leadership to achieve organisational outcomes.

3.6 Transformational leadership and patient outcomes

In any healthcare organisation, delivering high-quality care for patients is the primary goal. Leaders play a critical role in encouraging their nurses to gain a better understanding of patients' needs and values (Wong, Cummings, & Ducharme, 2013). However, healthcare all

over the world has undergone rapid changes such as changes in the economy and the advancement of communication, information and technology, resulting in significant challenges to optimal patient outcomes such as patient satisfaction, patient mortality, adverse events and complications and patient healthcare utilisation (Fraher, Spetz, & Naylor, 2015).

According to Lord and Dinh (2012) leadership is connected with patient outcomes through potential mechanisms such as staff attitudes and performance, guiding individuals, enabling nurses to participate in patient care decision making and creating a positive work environment (Lord & Dinh, 2012). In the past decade, evidence has linked a positive working environment to patient outcomes, including patient mortality and adverse events such as medication errors (Aiken, Clarke, Sloane, Lake, & Cheney, 2008; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Blegen, Goode, Spetz, Vaughn, & Park, 2011; Estabrooks, Midodzi, Cummings, Ricker, & Giovannetti, 2005; Hall et al., 2003; Kovner & Gergen, 1998; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002). Leaders who support their followers' needs, have helped to reduced turnover among nurses as they motivate them to perceive their work environment as a challenge as opposed to overwhelming, and by giving them adequate feedback about their performance (Bakker, Killmer, Siegrist, & Schaufeli, 2000). Additionally, Laschinger and Leiter (2006) found that effective nursing leadership strongly influences the working environment and thus promotes safe and high-quality patient care. Nurses' performance has been found to have an impact on meeting patient outcomes and the transformational leadership style is associated with organisational outcomes (Cummings, MacGregor, Davey, Lee, et al., 2010).

Wong, Cummings and Ducharme (2013) have highlighted the positive impact transformational leadership has on improving patient outcomes. Similary, McFadden, Henagan, and Gowen (2009) conducted a study to examine the relationship between transformational leadership and the quality improvement reforms implemented by various

departments of over 200 hospitals in the United States. The results of their study indicated that transformational leadership is positively correlated with patient safety, as the skills of the transformational leader are translated into better organisational and patient outcomes. Importantly, transformational leadership has been found to be associated with reduced medication errors and lower patient mortality (Wang, Oh, Courtright, & Colbert, 2011). Additionally, transformational leadership was significantly associated with high patient satisfaction in acute care and home healthcare settings.

The nature of the relationship between transformational leaders and nurses is posited to play a vital role in their responses to their work environments (Casida and Pinto-Zipp, 2008). Specifically, transformational leadership has been found to play a fundamental role in the quality of work environments and thereby directly affects patient outcomes (Laschinger & Leiter, 2006). Importantly, transformational leaders have increased retention of staff as they create a safe working environment and promote high performance, which results in a lower rate of patient mortality (Wong, 2015). Transformational leadership is essential in creating a positive work environment that optimises nursing practice, and as a result promotes high-quality patient care. Collaborative teamwork, adequate staffing and autonomous decision making all create positive and professional work environments that foster strong nursing practices and are aligned with patients' safety outcomes (Estabrooks et al., 2005). Thus, transformational leadership can have an indirect positive impact on patient outcomes by directly influencing the work environment of the nursing workforce (Wong & Cummings, 2007). Greco, Laschinger, and Wong (2006) claimed that nurses working in a positive working environment that is enhanced by transformational leaders are in turn able to reward their organisation by increasing the quality of nursing care delivery and patient outcomes Thus, focusing on improving the work environment should improve patient outcomes (Estabrooks et al., 2005). Effective leadership is therefore, a critical factor for creating a

positive work environment for nurses, which contributes to positive outcomes for patients (Capuano, Bokovoy, Hitchings, & Houser, 2005).

3.7 Nurses' perception of their nurse managers' leadership style

Nurses' perceptions are a vital component of leadership effectiveness as variation between managers' perceptions and nurses' perceptions may cause discontinuity. Firestone (2010) conducted a study to determine whether there were differences between managers' and staff's perceptions in relation to leadership behaviours and organisational outcomes. The results of this study revealed that there is a clear difference between managers and staff, with the mean scores for managers' responses about their leadership behaviours being higher than those of their staff (Firestone, 2010). However, the study showed that there were no differences between managers' and staff's perceptions of the dominant leadership style, which was the transformational leadership style.

Nonetheless, understanding the perceptions of nurses about their nurse managers is an important element to be considered as it helps in assessing the leadership styles, the performance of the nurse managers, helps in retaining nurses, and reflects the nature of a competent workforce (leaders/nurse managers) in achieving the organisational development/goals (Andrews et al., 2012). Differences in how nurses and nurse managers perceive the nurse manager's leadership style is related to satisfaction with the leadership. As discussed earlier, it is evident that satisfaction with leadership is an important element in the retention of nurses (Abualrub & Alghamdi, 2012). Furthermore, nurses' retention has a direct influence on performance and patient outcomes of modern institutions (Abuarub & Alghamdi, 2012).

In order to evaluate nurses' and nurse managers' perceptions of leadership style, Andrews et al. (2012) administered the Multifactor Leadership Questionnaire (MLQ) 5X-Short developed by Avolio et al. (1995) to a sample of nurses and nurse managers working at

a Florida hospital for children. In this study, differences in perceptions were evident; nurses' and nurse managers' discrepancies in ratings of leadership style were strongly related to nurses' satisfaction with the leadership (Andrews et al., 2012). Additionally, satisfaction with leadership was found to be positively predicted by transformational leadership and the contingent reward factor of transactional leadership. However, satisfaction with leadership was found to be negatively predicated by the laissez-faire subscale (Andrews et al., 2012).

In addition to satisfaction, there are other attributes that could affect nurses' perceptions about their managers. For instance, the abilities of nurses to understand their managers are an important area to consider. Focusing on these aspects, a study conducted by Casida, Crane, Walker, and Wargo (2012) in the USA assessed the influence of demographic factors and organisational dependent variables on nurses' perception of their nurse managers' leadership style. This study used the MLQ 5X-Short (Avolio et al., 1995) and Dension Organisational Culture (Denison & Neale, 1996) questionnaires and collected data from 274 full-time nurses. The findings of the study indicated that nurses with bachelor/graduate degrees viewed their managers' leadership style differently than nurses with diploma-level/associate degrees. Nurses with bachelor/graduate degrees had more favourable perceptions of their managers than nurses with diploma or associate degrees (Casida, Crane, Walker, & Wargo, 2012). Additionally, the results revealed that the portrayal of transformational leadership behaviours by the nurse managers was paramount in shaping the culture traits linked to high performance by nurses (Casida et al., 2012).

A similar study was conducted by Failla and Stichler (2008), involving a sample of 77 nurses and 15 nurse managers working at four hospitals in Southern California. Here the authors used the MLQ 5X-Short (Avolio et al.,1995) to look at the nurse managers' and nurses' perceptions of nurse manager's leadership styles. The results revealed that there was a lack of correlation between the nurse managers' self-perceptions of their transformational

leadership style and the nurses' perceptions of their manager's style. Failla and Stichler (2008) indicated that there is a need for nurse managers to validate their self-perceptions with a 360-degree analysis of how others perceive their leadership style.

Similarly, while focusing on the nurses' perceptions, but in a different dimension (cross-sectional study based on leadership domains), Zampieron et al. (2013) conducted a cross-sectional study in Italy to compare different leadership styles based on the perceptions of nurse leaders and their staff. These authors used a questionnaire adapted by Ekvall and Arvonen (1991) considering three leadership domains (change, production and employee relations), distributed among nurse managers and their staff at city hospitals in north-east Italy. The results revealed that the leadership styles preferred by nurses always scored higher than the styles their nurse managers actually adopted. The study indicated that nurses' perceptions of their nurse managers' leadership differed from those of their nurse managers in relation to their leadership (Zampieron et al., 2013). Nursing directors of hospitals should therefore, assess nurse managers' leadership styles and help them to remove obstacles to the adoption of their preferred leadership styles (Marquis & Huston, 2009; Sellgren, Ekvall, & Tomson, 2008; Tyler et al., 2012).

Numerous studies published in recent years have used a survey-based approach with the aim of ascertaining staff perceptions of nurse managers' leadership styles (Andrews et al., 2012; Casida & Parker, 2011; Failla & Stichler, 2008; Kleinman, 2004; McGuire & Kennerly, 2006). However, the results revealed by these studies may be questionable as surveys are not always objective, or efficient in evaluating the perceptions from various dimensions and correlating the perceptions with other factors. For instance, according to Andrews et al. (2012), the difference between nurse managers' perceptions of their leadership styles and the perceptions of nurses of their managers' leadership styles presents a problem in the process of evaluating the survey findings. Nonetheless, a number of studies conducted to

assess the self-perceptions and nurses' perceptions of their managers have highlighted the positive association between transformational leadership style and intent to stay and satisfaction (Cummings, MacGregor, Davey, Lee, et al., 2010; Gunther, Evans, Mefford, & Coe, 2007; Kanste, 2008; Raup, 2008). According to Cummings et al. (2010), motivation and satisfaction, which are associated with the transformational leadership style, could be directly affected by and inhibited by transactional and laissez-faire leadership styles.

3.8 Full range of leadership in nursing

There are different ways and styles of leading people and that style of leadership affects nurses' performance (Cummings, MacGregor, Davey, Lee, et al., 2010). According to Meleis (2011), there is a need to understand the history and theoretical knowledge and practice of nursing leadership to foster the nursing discipline. Many leadership theories and styles have been reviewed in the nursing literature supporting the perspective of the importance of the transformational leadership model (Casida et al., 2012; Snodgrass, Douthitt, Ellis, Wade, & Plemons, 2008). Within the framework of nursing leadership, three distinct paradigms are typically discussed as achieving the desired performance outcomes: the transformational, transactional and laissez-faire leadership styles. Following is a sample of previous transformational, transactional and laissez-faire leadership studies and their overall results.

3.8.1 Transformational leadership in nursing

Transformational leadership style can be understood as an approach that causes positive change among the followers and social systems for the attainment of goals. The approach includes various aspects such as identifying the change needed, planning and creating a strategy to implement the change through inspiration and managing the change among the committed members of the group (Bass, 1990). The leaders using this approach

also need to identify various mechanisms such as understanding and assessing the strengths and weaknesses of the followers; accordingly assigning the tasks to the followers that enhance their performance; being a role model to inspire the followers; challenging the followers to take ownership for their work; and building a sense of collectivism for achieving the designed goals and objectives (Bono & Judge, 2004).

In the field of nursing, many researchers have focused on transformational leadership because of its positive impact on organisational outcomes and staff performance as discussed earlier (Crawford, 2005; García-Morales, Jiménez-Barrionuevo, & Gutiérrez-Gutiérrez, 2012). As Casida and Parker (2011) contended, academics are actively pursuing a supportive and performance-enhancing paradigm that is capable of encouraging innovative, goal oriented and effective employee behaviour. Taking the aspect of performance enhancing paradigm, Salanova et al. (2011) examined the relationship between transformational leadership and nurses' extra-role performance using a cross-sectional study and a sample of 280 nurses and 17 leaders working in a large Portuguese hospital. The study showed that transformational leaders enhanced staff's extra-role performance by establishing self-efficacy and work engagement (Salanova et al., 2011).

The innovative paradigm was further investigated by Reuvers, Van Engen, Vinkenburg, and Wilson-Evered (2008) in a study examining the relationship between transformational leadership and staff innovative work behaviours. For this study they gathered data from four Australian hospitals, generating a dataset of 335 respondents. These authors found that there is a positive and significant relationship between transformational leadership and innovative work behaviour. Additionally, Reuvers et al. (2008) suggested that leaders should capitalise on the transformational leadership capabilities of managers.

The impact of collective paradigms such as behavioural, performance enhancing, effectiveness and satisfaction were analysed by Casida and Parker (2011) in a study of 278 nurses from four hospitals in Northeastern USA. Researchers used an exploratory correlational design, asking nurses to rate 37 nurse managers using the MLQ 5X-Short (Avolio et al., 1995). Their findings were that transformational leadership had a strong correlation with leadership outcomes, including staff leaders' extra effort, effectiveness and leadership satisfaction and was a predictor of leadership outcomes. Conversely, transactional leadership had weak correlations to leaders' extra effort, effectiveness and leadership satisfaction and did not predict leadership outcomes (Casida & Parker, 2011). Additionally, Casida and Parker (2011) suggested that transformational leadership training should be a basic competency requirement of nurse managers.

Another important aspect of transformational leadership is the ability of the leaders to maximise the output with minimum resources, which in other terms is effective and efficient management of resources. In a study focusing on resource utilisation and management, Raup (2008) identified nurse managers with effective leadership skills were found to be a critical component for managing nursing shortages (by motivating the existing nurses to take extra efforts and enhance their performance by instilling a sense of responsibility and ownership) as they can reduce turnover rates. Raup (2008) conducted a study in the USA to assess which types of leadership styles were used by nurse managers working in academic health centre hospitals and also to examine their influence on nurses' intent to stay, as well as patient satisfaction. In this study, Raup (2008) examined the correlation between transformational leadership and nurses' turnover using the MLQ 5X-Short (Avolio et al., 1995) with a sample of 15 nurse managers and 30 nurses. The findings showed that there was a positive correlation between transformational leadership and nurses' turnover with a lower attrition of nurses, but it also found that there was no effect on patient satisfaction (Raup, 2008).

However, the small sample size of nurse managers and nurses may limit the generalisability of these findings.

The transformational leadership style also focuses on the management skills of the leaders as well as how effectively they can handle issues or mitigate them for enhancing the performance of their staff. Lindholm, Sivberg, and Uden (2000) conducted a qualitative study at three Swedish hospitals to identify the meaning and application of the leadership style of nurse managers within a changing healthcare system. This study found that nurse managers who had a clear leadership style, such as transformational or transactional, experienced fewer management issues than nurse managers with a composite leadership style. Similarly, Stanley (2010) focused on a single issue of managing multi-generational workforce in a study and stated that understanding different generational groups would allow nursing leaders to consider what motivates or hinders nurses specifically for each group (Stanley, 2010). Considering the same, Sherman (2006) identified motivation and effective communication strategies need to be adopted by nursing leaders to reduce the conflicts between the generational groups. The managerial aspects of transactional leadership also need to consider all the stakeholders of an organisation including nurse executives/directors/deans, nurse managers and nurses. There is a need therefore, to assess the management aspects from this dimension and assess the relationship with various attributes. Considering this, Chen (2004) conducted a study in Taiwan which assessed the correlation between nursing faculties' perceptions of nursing deans' and directors' leadership style and nurses job satisfaction, using the MLQ 5X-Short (Avolio et al., 1995). In this study, Chen (2004) found that Taiwanese directors and deans tend to display transformational leadership more frequently than transactional leadership. This result was similar to the results of Dunham-Taylor (2000) who conducted a study in the USA on 396 randomly selected hospital nurse executives and 1115 of their reporting staff. Dunham-Taylor (2000) explored transformational leadership, stage of

power and organisational climate. Dunham-Taylor (2000) found that nurse managers used transformational leadership often, were very effective and achieved satisfied staff levels. Conversely, with increasing transactional leadership behaviours of nurse executives, staff satisfaction and effectiveness decreased (Dunham-Taylor, 2000). In a similar study, Janseen (2004) used the MLQ 5X-Short (Avolio et al., 1995) to examine the leadership characteristics of 63 hospital chief executive officers (CEOs) in Iowa and the factors that influenced their leadership style. In this study, Janseen (2004) found that the subordinates characterised CEOs as exhibiting transformational behaviours and traits *fairly often*. Furthermore, transformational leadership was highly correlated with organisational outcomes including increased levels of extra effort, satisfaction and perceptions of CEO effectiveness (Janseen, 2004).

The second level in the organisational structure after the nurse executives includes the nurse managers. It is essential to investigate the nurse managers' transaction leadership styles and their correlation with various dimensions in nursing management. With this in mind, Medley and Larochelle (1995) conducted a study in north-central Florida from four hospitals to explore how nurses distinguished between the transactional and transformational leadership behaviours of their nurse leaders and the correlation between nurse managers' leadership style and job satisfaction. Using the MLQ 5X-Short (Avolio et al., 1995), Medley and Larochelle (1995) found that nurses perceiveed their head nurses as demonstrating transactional and transformational leadership behaviours. This study found that transformational leadership behaviours and staff satisfaction are associated with transformational leadership more than transactional leadership. Similar results were found in a number of other studies. For instance, Morrison, Jones and Fuller (1997) found similar results in a study conducted using the MLQ 5X-Short (Avolio et al., 1995) for assessing leadership styles and Warr, Cook, and Wall's Job Satisfaction Scale (1979) for measuring job

satisfaction and psychological empowerment. The study included 442 nursing department staff of a regional medical centre in USA which comprised executives, nurse managers, licensed practical nurses, registered nurses, nursing assistants, and various administrative staff. The findings were that transformational leadership had a powerful impact on nurses' job satisfaction through its influence on a person's empowerment. For transactional leadership, on the other hand, there was no effect on empowerment, but it did have some direct effect on job satisfaction (Morrison, Jones & Fuller, 1997). Choi, Goh, Adam and Tan (2016) in a study focusing on 200 nurses employed in two large private and public hospitals in Malaysia, found that transformational leadership had a positive impact on job satisfaction and empowerment of these employees. As with previous studies, Choi et al. (2016) found that empowerment mediated the effect of transformational leadership on job satisfaction of nurses. Focusing on the same concepts of transactional and transformational leadership styles, Negussie and Demissie (2013) conducted a study at the Jimma University Specialised Hospital in Ethiopia to assess the relationship between the leadership style of nurse leaders and job satisfaction using the MLQ 5X-Short (Avolio et al., 1995) and the Minnesota Satisfaction Questionnaire (Weiss, Dawis, & England, 1967) with a total of 175 nurse participants. The results revealed that nurses preferred transformational leadership style over transactional leadership style with all five factors of transformational leadership style positively correlated with job satisfaction (Negussie & Demissie, 2013).

Another important dimension is the relationship between leadership styles and the organisation culture, and how they may affect the organisational development. Considering this issue as an objective of the research study, Casida (2007) used a descriptive, correlational exploratory design to explore the relationship between nurse managers' leadership style and nursing units' organisational culture (NUOC) in New Jersey, USA with a sample of 37 nurse managers and 278 nurses. The MLQ 5X-Short (Avolio et al., 1995) and Denison

organisational culture survey (UNTHSC, 2011) were used to measure the nurse managers' leadership style and NUOC. The results showed that there was a positive association between the transformational leadership style and NUOC measures. Extending the study to further assess the relationship between the leadership styles, unit culture, and performance levels, Casida (2012) investigated 278 nurses perceptions of their nurse managers' leadership from high-performing critical care and noncritical care units in four acute care hospitals in the Northeast region of the USA. In this study Casida (2012) found that leaders adopting transformation leadership styles could add value in improving performance levels as they were leaders more likely to shape unit cultures which are flexible and adaptive to the environmental challenges within and outside the nursing unit, and thus enhancing the organisational outcomes.

Another important aspect of leadership styles is the strategies adopted by the leaders which can be transactional or transformative. Considering the strategies as a point of focus, Andrews et al. (2012) conducted a study in the USA to examine nurses' and leaders' perceptions of leadership style using the MLQ 5X-Short (Avolio et al., 1995) with a sample of 16 supervisors and 179 nurses. Andrews et al. (2012) found that nurses perceived leaders as employing largely transformative leadership strategies. A more recent study supported the same results which conducted a cross-sectional quantitative study with 807 nurse participants from public, private, and religious hospitals, and used structural equation modelling for analysing the results (Lin et al., 2015). This study found positive relationships of transformative leadership strategies with all variables including job satisfaction, supervisor support, workplace support, job satisfaction and organisational commitment. The study also found that the strategy led to strong organisational commitment among the nurses which they considered as more important than job satisfaction (Lin et al., 2015). Boamah, Spence Laschinger, Wong, and Clarke (2017) conducted a study in Ontario with 378 acute care

nurses to investigate the effects of nurse managers' transformational leadership behaviors on job satisfaction and patient safety outcomes. The study found that transformational leadership strategies had a strong positive impact on the workplace environment and increased job satisfaction among nurses and reduced frequency of adverse patient outcomes (Boamah et al., 2017).

Various studies conducted across different settings as discussed above revealed that the transformational leadership was preferred to transactional leadership styles by nurses, as it is perceived that this leadership behaviour has numerous advantages. Moreover, these studies as discussed reflect that the transformational leadership styles can be more effective to transactional styles in shaping culture, adding value, enhancing performance and improving organisational outcomes.

3.8.2 Transactional leadership in nursing

Transactional leadership, unlike transformational leadership, focuses on the monitoring and management activities like supervision, organisation and performance, where the followers are offered both rewards and punishments, and does not focus on the change for future complications (Deluga, 1990). Despite the focus of research studies on transformational leadership style as an effective style positively associated with organisational outcomes, transactional leadership remains an important leadership style. Given this, there is a paucity of studies with a focus on nursing transactional leadership behaviour. However, researchers have identified significant benefits derived from transactional leadership behaviour in other fields including the banking industry (Chaudhry & Javed, 2012), the military (Bass et al., 2003), private organisations (Riaz & Haider, 2010) and academia (Zagoršek, Dimovski & Škerlavaj, 2009). These differences may be explained by the nature of the participants as males are often the predominant gender in many of the industries referred to above.

In addition, the distinction between transformational and transactional leadership styles is considered an important point in the study of leadership behaviours and has been the focus of research studies. For instance, Zagoršek et al. (2009) utilised the MLQ 5X-Short (Avolio et al., 1995) to measure leadership styles and to investigate the relationship between leadership and organisational outcomes in the Faculty of Economics of the University of Ljubljana in Slovenia. Specifically, the study aimed to identify the impact of transformational and transactional leadership on learning outcomes. The findings of the study indicated that transformational and transactional leadership affect all four constructs of organisational learning, directly influencing behavioural and cognitive changes during the learning process (Zagoršek et al., 2009). Additionally, and in relation to nursing practice, McGuire and Kennerly (2006) reported that transformational and transactional leadership models provided a framework for nurse leaders to develop their leadership skills, attributes and knowledge.

Transformational and transactional leadership also provide a model for shaping employees' commitment to the work environment. Furthermore, in order for nurse leaders to be effective, they need to balance their transformational and transactional behaviours to develop a leadership style that matches their subordinators' needs. Bass, Avolio, Jung and Berson (2003) investigated leadership ratings collected from army units operating under stable conditions and whether they predict subsequent performance of those army units operating under high stress and uncertainty. The study was on 72 light infantry rifle platoon leaders from the USA Army. These authors found that both transformational and transactional contingent reward leadership behaviour of platoon leaders and sergeants impacted positively on ratings of unit potency, cohesion and performance. Bass et al. (2003) in particular, reported on the platoon leadership to performance being somewhat mediated through the level of potency and cohesion of an army unit. Given this, the environmental

conditions therefore, are also an important factor that needs to be considered by leaders in adopting leadership styles and strategies.

Considering the working environment and impact on leadership behaviour and in particular transactional leadership, Riaz and Haider (2010) completed a study on 240 participants from various private organisations working in Islamabad, Pakistan. They found that transactional leadership behaviour significantly related to job success as compared to transformational leadership. Moreover, Riaz and Haider (2010) demonstrated that employees working in the private sector perceived their managers transactional leaders compared to the transformational leadership style. They explained these findings as in the private sector they practice transactional leadership behaviours managers and employees have an exchange relationship. Furthermore, in this industry, rewards and punishments are used as tools by leaders to positively and negatively influence subordinates (Riaz & Haider, 2010). These findings are in contrast to studies of nursing transactional leadership behaviour.

A study undertaken in Italy by Morsiani, Bagnasco and Sasso (2017) aimed to describe nurses' perceptions related to styles utilised by their nurse managers. The results of this study indicated that nurse managers adopted a transactional leadership style which had a negative correlation with job satisfaction. The differential impacts of transformative and transactional leadership styles were further assessed from various dimensions by Lowe, Kroeck and Sivasubramaniam (1996) in their meta-analytic review of the MLQ literature. The level of leader, organisational setting (public or private) and operationalisation (subordinate perceptions) dimensions were used. This study found that differential impacts were observed with respect to each dimension, with transformative styles gaining more positive impact over transactional styles.

3.8.3 Laissez-faire leadership in nursing

Laissez-faire leadership style is known as a non-leadership style. Leaders utilising this style avoid making decisions and are absent when needed (Jones & Rudd, 2008). A few researchers have addressed the laissez-faire leadership style (Chaudhry & Javed, 2012; Eagly, Johannesen-Schmidt, & Van Engen, 2003). For instance, Chaudhry and Javed (2012) conducted a study in Pakistan to explore the significance of laissez-faire leadership with a sample of 278 respondents in the banking industry. The study findings revealed that transactional leadership behaviours, including contingent reward, are more effective than laissez-faire leadership for retention and employee motivation (Chaudhry & Javed, 2012). Contingent reward leadership therefore, is most likely to have a motivational influence on followers' behaviours (Chen, Beck, & Amos, 2005). To explain this further, Spinelii (2006) claimed that regardless of the satisfaction of the followers with the leadership style, an active leadership style has a direct benefit on subordinates' perceptions of support. It is clear that laissez-faire leadership is inadequate when considering the scope of employee needs in many workforces, including nursing.

In another study conducted by Skogstad, Einarsen, Torsheim, Aasland and Hetland (2007), the impact of avoidant leadership on staff role conflict and co-worker conflict was assessed by using the MLQ 5X-Short (Avolio et al., 1995) with a sample of 2273 Norwegian employees. The findings confirmed that laissez-faire leadership had an association with elevated levels of role conflict and ambiguity. Additionally, Skogstad et al. (2007) suggested that negative workplace interactions could also lead to increased stressors and that they heightened role ambiguity, reducing employee satisfaction and communication frequency. Interestingly, in another study conducted by Skogstad, Hetland, Glasø and Einarsen (2014) on a sample of 1771 Norwegian employees, it was found that the laissez-faire leadership and destructive forms of leadership reduces job satisfaction; and as the dissatisfied employees

perceive their leaders negatively, these styles can be a better predictors of job satisfaction. In addition, laissez-faire leadership poses an authoritative approach which affects the communication between the leader and the followers, which can have negative impacts on the organisational outcomes (Hackman & Johnson, 2013).

It is clear, therefore, that effective nursing leadership must involve a much more active leadership style than what laissez-faire styles are able to provide. However, Rad and Yarmohammadian (2006) argue that the laissez-faire leadership style works effectively with motivated, self-directed and highly skilled employees with considerable years of experience. These authors suggested that the laissez-faire leadership style should not be used with employees who exhibit time management problems, are unmotivated or who lack skills and experience.

As with transactional leadership there is a paucity of studies with a focus on nursing laissez-faire leadership behaviour. In a recent study of the leadership style of nurse managers as perceived by nurses in Singapore, nurses reported that their nurse leaders exhibited laissez-faire behaviours but to lesser extent than both transformational and transactional leadership styles (Goh, Ang & Della, 2018). These findings are in contrast to another study conducted in the Hail Province of Saudi Arabia. Alshammari (2014) found laissez-faire was the predominant leadership behaviour of nurse managers, although transformational leadership was the most effective of the leadership types.

3.9 Review of leadership styles studies in Arab countries

The nursing leadership styles in Arab countries are specifically reviewed as the culture and social environments in Arab countries are different to the other regions of the world. The review in this specific context therefore, will assist in the understanding of the leadership styles and their impact in various dimensions.

In terms of leadership styles in a multinational environment such as many of the healthcare facilities in Saudi Arabia, Suliman (2009) investigated the predominant leadership style of nurse managers working at a National Guard Health Affairs hospital in Jeddah, Saudi Arabia. This study included 31 nurse managers and 118 nurses and the MLQ 5X-Short (Avoli et al., 1995) was used. The results demonstrated that both nurse managers and nurses working at this multinational environment reported transformational leadership as the predominant style of leadership. However, nurse managers perceived that they were fairly often transformational whilst nurses working under these leaders perceived them as only sometimes being transformational. This study also demonstrated that transformational leadership was a positive factor in staff retention (Suliman, 2009). Similarly, El Dahshan, Youssef, Aljouaid, Babkeir, and Hassan (2017) in a study of nurses' perceptions of the leadership styles of their nurse managers in two hospitals in Taif, Saudi Arabia, found transformational leadership style was rated higher than transactional leadership style in both hospitals. The findings revealed that transformational leadership was associated with job satisfaction and transactional leadership with job dissatisfaction. The results also suggested transformational nurse managers were more likely to contribute to a positive work environment, increased job satisfaction, commitment and motivation (Dashan et al., 2017). These results are consistent with Omer (2005) who investigated the leadership styles of nurse managers in National Guard hospitals in Jeddah in Saudi Arabia. Omer (2005) found that transformational leadership style was ranked higher by nurses compared to transactional leadership style. Moreover, these findings are compatible with Moussa et al. (2016) who reported that nurses working at a hospital in Riyadh, Saudi Arabia perceived their managers as transformational as opposed to transactional leaders.

In another study conducted in Saudi Arabia, Alshammari (2014) explored nurse managers' and nurses' perceptions of leadership styles in five hospitals in the Hail Province.

The MLQ 5X-Short (Avolio et al., 1995) was used to survey 33 nurse managers and 215 nurses who worked under these leaders. The findings of this study are contrary to those of other nursing leadership studies conducted in Saudi Arabia as laissez-faire was the predominant leadership style. However, transformational leadership was the most effective in achieving leadership outcomes including staff satisfaction and willingness to exert extra effort (Alshammari, 2014).

Randeree and Chaudhry (2012) studied the impact of leadership styles on job satisfaction and organisational commitment in the construction sector in United Arab Emirates (UAE). This study was conducted with 251 individuals using a questionnaire for the construction sector. The findings revealed that consultative and consensus leadership styles are prevalent in the industry and the leadership styles strongly influenced job satisfaction levels and moderately influenced organisational commitment.

It is essential that the demographic correlative studies are to be conducted for assessing the leadership from different perspectives. Considering this dimension, Neal, Finlay and Tansey (2005) conducted a comparative study on Arab women's attitude towards leadership authority. The study used Weber's (1978) administering survey with 320 participants from Oman, Lebanon, and the UAE. The quantitative analysis made using ANOVA revealed that authoritative leadership styles were observed in Oman and the UAE, whereas high levels of charismatic leadership styles were observed in Lebanon. The results reflect the practice of different leadership styles in similar regions. Yaseen (2010) conducted a similar study in the UAE but included both men and women in assessing the practice of leadership styles using the MLQ 5X-short questionnaire (Avolio et al., 1995). The findings revealed that Arab women exceeded Arab men on four transformational factors, including idealised influence, inspirational motivation, intellectual stimulation and individualised consideration. However, Arab men exceeded Arab women in transactional factors including

active and passive management by exception, and also in adopting laissez-faire leadership styles.

Though the analysis by demographic information gives more user centric analysis, there are also dimensions that are very important, such as quality of services/care. Considering the dimension of quality of care, El Amouri (2010) assessed culturally competent care (CCC) in a culturally diverse environment of the UAE at ten hospitals using a cross-sectional survey. The study identified the presence of both transformational and transactional leadership styles and found that both styles had significant impact on CCC and more than the organisational culture's impact in the delivery of CCC. Similarly taking the same concept, Sfantou, Laliotis, Patelarou, Sifaki-Pistolla, Matalliotakis and Patelarou (2017) conducted a systematic review study considering leadership styles and quality of care, and stated that leadership is one of the core elements for providing effective and integrated care/services.

As previously discussed, literature has identified that the relationship between leadership styles and the different levels of leaders can explain the impact from various perspectives (Lowe et al., 1996). For instance, Akbari et al. (2016) conducted a descriptive correlative study on 150 nurse managers at three levels including matron, supervisor and head nurse in hospitals in Isfahan, Iran. The results identified that organisational oriented leadership was beneficial for the organisations but decreased productivity in the long term. Furthermore, adopting human oriented leadership styles was preferred for increasing job satisfaction among followers and increasing organisational outcomes (Akbari et al., 2016). One of the important aspects when considering the levels of organisational structure is the perception of lower level employees about their manager at higher levels. Considering this point, Aboshaiqah at al. (2014) conducted a study on the nurses' perceptions of their managers' leadership styles. This was a cross-sectional descriptive correlation study with 272

nurses from two major government hospitals in Saudi Arabia. The results indicated that transformational behaviour is more preferred, followed by transactional style in achieving the outcome factors including effectiveness, extra efforts and satisfaction.

Similarly, the impact of leadership styles can be assessed for various dimensions such as motivation, satisfaction and retention. This approach helps the researcher to identify and analyse the impact of leadership in specific to individual factors. Considering organisational commitment as a factor, El Dahshan et al. (2017) analysed the impact of leadership styles by conducting a cross-sectional descriptive survey at two government hospitals in Saudi Arabia with 570 nurses. The study found that transformational style was rated highly by the participants compared to the transactional leadership styles. They found that both leadership styles positively impacted the nurses' commitment towards organisation (El Dahshan, et al. 2017). Contradicting these results however, is a cross-sectional descriptive study with 332 nurses at King Abdulaziz Medical City in Saudi Arabia study (Asiri, Rohrer, Al-Surimi, Da'ar & Ahmed, 2016). This study found that organisational commitment was negatively correlated with transformative leadership styles and positively correlated with transactional leadership styles. A very low impact on commitment was also found with laissez-faire leadership style. Furthermore, this study reported that most nurses perceived their managers as not exhibiting the optimal levels of transformational behaviours (Asiri et al., 2016).

In another study in Saudi Arabia, Al-Yami, Galdas and Watson (2017) examined the relationship between nurse managers' leadership styles and nurses' organisational commitment. The MLQ 5X-Short (Avolio et al., 1995) and Organisational Commitment Questionnaire (Allen & Meyer, 1990) were distributed to 219 nurses and nurse managers working in two hospitals in Riyadh, Saudi Arabia. This study found that transformational leadership was the most common and the greatest contributor to organisational commitment. These authors also established that there was an increase in perceptions of both

transformational and transactional leadership with increasing ages of nurses and nurse managers (Al-Yami et al., 2017). A similar study was conducted by Rahbi, Khalid and Khan (2017) by considering team motivation factor in the UAE at Abu Dhabi's healthcare sector. This study found that transformational, authentic and servant leadership styles are positively correlated with team motivation whereas transactional leadership style is found to be negatively correlated with team motivation.

Considering the job satisfaction as the point of focus, Abdelhafiz et al. (2015) investigated the impact of leadership styles on job satisfaction by deploying the MLQ 5X-Short questionnaire (Avolio et al., 1995) and a demographic survey at six hospitals in Jordan. This study found a positive relation between job satisfaction by the nurses and both transactional and transformational leadership styles; and a negative relation was observed with passive avoidant leadership style. A similar study was conducted by Hijazi et al. (2017) with 241 faculty members at seven universities in the UAE using the MLQ 5X-Short (Avolio et al., 1995) and the Minnesota Satisfaction Questionnaire (Weiss et al., 1967). This study found contradicting results with those of Abdelhafiz et al. (2015). The study found a positive relationship between the employee job satisfaction and transformational leadership styles, but a negative and significant relationship between job satisfaction and transactional leadership styles (Hijazi et al., 2017).

In another study, Musaed, Alshahrani and Baig (2016) evaluated the effect of transformational and transactional leadership styles of nurse managers on the job satisfaction of nurses in critical care units of a tertiary care hospital in Asser, Saudi Arabia. The MLQ 5X-Short (Avolio et al., 1995) and Job Satisfaction surveys (Spector, 1994) were used. The findings for this study are also contrary to those of Abdelhafiz et al. (2015), as nurses working under leaders with a transformational style of leadership exhibited significantly higher job satisfaction compared to nurses working under managers with a transactional

leadership style in private hospitals in Jordan. For this study, organisational outcomes were also better with transformational leadership (Musaed et al., 2016). These findings are supported by Abualrub and Alghamdi (2012) who evaluated the impact of leadership on job satisfaction of 308 nurses working in six hospitals in the Western Province of Saudi Arabia. This study found that nurses working with leaders who exhibited transformational leadership styles enhanced levels of nurses' job satisfaction and the nurses were more satisfied (Abualrub & Alghamdi, 2012). In a study of the impact of leadership styles adopted by head nurses on nurses' job satisfaction between government and private hospitals in Jordan, the level of job satisfaction among nurses was higher in public than in private hospitals (Abdelhafiz, Alloubani & Almatari, 2016). Positive relationships were found between the overall scores for transformational and transactional leadership styles and job satisfaction (Abdelhafiz et al., 2016).

Nurses' retention is one of the important aspects to be considered and managed by the nursing managers, especially in countries that rely on an expatriate nursing workforce. Considering this aspect as the point of focus, Nassar, Abdou and Mohmoud (2011) conducted a study using a modified version of Profile of Organisational Characteristics questionnaire (Likert & Likert, 1976) with 228 nurses at three hospitals in the UAE to investigate the relationship between management styles and nurse retention. The study found that consultative leadership style was preferred to be adopted by the nurse managers, and recommended a work environment that is caring and conducive. Abualrub and Alghamdi (2012) found in the Western Province of Saudi Arabia, the greater the nurses rated their manager as displaying a transformational leadership style, the lower was the turnover rate in the nursing units and wards. For an effective and efficient work environment, there is a need for implementing effective strategies for various purposes. Al Hosis, Plummer, and O'Connor, (2012) suggested succession planning strategies for retention of more Saudi nurses

in Saudi Arabia. The study also identified that effective succession planning is built on the framework of solid organisational vision and policy, and that this was not reflected in practice in the Saudi Arabian hospitals.

Ibrahim, Elsayed, Attala and Elmezin (2016) studied the impact of leadership styles on nurses' job performance in an emergency hospital in Egypt. Participants were recruited from all in-patient units in the hospital. The study was conducted with 110 individuals using a leadership questionnaire developed the researchers (Ibrahim et al., 2016), as well as a nurses' job performance evaluation (observation checklist) (Cobb, 2008). The findings revealed that there was no statistical significant relationship between leadership styles and nurses' performance. Furthermore, the level of performance among the nurses was low. Recommendations from the study included training programs on leadership styles and performance appraisal for nurses and head nurses (Ibrahim et al., 2016). In another study conducted in Egypt, Abd-Elrhaman and Abd-Allah (2018) investigated the impact of a transformational leadership educational program for head nurses on nurses' job performance. The study was conducted at a teaching hospital in Egypt including 103 head nurses and 138 nurses as participants. Three tools were used which included the MLQ 5X-Short (Avolio et al., 1995), a transformational leadership knowledge questionnaire as developed by the researchers based on a review of related literature (Abd-Elrhaman & Abd-Allah, 2018) and a nurses' job performance evaluation (observation checklist) (Cobb, 2008). The study found a highly statistically significant improvement in head nurses' transformational leadership skills and knowledge scores both immediately post and three months after completion of the program when compared to the pre-program scores. There was also a highly statistically significant improvement in nurses' job performance scores immediately post and three months after completion of the program when compared to the pre-program scores. Based on these findings, the researchers recommended ongoing in-service training and education

programs for refreshment and improvement of head nurses' knowledge and skills of transformational leadership (Abd-Elrhaman & Abd-Allah, 2018).

In a study conducted in Iran, the relationship between nurse managers' leadership styles and nurses' burnout was investigated. Ebrahimzade, Mooghali, Lankarani and Sadati (2015) used three tools for the study including a questionnaire on demographic characteristics, the MLQ 5X-Short (Avolio et al., 1995) and the Maslach burnout inventory (Maslach & Leiter, 1997). The participants included 207 nurses with findings of high burnout scores for reduced personal accomplishment, above average burnout scores for emotional exhaustion and low burnout scores for depersonalisation. For both transformational and transactional leadership there was a statistically significant negative relationship with total burnout, emotional exhaustion and depersonalisation. Laissez-faire leadership had a statistically significant negative relationship with reduced personal accomplishment. The researchers concluded that because transformational leadership enhances creativity and motivation among nurse, whilst transactional leadership emphasises collaboration, a combination of these two styles can reduce nurses' burnout (Ebrahimzade et al., 2015).

Shirazi, Emami, Mirmoosavi, Alavini, Zamanian, Fathollahbeigi and Masiello (2016) assessed the effects of a workshop on supportive leadership behaviour on the performance of head nurses' using a randomised controlled trial in 16 hospitals in Tehran, Iran. Participants included 110 head nurses and 660 subordinates such as registered nurses and nurse aids. Supportive leadership behaviours were assessed by questionnaire developed by the researchers (Shirazi et al., 2016). The results revealed a statistically significant difference in supportive leadership behaviour scores from baseline to a three month follow-up. Furthermore, the post-intervention scores were significantly higher in the intervention group compared to the control group for the study. These findings demonstrated the effectiveness of a leadership workforce in improving leadership performance and supportive behaviours of

head nurses in Iran (Shirazi et al., 2016). For exploration of effective nurse leaders in Iraq where delivery of healthcare continues to face disruption and change, Abed and Neill (2017) conducted a descriptive quantitative study. In two public hospitals in northern Iraq, 210 ward nurses completed a survey developed by the researchers (Abed & Neill, 2017), to identify perceived effective leadership characteristics displayed by the nurse leaders. The findings of this study demonstrated that for nurses, evidence of an effective nurse leader included demonstration of good clinical knowledge, effective communication and managerial skills, as well as attainment of high-level qualifications. Personal qualities of the nurse leaders were also important for nurses including politeness, ethical behaviour and trustworthiness (Abed & Neill, 2017).

In terms of qualitative studies of nursing leadership styles in Saudi Arabia, there is a paucity of these research studies in the literature. Omer (2005) conducted a mixed-method study at two National Guard Health Affair hospitals in the Western (Jeddah) and Central (Riyadh) Provinces of Saudi Arabia to assess leadership styles of nurse managers. For the qualitative data collection, 23 managers participated in face-to-face interviews and the data was analysed based on the Heideggerian Hermeneutical Phenomenological approach. The qualitative findings for this study identified "the lived experience of the nurse managers at the Saudi National Guard hospitals was shaped with three themes: the nature of the leadership process, the work environment, and the dynamic of the work relationship" (Omer, 2005 p.xv). However, there were a number of limitations which may impact on the transferability of the findings for this study. The demographic characteristics of the 23 nurse managers were limited as there was only one male and no Saudi Arabian managers. For the quantitative study, the majority of nurses were females and only three of 271 respondents were Saudi Arabian. The study was also conducted at military hospitals and not public hospitals which may impact on the generalisability of the results (Omer, 2005). Further limitations were that

the nurse managers were interviewed before they were surveyed. Contrary to this approach it could be argued that a researcher can obtain more information from the participants if the participants are surveyed prior to the interview as they are more informed about the research topic. Furthermore, Omer (2005) did not adhere to the principles of the phenomenological approach throughout the analysis of the qualitative results. In terms of the quantitative data analysis, Omer (2005) used research questions to guide the data analysis which is another limitation as this approach does not allow an opportunity to explore the data through further analysis.

Another qualitative study of nursing leadership styles in Saudi Arabia was completed by Saleh, O'Connor, Al-Subhi, Alkattan, Al-Harbi and Patton (2018). Similar to Omer (2005), semi-structured interviews were used using open-ended questions and a Heideggerian Hermeneutical Phenomenological approach for data analysis. In total 35 nurses participated in the study from various specialties of a medical city in Mecca in the Western Province of Saudi Arabia. Four major types of leadership styles were reported by the nurse participants: relational leadership, preferential leadership, communication chain leadership and ineffectual leadership. The findings of this study also demonstrated that the nurse managers' leadership style influenced nurses' job satisfaction, the turnover rate of nurses' and the quality of care delivered by nurses (Saleh et al., 2018). Limitations of this study included a small representative size of all nationalities as about half (n = 17) were from India, as well as nurses from a limited number of units from the hospital participated in the study (Saleh et al., 2018). Consideration of a larger study with a greater variety of demographic and professional characteristics may have increase the transferability of future qualitative studies of leadership styles in Saudi Arabia, especially when limiting the research methodology to a qualitative and not a mixed-method approach (Saleh et al., 2018).

The review has investigated studies focusing on the relationship between leadership styles and various dimensional factors in nursing management in Arab countries. The majority of studies found that transformational leadership styles positively correlated with various factors such as job satisfaction, motivation, nurse retention, work environment stress, and quality of care. Among nurses' perceptions of leadership styles of their manager, most studies support the transformational leadership style. A positive relationship was observed between transactional leadership styles and organisational commitment (El Dahshan et al. 2017). Few studies investigated laissez-faire leadership styles but were found to be ineffective towards the nurse management dimensional factors.

Although there are a number of studies that have been conducted in regard to leadership styles in Saudi Arabia (Abdelhafiz et al., 2015; Abualrub & Alghamdi, 2012; Aboshaiqah et al., 2014; Alshahrani & Baig, 2016; Alshammari, 2014; Al-Yami et al., 2017; Asiri et al., 2016; Dahshan et al., 2017; Moussa et al., 2016; Musaed et al., 2016; Omer, 2005; Suliman, 2009), no studies have been conducted in the Saudi Arabian hospitals located in the Eastern Province. Also, there is a paucity of qualitative data concerning nurse managers in Saudi Arabia (Omer, 2005; Saleh et al., 2018). Therefore, a mixed-methods research design was included in this study to address this gap in the literature.

3.10 Summary

A summary of the literature reviewed on the concept of leadership and the evolution of leadership theories was provided and also justification was provided for the application of the transformational leadership paradigm in the context of Saudi Arabia. In particular, this chapter has focused on the leadership theories and styles that can be used by nurse managers when managing nurses. The forms of leadership styles that were explored and analysed in this study were the transformational, transactional and laissez-faire leadership models. The

chapter also discussed the leadership outcomes of leader effectiveness, staff satisfaction and willingness to exert extra effort. In addition, it examined leadership practice in multicultural workforces. This chapter also reviewed recent studies investigating the impact of leadership styles on various factors in the Arab region. This chapter provided an overview of the research studies and practices of leadership styles in the Arab region. The review reflected contradicting results in assessing the impact of leadership styles on various dimensions in similar regions. The chapter thus provided a review on various leadership styles practised across various regions; the impact of these styles in relation to various dimensions; and nurses' preferences to the leadership styles in various organisational and social settings. The following chapter provides a more in-depth discussion of conceptual issues and the presentation of the conceptual framework of the study.

Chapter 4: Theoretical Framework

4.1 Introduction

For any workforce, the leadership style adopted by managers is an important factor for successful outcomes. This chapter outlines the full range leadership model as a conceptual basis of identifying the leadership style of nurse managers working at the Saudi Arabian hospitals and assessing the correlation between the leadership style adopted by the leader and organisational outcomes including leaders' effectiveness, job satisfaction and nurses' willingness to exert extra effort. This chapter also presents critique of the full range leadership model and the multifactor leadership questionnaire.

4.2 Theoretical framework of the study

In this study, the conceptual framework used to assess the study variables is based on Bass' (1985) full range leadership theory. The full range leadership theory is one of the leadership theories developed by Bass (1985), which incorporates elements from transformational leadership as well as elements from transactional and laissez-faire leadership. Bass' (1985) conceptualisation of transformational leadership included four factors: idealised influence, inspirational motivation, intellectual stimulation and individualised consideration. Leaders who display transformational factors are able to change their followers' values, help them exceed their performance expectations, and enhance organisational change as discussed in the previous chapter (House & Shamir, 1993; Jung & Avolio, 2000). Bass (1985) sees a transformational leader as one who motivates followers to do more than they originally expected to do. Transformational leaders have a mission and vision for their organisation which help in achieving outcomes and the development of the followers (Bass & Riggi, 2006). When transformational leaders articulate the vision and mission of the organisation, this will enhance followers' understanding of the importance of

the expected outcomes, and raise their performance expectations (Bennis & Nanus, 1985; Conger & Kanungo, 1998; House et al., 1991). Transformational leadership can transform both organisations as well as individuals. by creating a realistic vision and mobilising commitment to these visions (Tichy & Devanna, 1986). Discussion of the development of the full range leadership model and its different components will be presented in this chapter.

4.3 Development of the full range leadership model

Since people are the prime capital of any organisation, leaders in any organisation should focus on influencing this human capital for the benefit of the organisation. Indeed, Bass (1985) and Burns (1978) have developed a leadership theory that instils excellence in leaders to motivate followers to act beyond their original expectations to accomplish organisational outcomes. This theory, called the full range leadership model, has divided the leadership process in to two leadership styles: transactional and transformational.

Transformational and transactional theories were initially mentioned in the social science literature by Weber (1947) and later by House (1977) in relation to the topic of charismatic leadership. In *The Theory of Social and Economic Organization* (Weber, 1947) three types of authority are explained including charismatic authority. Weber (1947, p. 358) defined charisma as:

> a certain quality of an individual personality by virtue of which he is set apart from ordinary men and treated as endowed with supernatural, superhuman, or at least specifically exceptional powers or qualities.

Based on Weber's concept of charisma, House (1977) presents three characteristics of charismatic leaders which include self-confidence, dominance and a strong conviction of the moral righteousness of their mission. In the book *Leadership* (Burns, 1978) transformational and transactional leadership are described as a special form of power. Burns (1978) was the

first to distinguish between transformational and transactional leaders based on motivations of followers of leaders. According to Burns (1978), leaders can be either transformational or transactional but never both.

Bass (1985a) extended the horizon of the concept of transformational leadership from the sphere of needs to the sphere of awareness. Bass posited that transactional and transformational leadership are on a single continuum rather than on different continua (Northouse, 2012). Bass (1985) also expanded and popularised the transformational theory by extending the work of House (1977) on charismatic leadership by focusing on the emotional elements and the source of charisma. Bass suggested that charisma is an important element, but not a sufficient one for transformational leadership (Northouse, 2012). Bass' development of the transformational leadership through incorporating elements from transformational leadership, as well as elements from transactional leadership and laissez-faire leadership helped to shape what is known as transformational leadership theory.

4.4 The transformational leadership theory

The full range leadership theory is one of the leadership theories developed by Bass (1985) which incorporates elements from transformational leadership as well as elements from transactional leadership and laissez-faire leadership. It has been postulated that leaders who display transformational factors are able to change their followers' values, help their followers exceed their performance expectations as well as enhance organisational change (House & Shamir, 1993; Jung & Avolio, 2000). Bass (1985) sees a transformational leader as one who motivates followers to do more than they originally expected to do. Transformational leaders have a mission and vision for their organisation which helps in achieving outcomes and the development of the followers (Bass & Riggi, 2006). When transformational leaders articulate the vision and missions of the organisation, this will

enhance followers' understanding of the importance of the expected outcomes, and raise their performance expectations (Bennis & Nanus, 1985; Conger & Kanungo, 1998; House et al., 1991). Moreover, transformational leadership increases followers' awareness of what is right and significant thereby motivating followers to perform "beyond expectation' (Bass, 1985). As discussed previously, transformational leadership can transform not only organisations but individuals as well by creating a realistic vision, and mobilising commitment to these visions (Tichy & Devanna, 1986). Bass' (1985) conceptualisation of transformational leadership included four factors: idealised influence, inspirational motivation, intellectual stimulation and individualised consideration. The following paragraphs provide descriptions of the four factors of transformational leadership.

4.4.1 Idealised influence (II)

Idealised influence is one of the factors of transformational leadership where leaders become role models who are respected and imitated by followers. These leaders encourage their followers to share common goals and visions by demonstrating a strong sense of purpose with clearly outlined visions (Bass & Avolio, 1997). Charismatic leaders have the ability to build on the followers' needs and values through dramatic words and actions. Their success flows from their charisma however, they must demonstrate effectiveness as a leader and their actions must continue to benefit followers and the organisation (Bass & Riggi, 2006). Bass and Riggi (2006) asserted that charismatics may fail to bring about transformation as it will depend on how their charisma combines with other transformational factors of individualised consideration and intellectual stimulation in specific leaders.

4.4.2 Inspirational motivation (IM)

Inspirational motivation is when leaders inspire and motivate followers by expressing the importance of desired goals in simple ways but with high levels of expectation that provides followers with tasks which are worthwhile and demanding (Bass & Avolio, 1997).

Hence, this form of leadership is often dependent on a leader's ability to articulate a vision. The leaders also enhance their ability to inspire followers by motivating followers to be part of the shared vision (Nwoke, 2010). Leaders who practise inspirational motivation increase the followers' awareness and understanding of common goals by use of simple language and symbolic imagery thereby helping followers to place the interest of the organisation above self-interest (Bass & Avolio, 1994).

4.4.3 Intellectual stimulation (IS)

Intellectual stimulation occurs when leaders stimulate their followers to look at problems, beliefs and values from a new perspective (Nwoke, 2010). When transformational leaders provide intellectual stimulation, this will encourage followers to 'think outside the box' and engage in a generative thinking process (Sosik et al., 1997). This also infuses excellence in followers to have the confidence to provide new ideas as well as creative problem solutions (Bass & Avolio, 1995). Intellectual stimulation is important when an organisation or group faces ill-structured problems. This encourages followers to find new ways to solve old problems whilst looking at difficulties as issues that can be resolved through a logical approach (Bass, 1985).

4.4.4 Individualised consideration (IC)

Individualised consideration is the final factor of transformational leadership where leaders support their followers by listening to each follower's needs and concerns. This means that each member of the team will be treated differently according to their needs and capabilities (Bass & Riggi, 2006). Individualised consideration is the final factor of transformational leadership where leaders support their followers by listening to each follower's needs and concerns. Each member of the team will be treated differently according to their needs and capabilities (Bass & Riggi, 2006). Leaders work as a coach to assist individuals and with a preference for face-to-face and other communication styles that

enhance the followers' capacity and their satisfaction with their leader (Bass, 1985). Through this style of leadership individuals are treated equitably whilst individual differences are acknowledged and paid attention to (Bass & Avolio, 1994).

4.5 The transactional leadership factors

Transactional leadership is mainly based on contingent reinforcement. It is a style of leadership that values order and structure and focuses on supervision, organisation and performance. By contrast, transformational leadership seeks to motivate and inspire followers choosing to influence rather than promoting compliance (Bass, 1990). Both the leader and followers agree on what the followers need to do to be rewarded for making progress toward achieving goals (Bass, 1985). Burns (1978) argues that transactional leadership is an exchange between the leader and follower. Followers receive certain rewards when they act according to the leader's wishes, so a transactional leader motivates the follower to work as expected (Hartog et al., 1997). Bass' (1985) conceptualisation of transactional leadership included three factors: contingent reward, management-by-exception active and management-by-exception passive.

4.5.1 Contingent reward (CR)

The provision of contingent rewards emphasises a particular exchange system that relies on a clear agreement between the leader and the followers to accomplish organisational goals. As the workers provide their effort and time, the leader is then expected to provide rewards founded on the agreement that was established (Riaz & Haider, 2010). With this approach, leaders should be able to clarify goals and expectations as well as offer appropriate rewards and/or recognition in exchange for the accomplishment of tasks and goals. The efforts of followers are therefore rewarded by rewards for good performance and threats and punishment for poor outcomes (Bass & Aviolo, 1997).

4.5.2 Management-by-exception active (MBE-A)

The active approach to management by exception is when leaders use punitive action when subordinates are unable to agree to set standards. Transaction is through regular monitoring of the follower's performance by the leader, with corrective action based on these results (Jamaludin et al., 2011). This style of leadership involves constructive and corrective criticism whilst the leader diligently monitors their followers' performance (Bass, 1985).

4.5.3 Management-by-exception passive (MBE-P)

Leaders who utilise management-by-exception passive only intervene when objectives have not been met or after problems arise (Jamaludin et al., 2011). Hence, this style of leadership is characterised by negative feedback and negative reinforcement (Bass, 1985).

4.6 Laissez-faire or non-leadership factor (LF)

This factor represents the avoidance and absence of eldership, which is the most ineffective and inactive style. This leader avoids making a decision, hesitates taking actions, and is absent when needed. Laissez-faire leadership includes an absence of management practices with total control and responsibility given to followers with no supervision from leaders (Bass, 1997).

4.7 Summary of the full range leadership model

In Figure 4.1, the four transformational leadership style factors (idealised influence, inspirational motivation, intellectual stimulation and individualised consideration) and one transactional leadership style factor (contingent reward) which have been found as the most active and effective leadership behaviours, is placed at the top of the matrix. Contingent reward is placed under the individualised consideration because the former is the less effective of optimising staff performance than the four transformational factors placed above

it. These factors have been positively correlated to three organisational outcomes (job satisfaction, exert extra effort and effectiveness compared to the leadership styles positioned lower on the continuum. Laissez-faire leadership styles and the transactional leadership style factors, management-by-exception passive, are placed at the bottom of the matrix and considered as the most ineffective and passive leadership behaviours. Management-by-exception active is placed above these leadership styles as it is more effective and active than laissez-faire leadership and management-by-exception passive behaviours.

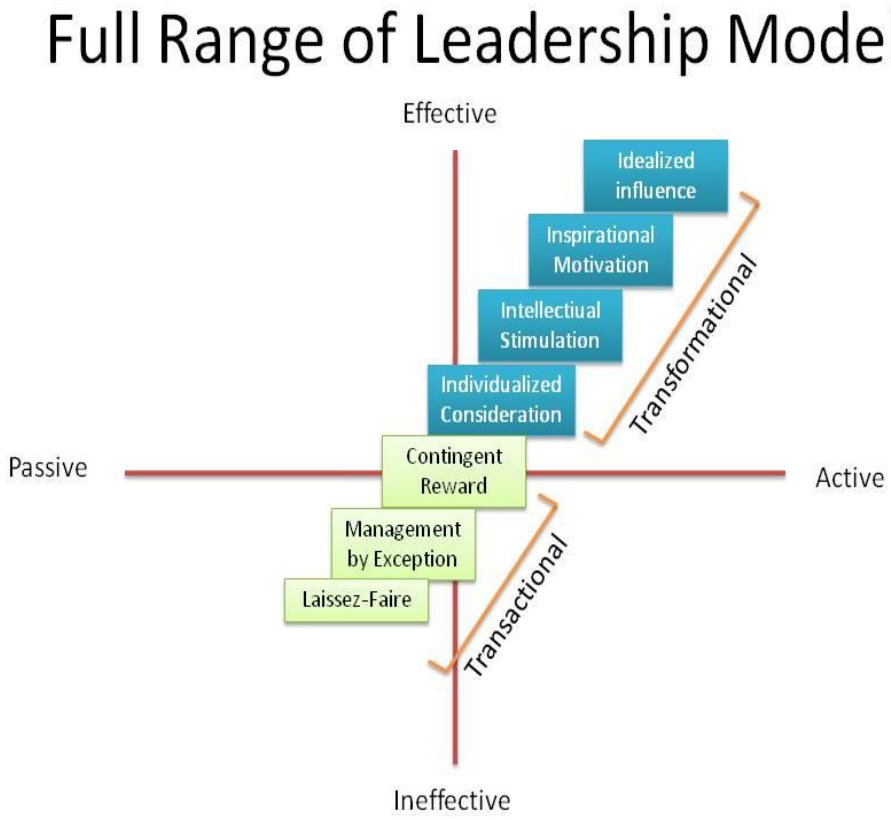


Figure 4.1 Full range leadership model (Source: Bass, 1997)

4.8 The Multifactor leadership questionnaire (MLQ)

Following an appraisal of Bass' (1985) transformational leadership model the MLQ was developed to measure the model. The MLQ measures the various leadership styles within three categories of transactional, transformational and laissez-faire leadership. The MLQ 5X-Short is a revised version of the MLQ which was first developed in 1995 by Avolio, Bass, and Jung (1995). The revision of the MLQ included expert assessment from six leadership scholars who recommended additions or deletions of items, and confirmatory factor analyses (Avolio et al., 1995). Using a large sample of pooled data (n = 1394), preliminary evidence for the construct validity of the MLQ (Form 5X) was provided (Avolio et al., 1995). A later study confirmed the validity of the MLQ 5X-Short using another large sample of pooled data (n = 3786) (Avolio, Bass, & Jung, 1999). This version of the MLQ is a 45-item questionnaire representing the full range of leadership factors and providing description of transformational and transactional behaviours. As the MLQ evaluates the full range leadership model, it also measures the degree to which followers are satisfied with their leader and the effectiveness of leadership styles (Bass & Riggi, 2006).

The MLQ 5X-Short (Avolio et al., 1995) has been used for measurement of the independent variables of this study which are perceived leadership styles of nurse managers as transformational, transactional, or laissez-faire leaders. This instrument has been used to measure the dependent variables for this study of staff willingness to exert extra effort, leader effectiveness and staff job satisfaction. For transformational leadership, the MLQ measures idealised influence attributes and behaviours, inspirational motivation, intellectual stimulation and individualised consideration. Transactional leadership is evaluated through contingent reward management-by-exception active and management-by-exception passive. Twenty items have been provided to ascertain transformational leadership, twelve items for transactional leadership, and four items for laissez-faire leadership. Four items are used to

assess willingness to exert extra effort, two items to assess satisfaction, and four items to assess effectiveness (Avolio et al., 1995). Further description of the MLQ 5X-Short questionnaire (Avolio et al., 1995) is included in section 5.12.2 of this thesis.

4.9 Critique of the full range leadership model

Despite the wide range of positive outcomes associated with the use of transformational leadership in work settings, there are a number of limitations and criticisms in terms of the theory's concepts, evidence, and generalisability that have been identified. A criticism has been that the theory emphasises the two-dimensional nature of leadership that is drawn out from a transformational-transactional perspective. As a result it has been argued that this provides a limited understanding of the complex nature of leadership and organisational behaviours (Alimo-Metcalfe & Alban-Metcalfe, 2005). Such conceptualisation of leadership associates much importance to traditional managerial views of leadership and ruling out other possibilities of leadership conceptualisations. By looking at leadership as either transformational or transactional, other components of organisations including politics, power and influence are greatly overlooked (Alvesson & Willmott, 1992). Power is recognised to be possessed by the leader, with leadership being structured as a range of transformational processes (Jackson, Hutchinson, Peters, Luck, & Saltman, 2013). Such understanding is drawn out from the assumptions relating to organisational cohesion with less attention being directed towards the impact of dissent and opposition on leadership or vice versa (Jackson et al., 2013). Both transformational and transactional explanations do not recognise that the concepts of dissent and opposition are relevant aspects of innovation and change. Hence, these factors potentially impact on their role in performing balanced processes of decision making (Tourish & Pinnington, 2002).

Another criticism of the full range of leadership model is associated with a limitation of the transformational leadership theory. In this instance it is argued that whilst

transformational leaders are expected to act with integrity and demonstrate behaviours aligned with their vision, this does not guarantee that they will act in an unethical manner or focus on personal interests. For example, the study undertaken by Sosika, Juzbasich and Chun (2011) examined managers' moral reasoning and found that although managers deemed themselves as transformational, the majority of them showed low cognitive moral reasoning levels which could result in unethical leadership behaviours. It has also been suggested that transformational leaders may encourage followers to seek immoral or unethical goals depending on their mission, vision and personal motives (Sosika et al., 2011).

An important issue associated with the full range leadership model is the limited research on the avoidance leadership approaches. Due to the reliance on the transformational model there has only been an increased focus on passive laissez-faire avoidance (Cummings, MacGregor, Davey, Lee, et al., 2010). In the nursing environment, there have been few attempts to extensively look into the nature and outcomes of avoidant leadership as well as to identify the contextual components that influence the ability to perform different leadership styles (Jackson et al., 2013). This has been a limiting aspect of nursing leadership literature, specifically in the context of safety and quality-related issues that have underlined the need to address avoidant and ineffective leadership in the healthcare industry (Horwitz et al., 2008).

In addition, gender and cultural considerations may also be lacking in the transformational leadership theory. The conceptualisation of transformational leadership along with its measurement instruments has been drawn out from male populations. This lack of a balanced gender viewpoint in the theory's development therefore, may overlook the female's roles, goals, beliefs and values (Kark, 2004). Additionally, the applicability of the transformational leadership theory to various countries may be limited in such a way that this model and its concepts have been drawn out from largely studies in the USA (Bass, 1997).

Moreover, cultural beliefs and values can have a strong impact on leader attributes and behaviours (Javidan, Dorfman, Sully de Luque, & House, 2006).

Finally, research on transformational leadership and nursing workforce attributes has been prevalent. Such studies have sought to increase the knowledge of the effects of transformational leadership on performance and other work-related outcomes such as job satisfaction and workplace support (Al-Hussami, 2009). A significant limitation of such research however, is that many of these studies focus on examining transformational leadership and work-related outcomes based on data gathered from the same subjects and at the same point in time. This methodology bias may undermine the validity of the results of such studies. Although there have been justifications for repeating research with the use of the same methods and instrument, there are limitations. There is a risk of overlooking other interpretations of leadership which may increase the chances of narrowing instead of expanding knowledge about transformational leadership in the nursing workplace. Furthermore, a number of studies may assert that the predominant nursing leadership is transformation even when the data generated implies alternative options and unclear explanations (Suliman, 2009). With leaders continually recognising themselves as transformational, questions should be raised with regards to the actual behaviours and attributes of these individuals, as opposed to focusing on leader self-reports and perceptions of followers. Moreover, it may be more practical for future studies to consider evaluating the extent of actual leadership behaviours (Harms & Credé, 2010).

4.9 Critique of the multifactor leadership questionnaire

Most research on transformational leadership has involved utilisation of the Multifactor Leadership Questionnaire to measure various aspects of transformational and transactional leadership. Although the MLQ 5X-Short (Avolio et al., 1995) is widely used, the instrument has been criticised in some areas for its conceptual framework (Charbonneau,

2004; Northouse, 1997). Furthermore, and in terms of applicability, the instrument used for the transformational leadership model is mainly based on the accuracy of its underlying subscales (Wilson, 2005). With a lack of clarity in terms of factor structure, research subjects may find it difficult to distinguish the different factors of the transformational subscales. The transformational leadership factor and its subscales are also comprised of more items compared to the other components. This larger number of items in the transformational leadership component may influence the perceptions of subjects and result in more positive ratings. With a larger number of items on the subscale, the greater the likelihood for it to generate favourable ratings (Wilson, 2005).

Another criticism of the MLQ 5X-Short (Avolio et al., 1995) has been the inter-correlation among the transformational leadership items. In addressing this, researchers often aggregate the subscales to generate total scores for transformational, transactional and laissez-faire approaches alike (Suliman, 2009). Researchers in the nursing context have recognised these concerns relating to inter-correlation among subscales in the transformational leadership component of the instrument. However, in other fields it has not drawn considerable attention towards recognising the possible outcomes in terms of generalisability and applicability of research findings.

Tepper and Percy (1994) conducted a study to examine the factor structure of the original MLQ72 item questionnaire with a modified version of 24. Two independent samples were studied, with 290 undergraduates in one group and 95 managers in the other. They found that none of the hypothesised models were confirmed. Results of the study revealed that inspirational leadership factors require improvement due to their relationships to the contingent reward factor (Tepper & Percy, 1994). In another study a confirmatory factor analysis was conducted using the original five-factor model hypothesised by Bass (1985). A sample of 376 nurses was used however as with the study by Tepper and Percy (1994), the

earliest version of the MLQ was used with only transformational and transactional items. Their findings included high proportions of error variance in the transactional scale and high intercorrelations among the transformational scale (Bycio, Hackett, & Allen, 1995). A more recent study completed a content qualitative analysis of 166 articles of the academic journal 'Leadership Quarterly' and found that the MLQ suffered "some shortcomings including lack of consideration of the gender balance, level of analysis and contexts" (Keshtiban 2013, p.1). Keshtiban argued that the MLQ is outdated as leadership should be considered as a broader concept rather than focus on the behaviour of leaders and their relationship with followers. In another study, Alonso, Saboya and Guirado (2010) conducted confirmatory factor analyses using a Spanish version of the MLQ for a sample of 954 participants. The results showed that the following four factors were a better fit for the data than Bass' categories: transformational leadership, developmental/transactional leadership, corrective leadership and avoidant/passive leadership

Nonetheless, Muenjohn and Armstrong (2008) tested three proposed models by confirmatory factor analysis using a multi-data source of 138 cases to measure whether the data from their study confirmed the structural validity of the latest version of the MLQ 5X-Short (Avolio et al., 1995). Two separate samples were studied including 47 leaders and 91 of their direct-reporting staff. Their results revealed that the MLQ 5X-Short (Avolio et al., 1995) adequately captured the full leadership factor constructs of transformational and transactional leadership. Furthermore, Muenjohn and Armstrong (2008) suggested that the full range leadership model (the nine factors model) appeared to be an excellent theoretical construct and representation of the MLQ 5X-Short (Avolio et al., 1995). This was whether it was tested with a small sample as with their study, or a large sample as with the Bass and Avolio (1995) study (n = 1394). The study by Muenjohn and Armstrong (2008) is not supported by previous research (Bycio et al., 1995; Hartog et al., 1997; Tepper & Percy, 1994) however, these

studies have only used a subset of the total items. Most of these targeted only the transformational factors rather than the full range leadership model. Furthermore, the MLQ was tested across various industrial and cultural settings with varying levels of leadership and groupings of raters or leaders that were not homogenous. The study by Bycio et al. (1995) also pooled raters who reported to leaders from different hierarchical levels and leader gender, which potentially may have impacted on patterns of factor correlations of the MLQ.

In a larger study, Antonakis, Avolio, and Sivasubramaniam (2003) included numerous samples with one comprised of 2279 males and 1089 females who evaluated same-gender leaders, and 18 independently gathered samples (n = 6525). Their findings supported the nine-factor leadership model proposed by Bass and Avolio (1997). In a study of 312 doctors in Pakistan, the results revealed that all leadership styles including transformation, transactional and laissez-faire were 'highly relevant' and useful for measuring leadership styles in the healthcare sector in Pakistan (Pahi, Umrani, Hamid, & Ahmed, 2015).

4.10 Summary

This study has focused on the exploration of nurse managers' behaviours on nurses and the impact of their behaviours on nurses' job satisfaction and performance. The full range leadership model is the conceptual framework of this study. This chapter provides an overview of the full range leadership model and described its components, as well as an introduction to the MLQ, an instrument for measuring leadership styles and outcomes. A critique for the full range leadership model and the multifactor leadership questionnaire was also included. The following chapter will provide an overview of the research design and methodology used for this study.

Chapter 5: Methodology

5.1. Introduction

As discussed in Chapter 4, the conceptual framework for this study was based on Bass' (1985) concept of the full range leadership model. A mixed methods research design, utilising characteristics of quantitative and qualitative methods was chosen for this study and will be discussed in this chapter. This chapter focuses on the research study's methodological approach starting with the philosophical assumptions. Further details of the research design are discussed including setting, recruitment, sampling techniques, data collection instruments and procedure and data analysis, rigor and ethical considerations for the study.

A researcher has to design a research study by adopting academically recognised methods to validate the process undertaken in achieving the aims and objectives of the research. Kothari (2004) stated that research methodology explains this process, which is defined as a systematic plan for conducting a research study. A research design should incorporate all the aspects including the philosophical approach, research strategy, research methods, research approach, data collection and analysis techniques, which enables the researcher to conduct the work within the scope of the research boundaries that are set. Saunders, Lewis and Thornhill (2011) proposed the '*Research Onion*' framework as shown in Figure 5.1 which was used to develop the methodology adopted in this study. The research onion framework provides an illustration of the stages that must be reviewed when developing a research strategy. This provides for an effective progression in the design of the research methodology.

In the first stage of the research onion framework the research philosophy requires definition. Research philosophy as such may be defined as the set of beliefs underpinning the area being investigated (Bryman, 2015). Indeed, the justification for how a research project

is conducted is driven by the assumptions created by a research philosophy (Flick, 2015). Furthermore, the choice of a research philosophy is determined by the type of knowledge being investigated in the study (May, 2011). For this research project research philosophies of both positivism and constructivism were adopted. Positivism assumes there is an independent relationship between what is studied and reality. Positivists believe in a single reality which can be measured and are more likely to use quantitative methods to measure this reality (Newman & Benz, 1998). For constructivism, there is a belief of no single reality in that what is observed and may be interpreted in many ways by participants (Östlund, Kidd, Wengström, & Rowa-Dewar, 2011). Constructivists are therefore, more likely to use qualitative methods to explore these multiple realities.

For the research approach for this study, a deductive approach was applied which allows for examination of the observed phenomena with what has been observed with previous research (Wiles, Crow & Pain, 2011). Combined with this an inductive approach was also included which allowed for observations to be a starting point with an opportunity for patterns to be looked for in the data by the researcher (Beiske, 2002). A research strategy of surveys and interviews was adopted which include a choice of a mixed methods approach. From this point, time horizons for the study were developed with consideration of the final stages of the research onion framework including data collection and data analysis.

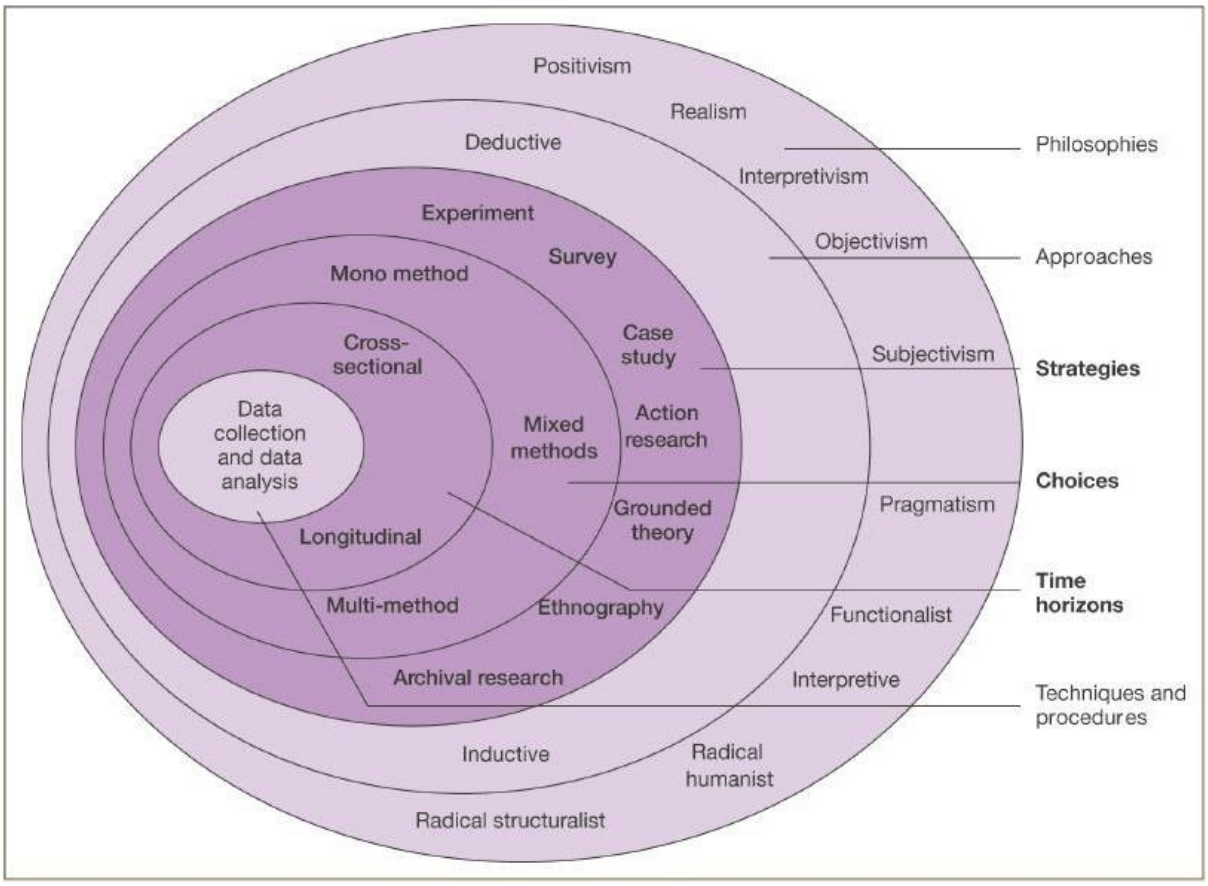


Figure 5.1 Research onion framework (Source: Saunders et al., 2011)

5.2 Philosophical assumptions

The philosophical assumptions as discussed for this study include the description of positivism and constructivism as adopted in the formulation of the research methodology according to the research onion framework. The following is a further exploration of the philosophical assumptions underpinning the choice of the research strategy for this study.

Mixed methods accomplish an "intellectual and practical synthesis based on qualitative and quantitative research" (Johnson, Onwuegbuzie & Turner 2007, p.129). Interpretivist (constructivist) and the post positivist (post empiricist) are the primary philosophical paradigms in mixed methods (Greene & Caracelli, 1997). According to Greene and Caracelli (1997) mixing paradigms will help to strengthen mixed methods research through employing an argumentation perspective. Additionally, by holding both qualitative

and quantitative paradigms “a general acceptance of the legitimacy of multiple philosophical traditions for social inquiry and an opening for inquiries to eschew allegiance to one in favour of taking advantage of social science’s full methodological repertoire” is achieved (Somekh & Zeichner 2009, p.274). This mixed methods study is based on the philosophical underpinnings of pragmatism which has its roots in the post-positivistic and constructivists theoretical perspectives (Creswell & Clark, 2007).

A pragmatic approach, as identified by Datta (1997, p.34), holds that “the essential criteria for making design decisions are practical, contextual, responsive, and consequential”. Rossman and Wilson (1985) were the first to link pragmatism with the mixed methods approach. Likewise, Teddlie and Tashakkori (2003) also associated pragmatism and mixed methods research. There are philosophical variations between methods of inquiry which are “logically independent and therefore can be mixed and matched, in conjunction with choices about method, to achieve the combination most appropriate for a given inquiry problem” (Greene & Caracelli 1997, p.8). According to Creswell and Plano Clark (2007), this worldview relies on the fact that there are singular and multiple realities when answering the research questions which help to provide many perspectives on the subject matter. These authors argued that research and the research problem is what should be used to choose the best paradigm and not the method.

The pragmatism paradigm extracts multiple ideas valuing both subjective and objective knowledge (Creswell & Clark, 2007). According to Creswell and Plano Clark (2007), the objective theoretical perspectives is associated with quantitative research which follows a post positivist (post empiricist) worldview. Objectivism implies that human minds perceive the object as having a true reality. Part of this study is based on the foundation of an objectivistic epistemology, which holds that “things exist as meaningful entities independently of consciousness and experience” (Crotty, 1998, p.5). The ontology of the post

positivist worldview is that there is a singular reality of an object which is neither a creation of social interaction, nor a human mind resulting in culturally influenced interpretation. Interpretivism (constructivism) will be considered the theoretical perspective for qualitative research meaning it is not discovered but constructed. Social constructivists see meaning created as an outcome obtained from the interaction of people with reality while being influenced by their socio-cultural background. Integrating both the qualitative and quantitative worldview will result in pragmatism. This research study followed the inquiry and research paradigm of the interpretivist (constructivist) and the post positivist (post empiricist) (Greene & Caracelli, 1997).

5.3 Approaches

The approach followed in the research is a very important consideration as it defines the research methods utilised (Burney, 2008). There are two major research approaches used widely, which include the:

- Inductive approach.
- Deductive approach.

A deductive research approach works from the more general to specific confirmations, where theories are formulated prior to specific confirmation via hypotheses and observation. An inductive research works from more specific to generalised theories, where specific observations are made to form patterns, and by using tentative hypotheses, generalised theories are formulated (Zarefsky, Bizzarri, & Rodriguez, 2005). This study is designed with multiple objectives focusing on the assessment of human behaviours, which is somewhat predictable, and uses a mixed methods approach. Accordingly, both deductive and inductive approaches were adopted in this study.

5.4 Research design

Quantitative, qualitative and mixed methods designs are the most common methodologies available to support research (Creswell et al., 2003). The selection of the research methods and design is dependent on the research questions and the research problem (Leedy & Ormrod, 2005). Additionally, design of the research, data collection and analysis are determined by the research aims and questions (Tashakkori & Teddlie, 1998). Researchers should understand what information is needed to be obtained. This then forms the basis for the selection of the research design that is best suited for answering the research questions. Researchers must therefore consider the research questions first, followed by the accessibility of the information and finally, whether the data are quantified based on the research design (Newman & Benz, 1998).

Quantitative methods are usually used where the number of participants or sample size in the data collection process is very high, and requires more effective tools like hypothesis testing and statistical methods in the data analysis process. The quality of the data collected using this method could be of poor quality as there are many influencing factors with the size of the sample whether small or large (Saunders et al., 2011). In contrast, qualitative methods are usually used when the number of participants or sample size is low and in situations where there is a need for more specific information. The data collection processes in this method usually involve interviews, direct observations and focus groups as a few examples (Bryman, 2006). The abilities of the researcher, such as knowledge and communication skills, can influence the quality and the type of data collected in the interviews (Saunders et al., 2011). Basically, there are three ways in which interviews can be performed. These are:

- Structured interviews: In this type of interview, the common format includes an interviewer who poses questions and interviewee who answer the questions. The questions and the interview process are pre-planned, and consequently there may be limited scope for out of the script questions to be posed (Turner III, 2010).
- Semi-structured interviews: The semi-structured interviews are more flexible and easy to be answered as it contains both closed-ended and open-ended questions. For closed-ended questions these are often answered by a simple 'yes' or 'no' with specific but often limited information. However, open-ended questions are designed to require a more meaningful answer to encourage and obtain clearer and more elaborate thoughts from the interviewee. Consequently, semi-structured interviews were used in this research to effectively collect the thoughts and views from the interviewee (Turner III, 2010).
- Unstructured interviews: The unstructured interviews resemble an everyday conversation as they are informal, open ended and free flowing. There are no pre-set questions, although there are topics for discussion researchers will have formulated in advance. The interview questions are based on each of the interviewee's responses and proceeds in a friendly and non-threatening manner. Each interviewee is asked a different series of questions and as a result, unstructured interviews may lack the reliability and precision of a structured interview (Gray, 2017).

The choice of a mixed method design for this study provided for important instruments in overcoming the limitations of both qualitative and quantitative mono-method research approaches (Kelle, 2006). This complementary approach for the same research topic can be beneficial rather than considering only one research methodology approach. Integrating both quantitative and qualitative methods therefore may aid in attaining expected

results as the strengths of one method may help to compensate the weaknesses of the other (Kelle, 2006).

5.4.1 Mixed methods design

Mixed methods are often considered as the most effective and efficient in answering research questions rather than mono-methods which using either qualitative or quantitative approaches (Mertens, 2014). As discussed, in a mixed methods approach and design the best of both methods is integrated and captured (Creswell, 2013). For example, in nursing research a large number of people may be surveyed using a quantitative instrument to obtain valid quantitative information. This is then followed up with qualitative interviews to gather participants' specific voice on the topic. By using both techniques, richness in context and understanding can be added to the quantitative inference by aligning these findings with those from a qualitative approach.

In addition, the first study that gave prominence to the value of the mixed method approach was undertaken by Campbell and Fiske (1959). Their study included an exploration of the validation of psychological traits. Campbell and Fiske (1959) advised that their reasoning for choosing a multiple data collection method was to rule out method effects. Despite the fact that Campbell and Fiske focused on mixing multiple quantitative data, their work pioneered the use of mixed methods (Sieber, 1973). This use of mixed methods involving both quantitative and qualitative techniques was later suggested by various authors by using the triangulation term that was borrowed from military naval science (Hanson, Creswell, Clark, Petska, & Creswell, 2005). According to Jick (1979), each method could uncover some unique variance that one single method may have overlooked.

Mixed methods research is formally defined as "the class of research where the researcher mixes or combines quantitative and qualitative research techniques in a single

study or set of related studies" (Johnson & Onwuegbuzie, 2004, p.17). Combining both qualitative and quantitative research approaches has created much interest and debate in the literature and has been used increasingly in nursing research (Foss & Ellefsen, 2002). In other areas of study, Trochim, Marcus, Mâsse, Moser and Weld (2008) evaluated the effectiveness of large research initiatives in the United States federal government by combining both qualitative and quantitative research approaches. Indeed, according to Trochim et al. (2008), their results could not have been accomplished without the use of an integrative mixed-methods approach. The concept of the mixed methods approach is founded on the principles of the quantitative and qualitative approaches which allow the researcher to explore different perspectives through the use of various methods (Creswell, 2013).

One of the reasons for using mixed methods is that it can answer research questions that other methodologies cannot when used individually. This is because quantitative and qualitative research answers different types of questions. Quantitative research questions are confirmatory, whilst qualitative research questions are exploratory (Creswell et al., 2003). Utilising mixed methods therefore, has a major advantage as it enables the researcher to simultaneously answer confirmatory and exploratory questions. Furthermore, quantitative and qualitative research methods are highly relevant in establishing a more detailed and comprehensive perspective. In particular, this includes the detailed information that can be obtained through qualitative methods which can reduce the likelihood of bias that may occur with the use of quantitative procedures (Brannen, 2005). While qualitative research can lead to an extensive examination of the subject this can however, generate bias and subjectivity that can bring about risks to conducting data analysis and generating sound conclusions (Johnson, Onwuegbuzie, & Turner, 2007). Combining these two methods can assist in removing the bias that each method has.

Similarly, using mixed methods provides for situations where some phenomena may require a variety of methods to better understand them. An example is the study of social phenomena which often cannot be fully understood using only one single research method (Cacciattolo, 2015). Hence, a mixed methods approach provides a variety of data sources and methods of analysis to fully understand such complexities. Accordingly, the quantitative survey from phase one for this research project uses a broader perspective of the study's objective of assessing the leadership styles of nurse managers in Saudi Arabia. Whilst as part of the qualitative approach, a more detailed and focused qualitative assessment and analysis is achieved using the interviews of nurse managers.

In relation to surveys that measure leadership, Hunt (1999) discusses that most of them have some limitations. Consequently, Hunt (1999) argued that there is a need to diversify methods that examine leadership such as through the inclusion of interviews. Similarly, Benson (1999) made suggestions toward using mixed methods to gather more comprehensive assessment of leadership. Additionally, Antonakis, Avolio and Sivasubramaniam (2003) made recommendations that future research studies should extend their methods to more fully explore leadership theories beyond survey assessment by combining both quantitative and qualitative approaches. Indeed, many of the surveys used to measure leadership investigate what a leader does with little or no explanation of why. By including a mixed methods approach provides an opportunity to address both the what and the why of leadership behaviours (Crotty, 1998). Also, integrating both approaches assisted in exploring the topic from multiple perspectives and to obtain more meaningful and reliable information (Creswell, Klassen, Plano Clark, & Smith, 2011). Hence, for this study the mixed methods design was utilised to gather quantitative and qualitative data that could help in understanding and interpreting findings related to the research questions.

Despite these identified advantages of using mixed methods, there are some difficulties associated with this approach. Creswell and Garrett (2008) argue that quantitative and qualitative methods should remain independent because of incompatibility and hence, the issues associated with integrating both approaches. In addition, it is not easy to combine both approaches due to the complexities of using different approaches and frameworks. Furthermore, challenges may be encountered if the findings of one method differ from the findings of the other (Salehi & Golafshani, 2010). Nevertheless, according to Risjord, Dunbar and Moloney (2002) using the mixed methods approach increases the accuracy of the research findings. Therefore, if one method is insufficient by itself to address the research problem, the additional use of another method may assist in answering the research questions.

Greene, Caracelli, and Graham (1989) identified five purposes of mixed methods evaluations which are triangulation, complementarity, initiation, development and expansion. Each of these terms has different meanings which describe the ways that mixed methods are used. Triangulation is based on the logic of convergence of results obtained through different procedures. Similarly, complementarity is combining both quantitative and qualitative approaches for the purpose of using the result from one method to enhance the result from the other. On the other hand, development is by using the result of the first method to help analysis for the other method. The intention of initiation is to discover new perspectives. Finally, expansion is to extend the breadth of the research study (Plano Clark & Creswell, 2008).

As previously mentioned, this research study followed the inquiry and research paradigm of interpretivist (constructivist) and the post positivist (post empiricist) (Greene & Caracelli, 1997). Accordingly, the aims and research questions of the research were framed on these paradigms. A mixed method approach involving quantitative and qualitative data

collection methods was therefore, used in this study to obtain comprehensive information for achieving greater validity (Foss & Ellefsen, 2002).

5.4.2 Types of mixed methods designs

There are a number of ways that a researcher can use mixed methods. Figure 5.2 illustrates four major mixed methods designs that a researcher might utilise in conducting research which include:

- Triangulation design: This is one of the most popular and well-known of the mixed method designs. The purpose of the Triangulation Design is to understand the research problem by obtaining "different but complementary data on the same topic" (Morse, 1991, p.122). In this design, quantitative and qualitative data are collected and propriety of data is equally distributed between both approaches. This may include directly comparing and contrasting quantitative results with qualitative findings or validating or expanding quantitative data with qualitative results (Creswell et al., 2003).
- Explanatory design: This design method is characterised by collection and analysis of quantitative data followed by a collection and analysis of qualitative data. The qualitative results are then used to assist in the interpretation and explanation of the quantitative data (Creswell et al., 2003).
- Exploratory design: For this approach, the results of the first method (qualitative) can help develop or inform the second method (quantitative). As this research design begins qualitatively it is most suited for exploring a phenomenon (Creswell et al., 2003), or useful in the development or testing of an instrument when one is not available (Creswell, 1999; Creswell, Fetters, & Ivankova, 2004).

- Embedded design: This design is similar to the concurrent triangulation design. However, either a qualitative or a quantitative method is dominant and guides the conduct of the research. Hence, one data set provides a primary role whilst the second data set provides a supportive, secondary role in the study (Creswell et al., 2003).

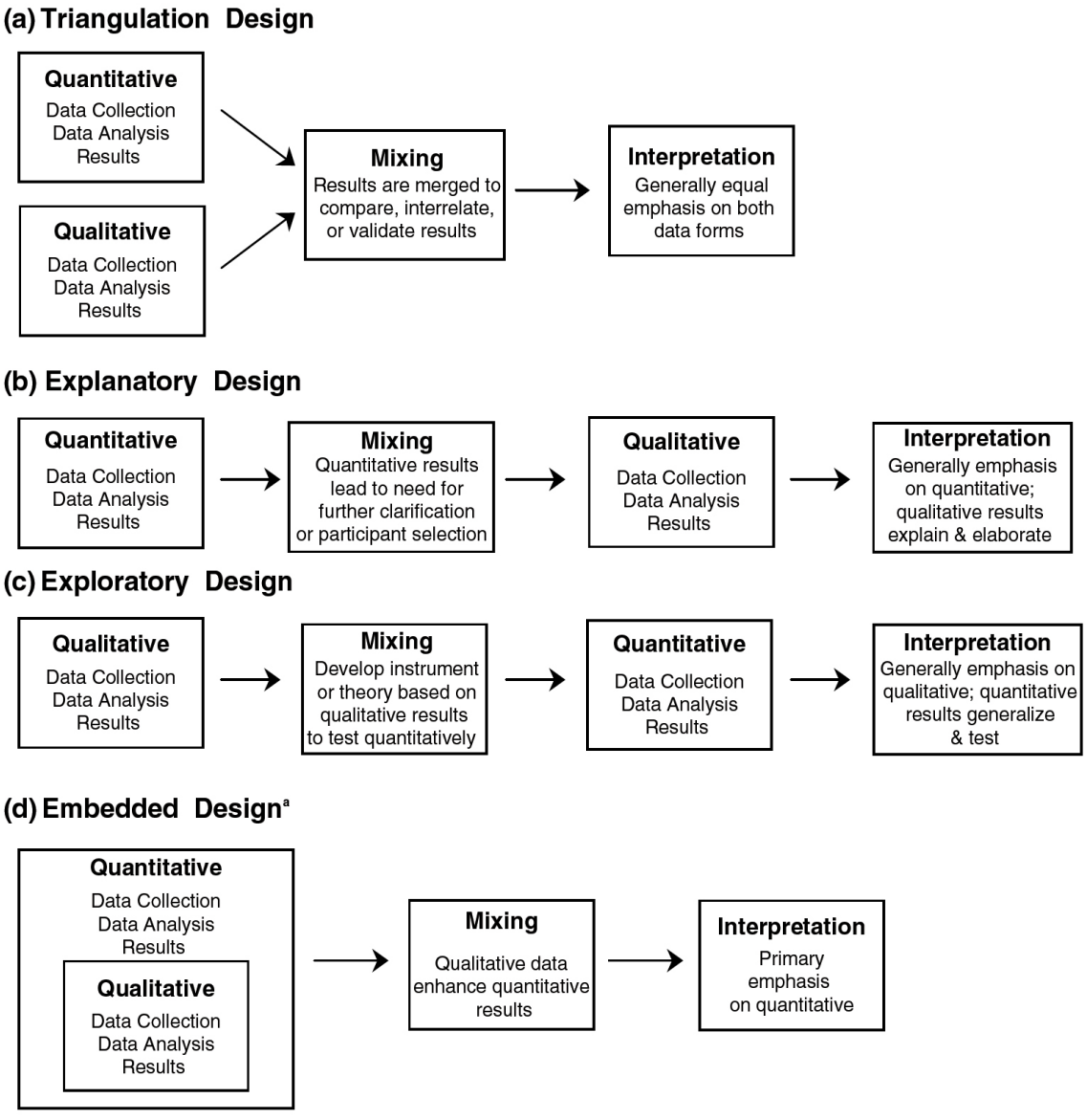


Figure 5.2 Major mixed methods designs (Source: Creswell, 2013)

5.4.3 Concurrent nested design

The design of this study is based on the concurrent nested strategy for a mixed method approach (see Figure 5.3) (Creswell, 2013). This concurrent nested design is similar to the concurrent triangulation design through the collection and analysis of both quantitative and qualitative data (Creswell & Clark, 2007). However, there are two data collection methods for concurrent nested strategy with one method embedded within the other (Hanson et al., 2005). For this study, priority was given to the quantitative data and analysis in guiding the project, whilst the qualitative data and analysis was the 'nested' method. This approach was adopted as it provides an opportunity for new insights or more refined thinking (Creswell et al., 2011). Indeed, the researcher used this design to gain a broader perspective than could be gained if only a single data collection method was used. For this study, the concurrent nested strategy also helped to address the various research questions and to garner information from different groups within an organisation.

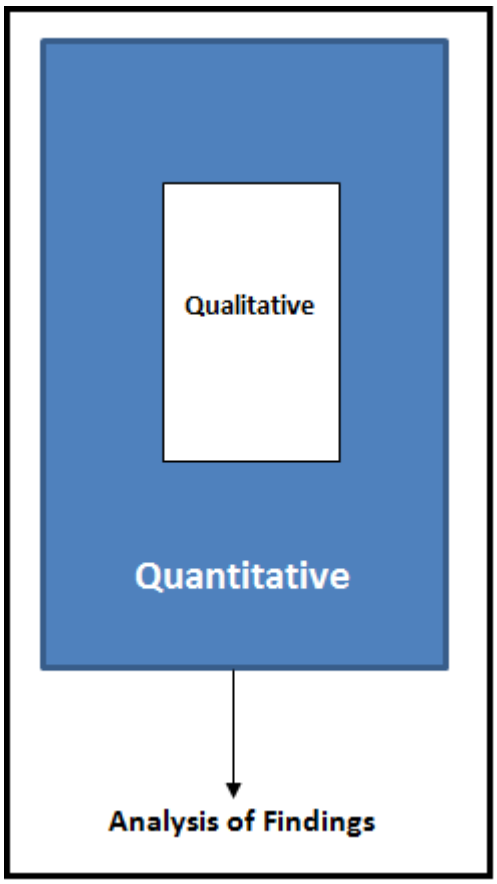


Figure 5.3 Concurrent nested design

The concurrent nested approach for this study was conducted in two phases. The quantitative phase was based on Bass' (1985) full range leadership model, using a non-experimental questionnaire instrument, called the Multifactor Leadership Questionnaire MLQ 5X-Short (Avolio et al., 1995) (see Appendix C). This instrument was used to measure transformational, transactional and laissez-faire leadership styles. The qualitative data was collected through semi-structured face-to-face interviews Semi-structured interviews involve asking a number of questions about which the researcher is trying to reveal information about the area of research interest (Mathers, Fox, & Hunn, 2002).

This nested design means that the embedded method addresses different question than the one that would be addressed by the dominant method, whilst also seeking information

from different levels. The data collected from the qualitative and quantitative method are analysed simultaneously during the analysis phase of the research. Researchers often use this design to serve a variety of purposes as using this design helps the researcher to gain broader perspectives (Creswell et al., 2003). Likewise, a primarily qualitative design could embed some quantitative data to enrich the description of the sample participants (Morse, 1991).

There are some limitations associated with the concurrent nested design. One of the limitations includes the transformation of the data from both quantitative and qualitative approaches so that the data may be appropriately integrated within the analysis phase of the research (Onwuegbuzie & Collins, 2007). Additionally, there is little written to guide a researcher on how to deal with discrepancies that occur between quantitative and qualitative data. Also, quantitative and qualitative approaches are unequal in their priority in nested design and this may be considered as a disadvantage when interpreting the final findings (Onwuegbuzie & Collins, 2007). Trying to view the qualitative and quantitative results as of equal value may therefore be difficult.

5.5 Strategy

The way a researcher collects and analyses the data is identified from the research strategy adopted. The reality or the factors from the real world like case studies, surveys or observations are used in collecting the data related to the study which can be analysed to evaluate the findings (Saunders, 2011). As this study adopts mixed methods, both survey instruments and interviews were used as strategies for collecting the data.

5.6 Aim of the study

The aim of this study was to investigate the leadership styles of nurse managers working in hospitals in the Eastern Province of Saudi Arabia. This study aimed to examine and explore the leadership styles of nurse managers as perceived by nurses and nurse

managers. In addition, the study assessed the relationship between nurses and nurse managers perceived leadership style to three organisational outcomes: effectiveness, job satisfaction, and willingness to exert extra effort.

5.7 Research questions

The research questions for this study in relation to hospitals in the Eastern Province of Saudi Arabia were:

1. What are the self-reported leadership styles of nurse managers?

2. What are nurses' reported perceptions of leadership styles of nurse managers?

3. Is there a relationship between leadership styles of nurse managers and nurses' job satisfaction and willingness to exert extra effort?

4. Is there a correlation between nurse managers' leadership styles and their effectiveness?

5. Is there a significant difference between how nurse managers perceive their leadership styles to that of nurses' perception of their managers' leadership styles?

6. Is there a significant difference between demographic characteristics and the leadership styles of nurse managers?

5.8 Study setting

Both phases of this study were undertaken in six hospitals within the Eastern Province of Saudi Arabia. An overview of the context of Saudi Arabia is discussed in Chapter 2. Each hospital was given a code for easy identification and to protect privacy. These have been named as hospitals A, B, C, D, E and F.

5.9 Sample and sampling technique

Sampling is "the selection of a fraction of the total number of units of interest by decision makers for the ultimate purpose of being able to draw general conclusions about the entire body of units" (Parasuraman et al. 2006, p. 356). The process deployed in identifying and obtaining the sample for this study was according to the guideline specified by Churchill and Iacobucci (2002) as show in the Figure 5.4 below:

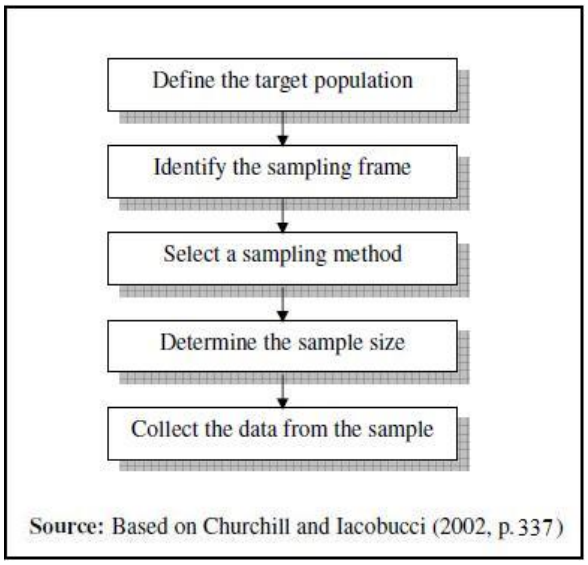


Figure 5.4 Sampling process

The sampling method employed for this study was convenience sampling. Convenience sampling is one of the more popular and widely utilised sampling methods. It is also called availability sampling, haphazard sampling or accidental sampling, and is considered to be one of the non-probability sampling methods (Saunders et al., 2011). The method is usually used when certain practical criteria, such as accessibility, geographical proximity, availability at a given time or the willingness to participate are met (Dornyei, 2007). Convenience sampling is affordable and easy to implement when the subjects are readily available (Saunders et al., 2011). Saunders et al. (2011) identified various advantages

of the convenience sampling method which include the simplicity of the technique and the associated ease of research. Furthermore, convenience sampling is helpful for undertaking pilot studies and for hypothesis generation, as well facilitating data collection in a shorter duration of time. Disadvantages of convenience sampling include that it is highly vulnerable to selection bias and influences beyond the control of the researcher, and not excluding high levels of sampling error (Saunders et al., 2011).

In contrast, random sampling may be difficult to achieve due to the variability in the number of nurses or nurse managers or inequality of their demographics or characteristics across study hospitals. In comparison, convenience sampling is a type of sampling which achieves good representation of a population who are available and accessible, whilst providing results with minimum cost or time (Saunders et al., 2011).

5.9.1 Inclusion and exclusion criteria

All eligible nurses and nurse managers were invited to participate in this study. Any nurses and nurse managers who worked in any of the mentioned hospitals (A, B, C, D, E and F) and who met the following inclusion criteria were subsequently invited to participate:

- Registered nurses and nurse managers.
- At least one year of work experience as a nurse/ nurse manager.
- Able to speak and read English fluently.

Any nurse and nurse managers who did not meet the inclusion criteria were excluded from the study including non-registered nurses such as nurse-assistants.

5.9.2 Sample size

To avoid bias and to ensure representativeness of each of the study settings, a clustered technique for the sampling strategy was used. The sample size obtained from each

selected hospital was therefore decided in accordance with the size and number of total nurses and nurse managers in each hospital. Consequently, all nurses and nurse managers in each hospital were recruited. As a result, the sample percentages were 93%, 16%, 39%, 3%, 9% and 7% for hospitals A, B, C, D, E and F, respectively.

5.10 Recruitment

The recruitment process commenced in June 2015 and concluded in September 2016. After obtaining all ethical approvals (described in more details later in this chapter), the data collection procedure was completed as follows:

- Formal letters of approval for conduct of the research study were sent to medical directors at the selected six hospitals from the MOH (Research & Studies Affairs Unit) located in the Riyadh Province.
- Upon receipt of the approval letters, the medical directors notified the nursing directors for each of the six selected hospitals. The researcher then contacted the nursing directors in each hospital to provide information about the research including purpose of the study, the two phases included in the study, data collection instruments and inclusion criteria. The steps required to complete Phase One (quantitative data collection) and Phase Two (qualitative data collection) of the study were agreed upon including questionnaire distribution to nurses and nurse managers for Phase One, and facilitation of meetings with nurse managers for Phase Two of the data collection process.
- Following this, the researcher contacted the assistant nursing directors in the selected hospitals who helped the researcher with the questionnaire distribution for Phase One. The assistant nursing directors for each hospital delivered the invitation letter to all invitees (see Appendix D). Subsequent to

this meeting, the assistant directors informed the nurses and nurse managers in the different wards about the research and encouraged their participation.

- Research packages were left in each ward for distribution including a written invitation in the form of a letter, a plain language statement (Appendix D) and the questionnaires (Appendix C).
- Participants were advised that participation in the study was voluntary. They were also informed about their right to withdraw from the study prior to completing the questionnaire or right to refuse to answer any question. In addition, they were also advised that the data would be aggregated and impossible to remove once the questionnaire had been submitted.
- To assist in their decision to participate in the study, each participant was encouraged to examine the questionnaire carefully prior to the completion of the survey. As the questionnaire was anonymous, consent was implied by submission of the questionnaire.
- Participants were asked to return the questionnaire in a sealed, stamped, self-addressed envelope that was provided or to submit the completed questionnaires in a locked return box located at the nursing management office of the hospitals included in the study.
- A time period of two weeks was provided for nurses and nurse managers to complete and submit the questionnaire with a reminder notice posted on the staff notice board following this time.
- Once collected, the questionnaires were screened, checked, coded and prepared for analysis.
- For Phase One and Two of the study, recruitment of participants ran concurrently. Following completion of the survey all nurse managers were

provided with an extended invitation to participate in a face-to-face interview to discuss their experiences of the culture of leadership. If they agreed to be interviewed, the nurse managers were asked to provide their contact details at the end of the survey.

- For Phase Two of the study, the researcher then contacted these nurse managers by email inviting them to participate in this phase of the study. Included in the email was the plain language statement (Appendix E) and consent form (Appendix F). Face to face interviews were undertaken at a mutually agreed upon time and place.
- Once the arrangements were made for the interviews, the participants were each allocated codes for data collection and analysis.

5.11 Variables of the study

The dependent, independent and confounding variables in this study are shown in Figure 5.5. The independent variables of the study were nurse managers' perceptions of their own leadership style and nurses' perceptions of their nurse managers' leadership style. These two independent variables were measured using three leadership styles which included transformational, transactional and laissez-faire which were further divided into five, three and one factors, respectively. The dependent variables of the study were the three organisational outcomes of leadership: leaders' effectiveness, staff job satisfaction and staff willingness to exert extra effort. The confounding variables of the study were age, gender, nationality, level of education and years of experience.

This study employed two different instruments to collect data from the participants. These instruments are discussed in the following sections.

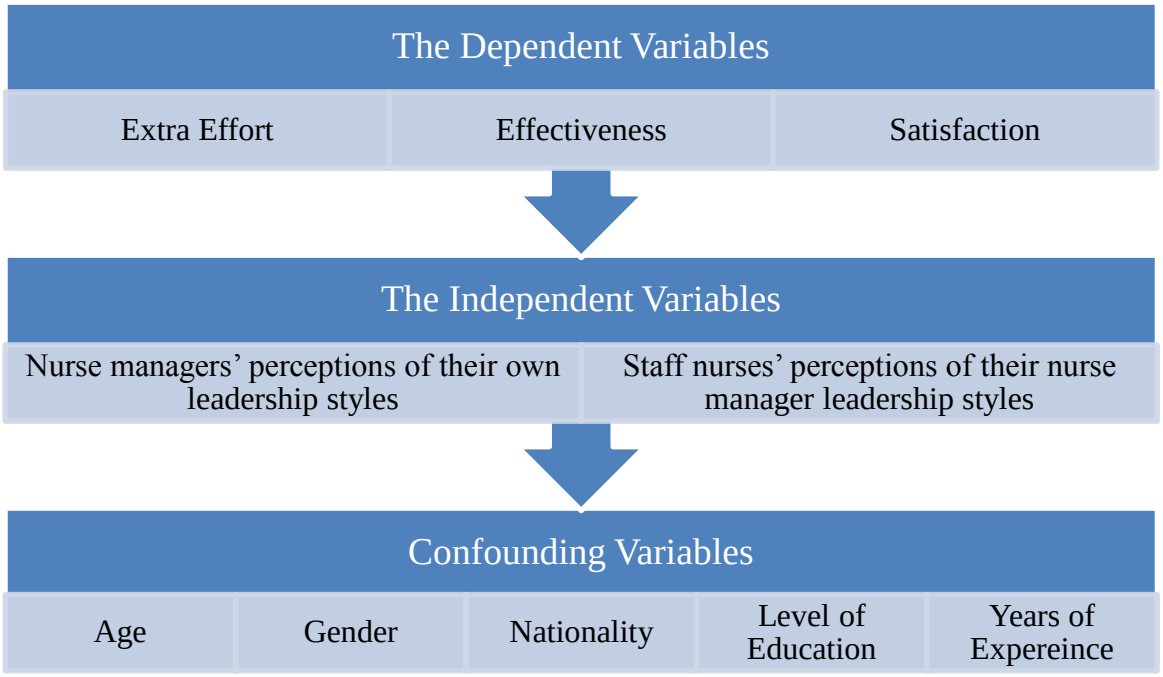


Figure 5.5 Variables of the study

5.12 Phase One: Quantitative study

The two instruments used to collect data from participants included a demographic survey and the MLQ 5X-Short (rater form and self-rate form) (Avolio et al., 1995). Both the demographic survey and the MLQ were in English as Saudi and some expatriate nurses and nurse managers use English as a common language.

5.12.1 Demographics

The demographic survey was developed by the researcher to collect background information on both the nurse managers and the nurses (see Appendix G). This instrument included data on selected demographic characteristics of the participants such as their age, gender, nationality and highest level of education, as well as professional information including years of experience. Nurse managers were also asked whether they held any formal management qualifications or had participated in any training concerning leadership or management.

5.12.2 The Multifactor leadership questionnaire

A questionnaire based survey was conducted in Phase One of this study to assess the leadership styles of nurse managers. The MLQ 5X-Short was used and is a comprehensive questionnaire survey developed by Avolio et al., (1995). The MLQ has gone through several reviews and modifications to make it more comprehensive which has resulted in the version called MLQ 5X-Short (Avolio et al., 1995). In this revised form, the MLQ measures 12 factors of the full range leadership model (five transformational, three transactional, one laissez-faire), as well the outcomes of leadership. This questionnaire contains 45 items representing leadership style factors including twenty questions covering the five factors of transformational leadership (idealised influence attributed, idealised influence behavioural, inspirational motivation, intellectual stimulation, and individualised consideration), twelve questions covering the three transactional leadership factors (contingent reward, management-by-exception active and management-by-exception passive), four questions covering laissez-faire leadership and nine questions covering three organisational outcomes. The three organisational outcomes include effectiveness, job satisfaction, and extra effort (four items are used to assess willingness to exert extra effort, two items to assess satisfaction, and four items to assess effectiveness).

The 45-item questionnaire asks both the managers and nurses to rate the frequency of behaviours and actions of the leader on a 5-point Likert scale from 0 (not at all) to 4 (frequently, if not always). The researcher gained permission to utilise the MLQ instrument from the original authors (see Appendix H). The MLQ 5X-Short is owned and copyright protected by Mind Garden, Incorporated of California (Avolio et al., 1995). The researcher was also required to pay a fee for each MLQ questionnaire used in the study. Table 5.1 shows the distribution of MLQ items for each of the three categories of leadership styles and outcomes.

Table 5.1 Distribution of the MLQ items (Source: Avolio at al., 1995)

MLQ Subscales	Number of Items	Question # in the MLQ
Transformational leadership factors:		
1. Idealized Influence-Attributed (II-A)	4	10,18,21,25
2. Idealized Influence-Behavior (II-B)	4	6,14,23,34
3. Inspirational motivation (IM)	4	9,13,26,36
4. Intellectual Stimulation (IS)	4	2,8,30,32
5. Individualized Consideration (IC)	4	15,19,29,31
Transactional leadership factors:		
1. Contingent reward (CR)	4	1,11,16,35
2. Management by exception-Active (MBE-A)	4	4,22,24,27
3. Management by exception-Passive (MBE-P)	4	3,12,17,20
Laissez-faire (LF)	4	5,7,28,33
Extra Effort (EE)	3	39,42,44
Effectiveness (EFF)	4	37,40,43,45
Satisfaction (SAT)	2	38,41

The MLQ 5X-Short (Avolio et al., 1995) collected data on the independent variables of this study which were leadership styles of nurse managers as transformational, transactional, or laissez-faire leaders. The instrument also measured the dependent variables of staff willingness to exert extra effort, leader effectiveness, and staff job satisfaction. As the MLQ 5 X-Short short evaluates the full range leadership model, it also measures the degree to which followers are satisfied with their leader and the effectiveness of leadership styles (Avolio et al., 1995).

There are two forms of the MLQ. The first is the self-rater form referred to as the MLQ 5 X-Short Leader which for this study nurse managers used to rate themselves. The second is a rater form referred to as the MLQ 5X-Short Rater, which nurses for this study used to rate their nurse managers. The questionnaire is the same for both forms but one is directed to the managers and the other is directed to the nurses (Avolio et al., 1995).

5.12.3 Validity and reliability of the MLQ

Validity refers to the accuracy of a measurement tool (Creswell et al., 2011), whilst reliability denotes the consistency of the measurement conducted (Robson, 2002). Cronbach's α is generally used to measure reliability (Creswell et al., 2011). If an instrument is measuring what it is likely to measure it will attain an α score close to one (Hanson et al., 2005).

For the MLQ, the reliability and validity of the factor structure of this instrument has been tested rigorously. In a study including 3786 respondents, Avolio et al. (1999) established the reliability for each of the leadership and outcomes factors for the MLQ 5X-Short (Avolio et al., 1995). The study was a larger and more heterogeneous population than any prior research of the MLQ. It included 14 independent samples varying in size from 45 to 549 respondents from the USA and other international firms and agencies. Furthermore, due to the size of the study by Avolio et al. (1999), it provided an opportunity to include a more comprehensive examination of the factor structure of the MLQ. Avolio et al. (1999) reported the reliability was relatively high for the MLQ with the Cronbach alpha reliability coefficients ranging from 0.63 to 0.92.

In another study, using confirmatory factor analysis and responses from nine diverse samples of 2154 respondents, Bass and Avolio (2004) demonstrated that the MLQ reliably measured each of the leadership factors across the nine data sets. From their study, Bass and Avolio (2004) confirmed that the MLQ tool exhibited high internal consistency. Antonakis et al. (2003), who tested the MLQ on a large pool of 6525 respondents with integration of 18 independent studies from different cultures, also confirmed the validity of the MLQ. Further evidence of the validity and reliability of the MLQ instrument is the wealth of studies it has been used in including over 500 doctoral dissertations in the years between 1995 and 2004 alone, along with several constructive outcomes for transformational leadership (Avolio &

Bass, 2004). The MLQ instrument has also been used in numerous nursing research studies of leadership styles (Aboshaiqah et al., 2014; Alshammari, 2014; Casida & Pinto-Zipp, 2008; Kleinman, 2004; Morsiani, Bagnasco, & Sasso, 2017; Omer, 2005).

5.12.4 Content validity

A panel of experts was established to validate the content of the questionnaires for use in Saudi Arabia. Members of the panel included PhD supervisors and specialists in research methodology. Selection of panel members was made through the researcher's professional network and on the basis of members' expertise in research and work experience in Saudi Arabia. The panel assessed the clarity of the questions used in the instruments including any concerns as to the words used and whether the instruments were relevant and acceptable for the population of the study. From this, it was determined that the questionnaires were suitable to use within the Saudi Arabian cultural context without the need for any changes or deletion of any items. Following this process, the questionnaires were then tested in a pilot study.

5.12.5 Pilot study

A pilot study is commonly undertaken to ensure validity of questionnaires or survey tools and for the identification of any items which may be misinterpreted by participants (Creswell, 2013). For this study, the pilot study included three of the original sample of nurses and nurse managers who fulfilled the inclusion criteria. The purpose of the pilot was to also assess how long it would take to complete the questionnaires, including clarity of the wording of the questionnaires. Two nurses and one nurse manager were recruited from one hospital in Saudi Arabia with employment of the same method of recruitment as used for the larger study. All participants for the pilot study were required to have satisfactory skills in English including reading and writing to ensure they could adequately review the instruments. The participants were requested to provide feedback as to the time to complete

the required questionnaire, clarity of the questions, suitability and applicability of the questions for Saudi Arabian culture. As per the findings of the pilot study, the questionnaires were easy to answer, required a maximum of 20 minutes to complete and the instruments were appropriate for Saudi Arabian culture. Based on these results, no changes were made to the questionnaires that were used for the larger study. The responses from the pilot study were not included in the analysis for the main study sample.

5.12.6 Data collection

Nurses from across the six hospitals in the Eastern Province of Saudi Arabia participated in the study. Participants included Saudi nationals and expatriates. The questionnaire package was distributed to 600 (nurses) participants across the six hospitals and the overall response rate was 47.2%.

The questionnaires packages were also distributed to 225 nurse managers across six hospitals, out of which a total of 121 nurse managers participated in the study. Participants included Saudi Arabian nationals and expatriates. The overall response rate from the six hospitals for nurse managers was 53.7%. This phase of data collection was important as it allowed nurse managers to assess their own leadership style.

5.13 Phase Two: Qualitative study

Phase Two of the study included face-to-face interviews to gain an understanding of nurse managers' perceptions of leadership styles and outcomes. Interviews as a data collection tool are commonly used in health sciences which permit participants to provide more detailed information (Creswell, 2013). The interview questions were developed by the researcher and were based on an extensive literature review and the results from Phase One. These questions were then used as a guide to conduct the interview (see appendix I for the

interview guide). Prompting or clarifying questions were then added during the interview to elicit more information.

5.13.1 Content validity

The same expert panel utilised for Phase One of the study were utilised to validate the interview questions used for Phase Two. The panel assessed the clarity of the interview questions and from this it was determined that the interview questions were suitable for use within Saudi Arabian culture. Following this process, the interview questions were then tested in a pilot study.

5.13.2 Pilot study

To pilot test Phase Two, a nurse manager from the same group who pilot tested the questionnaires was employed. From this interview the estimated time for the length of interviews was confirmed (45 to 60 minutes). As the questions were found to be clear and engaging during the pilot test, no structural modifications to the interview questions were made. However, the pilot interview did assist the researcher in refining their interview technique and process.

5.13.3 Data collection

For this study, the semi-structured interviews were based on open-ended questions which were designed to gather information about the nurse managers' experiences of the culture of leadership within the Saudi Arabian hospitals. Face-to-face interviews were held with 21 managers who had varying amounts of nursing experience and worked at different management levels. The researcher conducted the interviews following the same format with each lasting from 30 to 60 minutes.

Once arrangements were made for the interviews, the participants were each allocated codes for data collection and analysis and to ensure the anonymity of each of the nurse managers. Participants were required to sign a consent form prior to participating in the interview. The time and place of the interviews was arranged based on the most convenient time for the nurse managers, with the majority of interviews held at nurse managers' offices. Interviews were undertaken by the researcher in English as this is a language commonly spoken in the selected hospitals for both Saudi and expatriate nurse managers. All interviews were audio recorded and transcribed verbatim by the researcher.

5.13.4 Data saturation

In relation to sampling, an important feature to consider is saturation which refers to the repetition of new or discovered information and the confirmation of data previously collected (Morse, 2003). Saturation is achieved at the point the researcher determines the repetitive nature of the data (Speziale, Streubert, & Carpenter, 2011), although there is some query in the literature as to whether saturation exists and may be a myth (Morse, 2003). According to Polit and Hungler (1999), saturation is the process of collecting data to the point that a sense of closure is attained where data categories become repetitive and no new information can be gleaned by further data collection. For this study, there were 21 participants and data saturation was reached at interview 16 and 19. The researcher decided to proceed with all 21 interviews to gain additional information.

5.14 Phase One: Quantitative study

The quantitative data analysis for Phase One of the study was undertaken in several stages as explained in the following sections.

5.14.1 Data coding, entry and cleaning

The participants' responses from the questionnaires were manually coded using a codebook as a guide (Pallant, 2011). The researcher then entered responses into the IBM Statistical Package for Social Science (SPSS) version 22 software package. A number of questionnaires were checked by the researcher for entry errors. Following this, the data were screened and cleaned using the IBM SPSS version 22 software package. Any missing data were deemed to be a random occurrence and these missing scores were replaced by mean values for each variable (Tabachnick & Fidell, 2007).

5.14.2 Descriptive statistics

Descriptive analysis of the demographics and characteristics of the respondents was completed. Frequencies and percentages, as well as descriptive summary measures such as means and standard deviations, were used to summarise each of these variables including age, gender, nationality, highest level of education and length of nursing experience. For nurses and nurse managers, there were other demographic variables collected and analysed including management qualifications and leadership training. Descriptive analysis of the aggregate scores for each of the subscales of the MLQ 5X-Short questionnaire (Avolio et al., 1995) was also completed. Frequencies, percentages and measures of central tendency were generated for each of the subscales for both nurses and nurse managers.

5.14.3 Inferential statistics

The item reliability for each of the subscales of the MLQ questionnaire was initially analysed. Cronbach's α coefficients were generated for each of the subscales for both nurses and nurse managers. To assess for differences in leadership styles, one-way analysis of variance (ANOVA) or independent sample *t*-test were used across demographic variables. Correlation analysis was conducted to identify the correlation of nurses' perceived leadership style of their nurse managers and the three outcomes (extra effort, effectiveness and

satisfaction). The IBM SPSS version 22 software package was used for the statistical analysis of the results for this study.

5.15 Phase Two data analysis

The Phase Two or qualitative data analysis process involved making sense of the text data. It involved conducting an analysis, developing an understanding of the data and making an interpretation of the larger meaning of the data (Creswell, 2013). Interviews were transcribed into text in their entirety because 'each word a participant speaks reflects his or her consciousnesses and the 'participants' thought become embodied in their words' (Seidman 1998, p. 98). Each transcript was checked with the original recording of the interview by another person to ensure accuracy of the recordings by the researcher. Transcripts were read and re-read to identify emerging themes and these then were checked for correctness by seeking expert opinions from members of the supervisory team. This process continued with all of the transcripts and gradually labels were attached to the emerging themes (Raymond, 1992).

5.15.1 Thematic analysis

Thematic analysis was used to analyse the interview which focuses on identifiable themes and patterns of living and/or behaviour (Braun & Clarke, 2006). According to Boyatis (1998, p.4) thematic analysis is "a process for encoding qualitative information". Qualitative data are classified into patterns and categorised into major themes and subthemes (Aronson, 1995). p.4) thematic analysis is "a process for encoding qualitative information". For this study, the simple thematic analysis offered by Graneheim and Lundman (2004), Patton (2002) and Akhaven and Lundren (2012) were followed to identify relevant responses and commonality among the different interviews conducted. Themes were developed by identifying recurrent patterns from the data and then organising them into groups through a

process of inductive reasoning and deductive reasoning, allowing for the identification of similarities between responses (Patton, 2002). This process included for each interview, reading and re-reading the interview transcripts to identify themes that were relevant to the purpose and topic of the study (Akhaven & Lundgren, 2012). The researcher identified, coded, and categorised the patterns that emerged from the data following this thematic analysis process (Patton, 2002). Accordingly, coded responses were grouped according to content into various thematic categories (Akhaven & Lundgren, 2012). Further review and comparison of the thematic categories resulted in the development of the overall themes and conclusions which were representative of the different perceived elements for the group of participants of the study (Graneheim & Lundman, 2004).

5.15.2 Research rigour

Many strategies have been proposed in the literature to assess the trustworthiness or rigour of research data and findings. This study used the four criteria proposed by Lincoln and Guba (1985) namely, credibility, transferability, dependability and conformability, to test the rigor and trustworthiness of qualitative data which are described as:

- Credibility: It is one of the important aspects to establish trustworthiness. It essentially asks the researcher to clearly link the research study's findings with reality in order to demonstrate the truth of the research study's findings (Thomas & Magilvy, 2011). Two approaches (Noble & Smith, 2015) were implemented in this study to ensure the credibility of the findings: 1) utilising strategies to enhance the believability of the findings; and 2) providing evidence of credibility. The three techniques (Shenton, 2004) that were used by the researcher to achieve this were: prolonged engagement, mixed method and peer debriefing. These techniques are described as follows:

1. Prolonged engagement is where the researcher needs to have an in-depth and thorough knowledge of the cultural setting of the site in which the data will be collected, and has a relationship of trust with the study participants through their willingness to discuss various aspects of the research with the participants and answer their questions (Lincoln & Guba, 1985; Thomas & Magilvy, 2011). For the present study, the researcher spent large amounts of time engaging with the various hospitals' working environments whilst studying the various religious and cultural backgrounds of the nurse managers'. In addition, any relevant issues surrounding the nurse managers were examined by the researcher to assist in their understanding of the qualitative data collected and maximise credibility of the findings.
2. Mixed Method is where the researcher used multiple methods of data collection to increase the likelihood that the research findings would be credible (Lincoln & Guba, 1985; Thomas & Magilvy, 2011).
3. Peer debriefing is where the researcher included a discussion session with one objective peer to discuss and review the research to assess the external validity of the process (Lincoln & Guba, 1985; Thomas & Magilvy, 2011).

- Dependability: This study used an inquiry audit to demonstrate the stability of the data over a period of time and under particular conditions. The inquiry audit was conducted with the participation of the supervisors which evaluated the research methodology in terms of consistency and if any recommendations for modification or improvement were required (Lincoln & Guba, 1985). For the present study, no recommendations for modification or improvement were made.
- Conformability: This is a process to verify that the findings are shaped by participants more so than they are shaped by a qualitative researcher. It is related to the level of

confidence that a research study's findings are based on the participants' narratives and words, rather than potential researcher biases (Given, 2008). This study implemented an audit trail to demonstrate conformability of the data. An audit trail is a systematic collection of materials and documentation which allows independent auditors to arrive at a conclusion regarding the data and the research as a whole. As proposed by Polit and Hungler (1999), an audit trail can be achieved by following six classes of records: 1) raw data (verbatim transcripts of the interviews); 2) process notes (comprising notes taken by the researcher during meetings with supervisors); 3) personal reflections of the researcher, noting the researcher's perceptions of intention and disposition; 4) instrument development information (question guidelines by which to conduct the interviews); and 5) data reconstruction documentation (final draft report). Interestingly, Sandelowski (1986) elevated the importance of conformability as a criterion by stating that it could only be achieved when the other elements of credibility, dependability and transferability had been demonstrated.

- Transferability: This is similar to generalisability which can be established by providing readers with evidence that the research study's findings could be applicable to other contexts, situations, times and populations (Barnes et al., 2005). The researcher utilised thick description to generalise the data so that it may be relevant to other researchers in similar contexts. Thick description is described by Lincoln and Guba (1985) as a way of achieving a type of external validity. By describing a phenomenon in sufficient detail one can begin to evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations, and people. To achieve transferability for this study, the researcher included adequate description of the data to enable other researchers to evaluate its applicability in diverse contexts (Lincoln & Guba, 1985).

5.16 Ethical Considerations

In undertaking this study, the researcher ensured that ethical standards were maintained throughout the study beginning with ethics approval. Ethics approval was obtained from King Abdullah Medical City, Holy Capital (Institutional Review Board) (refer to Appendix A). In addition, the researcher received a facilitation letter from the MOH (Research & Studies Affairs Unit) in the Riyadh Province addressed to the Directors of the six hospitals within the Eastern Province of Saudi Arabia. Furthermore, the researcher obtained ethics approval from the Human Research Ethics Committee of the University of Technology, Sydney (refer to Appendix B).

Participants received a written invitation in the form of a letter to invite them to contribute to the research. The letter outlined the purpose of the study, data collection process and an assurance of anonymity and confidentiality in relation to their identity and the information they provide (refer to Appendix D). Questionnaires were enclosed in sealed envelopes, thereby maintaining the anonymity of the participants. The anonymous survey had no identification marks and consent was implied by the return of the survey. For the interviews the participants were required to sign a consent form prior to the interview. The interviews were digitally recorded with no mentioning of names or any irrelevant aspects and purely focused on the topic. The personal details of the interviewees were kept confidential to ensure privacy and security. All surveys and interview data were kept in a secure password-protected private location. Digital recordings were stored in a secure place available only to the researchers. It was strongly emphasised to the participants that their participation is voluntary and they were able to withdraw from the study at any time, should they wish to do so (Orb, Eisenhauer, & Wynaden, 2001). Participants were also told that there was no financial compensation for their involvement in the study. The participants were also informed there were no direct risks for participating in the study.

The researcher ensured all data and results were kept secure, with access limited to the researcher to protect the privacy and confidentiality of the participants. All electronic data were stored on a password-protected computer and owned by the researcher while the data was being collected and analysed in Saudi Arabia. All data travelled with the researcher in the cabin of the airplane while in transit. Upon return to Australia, data was stored on the university server and password-protected, with only supervisors and researcher having access. Hard copy data (for example, the surveys and consent forms) were collated and stored in a locked filing cabinet at the researcher's residence and then transferred to a locked filing cabinet at the university. All completed questionnaires and the study data are kept securely at RMIT University for five years before being discarded.

5.17 Summary

This chapter discussed the methodology employed which focused on assessing the leadership style of nurse managers working in Saudi Arabia. The study design is explained using Saunders' research Onion, focusing on the layers of philosophies, approaches, strategies, data collection and analysis. Accordingly, the study followed the inquiry and research paradigm of interpretivist (constructivist) and the post positivist (post empiricist) philosophical approachs using both inductive and deductive approaches with mixed methods as the research choice adopting both quantitative (surveys) and qualitative (interviews) research strategies. The study design therefore incorporated two phases of data collection and analysis. The research methodology in Phase One involved collecting data using the MLQ 5X-Short (Avolio et al., 1995) which is known to be valid and reliable. Descriptive and inferential statistical analyses were used to analyse data collected from Phase One of the study. Phase Two of the study focused on qualitative interviews with nurse managers for detailed assessment of information relating to the variables of the study.

The study was conducted at six hospitals within the Eastern Province of Saudi Arabia. The sample for the study included 283 nurses and 121 nurse managers. Prior to commencement of recruitment of participants, permission to conduct the study was obtained from the King Abdullah Medical City, Holy Capital (Institutional Review Board) and the MOH (Research & Studies Affairs Unit) located in the Riyadh Province. All nurses and nurse managers at the six hospitals who met the inclusion criteria were invited to participate in the study. All potential participants were provided with adequate information about the study and assurances of confidentiality of their responses. The next chapter will present the quantitative data obtained from the study as well as the analysis of these results.

Chapter 6: Quantitative Analysis

6.1 Introduction

The main aim of this study was to determine and assess the leadership styles of nurse managers working at Saudi Arabian hospitals located in the Eastern part of the country. This objective was achieved by assessing the perspectives of both nurse managers and nurses as to leadership styles. Examining the current leadership styles of nurse managers was essential to generating an evidence base for managing the nursing workforce challenges in Saudi Arabia. This chapter is a presentation of the results of the quantitative data analysis which include the respondents' demographic information, the inter-rater scale reliability analysis, patterns of leadership styles and correlation of perceived leadership styles to organisational outcomes including leader effectiveness, staff job satisfaction and willingness of staff to exert extra effort.

6.2 Characteristics of participants

6.2.1 Nurse respondents

In total, 600 questionnaires of the MLQ 5X-Short (rater form) (Avolio et al., 1995) (see Appendix C) were distributed to nurses working in the six selected hospitals based in the Eastern part of Saudi Arabia. To ensure as close to a representative sample as possible, the hospitals included in the study were representative of government, general and specialist hospitals in Eastern Saudi Arabia. Each of the hospital nursing directors was contacted and informed of the study and the nature of the research conducted. The bed capacity of each of the participating hospitals was around 200 beds with some slightly larger and some less in the number of beds.

Overall, 283 nurses responded to the survey yielding a response rate of 47.2%. From the responding participants, the majority were from Hospital A (38.7%, n = 232), with 11

participants from Hospital B, 27 participants from Hospital C, two participants from Hospital D, six participants from Hospital E and five participants from Hospital F. As per Table 6.1, the highest response rate was for Hospital A (92.8%) followed by Hospital C (38.6%), with the remaining hospitals having a response rate of less than 20%.

Table 6.1 Survey respondents (nurses)

Hospital	Number of surveys distributed	Number of responses	Response rate %
A	250	232	92.8
B	70	11	15.7
C	70	27	38.6
D	70	2	2.9
E	70	6	8.6
F	70	5	7.1
Total	600	283	**Overall response:** 47.2%

6.2.2 Nurse manager respondents

In total, 225 questionnaires of the MLQ 5X-Short **(**leader form) (Avolio et al., 1995) (see Appendix C) were distributed to nurse managers working in the six selected hospitals. Overall, 121 nurse managers responded to the survey yielding a response rate of 53.7%. From the responding participants, the majority were from Hospital A (34.2%, *n* = 77), with 11 participants from Hospital B, 23 participants from Hospital C, 1 participant from Hospital D, 7 participants from Hospital E and 2 participants from Hospital F. As per Table 6.2, the highest response rate was for Hospital C (92%) followed by Hospital A (77%), Hospital B

(44%) and Hospital E (28%), with the two remaining hospitals having a response rate of less than 10%.

Table 6.2 Survey respondents (nurse managers)

Hospital	Number of surveys distributed	Number of responses	Response rate %
A	100	77	77
B	25	11	44
C	25	23	92
D	25	1	4
E	25	7	28
F	25	2	8
Total	225	121	**Overall response:** 53.7%

6.3 General demographic data

Table 6.3 presents the demographic data of nurses and nurse managers. Out of the 404 respondents from the six hospitals for both nurses and nurse managers, the majority were female (76.2%, *n* = 93 of nurse managers and 84%, *n* = 238 of nurses). Most of the nurses were in the 20-29 age bracket (59.4%, *n* = 168), whilst the majority of nurse managers were older and in the 30-39 age bracket (48.4%, *n* = 59).

Table 6.3 Demographics of the respondents

Characteristics	Nurses *n* = 283	Percentage %	Nurse managers *n* = 121	Percentage %
Age Category (years)				
20-29	168	59.4	18	14.8
30-39	80	28.3	59	48.4
40-49	17	6	27	22.1
50-59	2	0.7	2	1.6
60+			2	1.6
Gender				
Male	29	10.2	15	12.3
Female	238	84.1	93	76.2
Nationality				
Saudi Arabia	118	41.6	36	29.7
Philippines	43	15.1	29	23.9
India	101	35.6	38	31.4
Egypt	2	0.7		
Malaysia	2	0.7		
Indonesia	1	0.3		
South Africa			1	0.8
USA			1	0.8
UK			1	0.8
Jordan			1	0.8
Experience (years)				
1-2	168	59.4	19	15.6
3-5	80	28.3	18	14.8
6-7	17	6	14	11.5
8-10	2	0.7	31	25.4
11+			26	21.3
Qualifications held				
Diploma	130	45.9	51	41.8
Associate degree	11	3.9	6	4.9
Bachelor degree	124	43.8	49	40.2
Master Degree	2	0.7	2	1.6

In terms of nationality, the sample was relatively diverse for both groups. Over half of the nurse respondents were expatriate (52.4%, *n* = 118) whilst 41.6% were from Saudi Arabia (*n* = 149). For the remaining nurse respondents, 35.6% were from India (*n* = 101) whilst 43 (15.1%) were from the Philippines and smaller proportions of nurses came from Egypt, Malaysia and Indonesia. For nurse managers, the largest group were from India (31.4%, *n* = 38), followed by Saudi Arabia (29.7%, *n* = 36) and 23.9% were from the Philippines (*n* = 29) and smaller proportions of nurse managers came from South Africa, USA, United Kingdom

(UK) and Jordan. These data clearly indicate that over half of the nurse and nurse manager respondents were expatriate. These findings may be explained by the increased demand for nurses in general in Saudi Arabia and that it is easier and quicker to recruit expatriate nurses compared to educating national nurses. Another possible explanation is that national graduate nurses in Saudi Arabia mainly prefer to move into administration roles in nursing (Alotaibi, Paliadelis, & Valenzuela, 2016). These results also demonstrated that most of the nurses and nurse managers who participated in this study came from Asian countries, less frequently from Middle Eastern countries and least from Western countries. These findings may reflect the number of nurses in these provinces who apply to work as nurses in Saudi Arabia. In addition, active recruitment occurs more in Asian countries as these nurses are paid at a lower salary level in their home country especially when compared to other countries such as Saudi Arabia (Van Rooyen et al., 2010).

The nurse manager participants varied in their work experience, ranging from 1 to 11 or more years. Their length of experience could be categorised as follows: 30.4% (n = 37) had 1 to 5 years of work experience, 36.9% (n = 45) had 6 to10 years of work experience and 21.3% (n = 26) had more than 11 years of work experience. However, the majority of nurses had 1 to 5 years of work experience (87.8%, n = 248) and the remaining had 6 to10 years of work experience (6.7 %, n = 19). The fact that the majority of nurses had 1 to 5 years of work experience could be best explained by many of the expatriates leaving Saudi Arabia when they have acquired enough experience to work and provide their services in more developed countries (Al-Dossary, Vail & Macfarlane, 2012).

In terms of nursing qualifications, the majority of nurse managers had a diploma as their highest qualification (41.8%, n = 51), although this number was closely followed by nurse managers with a bachelor degree as their highest qualification (40.2%, n = 49). Similarly, nearly half of nurses had a diploma (45.9%, n = 130) as their highest qualification,

followed by nurses with a bachelor degree as their highest qualification (43.8%, *n* = 124). There were slightly more nurses and nurse managers whose highest qualification was a diploma.

At the end of the demographic section of the questionnaire, nurses and nurse managers were asked two questions which required a yes/no response. The questions assessed the level of education and participation in leadership training (see Appendix G). From Table 6.4 it can be seen that the majority of nurses (96.8%, *n* = 274) and nurse managers (80.3%, *n = 98*) responded that they had no formal management qualifications. In addition, the majority of nurses (90.5%, *n* = 256) and nurse managers (57.4%, *n* = 70) indicated that they had not participated in any leadership training in the past 12 months (Table 6.5).

Table 6.4 Distribution of respondents who had formal management qualifications

Management qualification	**Managers**		**Nurses**	
Responses	**Frequency**	**Percentage %**	**Frequency**	**Percentage %**
Yes	23	18.9	9	3.2
No	98	80.3	274	96.8
Total	121		283	

Table 6.5 Distribution of respondents who had participated in leadership training in the past 12 months

Leadership training	Managers		Nurses	
Responses	**Frequency**	**Percentage %**	**Frequency**	**Percentage %**
Yes	51	41.8	27	9.5
No	70	57.4	256	90.5
Total	121		283	

6.4 Scale reliability analysis

Tables 6.6 and 6.7 include the reliability coefficients for each of the MLQ scales for transformational, transactional, laissez-faire leadership and the three organisational outcomes (effectiveness, willingness to exert extra effort and job satisfaction) for nurses and nurse managers, respectively. For each subscale, Cronbach's α coefficients were generated to determine the scale reliabilities for the data from nurse managers and nurses. This was to help identify question items on the scales that were not reliable. A cut-off of $\alpha = 0.70$ and above was used for the MLQ scales to be considered reliable (Polit & Beck, 2017).

The analysis of the subscales for nurses indicated that reliability coefficients for all scales were high except management-by-exception active ($\alpha = 0.58$) and management-by-exception passive ($\alpha = 0.59$) as shown in Table 6.6 Also, the reliability analysis of the subscales indicated that question 6 (idealised influence behavioural subscale) and question 17 (management-by-exception passive subscale) were unreliable. The α for idealised influence behavioural was 0.72. However, on removing question 6 this increased to 0.82. Additionally, the α reliability coefficient for the management-by-exception passive was 0.59 and the α for question 17 was 0.65; the α for management-by-exception passive scale without question 17

increased to 0.64 (see Table 6.6). The unreliable items that were removed from the subscales before calculation of the scale scores for nurses are listed in Table 6.6.

The analysis of the subscales for nurse managers scores indicated that reliability coefficients for almost all of the scales were below 0.75, except inspirational motivation (α = 0.76), intellectual stimulation (α = 0.82) and effectiveness (α = 0.77) as shown in Table 6.7 In addition, the analysis of the subscale indicated that question 6 (idealised influence behavioural subscale), question 19 (individualised consideration), question 1 (contingent reward) and question 39 (extra effort) were unreliable. This means removal of these items from their scales would increase the reliability of these scales using the remaining items. The α reliability coefficient for the idealised influence behavioural scale was 0.54. However, the α reliability coefficient of this scale with question 6 removed increased to 0.75. Additionally, the α reliability coefficient for the individualised consideration scale was 0.54 but on removing question 19 it increased to 0.58. Also, the α reliability coefficient for the extra effort subscale increased from 0.53 to 0.67 after excluding question 39 as shown in Table 6.7. The unreliable items that were removed from the subscales before calculation of the scale scores for nurse managers are listed in Table 6.7.

Table 6.6 (A) Reliability analysis scales (nurses)

Multifactor leadership questionnaire scales	Cronbach's alpha	Cronbach's alpha after removing the unreliable item	Item number	Cronbach's alpha if item deleted	After removing unreliable item
Idealised influenced (attributed)	0.80		Q10	0.75	No need to remove these items as α reduces if item is removed
			Q18	0.78	
			Q21	0.72	
			Q25	0.74	
Idealised influenced (behavioural)	0.72	0.82	Q6	0.82	Q6 removed
			Q14	0.57	0.71
			Q23	0.59	0.77
			Q34	0.62	0.77
Inspirational motivation	0.85		Q9	0.84	No need to remove these items as α reduces if item is removed
			Q13	0.81	
			Q26	0.78	
			Q36	0.79	
Intellectual stimulation	0.82		Q2	0.78	No need to remove these items as α reduces if item is removed
			Q8	0.81	
			Q30	0.76	
			Q32	0.75	

Table 6.6 (B) Reliability analysis scales (nurses)

Multifactor leadership questionnaire scales	Cronbach's alpha	Cronbach's alpha after removing the unreliable item	Item number	Cronbach's alpha if item deleted	After removing unreliable item
Individualised consideration	0.72	0.74	Q15	0.64	0.65
			Q19	0.74	Q19 removed
			Q29	0.65	0.75
			Q31	0.59	0.55
Contingent reward	0.79		Q1	0.79	No need to remove these items as α reduces if item is removed
			Q11	0.75	
			Q16	0.72	
			Q35	0.68	
Management-by-exception active	0.59		Q4	0.54	No need to remove these items as α reduces if item is removed
			Q22	0.42	
			Q24	0.50	
			Q27	0.57	
Management-by-exception passive	0.59	0.64	Q3	0.52	0.59
			Q12	0.40	0.41
			Q17	0.65	Q17 removed
			Q20	0.48	0.60

Table 6.6 (C) Reliability analysis scales (nurses)

Multifactor leadership questionnaire scales	Cronbach's alpha	Cronbach's alpha after removing the unreliable item	Item number	Cronbach's alpha if item deleted	After removing unreliable item
Laissez-faire leadership	0.69		Q5 Q7 Q28 Q33	0.63 0.64 0.62 0.63	No need to remove these items as α reduces if item is removed
Extra effort	0.88		Q39 Q42 Q44	0.86 0.81 0.81	No need to remove these items as α reduces if item is removed
Effectiveness	0.89		Q37 Q40 Q43 Q45	0.86 0.86 0.86 0.85	No need to remove these items as α reduces if item is removed
Satisfaction	0.83		Q36 Q41	Cannot calculate α if item for a two-item scale is removed	

Table 6.7 (A) Reliability analysis outputs (nurse managers)

Multifactor leadership questionnaire scales	Cronbach's alpha	Cronbach's alpha after removing the unreliable item	Item number	Cronbach's alpha if item deleted	After removing unreliable item
Idealised influenced (attributed)	0.57		Q10	0.47	No need to remove these items as α reduces if item is removed
			Q18	0.44	
			Q21	0.58	
			Q25	0.48	
Idealised influenced (behavioural)	0.54	0.75	Q6	0.75	Q6 removed
			Q14	0.40	0.69
			Q23	0.25	0.66
			Q34	0.42	0.65
Inspirational motivation	0.76		Q9	0.70	No need to remove these items as α reduces if item is removed
			Q13	0.65	
			Q26	0.70	
			Q36	0.76	
Intellectual stimulation	0.71		Q2	0.63	No need to remove these items as α reduces if item is removed
			Q8	0.66	
			Q30	0.64	
			Q32	0.63	

Table 6.7 (B) Reliability analysis outputs (nurse managers)

Multifactor leadership questionnaire scales	Cronbach's alpha	Cronbach's alpha after removing the unreliable item	Item number	Cronbach's alpha if item deleted	After removing unreliable item
Individualised consideration	0.54	0.58	Q15	0.54	0.56
			Q19	0.58	Q19 removed
			Q29	0.36	0.62
			Q31	0.39	0.23
Contingent reward	0.45	0.53	Q1	0.53	
			Q11	0.38	0.46
			Q16	0.43	0.46
			Q35	0.15	0.36
Management-by-exception active	0.55		Q4	0.52	No need to remove these items as α reduces if item is removed
			Q22	0.40	
			Q24	0.43	
			Q27	0.54	
Management-by-exception passive	0.46		Q3	0.41	No need to remove these items as α reduces if item is removed
			Q12	0.37	
			Q17	0.42	
			Q20	0.34	

Table 6.7 (C) Reliability analysis outputs (nurse managers)

Multifactor leadership questionnaire scales	Cronbach's alpha	Cronbach's alpha after removing the unreliable item	Item number	Cronbach's alpha if item deleted	After removing unreliable item
Laissez-faire leadership	0.53	0.54	Q5 Q7 Q28 Q33	0.41 0.54 0.40 0.45	0.45 0.38 0.49
Extra effort	0.53	0.67	Q39 Q42 Q44	0.67 0.35 0.28	No need to remove these items as α reduces if item is removed
Effectiveness	0.77		Q37 Q40 Q43 Q45	0.67 0.77 0.69 0.74	No need to remove these items as α reduces if item is removed
Satisfaction	0.53		Q36 Q41	Cannot calculate α if item for a two-item scale is removed	

6.5 Correlation between the MLQ Scales

Cronbach's alpha (α) coefficients are often calculated to assess internal consistency of scales (Cronbach, 1951). Two issues arise when determining α. First α is affected by the number of items in a scale. According to Nunally (1967), $\alpha > 0.70$ is considered adequate but, inter-item correlation would be expected to be high if the α of a scale has many items. Secondly, α is also affected by the dimensionality of a scale. Although α decreases as a function of multidimensionality, α can be high even when items are somewhat interrelated in a multidimensional scale (Cortina, 1993). Therefore, in addition to calculating α, the average of inter-item correlations was also calculated. Next, the correlations between the 12 dimensions (9 leadership factors and three organisational outcomes) of the MLQ were calculated. The criterion used in this study for average inter-item correlations is that they should be > 0.30. The correlation between MLQ factors of transformational, transactional, laissez-faire leadership and organisational outcomes are reported in Tables 6.8 and 6.9 for nurses and nurse managers, respectively.

For nurses, laissez-faire leadership and management-by-exception passive correlated positively (0.61) with each other but, both correlated negatively with all transformational leadership factors, the other two factors of transactional leadership and organisational outcomes effectiveness, satisfaction and job satisfaction (see Table 6.8). This means the more laissez-faire that the manager, is the more they are ineffective managers and they manage punitively.

The correlation between the other two factors of transactional leadership, contingent reward and management-by-exception active was positive (0.41) and lower than their correlation with all the transformational factors with contingent reward ranging from 0.77 to 0.82 and active management-by-exception ranging from 0.40 to 0.51. In other words, the more there is agreement to accomplish goals, the more there are punitive actions if

subordinates are unable to agree to set standards. Therefore, contingent reward factor correlated higher with transformational leadership factors than with transactional leadership factors. The correlation between the transformational leadership factors was high. Correlation between organisational outcomes with transformational leadership was also high as shown in Table 6.8. The clearer the goals and the lines of communication from the manager, the more likely to award subordinates well so staff work hard and are amenable to change.

As with nurses for nurse managers, the laissez-faire leadership and management-by-exception passive correlated positively with each other (0.51) and negatively with all other leadership factors, including management-by-exception active. Contingent reward (transactional factor) correlated positively with management-by-exception active (0.35), and also correlated positively with all transformational leadership factors (ranging from 0.41 to 0.58). Management-by-exception active correlated positively with three transformational factors (idealised influence behaviours, intellectual stimulation and individualised consideration (ranging from 0.32 to 0.39). In other words, the more management-by-exception active the manager is, higher likelihood of intellectual stimulation, coaching, listening and being treated individually or being fully actualised. However, management-by-exception active correlated low with idealised influence and inspirational motivation (0.15 and 0.25, respectively).

The correlation between the transformational leadership factors was high (see Table 6.9). Also, correlation between organisational outcomes and transformational leadership factors was high as shown in Table 6.9.

Table 6.8 (A) Correlation matrix of scale scores (nurses)

Correlation	Idealised influence attributed	Idealised influence behavioural	Inspirational motivation	Intellectual stimulation	Individualised consideration	Contingent reward	Management by exception active	Management by exception passive	Laissez-faire leadership	Extra effort	Effectiveness	Satisfaction
Idealised influence attributed	1	0.77**	0.83**	0.78**	0.79**	0.81**	0.42**	0.20**	0.32**	0.77**	0.78**	0.72**
p		<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Idealised influence behavioural		1	0.84**	0.82**	0.79**	0.78**	0.51**	0.18**	0.31**	0.75**	0.77**	0.69**
p			<0.001	<0.001	<0.001	<0.001	<0.001	0.003	<0.001	<0.001	<0.001	<0.001
Inspirational motivation			1	0.85**	0.81**	0.80**	0.44**	0.24**	0.37**	0.82**	0.84**	0.73**
p				<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Intellectual stimulation				1	0.78**	0.78**	0.44**	0.24**	0.33**	0.78**	0.79**	0.71**
p					<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001	<0.001
Individualised consideration					1	0.78**	0.40**	0.18**	0.34**	0.75**	0.75**	0.69**
p						<0.001	<0.001	0.004	<0.001	<0.001	<0.001	<0.001
Contingent reward						1	0.41**	0.19**	0.36**	0.79**	0.80**	0.76**
p							<0.001	<0.001	<0.001	<0.001	<0.001	<0.001

**. Correlation is significant at the 0.01 level (2-tailed)

Table 6.8 (B) Correlation matrix of scale scores (nurses)

Correlation	Idealised influence attributed	Idealised influence behavioural	Inspirational motivation	Intellectual stimulation	Individualised consideration	Contingent reward	Management by exception active	Management by exception passive	Laissez-faire leadership	Extra effort	Effectiveness	Satisfaction
Management by exception active							1	-0.18**	-0.05	0.35**	0.33**	0.32**
p								0.004	0.45	<0.001	<0.001	<0.001
Management by exception passive								1	0.61**	-0.25**	-0.31**	-0.27**
p									<0.001	<0.001	<0.001	<0.001
Laissez-faire leadership									1	0.35**	0.44**	0.34**
p										<0.001	<0.001	<0.001
Extra effort										1	0.89**	0.79
p											<0.001	<0.001
Effectiveness											1	0.82**
p												<0.001
Satisfaction												1

**. Correlation is significant at the 0.01 level (2-tailed)

Table 6.9 (A) Correlation matrix of scale scores (nurse managers)

Correlation	Idealised influence attributed	Idealised influence behavioural	Inspirational motivation	Intellectual stimulation	Individualised consideration	Contingent reward	Management by exception active	Management by exception passive	Laissez-faire leadership	Extra effort	Effectiveness	Satisfaction
Idealised influence attributed	1	0.41**	0.46**	0.43**	0.44**	0.41**	0.15	0.17	-0.12	0.44**	0.39**	0.47**
p		<0.001	<0.001	<0.001	<0.001	<0.001	0.097	0.062	0.184	<0.001	<0.001	<0.001
Idealised influence behavioural		1	0.66**	0.64**	0.60**	0.58**	0.39**	0.14	0.12	0.45**	0.52**	0.51**
p			<0.001	<0.001	<0.001	<0.001	<0.001	0.114	0.187	<0.001	<0.001	<0.001
Inspirational motivation			1	0.68**	0.50**	0.50**	0.247**	0.09	0.15	0.61**	0.65**	0.51**
p				<0.001	<0.001	<0.001	0.006	0.300	0.253	<0.001	<0.001	<0.001
Intellectual stimulation				1	0.51**	0.50**	0.37**	0.14	0.13	0.50**	0.59**	0.39**
p					<0.001	<0.001	<0.001	0.115	0.141	<0.001	<0.001	<0.001
Individualised consideration					1	0.58**	0.32**	0.17**	0.14**	0.47**	0.46**	0.57**
p						<0.001	<0.001	0.050	0.124	<0.001	<0.001	<0.001
Contingent reward						1	0.35**	0.18	0.04	0.44**	0.36**	0.53**
p							<0.001	0.054	0.642	<0.001	<0.001	<0.001

Table 6.9 (B) Correlation matrix of scale scores (nurse managers)

Correlation	Idealised influence attributed	Idealised influence behavioural	Inspirational motivation	Intellectual stimulation	Individualised consideration	Contingent reward	Management by exception active	Management by exception passive	Laissez-faire leadership	Extra effort	Effectiveness	Satisfaction
Management by exception active							1	-0.06	0.03	0.07	0.19*	0.28**
p								0.532	0.680	0.403	0.031	0.002
Management by exception passive								1	0.51**	-0.12	-0.12	-0.15**
p									<0.001	0.189	0.194	0.108
Laissez-faire leadership									1	-0.11	-0.14	-0.14
p										0.244	0.122	0.121
Extra effort										1	0.62**	0.48**
p											<0.001	<0.001
Effectiveness											1	0.50**
p												<0.001
Satisfaction												1

**. Correlation is significant at the 0.01 level (2-tailed)

*. Correlation is significant at the level 0.05 level (2-tailed)

6.6 Descriptive statistics of the subscales

To provide an overall description of the scores obtained from the subscales, means (M), standard deviations (SD) were obtained (see Table 6.10). The highest mean reported subscale was inspirational motivation for both nurses (M = 2.64) and nurse managers (M = 3.15). For organisational outcomes, effectiveness (M = 2.68) and satisfaction (M = 2.68) were equally the highest mean subscale reported for nurses whilst for nurse managers, satisfaction (M = 3.28) had the greatest mean subscale value.

Table 6.10 Descriptive statistics of the subscales

	Nurses		**Nurse managers**	
Subscales	**M**	**SD**	**M**	**SD**
Idealised influence attributed	2.57	1.02	2.93	0.77
Idealised influence behavioural	2.55	0.89	2.93	0.63
Inspirational motivation	2.64	1.05	3.15	0.66
Intellectual stimulation	2.50	0.97	2.97	0.73
Individualised consideration	2.44	0.94	3.00	0.63
Contingent reward	2.54	0.94	3.00	0.62
Management-by-exception active	2.42	0.86	2.47	0.87
Management-by-exception passive	1.42	0.90	0.82	0.71
Laissez-faire leadership	1.26	0.98	0.49	0.59
Extra effort	2.62	1.15	3.00	0.69
Effectiveness	2.68	1.08	3.17	0.66
Satisfaction	2.68	1.18	3.28	0.66

6.6.1 Transformational leadership

The means (M) and standard deviations (SD) of the nurse managers' responses on MLQ items that measure the five factors related to transformational leadership were examined (see Table 6.10). High mean scores for nurse managers were obtained for the following sub-scales: inspirational motivation (M = 3.15), individualised consideration (M = 3.00), intellectual stimulation (M = 2.97), idealised influence attributed (M = 2.93) and idealised influence behavioural (M = 2.93). These results indicated that all 121 nurse managers perceived themselves as utilising the transformational factors *fairly often.* Inspirational motivation had the highest mean score, which indicated that nurse managers were utilising it more than the other four factors.

The means and standard deviations of the nurses' response on MLQ items that measure the five factors related to transformational leadership were examined (see Table 6.10). Higher mean scores were obtained for nurses as follows: (M = 2.64) for inspirational motivation, (M = 2.57) for idealised influence attributed, (M = 2.55) for idealised influence behavioural, (M = 2.5) for intellectual stimulation and (M = 2.44) for individualised consideration. These results suggest that on average nurses perceived their nurse managers as utilising the five factors of transformational leadership *sometimes* to *fairly often*. Inspirational motivation had the highest mean followed by idealised influence attributed which suggests that nurses perceive their nurse managers as utilising inspirational motivation more than the other four factors. Furthermore, these results indicate that nurse managers perceived themselves as utilising transformational leadership factors to a much greater degree than as perceived by their staff.

6.6.2 Transactional leadership

The means and standard deviations of the nurse managers' responses on MLQ items which measure the three factors related to transactional leadership were examined (see Table

6.10). The nurse managers had high mean scores for the following factors: contingent reward (M = 3.00) and management-by-exception active (M = 2.47). These results indicate that nurse managers utilised contingent reward *fairly often* and management-by-exception active *sometimes* to *fairly often.* Management-by-exception passive had the lowest mean score (M=0.82), which indicated that nurse managers were utilising this less than the other two factors. This means that nurses perceived that nurse managers did not provide information, articulate goals or create effective solutions and timely responses, whereas nurse managers believed they did.

The means and standard deviations of the nurses' responses on MLQ items that measure the three factors for transactional leadership were examined (see Table 6.10). High mean scores for nurses were obtained for the following: contingent reward (M = 2.54) and management-by-exception active (M = 2.42). These results indicated that nurses perceived their nurse managers as utilising contingent reward and management-by-exception active *sometimes* to *fairly often.* Nurses rated their nurse managers (M = 1.42) for management-by-exception passive. However, nurse managers rated themselves lower in utilising management-by-exception passive transactional leadership with a mean value of M = 0.82. Similarly, nurse managers rated themselves as utilising contingent reward (M = 3.00) more than their staff rated them utilising this transactional leadership factor (M = 2.54). Likewise, for management-by-exception active, this was rated higher by nurse managers (M = 2.47) in utilising this transactional factor more than nurses (M = 2.42) rating their use of this leadership behaviour. Nurse managers perceived that they provided a clear agreement with their staff to accomplish organisational goals, whereas nurses did not believe their managers did.

6.6.3 Laissez-faire leadership

The means and standard deviations of the nurse managers' and nurses' responses on MLQ items that measure the laissez-faire leadership were examined (see Table 6.10). The mean of nurse managers' responses was M = 0.49 with a SD of 0.58 and the mean of nurses' responses was M = 1.26 with a SD of 0.98. These results indicate that nurse managers perceives themselves as utilising laissez-faire leadership *not at all* and nurses perceived their nurse managers as utilising this leadership style *not at all to once in a while.* These results indicate nurse managers perceived themselves as using laissez-faire leadership lower than their staff nurses. Furthermore, results suggest that laissez-faire leadership seems to be the least preferred style for both nurse managers and nurses.

The findings from this section demonstrated that nurses perceived their nurse managers as utilising laissez-faire leadership and management-by-exception passive *not at all to once in a while and* both transformational leadership and two transactional leadership factors *sometimes* to *fairly often.* In contrast, nurse managers rated themselves as using transformational and transactional factors greater than the nurses perceived them utilising these various leadership styles. Nurse managers however, rated themselves lower than nurses in both laissez-faire and management-by-exception passive. Nurse managers rated themselves using transformational and transactional leadership factors *fairly often, frequently, if not always.*

6.7 Patterns of leadership

To assess for differences in leadership style scores, one-way analysis of variance (ANOVA) or the independent samples *t*-test was used across demographic variables. Dunnett's T3 multiple comparison tests, controlling for Type 1 error where homogeneity of variance was violated or the Bonferroni procedure when it was not. Responses from nurse managers (n = 121) and nurses (n = 283) were examined in separate analyses. The selected

demographic characteristics assessed for differences were age, gender, years of experience, nationality and level of education (see Tables 6.11, 6.12, 6.13, 6.14, 6.15, 6.16, 6.17, 6.18, 6.19, 6.20).

6.7.1 Gender

For the nurse respondents, the independent sample *t*-test comparing males and females across the various factors showed that there were no significant differences across gender for the mean scores for the five transformational leadership factors and transactional leadership factors which include contingent reward and management-by-exception active and passive. In terms of laissez-faire leadership and for organisational outcomes mean scores, there was also no significant difference across gender (see Table 6.11).

For nurse manager respondents, Table 6.12 showed that there were no significant differences across gender for the mean scores for all 9 leadership factors and two organisational outcomes (effectiveness and extra effort). There was however, a significant difference across gender on satisfaction (organisational outcome) (p = 0.04); females had a higher mean score than males (see Table 6.12).

Table 6.11 Gender difference across leadership factors and organisational outcomes (nurses)

	Male		Female			
Variables	**M**	**SE**	**M**	**SE**	***t***	***p***
Idealised influence attributed	2.44	0.22	2.61	0.07	-0.84 (*df*=263)	0.40
Idealised influence behavioural	2.40	0.19	2.59	0.06	-1.06 (*df*=260)	0.29
Inspirational motivation	2.44	0.24	2.71	0.07	-1.29 (*df*=262)	0.29
Intellectual stimulation	2.49	0.22	2.55	0.06	-0.28 (*df*=258)	0.78
Individualised consideration	2.14	0.22	2.52	0.06	-2.01 (*df*=263)	0.10
Contingent reward	2.34	0.19	2.61	0.06	-1.46 (*df*=262)	0.15
Management-by-exception active	2.18	0.16	2.45	0.06	-1.59 (*df*=260)	0.11
Management-by-exception passive	1.12	0.18	1.47	0.06	-1.97 (*df*=254)	0.05
Laissez-faire leadership	1.36	0.17	1.25	0.06	0.54 (*df*=262)	0.59
Extra effort	2.32	0.24	2.69	0.07	-1.66 (*df*=263)	0.09
Effectiveness	2.38	0.23	2.75	0.07	-1.78 (*df*=260)	0.76
Satisfaction	2.50	0.24	2.75	0.07	-1.07 (*df*=265)	0.29

Table 6.12 Gender difference across leadership factors and organisational outcomes (nurse managers)

	Male		Female			
Leadership Factors	**M**	**SE**	**M**	**SE**	***t* (*df*=106)**	***p***
Idealised influence attributed	3.22	0.18	2.85	0.08	1.74	.085
Idealised influence behavioural	3.17	0.19	2.94	0.07	0.40	0.69
Inspirational motivation	3.08	0.19	3.16	0.07	-0.41	0.68
Intellectual stimulation	3.13	0.19	2.94	0.08	0.94	0.44
Individualised consideration	2.93	0.22	3.08	0.06	-0.84	0.41
Contingent reward	3.03	0.18	2.99	0.06	0.22	0.83
Management-by-exception active	2.40	0.24	2.48	0.09	-0.30	0.76
Management-by-exception passive	0.88	0.24	0.76	0.07	0.49	0.63
Laissez-faire leadership	0.68	0.16	0.45	0.06	1.50	0.14
Extra effort	3.04	0.19	3.03	0.07	0.08	0.94
Effectiveness	3.10	0.17	3.21	0.07	-0.62	0.54
Satisfaction	2.93	0.19	3.32	0.07	-2.08	0.04

6.7.2 Level of education

In terms of level of education, the independent samples *t*-test was conducted to compare diploma and bachelor (BSN) degree respondents whilst other levels of education were excluded due to their small numbers. For the nurse respondents, results of independent samples *t*-test showed that there was no significant difference across level of education on mean scores based on transformational and transaction leadership factors, and the three organisational outcomes. However, there was a significant difference across level of education on laissez-faire leadership mean scores ($p < 0.001$) (see Table 6.13). Nurses who held diplomas had a higher mean score than nurses who held bachelor degrees. Graduates from diploma programmes tend to be more skills focused whereas bachelor graduates have a deeper understanding and knowledge focus. For the nurse manager respondents, results of independent samples *t*-test showed that there was no significant difference across level of education on mean scores based on transformational, transaction leadership and laissez-faire leadership factors, and the three organisational outcomes (see Table 6.14).

Table 6.13 Level of education difference across leadership factors and organisational outcomes (nurses)

	Diploma		BSN			
Variables	**M**	**SE**	**M**	**SE**	***t***	***p***
Idealised influence attributed	2.63	0.09	2.55	0.08	0.61 (*df*=250)	0.54
Idealised influence behavioural	2.57	0.09	2.60	0.08	-0.26 (*df*=247)	0.79
Inspirational motivation	2.69	0.10	2.67	0.09	0.18 (*df*=249)	0.85
Intellectual stimulation	2.57	0.09	2.52	0.08	0.46 (*df*=245)	0.65
Individualised consideration	2.42	0.09	2.56	0.08	-1.19 (*df*=250)	0.23
Contingent reward	2.63	0.09	2.55	0.08	0.69 (*df*=249)	0.49
Management-by-exception active	2.41	0.08	2.43	0.08	-0.15 (*df*=247)	0.88
Management-by-exception passive	1.48	0.08	1.34	0.08	1.15 (*df*=242)	0.25
Laissez-faire leadership	1.48	0.09	0.96	0.08	4.38 (*df*=279)	<0.001
Extra effort	2.69	0.11	2.60	0.09	0.60 (*df*=250)	0.55
Effectiveness	2.75	0.10	2.69	0.09	0.48 (*df*=247)	0.63
Satisfaction	2.76	0.11	2.70	0.09	0.38 (*df*=250)	0.71

Table 6.14 Level of education difference across leadership factors and organisational outcomes (nurse managers)

	Diploma		BSN			
Variables	**M**	**SE**	**M**	**SE**	***t* (*df*=98)**	***p***
Idealised influence attributed	2.87	0.11	0.27	0.10	-0.64	0.53
Idealised influence behavioural	2.91	0.09	3.05	0.08	-1.11	0.27
Inspirational motivation	3.09	0.11	3.28	0.08	-1.42	0.16
Intellectual stimulation	2.96	0.10	3.05	0.10	-0.66	0.51
Individualised consideration	3.01	0.09	3.19	0.08	-1.46	0.15
Contingent reward	2.98	0.09	3.08	0.08	-0.83	0.41
Management-by-exception active	2.38	0.13	2.58	0.12	-1.12	0.27
Management-by-exception passive	0.52	0.09	0.74	0.09	0.83	0.41
Laissez-faire leadership	0.54	0.08	0.43	0.07	1.00	0.32
Extra effort	3.99	0.09	3.18	0.09	-1.45	0.15
Effectiveness	3.21	0.08	3.28	0.08	-0.59	0.56
Satisfaction	3.25	0.09	3.35	0.09	-0.79	0.43

6.7.3. Age

Tables 6.15 (A, B and C) and 6.16 (A, B and C) showed the one-way ANOVA results across age categories on leadership factors and organisational outcomes mean scores for both groups. The results indicated that there were no significant differences across age categories on the nine leadership factors and the three organisational outcomes mean scores.

Table 6.15 (A) Mean comparison across age groups (nurses)

Leadership Factors	Age group (Years)	N	M	SE	*F*	*p*
Idealised influence-attributed	20-29	167	2.57	0.08	1.35	0.26
	30-39	79	2.69	0.11	(*df*=2,262)	
	40-49	17	2.28	0.24		
	Total	263	2.59	0.06		
Idealised influence-behavioural	20-29	164	2.56	0.07	0.02	0.98
	30-39	80	2.59	0.10	(*df*=2,259)	
	40-49	16	2.58	0.24		
	Total	260	2.57	0.06		
Inspirational motivation	20-29	165	2.65	0.08	0.24	0.79
	30-39	80	2.73	0.12	(*df*=2,261)	
	40-49	17	2.76	0.22		
	Total	262	2.68	0.06		
Intellectual stimulation	20-29	165	2.57	0.07	0.33	0.72
	30-39	78	2.50	0.11	(*df*=2,257)	
	40-49	15	2.39	0.22		
	Total	258	2.54	0.06		

Table 6.15 (B) Mean comparison across age groups (nurses)

Leadership Factors	Age group (Years)	N	M	SE	*F*	*p*
Individual consideration	20-29	166	2.48	0.08	0.03	0.97
	30-39	80	2.50	0.10	(*df*=2,262)	
	40-49	17	2.45	0.21		
	Total	263	2.48	0.06		
Contingent reward	20-29	167	2.57	0.07	0.07	0.94
	30-39	78	2.61	0.11	(*df*=2,261)	
	40-49	17	2.54	0.15		
	Total	262	2.58	0.06		
Management-by-exception active	20-29	166	2.43	0.07	0.27	0.77
	30-39	78	2.38	0.09	(*df*=2,259)	
	40-49	16	2.53	0.20		
	Total	261	2.42	0.05		
Management-by-exception passive	20-29	161	1.39	0.07	1.91	0.15
	30-39	78	1.44	0.11	(*df*=2,253)	
	40-49	16	1.84	0.25		
	Total	255	1.43	0.06		

Table 6.15 (C) Mean comparison across age groups (nurses)

Leadership Factors	Age group (Years)	N	M	SE	*F*	*p*
Laissez-faire leadership	20-29	166	1.23	0.08	0.45	0.64
	30-39	79	1.27	0.12	(*df*=2,261)	
	40-49	17	1.46	0.24		
	Total	262	1.26	0.06		
Extra effort	20-29	166	2.62	0.09	0.19	0.83
	30-39	80	2.71	0.13	(*df*=2,262)	
	40-49	17	2.59	0.22		
	Total	263	2.65	0.07		
Effectiveness	20-29	165	2.73	0.08	0.47	0.63
	30-39	80	2.73	0.12	(*df*=2,259)	
	40-49	15	2.47	0.21		
	Total	260	2.71	0.07		
Satisfaction	20-29	168	2.71	0.09	0.08	0.93
	30-39	80	2.72	0.14	(*df*=2,264)	
	40-49	17	2.82	0.22		
	Total	265	2.71	0.07		

Table 6.16 (A) Mean comparison across age groups (nurse managers)

Leadership Factors	Age group (Years)	N	M	SE	*F* (*df*=2,101)	*p*
Idealised influence-attributed	20-29	18	2.83	0.21	1.28	0.28
	30-39	59	3.00	0.09		
	40-49	27	2.66	0.15		
	Total	104	2.88	0.08		
Idealised influence-behavioural	20-29	18	2.74	0.15	1.79	0.17
	30-39	59	2.94	0.09		
	40-59	27	3.02	0.08		
	Total	104	2.93	0.06		
Inspirational motivation	20-29	18	3.13	0.17	0.39	0.68
	30-39	59	3.11	0.09		
	40-59	27	3.18	0.12		
	Total	104	3.13	0.07		
Intellectual stimulation	20-29	18	2.83	0.22	0.44	0.65
	30-39	59	2.97	0.09		
	40-59	27	2.95	0.12		
	Total	104	2.94	0.07		

Table 6.16 (B) Mean comparison across age groups (nurse managers)

Leadership Factors	Age group (Years)	N	M	SE	*F* (*df*=2,101)	*p*
Individual consideration	20-29	18	2.75	0.15	2.64	0.08
	30-39	59	3.11	0.08		
	40-59	27	3.06	0.11		
	Total	104	3.04	0.06		
Contingent reward	20-29	18	2.85	0.15	2.28	0.11
	30-39	59	2.94	0.09		
	40-59	27	3.12	0.09		
	Total	104	2.97	0.06		
Management-by-exception active	20-29	18	2.28	0.22	1.22	0.29
	30-39	59	2.42	0.12		
	40-59	27	2.66	0.18		
	Total	104	2.46	0.09		
Management-by-exception passive	20-29	18	0.88	0.18	0.17	0.85
	30-39	59	0.77	0.09		
	40-59	27	0.79	0.09		
	Total	104	0.79	0.07		

Table 6.16 (C) Mean comparison across age groups (nurse managers)

Leadership Factors	Age group (Years)	N	M	SE	*F* (*df*=2,101)	*p*
Laissez-faire leadership	20-29	18	0.49	0.15	0.64	0.53
	30-39	59	0.54	0.08		
	40-59	27	0.39	0.09		
	Total	104	0.49	0.06		
Extra effort	20-29	18	3.00	0.21	0.64	0.53
	30-39	59	2.98	0.09		
	40-59	27	3.09	0.13		
	Total	104	3.03	0.07		
Effectiveness	20-29	18	3.09	0.20	0.97	0.38
	30-39	59	3.16	0.09		
	40-59	27	3.26	0.09		
	Total	104	3.17	0.06		
Satisfaction	20-29	18	3.14	0.17	1.05	0.35
	30-39	59	3.23	0.09		
	40-59	27	3.35	0.11		
	Total	104	3.25	0.07		

6.7.4 Nationality

Table 6.17 (A, B and C) show the one-way ANOVA results for nurse data for nationality which included only nationals of Saudi Arabia, India and the Philippines. Other nationals were excluded due to their very small numbers. The one-way ANOVA results indicated that there was no significant difference on transformational and transactional leadership factors and the three organisational outcomes mean scores across nationality. However, there was a significant difference on laissez-faire leadership mean scores across nationality (F (3, 259) = 5.18, p = 0.003) with significant differences in mean score across nationality groups as follows: Saudi Arabian and Indian (p = 0.003); Saudi Arabian and Philippines (p = 0.005). Saudi Arabian nurses had the higher mean score.

Table 6.18 (A, B and C) displays the one-way ANOVA results for the nurse manager data for nationality and included only nationals of Saudi Arabia, India, and the Philippines. The one-way ANOVA results indicated that there were no significant differences on transactional, laissez-faire leadership factors and the three organisational outcomes mean scores across nationality. However, there was a significant difference on idealised influence attributed (transformational factor) mean scores across nationality (F (3,102) = 8.84, $p < 0.001$) with significant difference in mean score between Saudi Arabian and Indian ($p < 0.001$) and Saudi Arabian versus Filipinos ($p < 0.001$). Saudi Arabian nurse managers had the higher mean score.

Table 6.17 (A) Assessing mean differences across nationalities (nurses)

Leadership Factors	Nationality	N	M	SE	*F*	*p*
Idealised influence-attributed	Saudi	115	2.55	0.11	0.24	0.87
	Philippines	101	0.62	0.09	*df*=(2,256)	
	Indian	43	0.60	0.10		
	Total	259	2.59	0.06		
Idealised influence-behavioural	Saudi	114	2.45	0.09	0.93	0.43
	Philippines	99	0.61	0.08	*df*=(2,253)	
	Indian	43	2.69	0.11		
	Total	256	2.57	0.05		
Inspirational motivation	Saudi	115	2.60	0.11	0.82	0.49
	Philippines	100	2.69	0.09	*df*=(2,255)	
	Indian	43	2.86	0.13		
	Total	258	2.68	0.06		
Intellectual stimulation	Saudi	114	2.53	0.10	0.15	0.93
	Philippines	97	2.59	0.09	*df*=(2,251)	
	Indian	43	2.50	0.11		
	Total	254	2.54	0.06		

Table 6.17 (B) Assessing mean differences across nationalities (nurses)

Leadership Factors	Nationality	N	M	SE	*F*	*p*
Individual consideration	Saudi	116	2.31	0.09	2.68	0.05
	Philippines	100	2.65	0.09	*df*=(2,256)	
	Indian	43	2.56	0.10		
	Total	259	2.48	0.06		
Contingent reward	Saudi	117	2.55	0.09	0.19	0.90
	Philippines	100	2.65	0.08	*df*=(2,256)	
	Indian	42	2.58	0.11		
	Total	259	2.59	0.058		
Management-by-exception active	Saudi	116	2.39	0.08	0.43	0.74
	Philippines	99	2.45	0.09	*df*=(2,254)	
	Indian	42	2.49	0.12		
	Total	257	2.43	0.05		
Management-by-exception passive	Saudi	112	1.44	0.09	0.09	0.45
	Philippines	95	1.42	0.09	*df*=(2,247)	
	Indian	43	1.49	0.14		
	Total	250	1.44	0.06		

Table 6.17 (C) Assessing mean differences across nationalities (nurses)

Leadership Factors	Nationality	N	M	SE	*F*	*p*
Laissez-faire leadership	Saudi	115	1.51	0.09	7.19	0.003
	Philippines	101	1.06	0.09	*df*=(2,255)	
	Indian	42	1.04	0.11		
	Total	258	1.26	0.06		
Extra effort	Saudi	117	2.63	0.12	0.33	0.81
	Philippines	99	2.71	0.09	*df*=(2,256)	
	Indian	43	2.57	0.13		
	Total	259	2.65	0.07		
Effectiveness	Saudi	114	2.69	0.11	0.08	0.97
	Philippines	99	2.76	0.09	*df*=(2,253)	
	Indian	43	2.72	0.13		
	Total	256	2.72	0.07		
Satisfaction	Saudi	117	2.68	0.12	0.57	0.63
	Philippines	101	2.84	0.11	*df*=(2,258)	
	Indian	43	2.60	0.15		
	Total	261	2.73	0.07		

Table 6.18 (A) Assessing mean score difference across nationalities (nurse managers)

Leadership Factors	Nationality	N	M	SE	*F* (2,100)	*p*
Idealised influence-attributed	Saudi	36	3.38	0.09	8.84	<0.001
	Philippines	38	2.59	0.12		
	Indian	29	2.71	0.15		
	Total	103	2.89	0.08		
Idealised influence-behavioural	Saudi	36	3.06	0.09	2.06	0.11
	Philippines	38	2.76	0.12		
	Indian	29	3.05	0.10		
	Total	103	2.95	0.06		
Inspirational motivation	Saudi	36	3.29	0.07	1.97	0.12
	Philippines	38	2.96	0.13		
	Indian	29	3.26	0.13		
	Total	103	3.16	0.07		
Intellectual stimulation	Saudi	36	3.19	0.09	3.621	0.06
	Philippines	38	2.66	0.15		
	Indian	29	3.01	0.11		
	Total	103	2.95	0.07		

Table 6.18 (B) Assessing mean score difference across nationalities (nurse managers)

Leadership Factors	Nationality	N	M	SE	*F* (2,100)	*p*
Individual consideration	Saudi	36	3.03	0.10	0.45	0.72
	Philippines	38	3.03	0.10		
	Indian	29	3.16	0.12		
	Total	103	3.07	0.06		
Contingent reward	Saudi	36	3.10	0.09	3.42	0.08
	Philippines	38	2.81	0.12		
	Indian	29	3.09	0.09		
	Total	103	2.99	0.06		
Management-by-exception active	Saudi	36	2.44	0.15	0.36	0.78
	Philippines	38	2.43	0.15		
	Indian	29	2.59	0.17		
	Total	103	2.48	0.09		
Management-by-exception passive	Saudi	36	0.74	0.14	0.19	0.82
	Philippines	38	0.84	0.09		
	Indian	29	0.80	0.13		
	Total	103	0.79	0.07		

Table 6.18 (C) Assessing mean score difference across nationalities (nurse managers)

Leadership Factors	Nationality	N	M	SE	*F* (2,100)	*p*
Laissez-faire leadership	Saudi	36	0.67	0.11	3.41	0.04
	Philippines	38	0.34	0.08		
	Indian	29	0.42	0.09		
	Total	103	0.48	0.06		
Extra effort	Saudi	36	3.12	0.95	1.84	0.15
	Philippines	38	2.83	0.12		
	Indian	29	3.18	0.14		
	Total	103	3.03	0.07		
Effectiveness	Saudi	36	3.29	0.08	1.56	0.20
	Philippines	38	3.145	0.13		
	Indian	29	3.10	0.12		
	Total	103	3.19	0.06		
Satisfaction	Saudi	36	3.32	0.10	1.25	0.29
	Philippines	38	3.32	0.11		
	Indian	29	3.14	0.13		
	Total	103	3.27	0.07		

6.7.5 Years of experience

The result of the one-way ANOVA across years of experience for nurse respondents (see Table 6.19 (A, B and C)) indicated that there was no significant difference across years of experience on the eight leadership factors and the three organisational outcomes mean scores. However, there was a significant difference across one transactional leadership factor (management-by-exception passive) across years of experience; nurse managers who worked more than 11 years had the highest mean score on management-by-exception passive. Furthermore, Table 6.20 (A, B, and C) shows the one-way ANOVA results across years of experience for nurse managers. The results indicated that there was no significant difference across transformational and transactional leadership and the two organisational outcomes (extra effort and effectiveness) mean scores across years of experience. However, there was a significant difference across years of experience on satisfaction (organisational outcomes) with respect to the mean score (F (2,105) = 6.5, $p < 0.001$) with significant difference in mean score in years of experience as follows: 1 to 5 years and 6 to 10 years ($p < 0.001$); 6 to 10 years and more than 11 years ($p < 0.001$). In addition, there was a significant difference across years of experience on laissez-faire leadership mean scores ($p = 0.04$) with significant difference in mean score across years of experience as follows: 6 to10 years and more than 11 years ($p = 0.004$). Nurse managers who worked 6 to 10 years had the highest mean score on laissez-faire leadership. These findings indicate that nurse managers who had worked 6 to 10 years were more likely to adopt the laissez-faire leadership.

Table 6.19 (A) Assessing mean score differences across years of experience (nurses)

Leadership Factors	Years of experience	N	M	SE	*F*	*p*
Idealised influence-attributed	1-5	83	2.69	0.11	0.79	0.46
	6-10	88	2.49	0.11	*df*=(2,262)	
	More than 11	94	2.59	0.10		
	Total	265	2.59	0.10		
Idealised influence-behavioural	1-5	82	2.67	0.10	0.76	0.47
	6-10	86	2.52	0.09	*df*=(2,259)	
	More than 11	94	2.53	0.09		
	Total	262	2.57	0.06		
Inspirational motivation	1-5	82	2.73	0.11	0.43	0.65
	6-10	87	2.59	0.11	*df*=(2,261)	
	More than 11	95	2.72	0.11		
	Total	264	2.68	0.06		
Intellectual stimulation	1-5	82	2.61	0.11	0.52	0.59
	6-10	87	2.55	0.09	*df*=(2,257)	
	More than 11	91	2.45	0.09		
	Total	260	2.54	0.06		

Table 6.19 (B) Assessing mean score differences across years of experience (nurses)

Leadership Factors	Years of experience	N	M	SE	*F*	*p*
Individual consideration	1-5	83	2.61	0.10	1.04	0.36
	6-10	87	2.44	0.10	*df*=(2,262)	
	More than 11	95	2.41	0.09		
	Total	265	2.48	0.06		
Contingent reward	1-5	84	2.67	0.11	0.79	0.45
	6-10	85	2.49	0.11	*df*=(2,261)	
	More than 11	95	2.59	0.09		
	Total	264	2.58	0.057		
Management-by-exception active	1-5	83	2.55	0.11	1.29	0.28
	6-10	86	2.35	0.09	*df*=(2,259)	
	More than 11	93	2.38	0.08		
	Total	262	2.42	0.05		
Management-by-exception passive	1-5	79	1.31	0.09	3.62	0.03
	6-10	86	1.33	0.09	*df*=(2,253)	
	More than 11	91	1.64	0.10		
	Total	256	1.4	0.06		

Table 6.19 (C) Assessing mean score differences across years of experience (nurses)

Leadership Factors	Years of experience	N	M	SE	*F*	*p*
Laissez-faire leadership	1-5	82	1.10	0.10	1.56	0.21
	6-10	87	1.34	0.12	*df*=(2,261)	
	More than 11	95	1.33	0.09		
	Total	264	1.26	0.06		
Extra effort	1-5	83	2.65	0.12	0.18	0.83
	6-10	87	2.59	0.13	*df*=(2,264)	
	More than 11	95	2.69	0.12		
	Total	265	2.65	0.07		
Effectiveness	1-5	83	2.81	0.12	0.73	0.49
	6-10	86	2.61	0.11	*df*=(2,259)	
	More than 11	93	2.72	0.11		
	Total	262	2.71	0.07		
Satisfaction	1-5	84	2.83	0.12	1.98	0.14
	6-10	88	2.52	0.12	*df*=(2,264)	
	More than 11	95	2.81	0.12		
	Total	267	2.72	0.07		

Table 6.20 (A) Assessing mean score differences across years of experience (nurse managers)

Leadership Factors	Years of experience	N	M	SE	*F* (*df*=2,105)	*p*
Idealised influence-attributed	1-5	37	3.07	0.14	1.57	0.21
	6-10	45	2.78	0.09		
	More than 11	26	2.87	0.16		
	Total	108	2.90	0.07		
Idealised influence-behavioural	1-5	37	3.05	0.09	1.06	0.35
	6-10	45	2.85	0.11		
	More than 11	26	2.99	0.09		
	Total	108	2.95	0.06		
Inspirational motivation	1-5 years	37	3.28	0.09	1.75	0.18
	6-10	45	3.01	0.11		
	More than 11	26	3.20	0.13		
	Total	108	3.15	0.07		
Intellectual stimulation	1-5	37	3.034	0.11	0.94	0.39
	6-10	45	2.85	0.12		
	More than 11	26	3.07	0.15		
	Total	108	2.97	0.07		

Table 6.20 (B) Assessing mean score differences across years of experience (nurse managers)

Leadership Factors	Years of experience	N	M	SE	*F* (*df*=2,105)	*p*
Individual consideration	1-5	37	3.11	0.10	1.03	0.36
	6-10	45	2.96	0.11		
	More than 11	26	3.17	0.09		
	Total	108	3.06	0.06		
Contingent reward	1-5	37	3.09	0.09	2.08	0.13
	6-10	45	2.86	0.11		
	More than 11	26	3.12	0.09		
	Total	108	3.00	0.06		
Management-by-exception active	1-5	37	2.44	0.14	1.15	0.32
	6-10	45	2.60	0.14		
	More than 11	26	2.27	0.17		
	Total	108	2.47	0.09		
Management-by-exception passive	1-5	37	0.63	0.08	2.85	0.06
	6-10	45	0.98	0.12		
	More than 11	26	0.71	0.13		
	Total	108	0.79	0.07		

Table 6.20 (C) Assessing mean score differences across years of experience (nurse managers)

Leadership Factors	Years of experience	N	M	SE	*F* (*df*=2,105)	*p*
Laissez-faire leadership	1-5	37	0.41	0.08	3.17	0.04
	6-10	45	0.64	0.09		
	More than 11	26	0.31	0.08		
	Total	108	0.48	0.05		
Extra effort	1-5	37	3.09	0.13	1.01	0.37
	6-10	45	2.92	0.11		
	More than 11	26	3.13	0.10		
	Total	108	3.03	0.07		
Effectiveness	1-5	37	3.34	0.11	2.55	0.08
	6-10	45	3.03	0.09		
	More than 11	26	3.28	0.11		
	Total	108	3.19	0.06		
Satisfaction	1-5	37	3.46	0.09	6.511	0.008
	6-10	45	3.00	0.12		
	More than 11	26	3.44	0.09		
	Total	108	3.26	0.07		

6.8 Correlation analysis

Correlation analysis was conducted to identify the correlation of nurses' perceived leadership style of their nurse managers and the three outcomes (extra effort, effectiveness and satisfaction). Table 6.21 shows the correlation between satisfaction, effectiveness and extra effort and each of the leadership styles (transformational, transactional and laissez-faire leadership).

For nurses, the correlation coefficients indicated that idealised influence attributed, idealised influence behavioural, inspirational motivation, intellectual stimulation, individual consideration and contingent reward leadership styles had strong positive correlation with nurses' job satisfaction, effectiveness and extra effort as shown in Table 6.21. In other words, nurses perceived that nurse managers who had higher transformational leadership factors would result in more job satisfaction, effectiveness and extra effort from nurses. Transformational leadership behaviour achieves better organisational outcomes as far as nurses are concerned. Management-by-exception active has moderate positive relationship with satisfaction, extra effort and effectiveness (see Table 6.21). However, management-by-exception passive and laissez-faire leadership have a negative correlation with the three organisational outcomes. Nurses perceived that nurse managers who were more laissez-faire resulted in less job satisfaction, effectiveness and extra effort from nurses.

For nurse managers, the correlation coefficients indicated that idealised influence attributed, idealised influence behavioural, inspirational motivation, intellectual stimulation, individual consideration and contingent reward leadership styles had moderate positive correlation with nurses' job satisfaction, effectiveness and extra effort (see Table 6.21). However, management-by-exception active, management-by-exception passive and laissez-faire leadership have negative correlation with satisfaction, effectiveness and extra effort as

shown in Table 6.21. This indicates that the nurse managers agreed with the nurses' perceptions of the managers but to a lesser extent.

Table 6.21 Correlation between leadership styles (transformational, transactional and laissez-faire) with extra effort, satisfaction and effectiveness

Leadership styles	Correlation (r) with extra effort		Correlation (r) with satisfaction		Correlation (r) with effectiveness	
	Nurses	Nurse managers	Nurses	Nurse managers	Nurses	Nurse managers
Idealised influence attributed	0.77**	0.44**	0.72**	0.47**	0.78**	0.39**
Idealised influence behavioural	0.75**	0.45**	0.69**	0.51**	0.77**	0.52**
Inspirational motivation	0.82**	0.61**	0.73**	0.51**	0.84**	0.65**
Intellectual stimulation	0.78**	0.50**	0.71**	0.39**	.079**	0.59**
Individual consideration	0.75**	0.47**	0.69**	0.57**	0.75**	0.46**
Contingent reward	0.79**	0.44**	0.76**	0.53**	0.80**	0.36**
Management-by-exception active	0.35**	0.07	0.32**	0.28**	0.33**	0.19*
Management-by-exception passive	-0.25**	-0.12	-0.27**	-0.15**	-0.31**	-0.12
Laissez-faire leadership	-0.35**	-0.11	-0.34**	-0.14	-0.44**	-0.14

**Correlation is significant at the 0.01 Level (2-tailed).

*Correlation is significant at the level 0.05 level (2-tailed).

6.9 Regression analysis

A regression analysis was run on the three organisational outcomes with the three leadership styles (nine factors) for both nurses and nurse managers to find the leadership style that best predicted outcomes. This was because the correlation was found to be high between the leadership factors and organisational outcomes.

6.9.1 Nurses

This analysis found that effectiveness was significantly predicted by one transformational factor: inspirational motivation (Beta = 0.35, $p < 0.001$) which had the largest impact on effectiveness scores. Effectiveness score was also significantly predicted by one transactional factor: contingent reward (Beta = 0.22, $p < 0.001$). In addition, effectiveness was significantly predicted by laissez-faire leadership (Beta= -0.39, $p < 0.001$) (see Table 6.22). The negative Beta value indicated that laissez-faire leadership reduced the effectiveness score.

In term of satisfaction, it was found that this was significantly predicted by contingent reward (Beta= 0.43, $p < 0.001$). This indicates that contingent reward is the only leadership factor that had the largest impact on satisfaction (see Table 6.23). Finally, it was found that extra effort was significantly predicted by two transformational factors: inspirational motivation (Beta= 0.34, $p < 0.001$) and intellectual stimulation (Beta= 0.75, $p < 0.001$) and contingent reward (Beta= 0.26, $p < 0.001$). The beta coefficient values indicate that intellectual stimulation had the largest impact on extra effort. Extra effort was also significantly predicted by laissez-faire leadership (Beta= -0.31, $p <0.001$) (see Table 6.24). The negative Beta value indicated that laissez-faire leadership reduced the extra effort score.

Table 6.22 Regression analysis for leadership styles factors and effectiveness score (nurses)

Leadership factors	B	Std. error	Beta	*t*	*p*
Constant	1.71	0.54		3.17	0.002
Idealised influence attributed	0.13	0.07	0.12	1.95	0.05
Idealised influence behavioural	0.09	0.08	0.08	1.25	0.21
Inspirational motivation	0.36	0.07	0.35	4.94	< 0.001
Intellectual stimulation	0.09	0.07	0.08	1.34	0.18
Individualised consideration	0.09	0.07	0.08	1.36	0.18
Contingent reward	0.25	0.07	0.22	3.56	< 0.001
Management-by-exception active	-0.06	0.05	-0.05	-1.26	0.21
Management-by-exception passive	-0.08	0.08	-0.06	-0.95	0.35
Laissez-faire leadership	-0.43	0.07	-0.39	-5.94	< 0.001

Table 6.23 Regression analysis for leadership styles factors on satisfaction scores (nurses)

Leadership factors	B	Std. error	Beta	*t*	*p*
Constant	0.40	0.38		1.07	0.29
Idealised influence attributed	0.06	0.05	0.10	1.33	0.19
Idealised influence behavioural	0.01	0.05	0.01	0.16	0.87
Inspirational motivation	0.091	0.05	0.16	1.79	0.07
Intellectual stimulation	0.05	0.05	0.08	0.96	0.34
Individualised consideration	0.06	0.05	0.09	1.34	0.183
Contingent reward	0.27	0.05	0.43	5.55	< 0.001
Management-by-exception active	-0.03	0.03	-0.04	-0.97	0.33
Management-by-exception passive	-0.06	0.05	-0.09	-1.27	0.20
Laissez-faire leadership	-0.18	0.04	-0.29	-4.18	< 0.001

Table 6.24 Regression analysis for leadership styles factors on extra effort score (nurses)

Leadership factors	B	Std. error	Beta	*t*	*p*
Constant	0.096	0.473		0.20	0.84
Idealised influence attributed	0.065	0.058	0.075	1.11	0.27
Idealised influence behavioural	0.042	0.068	0.042	0.61	0.54
Inspirational motivation	0.280	0.064	0.340	4.36	< 0.001
Intellectual stimulation	0.132	0.062	0.75	19.22	< 0.001
Individualised consideration	0.064	0.059	0.068	1.08	0.28
Contingent reward	0.236	0.061	0.26	3.88	< 0.001
Management-by-exception active	-0.036	0.041	-0.035	-0.883	0.38
Management-by-exception passive	-0.06	0.07	-0.06	-1.32	0.75
Laissez-faire leadership	-0.27	0.06	-0.31	-4.48	< 0.001

6.9.2 Nurse managers

It was found that effectiveness was significantly predicted by only one transformational factor: inspirational motivation (Beta = 0.40, $p < 0.001$) (see Table 6.25). In terms of satisfaction, it was found that it was significantly predicted by two transformational leadership factors: idealised influence attributed (Beta= 0.23, $p = 0.01$) and individualised consideration (Beta= 0.25, $p = 0.01$) (see Table 6.26). The beta coefficient values indicate that this impact was about the same for both factors. Finally, it was found that extra effort was significantly predicted by inspirational motivation (Beta= 0.38, $p < 0.001$) having about the same impact as inspirational motivation on effectiveness scores (see Table 6.27).

Table 6.25 Regression analysis for leadership styles factors on effectiveness score (nurse managers)

Leadership factors	B	SE	Beta	*t*	*p*
Constant	2.27	1.51		1.51	0.13
Idealised influence attributed	0.07	0.07	0.08	0.95	0.35
Idealised influence behavioural	0.05	0.11	0.05	0.47	0.64
Inspirational motivation	0.40	0.11	0.40	3.75	< 0.001
Intellectual stimulation	0.19	0.09	0.21	2.06	0.42
Individualised consideration	0.11	0.09	0.11	1.11	0.27
Contingent reward	-0.02	0.09	-0.02	-0.21	0.84
Management-by-exception active	-0.03	0.06	-0.04	-0.56	0.58
Management-by-exception passive	-0.06	0.09	-0.06	-0.59	0.55
Laissez-faire leadership	-0.12	0.12	-0.12	-1.03	0.31

Table 6.26 Regression analysis for leadership styles factors on satisfaction (nurse managers)

Leadership factors	B	SE	Beta	*t*	*p*
Constant	0.51	0.77		0.67	0.50
Idealised influence attributed	0.09	0.38	0.23	2.61	0.01
Idealised influence behavioural	0.05	0.06	0.09	0.85	0.36
Inspirational motivation	0.10	0.05	0.20	1.84	0.07
Intellectual stimulation	-0.7	0.04	-0.16	-1.54	0.13
Individualised consideration	0.13	0.05	0.25	2.58	0.01
Contingent reward	0.11	0.05	0.20	2.12	0.36
Management-by-exception active	0.02	0.30	0.06	0.73	0.46
Management-by-exception passive	-0.05	0.05	-0.10	-0.95	0.34
Laissez-faire leadership	-0.05	0.06	-0.09	-0.85	0.39

Table 6.27 Regression analysis for leadership styles factors on extra effort score (nurse managers)

Leadership factors	B	SE	Beta	*t*	*p*
Constant	1.11	1.21		0.92	0.36
Idealised influence attributed	0.10	0.60	0.15	0.71	0.91
Idealised influence behavioural	-0.03	0.91	-0.39	-0.35	0.73
Inspirational motivation	0.30	0.86	0.38	3.49	< 0.001
Intellectual stimulation	0.81	0.75	0.12	1.09	0.28
Individualised consideration	0.14	0.79	0.17	1.74	0.85
Contingent reward	0.10	0.80	0.12	1.26	0.21
Management-by-exception active	-0.10	0.47	-0.17	-2.13	0.35
Management-by-exception passive	-0.07	0.08	-0.09	-0.84	0.40
Laissez-faire leadership	-0.05	0.09	-0.06	-0.57	0.57

6.10 Summary

The results of the quantitative data analysis indicated that both nurses and nurse managers working at the Saudi Arabian hospitals located in the Eastern Province perceived the leadership style of nurse managers to be transformational and transactional. A higher rating was given to transformational leadership style. There were significant differences between the ratings of nurses and the ratings of nurse managers. The nurse managers rated themselves higher in all nine leadership factors except for management-by-exception passive and laissez-faire leadership style. The results also indicated that there were positive correlations between the perceived leadership style and organisational outcomes: effectiveness, satisfaction and extra effort. Transformational leadership style was considered therefore, as the most effective style in terms of achieving the organisational outcomes. In addition, contingent reward (transactional leadership) had a positive correlation with organisational outcomes. In contract, laissez-faire and management-by-exception passive were the least preferred leadership style from both groups of participants and negatively impacted the organisational outcomes. The next chapter presents the qualitative data findings and analysis.

Chapter 7: Qualitative Analysis

7.1 Introduction

This chapter discusses the results from the interviews held with the managers asking them about their experiences of the culture of leadership in the Saudi Arabian hospitals located in the Eastern Province. There were 21 managers interviewed. These managers worked at various levels of management from managers of a ward, managers of a floor containing a number of wards and evening/night supervisors managing more than one area. Managers were a mixture of Saudi Arabian and expatriate nurses. The data revealed a number of themes which includes: ensure good patient care and safety leadership according to the situation, be a role model, maintain good working relationship, caring about staff, know how to motivate staff, be a good leader, be a good communicator and challenges. Discussion of the data is accentuated with the addition of quotes which provide evidence and illustrate the point. These quotes are identified by adding an initial for the country the participant came from, whether they were female or male and the participant number. For instance, a female manager from South Africa has been identified as SAF2. Managers from Saudi Arabia are labelled KSA to distinguish them from South African managers. The excerpts from the transcripts that appear as quotes have been deliberately presented as the direct translation in order to more reflect the essence of the participant data. These quotes, therefore, are in some cases in broken English.

7.2 Demographics of nurse managers participants

There were a total of 21 nurse managers, 11 were from hospital A and 10 from hospital B. Of these nurse managers, 5 were Saudi Arabian and 16 non-Saudi Arabian which represented diversity of nationalities although most managers were from India and the Philippines. Nurse managers were predominantly females, with only four male participants. Their ages ranged from 20 to 49 years and above, 9.5% (n = 2) were greater than 50 years,

38.2% (*n* = 8) were aged 30-39 years, 33.3% (*n* = 7) were aged 40-49 years and 19% (*n* = 4) were aged from 20-29. Regarding their work experience as a nurse manager, 38.2% of participants (*n* = 8) had between 1-5 years, 28.7% (*n* = 6) had between 6-10 years and 43% (*n* = 9) had more than 10 years. Over half of the nurse managers' (66.7%, *n* = 14) highest qualifications included a bachelor degree, 28.7% (*n* = 6) a diploma and only one nurse manager had an associate degree. None of the nurse manager participants had a graduate degree (Master of Science in Nursing). The details of the demographic characteristics of the nurse managers are presented in Table 7.1.

Table 7.1 Demographic characteristics of nurse managers (*n* = 21)

Demographic variables	*n*	%
Country		
Kingdom of Saudi Arabia	**5**	**23.8**
(KSA)	**8**	**38.1**
India (I)	**4**	**19.1**
Philippines (PH)	**1**	**4.8**
United States (US)	**1**	**4.8**
South Africa (SA)	**2**	**9.5**
Jordan (J)		
Sex		
Male	**17**	**81**
Female	**4**	**19**
Age (years)		
20-29	**4**	**19**
30-39	**8**	**38.2**
40-49	**7**	**33.3**
50-59	**2**	**9.5**
Years of experience		
1-2	**2**	**9.5**
3-5	**6**	**28.7**
6-7	**4**	**19**
8-10	**2**	**9.5**
11 +	**7**	**33.3**
Qualification		
Diploma	**6**	**28.6**
Associate degree	**1**	**4.7**
BSN	**14**	**66.7**
MSN	**0**	**0**
Participating in training concerning leadership	**13**	**62**

7.3 Themes

Theme labels were reflected in the participants own words. These included: *ensure good patient care and safety, leadership according to the situation, be a role model, maintain good working relationship, caring about staff, know how to motivate staff, be a good communicator, challenges and need to go through all the steps.*

Some quotes from the original transcripts of interviews have been included in this chapter to support the findings. Transcripts of the interviews contain some grammatical errors as for the majority of the nurse managers interviewed, English was their second language.

However, the transcripts have been left in their original form as making any alteration and correction may change the original intent of what nurse managers wished to communicate.

7.3.1 Ensure good patient care and safety

There are various components to managing an area with the ultimate aim of ensuring that policy and procedures are followed to ensure optimal patient care and safety. Working towards this therefore, the prime role and responsibility of the manager is to ensure that the area they are managing is working effectively. In other words:

> *'... by keeping things running smoothly and efficiently creating systems that meet the highest standards of accountability ...'* (IF13)

Managers commented that the reason why this was so important was because for them, for instance:

> *'... the first priority is patient care and safety of my patients ...'* (IF12)

In order to achieve excellence in patient care, it was also important to:

> *'... make sure that all staff they are doing correct skills to provide quality care ...'* (JM17)

To be able to ensure that staff were performing correct skills and providing quality care was dependent on a number of factors. The first of these was to ensure that:

> *'... we have to keep ourselves update ...'* (KSAF9)

Ensuring that the staff were using evidence based practice was only part of this, however. What was also required was to ensure that:

> *'... we are always updating policy ...'* (IF7)

Having up to date and evidenced based policy and procedures helped ensure that the staff were practising according to the current evidence. It was not only the staff, however, who needed to be up to date with the evidence. The data identifies why it was so important for managers to also keep up to date and believed that this was part of being a 'good leader' because:

> *'... sometime you are a leader by nature but you need to sharpen your skills knowledge ...'* (JF1)

Then of course in order to provide quality care it was important that the managers be:

> *'... very strict with the policy and procedure. I am very particular with the policy and procedure ...'* (IF4)

Managers, however, cannot be strict about ensuring the staff follow the policy and procedures without them being aware of what these policy and procedures are themselves. The other reason why it was important that the manager be familiar with the policy and procedures is articulated in the following:

> *'... to be effective for every decision I made I should know the policy and procedure of the hospital because this is my guideline ...'* (PHM8)

There was also the belief expressed by the managers that as a result of the nurses following the policy and procedures this would result in encouraging them. In other words:

> *'... those who are working in good manner and according to the policy and procedure we will motivate them more to do ...'* (IF5)

Ensuring that policy and procedures were being followed did not mean that if nurses did something wrong they should be punished. The opposite was in fact the case for these

managers and this speaks more about the good relationship that managers believed they needed to have with the staff. In other words:

'... so we also encourage staff in a negative situation when something went wrong, because of human error, come forward and be honest on what you have done… can look at it as opportunity to improve our practice ...' (SAF2)

This was not about letting staff get away with making a mistake either as it was important to:

'... maintain appropriate disciplinary action ...' (IF11)

Managers also believed that another way to ensure that staff were performing well and not making mistakes was to:

'... observe the work of the staff and I will correct them if I will find anything wrong ...' (IF12)

This insinuates that the managers in this study were actually working with the staff to be able to identify if they were doing something wrong and were therefore, actively participating in the managing of the area. It was clear that the managers believed that there was an appropriate way to deal with staff who had made a mistake and about being professional in identifying this. In other words:

'... if they did mistake so I have to talk to them not in front of other people ...' (PHF6)

7.3.2 Leadership according to the situation

It was clear from the data that the participants interviewed reflected the practice of adopting various leadership styles. This meant that the managers practiced a mixed style of leadership reflecting a combination of styles and each style was used as when needed. The managers saw that a mix of leadership styles could be adopted in order to maintain an

effective working environment that was focused on achieving the collective goal and organisational objectives. Accordingly:

'...I mix according to the situation ...' (JF1)

On the whole, the predominate leadership style used by the participants was democratic. Democratic leadership is a style where the leaders adopt a participative approach where all the members of the unit could play an important role the decision making process (Iqbal, Anwar, & Haider, 2015). As discussed in the literature review and as part of the conceptual model, democratic leadership is part of the transactional leadership factors. Indeed, the transactional leadership style is commonly referred to as 'democratic' (Bass, 1997). Democratic leadership reflects the philosophy of working together as a team and based on respect and trust of individual members to get the job done. Managers identified that they adopted democratic style of leadership more during times when the ward was functioning well and staff were just getting on and doing the tasks of caring for patients. This resulted in a good working environment and instilled a sense of freedom and responsibility among the nurses.

The reasons for adopting a democratic approach varied. For instance, a democratic approach was used to engender a state of shared decision making among nurses working in the unit. In other words:

'*…to emphasise teamwork ... discuss work together with my team …*' (IF21)

This shared decision making, however, was more than having open discussions about an issue in the unit. Managers commented that this also involved listening to staff and actively:

'... asking my colleagues about my ideas and asking opinions from them ...' (PHF15)

An interesting side reason for managers adopting democratic leadership style was discussed by one participant who added that this was also to:

'... engage them also in decision making to have better job satisfaction ...' (KSAF18)

As can be seen by this quote, job satisfaction was enhanced by using a democratic leadership style. This is an important consideration for nursing in Saudi Arabia due to the many challenges that nursing in Saudi Arabia is currently facing and as identified in Chapter 2. Part of this democratic leadership which further enhances job satisfaction is supporting staff and working in a friendly environment. This is also acknowledging that:

'...we are human, if any staff make any mistake or something, stay with me and discuss the issue easy ...' (JM17)

A key component of having a democratic leadership style is having the ability to step back and have the confidence to not micro manage. This requires the manager to be:

'... I am always very observant. I try not to micro manage' (SAF2)

In other words, from a someone who is an overall supervisor and not directly in the ward:

'I always allow head nurses to make decisions as well as the charge nurses. Only if the problem cannot be solved at their level, then they escalate the problem to me ...' (SAF2)

This quote reflects the fact that this manager only became involved in the situation of making a decision when they were needed and not interfering before that time. Such a manager is giving the full freedom to ward level managers to manage the activities on their own, independently. Obviously if required to, this manager would intervene.

Even though democratic was the main leadership style, it was acknowledged by the participants that other styles may be more appropriate under different circumstances. This is clearly illustrated in the following quote:

'…*I am using most of the time democratic style but it also depends on the situation sometimes I should be autocratic and sometimes lassie-faire* …' (KSAF14)

In some situations, however, participants believed that there was the need for autocratic leadership style depending on the circumstances in the ward. Autocratic leadership styles for instance, tended to be needed during situations of:

'…*emergencies or crisis* …' (JF1)

The insinuation behind this therefore, is that sometimes during times of crisis people needed clear direction as they may otherwise sometimes flounder hopelessly trying to work through the crisis. In these circumstances an autocratic leadership style is needed to tell the staff what they need to do and help them focus on what tasks are required to be done. In other words, the managers believed that these situations needed them because:

'…*in crisis will have to be autocratic and take decisions* …' (JF1)

There were other times that the managers believed an autocratic leadership style was required. The other circumstances participants identified as to why they needed to use an autocratic leadership style was because:

'…*sometimes you find some people trying to overpower you as a leader then you wish you are more autocratic* …' (SAF2)

The type of leadership style adopted by the manager was also dependent on the role that the manager had. For instance:

‘ *... during night time supervisor we are representing the nursing department ... because we are covering all the unit so we use autocratic kind of leadership because they need to find what do you want because looking for the all the hospital …*’ (PHM8)

Night time supervisors are managing a number of wards and this means they are managing a lot more staff. The nature of this position is that the manager is moving around the hospital and checking in on the wards to make sure there are no issues. In other words, this manager is not staying in one area long enough to know what is going on. These managers therefore, do not really know the staff or what is going on in that area. In addition, the night supervisor is only contacted when a crisis has occurred that the staff are not able to deal with:

A completely different leadership style was identified by a manager from USA who described his leadership style as:

‘... coming from the principle of magnet ...’ (USM3)

This was described an extension of team work in that it is based on:

‘*… principles of shared governance ...*’ (USM3)

What this meant was that the manager shared their decision making and power among the staff they managed and involved them in various activities by forming committees for different activities. This included setting up a number of committees including a communication committee, a nurse excellence committee, an infection control committee, a wellness committee, a social committee and so forth. Magnet leadership was a way of formalising a democratic leadership style and almost focusing the staff to be involved in the collective decision making by being on various committees.

Another dimension identified from the data was integrating the magnet theory of shared governance with transformational leadership. This meant that managers:

> '*… are encouraging everyone to be to apply transformational leadership style …*' (KSAF9)

The managers in this study believed that in some circumstances, no leadership style was required so that the staff could enjoy full freedom in decision making relating to an event. This enhanced a good relationship among the team members. In other words:

> '*… I am laissez-faire sometime in simple matter like parties or social activates that they want to do I leave it up to them to decide how they want to do it …*' (JF1)

It can be noticed from this quote that this manager was referring to an environment outside of work.

It was evident from the data that the majority of the participants used a blend of leadership styles depending on the situations. The majority of the managers, however, preferred a democratic approach which is more commonly known than transformational leadership style. Indeed, transformational leadership is basically an extension of the democratic leadership style.

7.3.3 Be a role model

Importantly, many of the managers commented that they believed in order to be an effective leader it was important to be a role model. There were a number of reasons expressed in the data as to why this should be the case but ultimately being a role model was about:

> *'… making myself as an example for them …'* (PHF10)

This was not just about what the manager did or said to the staff but also about their appearance. In other words:

'... uniform you need to follow the uniform policy your image ...' (PHM8)

The reasons identified as to why it was important for the manager to be a role model in the data encompassed all aspects of being a nurse manager:

'... should be a good role model among all so that the others can learn from you the way you have the knowledge and patience and everything ...' (IF7)

Such was the importance of being a role model to these managers, that they believed that this meant they needed to be perfect in their day to day work. This was because:

'... whenever I am talking with the staff I should very perfect about what I am talking to them because of course they see what I am doing ...' (IF4)

In contrast, however, this manager commented that this was also about working within acceptable boundaries, meaning that:

'... if I am doing something wrong and I am asking somebody to do it, it is not acceptable ...' (IF4)

Interestingly, being a role model was not just about nurses learning from their manager about how to work, behave, look and communicate. Being a role model also included developing a good relationship between the manager and the staff. This involved two aspects of this relationship. Firstly:

'... when you say something you should be a role model to your staff so that you can gain their trust ...' (JF1)

This was also about developing respect within the relationship. In other words:

'... when I start to respect them, they will respect me ...' (IF5)

Ultimately then being a role model was about having a good relationship with the staff and was also the essence of having a transformational leadership style.

7.3.4 Maintain good working relationship

Another part of being a good manager is to have a good working relationship with the staff that are being managed. This involved a number of different aspects including the importance of working as a team or:

'... we are members of a team we are members of a family; this is what I always tell the staff ...' (SAF2)

Such was the belief to work 'as members of a family' that some took this further. For instance:

'... like mother and baby they are my children ...' (IF5)

This quote could indicate that this relationship could be viewed as condescending or dependent but it was clear from the data that this was much more than this. It was truly working together as a team because:

'... sometime they call me Mama I like that one because the respect is there ...' (PHF6)

There were two sides of this philosophy that is evident from this quote as it is not just about working together as a team. It is also about caring for each other. For instance:

'... look at me like your mother the one you will approach very easily with your problem ...' (SAF2)

This emphasises the importance of the manager having a good relationship with the staff and the fact that they are working together as a team or family. This then is the essence of being a good manager. In other words:

'... my working relationship with my staff as friend not as manager or leader ...' (KSAF14)

If this 'good relationship' is not there, there are consequences, as can be seen in the following:

'... if there is no good relationship with your staff, very difficult to manage them ...' (IF4)

The emphasis here is the fact that being a manager is more than being able to manage and is reflected in the need to have a good relationship with the staff:

'... people always appreciate how skilful and manageable you will be but they appreciate more how you approach them communicate ...' (JF1)

This same manager reflected that developing a good relationship with staff was more than getting to know them and working as a team but importantly about:

'... put yourself in their shoes to be able to understand how to deal with them ...' (JF1)

The reason why being able to understand the staff is so important was explained in the following:

'... if you know the person, you will know how to guide them ...' (IF7)

Another important reason why it was crucial to get to know the staff was related to the fact that nurses working in Saudi Arabia come from vastly different backgrounds. This

therefore, made this getting to know the staff even more important but at the same time, needless to say, more difficult. This meant therefore, that as managers:

'... we should have more patience because our nurses all are not the same. Everyone has different characters and different behaviours ...' (IF7)

The other aspect of this relationship was of course being the manager. So, from the data it was clear that the manager had a role to play in ensuring this 'good relationship'. This is illustrated in the following:

'... most important thing is humility as a leader ...' (SAF2)

Furthermore, managers commented that while being friendly with the staff, it was also important not to be too friendly with the staff. This is because:

'... if you are managing one unit you are much closer to each other but you need to distance yourself from them ...' (PHM8)

The reason that this manager believed it was important to have some distance between the manager and the staff is that otherwise:

'... some of them will take advantage ...' (PHM8)

It was also evident that the manager also needed to be seen to be part of the staff in order to gain respect and have this good relationship with the staff. Being part of the staff meant that:

'... if they are busy I am helping them because we want to finish ...' (PHF6)

Helping the staff could be seen to be beneficial on a number of levels. For one thing this showed the staff that the manager could function as a nurse and was not therefore, above them in status in that they could work alongside the staff. This also showed that the manager

was working with the staff as a team and helping them finish their duties so that they could all get home. Helping the staff also indicated a level of respect on both sides for each other.

Having a good relationship does not mean, however, that the manager does not tell them if things are wrong in any way. In other words, it is important that the manager:

> *'... be nice and kind manager at the same time tough and strong when it is needed ...'* (KSAF14)

It was after all important for the smooth running of the area to have harsh words with staff if they have done something wrong in order for them to learn. In other words:

> *'... identify areas for improvement and I deal with it like immediately ... and make her accept it in a positive way ...'* (SAF2)

This was about disciplining people in a supportive way. In other words:

> *'...getting the person to know that you are trying to help her and not to bring her down, being humble and accepting each other ...'* (SAF2)

Sometimes, however, managers needed to be tough with their staff in order for the area to function well. This meant that sometimes therefore:

> *'... I am very strict and I am very rude sometimes but as a person I am trying to keep good relationship ...'* (IF4)

It was clear from the data that the effort to maintain a good working relationship was ongoing and required continual work. Ultimately, managers identified that:

> *'... you have to be patient with relationship to gain acceptance you get people to know you trust them ...'* (JF1)

Ultimately it was important for the managers to remember where they themselves have come from. In other words:

'... have to respect your subordinates this is important because before we are in this position we are also the same so that one ...' (PHF6)

Managers after all usually had worked as a bedside nurses for some time before they were appointed as the manager. Evidence of the effect that occurred when a manager had a good relationship with the staff is illustrated in the following:

'... I have good relationship ... when took decision to move ... they want to move to the area because I am going to move to that one ... nurses they want to move with you ...' (KSAF9)

7.3.5 Caring about staff

One of the components/ways that managers could have/develop a good working relationship with the staff was by caring for them. Managers identified the need to support and care for the staff they managed and felt that this was an important component of their role. Such is this importance that the following statement was made:

'… *we are here to support them ...'* (PHM8)

So strong was the conviction about the need to do this at any management level that the comment was made that:

'… *nursing in particularly we have to keep in mind that we need to remain caring no matter what our position ...'* (JF1)

The reasons identified in the data as to why it was so important to care relates to the role modelling that this caring role had as well as the fact that:

'... if you care about your staff that will very much of motivation and you will gain their reality I learn through my career that as a leader I have to stand for my staff and nursing deserve support because they deal with patient ...' (JF1)

Whether this quote is also acknowledging the sometimes challenging work that is involved with nurses caring for patients, is not clear. It was clear however, that this caring for staff also meant getting to know the staff after all:

'... they are all coming from different style, family, and attitude so we should know each staff ...' (IF4)

It was clear from the participants that there is two sides to this caring for staff. The other side of this caring for staff is to:

'... be approachable, be somebody that people will come to you not run away from you ...' (SAF2)

The reason identified in the data as to why caring for staff was important was because this affected the relationship and therefore:

'... everything will be smooth if the relationship is very good ...' (PHF6)

Being approachable and having a good relationship with staff was also about something much more important and certainly contributed to the smooth running of the area. This was because:

'... if they are afraid of you to approach if they did mistake they will not tell ...' (PHF6)

The issue of cultural diversity among the staff was highlighted here as well. Part of being approachable and caring was ensuring that all staff was treated equally. In other words:

'... look for everybody with the same eye don't show any favouritism ...' (SAF2)

This was particularly the case in Saudi Arabia because of the number of expatriate nurses who came from many countries. It was therefore important that there was:

'... no partiality with Saudi non-Saudi Indian Philippine Egyptian this the first priority ...' (IF4)

To the managers in this study, caring was much more than being approachable and having a good relationship with the staff but also about being approachable, such that:

'... anytime of my duty, they can come and tell their problem to me ...' (IF5)

This is suggesting that this caring for staff goes beyond the normal working relationship issues into the personal realm of caring. For instance, it was identified that it was important to:

'... listen for them and support them and help them and try to solve the problem ...' (KSAF20)

Saying that it is important to 'solve the problem' suggests that this is about solving personal problems and not just work related issues. In addition, according to the participants, this caring role went beyond work hours:

'... sometimes suddenly something happened to them or their relationship so easy reachable my mobile number with them always ...' (IF5)

This could relate to the fact that the expatriate nurses actually live within the hospital complex and are usually in Saudi Arabia without family or other supporting networks, apart from the people they are working with. This creates a unique situation for the nurse managers who need to take these factors into consideration as part of their day to day management and therefore, go further than managers in other countries, like Australia, would need to do.

7.3.6 Know how to motivate staff

Having a good working relationship, caring for and getting to know the staff was also identified by the managers as an important part of them then knowing how to motivate the staff. After all:

'... when you understand people well, you know how to motivate each of them ...' (JF1)

There were different ways that were identified in the data as to how the managers could motivate the staff. One of the ways staff could be motivated was:

'... by encouraging them all the time and complimenting their good job ...' (KSAF14)

There were a number of reasons identified in the data as to why motivating the staff was an important aspect of being a good manager. It is, after all, easier not to worry about motivating staff and to just focus on the task of managing. The first reason is that:

'... motivation is important to give their best ...' (SAF2)

This was, therefore, important because:

'... I like to have encouraging them or motivate them so that they can do it because without motivation they can't improve ...' (IF4)

Motivation is therefore, about getting the best performance from the staff. This may not require much effort from the manager as can be seen from the following:

'... Some of them they will be motivated only with simple word of recognition and that will be enough to energise them for a year ...' (JF1)

Fundamentally, motivation is about:

'... being thankful for everything they do, when you thank somebody, they will outdo themselves ...' (SAF2)

This quote exemplifies how easy it is to motivate staff and does not require much effort from the manager. Motivating staff in this manner therefore informs the staff that they have done a good job and helps them want to improve themselves. It also about empowering them which results in:

'... nurse now they empowered to speak up and they are taking the decision they think it is the best for their service ...' (KSAF9)

This is an important aspect of improving the service generally as it is important that nurses challenge other health professionals about decisions and care that is being provided in order to ensure the best evidence based practice. In addition:

'... when they provide good patient care I will appreciate them for their good performance ...' (IF12)

Motivating staff can be undertaken in a number of other ways. For instance:

'... smile sometimes can motivate people. Simple tap in their back give them energy we are human being at the end so again caring about staff feeling that somebody is there to listen to them ...' (JF1)

This also highlights that different people are motivated by different things. Some people are only motivated by money as opposed to what was identified in the above quote. In a hospital environment it is not possible to give staff a financial bonus. The other option therefore, is to support them financially though other means, for example:

'... some of them they want to go attend conference ...' (JF1)

Attending conferences could mean that the staff are given money for the conference registration and/or time off to attend the conference. It was not clear from the data what this could be in this instance. There are other ways that staff can be financially rewarded that was highlighted in the data as follows:

> *'... we have best nurse this one for motivation for them who most improve in this department and best note each month and we will give extra off ...'* (PHF6)

It was not clear from the data how this 'extra time off' was facilitated considering the high workload due to staff shortages. One way this may have been facilitated could be by staff going home early after a shift which is what is insinuated in the following:

> *'... if they do something good I give them sometimes extra off and extra hours sometimes ...'* (KSAF20)

Acknowledgement of staff efforts publicly was a common thread in the data as a way of motivating staff. For instance, many managers mentioned the following way:

> *'... every month I am selecting the best staff I am selecting best nurse of the month selection according to the assessment of the staff ...'* (PHF15)

What this 'best staff' entails was not clear but could be an acknowledgement in the form of:

> *'... I am giving certificate for best nurse ...'* (KSAM21).

This acknowledgement, however, may not be as formalised at this. It simply may be just:

> *'... by thanking them in front of people ...'* (JF1)

As mentioned previously, how people are motivated varies but the importance of the need for managers to motivate the staff somehow was clear.

7.3.7 Be a good communicator

One of the most important qualities of a good leader as identified by the participants, is effective communication skills. Communication skills are, therefore, crucial for a leader to lead effectively. To achieve professional success, nurse managers must be effective and convincing communicators. This will not only help staff to complete their job successfully, but will also enable the organisation to achieve its outcomes. Different aspects of communication were identified by the participants; one of these aspects is open communication. Open communication refers to the process where members of a team are able to express ideas with each other through both formal and informal communication approaches. One of the reasons identified by participants as to why they believed open communication was important was because it is:

'... the key to have a good relationship with everyone…' (PHF10)

The importance of a manager having open communication was clearly identified but participants also acknowledged the difficulties encountered when trying to achieve this. In other words, with open communication:

'*... sometimes it is very time consuming and effort consuming…*' (JF1)

One of the strategies identified by the participants that assisted with achieving open communication was having an open door policy with staff. An open door policy refers to the fact that the manager literally has an open office door and also means that they are available at any time for the staff to come and talk with them. This is aimed at encouraging openness and transparency. The reason this was identified as being useful was because with an open door policy this means that staff:

'*... will communicate openly with me without any restriction…*' (KSAF9)

This open door policy meant that nurses felt comfortable communicating with their nurse manager. In addition, open door communication policy can make the staff feel safe to communicate freely about any personal or work issues. To make this work though, importantly the manager must ensure confidentiality. It is essential for the leaders therefore to reflect this policy by mentioning it to the staff in an effective way. Another aspect of open communication is the nurse manager making themselves available for the staff. In other words:

'*... they (nurses) can call me and saying that we have issues that we need to discuss…*' (KSAF9)

Open door policy not only referred to being physically available for staff to communicate with. Managers are often required to attend meetings or they may not be in their office for other reasons. It is important therefore, for the manager to be available for the staff to be able to communicate with the manager by other means available. This translates to:

'*... I do have open communication, anyone can come at any time talk to me and if I am not around I am encouraging them to send an email, especially if it is an urgent matter…*' (PHF10)

Good leaders should also be aware of the fact that productive communication is not just a one-way process. It is important to acknowledge there are two key factors which complete the communication process: speaking and listening with understanding. Listening was, therefore, identified as from the data as an important aspect that leaders needed to consider. The participants reflected that being a good listener and good communicator are two characteristics that leaders should have which will help them in:

'*…leading them to be where they want to be and what is the best for the organisation…*' (KSAF9)

One of the reasons identified by the manager as to why listening was an important aspect of their role was because this:

'*… will reduce the distance between staff and head…*' (KSAM19)

An extension of listening identified by participants involved actively asking staff for suggestions regarding an issue or decision that needed to be made. In other words, it was important that the manager:

'*… ideas I am asking my assistant and my colleagues about my ideas and asking also opinion from them…*' (PHF15)

There was a belief also that it was a nurse manager's communication skills which helped motivate and inspire staff to work hard and achieve the team and organisational goals as well.

7.3.8 Challenges

The participants identified that there were a number of challenges that they encountered as they undertook their management role. One of the biggest challenges identified was the communication issues of working with such a large expatriate nursing population. This was because:

'… we have some staff from almost all over the world …' (USM3)

Even though English was identified as the common language between all staff and patients, there still were issues with this as identified:

'… English is the dominate language should be spoken in the hospital but it not always spoken …' (USM3)

This created further communication issues. The communication challenge was identified as an issue because:

> *'... once I become a head nurse my work started as a challenge because I should understand each and every staff ...'* (IF5)

Communication challenges was not only about understanding other staff members but was also:

> *'... the language also communication between staff and patient ...'* (JM17)

Interestingly enough, these communication challenges were identified as not being unique to the Saudi Arabian nursing population:

> *'... it is also the same issue we face in the United States ...'* (USM3)

Communication was identified as not just about being able to understand the conversations that people had. It was also about going beyond the language because communication is not just about what people say. Otherwise there is:

> *'... a challenge miscommunication sometimes about different culture also ...'* (JM17)

It was therefore identified that it was also important that the managers needed to incorporate cultural understanding within communication because:

> *'... to understand behaviours and understating personality need to know how people interpret you ...'* (SAF2)

Specifically, the managers' cultural diversity added an extra level of complexity to the communication difficulties experienced in the work environment. The extent that this was needed to be considered was clearly illustrated in the following:

'... here I should watch what I say and how I say it ... communication barriers, misconception of ideas because I can say something and the staff can interpret it differently ... more stressful being a manager here than if I had a choice in South Africa ... but the challenges help develop me as a leader ...' (SAF2)

Ultimately though, this manager could see the positive aspect of this challenge, that is, making her a better leader as a result because this was about learning how to deal with different people in the workplace.

The managers also identified a number of other challenges apart from the difficulty with communication. Whether this was related to the issues of communication was not clear from the data. Challenges were identified because the managers needed to:

'... think to interact with different people ...' (KSAF9)

A specific added difficulty was identified as:

'... I am also dealing with physician and with patients as well so those are the challenges ...' (PHF10)

Infrastructure problems were also identified as challenges by the participants. Such things as:

'... difficult for supplies sometimes ...' (JM17)

In addition:

'... other department we have difficulty with maintenance ...' (JM17)

Patients were also identified as creating challenges to the managers for a number of reasons. This included:

'... the challenge is there are too many patients they are always asking single room ...' (PHM8)

Also, there was a belief that:

'... Patient satisfaction main challenge for us ...' (IF7)

Staffing was also identified as a challenge to the managers for a number of reasons. One of these being that:

'... less of staff some staff sick leave ...' (KSAF20)

Having staff off on sick leave would affect the workload for staff as there would be less staff to care for patients. Another reason identified for staff being absent from the shift related to the fact that for Saudi Arabian nurses they may not have any choice but to take leave as they are the main carers of their children:

'... Saudi staff most of them they absent because they have child especially in the night nobody can take care of the baby for them ...' (KSAF20)

The other factor that affected the workload and created different challenges for the managers was the fact that expatriate nurses tended not to stay in Saudi Arabia for very long periods of time. In addition, there was a tendency to recruit newly graduated nurses to replace those who had left. This meant that:

'... we are receiving new staff and some of them they are not experience ...' (JM17)

One of the other challenges identified by the managers and already partially alluded to above is the issue of the large expatriate workforce and the implication that this had for the managers. The difficulty that this diverse workforce had is clearly illustrated in this quote:

'... having diversity of culture this is something you really need to work on ... it gives you extra emphasis to be placed on ... if you as a nurse manager do not understand culture diversity, you really lead yourself in a lot of problems ...' (SAF2)

This therefore, created another level of complexity to the managers that they needed to deal with, that could potentially result in disharmony and therefore:

'... if you understand (cultural diversity) it makes you flow much easier in resolving issues with your staff ...' (SAF2)

This was not just about taking individual cultural diversity into consideration on a daily basis. However, it was clear from the data that this went much further than this because it was also important that:

'... when dealing with multi nationality staff keep a keen sense of justice among them and mastery of details ...' (IF12)

In this example, 'mastery' refers to the importance of ensuring that communication was provided in detail in order for there to be clear communication regarding instructions or orders.

The extent of the difficulty that a multi-cultural workforce had on the managers is clearly demonstrated in the following comment from a manager who came from South Africa:

'... if I am a nurse manager in South Africa it would be much easier because I understand my people I understand my culture ...' (SAF2)

Another aspect of working in a multi-cultural environment is remembering that the managers were also working in Saudi Arabia and needed to incorporate these Saudi Arabian

nurses into the cultural sensitivity directed at other staff. In other words, each staff member's individual culture, no matter where they came from, leaders needed to be culturally aware of:

'... especially the male in this culture, we have to respect them ...' (PHF6)

7.3.9 Need to go through all steps

This theme describes what experience the participants believed that a nurse needed to gain at the bedside caring for patients before becoming a manager. In other words, working as a bedside nurse and learning how to be a nurse, enabled the development of knowledge and skills as a nurse which participants thought were important before becoming a manager. The insinuation here is that nurse managers cannot manage the staff without having an understanding of what it is to be a bedside nurse caring for patients and making clinical decision. This is in order to have:

'... solid knowledge that they should have as a nurse before they will decide to have their career path in administration or management ...' (KSAF9)

The nurse manager needs to learn various activities related to clinical experience before becoming a manager, which not only enables them to have awareness of all activities relating to nursing management but also the ability to assess and address any issues in daily clinical activities that may arise while working as a nurse manager. There was a strong believe therefore, that a manager had to:

'... prove themselves first as a bedside leader ...' (KSAF9)

The reason that this was identified in the data as an issue was that there was a tendency seen to be to favour Saudi Arabian nationals to be appointed in a management position once they graduated. In addition, Saudi Arabian nurses favour applying for these positions as they would prefer to work Sunday to Thursday and day shifts rather than

working on weekends or night shift. This results in Saudi Arabian nurses generally having minimal bedside nursing experience before becoming a manager. This issue was highlighted by a Saudi Arabian nurse manager. This manager believed that:

> *'... Saudi nurses that I think they need to go through all steps before…[becoming a]…nurse manager ....'* (KSAF9)

This issue was also identified by expatriate managers who commented about how quickly Saudi Arabian nurses became managers. The appointment of Saudi Arabian nurses to be managers in a short time could also reflect the fact that Saudi Arabian nurses are excellent bedside nurses and therefore, have the necessary experience to become a manager. In other words:

> *'... so I think the Saudi they are learning very quick ...'* (PHM8)

It was not clear from the data as to the reason for these comments. The important emphasis identified from the data is that a good manager also needs to be a good bedside nurse:

> *'... even if you have that leadership skills you should have also clinical skills ...'* (KSAF9)

In other words:

> *'... walk the talk all the time and stay close of your team don't work in isolation share thoughts involve people ...'* (JF1)

7.4 Summary

This chapter has reviewed and analysed the qualitative data findings. The analysis revealed the following categories: ensure good patient care and safety leadership according to the situation, be a role model, maintain good working relationship, caring about staff, know how to motivate staff, be a good leader, be a good communicator and challenges. This analysis has found that some of the nurse managers adopted leadership styles according to the situation, but predominantly used transformational and to lesser extent laissez-faire. The importance of being a good communicator, caring and motivating the staff, setting clear goals, relationship building, and most importantly having a dedicated mind with honesty and integrity were identified. In addition, the participants identified a number of challenges, including cultural diversity, associated language difficulties and workload issues. The importance of the need for managers to gain experience working at the bedside prior to going into management was emphasised. The next chapter discusses both the quantitative and qualitative results in relation to the literature to describe the contribution this study has made in this area of leadership.

Chapter 8: Discussion

8.1 Introduction

This chapter presents a synthesis of the findings from the quantitative and qualitative phases of this study. The overall aim of this chapter was to examine the findings of this study on nursing leadership in relation to that found in the literature. These insights are categorised broadly into those that confirm existing knowledge, these that extend on existing literature and finally what contributions this study has made in relation to new knowledge in the area of leadership in nursing.

This thesis used a nested design mixed methodology approach (discussed in Chapter 5) as priority was given to the quantitative data and analysis guiding the project, whilst the qualitative data and analysis was the 'nested' approach. This approach was adopted as it provides an opportunity for new insights or more refined thinking (Creswell et al., 2011). The approach enabled a broader perspective than could be achieved if only a single data collection method was used. With this in mind, the quantitative analysis was given priority with the qualitative analysis being the 'nested' approach through the discussion.

This chapter begins with the research questions in order to situate the findings from the study. This is followed by a paragraph of the significant findings from both the quantitative and qualitative data. The literature will then be used to explore the meaning of the results and to identify new knowledge that this research has contributed to.

8.2 Research questions

The research questions for this study in Saudi Arabian hospitals in the Eastern Province were:

1. What are the self-reported leadership styles of nurse managers?

2. What are nurses' reported perceptions of leadership styles of nurse managers?

3. Is there a relationship between leadership styles of nurse managers and nurses' job satisfaction and willingness to exert extra effort?

4. Is there a correlation between nurse managers' leadership styles and their effectiveness?

5. Is there a significant difference between how nurse managers perceive their leadership styles to that of nurses' perception of their managers' leadership styles?

6. Is there a significant difference between demographic characteristics and the leadership styles of nurse managers?

8.3 Summary of findings

This section discusses the summary of findings from the quantitative and qualitative findings of the study.

8.3.1 Quantitative findings

The significant demographic characteristic findings are presented in the next section of the thesis. This section presents the significant findings from the analysis of the MLQ results. These results indicated that transformational leadership was the predominant style of leadership behavior as perceived by nurse managers. Laissez-faire leadership was the least preferred style as perceived by the nurses and nurse managers.

For the nurses, the more laissez-faire the nurse managers were, the more ineffective was the management, which resulted in decreased job satisfaction and effectiveness. Furthermore, the more laissez-faire that the nurse manager was, the more they were perceived as ineffective managers and they managed punitively. The more there is agreement to accomplish goals, the more punitive action by nurse managers if nurses are unable to agree to set standards (Alshammari, 2014). Correlation factors were high between the transformational factors which correlated high with the organisational outcomes. This

indicates that the clearer the goals and lines of communication from the nurse managers, the more likely the ward functioned well, nurses work hard and are amenable to change with nurses working collaboratively.

For the nurse managers there was agreement with the nurses with these. There was a positive correlation found between management-by-exception active (transactional leadership factor) and the transformational leadership factors. This indicates that the more management-by-exception active the nurse manager was the more there was intellectual stimulation, coaching, listening, and being treated individually. Nurse managers rated themselves lower than the nurses rated the nurse manager in utilising management-by-exception passive. In other words, nurses perceived that their nurse manager did not provide information, articulate goals or create effective solutions and timely responses, whereas nurse managers believed that they did do these things.

In relation to the demographic variables and patterns of leadership for nurses, female nurses had higher mean MLQ scores for organisational outcomes compared to male nurses. In relation to highest achieved qualification, nurses with a diploma qualification had higher mean MLQ scores than nurses with bachelor qualification on laissez-faire leadership. Saudi Arabian nurses had higher MLQ mean scores for laissez-faire leadership style compared to nurses from the Philippines and India who had the lowest values.

For nurse managers, those from Saudi Arabia had a higher mean MLQ score on idealised influence attributed compared to Indian and Philippine managers who had the lowest mean MLQ value. There was a significant difference in mean MLQ score in 1 to 5 years of experience on satisfaction compared with more than 11 years and with 6 to 10 years being the lowest mean MLQ value. Nurse managers who had 6 to 10 years of experience had the highest mean score MLQ for laissez-faire leadership style.

Finally, in relation to transformational leadership factors, nurses perceived that nurse managers who had higher transformational leadership factors would result in more job satisfaction, effectiveness and extra effort from the nurses. In other words, transformational leadership achieves better organisational outcomes as far as the nurses were concerned. In contrast, nurses perceived that nurse managers who were more laissez-faire and used management-by-exception passive resulted in less job satisfaction, less effective work and less effort from nurses. Nurse managers agreed with this but not as strongly as nurses perceived of their managers.

8.3.2 Qualitative findings

There were nine distinct themes identified from the analysis of the interviews with the nurse managers and these will be briefly described. For theme one, the nurse managers discussed the need to ensure good patient care and safety though the use of policies and procedures which were kept up to date with the latest evidence-based practice. They saw this essential for the smooth running of the area and ensuring that the staff were performing well. This included appropriate discipline of nurses if needed.

Theme two discussed the fact that nurse managers used different leadership styles depending on the circumstances. Predominantly this was using a transformational leadership style but sometimes an autocratic style was rarely needed in times of crisis. There was also discussion from the different levels of nurse managers and when they saw that different leadership styles were needed depending on the position that they were in. Laissez-faire was viewed as being useful for social situations but not mentioned as useful in managing the ward.

The need to be a role model to the nurses they manager, was the third theme identified from the nurse managers interviews. This theme discussed the importance of nurse managers'

need to look, behave and talk in a professional manner that others could emulate and thereby respect the manager.

There was a lot of discussion on the fourth theme which identified the need for the nurse managers to have a good working relationship with the nurses. This highlighted the various strategies that were used and the importance of the nurses working together as a team. There was also the discussion of needing to be tough at times but that this was all part of the nurse managers role. This also flowed into the next theme of caring for nurses and the importance of this fact working in a caring profession of nursing.

Theme six identified the need to motivate the nurses through various means by encouraging staff but also by rewarding them. The rewarding of nurses came in various ways including acknowledging them, thanking them for a job well done, giving them certificates for the best nurse and by assisting them financially or by time off to attend conferences or seminar days.

Needless to say, none of this can be achieved without also needing to be a good communicator. This theme, theme seven, discusses the various strategies that the nurse managers needed to use in communicating with the nurses including the need to understand the nurses in order to communicate better. There was also discussion about the difficulties in communication considering the expatriate workforce and what this entailed.

For theme eight the nurse managers discussed the many challenges that they faced in day to day management of the area including the lack of nurses and heavy workload. Finally, theme nine included discussion of the need for nurse managers to learn how to be a bedside nurse and the importance of them gaining experience before they were placed into management positions.

8.4 Characteristics of participants

This section discusses the significant findings from the quantitative phase of this study specifically the response rate and demographic information in relation to other studies.

8.4.1 Nurse respondents

In total, 600 surveys of the MLQ-5X Rater form (Avolio et al., 1995) (see appendix C) were distributed to nurses working in the six selected hospitals based in the Eastern Province of Saudi Arabia. Overall, 283 nurses responded to the survey yielding a response rate of 47%. When comparing this response rate to other Saudi studies, it is consistent with Abualrub and Alghamdi (2012) response rate of 51% and slightly higher than the response rate (42%) from the study conducted by Randeree and Chaudhry (2012). In contrast, the response rate achieved in this study is lower compared to other Saudi studies undertaken by Nafei, Khanfar, and Kaifi (2012) with 85% and Alharbi and Yusoff (2012) with 77%.

The low overall response rate achieved in the study can be attributed to various reasons, especially the recruitment process. The response rate in hospital A is very high compared to the other hospitals because of the support provided by the assistant nursing director, who actively helped in distributing questionnaires. In some hospitals specifically B, D, and E, the very low response rates can be explained because of the approval process for conducting the questionnaires being complex and lengthy. In addition, there was no cooperation from the nursing managers and directors with the questionnaire distribution process at these hospitals. A further explanation for why overall rates from nurses were low was because they may have been concerned that their responses might affect their relationship with the nurse managers. This may be why there were some partially filled responses to the questionnaire. This is supported by the fact that other research studies in Saudi Arabia but not on leadership styles, have had much higher response rates. For example, a study conducted by Almalki (2017) on the barriers and facilitators of research utilisation

among nurses had an 86% response rate, whilst the study conducted by Alqahtani (2014) on knowledge, attitudes and beliefs of oncology unit nurses towards pain management had an 80% response rate. Moreover, some public hospitals were not familiar with the process of analysing staff abilities and which may have also affected the response rate.

8.4.2 Nurse manager respondents

In total, 225 surveys of MLQ-5X Leader form (Avolio et al., 1995) (see appendix C) were distributed to nurse managers working in the six selected hospitals based in the Eastern Province of Saudi Arabia. Overall, 121 nurse managers responded to the survey yielding a response rate of 54%, which is consistent with the response rate of 51% in the study conducted on leadership by Aburalrub and Alghamdi (2011) in Saudi Arabia and with the response rate of 55% in the study conducted by Al-Hosis et al. (2012). Even though the response rate was 54%, this is considered low compared with other Saudi Arabian studies in this area. Suliman (2009) conducted a study on leadership styles in Jeddah, Saudi Arabia and had a 79% response rate, whilst a study conducted by Zampieron et al. (2013) in Padova, Italy had a 73% response rate. It was explained through an employee at one of the selected hospitals that, as the questionnaire is related to the rating of leadership styles of nurse managers, the administration and management team were afraid and not keen to cooperate with the questionnaire distribution process which could help explain the low response rates in the study (Personal communication, 24 October, 2017). Furthermore, there have been few studies undertaken in the Eastern Province compared to other areas in Saudi Arabia, which could also explain the lower response rates.

8.4.3 Gender

Out of the 404 respondents from six hospitals, the majority of the managers (76%) and nurses (84%) were female. This is in contrast to the findings of the Ministry of Health (2016) which states females constitute 52% of nurses. These findings are consistent with

another Saudi Arabian study conducted by Abualrub and Alghamdi (2012) which had 71% female nurse participants. Generally speaking, there are more females in nursing than males. In Australia for instance 89% of nurses are female. (Australian Health Practitioner Regulation Agency, 2017). It is therefore surprising that there are more males in Saudi Arabian according to the MOH. However, for this study the percentage of male nurse managers was high compared to male nurses. This may be because males usually prefer to work in administrative roles, especially in a conservative country like Saudi Arabia (Alotaibi et al., 2016).

There was a significant gender difference found in this study on satisfaction (organisational outcome) for nurse manager participants. Female nurse managers had higher mean satisfaction scores than their male counterparts. In other words, female nurse managers were more likely to use leadership strategies that resulted in staff satisfaction as well as trying to work with others in a satisfactory way. This could be because females are more caring and sensitive to the needs of the staff. This is supported from the qualitative findings that described the need for managers to support and care for staff.

There is a great deal of literature on the relationship between gender and leadership styles which report mixed findings (Alghamdi, Topp, & AlYami, 2018; Paustian-Underdahl, Walker, & Woehr, 2014). Female leaders are more likely to use the transformational leadership style than male leaders (Powell, Butterfield, & Bartol, 2008). According to Yaseen (2010), Arab women exceeded men on all the transformational factors and men exceed women on transactional factors and in adopting laissez-faire. In this study, female nurses perceived their managers as utilising the transformational leadership factors more than male nurses perceived them. Female and male nurses however, rated themselves similarly in utilising the transformational leadership factors. With regard to transformational leadership behaviours, a study was conducted to investigate if transformational leadership is a route to a

female's promotion prospects (Vinkenburg, Van Engen, Eagly, & Johannesen-Schmidt, 2011). This study found that female leaders use individualised consideration and male leaders are more likely to use inspirational motivation (Vinkenburg et al., 2011). The authors suggested that female leaders should mix individualised consideration with inspirational motivation in their leadership behaviour because inspirational motivation is considered as an important factor for promotion. Moreover, male leaders tend to use transformational leadership in more innovative behaviour, compared to females (Reuvers, Van Engen, Vinkenburg, & Wilson-Evered, 2008). Furthermore, male leaders use the transactional leadership style in the form of the management-by-exception (Eagly, Johannesen-Schmidt, & Van Engen, 2003). In contrast, some researchers found that there is no evidence showing that gender had an impact on transformational or transactional leadership (Barbuto Jr, Fritz, Matkin, & Marx, 2007).

In relation to gender and leadership traits among Arab populations, some differences have been identified. Yaseen (2010) conducted a study comparing leadership traits for Arab men and women using the MLQ 5X-Short (Avolio et al., 1995) with a total sample of 100 participants (40 females and 60 males). This study found that Arab women preferred the transformational leadership style in the form of idealised influence, inspirational motivation, intellectual stimulation and individual consideration. It was also found that although Arab women were using contingent reward behaviour, Arab men scored higher in this regard. In this study, male and female participants (nurse and nurse manager) had similar ratings for contingent reward. This indicates that both female and male nurse managers are clearly articulating what staff can expect to receive when they achieve goals.

In Saudi Arabia however, there are a number of factors which may affect the underlying assumption with regards to gender (Ramady, 2013). One of these factors is that women in Saudi Arabia do not have the same freedom and the same social benefits as men.

Therefore, this may affect the underlying assumptions with regard to gender (Ramady, 2013). Social beliefs and traditions in Saudi Arabia forbid the idea of gender mixing in the workplace or even a woman directing a man. Thus, this reflects the traditional perception that women are using and practicing laissez-faire behaviours (Alshammari, 2014). However, a study conducted by Taleb (2010) to investigate leadership style among Saudi Arabian females in the academic environment found that women tend to adopt and use democratic and transformational leadership styles. This could be because the academic workforce in Saudi Arabia is not a mixed gender environment. Al-Mahmoud, Mullen and Spurgeon (2012), Almutairi and McCarthy (2012) and Ramady (2013) explained that the gender issues inherent in the Saudi Arabian working environment's socio-legal constraints could be addressed by the predominantly female nurses gaining social status. Until recently, advanced nursing qualifications were only available internationally, for Saudi Arabian men. This has contributed to the belief that nursing has an image of an occupation, rather than a profession for graduates (Al-Mahmoud et al., 2012).

The impact of gender on job satisfaction is an important area of research. This study has found that there were no major impacts of gender on the adoption of any leadership style or on job satisfaction. Similarly, Chen, Chen and Chen (2010) found in Shanghai, China that participants had the same job satisfaction with transformational leadership regardless of gender. However, transactional leadership does impact workers' satisfaction depending on gender (Chen et al., 2010). Barbuto et al. (2007) also pointed out that gender has a direct impact on leadership behaviours. Paustian-Underdahl, Walker and Woehr (2014) reviewed 95 studies and found that when all leadership contexts were considered, men and women did not differ in perceived leadership effectiveness. However, women were rated as significantly more effective than men. In contrast, Alghamdi et al. (2018) conducted a study to investigate the effect of gender on transformational leadership and satisfaction using a sample of 308

Saudi Arabian nurses (133 male and 175 female). Alghamdi et al. (2018) also identified higher levels of job satisfaction when the nursing manager was male. This result is consistent with other studies conducted in male dominated societies where males are perceived as more effective leaders and have a higher level of staff job satisfaction (Abualrub & Alghamdi, 2012).

8.4.4 Qualifications

Included in a component of the demographic section of the questionnaire, nurses and nurse managers were asked two questions which required a yes/no response. These questions assessed the level of education and participation in leadership training (see appendix G). The majority of nurses (97%) and nurse managers (80%) responded that they did not have any formal management qualification. In addition, half of nurse managers (57%) and the majority of nurses (91%) indicated that they had not participated in any leadership training in the past 12 months. It can be observed that most of the participants did not have management qualifications, especially the nurse managers and also most of them had not participated in leadership training in the past 12 months. This is a surprising finding as it would have been expected that managers would have at least undertaken some management education. This may be reflective of the younger and less experienced nurses and the fact that there is a large group of expatriate nurses. This is also reflective of the workforce challenges that Saudi Arabians are facing, as discussed in Chapter 2. Support for this is reflected in the study undertaken by Baddar, Salem and Hakami (2016) in Saudi Arabia. Baddar, Salem and Hakami (2016) found that nursing managers and nurses were in need of improving skills to delegate effectively, as the nurses were younger with less experience, and were lacking in self-confidence and trust.

In terms of nursing qualifications, 42% of nurse managers had a diploma as their highest qualification while nearly half of nurses had a diploma (46%) as their highest

qualification. This is lower than another leadership study undertaken in Saudi Arabia that found 79% of managers and 54% nurses had a diploma as their highest qualification (Alshammari, 2014). In contrast, a Saudi Arabian study undertaken on a different topic indicated that there were only 27% of nurses whose highest qualification was a diploma (Almalki, 2017). The result of this study is similar to that found by of Alghamdi, Topp and AlYami (2018) with 51% of their nurse participants having a diploma as their highest qualification. This result is also similar to the results obtained by Negussie and Demissie (2013) in which 79% of nurses who participated in their study held diplomas. However, Negussie and Demissie's (2013) study did not examine the relationship between leadership styles and qualifications. The fact that the majority of the participants were qualified with diploma in nursing is a surprising finding. This is because nursing education worldwide tends to be more at a bachelor level (Roets, Botma, & Grobler, 2016). The reason could be because of the easy entrance in to a bachelor program after completing a diploma for nursing or early access to job opportunities (Kamanyire & Achora, 2015; Roets et al., 2016). High levels of participants with a diploma could also be explained by a higher number of Saudi Arabian nurses in this study. The Bachelor of Science in Nursing (BSN) in Saudi Arabia was established in 1976 but was limited to females only for many years. It was only in 2004 when the BSN course was established for men. This study had a higher response rate from men. It could also be that nurses with diplomas were more likely to complete the questionnaire.

One of the issues facing the MOH in improving nursing standards in Saudi Arabia is that most national nurses hold only a diploma, with no opportunities to advance their qualifications. In a Saudi Arabian study, Al-Mahmoud et al. (2012) assessed the nursing education structure and policy in Saudi Arabia and found that there was no database that provided data related to nursing qualifications for Saudi Arabia, but they reported that local nurses' training remained at the diploma level. Similarly, Almadani (2015) has stated that

poor educational qualifications in nursing can affect the delivery of quality care. Accordingly, Al-Qrishah (2017) proposed a strategic framework to improve such situations by referring to the practices of training, learning while working and bachelor degree education as an entry level qualification. This is because bachelor programs in nursing educate nurses about why things are done and are based on evidence-based practice. Diploma programs in nursing do not include as detailed curriculums as bachelor programs nor discuss evidence-based practice. For several years, the MOH continued to operate two levels of nursing education: the 'Post-Intermediate Nursing Institute' (3-year course with a diploma) and the 'Post-High School Nursing College' (bachelor degree in nursing). However, recently the Ministry of Education (MOE) has recommended that the Baccalaureate of Nursing be the minimum required degree for professionalism, and entry level to nursing practice (Jradi, Zaidan, & Al Shehri, 2013).

In this study, there was a significant level of education difference on laissez-faire leadership scores for nurse participants. Nurses who held a diploma had a higher mean score for laissez-faire leadership than nurses who held bachelor degrees. This result indicates that nurses who held a diploma perceived their manager more as having passive avoidant characteristics. Casida et al. (2012) found that nurses with high qualifications rated their nurse manager's leadership styles differently than nurses with a diploma. Similarly, Chen et al. (2010) found that the level of education had an impact on staff satisfaction with leadership styles (transformational and transactional) and could also impact on trust. The reason could be because nurses with bachelor or higher degrees are more likely to have high professional identities and values than nurses with diplomas or lower degrees (Kubsch, Hansen, & Huyser-Eatwell, 2008). Also, nurses with diplomas or associate degrees are more task oriented and have minimal education preparation on evidence-based practice or leadership (Casida et al., 2012).

In the literature, it is evident that transformational leadership style behaviours are correlated with qualifications and working environment (Abualrub & Alghamdi, 2012;

Dunham-Taylor, 2000; Suliman, 2009). Saudi researchers recommend promoting more leadership training in order to improve work environments (Al-Mahmoud et al., 2012; Almutairi & McCarthy, 2012). The MOH took the first step to improving nursing education and leadership training in Saudi Arabia by upgrading the health institutes that were offering diploma qualifications to Colleges of Health Science in 2011 (Ministry of Health, 2013). Also, in 2011, the MOH established a Saudi Arabian nursing leadership program trying to upgrade nurse diplomas (Ministry of Health, 2013). In addition, in Saudi Arabia there is a need for nurse educators to continue to promote nursing as a desirable profession for local women and men (Al-Hazmi & Windsor, 2013).

An interesting finding from this study revealed during the interviews was that they believed that managers should not be appointed without the necessary experience. In other words, nurses should gain experience working by the bedside on the ward before they are placed in management positions. The insinuation here is that nurse managers cannot manage the staff without having an understanding of what it is to be a bedside nurse caring for patients and making clinical decisions. As previously mentioned, it is not uncommon for Saudi nationals to be quickly appointed as managers without gaining much experience as a bedside nurses (Personal communication, 24 October, 2017). Having no or minimal education on how to be a leader would compound this identified problem.

8.4.5 Nationality

As previously discussed, the nursing workforce in Saudi Arabia is a multicultural workforce due to the large expatriate population. In terms of nationality, the study sample was relatively diverse for nurses and nurse managers. Only 42% were from Saudi Arabia and over half of the nurse respondents were expatriate (52%). For the expatriate population 36% were from India while only 15% were from the Philippines and smaller proportions of nurses came from Egypt, Malaysia and Indonesia. For nurse managers, the largest group were from

India (31%), followed by Saudi Arabia (30%) and 24% were from the Philippines and smaller proportions of nurse managers came from South Africa, USA, UK and Jordan. This study is similar to the study by Alshammri (2014) who found that 35.3% of his respondents were Saudi Arabians. In contrast, these expatriate response percentages were much less than other Saudi Arabian studies (Alyami et al., 2017; Goh, Ang, & Della, 2018) which had more than 80% of non-Saudi Arabian participants. The results showed that over half of the respondents were expatriate nurses. This may be explained by the increased demand for more nurses as it is easier and quicker to recruit expatriate nurses compared to educating national nurses. Another reason is that national graduate nurses tend to move into the administration roles in nursing. Also, the study sample data showed that most of the nurses and nurse managers who participated in this study came from Asian countries and less frequently from Middle Eastern countries and least from Western countries. These findings may reflect the number of nurses in these regions who apply to work as a nurses in Saudi Arabia. In another Saudi Arabian study conducted by Almutairi and McCarthy (2012), it was found that the expatriate nurse respondents were from the Philippines, India and Pakistan, with small numbers from other Arab countries. In this study, expatriate nurses were from the Philippines, India, Jordan, USA, UK and South Africa.

A high number of Saudi Arabian participants was observed in this study (36% of the total) compared to other studies (Al-Ahmadi, 2009; Saleh et al., 2018) who had (6%; 9%, respectively) Saudi Arabian participants in their study. This may be due to the impact of the Saudisation programme which is now active and is gradually focusing on replacing expatriate nurses with Saudi Arabian nurses (Al-Mazrou, Al-Ghaith, Yazbeck, & Rabie, 2017; Alloubani, Abdelhafiz, Abughalyun, Edris, & Almukhtar, 2015). Furthermore, this could be because of the geographic location the study was conducted in with more liberal cultural views which make people more likely to enter the nursing profession. This could be the

reason for the higher numbers of male nurses found in this study. These results also may indicate that more Saudi Arabian nurses completed the survey.

In regard to transformational leadership factors, nurse manager respondents from Saudi Arabia had higher mean scores for all transformational factors than Indian and Philippine nurse managers did. This reflects that Saudi Arabian nurse managers are more likely to display transformational characteristics. Furthermore, results of this study revealed that there was a significant difference between Saudi Arabian and Philippine nurse managers in regard to idealised influence attributed factor. In other words, Saudi Arabian nurse managers were more likely to go beyond self-interest for the good of the group and also act in a way that builds respect for them. This study also found that Saudi Arabian and Indian nurse managers resorted to using the transactional leadership style more often than Philippine nurse managers. This result differs from the result found by Alshammari (2014) who found that Philippine nurse managers were using the transactional leadership style more often than their Saudi Arabian and Indian counterparts. This is a notable difference with this study, however, as nurses were voicing opinions about their specific managers this may have influence the results due to the power relationship (Alshammari, 2014).

The majority of Saudi Arabian and Indian managers were women, which may suggest that they are more likely to recognise the cultural differences among the staff and practise a non-interventionist style. Philippine nurses had high mean scores for all transformational factors except for idealised influence (attributed (M = 0.62) and behavioural (M = 0.61)). This indicates that Philippine nurses in this study did not perceive their manager as behaving as a role model. On the other hand, Indian and Saudi Arabian nurses saw their nurse managers as instilling pride and confidence in them and motivating them towards their goals. However, this was reported to a lesser extent for Philippine nurses. In regard to individualised consideration (transformational leadership factor), Saudi Arabian nurses had lower mean

scores compared to Indian and Philippine nurses. This may indicate that Saudi Arabian nurses need more support than other nationalities. A possible explanation of this could be that Saudi Arabian nurses are often appointed as managers with minimal experience. The results from the qualitative phase of this study certainly support this under the theme 'need to go through all the steps'. This theme highlighted the fact that the Saudi Arabian nurses are appointed as managers with minimal bedside nursing experience. Therefore, for laissez-faire leadership scores, there was a significant difference between Saudi and Philippine nurses. Nurses from India and Philippines had higher mean scores compared to Saudi Arabian nurses. This indicates that Saudi nurses do not perceive their manager as passive-avoidant leaders. Al-Rasheed (2010) and Malshe, Al-Khatib, Al-Habib and Ezzi (2012) explained that in Saudi Arabia, and generally in Arab society, traditional and bureaucratic authority structures provide an expectation that leadership is extensively involved in everyday operations (that is, an authoritarian directive style). Malshe et al. (2012) note a conspicuous absence of communication between the bureaucratic management layers. Further, as previously mentioned Saudi Arabian nurses encounter a lack of social status for the profession in Saudi Arabia (Almalki et al., 2011). Similar Saudi Arabian studies (Yaseen, 2010; Taleb, 2010) reported that the result of greater use of a laissez-faire leadership style by Saudi nurse managers is more consistent within an Arab working environment.

In this study, however, Saudi nurse managers also rated themselves lower in utilising the laissez-faire leadership style and had a lower mean score compared with Indian and Philippine nurse managers. This result is similar to the finding of Alshammari (2014) who found that Saudi Arabian nurses had lower mean scores compared to Indian and Philippines nurses in regard to laissez-faire leadership. In other words, these three nationalities perceive leadership differently from each other.

8.4.6 Work experience

The nurse managers and nurse participants varied in their experience, ranging from one to eleven or more years. Most nurses had 1 to 2 years of experience as a nurse. In contrast, a larger percentage of nurse managers had 8 to 10 years of experience. These findings may also account for the larger proportion of nurses from this study who had the highest qualification of diploma. Regarding the 1 to 2 years of experience, this might be because many of the expatriates leave Saudi Arabia usually after 2 years when they have acquired enough experience to work and provide their services in more developed countries (Al-Dossary et al., 2012). Furthermore, younger and less experienced nurses are more likely to be attracted to nursing in Saudi Arabia as they are early in their careers and less likely to have family commitments (Miller-Rosser et al., 2006). In addition, the recruitment strategy of recruiting agents may target newly qualified nurses as they can be offered lower wages (Almalki et al., 2011). This could also indicate that more of the less experienced nurses completed the survey. In contrast, other Saudi Arabian studies have indicated that the majority of the participants had around 10 years of experience (Alshammari, 2014; Almalki, 2017).

In this study, there was no significant difference across years of experience categories on eight leadership styles factor scores; however, there was a significant difference on management-by-exception passive (transactional leadership factor) across years of experience for nurse participants. This result indicates that nurses who had more than 11 years of experience rated their managers more as having withdrawal behaviours and more likely to wait for things to go wrong before taking action. A study in Saudi Arabia by Suliman (2009) found no difference across years of experience on leadership style factor scores. In terms of transformational leadership factors, nurses with less experience (1 to 5 years) had higher mean scores on all nine leadership style factors compared to nurses with more experience. Nurse managers who had 1 to 5 years of experience rated themselves higher than their nurses

rated them in all leadership styles factors. This result is similar to the results of the study conducted in Saudi Arabia by Alyami et al. (2017) who found that participant with less than 7 years of experience had a higher mean score on all transformational leadership factors compared to participants with longer experience.

The results of this study also revealed that there was a significant difference across years of experience on job satisfaction (organisational outcome). Nurse managers who had 1 to 5 years and more than 11 years of experience had the same mean scores for satisfaction. This is considered high compared with nurse manager participants whose experience fell between 6 and 10 years. Additionally, manager participants who had work experience ranging between 6 and 10 years scored higher in perceiving the laissez-faire leadership style compared with nurse managers whose experience level were in the categories 1 to 5 years and more than 11 years. Alshammari (2014) obtained a negative correlation between years of experience and laissez-faire leadership style suggesting that the more experienced the nurse the less likely the nurse would exhibit this leadership style. This could indicate that nurses learn from experience that laissez-faire is not the best leadership style in relation to positive organisational outcomes.

8.5 Transformational leadership style

In this study, nurses perceived their managers as utilising the transformational leadership factors *fairly often*, whereas nurse managers perceived themselves to be more transformational leaders. Similar results were observed in the studies conducted in a multi-cultural environment by Suliman (2009), Zampieron et al. (2013) and Alyami et al. (2017) in which the nurse managers rated their leadership styles as more transformational than the ratings given by their staff (nurses). Various other studies (Casida & Parker, 2011; Crawford, 2005; García-Morales et al., 2012; Salanova et al., 2011) have identified positive influences

of transformational leadership in work environments. Various dimensions of transformational leadership and the results for each factor are discussed in the following sections.

8.5.1 Inspirational motivation

Inspirational motivation is when leaders inspire and motivate followers which often depend on their ability to articulate a vision (Nwoke, 2010). Inspirational motivation refers to leaders who energise their staff by talking optimistically about the future, sharing ambitious goals and idealising a realistic vision (Casida & Parker, 2011). The findings from this study demonstrated contrasting results as nurse managers frequently perceived that they adopted an inspirational motivation approach as part of their leadership style. This is in comparison with nurse participants who observed this leadership style as moderately adopted by nurse managers. Although the concept is identified by some literature (Casida & Parker, 2011; Salanova et al., 2011), there were no empirical studies identified on inspirational motivation. In contrast, a study conducted by Aboshaiqah et al. (2014) in Saudi Arabia on the nurse perception of the managers' leadership styles had a higher mean for inspirational motivation than the one found in this study. The correlation between the inspirational motivation and the management-by-exception passive and laissez-faire leadership based on the results of nurse and nurse manager participants, indicates that both factors are negatively related with inspirational motivation. This result indicates that leaders who used the inspirational motivation factor are not considered as a passive-avoidant leaders.

Both nurse managers and nurse participants agreed that an inspirational and motivating leader can build confidence among the members in achieving goals, interacts and collaborate with the members in building vision and achieving it. Correlational analysis from nurses showed that the correlation between inspirational motivation and all other transformational leadership factors and contingent reward (transactional leadership) are very high. This indicates that leaders who practise all transformational factors and contingent

reward could inspire staff. In addition, from all the transformational leadership factors, inspirational motivation has highest and positive correlation with the three organisational outcomes, including effectiveness, job satisfaction and extra effort for both nurse and nurse manager participants. Thus, this result indicates that nurse managers who talk optimistically about the future and enthusiastically about what needs to be accomplished are effective and more likely to have staff that would exert extra effort and have greater job satisfaction. Bass (2012) found that staff would perform beyond their expected levels of performance as a result of the leader's influence. This occurs through their intrinsic work motivation and sense of purpose or mission that drives them to exert extra effort beyond the standard limits. By sharing values, transformational leaders can help their staff to maximise performance.

The findings from the qualitative data indicated different factors that helped to motivate staff but no mention of inspiration. Nurse managers who participated in the qualitative part of this research study claimed that they considered themselves as being a role models for their staff. According to Bass (1985) charismatic leaders utilise inspirational motivation to influence their followers and are characterised by being a role model together with skills in articulating goals (Chemers, 2000). This is supported by Hetland, Hetland, Bakker and Demerouti (2018) who added that inspirational motivation can be utilised by leaders to influence the followers approach towards achieving the goals. Additionally, the qualitative part of this study found that good communication was an important skill that leaders should have. According to Thyer (2003), the transformational leadership style has an impact on communication. By using the inspirational motivation leadership factor, the nurse manager can communicate values, vision and goals clearly for their staff (Avolio & Bass, 2002).

8.5.2 Individualised consideration

Individualised consideration is one of the transformational leadership factors where leaders support their followers by listening to each follower's needs and concerns (Casida & Parker, 2011). Individual consideration is the leader's ability to advise and support the individual needs that are essential for the development and self-actualisation of followers (Casida & Parker, 2011). The nurse participants agreed that their managers noticed their needs and offered support to a certain degree. However, nurse managers stated that they adopted the individualised consideration approach to a greater extent than perceived by nurses. These results were in agreement with the result of Asiri et al. (2016) who conducted their study in Saudi Arabia, but less than the result obtained by Alloubani et al. (2015), Lapeña et al. (2018) and Alyami et al. (2017). The correlation between the individualised consideration and management-by-exception active based on the nurse participants' ratings were found to be significantly positive. However, there was negative correlation identified between the individualised consideration and management-by-exception passive and laissez-faire leadership based on nurses' and nurse managers' ratings. This indicates that nurse managers who treated others as individuals rather than just as members of a group were more likely to not demonstrate passive leadership behaviours. A close relationship between individualised consideration and participative management in transformational leadership was identified by Tomey (2009), whose results indicated a significant relationship. In terms of organisational outcomes, individual consideration was highly and positively correlated with the three organisational outcomes (effectiveness, satisfaction and extra effort). Weberg (2010) found that addressing the followers' needs through transformational leadership could enhance or increase well-being and satisfaction.

The qualitative part of this mixed-methods study revealed that nurse managers claimed that providing a supportive relationship through individual consideration was

shaping their experience of culture of leadership within Saudi Arabian hospitals. Leaders who utilise the transformational leadership style were raising the relationship with their staff to a higher level than with an exchange relationship. There was a lot of discussion during the interviews about a supportive community together with different ways this could be achieved. The qualitative data for this study also revealed that nurse managers were working in a supportive, sharing and team working environment. Similar findings were revealed from two other qualitative studies undertaken in Saudi Arabia on leadership in nursing (Omer, 2005; Saleh et al., 2018). Saleh et al. (2018) interviewed nurses about their perceptions of nurse managers which emphasised the significance of the relationship with their manager to their job satisfaction. This was identified in this study as particularly important for expatriate nurses who usually are in Saudi with no family and therefore the relationship they have with their colleagues is more important to them. This supportive environment can relate to the fact that nurse managers are utilising transformational and transactional leadership factors in the form of contingent reward. According to Upenieks (2003), supportiveness is considered as one of the most effective leadership qualities in today's healthcare environment. Furthermore, Baggs et al. (1999) found that a supportive relationship between nurse managers and nurses resulted in positive patient outcomes. Additionally, various studies (Boamah & Laschinger, 2016; Gunnarsdóttir, Clarke, Rafferty, & Nutbeam, 2009; Numminen et al., 2016) have found that supportive relationships can result in professional development and job satisfaction, and consequently help retain nurses in the workforce. This is supported by the Saleh et al. (2018) who concluded that having a supportive manager increases not only job satisfaction, but could affect the retention of staff (Saleh et al., 2018).

One of the findings from the qualitative data was that the managers believed that it was important to treat all nurses the same. This was especially the case because of the fact that there is a large expatriate workforce in Saudi Arabia. In contrast to this, Saleh et al.

(2018) undertook interviews with nurses on leadership styles in Saudi Arabia. Saleh et al. (2018) found that there were perceptions of preferential leadership from nurse managers and that all nurses were not treated equally based on nationality. Saleh et al. (2018) provided an example of if the nurse manager was from India then they favoured Indian nurses for better patient assignments. To some extent, this is understandable considering the commonalities in a particular country (Smith, 2013). Displaying favouritism, however, can lower the morale of those not in this group who may then feel neglected and unmotivated (Fleischman, 2015). Under these circumstances then it is difficult for managers to build a culture of trust (Whipple, 2010).

8.5.3 Intellectual stimulation

Intellectual stimulation occurs when leaders stimulate their followers to look at problems, beliefs and values from a new perspective (Nwoke, 2010). Intellectual stimulation is the ability of the leaders to challenge their followers to think creatively and solve problems (Casida & Parker, 2011). It has been linked to innovation and productivity (Howell & Avolio, 1993). Bally (2007) strongly supports an intellectually stimulating work environment. Also, McGuire and Kennerly (2006) found that nursing teams working under transformational leaders could be more productive. However, there is a slight difference, as nurses and nurse managers preferred intellectual stimulation practice by nurse managers. A strong relationship was identified from the correlation analysis between intellectual stimulation and all other transformational factors and management-by-exception active based on the responses from the nurse and nurse manager participants. However, there was a negative relationship identified between the intellectual stimulation and management-by-exception passive based on nurses and nurse manager's ratings and also with laissez-faire leadership.

Nurse managers who participated in the qualitative part of this study, believed that they shared their ideas with their staff which means that nurse managers were sharing their

ideas by intellectually stimulating their staff to develop new ideas. Managers also commented that they encouraged the nurses to share with them in a two-way collaborative process. This sharing could promote development of the relationship between nurse managers and their staff as well as help in fostering innovation and creativity. Likewise, Omer (2005) also found that managers needed to listen to the nurses and involve them in decisions. Saleh et al. (2018) also discussed the need for nurses to be involved in the decisions made by the nurse managers. This study interviewed nurses about their perceptions of the nurse managers which reflected the nurses' perspectives, that the nurse managers needed to communicate with the nurses more.

There are no empirical studies identified supporting this factor/behaviour of leadership. However, the intellectual stimulation factor is referred to as one of the transformational leadership styles which could lead to effective nurse management and productivity (Bally, 2007; McGuire & Kennerly, 2006). Internally oriented transformational leaders will be more confident in their ability to influence the work environment, which can be achieved by pursuing creative strategies. Howell and Avolio (1993) found that this internal control of leaders was directly related to the intellectual stimulation by their followers. Furthermore, intellectual stimulation was positively correlated with organisational outcomes, including extra effort, satisfaction and effectiveness which indicate that leaders who seek different perspectives when solving problems are more effective and have the ability to let their staff to exhibit extra performance. However, no studies to date have specifically measured the effect of this transformational leadership behaviour on organisational outcomes.

Nurse managers being able to stimulate and challenge their followers to think creatively and solve problems is specifically an issue for the nursing workforce in Saudi Arabia (Casida & Parker, 2011). Nursing faces many challenges, as identified earlier in this thesis. Many of these are supported by the nurse manager interview data that discussed the

issues faced by the multicultural workforce, and the communication issues that result from this, lack of staff and high staff turnover. Creating an environment of intellectual stimulation and transformational leadership style assists with accommodating and solving these challenges (Bally, 2007; McGuire & Kennerly, 2006). Omer (2005) also discussed the challenges of working in a multicultural environment in the qualitative component of the study from Saudi Arabia.

8.5.4 Idealised influence (attributed and behavioral)

Idealised influence is one of the factors of transformational leadership where leaders become role models who are respected and imitated by followers (Bass, 1990). Idealised influence, attributed and behavioural, is when nurse leaders act as role models for their staff, sharing their values and beliefs in a way that builds their confidence and provides them with a sense of responsibility and mission that will be aligned with organisational outcomes (Casida & Parker, 2011). The outcomes of the study are similar with the outcomes of the studies conducted by Weng, Huang, Chen and Chang (2015) in Taiwan and Morsiani, Bagnasco and Sasso (2017) in Italy. These studies have also identified the impact of idealised influence in increasing job satisfaction, and developing nurse innovation behaviour. The qualitative findings from this study also identified the importance of the nurse manager being a role model and what that entail. Specifically, the managers discussed the need to look, behave and talk in a professional manner that others could emulate and thereby respect the manager. Likewise, Omer (2005) and Saleh et al. (2018) also identified the importance of the nurse managers being a role model to the staff both from a nurses and nurse managers perspective.

A negative correlation was identified between idealised influence (attributed and behavioural) and management-by-exception passive with nurse participants. Negative correlations were also identified based on the results from nurse managers, between idealised influence attributed and some other variables including management-by-exception passive,

and laissez-faire leadership. These results are similar to other studies in USA and Portugal (Casida & Parker, 2011; Salanova et al., 2011).

In line with the findings, it is concluded that the nurses respond to the idealised influence approach in transformational leadership which increases their job satisfaction and productivity. The participants in this study associated staff respect, confidence and communication, which are considered to be qualities of idealised influence, with transformational leadership. Another study conducted by Voon et al. (2011) to identify the effect of transformational leadership on performance found that transformational leadership is more effective than transactional in relation to the performance of individuals and teams (Wang et al., 2011). Furthermore, the analysis of the quantitative data of this study showed that attributed and behavioural idealised influence were positively correlated with organisational outcomes, including extra effort, job satisfaction and effectiveness. In other words, leaders who consider the moral and ethical consequences of decisions and emphasise the importance of having a collective sense of mission are more likely to be effective. Nurse participants in this study responded to idealised influence, which means that this increased performance and productivity. However, no studies to date have specifically measured the effect of this transformational leadership behaviour on organisational outcomes.

Furthermore, Salanova et al. (2011) examined the relationship between transformational leadership and extra-role performance and found that nurse managers who employ a transformational leadership style can enhance extra-role performance, which supports the results of this study. Research was also conducted to explore the association between transformational leadership and organisational outcomes. The findings were that transformational leadership has a strong relationship with extra effort, satisfaction and effectiveness (Casida & Parker, 2011). In addition, the findings of this study are similar to findings by Andrews, Richard, Robinson, Celano and Hallaron (2012). These studies did

associate with transformational leadership and not specifically with only idealised influence (attributed and behavioural). In conclusion, in order to enhance staff performance and productivity, nurse managers should treat their staff with respect and build their confidence. With regard to Saudi Arabian nurses, nurse managers need to respect their Islamic cultural behaviours and their preferences in the working environment, which will help to build their confidence and thus increase productivity.

8.6 Transactional Leadership Style

Transactional leadership style categories of three factors include: contingent rewards and management-by-exception active and passive. Those factors will be discussed in the next section.

8.6.1 Contingent rewards

The provision of contingent rewards emphasises a particular exchange system that relies on a clear agreement between the leader and the followers to accomplish organisational goals. As the workers provide their effort and time, the leader is then expected to provide rewards founded on the agreement that was established (Riaz & Haider, 2010). With this approach, leaders should be able to clarify goals and expectations as well as offer appropriate rewards and/or recognition in exchange for the accomplishment of tasks and goals. Sheaffer, Bogler and Sarfaty (2011) identified the use of contingent rewards as passive or active manager-by-exception. Active transactional managers only intervene to address the problems with staff; and passive transactional managers may identify and record faults and adopt a punitive style. This study identified that the contingent rewards approach was preferred by nurse managers, and was moderately favoured by the nurses. Contingent reward has been strongly and positively correlated with organisational outcomes (extra effort, effectiveness and satisfaction). Therefore, nurses and nurse managers agreed that leaders who discuss in specific terms who are responsible for achieving performance targets and express satisfaction

when others meet expectations, exhibit effective leadership and get others to do more than they are expected to do and work with others in a satisfactory way.

In determining the correlation between the contingent rewards and management-by-exception passive with the nurses group, a negative correlation was obtained. Considering the responses from the nurse managers, correlation between contingent rewards and management-by-exception passive, a negative relation was identified, and also a significant negative relation was identified with laissez-faire leadership. A few nurse managers were identified as practicing contingent rewards with transformational leadership styles by appreciating and rewarding the staff who met the goals. These findings were similar to the findings of Wang et al. (2011) which explained the importance of contingent rewards as they provide better clarity regarding the roles and responsibilities in the organization. Additionally, contingent rewards has been associated with transformational leadership styles in a psychological nursing environment (Malloy & Penprase, 2010).

In the qualitative part of this study nurse managers believed that they discussed the need for the contingent reward. This data identified the need to motivate the staff through various means by encouraging staff but also by rewarding them. This rewarding of staff came in various ways including acknowledging them, thanking them for a job well done, giving them certificates for the best nurse and assisting them by either financial means, or giving them time off to attend conferences or seminar days. Neither Omer (2005) nor Saleh et al. (2018) reported this finding in their studies.

8.6.2 Management-by-exception active and passive

Active Management-by-exception (MBE) refers to leaders who focus their attention on mistakes to meet standards, and passive MBE refers to leaders who avoid intervening until problems become serious (Bono & Judge, 2004; Casida & Parker, 2011). The active management as preferred by the nurse managers group was average and as perceived by

nurses was slightly less than average. Nurse managers and nurses rated passive management-by-exception as the least preferred leadership factor, but nurses perceive it slightly higher on this perspective about their managers. It is identified that nurses perceive their managers as utilising the two factors of transactional leadership using the active management-by-exception and contingent reward leadership factors *sometimes* to *fairly often*. Also, nurses perceive their nurse managers utilising the passive management-by-exception leadership factor *not at all* to *once in a while*. The mean scores for transactional leadership factors were higher as perceived by nurse managers compared to the findings for nurses, but lower than nurses for the passive management-by-exception. Nurse managers perceive themselves as using active management-by-exception and contingent reward greater than their staff perceived them. In other words, nurses perceived that nurse managers did not provide information, articulate goals and do create effective solutions and timely responses. Whereas managers perceived that they provided clear agreement with their staff to accomplish organisational goals. This will be discussed further later in this chapter.

The results of this study were similar to the results of the research by Aboshaiqah et al. (2014), in that nurses perceived that their nurse managers were more frequently using transformational and transactional leadership styles rather than laissez-faire. These findings however, differed from those of Alyami et al. (2017) where leaders rated themselves higher in active management by exception. Considering the responses from nurses, active and passive management-by-exceptions are negatively correlated. In addition, active management-by-exception is also negatively correlated with laissez-faire leadership. Passive Management-by-exception is negatively correlated with satisfaction, extra effort and effectiveness. Although this study showed significant correlation between extra effort, satisfaction and effectiveness and active management-by-exception, the magnitudes of the correlations were low indicating poor association especially from the responses of nurse

managers. Cummings et al. (2010) stated that leaders who demonstrate transactional behaviours could possibly reduce satisfaction, effectiveness and productivity and performance among nurses.

Considering the responses from nurse managers, active and passive management-by-exceptions were negatively correlated. In addition, active management-by-exception was negatively related with laissez-faire leadership, extra effort, effectiveness and satisfaction. Al-Hussami (2008) has identified similar results of transactional leadership factors with satisfaction, commitment and support. Similar results were also identified by (Lapeña, Tuppal, Loo, & Abe, 2018; Park, 1997). Lorber, Treven and Mumel (2016), on the other hand identified that emotional intelligence, communication, personal characteristics, and the decision-making process are the main factors that affect the leadership styles, reflecting that personal characteristics are important factors influencing leadership styles rather than organisational structure and attributes. Transactional leadership style was positively correlated with organisational commitment in a study conducted by Asiri, Rohrer, Al-Surimi, Da'ar and Ahmed (2016), and it was also identified that the nurses' nationality was significantly associated with organisational commitment.

The results of this study are also similar to the study by Bass and Avolio (2000) regarding contingent reward and management-by-exception active. The findings of this study were higher than those reported by Altieri (1995), where the leader participants viewed themselves as being lower in active management-by-exception. Also, the results of this study were different from the findings of Cohen (1998) where leaders viewed themselves lower in contingent reward. Further, this study is different from a study conducted by Alshahrani and Baig (2016). They found that a majority of nurse managers who participated in their study utilised a transactional leadership style. However, their research confirmed the finding of the study that transformational leadership positively associated with job satisfaction.

8.7 Laissez-faire leadership style

This factor represents the avoidance and absence of leadership, which is the most ineffective and inactive style (Bass, 1985). This leader avoids making a decision, hesitates taking actions, and is absent when needed. Nurse managers perceive themselves as using laissez-faire *not at all*, while nurses perceived their managers as adopting laissez-faire *once in a while* to *not at all*. The correlation analysis from nurse managers responses has indicated that laissez-faire is negatively correlated with extra efforts, effectiveness, and satisfaction. This result indicate that leaders who display passive-avoidant behaviours lead to less satisfied nurses and have more withdrawal behaviours. The study result indicates that nurse managers perceived themselves as utilising laissez-faire leadership lower than their nurses perceived them; and also laissez-faire leadership seems to be the least preferred style for both nurse managers and nurses. There are various studies (Abdelhafiz et al., 2015; Cummings, MacGregor, Davey, Lee, et al., 2010; Negussie & Demissie, 2013) that have identified the transformational leadership style to be more effective compared to laissez-faire. However, the adoption of the laissez-faire approach is more prevalent in a multi-cultural work environment as in Saudi Arabia, as identified from the results and the reason could be of the male domination and cultural influence. Additionally, Merrill (2015) suggested that nursing managers must concentrate on developing transformational leadership skills while also diminishing negative leadership styles.

Nurse managers who participated in the qualitative part of this study stated that they were approachable to their staff and having open communication skills. These findings confirm the absence of the laissez-faire leadership style which is unlikely that this style would be found in this supportive positive working environment. Predominantly the managers commented that they used transformational leadership style and only used the laissez-faire leadership style in activities that were not related to work such as social activity.

Similar emphases on being approachable and open communication were discussed in the findings from Omer (2005) and Saleh et al. (2018).

8.8 Leadership styles and organisational outcomes

To determine the relation and impact of leadership styles of nurse managers and perception by nurses, the outcome measure extra efforts was used. A strong relationship was identified between transformational factors including idealised influence (attributed and behavioural), inspirational motivation, intellectual stimulation, individualised consideration, and extra efforts. Furthermore, a strong relationship was identified with only one type of transactional leadership factor (contingent rewards) and extra efforts. Weak relationships were identified with remaining transactional factors including management-by-exception (active and passive) and laissez-faire leadership. The findings suggest that transformational leadership factors were more useful in achieving extra efforts from the nurses rather than transactional or laissez-faire leadership styles. Similar results were found by McGuire and Kennerly (2006), Salanova et al. (2011) which identified that productivity can be greatly increased by transformational leadership. Callier (2016) has found that transformational leadership style would positively influence the nurses' behaviour by accepting the extra role behaviour. Other studies (Alboliteeh, Magarey, & Wiechula, 2017; Suliman, 2009) have correlated a similar positive impact of transformational leadership style on achieving extra efforts from nurses by nurse managers.

To determine the relationship and impact of leadership styles of nurse managers and perception by nurses, the outcome measure 'satisfaction' was used. A strong relation was identified between transformational factors including idealised influence (attributed), inspirational motivation, intellectual stimulation, and extra efforts. With other remaining transformational factors including idealised influence (behavioural), individualised consideration, and satisfaction, a moderate relationship was identified. A strong relationship

was identified with only one type of transactional leadership factor (contingent rewards) and satisfaction. Weak relationships were identified with remaining transactional factors including Management-by-Exception (active and passive) and laissez-faire leadership. The findings suggest that transformational leadership factors are more useful in achieving satisfaction among the nurses rather than transactional or laissez-faire leadership styles. Similar results were identified by other studies in this area (Abdelhafiz et al., 2015; Cummings et al., 2010; Negussie & Demissie, 2013) where the transformational factors achieved greater satisfaction, enhanced retention among the nurses. In this study, the mean score for job satisfaction was high indicating that nurses had relatively high job satisfaction. This result stands in contrasts to previous study conducted by Vanaki and Vagharseyyedin (2009) which found low satisfaction among nurses.

To determine the relationship and impact of leadership styles of nurse managers and perception by nurses, the outcome measure 'effectiveness' was used. A strong relationship was identified between transformational factors including idealised influence (attributed and behavioural), inspirational motivation, intellectual stimulation, individualised consideration, and effectiveness. A strong relationship was identified with only one type of transactional leadership factor (contingent rewards) and effectiveness. Weak relationships were identified with remaining transactional factors including management-by-exception (active and passive) and laissez-faire leadership. The findings suggest that transformational leadership factors are more useful in achieving effectiveness from the nurses rather than transactional or laissez-faire leadership styles. Accordingly, Manning (2016) has identified that the use of transformational and transactional leadership styles could increase the engagement through effective communication and result in increased organisational outcomes. Similar results were also identified by Hayati, Charkhabi and Naami (2014) in a study conducted in government hospitals in Iran.

8.9 Nurses' and nurse managers' perceptions of leadership styles

The results revealed that nurse managers' and nurses' perceptions of the leadership styles were different. Nurse managers rated their leadership behaviours (all nine factors) higher than their nurses rated them. Jannsen (2004) and McGuire and Kennerly (2006) confirm this discrepancy between the perceptions of nursing staff and nurse managers. From the followers' perspective, the leadership style preferred by the followers is always rated higher than the leadership style that their leaders are actually utilising (Janssen, 2004; McGuire & Kennerly, 2006). When nurse managers preferred a specific leadership style, they scored the preferred leadership style higher than the actual adopted one, as they reflected their interests in adopting the leadership styles they want but which they could not (Zampieron et al., 2013). Andrew et al. (2012) linked the different perceptions of the leadership style to low satisfaction with supervision and cultural orientation. Jogulu (2010) found that Malaysians preferred transformational leadership but Australians preferred the transactional leadership style. In this study, nurses perceived their nurse leaders as utilising the five factors of the transformational leadership and contingent reward. A similar study conducted by Salem et al. (2012) found that nursing students in Saudi Arabia perceived their managers as utilising transformational leadership. Snodgrass, Douthitt, Ellis, Wade, and Plemons (2008) found that nurses perceived the leadership style of their nurse managers as transformational, which had a positive impact on job satisfaction and therefore will significantly impact on patient outcomes and health organisation viability. Furthermore, Casida and Parker (2001) found that nurses viewed their nurse managers' leadership styles as being an effective style. According to Bass and Avolio (1990) nurse managers tended to have higher ratings than those who rate them. In the literature, there were no clear reasons for this significant difference between perceptions of nurse managers and nurses and this could be because nurse managers tended to overrate themselves and nurses tended to underrate their managers.

There are a number of research studies that do not confirm or support these previous findings. For instance, Failla and Stichler (2008) and Casida et al. (2012) found that there was no difference in the perceptions of leadership styles between nurses and nurse managers, specifically with regard to the age, gender and years of experience of the nurses. However, differences were instead related to the type of nursing department, such as critical care units where nurses viewed their nurse managers as less transformational than other units.

8.10 Critique of application of theoretical framework

The theoretical framework underpinning this study is based on Bass (1985) full range leadership theory. This theory incorporates elements from transformational leadership as well as elements from transactional and laissez-faire. There have been many other nursing studies undertaken on leadership styles that have used this same theoretical framework (for example, Aboshaiqah et al., 2014; Alshammari, 2014; Omer, 2005).

Chapter 4 of this thesis provides a critique of the use of this theoretical framework. Generally, this critique identified a number of issues with the use of this framework, including the fact that it provides a limited understanding of the complete nature of leadership and organisational behaviour (Alimo-Metcalfe & Alban-Metcalfe, 2005). The effect of this is that other components of organisations including polities, power and influence are greatly overlooked (Alvesson & Willmott, 1992). Certainly, for this study undertaken in Saudi Arabia, there are number of distinct organisational behaviours that could influence the nature of leadership and would need to be incorporated. Specifically, the multicultural workforce adds a whole complexity to not only the nature of leadership but also to the organisational behaviours.

Another criticism of this theoretical framework identified in Chapter 4 relates to the lack of gender and cultural considerations interpreted within this framework. This is because the theoretical framework was drawn from studies in the United States with a predominantly

male population (Kark, 2004). Application of this theoretical framework to a country vastly different to USA and with predominantly female population highlights the lack of gender and cultural considerations that are lacking. This theoretical framework therefore lacks a balanced gender and cultural beliefs and values that are crucial considerations for research undertaken in Saudi Arabia. A number of researchers have agreed that the framework requires a through revision to accommodate these other considerations found lacking (Alshammari, 2014; Carless, 1998; Rafferty & Griffin, 2004).

Despite their criticism, this theoretical framework proved useful in guiding the research process from data collection, analysis through to discussion. This has provided a clear framework to undertake this research making it easier for other researchers to emulate. In addition, the theoretical framework, allowed a richer discussion with participants as it connected and linked the necessary variables to leadership styles. This framework has therefore guided and enabled the understanding of the correlations and enabled the researcher to make the link between the associated variables while maximising the researcher's understanding of complex phenomena. The theoretical framework also provided a framework in which to present a discussion of the research findings in this chapter. The theoretical framework has, therefore, proved useful in developing implications from reviewing the research results.

8.11 Summary

This chapter discussed the study findings with reference to the literature in nursing leadership styles and in the context of healthcare in Saudi Arabia. The leadership style identified was the transformational leadership style. The results of this study also revealed that nurse managers were also utilising the transactional leadership style in the form of contingent reward. Transformational leadership style and contingent reward were positively correlated with organisational outcomes including: effectiveness, satisfaction and extra effort.

Additionally, the qualitative results of this study supported these results. Nurse managers during the interview claimed that they motivated their staff, supported them and had open communication with them. They also indicated that they were rewarding their staff for instance, each month they chose the best nurse and provided her/him with a certificate. The next chapter concludes the study.

Chapter 9: Conclusion

9.1 Introduction

This chapter presents the implications of the findings including research, education and training, clinical practice and policy, along with recommendations to improve the nursing workforce in Saudi Arabia through education and training. It also presents the limitations of the study. The final part of this chapter presents concluding statements which summarise the study.

9.2 Overview of the study

This study was conducted to examine the leadership styles of nurse managers working at Saudi Arabian hospitals in the Eastern Province, as well as to identify the correlation between perceived leadership styles and three organisational outcomes including effectiveness, satisfaction and extra effort. A mixed-method approach of quantitative (survey) and qualitative (interviews for only nurse managers) was used to accomplish the aim of the study. This study was based on the full range of leadership model using the MLQ 5X-Short (Avolio et al., 1995) to obtain data from nurses and nurse managers. This was undertaken in six Saudi Arabian hospitals.

9.3 Summary of study results

The demographic findings for this study indicated that both nurses and nurse managers were predominantly female. Most of the nurses were 20 to 29 years old, whilst the majority of nurse managers were older and aged 30 to 39 years old. Over half of the nurses and nurse managers were expatriates. In terms of nationality, the study sample was relatively diverse for nurses and nurse managers. The nurses came predominantly from India, followed by the Philippines and smaller proportions of nurses from Egypt, Malaysia and Indonesia. For

nurse managers, the largest group were from India, followed by Saudi Arabia and the Philippines and smaller numbers of nurse managers from South Africa, USA, UK and Jordan.

For this study, most nurses had 1 to 2 years of experience as a nurse whilst the majority of nurse managers had 8 to 10 years of experience. In terms of nursing qualifications, a diploma was the highest qualification for most nurses and nurse managers. The majority of nurses and nurse managers responded that they did not have any formal management qualification. In addition, half of the nurse managers and the majority of nurses indicated that they had not participated in any leadership training in the past 12 months.

In terms of leadership styles, transformational leadership was the dominant style practiced by nurse managers in this study. For both the nurses and nurse managers the laissez-faire leadership was the least preferred style. For the nurses, the more laissez-faire the nurse managers were, the more ineffective was the management which resulted in decreased job satisfaction and effectiveness. The more agreement to accomplish goals there was, then the more punitive the action if subordinates were unable to agree to the set standards. The results indicated that there was a high correlation between all the transformational factors and organisational outcome. This indicates that the clearer the goals and lines of communication from the nurse managers, the more likely the ward functioned well, nurses work hard and were amenable to change with nurses working collaboratively. For the nurse managers there was agreement with the nurses with these conclusions.

There was a positive correlation found between management-by-exception active and the transformational factors. This indicates that the more management-by-exception active the nurse manager is, the more there is intellectual stimulation, coaching, listening and being treated individually. Nurse managers rated themselves lower than the nurses rated the nurse managers in utilising management-by-exception passive. In other words, nurses perceived that their nurse manager did not provide information, articulate goals or create effective

solutions and timely responses, whereas nurse managers believed that they did do these things.

In relation to the demographics variables and patterns of leadership for nurses, female nurses had higher mean scores for the MLQ for organisational outcomes compared to male nurses. In relation to highest achieved qualification, nurses with a diploma had a higher mean score than nurses with bachelor qualifications on laissez-faire leadership. Saudi Arabian nurses had higher mean MLQ scores for laissez-faire leadership style compared to Philippine and Indian nurses who had the lowest.

For nurse managers, those from Saudi Arabia had a higher mean MLQ score on idealised influence attributed compared to Indian and Philippine nurse managers who had the lowest mean score. There was found a significant different in MLQ mean score in 1 to 5 years of experience on satisfaction compared with more than 11 years and with 6 to 10 years being the lowest MLQ score. Nurse managers who had 6 to 10 years of experience had the highest mean MLQ score for laissez-faire leadership style.

In relation to transformational leadership factors, nurses perceived that nurse managers who have higher transformational leadership factors will result in more job satisfaction, effectiveness, and extra effort from the nurses. In other words, transformational leadership achieves better organisational outcomes as far as the nurses were concerned. In contrast, nurses perceived that nurse managers who were more laissez-faire and used management-by-exception passive engendered less job satisfaction, less effective work and less effort from nurses. Nurse managers agreed with this but not as strongly as nurses perceived of their managers.

Themes from the qualitative data were developed by identifying recurrent patterns from the data and then organising them into groups through a process of inductive reasoning. Theme labels were then reflected in the participants own words. These included the

following: ensure good patient care and safety, leadership according to the situation, be a role model, maintain good working relationship, caring about staff, know how to motivate staff, be a good communicator, challenges and need to go through all the steps.

9.4 Strengths of the study

This thesis utilised a mixed-method approach which is a strength as the qualitative findings enhanced the quantitative results. The quantitative findings found the dominant leadership style which was transformational and identified, for instance, nurse managers utilised idealised influence (transformational factor). The qualitative findings then described what constituted this factor in practice and why it was important, that is, why managers should be role models. Most of the studies in this area of leadership have only been quantitative. Another main strength was the use of a recognisably validated tool for the quantitative phase of this research which has been utilised in many studies conducted in Saudi Arabia and elsewhere in the world. Also, a novel approach of this study is that it is the first study in the area of leadership styles in the hospitals located in the Eastern Province of Saudi Arabia. Moreover, the study is unique because it measured two groups, including nurses and nurse managers, whereas other studies tended to examine only the perceptions of one group. Furthermore, in this study there were more males compared to other studies in the area which tended to have more females (Alshammari, 2014). This enabled more of an analysis of males as compared to females. The study also had more managers and managers at different levels rather than one single group of managers, such as at ward level, for example. These are all further strengths of this study. A further strength of this study was that the analysis of the quantitative data followed the findings from the analysis and explored these further to explain the why of the data, rather than analysing the data under the research questions. This provided a deeper analysis and enabled further exploration of the data.

9.5 Limitations of the study

There are a number of limitations in this study that may have impacted the results. One of the main limitations is the sample size for nurse manager participants. Also, a convenience sample was used which may not have been representative for the population. In addition, this study had participants from only public hospitals and did not include other hospitals. It is therefore difficult to apply the results to the private sector or to military and university hospitals as these could have different management experiences. Gender will be an important factor in the study of nursing leadership, but only four male nurse managers participated in the qualitative part and 44 in the quantitative part. For the quantitative component there were only 29 nurses and 15 nurse managers who were males. This is an important consideration in Saudi Arabia as males and females are often segregated and may have different preferences and dispositions towards leadership because of the cultural influences. Additionally, language barrier could be also one of the limitations as the questionnaires were written in English; for most of the nurse and nurse manager respondents, English is their second language which may have minimised their ability to understand the questionnaire. Use of self-reported questionnaires may also be considered as a limitation as it is often difficult to assess or avoid response bias due to poor understanding of the questionnaire items, or participants' answers as per perceived socially desirable responses. As the questionnaire was focused on rating the nurse managers' leadership attributes, and other behavioural aspects, it is possible that the participants (nurses) may have experienced difficulty and fear in completing the questionnaire. This could be one of the major reasons for achieving a low response rate despite accessing a high sample population. As a result, there were a few partly filled and or empty survey responses included in responses for the MLQ questionnaire. Another contributing factor to undertaking this research could be the possible conservative attitudes Saudi Arabian people, as well as Filipinos have, where freedom of expression is limited. This may have affected the honesty of the nurses' responses. This study

was also conducted in only one Province in Saudi Arabia and in six hospitals which could be another limitation for this study. Furthermore, the researcher had to pay for using the MLQ questionnaire which limited wider distribution due to limited financial resources. In addition, nurse managers participated in this study were at a different levels which they had different roles and different perspective of their role. Other studies on leadership have used all ward managers as participants. In addition, this study did not match the nurses with their nurse manager. This could be viewed as a limitation as it is not known whether the nurse manager the nurse was commenting about was a participant or not. This could also however be viewed as strength as the nurses may have felt less restricted in their responses.

9.6 Implications of the findings

The findings of this study have implications for developing nursing workforces and nursing leadership in Saudi Arabia. Transformational leadership was found to be the dominant style. In this study, half of both nurse and nurse manager participants held a diploma and about 80% of nurse managers had no formal management qualifications. Also, half of the nurse managers had not participated in leadership training in the last year. Thus, these results may assist policy makers and healthcare administrators in taking action or investigation further. Nurse directors working at Saudi Arabian hospitals need to regularly evaluate the unit nurse leaders' leadership styles and provide feedback. Furthermore, nurse managers should be supported to achieve the management vision and to overcome challenges. Nurse managers should be motivated to practise and adopt the most effective leadership style that best suits the multinational nursing workforce.

9.6.1. Implications for education and training

The findings of this study showed no relationship between the level of education and leadership styles. However, there was a significant difference between level of education and laissez-faire leadership. Nurse managers who held a higher level of education had higher

transformational scores (Dunham-Taylor, 2000). More than half of the nurse managers in this study had not participated in a leadership training course in the last year and 41.8% of them held just a diploma. Thus, leadership training courses need to be reconsidered by policy makers in Saudi Arabia to make sure that all nurse managers have annual leadership training. A study conducted by Janssen (2004) showed that there is a relationship between leadership style and hours of leadership training. Therefore, leadership training is one of the most important elements that should be promoted. This could include a range of training opportunities from regular in-service education, to seminar days or conference and short course components.

These results highlight the importance of including a leadership course in all diploma programmes of nursing in KSA. The Bachelor degree of Nursing Science in Saudi Arabia is offering leadership and management units in the final year, thus it will be beneficial if they can offer this course earlier and include transformational and transactional leadership styles. By doing so, nursing educators may assist nursing students by teaching them methods that could assist them in achieving organisational outcomes through using the transformational leadership style. Nurses appointed as managers should undertake higher degree programs in nursing and healthcare management.

The results of this study highlight the importance of nursing and hospital directors to regularly evaluate nurse managers for their leadership styles and skills. Furthermore, hospitals must promote compulsory training for nurses and nurse managers, specifically a transformational leadership training course. According to Al-Harthi et al. (2013), the transformational leadership style is crucial to achieving organisational and patient outcomes. A study conducted in a Turkish University Hospital by Duygulu and Kublay (2011) revealed that transformational leadership training courses had a positive relationship with the effectiveness of leaders' practices.

The results of this study highlights the need for both nurses and specific nurse managers to receive some education and workshops on communication strategies to ensure there is good communication.

9.6.2 Implications for clinical practice

The results of this study could benefit nursing practice by showing the positive impact of adopting transformational leadership on organisational outcomes including satisfaction, effectiveness and exerting extra effort. To advance the leadership skills of nurse managers working at Saudi hospitals, there is a need for continuous nursing leadership education. For both experienced and new nurses, training sessions, policies and procedures should continually be reviewed. This study also helps nurses and current and future nurse managers to identify their leadership styles and develop their preferred and most effective leadership styles. Furthermore, this study could help healthcare organisations with strategies for selecting and recruiting nurse managers based on their transformational leadership behaviours. Nurse managers working at Saudi Arabian hospitals need to use and adopt transformational leadership behaviours in order to enhance the work environment and attract and retain nurses and recruit more nurses into bachelor, not diploma, qualifications. As identified earlier in this thesis, nursing in Saudi Arabia is facing management challenges that necessitate the need for stronger leadership practice. Importantly, nurse managers need strategies to retain nurses and ensure they are motivated to provide good patient care. Hospitals should encourage the gathering of nurse managers on a regular basis to discuss these challenges and develop strategies and work through them. This could be in form of meetings, seminar days or conferences at national level.

9.6.3 Implications of health policy

Transformational leadership is crucial to improve leadership and may assist in the growth of leadership competency; thus, transformational leadership should shape health

policy. Nurse managers working at Saudi Arabian hospitals may influence policy by including them in the health policy process and decision making. Also, nurse managers should contribute to improving the image of the nursing profession and help with recruiting Saudi Arabia nurses into nursing as a career. To ensure that nurse managers will be able to face the challenges they face, well-planned strategies should be developed to identify potential leaders and develop their leadership skills by providing leadership education (Huston, 2008). Human resources may help nurse managers by encouraging them to use Multifactor Leadership Questionnaire (MLQ) (Bass, 1985) and assisting them with the results, in order to help them identify their current leadership style. This could help them to improve their leadership practice. Healthcare administrators should show caution when replacing experienced expatriate nurse managers with less experienced Saudi Arabian nurses.

9.6.4 Implications for research

This study adds to the knowledge base of the nursing profession. Further research on the topic of leadership styles is recommended in order to assess the leadership styles not only in the nursing workforce but also in other heath sectors in Saudi Arabia. Also, further study should be conducted in private, public, specialist and teaching hospitals in all provinces of Saudi Arabia in order to compare the leadership styles in these different sectors. Future research on leadership style may also use a large sample of nurse managers from different provinces in Saudi Arabia for better results and outcome measures. Furthermore, researchers should consider using the Arabic version of the MLQ (Bass, 1985) to overcome language barriers and to ensure the validity of the tool. Moreover, it is highly recommended to conduct studies that evaluate any changes in nurse managers' perceptions of leadership styles and behaviours after transformational leadership training. This expected to help to develop their leadership skills as well as help to improve leadership training courses for future nurse managers. Researchers could take this study further by assessing the relationship between

transformational and transactional leadership style with other organisational outcomes including retention and patient outcomes. Also, more qualitative research should be conducted to investigate the most effective leadership style. Saudi Arabia should encourage and support nursing research, specifically in leadership style in healthcare sectors.

9.7 Thesis conclusion

There are many challenges and changes in the current healthcare sector in Saudi Arabia, involving economic, IT and political factors. Therefore, it is important to have strong, skilful and competent nurse managers in order to effectively manage healthcare systems and a multicultural workforce, ensuring that staff deliver quality healthcare services. Currently, the MOH in Saudi Arabia is trying to develop the clinical practices of nurse leaders in order to improve the quality of healthcare within Saudi hospitals.

The aim of this study was to identify the leadership style of nurse managers working at Saudi Arabian hospitals in the Eastern Province and also to examine the relationship between leadership style and three organisational outcomes: effectiveness, job satisfaction and exerting extra effort. This enabled the researcher to examine the current leadership style practised by nurse managers and to then identify the most effective and most suitable leadership style for the healthcare environment in Saudi Arabia.

This research is expected to benefit nurse managers, educators and policy makers by enabling them to identify their current leadership style and then adopt the most effective leadership style to help them manage the challenges that they are facing. This study contributes to the base knowledge of nursing leadership in public and specialist hospitals in Saudi Arabia. Also, this study hopes to generate insights and fill a gap in the literature on leadership styles in Saudi Arabia. This thesis shows the characteristics of the leadership styles of nurse managers in hospitals located in the Eastern Province of Saudi Arabia. Further, this

study provides information on the level of leadership training that nurse managers need in order to increase their effectiveness in leading their nursing staff.

In this mixed-methods study, the leadership style of nurse managers has been assessed using two sample nurse managers and nurses because perceptions of the current leadership style practised by nurse managers plays an important role in the motivation and performance of nurses. The differences in both groups' perceptions of the leadership style were examined. Mixed methods were used to examine the difference in the views of these two samples to help to identify ways to align their perceptions. Exploring this difference is expected to help in improving nurse performance and overall healthcare services. Also, this study enables to identify how to improve the working environments for nurses and outcomes on individual, team and organisational levels. The quantitative part of this study was a non-experimental descriptive and correlational design using the Multifactor Leadership Questionnaire MLQ 5X-Short (Leader and Rater Forms). The data were stored and analysed using SPSS version 22. The qualitative part of this research used interviews to explore the experience of nurse managers of the culture of leadership in Saudi Arabian hospitals located in the Eastern Province.

The findings of this study showed that nurse managers perceived themselves as practising transformational and transactional leadership (contingent reward) styles with the former being more prevalent. Nurses also perceived their nurse manager as utilising transformational and transactional (contingent reward and management-by-exception active) styles. The results of this mixed-method study also revealed that there was a difference in the perceptions of the two samples regarding the leadership styles of nurse managers. There was also a positive correlation between transformational and transactional leadership styles and three organisational outcomes including effectiveness, satisfaction and exerting extra effort. However, management-by-exception passive (transactional leadership factor) and the laissez-

faire leadership style were negatively associated with the three organisational outcomes. Also, nurse managers rated themselves as utilising the transformational leadership style higher than their staff rated them.

The qualitative interviews showed that the experience of nurse managers regarding the experience of the culture of leadership at Saudi Arabian hospitals located in the Eastern province was shaped by nine themes including: *ensure good patient care and safety leadership according to the situation, be a role model, maintain good working relationship, caring about staff, know how to motivate staff, be a good leader, be a good communicator* and *challenges.*

Half of the nurse managers who participated in this study were diploma holders, and in the diploma course there are no leadership and management units. Also, half of the nurse managers had not participated in any leadership training and the majority of them did not have a formal management qualification. However, this study helped the nurse managers to identify and understand their leadership style, which is expected to help them to improve their leadership skills and to adopt a leadership style that enables them to manage their staff effectively.

Identifying the current leadership style of nurse managers working in Saudi Arabian hospitals provided evidence of the need to introduce a suitable leadership programme in order to transform the status of nursing leadership in Saudi Arabia. This would ensure that nurse managers engage in continuous learning about leadership skills and the behaviours that is expected to help them to improve the work environment and manage their staff. This in turn will also enable nurse managers to handle the nursing workforce challenges that they face and to provide better healthcare services and outcomes. It is essential that a transformational leadership training programme be implemented and that each nurse managers working in Saudi Arabian hospitals should participate annually in this programme. Healthcare

administrators should also include future Saudi nurses in this programme, as this is expected to prepare them for leadership positions, and nurse managers should be supported to advance their level of education. In addition, improving the skills of nurse leaders will facilitate retention and recruitment.

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Appendix A: Ethical approval from King Abdulla Medical City

مدينة الملك عبدالله الطبية
KING ABDULLAH MEDICAL CITY

المملكة العربية السعودية Kingdom of Saudi Arabia
وزارة الصحة Ministry of Health
مدينة الملك عبد الله الطبية بالعاصمة المقدسة King Abdulla Medical City in Holy capital
اللجنة المحلية لأخلاقيات البحث Institutional Review Board

Institutional Review Board Opinion Letter

Protocol Title	Leadership Style of Nurse Managers Working at Saudi Arabian Hospitals
Version	RS-MoH 018-35
Principal investigator	Noura Alsadaan
IRB number	14-117
Sponsor	Ministry of Higher Education

Dear Noura,

This is to inform you that the above mentioned proposal has been the subject of expedited review by KAMC IRB registered at the National BioMedical Ethics Committee, King Abdulaziz City for Science and Technology on 14-07-1433 (Registration no. H-02-K-001).

The decision for expedited review was based on the following submitted documents:

1. The protocol proposal (RS-MoH 018-35)
2. English & Arabic invitation letter
3. English & Arabic informed consent form for participation
4. English & Arabic questionnaire for staff nurses
5. English & Arabic questionnaire for leadership
6. questions leading the interview

The opinion of the IRB is to approve this proposal with its current design:

- The study is approved for 7 months from the date of this letter.
- To conduct research as per the approved documents
- Amendments to the approved documents require IRB approval before implementation
- The study conduct may be subject to audits by KAMC Human Research Protection Program (HRPP)
- Research participant confidentiality should be protected at all times and may be subject to audits by KAMC HRPP
- Document retention: all study documents should be kept by the principal investigator for a period of three years from study completion

Dr Tahani Hassan Nageeti		**28/05/2014**
(Name of IRB Chair)	*(Signature)*	*(Date of approval)*

مدينة الملك عبدالله الطبية
KING ABDULLAH MEDICAL CITY

Institutional Review Board Opinion Letter

Protocol Title	Leadership Style of Nurse Managers Working at Saudi Arabian Hospitals
Version	RS-MoH 018-35
Principal investigator	Ms. Noura Alsadaan
IRB number	14-117
Sponsor	Ministry of Higher Education

Dear Ms. Alsadaan,

This is to inform you that the above mentioned proposal has been the subject of expedited review by KAMC IRB registered at the National BioMedical Ethics Committee, King Abdulaziz City for Science and Technology on 14-07-1433 (Registration no. H-02-K-001).

The decision for **exempted review** was based on:

1. Previously submitted documents (protocol version RS-MoH 018-35)
2. Amendment request

The opinion of the IRB is to **approve** the extension of the previously approved protocol on 30/05/2016:

- The study is approved for another six months from the expiry date of the first approval i.e. the approval expiry date is 30/09/2016
- Extension can be requested one month before the expiry of the approval.
- To conduct research as per the approved documents
- Amendments to the approved documents require IRB approval before implementation
- End of study report is expected before expiration of approval
- The study conduct may be subject to audits by KAMC Human Research Protection Program (HRPP)
- Research participant confidentiality should be protected at all times and may be subject to audits by KAMC HRPP
- Document retention: all study documents should be kept by the principal investigator for a period of three years from study completion
- Copy of all participants' consents should be submitted to IRB.
- Final manuscript should be submitted to IRB for review before Journal Submission.

Dr. Tahani Hassan Nageeti		**16/06/2016**
(Name of IRB Chair)	*(Signature)*	*DD/MM/YYYY (Date of approval)*

Appendix B: Ethical approval from University of Technology, Sydney

Dear Applicant

Thank you for your response to the Committee's comments for your project titled, "Leadership Style of Nurse Managers Working at the Saudi Arabian Hospitals.". Your response satisfactorily addresses the concerns and questions raised by the Committee who agreed that the application now meets the requirements of the NHMRC National Statement on Ethical Conduct in Human Research (2007). I am pleased to inform you that ethics approval is now granted.

Your approval number is UTS HREC REF NO. 2013000623
Your approval is valid five years from the date of this email.

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

You should consider this your official letter of approval. If you require a hardcopy please contact Research.Ethics@uts.edu.au.

To access this application, please follow the URLs below:
* if accessing within the UTS network: http://rmprod.itd.uts.edu.au/RMENet/HOM001N.aspx
* if accessing outside of UTS network: https://remote.uts.edu.au , and click on "RMENet - ResearchMaster Enterprise" after logging in.

We value your feedback on the online ethics process. If you would like to provide feedback please go to: http://surveys.uts.edu.au/surveys/onlineethics/index.cfm

If you have any queries about your ethics approval, or require any amendments to your research in the future, please do not hesitate to contact Research.Ethics@uts.edu.au.

Yours sincerely,

Professor Marion Haas
Chairperson
UTS Human Research Ethics Committee
C/- Research & Innovation Office
University of Technology, Sydney
T: (02) 9514 9772
F: (02) 9514 1244
E: Research.Ethics@uts.edu.au
I: http://www.research.uts.edu.au/policies/restricted/ethics.html
P: PO Box 123, BROADWAY NSW 2007
[Level 14, Building 1, Broadway Campus]
CB01.14.08.04

Ref: E13

Appendix C: Multifactor Leadership Questionnaire

MLQ Multifactor Leadership Questionnaire
Leader Form (5x-Short)

My Name: _____ Date: _____

Organization ID #: _____ Leader ID #: _____

This questionnaire is to describe your leadership style as you perceive it. Please answer all items on this answer sheet. **If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.**

Forty-five descriptive statements are listed on the following pages. Judge how frequently each statement fits you. The word "others" may mean your peers, clients, direct reports, supervisors, and/or all of these individuals.

Use the following rating scale:

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

1.	I provide others with assistance in exchange for their efforts	0	1	2	3	4
2.	I re-examine critical assumptions to question whether they are appropriate	0	1	2	3	4
3.	I fail to interfere until problems become serious	0	1	2	3	4
4.	I focus attention on irregularities, mistakes, exceptions, and deviations from standards	0	1	2	3	4
5.	I avoid getting involved when important issues arise	0	1	2	3	4
6.	I talk about my most important values and beliefs	0	1	2	3	4
7.	I am absent when needed	0	1	2	3	4
8.	I seek differing perspectives when solving problems	0	1	2	3	4
9.	I talk optimistically about the future	0	1	2	3	4
10.	I instill pride in others for being associated with me	0	1	2	3	4
11.	I discuss in specific terms who is responsible for achieving performance targets	0	1	2	3	4
12.	I wait for things to go wrong before taking action	0	1	2	3	4
13.	I talk enthusiastically about what needs to be accomplished	0	1	2	3	4
14.	I specify the importance of having a strong sense of purpose	0	1	2	3	4
15.	I spend time teaching and coaching	0	1	2	3	4

Continued =>

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

16.	I make clear what one can expect to receive when performance goals are achieved	0	1	2	3	4
17.	I show that I am a firm believer in "If it ain't broke, don't fix it."	0	1	2	3	4
18.	I go beyond self-interest for the good of the group	0	1	2	3	4
19.	I treat others as individuals rather than just as a member of a group	0	1	2	3	4
20.	I demonstrate that problems must become chronic before I take action	0	1	2	3	4
21.	I act in ways that build others' respect for me	0	1	2	3	4
22.	I concentrate my full attention on dealing with mistakes, complaints, and failures	0	1	2	3	4
23.	I consider the moral and ethical consequences of decisions	0	1	2	3	4
24.	I keep track of all mistakes	0	1	2	3	4
25.	I display a sense of power and confidence	0	1	2	3	4
26.	I articulate a compelling vision of the future	0	1	2	3	4
27.	I direct my attention toward failures to meet standards	0	1	2	3	4
28.	I avoid making decisions	0	1	2	3	4
29.	I consider an individual as having different needs, abilities, and aspirations from others	0	1	2	3	4
30.	I get others to look at problems from many different angles	0	1	2	3	4
31.	I help others to develop their strengths	0	1	2	3	4
32.	I suggest new ways of looking at how to complete assignments	0	1	2	3	4
33.	I delay responding to urgent questions	0	1	2	3	4
34.	I emphasize the importance of having a collective sense of mission	0	1	2	3	4
35.	I express satisfaction when others meet expectations	0	1	2	3	4
36.	I express confidence that goals will be achieved	0	1	2	3	4
37.	I am effective in meeting others' job-related needs	0	1	2	3	4
38.	I use methods of leadership that are satisfying	0	1	2	3	4
39.	I get others to do more than they expected to do	0	1	2	3	4
40.	I am effective in representing others to higher authority	0	1	2	3	4
41.	I work with others in a satisfactory way	0	1	2	3	4
42.	I heighten others' desire to succeed	0	1	2	3	4
43.	I am effective in meeting organizational requirements	0	1	2	3	4
44.	I increase others' willingness to try harder	0	1	2	3	4
45.	I lead a group that is effective	0	1	2	3	4

MLQ Multifactor Leadership Questionnaire
Rater Form (5x-Short)

Name of Leader: _____ Date: _____

Organization ID #: _____ Leader ID #: _____

This questionnaire is to describe the leadership style of the above-mentioned individual as you perceive it. Please answer all items on this answer sheet. **If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.** Please answer this questionnaire anonymously.

IMPORTANT (necessary for processing): Which best describes you?

___ I am at a higher organizational level than the person I am rating.
___ The person I am rating is at my organizational level.
___ I am at a lower organizational level than the person I am rating.
___ I do not wish my organizational level to be known.

Forty-five descriptive statements are listed on the following pages. Judge how frequently each statement fits the person you are describing. Use the following rating scale:

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

THE PERSON I AM RATING. . .

1.	Provides me with assistance in exchange for my efforts	0	1	2	3	4
2.	Re-examines critical assumptions to question whether they are appropriate	0	1	2	3	4
3.	Fails to interfere until problems become serious	0	1	2	3	4
4.	Focuses attention on irregularities, mistakes, exceptions, and deviations from standards	0	1	2	3	4
5.	Avoids getting involved when important issues arise	0	1	2	3	4
6.	Talks about their most important values and beliefs	0	1	2	3	4
7.	Is absent when needed	0	1	2	3	4
8.	Seeks differing perspectives when solving problems	0	1	2	3	4
9.	Talks optimistically about the future	0	1	2	3	4
10.	Instills pride in me for being associated with him/her	0	1	2	3	4
11.	Discusses in specific terms who is responsible for achieving performance targets	0	1	2	3	4
12.	Waits for things to go wrong before taking action	0	1	2	3	4
13.	Talks enthusiastically about what needs to be accomplished	0	1	2	3	4
14.	Specifies the importance of having a strong sense of purpose	0	1	2	3	4
15.	Spends time teaching and coaching	0	1	2	3	4

Continued =>

Not at all	Once in a while	Sometimes	Fairly often	Frequently, if not always
0	1	2	3	4

16.	Makes clear what one can expect to receive when performance goals are achieved	0	1	2	3	4
17.	Shows that he/she is a firm believer in "If it ain't broke, don't fix it."	0	1	2	3	4
18.	Goes beyond self-interest for the good of the group	0	1	2	3	4
19.	Treats me as an individual rather than just as a member of a group	0	1	2	3	4
20.	Demonstrates that problems must become chronic before taking action	0	1	2	3	4
21.	Acts in ways that builds my respect	0	1	2	3	4
22.	Concentrates his/her full attention on dealing with mistakes, complaints, and failures	0	1	2	3	4
23.	Considers the moral and ethical consequences of decisions	0	1	2	3	4
24.	Keeps track of all mistakes	0	1	2	3	4
25.	Displays a sense of power and confidence	0	1	2	3	4
26.	Articulates a compelling vision of the future	0	1	2	3	4
27.	Directs my attention toward failures to meet standards	0	1	2	3	4
28.	Avoids making decisions	0	1	2	3	4
29.	Considers me as having different needs, abilities, and aspirations from others	0	1	2	3	4
30.	Gets me to look at problems from many different angles	0	1	2	3	4
31.	Helps me to develop my strengths	0	1	2	3	4
32.	Suggests new ways of looking at how to complete assignments	0	1	2	3	4
33.	Delays responding to urgent questions	0	1	2	3	4
34.	Emphasizes the importance of having a collective sense of mission	0	1	2	3	4
35.	Expresses satisfaction when I meet expectations	0	1	2	3	4
36.	Expresses confidence that goals will be achieved	0	1	2	3	4
37.	Is effective in meeting my job-related needs	0	1	2	3	4
38.	Uses methods of leadership that are satisfying	0	1	2	3	4
39.	Gets me to do more than I expected to do	0	1	2	3	4
40.	Is effective in representing me to higher authority	0	1	2	3	4
41.	Works with me in a satisfactory way	0	1	2	3	4
42.	Heightens my desire to succeed	0	1	2	3	4
43.	Is effective in meeting organizational requirements	0	1	2	3	4
44.	Increases my willingness to try harder	0	1	2	3	4
45.	Leads a group that is effective	0	1	2	3	4

Appendix D: Invitation letter (Survey)

Invitation letter

Dear colleague,

You are invited to participate in as study about leadership style. This project is being conducted to explore how leadership style is viewed by nurse managers and staff nurses working in the Ministry of Health in Saudi Arabia. It is being undertaken in order to learn how managers' style of leadership influences working relationships and worker effectiveness. The results of the study will help us to understand the preferred leadership style for use in nursing services in Saudi Arabia.

Procedure: Participants are asked to complete a pencil and paper survey that asks about leadership style and how it influences the work of the organization. Your consent to participate in the study will be indicated by completing the survey.

If you agree to participate, you will be asked to complete a survey called 'Multifactor Leadership Questionnaire'. It consists of 45 questions and takes about 20 minutes to complete. The survey will be delivered to you on your nursing unit in a sealed envelope. In addition, nurse managers will be also invited to participate in an interview about leadership; this interview will last for about 30 minutes.

Confidentiality: The information you give in this study will be kept confidential, no names will be used, and all the data will be coded solely for the purpose of the aggregating responses. The anonymous survey will have no identifying marks, and the information obtained will only be used for the purpose of this study. All surveys and interview data will be kept in a secure, private location and seen only by the investigator.

Risks: There are no known risks (physical, psychological, social or legal) to participating in the survey. No individuals other than the investigator will see the completed survey and there is no record of survey participation.

Benefits: There are no direct benefits to individuals for participating in the study, although we hope the findings of this study will help identify new information that will be helpful to the nursing profession in the future.

Participation: Your participation is voluntary and you may withdraw at any time and for any reason. There is no penalty for not participating or withdrawing from the study.

Contacts: This study is being conducting by Nourah Alsadaan, a doctoral candidate in the faculty of Nursing, University of Technology, Sydney. She can be reached at Email nourah.a.alsadaan@student.uts.edu.au, for any question or complaints.

Appendix E: Invitation letter (interviews)

Nurse managers invitation letter

Dear Nurse managers,

You have been selected to participate in the interview portion of a study about nursing leadership. This research project is being undertaken in order to learn how style of leadership influences working relationships and work unit effectiveness in the Saudi Arabian hospitals. It is anticipated that the results of the study will help us to understand the preferred leadership style for use in nursing services.

If you agree to participate in this study, you will be asked to participate in an interview that will last for about 30 minutes, at a time and location convenient for you. The interview will be audio taped. The researcher will ensure the security of the audiotapes to protect the confidentiality of the information provided by participants, and the information obtained through the interview will be used solely for the purpose of the study.

If you are willing to participate in the interview, please sign and return the consent form in the enclosed envelope and return it to the investigator. Your participation is voluntary and you can withdraw at any time and for any reason. There is no penalty for not participation in or withdrawing from the study.

Appendix F: Consent Form

Consent to participate

I agree to participate in the research project LEADERSHIP STYLE being conducted by NOURAH ALSADAAN of the University of Technology, Sydney.

I have read this Informed Consent letter

I understand that the purpose of this study is to learn how style of leadership influences work effectiveness in Saudi Arabian hospitals.

I understand that my participation in this research will involve an interview, which will take approximately 30 minutes to complete.

I understand that the researcher will kept my information safe, the audiotape of my interview will be placed in a locked file cabinet. And the researcher will enter study data on a computer that is password-protected and uses special coding of the data to protect the information.

I understand that my real name will not be used in the audiotape and the written copy of the discussion.

I understand that after tape is transcribed (written out), I will be not be asked to review it.

I am aware that I can contact NOURAH ALSADAAN if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish, without consequences, and without giving a reason.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____ Signature (Participant)

_____Nourah Alsadaan_____ Signature (Researcher)

Appendix G: Demographic data

Demographic Data

Participants Demographics

Check/Fill in all that apply:

1. **Age:**
   20-29 ( ) 30-39 ( ) 40-49 ( ) 50-59 ( ) 60+ ( )

2. **Gender:**
   Male ( ) Female ( )

3. **Marital status:**
   Single ( ) Married ( )

4. **I am currently working as a staff nurse:** Yes ( ) No ( )

5. **Total years of experience as a nurse within your current hospital:**
   1-2 year ( ) 3-5 years ( ) 6-7 years ( )
   8-10 years ( ) 11 years and more ( )

6. **I am currently working as a Nurse Manager:** Yes ( ) No ( )

7. **Total of years of experience as a nurse manager in this position within your current hospital:**
   1-2 year ( ) 3-5 years ( ) 6-7 years ( )
   8-10 years ( ) 11 years and more ( )

8. **I am a Saudi citizen** ( ) **I am a Non-Saudi citizen** ( )

9. **If you are Non-Saudi:**

   Nationality: ……

10. **Highest Level of Nursing Education Attained**:
    Diploma ( ) Associate Degree ( ) BSN ( ) MSN ( )
    Doctorate ( )

11. **Do you hold any formal management qualification?**
    Yes ( ) No ( )

12. **In the last 12 months have you participated in any training concerning leadership or management?**
    Yes ( ) No ( )

Appendix H: permission to use MLQ

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To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material for his/her thesis or dissertation research:

Instrument: ***Multifactor Leadership Questionnaire***

Authors: ***Bruce Avolio and Bernard Bass***

Copyright: ***1995 by Bruce Avolio and Bernard Bass***

Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

Robert Most
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To Whom It May Concern,

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Multifactor Leadership Questionnaire

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Citation of the instrument must include the applicable copyright statement listed below.
Sample Items:

As a leader ....

I talk optimistically about the future.
I spend time teaching and coaching.
I avoid making decisions.

The person I am rating....

Talks optimistically about the future.
Spends time teaching and coaching.
Avoids making decisions

Sincerely,

Robert Most
Mind Garden, Inc.
www.mindgarden.com

Appendix I: Interview questions guide

1. What are your responsibilities as nurse managers?
2. How would you describe your leadership style?
3. What major challenges and problems did you face on your current position?
4. What do you think are the most important skills as leader should have?
5. How do motivate and retain your staff? Can you give me an example?