Cardiff University

School of Healthcare Sciences

Eastgate House Campus, 35-43 Newport Road, 12th Floor, Cardiff, CF24 0AB

South Wales, United Kingdom

Developing culturally appropriate leadership for nursing in Saudi Arabia

Thesis submitted in partial fulfilment for the degree of Doctor of Philosophy.

Abdulrahman A Aldawood

Student Number D1155438

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Supervised by

Professor Daniel Kelly

Professor Dianne Watkins

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ABSTRACT

The healthcare services in Saudi Arabia currently face many challenges, the most pressing being the shortage of local nurses. In common with many other countries in the Gulf region this has necessitated the hire of expatriate nurses and has led to health care provision in Saudi Arabia being highly multicultural in its composition. The ensuing cultural diversity of the health care professional population has resulted in there being a significant challenge regarding the lack of culturally competent nurses to meet the growing needs and expectations of health care provision in Saudi Arabia. In essence, there is a cultural mismatch between the nurses and those they care for that extends far beyond not sharing the same native language. Moreover, the staff group itself is culturally diverse and as well as not sharing the same mother tongue they do not share the same mores, values, religion and training.

In turn, culturally competent and effective nursing leadership, the literature suggests, is sadly lacking and not addressing the deficit in culturally appropriate nursing care for the Saudi population. Moreover, this lack of culturally competent leadership will negatively impact not only on work performance and quality of nursing care delivered but also on the job satisfaction of this multicultural and diverse staff group.

The overall aim of this thesis is to understand the relationship between nurse leadership and the cultural sensitivity of nursing care delivered in the hospital setting in Saudi Arabia. Furthermore, this study will attempt to identify the future training and development needs of nurse leaders in Saudi Arabia to enable a service to be delivered that can best address the needs of its people.

This thesis is based on a qualitative study carried out from the perspective of nurse leaders working in the medical city in Riyadh, the capital of Saudi Arabia. The sample in the study consisted of 46 participant nurse leaders from different cultural backgrounds who work in the largest Medical City in Riyadh (King Saud Medical City). Data for this qualitative study were collected by semi-structured interviews and 6 focus groups and were analyzed thematically.

The results indicated that culturally competent nurse leaders require a set of characteristics and personal qualities. Moreover, it is demonstrated that cultural factors are of critical importance; not only in influencing the quality of nursing care delivered, but also on the effectiveness of the leadership style of nurse leaders and how they learn and develop professionally.

This research study suggests that there are three considerations which need to be taken into account for the development of nurse leaders in this context. First, gender is a key issue and its implications are important for the future of nursing in Saudi Arabia. Second, key characteristics and essential personal qualities are required for culturally competent nurse leaders. Third, exploration of what works and (what does not) for nurse leaders is required to overcome situations where there may be a risk of cultural conflict.

There has been a lack of previous research and knowledge into nurse leadership development in Saudi Arabia and the significance of this study is that it provides new empirical evidence to address this deficit. This new evidence will inform the development of training programmes for nurse leaders in Saudi Arabia that stress the need for cultural awareness and competency. The provision of such training could have far reaching

benefits not only for nurse leaders and the staff they manage, but also for the quality of nursing care delivered and how it is perceived by the recipients of that care. In turn, this could impact the recruitment and training of other health care professionals in Saudi Arabia and delivery of its health care policy in a wider context.

Keywords: cultural competence, nursing leadership, Saudi Arabia, expatriate, multicultural, thematic analysis, qualitative method.

Note: Throughout this thesis the full name of Saudi Arabia, and its shortened form SA, are used interchangeably.

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DEDICATION

First and foremost, to the soul of my great stepfather who raised me since I was one year old and encouraged me during life, including this Ph.D. journey, but unfortunately passed away before I submitted my thesis. I would also dedicate this work to my family; my wife, my children, my sisters and brothers for their continual encouragement and countless prayers.

إهـــداء

إلى أبي الحبيب، المرحوم بإذن الله، **عبد الرحمن بن ناصر الداود**، الذي كان دائما الأب الحنون والملجأ لي بعد الله في كل صغيرة وكبيرة والذي طالما سعدت بقربه ونعمت برعايته وهنأت بوجوده ومسامرته والتعلم منه ولطالما حفني بدعائه لي بالتوفيق والنجاح وقد كانت تلك الدعوات الوقود لحياتي والدليل في طرقاتي. أعلم أن أبي سيكون فخوراً بي لإكمالي رسالة الدكتوراه. رحمك الله يا أبي واسكنك فسيح جناته وجمعني وإياك ووالدي ووالدتي والمسلمين والمسلمات في جنات الفردوس.. اللهم آمين

إلى أخي الأكبر **سعــد** رحمه الله والذي كان لي دائما المعلم والمرجع والقدوة والصديق ومؤنس الحديث ولولا الله ثم وقوفه بجانبي في جميع مراحل حياتي لما استطعت أن أحقق ما حققت. أخي سعــد ثق بأنه لو كان بإمكاني لمنحتك شهادة الدكتوراه في كل العلوم لما أحطت به من معرفة وعلم وإطلاع. أدعوا الله العلي القدير ان يرحمك ويجعل ما أصابك رفعة لك في الفردوس الأعلى وأن يجمعنا الله بك في جنات النعيم.

إلى زوجتي المحبة والمخلصة والمتفانية **ســارة** التي لم تألو جهدا ولم تدخر وسعاً في تشجيعي والوقوف بجانبي وتذليل ما كان يصعب علي لكي أكمل دراستي وأحصل على درجة الماجستير لقد صبرت وعانت الكثير من أجل تحقيق حلمنا العائلي فأقول لها أحبك وشكراً لوجودك في حياتي وإليك أهدي كل نجاحاتي.

إلى أبني **عبــدالله** و بنتي **ثمــراء** وبنتي **ميسم** الذين ملئوا حياتي بهجة وسرور وأحاطوني بأجمل لحظات عمري. أقول لهم أنتم أغلى هدية وهبني الله إياها. راجيا" من المولى القدير أن يحفظكم ويسدد خطاكما كما أرجوه تعالى أن يمد في عمري واحضر كل اللحظات الجميلة وكل الإنجازات الكبيرة في حياتكم إنه على كل شيء قدير.

إلى جميع أفراد عائلتي إلى أختي **النـوري** وأخي **حســن** وأختي **وفـاء** وأخي **عبـدالله** وأخي **بنـدر** وأختاي الجميلتان **سلمـى** و **سميـرة** وبالطبع لن أنسى كل **أفراد أُسر** أخواني وأخواتي من **زوجات** و **أزواج** و **أولاد** و **بنات**. أهديهم هذا الإنجاز وأقول لهم جميعا شكرا لكل ما فعلتموه من أجلي وشكرا لمؤازرتكم لي ولحبكم وعطفكم وحنانكم الذي غمرتموني بهم.

ولا يفوتني ان أهدي هذا النجاح إلى أصدقائي الأعزاء **منصور** اليامي ومحمد الغامدي **أبوقمر** و**صالح** العبيد و**حسن** الشهراني و**حسين** المالكي و**مرزوق** العتيبي و**نواف** العنزي و**نايف** اليحيا و**عايض** الحارثي و**علوان** الشمراني و**عثمان** الشهري و**فهد** البلوي و**محمد** الحجي وعبدالله العتيبي **أبوجوجو** كل هؤلاء وغيرهم كانوا ولازالوا لي نعم الأخوة والأخلاء والأصحاب والمستشارين المنصحين ورفقاء الدرب الأوفياء في هذه الحياة.. شكراً لكم ولوجودكم في حياتي.

CHAPTER ONE: Introduction

1.1 Introduction

Most countries, if not all, are experiencing shortages of nursing staff, reflecting a significant challenge to the provision of optimal nursing care. According to Buchan et al. (2003), shortages of nurses threaten both developed and developing countries. Saudi Arabia is considered a developing country based on per capita GDP but this is only one factor of many leading Saudi Arabia to suffer from a shortage, in common with many other countries. The only way to address this shortage is to hire qualified nurses from other countries and in Saudi Arabia, the majority of nurses are expatriates, recruited from many different countries, but in particular from The Philippines and India. In Arabian countries only 10% to 20% of registered nursing staff are nationals and in Saudia Arabia it is common for health organizations, such as hospitals, rely on expatriate nurses from 30 to 50 different countries [Tumulty, 2001]. These nurses come from very different cultures, ethnic backgrounds, beliefs and values from those of the indigenous population. It is worth noting that this diversity brings a variety of expertise and experiences to the workplace as well as presenting challenges.

Nurse leaders are crucial to the effective co-ordination of patient care via Registered Nurses, nursing assistants, medical staff, consultants, other professionals and the wider hospital leadership team. Their workload is undoubtedly heavy as they endeavor to lead their teams in addressing the challenge of both the workload and its effective administration. The Ministry of Health (MoH) of Saudi Arabia has identified nurse leaders as a potent task force in the provision of healthcare services in new medical

cities (Ministry of Health, 2013a) and research hospitals, as well as for improving the quality of all health services.

Saudi Arabia's rapid movement toward globalization in all aspects (economic, social, technical and political) has made its people more connected to the outside world. This interconnection leads to an exchange of cultural norms and means organizations need to be effective, in a multi-national sense, and moreover to assign culturally sensitive leaders to manage organizations with this multi-cultural mix of staff (House and Javidan, 2004).

Globalization has raised the need to understand the interaction of leadership with cultural diversity. It has also raised the requirement to prepare leaders to become culturally competent and sensitive to others' beliefs and behaviours. This preparing and training nurse leaders in cultural competence awareness may enhance nursing efficiency and quality:

"Nurses shall be educationally prepared to promote and provide culturally congruent health care. Knowledge and skills necessary for assuring that nursing care is culturally congruent shall be included in global healthcare agendas that mandate formal education and clinical training, as well as required ongoing, continuing education for all practicing nurses" (Douglas et al., 2011. pp. 317-333).

Understanding cultural norms and diversity are vital to the provision of appropriate and individualized nursing care. Indeed, Dreher and Macnaughton (2002) contend that cultural competence is really a dimension of nursing competence itself.

1.2 Background

Oil industrialization has paved the way for the Saudi Arabian government in social as well as economic development (Brown and Busman, 2003). From the beginning, the Saudi Arabian government has been trying to achieve its goal of providing optimum healthcare services to the residents of the nation by developing an efficient healthcare system. Since the nation is lacking the required man/womanpower in the health sector, it is one of the prime concerns of the Saudi Arabian government to achieve the set target of required employees to carry out the work of health agencies and to run them effectively (Gallaher & Searle, 1985). Nevertheless, this planned target in the health sector has not been met at a national level. Hence the incremental rise in training capacity and education across all public sectors has been given priority but the training of individuals in the healthcare sector remains a major priority. In reality leadership and management requirements are only able to be met by mixing Western concepts with Middle Eastern philosophies. Some argue that it is important to understand the recent historical background of the country in order to reach a full consideration of the present Saudi Arabian context (Al Hosis, Plummer and O'Connor, 2012).

In 1930, when oil reserves were discovered in the nation, it was in the interests of western governments and business to take every opportunity to understand the leaders of Gulf countries. Saudi Arabian leaders were particularly targeted and although there may have been some benefits to this process of awareness raising unfortunately it also resulted in a proliferation of stereotypes, and had little benefit either economically or culturally (Bjerke and Al-Meer, 1993). In 1996, Al-Meer addressed Saudi Arabian leaders and highlighted that despite some differences in leadership styles they shared the same Islamic culture and linguistic heritage as their counterparts in neighboring

countries such as Jordan, Morocco, Syria and Tunisia. On the other hand, there are still significant differences, even between neighboring countries and Saudi Arabia, when examining the values and rituals of their respective citizens. Indeed, the philosophies, ideologies, and beliefs are somewhat different in every country in the Middle East (Ali, 1986).

The differences in lifestyle, leadership and production patterns between Saudi Arabia and the Western world is even more marked (Al-Meer, 1996). In 1993, Bjerke and Al-Meer conducted a large-scale study to compare the cultural heritage of citizens of America and Saudi Arabia and concluded with an examination of how this affected bilateral ties and how crucial an acknowledgment of respective cultures was to managing future relations between nations. They concluded that a nation's social situation was based on diverse factors such as individualism/collectivism; the cultural nature of power; the impact of expectations around masculinity/femininity and uncertainty avoidance. These results clearly indicate that there may be significant gaps between leaders and employees both socially and in terms of power differentials.

However, what Saudi Arabian leaders and the general Muslim population have in common is an intolerance of any move against their religious beliefs, even if this is recognised to be in their ultimate interests and perceived to be of benefit. Alongside this they are also very loyal to Bedouin traditions and Islamic teachings and the institutions that provide them. This collectivism can also be clearly observed in their negativity towards being involved in conflict. However, if conflict does arise it almost always requires the intervention of higher authorities. Furthermore, the importance of self-esteem and the pride of leaders and influential people receiving respect in the country has always been a part of social harmony preservation, and goes alongside

humbleness as a desirable quality. Foreign nationals from more developed and richer countries who enter Saudi Arabia on visas supplied by the government to meet a skills shortage in the health care sector, may well have a different world view and may also have very different attitudes and expectations towards leaders (Al-Meer, 1996).

In Saudi Arabia healthcare centers may have state-of-the-art technology and advanced equipment in any medical specialty but their optimum use is not always possible due to a shortage of properly trained and experienced local staff. As previously noted, this has resulted in hospitals being staffed by nurses, and other professionals, with a multiplicity of different ethnicities, religions, national origins and experience. The main advantage of this is that it results in a wide range of professional qualifications and expertise being added to the SA workforce. However, it also increases the dependence of the nation on foreign employees for regular nursing work and providing healthcare services to the comparatively large Saudi Arabian population. It has been proved, such as during the Gulf war in 1990, that dependence of any nation on a foreign workforce is dangerously problematic if diplomatic ties are broken. Undeniably, given the fact that 60% of the nursing staff of Saudi Arabia are foreign nationals, there is a risk that in the event of war necessitating a return to their country of origin, medical services in Saudi Arabia would rapidly be decimated (Al Hosis et al, 2012).

A study was carried out by Almaki, FitzGerald and Clark in 2011 to evaluate basic data regarding the healthcare industry in Saudi Arabia. This has provided some interesting findings including the fact that the country is suffering from 'institutional inefficiency' and a paucity of properly trained local staff in the healthcare sector. It was mooted that, in order to counteract this problem, that nurse leaders should be

required to enable, motivate and coordinate staff to exert more effort in their everyday work and thus increase efficiency and output. Their leadership style should be such that, as influential and effective leaders, they are aware of the day to day concerns of their staff and are supportive in suggesting ways to address these said concerns. This might result in boosting the efficiency of individual staff and also their willingness to share the workload more fairly with each other which will ultimately result in improved outputs.

Commitment to the work of healthcare is an essential part of the job and a nurse leader can act to improve this by interacting and motivating their staff. They can do this by explaining the opportunities each has as an individual to enhance their career progression, whilst at the same time encouraging them to share the vision of the healthcare agencies employing them. Thus, awareness of the most appropriate leadership style is as crucial as making the right choice of leader. This is clearly noted in a research paper in which staff nurses evaluated their work by considering job satisfaction and the opportunities provided by their leader and their subsequent opinion about him/her (Duygulu and Kublay, 2011). If given the chance to air an individual opinion on a topic or issue, nursing staff were more likely feel part of the process of decision-making and also more likely to develop trust in their leader. This trust also made them more willing to accept any subsequent decisions made and also to respond in a positive way to changes in established routines. As a result, the workforce may become better informed and efficient and will be better able to achieve their goals; as well as being more willing to accept the vision of the institution.

1.3 Statement of the Problem

The findings of several research studies that have already been mentioned support the idea that leadership and individual nurse leaders can influence organizational culture and impact performance. It is also suggested that leadership styles contribute towards achieving specific targets and goals of an organization. The literature suggests that organizations should involve a variety of leadership styles and behaviours, and ideally from different cultures, in order to bring different experiences, values, and attributes to the workplace (Avolio and Bass, 1993). This is important when recent investment in the Saudi health service is considered.

The SA government, between 2005 and 2008, allocated approximately SAR 23.5 billion per annum with a cumulative amount of SAR 94 billion investments in the healthcare sector. This rose substantially between 2010 and 2011 to SAR 68.7 billion per annum (11.8% of the total government budget), and a cumulative allocation of SAR 113 billion (Mansoor, 2012). Approximately 60% of all hospitals within the Kingdom are owned and operated by the Ministry of Health (MOH) and provide basic healthcare services, as well as, in certain cases, specialized facility centres (Mansoor, 2012). Nevertheless, these services are believed to be less than satisfactory (Al-Doghaither et al., 2003). Patient satisfaction with nursing care in SA was found to be an important predictor of overall satisfaction with hospital care (Greeneich, 1993). A study by Cleary et al. (1988) also found nursing care to be the most important factor for the evaluation of patients' general levels of satisfaction with healthcare services. Therefore, we need to consider the role of nursing leadership in SA within this financial investment picture.

MOH hospitals, traditionally, are obliged to provide jobs for all Saudi nursing graduates, regardless of their qualifications or experience. Furthermore, nurse leaders in these hospitals may come from the same graduate population and may have neither the proper qualifications, nor effective leadership styles, for the task. Some nursing leaders in these hospitals also come from other countries such as India and the Philippines, therefore their cultural backgrounds will inevitably play a role in their everyday leadership styles.

Notwithstanding organizational culture and individual nursing leadership styles the way that these important variables impact on each other may have a powerful influence on the health services delivered by health organizations. Importantly, however, much of the available research literature does not relate to Saudi Arabia specifically; especially in relation to the MOH and its constituent organizations. This is important as the majority of healthcare services in SA are actually being delivered by the MOH, and they are the sponsors of this study. Given this background the aims of the present study will now be presented.

1.4 Aims and Objectives of the Study

The purpose of this study is to understand the relationship between nurse leadership and cultural differences in Saudi Arabia's (SA) hospital settings. Furthermore, this study will identify the future training and development needs of nurse leaders in Saudi Arabia. To meet these aims, a qualitative design was adopted, using in-depth interviews and focus groups.

The researcher set out to achieve the following objectives:

1. To compare and contrast the participants' accounts on what type of leadership style they value in relation to their own cultural backgrounds.

2. To examine the participants' views and understanding of the relationship between culture and nursing leadership in SA.

3. To gain the participants' views and opinions on the factors (skills, characteristics, and training) that make a good nurse leader in SA, and how they/we might develop them further.

The overall objective of the study was to obtain knowledge on different aspects of leadership and culture with the aid of critical inquiry. These topics are explored in terms of the relationship between leadership and society and in the context of a country in a process of rapid transition. The study highlights inadequacies in the current epistemological and predilections of organizations, cross-culture research, and leadership. The study also aims to be distinctive in respect of the methodology and its aspiration to acquire a strong description of leadership practice in SA (Geertz, 1973). It set out to aid in the understanding of complex organisation and leadership dynamics within this unique cultural setting. The social and political context of Saudi Arabia is particularly relevant to this study and supports the need for the background information that is provided.

The purpose of this research is to ensure that its outcomes are easily understandable by individuals employed at a leadership level. The study also tries to find whether there is a distinctive style of leadership of Saudi Arabia, and whether the root of this can be found in the country's culture. The roots of this form of leadership can be described as a geo-cultural, which may be different to the style of many western

leadership theories in the present day. To summarize this situation there are three concerns to address:

- If studies find different patterns and structure of leadership, what behavior would Saudi Arabian leaders be best advised to display?
- What would be the indications for this distinction?
- Can we say how culture affects the leadership process and what are the practical implications for this in the health workplace in Saudi Arabia?

It was felt that the best way to start to find answers to the above was by generating and collecting the relevant data. During this phase, I faced the problem of representing, organizing, and making data comparisons with the cultural framework of SA. Keeping it within the complete cultural framework of SA helps make the research findings more relevant. However, I suggest that the above problems can only be answered in three ways -

- By examining leadership in nursing practice,
- By determining how culture and leadership practice can be taken into account by the organisation.
- By establishing relevant policies in nursing leadership practice.

The next section justifies the rationale for the study in light of these beliefs.

1.5 Rationale of the Study

The thesis enables a greater understanding of self and identity at distinctive levels; namely at the individual, organisational, national and international level. It illuminates how each leader's cultural identity can be considered of relevance to accomplishing the task of leading or managing. The study aims to include previously unheard, marginalised or under-represented voices concerning nursing leadership identities and

practice. It also illustrates the dilemmas that emerge with the extension of modernization and with identity management and maintenance at different levels in SA.

Considering the international context of globalization, the subjects researched here are essential for understanding the role of transactional, organizational and multinational co-operation. They will enhance the level of understanding shown to societies and economies such as Saudi Arabia seeking to improve their healthcare services. The implications that are generated here can also be expected to have some relevance to the carrying out of other forms of business in SA at an international level. The wider implications for multi-national companies include gaining a better understanding of cultural dimensions of leadership so that it might be more obvious whether or how they should engage local SA companies. For instance, this might include how to lead discussions on involvement via joint ventures, alliances or wholly owned subsidiaries via licensing, outsourcing and franchising.

It is apparent that this research also has relevance and significance for Western organizations in understanding leadership and management issues in SA. This can be considered as an alternative to simply making assumptions. The application of findings could include being able to share training programmes in leadership and management. Finally, there may also be tremendous scope for informing the process of human resource recruitment and to develop a greater understanding of leadership dynamics to support international nurses in SA. The changes in public policy formulation that could also emerge as a consequence of new insights are varied and complex but also highly relevant.

The next section explores leadership and management issues in more depth before supporting the need for empirical data to shape new training programmes in SA.

1.6 Nursing Leadership and Management

Nurses and the care they provide are considered to be pivotal in whether or not a health care organisation achieves the goal of being a quality healthcare provider. In turn this quality can be influenced by their nurse leaders' behavior and leadership style. Many researchers support this idea; Timmreck (2001), for example, suggested that nurse leaders are capable of demonstrating leadership behaviours and implementing work schedules that will improve job satisfaction for their staff. The nursing literature identifies that a positive and professional relationship with the immediate leader is an influential factor in continued job satisfaction and organisational commitment for nursing staff (Wagner, 2006). Leadership and job satisfaction are regarded as essential components influencing the overall effectiveness of a health care organisation (Chen et.al, 2005). Evidence from nursing scholars has also suggested that leadership style is a critical component of staff retention (Kleinman, 2004).

There are a wealth of theories and views concerning leadership with many strengthening the concept that leadership can be viewed as a mixture of personality traits and professional training. If these complement each other, then a successful nurse leader will be created. Some of these are reviewed in the following chapter.

Nursing leadership can impact on many aspects of healthcare systems, such as outcomes, performance, staff satisfaction and retention. These in turn will impact on the quality of healthcare delivered to the recipients (Chen et.al, 2005). Therefore, nursing leadership throughout Saudi Arabia must also continue to respond to healthcare changes and continued development.

Researchers in different fields have shown an interest in studying leadership as they believe it has an impact on these many other variables. Leadership has been described in a variety of different ways and is occasionally interchangeable with definitions of management. In the past, leadership has been viewed as a form of social influence, but recently it has begun to be viewed as a form of organising and achieving.

According to Utriainen and Kynga (2009), nurses' job satisfaction is based primarily on the communal aspects of nursing work: interpersonal relationships, social interaction, and communication with peers. This can be understood when the typical characteristics of transformational leadership are considered. A transformational leadership style, for instance, decreases levels of exhaustion and burnout and increases wellbeing and job satisfaction (Kanste, 2008). In contrast, the transactional leadership style has been associated with burnout, exhaustion and poor job satisfaction (Weberg, 2010).

It has been suggested that the transformational leadership style is the most effective when difficulties are addressed and job satisfaction improves and staff retention is raised. Consequently, staff performance and organisational productivity is maximized. Nevertheless, it would seem that there is no one ideal leadership style for every situation. Flexibility and knowledge of different leadership styles are key.

The nursing profession in Saudi Arabia needs well educated and culturally sensitive nurse leaders to be placed in the highest nurse positions and contribute to the development of the nursing in the country. Nursing leadership development is part of the future of the country’s development (Tumulty, 2001).

Taking the lead from Western thinking, leadership training has been introduced as an essential for the professional development of the nursing profession in Saudi Arabia

and in particular for nurse leaders in the Ministry of Health. Current thinking is that Saudi nurse leaders require advanced qualifications and training in order that the nursing profession, at both national and international levels, so as to be equal to the nursing profession in developed countries

Leadership development is an essential part of organisational development in any country. If one considers all the elements of professional development, leadership, it can be argued, is perhaps the most important. Leadership gains its importance from the variety of functions it performs from goal setting and defining the norms and culture of an organization to controlling resources, delivering communications and creating and distributing rewards.

According to Stanley (2008), it is an integral part of providing excellent healthcare that nursing staff are managed and their needs are met by a leader who has the capacity to fully understand them. If such a manager is in place this will result in improved quality of care as well as reducing the costs of care provision. Training to develop authentic skills of leadership, and their application in their workplace, will greatly enhance the output of the organisation. This will benefit not only the hospital nursing staff, and the hospital administrative system, but also society as a whole (Shirey, 2006).

Most people are fully aware of the fact that a nursing role has the capacity to be quite exhausting and requires working in a stressful environment. As a result, it is not uncommon for reports of absenteeism, burnout and even disability to be recorded (Stanley 2008). This has led to there being an increased requirement to develop healthy working conditions for nursing staff in order to maintain a stable workforce. This becomes mandatory in the current situation of global scarcity of highly and properly

trained professionals. Thus, a nurse leader plays a pivotal role in maintaining a satisfied workforce as well as favorable conditions for nurses employed in healthcare institutions.

1.7 Nursing Leadership Training and Development

In the Saudi MOH, there is no current evidence of advanced leadership programmes being introduced. High standards and national programmes for leadership boards need to be established in the country in order to enhance leadership development in all fields and especially in the nursing profession. Nursing leadership courses also seems to be lacking in undergraduate nursing education programmes in Saudi Arabia. These, it has been recommended, should incorporate leadership related theories and leadership related competencies should be included in the curriculum (IOM, 2010). After all, one of the biggest challenges that the nursing profession now faces is the development of future nurse leaders (Mahoney, 2001).

1.7.1 The Need for Nursing Leadership Training

Leadership skills are often stated as essential requirement in the field of nursing, as nurses are accountable for managing and maintaining an optimal patient environment and experience. The skills of leadership need to be demonstrable when communicating with colleagues, patients and their families (Heller et al, 2004). It is, therefore, recommended that through training and education, the challenges of nursing leadership, both within clinical care and management duties, can be met more effectively (Kleinman, 2003). More precisely it has been advised by Mahoney (2001) that through tailored programmes of leadership, specialized education seminars and workshops, nurses can be helped to improve their leadership skills. Finally, as concluded by Cummings et al (2008) leadership can only really be advanced only by

precise training and educational activities that encourage leadership capabilities and modeling to be carried out.

1.7.2 Promoting and Maintaining Nursing Leadership Development in Practice

As already noted, leadership in the fields of nursing and healthcare are necessary for various reasons; staff maintenance and enhancement of patient safety outcomes are among the most vital specifications. However, what can actually be done by SA organizations to promote nurse leadership? Highlighted in the previous sections are the role of training and education along with transformational leadership approaches that appears most appropriate for improving the working lives of nursing, and perhaps it should be compulsory for nursing managers and health service administrators to consider these findings during the recruitment and promotion of personnel in healthcare organizations? Recruiting staff with pertinent qualifications, such as graduate degrees in nursing and leadership, as well as building a CPD program are important to this process (Kleinman, 2003). Building an acceptable and caring organizational culture with good working conditions are other necessities that can be implemented to create leaders and enhance effective leadership. As specified by Shobbrook and Fenton (2002) the culture of an organization and its style of leadership remain important contributory factors in improving nurse turnover. It was found that by decreasing the tiers in an organization and the promotion and sharing of leadership roles, professional development was enhanced. Ritter (2010), who determined that a healthy working environment had a positive effect on nurse retention, further shared this opinion. A study was conducted by Mok and Au-Yeung (2002) in an acute hospital in Hong Kong to explore the relationship between organizational conditions

and empowerment amongst nurses. Results specified that helpful leadership and organizational environment are interrelated with the improved retention and recruitment of nursing staff. Healthcare organizations that offered skilled development prospects for staff, and rewarded their contributions and efforts with positive feedback, were also found to contribute to an empowering and supportive work environment (Patrick and Laschinger, 2006).

Another approach that can be used for the development of prospective leaders is empowerment. A link between empowering work conditions and insights of support and role satisfaction has been demonstrated by research undertaken with middle-level nurse managers in Canada. Interestingly, as reported by these managers, when they received sufficient feedback and recommendations for enhancing their performance, expectations of credit being given for novelty was minimal. Delegation is a further example of a strategy for enhancing empowerment of workers by the leader. Opportunities for sharing ideas, collective working and learning are provided when projects and tasks are allocated to the staff (Curtis and Redmond, 2009). Additionally, seeds of collegiality, self-respect, leadership, and professionalism are planted by empowerment (Marquis and Huston, 2009). Conversely, building an empowering work environment is difficult; success could be jeopardized by numerous blocks and it is a leader's responsibility to detect these blocks and eliminate them, after which plans can be implemented for empowering staff.

Mentoring is another strategy which can be used for evolving leaders and leadership (Kleinman, 2003). By associating himself or herself with an experienced colleague, it is possible for an individual leader to gain insights into the role of leadership and change management. Leadership 'guides' are individuals who are often well-placed

in organisations and such senior people tend to create present or life-long relationships with junior associates whom they help to become leaders in their own right. Although the relationship between a mentee and a mentor is an informal one, its benefits are such that it has been suggested that some organizations should try using it in a more formal way (Hughes et al, 2006). As stated by Marquis and Huston (2009), mentors can aid a beneficial role in helping nurses adapt to management or leadership roles and research conducted by Connor et al (2000) confirms that mentoring has a positive effect on nurses' professional development.

1.8 Islamic Leadership

A different type of approach is needed when studying leadership in SA by embedding it appropriately within religion and culture. Before going on to focus on leadership and Islam, let us now gain a brief insight into Islam as a religion and its impact on nursing leadership.

Islam can be defined as a religion which advocates for submission and obedience to Allah. There is a common belief in Islam that Muslims believe only Allah can foresee the future and that plans must be based on His will alone (Bowker, 2000). Islam is said to have created a unique management paradigm that nurtures civility, prosperity, diversity and happiness among people of different origins around the globe (Abbasi et al, 2010). Leadership is broadly divided into two roles from the Islamic perspective, the 'servant leader' and the 'guardian leader'. The former can be defined as leadership being a service to the organisation and its members (Chowdhary & Saraswat 2003). Servant leaders believe that their first role is to serve and only then to lead (Crippen, 2005). Here it is believed that serving others and taking care of their needs is the foremost role of a leader and leadership follows on as secondary. The second role

perceived by Islam is that of the guardian leader. As the name suggests, guarding the community is their foremost duty. According to Beekun and Badawi (1999), such leaders instill the sense of drive in their followers by processes which include being helpful by reaching out to everybody, accepting verbal commitments of others and by using a motivational approach. They apply a positive reinforcement style in order to increase the morale of their followers. Understanding the unique potential of each person, they allocate an assignment and subsequently exhibit patience and understanding towards their followers. This process is not only positively motivational but also stimulates the follower intellectually and can be considered a further important factor of leadership.

The Islamic value system maintains that certain factors and characteristics make a person a good leader and specifies the factors that are needed in leadership. According to the Islamic value system, an effective leader should be trustworthy, righteous, intelligent, knowledgeable, informed, confident and strong, yet moderate, consistent, disciplined, cooperative, content, humble, just and kind (Abbasi, 2009). Furthermore, Kraines asserts that every leader has to deliver all the elements of his responsibility (Kraines, 2001). It is stated that the vision of Islamic leadership has four components: future orientation, learning from the past, the welfare of all stakeholders and protection (Abbasi, 2009).

The concept of leadership can thus differ in its approach depending on the context of its implementation. On doing a comparative analysis of leadership in the West and in the Islamic world, Moten (2011) states that according to Islam consent of the people is crucially important in order to establish leadership. This must be carried out by the people through free and fair elections. Also, according to Islam, the basis of leadership

is the Ummah, the Islamic social order. The leader also must be endowed with qualities which would enable him to fulfill his responsibilities and he will be held accountable for all his decisions and actions (Moten, 2011).

1.9 Summary

The above introduction, briefing and background section has been shaped by searching the literature on organisational culture, social culture and leadership, as well as personal insights into Islamic culture, and all have been used to inform a specific set of social-cultural values that may apply to the SA context. The role of leadership will be explored further in the literature review section by examining evidence that exists on change management and leadership. The cultural context will also be further explored next so as to locate this study before identifying existing gaps in the evidence base and the methods for the present study.

CHAPTER TWO: Contextual Background

2.1 Introduction

It is necessary to understand the current position of a country regarding the education system before developing a new one. In this section, the Saudi Arabian context is explored further. This includes the social, legislative, physical and economic environment in which the nurses reside and work in Saudi Arabia. It includes a summary of the history and presents some relevant demographic data. This is followed by a description of the Ministry of Health and the government of Saudi Arabia in its jurisdiction area. Finally, the distinct features of the nurse leader in this cultural context are examined.

2.2 Overview of Saudi Arabia

Saudi Arabia is considered one of the largest and richest countries in the Middle East. It has the world's second-largest oil reserve and this accounts for more than 95% of exports and 70% of government revenue. SA also has the world's sixth largest natural gas reserves (Colliers International, 2012). It has an area of approximately 2,250,000 km2 (870,000 square miles). The 2010 Census indicated the population of Saudi Arabia to be 27,136,977; 18,707,576 Saudi nationals and 8,429,401 non-nationals. SA's population is characterised by rapid growth and a large cohort of youth (Saudi Gazette, 2010).

Figure 1. Kingdom of Saudi Arabia's geography (Source: CIA, 2014)

As one of the richest and biggest oil producer countries, SA development is considered accelerated in all disciplines, but especially in nursing and health (Aldossary et al., 2008). However, the rapid growth of the Saudi population has resulted in a corresponding demand for health professionals that far outstrips the number of trained Saudi national health professionals. The nursing profession is suffering from a limited number of graduates as the majority of nurses have low qualifications. Only a few years ago the vocational nursing diploma certificate was the highest qualification that could be achieved by male students in Saudi male Nursing Schools. Abu-Zinadah (2004) is one author who criticized the insufficient number of Saudi graduates from nursing schools. As explained earlier this resulted in most of the health workers in SA, especially nurses, being expatriates from many different countries, but especially from the Philippines and India (Almalki et. al, 2011). Some expatriate nurses are from a cultural background that may be considered incompatible with the culture of SA and it has been argued that they are at a disadvantage as care providers for Arabic speaking patients because of the language barriers and cultural differences (Almalki et. al,

2011). Some of these factors have to be explained in order to explore leadership in this cultural context.

2.3 Tribal Affiliation in SA

Tribal affiliation in most of the countries in the Middle East has its roots deep within the history of the region. The influence of such affiliations is still evident, despite major transformations occurring in the countries of the region. There is much debate as to what extent tribal affiliation impacts on the way that certain tribe members treat each other or react to the actions of others, including non-tribe members (Al-Said, 1982). The role of tribal affiliation is determined by variable factors linked and pertinent to the construction of the tribe itself, including the political and cultural nature of the tribe. Therefore, the role of tribal affiliations may be used by members for the benefit of each other, or indeed against other tribe members (Kostiner, 1991). Health care workers, including nurses, are not immune to the influence that being a member of a particular tribe will bring to their nursing care and their relationship with others within the team who share an affiliation, or otherwise.

Saudi Arabia, especially the Najd region, in the east and the south, contains many of the tribes of the Arabian Peninsula. However, it should be noted that Mecca, Medina (the Muslim holy places) and Jeddah in SA remain the most socially open and tribal affiliation is not as noticeable as in the other regions. This social openness has its origins in the large number of foreigners who visit the holy cities (Mecca and Medina) from all over the world and the trading activity resulting from this (Shaker, 2013). Nevertheless, tribal affiliation is to some extent dominant throughout the country. Tribal connections between some people in SA, therefore, must be considered to have

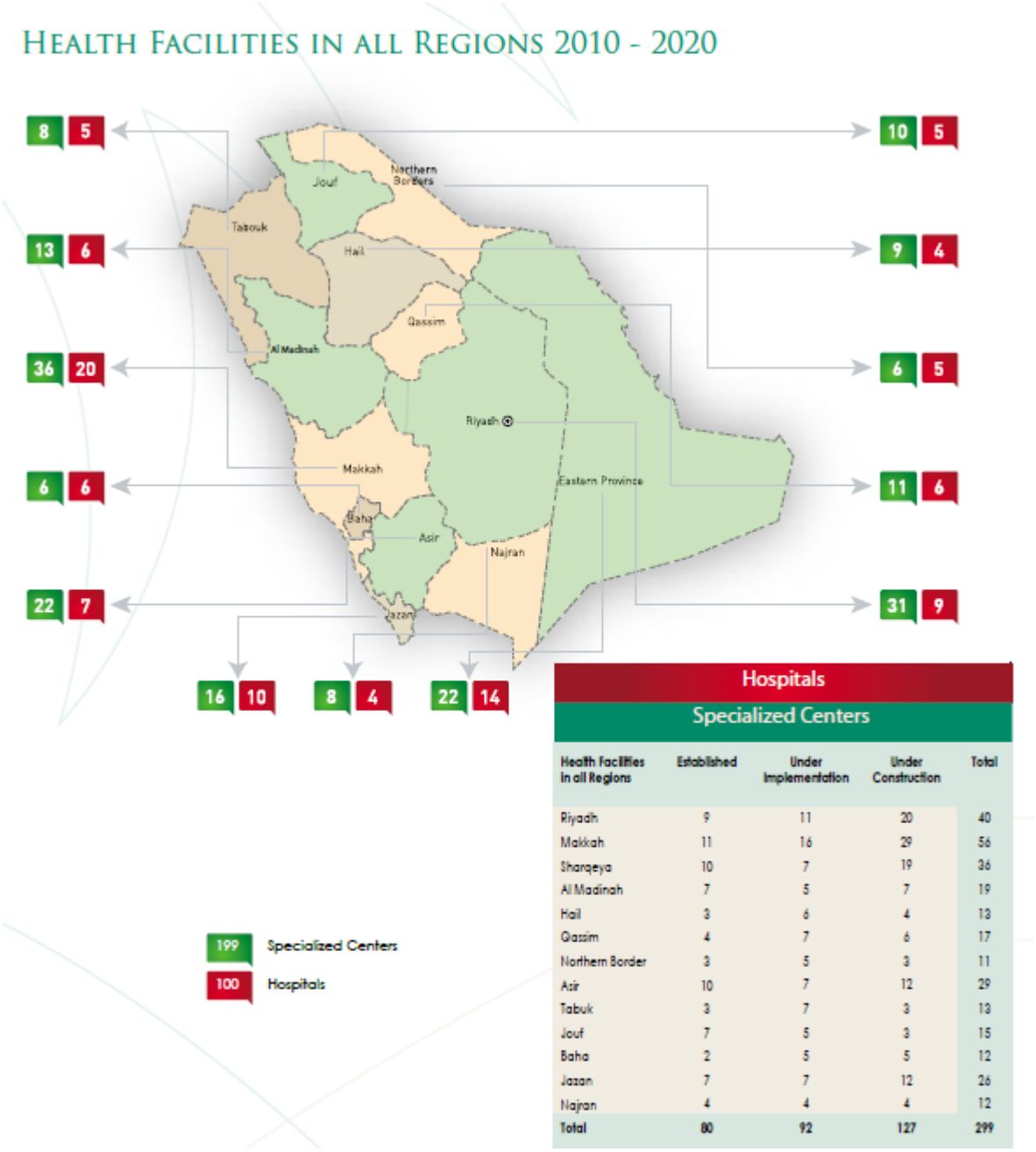
some degree of influence on how some leaders might treat workers from the same or different tribes.

2.4 Saudi Arabian Healthcare System

In 2013 the World Health Organisation (W.H.O.) examined and reviewed the healthcare system of Saudi Arabia. Saudi Arabia had developed a five-year plan dedicated to improving healthcare services in the country. In this 2009-2013 plan the Ministry of Healthcare started to address a 10-year strategy which included various measures to further develop the healthcare system and infrastructure. For example, one measure was that there should be a 10% incremental rise in the number of healthcare centers, together with a proportionate increase in the number of staff in the industry. The newly imposed model of healthcare was comprehensive and integrated in its design, and was intended to be applied at four levels of care i.e. primary, secondary, tertiary and quaternary. It was based on seven key elements which included primary healthcare, homecare, dental care, preventive health, mental health, hospitals and rehabilitation centers.

The World Health Organisation observed that this plan had raised standards and operational procedures thus ensuring an improvement in the quality of healthcare facilities in Saudi Arabia. The Ministry of Healthcare received accreditation for this improvement. The W.H.O. also stated that the essential feature of the nation's reliance on foreign national human resources, with its correspondingly high levels of economic turnover, was being addressed. In 2013, W.H.O. praised the effort of the government towards the indigenization of the workforce in the sector on each and every level i.e. medical and nursing institutions, universities and training institutions. For example, scholarship programs in leading institutions were commenced, resulting in a

corresponding rise in the quality of trained professionals working in the health sector. Fig 2 shows the distribution of medical centres and hospitals across the country.



Hospitals				
Specialized Centers				
Health Facilities in all Regions	Established	Under Implementation	Under Construction	Total
Riyadh	9	11	20	40
Makkah	11	16	29	56
Sharqeya	10	7	19	36
Al Madinah	7	5	7	19
Hail	3	6	4	13
Qassim	4	7	6	17
Northern Border	3	5	3	11
Asir	10	7	12	29
Tabuk	3	7	3	13
Jouf	7	5	3	15
Baha	2	5	5	12
Jazan	7	7	12	26
Najran	4	4	4	12
Total	80	92	127	299

Figure 2. Ministry of Health: Medical Centers and Hospitals 2010–2020 (Source: Ministry of Health, 2013)

2.5 Healthcare privatization in Saudi Arabia

Rapid growth in the population of the country and the ever diversifying of disease patterns are posing a heavy threat to the healthcare system of the kingdom. Counter-measures are taken by the ministry of the kingdom by implementing policy changes in an effort to ensure the expansion of capacity and quality improvements of the healthcare system. However, it can be argued that the ambitious plan of governmental reforms will fall short if the ministry does not open the gates for the private sector to flourish in the delivery and financing of healthcare.

Saudi Arabia is a member of the Gulf Cooperation Council and so has a relationship with many countries in the region, both rich and poor. The Saudi Arabian government has a goal of improving the access and efficiency of the healthcare system by ensuring some part of the system is privatized. Gulf countries are facing a challenging situation with their economy as the price of oil is dropping drastically in the global market. Saudi Arabia is not exempt from the situation as the main source of kingdom's income is reliant on the oil industry. The government is now having difficulty in financing healthcare services and so has decided to look for help from the private sector. In the current scenario, the Ministry of Healthcare alone provides 60% of overall services. When we add the contribution from other departments such as the Ministry of Defense, Ministry of National Guard, Ministry of Education and the Ministry of Internal Affairs, this sum adds up to 80% of services all over the country being government funded. With the contribution of other service providers the Ministry of Healthcare delivers short and long term services. Citizens are provided with all kinds of curative services as well as a full range of care from primary to quaternary; from home care to rehabilitation.

In 1999, a Compulsory Employment-Based Health Insurance (CEBHI) was introduced. Under this system, the medical care costs of the employee in the private sector are borne by the respective employer. This health insurance covers not only all the employees in the private sector but also their families. It was anticipated that these reforms would guarantee healthcare provision throughout the kingdom. However, after a decade this has been shown not to be the case as the population has outpaced the rate of development of the healthcare industry. The Ministry of Healthcare has remained the largest service provider and services have been expanded considerably. In 2009 the Government established five medical cities. The King Abdullah Medical City in Makkah; King Fahd Medical City in Riyadh and Prince Mohammad Bin Abdulaziz Medical City in Al Madinah to serve the Northern provinces; King Faisal Medical City for the southern provinces; and King Khalid Medical City in Dammam to serve the Eastern province.

2.6 The Nursing Profession in Saudi Arabia

Nursing staff are the largest group of all healthcare professionals. They are responsible for delivering the highest percentage of patient care, both preventative and curative (Oulton, 2006). Although nurses are the largest healthcare professional group in SA, there is still a severe shortage of qualified professionals; and accordingly, health care delivery is affected (Chan and Morrison, 2000). Providing the minimum number of qualified staff nurses is still a challenge for several countries (Buchan and Calman, 2004). Nursing shortage is considered a serious threat to the efficiency and the effectiveness of providing adequate healthcare throughout healthcare delivery systems (Fang, 2001).

There is a growing shortage of registered nurses across the globe. This can be observed through various numerical indicators including the increasing average age of registered nurses which is 44.4 years. This average age reflects that less new registered nurses are entering the profession (or at least participating as a registered nurse). Fig 3 summarizes this challenge.

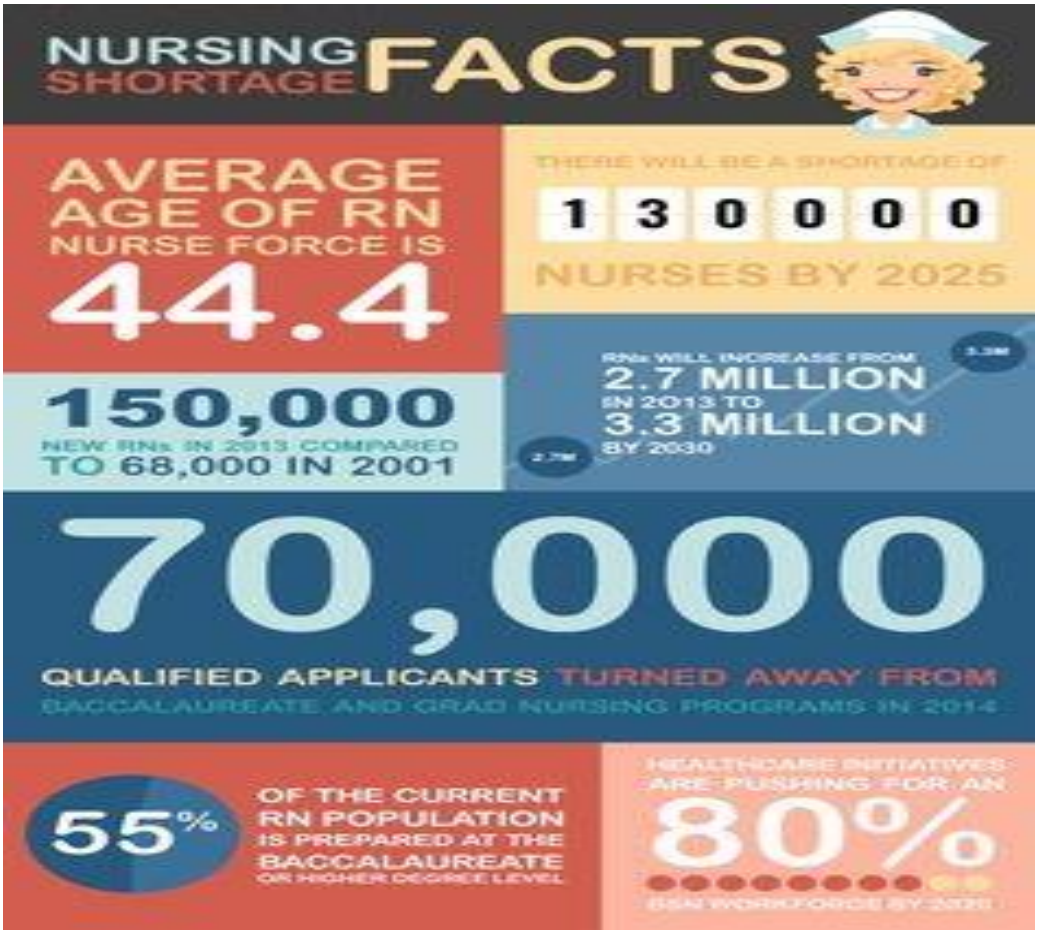


FIG 3. (Source Credit - http://www.travelnursing.org/)

Globally, the total number of registered nurses was 2.7 million in 2013 with only 150,000 new registered nurses as compared to 68,000 in 2001. If this pace continues the world will face a shortage of 130,000 of registered nurses by the end of 2025 and in the year 2030 there will only 3.3 million nurses globally. There are two factors that can be considered to play a significant role in the afore-mentioned nursing shortage

(Oulton 2006). The first concerns the fact that less applicants are applying to train as nurses. In 2014 there was a decline/withdrawal of 70, 000 applicants from baccalaureate and graduation programmes. These programmes contribute to 55% of the current population of nurses so any reduction will have a significant impact. The second factor is that health care initiatives are resulting in an increased demand for trained nurses globally pushing for an 80% increase of the workforce by 2020.

The shortage of nurses can be attributed to the joint challenges existing of nursing recruitment and retention. The impact of the shortage can be easily seen on hospital wards, operating theatres and out–patient departments (Institute of Medicine, 2004). The nursing workforce shortage means that patients have their access to healthcare reduced. In the last two decades, a descriptive study has been conducted which examined the ways in which several hospitals have encouraged the retention of nurses (Institute of Medicine, 2004). The characteristics in common that were identified as significant can be viewed under the headings of administration, professional practice and professional development. A further important factor was whether nurse leaders were of a supportive nature, acted as nurse advocates and were visible in the workplace. The study clearly demonstrated the role that nurse leaders play in nurse retention and suggested that the supportive work they do can have a significant impact.

In conclusion, despite the notable advances in nursing education and in the workplace, the nursing profession is suffering from a chronic shortage of nurses; globally as well as in SA. This shortage is accompanied by rapid growth in the Saudi population and the subsequent expansion of health services means which results in a significant threat to achieving quality health care provision. In order to address this shortage both the public and private healthcare sectors in Saudi Arabia depend largely on recruiting nurses from other countries.

2.7 The Nursing Workforce

Healthcare indicators demonstrate a shortage of physicians, nurses and beds in all the Gulf Co-operation Council (GCC) countries. However, Saudi Arabia currently has the lowest number of beds, nurses and physicians within these countries (Colliers International, 2012). In Saudi Arabia, the Ministry of Health hospitals and other healthcare sectors suffer from a severe shortage, especially of Saudi nurses. Fig 4 shows the state of the health workforce in GCC nations compared to developed nations.

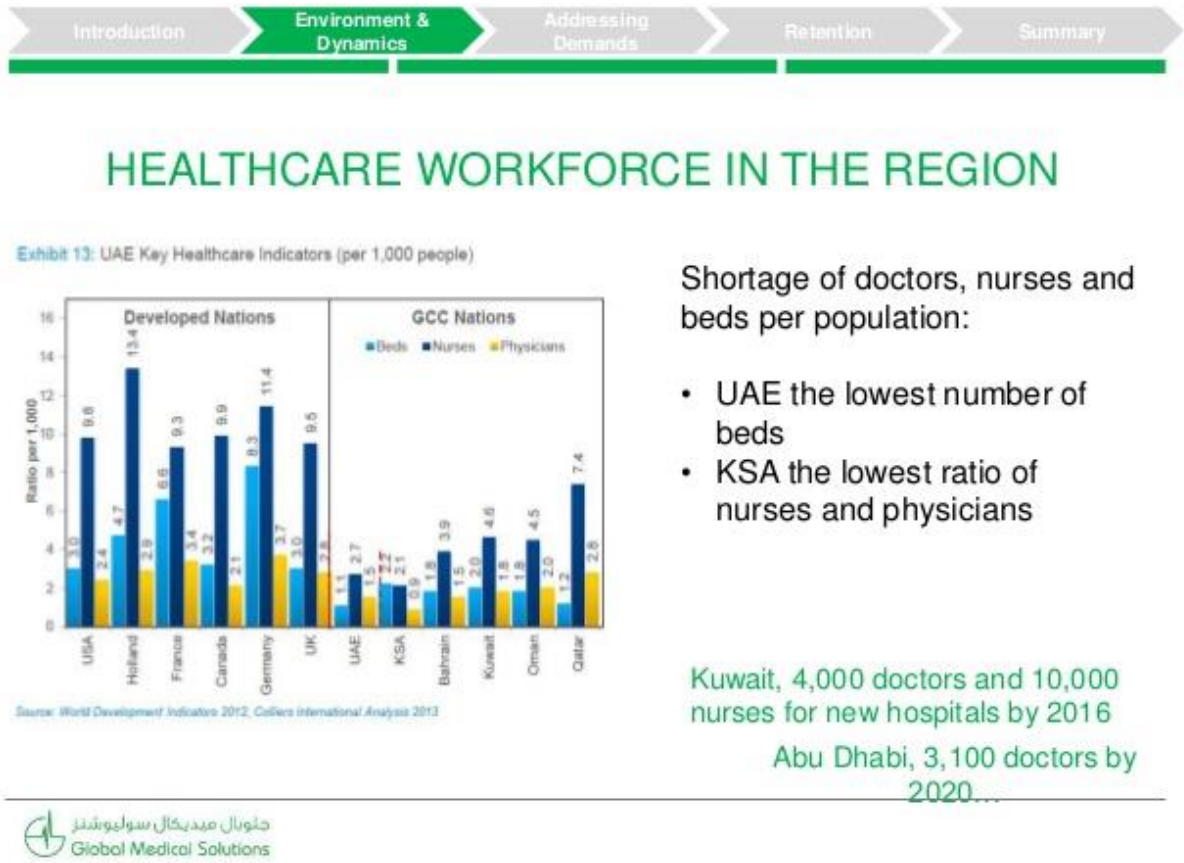


Fig 4. (Source: Global Medical Solution)

The following table demonstrates the total numbers of nurses working in all healthcare sectors in Saudi Arabia. This number is approximately 101,298. However, only 29.1% of them are local nurses (MOH, 2012).

Table 1. Nursing personnel in the healthcare sectors in Saudi Arabia (MOH, 2012)

Sector	No.	Saudis	%	Non-Saudi	%
Ministry of Health	55,429	24, 689	(44.5)	30,740	(55.5)
Other government facilities	23,536	3,908	(16.6)	19,628	(83.4)
Private sector	22,333	909	(04.1)	21,424	(95.9)
Total	101,298	29,506	(29.1)	71,792	(70.9)

2.8 Nursing Practice in SA

In Saudi Arabia nursing practice has recently experienced an increase in awareness as more bachelor degree nursing graduates are joining the field. Only in 1987 did nursing in Saudi Arabia achieve formal representation when the Ministry of Health (MOH) established the Central Nursing Committee. Since then SA has started to encourage more Saudis to take up nursing as a career and the committee has also started to enhance the quality of nursing care. Prior to 1987 the nursing profession in Saudi Arabia was represented and supervised by physicians (Aboul-Enein, 2002). In 2002 the highest nursing authority, The General Directorate of Nursing (GDN), was established at the MOH. This department is managed by highly educated and qualified expert Saudi nurses.

One of the main contributions of the GDN was the establishment of 20 nursing directorates in all the country areas and cities in Saudi Arabia. Since then the nursing profession has gained in terms of empowerment and development. Such development has improved nursing practice and contributed to the enhancement of nursing professionalism (MOH, 2012). This development process began only a few years ago and continues to this day. However, there are still some important obstacles and difficulties preventing the nursing profession's advancement in Saudi Arabia. Some of these are now examined.

2.9 Communication Barriers

In countries where there are several existing native languages and English is not the first language of most of the people it has, nevertheless, become the most widely and predominantly used language. English has occupied this high status, next to the mother tongue, and this is also true for expatriates who are non-native English speakers. In Saudi hospitals, unsurprisingly, most healthcare providers, including nurses, communicate with their patients and the families in English. This is despite the fact the vast majority of those patients and their families are Saudi nationals with Arabic as their first language and little proficiency in any other language. Atypical as this situation may be, it is the result of the nursing workforce in Saudi Arabia being composed, to varying degrees, of expatriates (Aboul-Enein, 2002; Suliman, 2009) who are seldom competent in Arabic and for whom English is generally not their first language - so this can lead to communication difficulties (Simpson et al., 2006).

The overwhelming majority of expatriate nurses working in MoH facilities are Indian or Filipino (Tumulty, 2001b). Others come from North America, the UK, Australia, South Africa, Malaysia and other parts of the Middle East (Aboul-Enein, 2002;

Aldossary et al., 2008). The Hail region attracts mainly Arab, Filipino, Indian, Pakistani and Middle Eastern expatriates. The latest figures for the region show that the number of Saudi nurses has increased from 9% in 1996 to 22% of the total nursing workforce. However, despite the increasing interest of Saudi nationals in enrolment in various nursing education programs, it has been estimated that it will take a further 25 years to train sufficient numbers of Saudi nurses to increase the local component to 30% of the nursing workforce requirements (Abu-Zinadah, 2004).

2.10 Culture and Gender Segregation in Saudi Arabia

Culture is deduced and derived over a considerable period of time. It includes the kaleidoscopic ways in which families, societies, and institutions work and how social relationships are governed. It can be viewed as a system of shared beliefs, behaviors, values, customs and symbols that get transmitted from one generation to another (Cortis, 2004). Several factors, including religion, race, the level of education, economic status, and environmental factors shape the culture of a given society. (Al-Shahri, 2002) The Saudi culture, which is basically Arabic with a dominant Islamic influence developed over a period of 1,400 years since the first emergence of Islam and it is this that steers the mindset and behavior of Saudi people (Almutairi and McCarthy, 2012). Sharia law, which is based on the holy Qur'an and the Prophets traditions (Sunnah), forms the foundation of the constitution of Saudi Arabia (Almutairi and McCarthy, 2012). Jurisprudence in Islam comprises the core elements of consensus (ijma) and analogy (qiyas). A further element of innovation and logical thinking (ijtihad) allows Islamic scholars to make decisions regarding new events of modern society, culture, and technology, to ensure that laws regarding these events are congruent with Islam, despite their not being mentioned in the Qur'an or Sunnah.

Thus, as it is prevalent in other cultures, in Saudi Arabia it is Sharia law that governs all aspects of life, including politics, economics, banking, business, family, sexuality, hygiene and social issues (Almutairi and McCarthy, 2012).

In terms of gender parity as per overall MIWA (Mastercard Index of Women's Advancement) the 2013 score was 18.2 (2007: 18.4) relative to their regional peers. This meant that the least progress was achieved by Saudi Arabian women. In terms of female political leaders, business leaders and business owners SA was also lowest. As the lowest across all 26 markets the leadership sub index was only 1.3, unchanged from 2007. This is summarized in (Figure 5).

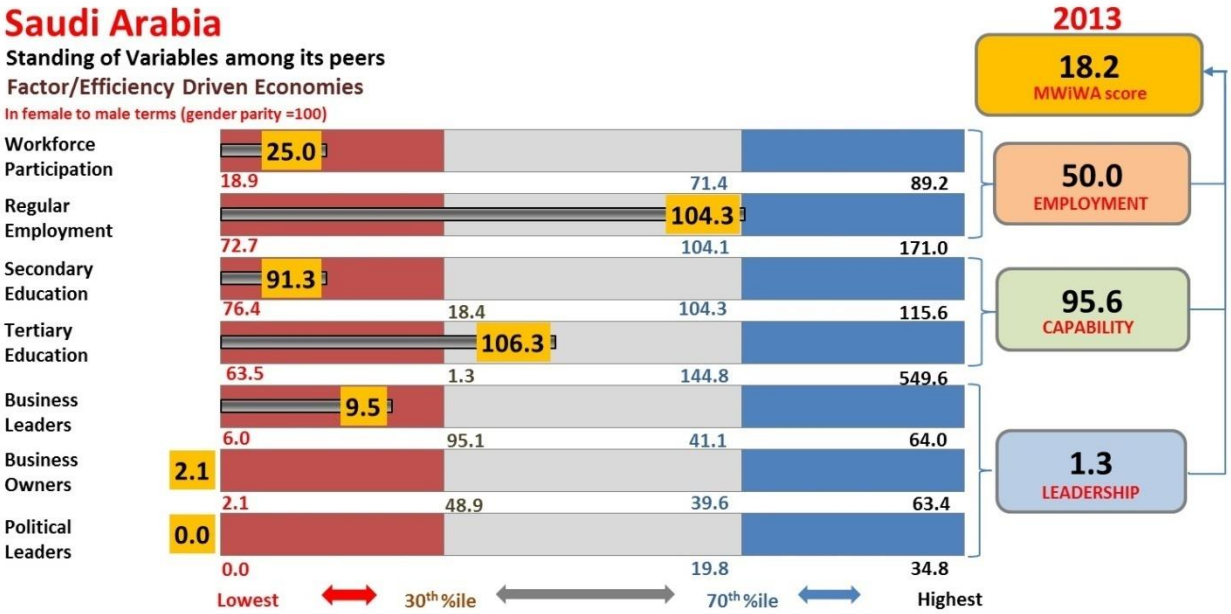


Figure 5.

(Source http://www.masterintelligence.com/content/intelligence/en/research/reports/2013/mastercard-index-of-womens-advancement-2013-findings-on-womens-p.html)

Segregation based on gender is the accepted norm in Saudi culture. It is enforced by government structures, which in turn are a result of the study of its religious texts. Segregation generally attracts societal approval because such a culture has become inherent and automatic to its followers. For example, members of the opposite sex,

unless they are members of one family, are not allowed to be together in public areas and there are separate physical areas assigned to males, females and families. Saudi women are not allowed to interact and work with unrelated men in most settings, unless it is a necessity. In view of the fact that Islamic societies are mainly patriarchal, there are always fewer opportunities for women in general. The majority of women are employed in a very few institutions or professions, including in universities, social work and development programs for women, banking and the healthcare sector. These may be referred to as the "safer" sectors. The dependence of women on their male counterparts is further increased because they are generally prohibited from driving motor vehicles or riding bicycles in public areas (Winter and Chevrier, 2008). This has altered only recently with a change in the law in 2017.

The financial responsibility of the household is the realm of the husband even if the wife works and has her own income. However, a joint decision can be made for an alternative arrangement in which the wife is given a concession to manage the household finances (Dwairy et al. 2006). However, Saudi women have the freedom to build their own businesses, invest money and own property.

Tumulty (2001a) estimated that males comprise approximately 25% of the Saudi nursing profession. Hence, it is relevant to consider the strict segregation of males and females at all levels of education, including nursing school, even though the curricula content is the same. As a result of the limited interaction between males and females in Saudi society, as well as due to other cultural considerations, some Saudi female nurses prefer not to care for male patients. The reasons are probably because there is awkwardness and hesitancy in having any sort of interaction with men, even if it is purely professionally related. This has led to the obvious gender-based separation in

nursing care, which means that male nurses provide care to male patients and female nurses look after female patients. Only in unavoidable circumstances, such as a serious shortage of staff, do all nurses care for all patients irrespective of gender.

Such cultural restrictions can impact on nursing leadership as hospitals must employ female and male nurse leaders to manage the female and male wards, respectively. Expatriate nurse leaders are not restricted in this way and so there is an inequality of opportunity existing between them and their native counterparts.

2.11 Summary

This chapter has provided an overview of Saudi Arabia and its healthcare system. The nature of the Saudi nursing workforce, and the education and governance structures supporting it were also outlined. The following chapter presents a literature review of leadership theories and current nursing leadership styles. This precedes a description of the methods for the present study that seeks to explore the experience of nurse leadership in this cultural context.

CHAPTER THREE: Literature Review

3.1 Introduction

When a country develops it seeks to encourage innovative practices and changes for numerous professional occupations. Nursing in Saudi Arabia is no exception to this and in the span of a few years the nursing profession and nursing practices have evolved and expanded dramatically in their scope. This has necessitated the required authorities to search for innovative but appropriate solutions to manage the enormously diverse nursing workforce that exist in Saudi hospitals. In turn, there is an overwhelming demand in Saudi Arabia for nurse leaders who have the capacity to collaborate, delegate, think creatively and perform confidently. Essentially, two factors have fueled this demand. The first is the acute shortage of nurses in the country and the second is the dynamism and sheer complexity of the country's current healthcare system. Furthermore, the present trends in nursing point to an even greater future demand for nurse leaders who will be required to guide the nursing profession in an environment likely to become increasingly more complex (Daniels, 2004). These considerations have provided the impetus for this research study. The literature review, therefore, focuses on exploring emerging leadership styles and theories over time, and assessing the effectiveness of leadership models and particularly identifying those styles that may increase the staff satisfaction and work effort of those they manage. The literature themes reviewed are illustrated in the next diagram (Figure 6).

Literature review themes

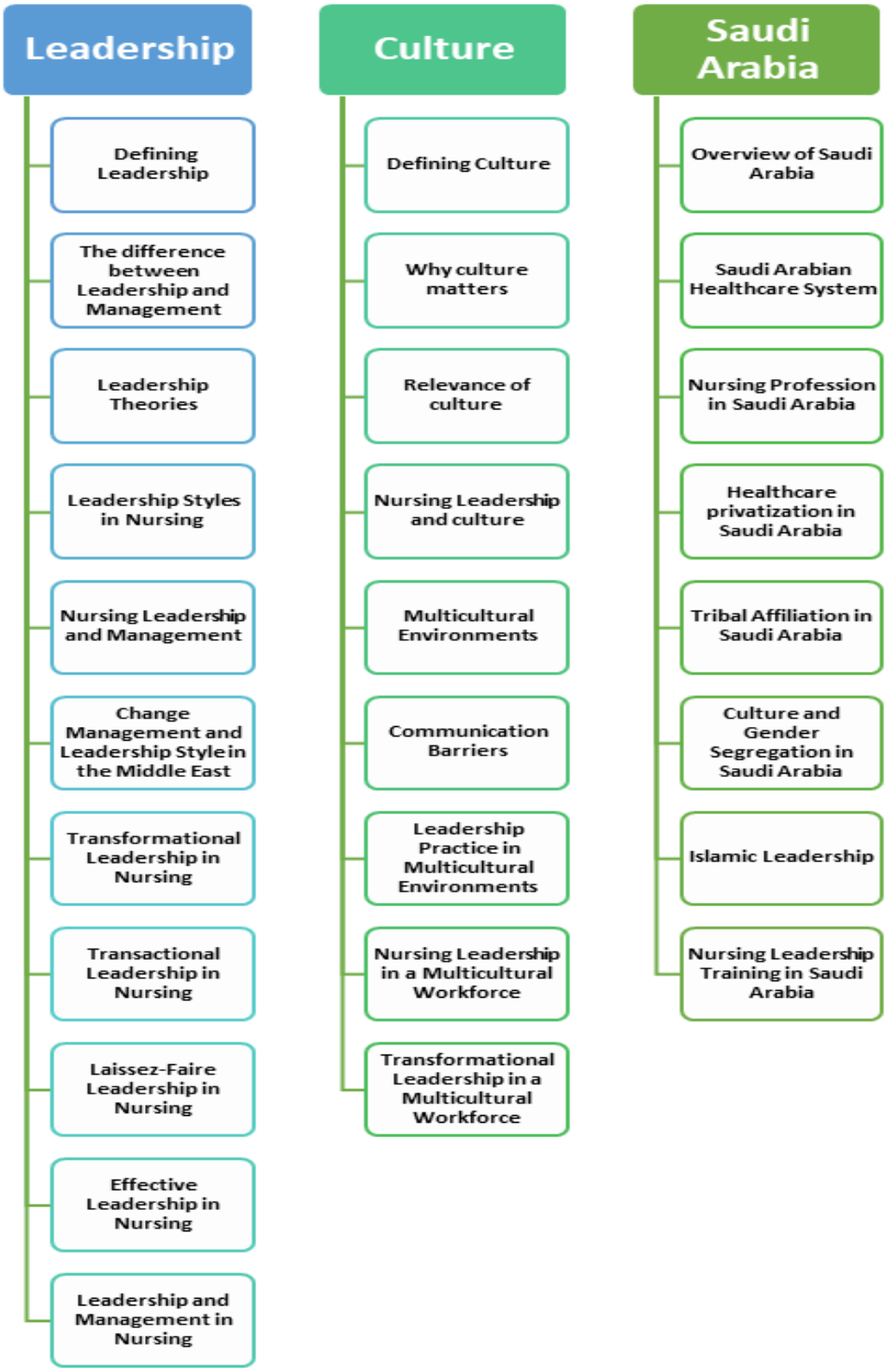


Figure 6. Literature review themes

3.1.1 Literature Search Strategy and Keywords

Reviewing literature in the fields of culture and leadership research draws on numerous distinctly separate, but relevant, areas of literature. Although the literature covers a wide variety of leadership studies and research approaches, the interest for this review is leadership definitions, nursing leadership and the concept of the ideal leader.

To ensure a comprehensive literature retrieval when undertaking a literature review the following multi-databases were used:

1. CINAHL via EBSCO
2. Cochrane library
3. MEDLINE via OvidSP (incorporation PsycINFO)
4. Google Scholar

Main Keywords

This review employed the following search terms as main keywords**:**

1. Leadership
2. Nursing leadership
3. Culture
4. Organisational culture
5. Saudi Arabia nursing
6. Saudi Arabian culture
7. Tribes, tribal affiliation Saudi Arabia

3.1.2 Inclusion and Exclusion Criteria

Inclusion criteria:

This search of the literature was limited to:

1. Studies that addressed the impact of formal nursing leadership (for example leadership behaviour, leadership style) on culture, organisational culture, performance, or all of these outcomes.
2. Studies published to the present day.
3. Literature in the English and Arabic languages.
4. Studies that evaluated leadership development programmes.
5. Studies conducted in healthcare settings (as well as some other settings if relevant).

Exclusion Criteria:

1. Studies that investigated business leadership more generally.
2. Studies that tested different leadership instruments.
3. Studies published before January 1980.

3.1.3 Organization of the review

The following literature review is divided into themes. The first comprises definitions of leadership and relevant research, including the significance to the study topic in SA. It then proceeds to explore leadership and culture, workplace issues and leadership in a multi-cultural environment. This review is not presented as exhaustive as leadership is a vast topic and all relevant work cannot be included. The aim has been to present a scan of the current state of knowledge of relevance to this research study.

The researcher brought the relevant Middles Eastern Empirical Studies that have been reviewed in this research together in the next table (Table 2).

3.1.4 Critique of relevant Middle Eastern Empirical Research Studies

AUTHOR, YEAR and Journal	Title of the Study	AIMS	RESEARCH METHODS	SAMPLE (n=)	MAIN RESULTS	QUALITY ASSISSMENT
Almutairi A. McCarthy A., and Gardner E. (2015) *Journal of Transcultural Nursing*	Understanding Cultural Competence in a Multicultural Nursing Workforce: Registered Nurses' Experience in Saudi Arabia	To understand how cultural diversity can be effectively managed in this multicultural environment Specifically, to explore notions of cultural competence with non-Saudi Arabian nurses working in a major hospital in Saudi Arabia The study questions were clearly stated	A single-embedded case study design (Yin, 2009) enabled an in-depth exploration of the multicultural nursing workforce in a tertiary Saudi Arabian hospital. Face-to-face, audio-recorded, semi structured interviews The methods used was appropriate for a case study type of research.	24 non-Saudi Arabian nurses selected by purposive sampling Sample size is good enough as representative of the target respondents Inclusion and exclusion criteria were presented	Nurses within this culturally diverse environment struggled with the notion of cultural competence in terms of each other's cultural expectations and those of the dominant Saudi culture. Results of this study may allow other researchers to replicate if applied to their local setting	None of the limitations are thought to decrease the validity of the conclusion. There is a clear statement of the aims of the research. All important and relevant studies were included and referenced in this study. The results of all the included studies are clearly displayed and expressed accordingly. The results may be applied to the local SA population in terms of culturally competence.
Al Hazmi A. and Windsor C. (2013)	The Role of Nurse Educators in Student Clinical Education in Saudi Arabia	This research explored the role of nurse educators in student clinical education in Saudi	Glaserian grounded theory methods i.e face-to-face interviews, purposive &	14 Nurse educators from both hospital and faculty	The results of the study were represented in the core category of 'Redefining Identity Work' and its two constituent categories	All of the sections of the research were appropriate for the research questions. There was enough information on the population being studied. A qualitative methodology was appropriate because the research sought to interpret or illuminate the actions and/or

International Journal of Nursing and Health Care		Arabia	theoretical sampling.	settings in King Abdu-Aziz University (KAU) and King Abdu-Aziz University Hospital (KAUH)	'Questioning the Situation' and 'Creating Role Identity'. The core and sub- categories were generated through a theoretical exploration of the identity work of nurse educators in Saudi Arabia. This study also presents implications and recommendations that may contribute to the development of nursing as a profession that may be perceived as a desirable career option for Saudi women and men.	subjective experiences of research participants. This research design (Grounded theory) is appropriate to address the aims of this study. The recruitment strategy was appropriate to the aims of the research, the author purposefully recruited 10 participants with the experience and knowledge directly relevant to the research focus. The researcher explained how and why the participants were selected as they were the most appropriate to provide access to the type of knowledge sought by the study. The researcher also explained how the data presented were selected from the sample to demonstrate the analysis process.
ABUALRUB R. and ALGHAMDI M. (2012) *Journal of Nursing Management*	The impact of leadership styles on nurse satisfaction and intention to stay among Saudi nurses	To examine the impact of leadership styles of nurse managers on Saudi nurses job satisfaction and their intent to stay at work.	This study used descriptive correlational design. A structured questionnaire was used for collecting the data consisting of the Multifactor Leadership Questionnaire	Convenience sample of 308 Saudi nurses.	Saudi nurses were moderately satisfied in their jobs. In addition, nurses were more satisfied with leaders who demonstrated transformational leadership styles, also those who were more satisfied with their jobs intended to stay. The background variables,	This study addresses a clearly focused question and there was enough information on the population studied. The authors had an appropriate study design in evaluating the impact of leadership styles on nurses' satisfaction and intention to stay. The Inclusion criteria for the selection of respondents were provided. Data collection and statistical procedures were appropriately described. Moreover, the respondents covered by the study were sufficiently broad to represent the local setting.

			(MLQ-5X) (Bass & Avolio 2004), Job Satisfaction Survey (Spector 1985), the McCains Intent to Stay Scale (McCloskey & McCain 1987) and the demographic form.		the transformational leadership style and the transactional style explained up to 32% of the variation in job satisfaction.	
Asiri S., Rohrer A. Wesley W., Al-Surimi K., Da'ar O. and Ahmed A. (2016) *BMC Nursing*	The association of leadership styles and empowerment with nurses' organizational commitment in an acute health care setting: a cross-sectional study	This study measured the effects of nurses' overall perception of the leadership style of their managers, and psychological empowerment on organizational commitment in acute care units, in National Guard Health Affairs, Riyadh City, Saudi Arabia.	This was a cross-sectional survey Three validated survey instruments were used to: (1) The Multifactor Leadership Questionnaire (MLQ), by Bass and Avolio (1997), (2) The Psychological Empowerment Scale by Spreitzer (1995) and (3) The Three-Component Model of Employee	332 randomly selected nurses at King Abdulaziz Medical City representing a response rate of 95 %.	Overall most nurses perceived their immediate nursing managers as not displaying the ideal level of transformational leadership (TFL) behaviors. Nurses' commitment appeared to be negatively correlated with TFL style and perceived psychological empowerment. However, commitment was positively correlated with the Transactional Leadership (TAL) style. Other important predictors of	Sufficient information about the population studied was clearly stated. This study is substantial in its scope and used validated instruments on leadership styles, psychological empowerment and employee commitment. Nurses who agreed to participate in the study completed the survey questionnaires anonymously. Overall, the results were analysed using appropriate statistical tests and were expressed appropriately. Findings could be applied in the local setting in Saudi Arabia.

			Commitment developed by Meyer and Allen (1997).		commitment include TAL (P = 0.027), Laissez-faire Leadership (LFL (P = 0.012), and autonomy (P = 0.016). The linear combination of these predictors explained 20 % of the variability of nurses' commitment.	
Suliman W. (2009) *Nursing Administration Quarterly*	Leadership Styles of Nurse Managers in a Multinational Environment	The study explored the predominant leadership style of nurse managers through self-evaluation and staff nurses' evaluation and the impact of working in a multinational environment on their intention to stay or quit.	Descriptive study Used Bass and Avolio's (1995) Multifactor Leadership Questionnaire.	31 nurse managers and 118 staff nurses	The results showed that nurse managers and staff nurses reported transformational leadership as dominant with significant difference in favour of nurse managers. The implications highlight the need for senior nursing management to set effective retention strategies, and for transformational nurse managers who work at multinational environments.	This study addresses clearly focused questions. All important and relevant studies were included. Inclusion criteria for the selection of the sample were provided. Overall results of the study were tested using appropriate statistical test and displayed clearly. There are clear implications for the SA setting.
Chaudhry A. and Husnain J. (2012)	Impact of Transactional and Laissez Faire	To identify which leadership style is considered best for the employee	Descriptive Correlational study	278 public and private sector banking	Transformational leadership had positive, strong and significant association with the	This study clearly focused on the research question. The authors had sufficient research related studies that were used for the review. It was not clear whether all important and

International Journal of Business and Social Science	Leadership Style on Motivation	to increase their motivation within the organization.	A structured questionnaire was used to identify the relationship between leadership and motivational level within their organization	organization employees	levels of commitment. However, motivational levels in relation to Laissez Faire were lower. Laissez Faire was the least important style that boosted the motivational level of workers as compared to other leadership styles.	relevant studies were included. Overall, the results were subject to appropriate statistically tests in order to identify the impact of transactional and laissez faire leadership styles on motivation. The study had relevance to the local SA setting.
Ebrahim M., Youssef H., Aljouaid M., Babkeir R., and Hassan W. (2017) *Journal of Nursing and Health Science*	Effect of Nurse Managers' Leadership Styles on Organizational Commitment of Nurses Working at Taif Governmental Hospitals in Kingdom of Saudi Arabia	To explore and describe nurse managers' leadership styles and its effect on nurses' organizational commitment at Taif governmental hospitals in Kingdom of Saudi Arabia	A cross sectional descriptive survey study was conducted in two selected Hospitals; King Abdul Aziz and King Faisal hospitals. Leadership Styles and Organization Commitment Questionnaires were used	570 nurses	This study revealed that most of leaders in the two selected hospitals use both leadership styles from the nurses' perspectives. The greatest majority of nurses had commitment to their organization, whereas, only a small percentage did not.	There was enough information on the population being studied. Inclusion criteria for the respondents were also provided. Approval of institutional review board (IRB) at the selected hospitals was obtained. The results were tested using appropriate statistical methods and presented clearly. The relevance of the study for the SA setting was apparent.
Tumulty G. (2001) *Journal of Nursing Administration*	Educational Needs of Nurse Administrators in the Middle East.	To determine the educational needs of directors of nursing in ministry of health hospitals in Saudi Arabia	Collaborative research project based on the 11 management functions as defined by the	176 nursing directors from different countries: Saudi Arabia, Philippines,	Promoting development of a professional staff and a more productive, positive environment is a challenge faced by many	This study had a clear focused question. The author reviewed relevant papers related into her study. The method was appropriate to the question asked and the international sample enhanced the range of opinions. Overall, the results of the study were precisely expressed by

			World Health Organization (WHO) 55-item questionnaire divided into 11 subscales according to the 11 WHO management functions used for data collection.	England, India, Pakistan, North America, US and Canada	nurse administrators. However, Middle Eastern nurses face the special challenge of living within the constraints of the conservative Muslim society. Nurses are housed within the hospital compounds and have restricted freedom of movement. Many expatriate nurses had difficulty adapting to both the work and the living conditions. The director of nursing is in the unique position of trying to deal with morale issues both on and off the nursing unit. A recurring issue was that of the language barrier and other issues were inherent in managing such a diverse multicultural staff.	the author. Further, the result may have relevance to directors in other countries for comparative purposes.
Karout N., Abdelaziz S., and Altuwaijri S. (2013)	Cultural diversity: A qualitative study on Saudi	To describe the experiences of women who were admitted to	A qualitative phenomenological approach was utilized.	Purposively selected Saudi 37 women who admitted	Participants considered that there were many factors affecting their experience.	There is a clear statement of the aims of the research. The qualitative phenomenological method appropriate in order to identify themes expressed by the participants. In addition, the

Journal of Nursing Education and Practice	Arabian women's experience and perception of maternal health services	maternity wards to gain their perceptions and understanding of the cultural diversity exhibited by health care providers.	The principal method of data collection was a semi structured, open-ended interview.	to a private hospital in Saudi Arabia and related to cultural diversity of health providers' team.	One of these was the linguistic diversity among staff in the maternity wards, which was consistent with many other studies that identified the importance of the linguistic diversity among staff. Participants recognized that there were some religious and gender based issues that also affected the quality of services provided. Some participants insisted on the existence of the 'evil eye' of Non-Muslim nurses or physicians that may hurt them.	research design appropriate to address the aims of the research. It is clear how the categories/themes were derived from the data. The researcher discusses the contribution the study makes to existing knowledge or understanding in the local SA setting.
Cruz, J.P., Alquwez N., Cruz C.P. Reynaldo R.F.D. Vitorino L.M. (2017) *International Nursing Review*	Cultural competence among nursing students in Saudi Arabia: a cross-sectional study	This study assessed the cultural competence of nursing students in a Saudi University.	A descriptive cross-sectional study Self-administered questionnaire consisting of two parts, namely the respondents' demographics and cultural	272 nursing students in a Saudi university	The respondents showed the highest competence in their ability to demonstrate communication skills with culturally diverse patients and lowest in the familiarity with health- or illness-related cultural knowledge or	The authors identify that nursing students were highly culturally competent yet was not able to address the impact of having a low score on knowledge pertaining to medical practice. However, the study did not clearly express the impact and relationship of having high cultural competence but low knowledge on familiarity on health and illness related knowledge. Also, data were limited to questionnaire, and it would have been stronger if qualitative methods were

			background information sheet and the Cultural Capacity Scale Arabic version.		theory. Gender, academic level, clinical exposure, prior diversity training, the experience of taking care of culturally diverse patients and patients belonging to special population groups were significant factors that influenced cultural competence.	also conducted. The study has relevance to the local SA setting.

3.1.5 Summary of relevant Middle Eastern Empirical Research articles

Research studies on culture and leadership styles of SA nurse leaders are limited. Previous studies have focused mainly on the use of Campinha-Bacote's cultural competence model for nurses' experiences (Almutairi, et.al. 2015); the role of nurse educators in student clinical education (Al-Hazmi, et.al. 2013); and the impact of leadership styles of nurses on their job satisfaction (Abualruband Alghamdi 2012). It was shown that there is a need for further attention to be paid to training and development of effective leadership. Nurse administrators in Saudi Arabia should also capitalize on the importance of transformational leadership style in enhancing the level of job satisfaction. Moreover, Cruz, et.al. (2017) studied cultural competence among nursing students in Saudi Arabia and suggested that ensuring the level of culturally competent care rendered by Saudi nursing students needed to be improved. Suliman (2009) further advocated exploring effective strategies needed for development of positive leadership characteristics among nurse managers, and that this is designed to focus on other factors that might contribute to the level of commitment and empowerment among nurses in other national contexts and organizational environments. Further research in the area of leadership and multiculturalism has been shown to be limited. Understanding the concept of culture and the factors related to it may help enhance the quality of care provided by health care teams and may also play a positive role during recruitment of the health team providers and in the provision of any continuous education programmes (Karout, et.al. 2013). Studies on policy and practice, including the need for training of health practitioners to work with diverse populations, implementing evidence-based practice and providing an organizational context which supports practitioners to respond to

diversity without using cultural stereotypes, are essential. Future studies should be conducted to include wider settings and issues concerning communication in multi-cultured healthcare facilities.

With the foregoing limited available studies and research gaps and concepts mentioned earlier, these led the researcher to generate research questions focussing on the culture and leadership styles among Saudi Arabia nurse leaders. Specifically, the study aimed to investigate: 1) The nature of the relationship between culture and the leadership style of SA nurse leaders in practice; (2) The qualities that nurse in Saudi Arabia need in order to be identified as culturally competent nurse leaders; (3) The impact of changing nature of healthcare in Saudi Arabia on their role and leadership style; (4) The training nurse leaders in SA need in relation to their present role; and (5) The ways that such training and development might best be delivered.

The most pertinent articles reporting research from SA in table 2 were evaluated using the Critical Appraisal Skills Program (CASP). "CASP's aim is to enable decision makers and those who seek to influence them acquire skills to make sense of, and act on, the evidence. CASP has developed appraisal tools to help make sense of a variety of evidence (including randomised controlled trials, systematic reviews, qualitative research, cohort studies and economic evaluations) and through a variety of learning styles (including workshops, training sessions and paper- and computer-based open learning packages)." (Spittlehouse, Acton, et al. 2000. p403-404).

An appropriate CASP tool was used to consider each article. The CASP Tools for Qualitative Research Studies is a well-known tool for nurse researchers. Some of the

articles are qualitative and used small but focused samples in group discussions, interviews and observation. (Table 2). Qualitative methods produce information only on the particular cases studied, and any more general conclusions can only be propositions (informed assertions). Other evaluated articles had used quantitative methods, and larger samples, that are used to survey or to support or reject particular research hypotheses.

3.2 Defining Leadership

A review of the literature in the field of leadership shows that numerous research studies have been conducted to study different aspects of the concept of leadership. Leadership has been extensively studied by social-science researchers in the past few decades (Yukl, 2006). Marriner-Tomey (1993) found that the definitions of leadership are often confusing and unclear because of the use of some terms such as ‘authority’, ‘management’, ‘power’, ‘administration’ and ‘supervision’. Bass’s leadership definition also has multiple views including styles of leaders and the nature of tasks to be achieved (Marriner-Tomey, 1993). In addition, leadership has been defined as a power relationship as well as an instrument of goal achievement.

Marshall (2011, p.2) suggested the following simple definition of leadership: “leadership is the discipline and art of guiding, directing, motivating, and inspiring a group or organisation toward the achievement of common goals”. Bass (1985) defined leadership as a transformative process through which the leader creates a vision of a future state for the organisation and articulates new ways for the followers to accomplish organisational goals.

The literature agrees that leadership encompasses an ability to inspire and influence people towards a vision of the desired future. The person who has this ability to motivate and inspiring people towards that vision are called a 'Leader'. However, every leader has their own style of work and different strategies that they follow to motivate their followers to his or her vision or goal (Marshall 2011, Marriner-Tomey 1993). However, in order to become a successful leader it is suggested that one must have a range of personal qualities, which are illustrated and considered in Figure 6 below:

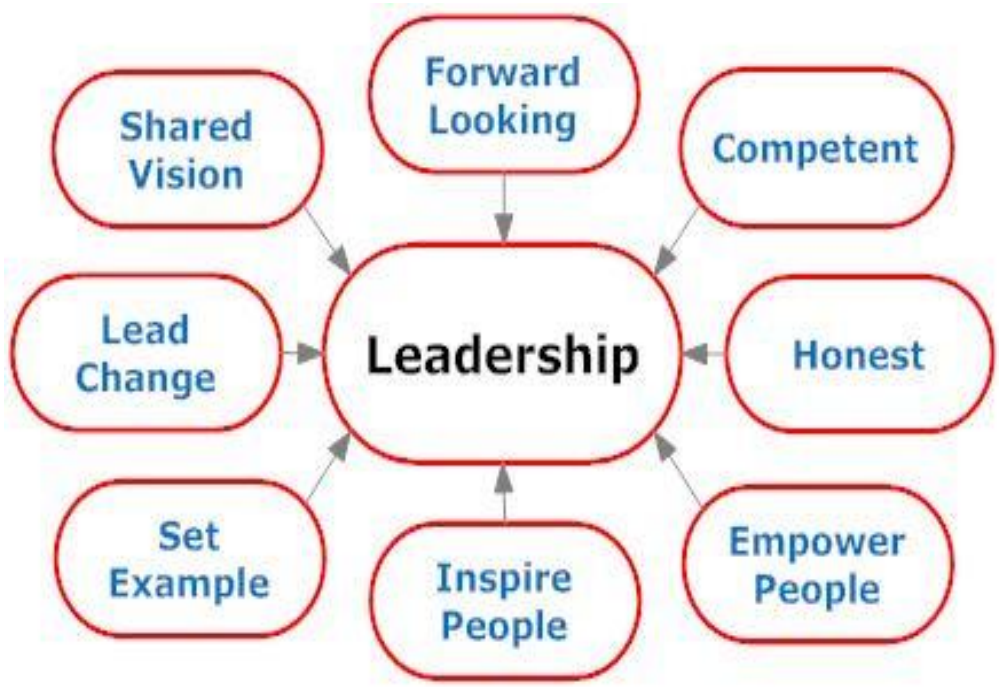


Figure 7. (Reference - http://mcxl.se/thoughts/qualities-of-a-good-leader/)

This suggests core qualities of a leader that agrees with much of the published literature:

a. Honesty:

A leader must be loyal and honest so that they can win the trust and belief of their followers.

b. Shared Vision:

If the leader is able to identify a shared vision for those they are leading they will energize and provide focus for them.

c. Competence:

A leader must be strategic and have the requisite knowledge and skills to accomplish their vision.

d. Inspire People:

A leader requires good communication skills, integrity and passion for their vision to be realized and also for the needs of their followers to be addressed.

e. Lead change:

Leaders have to be capable of making major strategic changes and of undertaking initiatives that will benefit the welfare of their followers.

f. Forward looking:

In order that leadership can be considered good a leader must have the capacity to envision the future and the means by which this can be achieved.

g. Empower People:

Leaders must have ability to encourage their followers in such a way that they will be creative and innovative and their capabilities in terms of performance and having bright ideas will be optimized.

h. Set an Example:

A leader must demonstrate to followers that he/she puts into practice what he aspires for them. In other words, a leader must set a good example for others to follow and emulate.

It is apparent that many, but similar, definitions of leadership exist and that finding a single universally accepted definition does not appear to be easy because an

appropriate choice of a definition depends on the various aspects of leadership being considered (Marshall, 2011). Leadership is affected by many factors that will increase the problem of concluding with a definite definition (Sherring, 2012).

In this overview of leadership definitions, the reviewer decided to focus on the organizational leadership definition developed by House and Javidan in 2004. This definition provides a sound foundation for the concepts of transformational and charismatic leadership and seems to combine these basic features in addition to describing the abilities individuals require in the leadership role they play in organization in which they are placed.

They define leadership as follows:

> "The ability of an individual to influence, motivate, and enable others to contribute toward the effectiveness and success of the organisations of which they are member" (House & Javidan, 2004, p. 15).

Thus, leadership is being defined here as the ability of an individual that can be observed within the context of a given organization or situation. Some features of this definition display influences of leadership research history, which will be introduced briefly in the following section.

While researching leadership, Bryman (1992) presented four classifications of historical trends of leadership research. Although it was a fairly rough classification and does not encompass all the details of a historical overview of leadership notions, it nevertheless presents a brief overview of some major evolutions in leadership exploration, these continue to influence current leadership theories.

Initially, Bryman (1992) outlined the *Trait Approach*. Until the late 1940's, the *Trait Approach* deemed leadership to be an inborn trait. Researchers proposed that

leadership characteristics are produced by personality traits whereby leaders are 'born not made'. Accordingly, in order for a person to be identified as a leader, she/he should possess a combination of specific traits. However, the attention of leadership research moved, thereafter, from leader traits to leader behavior. Despite this leader traits still feature significantly in many features of leadership training and promotion material (Heinitz, 2006).

Subsequently, in the late 1960s, the *Style Approach* began to take the lead in the focus of leadership research, moving away from the Trait Approach. The *Style Approach* (or the *Behavioural Approach*, e.g. Yukl, 2002) viewed the leader's behaviour as the core of leadership effectiveness. This style describes a fixed invariant behavioural approach that is 'in built'. In other words, leadership behaviour does not differ according to each situation and is not context-bound (Staehle, 1999). In this style of approach the researchers presumed that behavioural training could produce a successful leader for any given situation. This presumption still persists in contemporary theories. Hence leadership is still perceived as the ability to behave in a particular way and can be taught as a set of skills.

The third approach, the *Contingency Approach,* is presented by Bryman (1992) and was popular from the late 1960s until the beginning of the 1980s. In this approach, the effectiveness of a particular leadership style is propounded to be situationally contingent. A leadership style is perceived as effective in some situations but not in others, which suggests that there is not one leadership style that would be adequate in all climates. Moreover, the impact of situations is recognised in modern leadership theories as context is frequently taken into consideration when leadership is put to the test. Consequently, the concept of organisational leadership has emerged which

highlights the importance of the context of the organisation. This style is important when considering the topic of this study.

Lastly, the New Leadership Approach was the label given by Bryman (1992) to the leadership approach since the early 1980s, which encompasses transformational (Bass, 1985) and charismatic leadership (Conger and Kanungo, 1988). Theories of this approach originated alongside the increasing attention paid to the re-engineering of organisations and the accompanying progression of transformation and development in individuals and organisations (Heinitz, 2006). Sequentially, researchers have tried to understand and identify the leadership behaviour that will foster and enhance the diverse imperative transformations in organisations. This approach takes into account the ability of an individual leader to influence and motivate in any given context.

The new leadership theories appear to produce a significant enrichment to earlier perceptions of leadership processes. Firstly, they furnish an explanation for the extraordinary influence some leaders possess on followers, which could not sufficiently be interpreted by the before-mentioned theories, such as situational leadership. Secondly, the new leadership theories highlight the notable feature of the emotional reactions of followers to their leaders, whereas the afore-mentioned theories underlined more rational features of leader-follower interaction. The new theories also recognise the ‘rule’ of the leader in making events meaningful for their followers. Ultimately, the new leadership theories incorporate a comprehensive collection of variables (traits, behavior and situational context) and produce a more integrative perspective on effective leadership than the earlier theories (Yukl, 2002).

Nursing researchers have also suggested that leadership is one of the key areas that require further exploration to promote the role of nursing in healthcare (Williams and Irvine, 2009). By achieving the inspiration and engagement of employees, an effective nurse leader should have followers that will have experienced some degree of enhanced performance. This, in turn, will improve the quality of nursing care in any given organization (Williams and Irvine 2009). However, it is also important to consider exploring nursing leadership research and its impact on staff and quality health services from a cultural perspective. This is a topic that has not been addressed to a great extent in Saudi Arabia, and not in the Ministry of Health context.

As a starting point, it is important to note that the meaning of the word *leadership* has changed over the years. According to Taylor (1911) and Weber (1947) leadership research was traditionally concerned with identifying the necessary facilities provided to leaders, such as management and administration to achieve organizational control, certainty and stability. It was suggested that this could be facilitated by the organization imposing a structure and standard operating procedures (Barker 2001: 485). Some of the above definitions viewed leadership as the application of a systematic set of rules which are quite predictable and can be easily defined using numeric constants, such as personality traits. This perspective makes leadership, management and administration appear similar with respect to their concepts, content and meaning, however the concept of leadership has travelled a long way since that time. What in the present era is called leadership, in the early 1960s was largely understood as administration and in 1980s as management. Hence, early scholars like Gary Yukl & David Van Fleet (1940-1986), assume leadership is all about influencing people to perform tasks and to implement strategies whereas Barker (2001: 481),

stated leadership and management are not similar but actually the same concept. What these theories do not consider is the cultural context of their application.

In recent times and despite differences of opinion in terms of leadership definitions, most academics, such as Ford (2010), have concluded that the concept of leadership requires further in-depth study and must take into the background situations, events, institutions, ideas, social practices and processes. Thus, it is being argued that understanding leadership requires an understanding of local social processes and cultural context. A univocal model of leadership, which is more patriarchal in its approach and possibly considered exclusionary, homogenous and privileged has been challenged by academics. Ford, amongst others, for example, has called for contemporary definitions of leadership that incorporate a greater awareness of primitive and interpretative approaches. This approach would take into account individual experiences, identities, influences, and inter-subjectivities as well as acknowledging the presence of a diverse range of gender-based workplace behaviors (Ford 2010: 48). This position begins to align with the concerns put forward in the introduction to SA offered in previous chapters.

This definition also illuminates the key differences that are enshrined in contemporary leadership models that give more prominence to identity building and power politics as opposed to focusing on the standardized, abstract and universal inferences and meanings of leadership. On a similar vein Barker (2001) stressed the need to distinguish leadership from other forms of social organization, such as management. He believed leadership is characterized by experience, and that it is situational and even metaphysical in nature rather than quantitative (Barker 2001).

Ford (2010) is also relevant as it further examines the multi-faceted nature of leadership. Firstly, presenting leadership as a process of revision and of growth, and a process that involves energy rather than structure. Secondly, leadership is a subjective process and the result of the changing aspects of shared will which require organizing in order that they meet various needs. In other words, it is the process of active conversion of ideas and the interchange of values. Thirdly, Leadership is often also unorthodoxy from normal convention. In this way leadership differs from management; leaders pursue stability whereas leadership embraces new ideas and accepts change. Leadership, then, can be defined as a process of transformative change where the ethics of individuals are integrated into the mores of a community as a means of evolutionary social development (Barker 2001: 491).

Based on the above argument, the central point to be made is that a focus on the word "process" is crucial. In the words of Hosking, in order to understand leadership, it is fundamental and important to change our focus from leaders, as persons, to leadership as “processes" (1988: 147), as leadership skills (of a person) are embedded in the complex social, political and decision-making processes – where such processes – “are viewed as fundamental to the creation and maintenance of social order [reality] within and between groups“ (Hosking 1988: 147).

The above definition sheds further light on the concept of leadership in relation to this study. Hosking illuminates what is required and should be focused on when a leader is chosen for a specific situation, such as a hospital. It implies leadership within such an organisation cannot merely be considered and viewed through a single focal point such as focusing on individual parameters, or the organisation's functionality, or by setting boundaries. Leadership is more closely related to social processes of the

hospital (as a community in itself) and its cultural context. The process continues to remain universal, even when leadership is associated with an individual with the top position in a hierarchy (Barker 2001), or who is considered the higher in a superior /subordinate relationship. (Alvesson & Deetz 2000).

If we relate leadership with culture, as in this study, then it is necessary to consider these aspects of power and how they impact in SA.

3.3 Leadership Theories

Leadership theories have evolved over time, as described by various scholars such as Bolden, Gosling, Marturano and Dennison (2003) and Casida (2007). According to Casida (2007), the evolution of leadership theories started with the 'Great Man' Theory (pre-1900s), followed by the 'Trait Theory' between 1900 and 1948. The 'Contingency theory' was then prominent between 1948 and 1980, after which the more contemporary 'Transformational leadership' theory emerged. The following sub-sections describe in more detail the key theories as identified by Casida (2007).

3.3.1 Great Man Theory

The underlying structure of this theory, as given by Nye (2008), states that leadership is a quality that a person is born with rather than one they acquire over a period of time in their life. This theory implies that if one is not born with these quality/qualities, they can never be a good leader. In fact, the great man theory defines a great leader as a person who is heroic and destined to lead when the need arises. This theory focuses on the materialization of a leader who has much influence in the community. Bolden et al. (2003) who argued that leadership is instinctive and not developed through training and experience also upholds this view. Bolden et al. also asserted that during

the nineteenth century, leadership was essentially viewed as the exclusive domain of men because women were perceived as unable to hold any leadership role in the society. It is only men who possessed the realm of leadership. A look back into history shows that all the great leaders who helped bring about change and revolution in a society might be considered Great Men (and some Great Women). For instance, Julius Caesar, Abraham Lincoln, Mahatma Gandhi, Sir Winston Churchill and Nelson Mandela are often cited as examples of successful leaders who fit well into the great man category. Cleopatra, Elizabeth 1 and Queen Victoria are examples of women who also stand out in this regard.

The major limitation of this theory is that it was established after observing those who are, or have been, proven leaders, without any consideration of others who may been potential leaders but who did not have the opportunity to lead. It also ignores the 'situational emergence' of leaders, whereby leadership is thrust upon a person simply because there is no one else to lead at the time and with no consideration as to whether the proposed person actually possesses any leadership abilities or not. In this case a person can become a leader just by being 'in the right place at the right time'. Many examples of this can be found and continue to take place, particularly in the political arena where the leadership of a political party, or even of a country, has been thrust upon, for example, a close relative of a deceased leader (Northouse, 2012).

3.3.2 Trait Theory

The trait theory is merely an extension of the great man theory in certain respects, mainly in the suggestion that some leadership behaviours are common to all leaders (Casida, 2007; Bolden et al., 2003).

Trait theories of leadership emphasize identifying different personality traits and attributes that are linked to successful leadership in various situations. These are summarized in Figure 6.

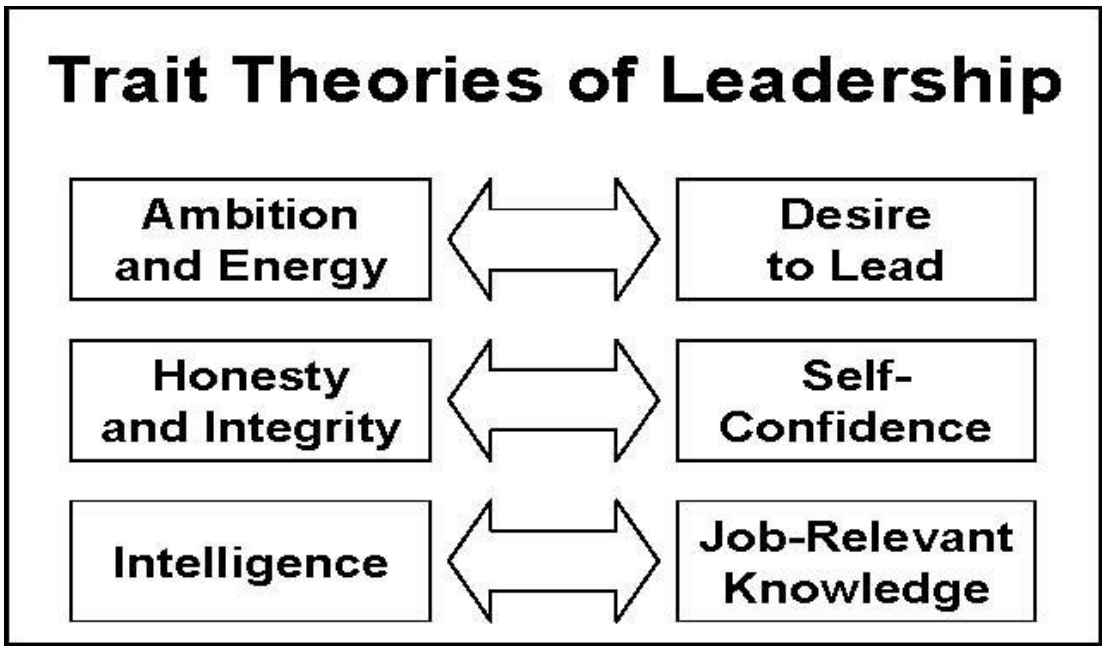


Fig 8. *(Reference: http://www.geneticdisorders.info/article/7128117566/effective-leading-by-trait-theory-of-leadership/)*

Trait theories of leadership include many qualities as it is a combination of many characteristics that a leader is considered to possess. The trait theories of leadership describe the difference between a leader and a follower. There has been considerable study of the traits of leadership and many variables identified. However, there are some prominent traits that are believed to make a major difference and are particularly important. These are intelligence, self-confidence, honesty, integrity, determination and a desire to lead. They are also required to be ambitious, energetic and to possess sufficient job-relevant knowledge.

This theory further assumes that persons who possess these leadership behaviours or qualities are predestined to be good and successful leaders. Although various

disciplines are known to utilise the trait theory, the military is one of the best examples of an organisation that depends on its application. In the process of selecting and recruiting new soldiers from a host of many, they make sure that the selected ones have certain 61 physical attributes, such as a certain height, weight, and physical fitness. Bolden et al. (2003), however, noted that it was rare to find common qualities and behaviours shared by all leaders, implying that the theory is vague and cannot be applied everywhere under different circumstances.

3.3.3 Contingency Theory

During the 1960s, Hutchins and Fiedler introduced the contingency model of leadership (Fiedler, 2015). They negated the ideal leadership style theory and instead claimed that effectiveness and practicability of a particular leadership style depend more on the situation. They identified three aspects of a situation that structure the leader's role:

(1) Leader–member relations, (2) task structure and (3) position power.

Leader–member relationships thrive on the level of confidence and loyalty that subordinates have for their leader. In a nursing context, followers who have good relations with their leader tend to have higher confidence and loyalties for their nurse leaders (Young-Ritchie, Spence and Wong, 2009). Task structure, on the other hand, is considered as 'high' or favourable when the task is described straightforwardly to the subordinates and is easy to perform. To simplify matters, Fiedler created four criteria to help nursing leaders in finding the right level of task structure:

(1) Objective clarity or the degree to which the subordinates understand the objective

(2) The degree to which the decision can be validated or the ability to recognize who is responsible for the task

(3) The multiplicity of goal paths, or the number of solutions available to complete a given task;

(4) The specificity of a solution, or the number of correct solutions available.

The contingency model proposes that leader effectiveness depends primarily on the interaction between the leader's motivational disposition and the compatibility of the work environment. According to this model, task-oriented leaders perform more effectively in situations classified as very favourable or very unfavourable, while situations of moderate favourability are better suited for relations-oriented leaders (Fiedler, 1967, 1971). This idea was also supported by the findings of Miller, Butler and Cosentino (2004), who investigated the degree to which the knowledge of followers' motivational dispositions, and of the situational favourability for follower influence, could be used to predict follower effectiveness. This study on a sample of 108 male junior personnel concluded that relations oriented followers performed better in average favourable situations. On the hand, task oriented followers may have skills to perform better in highly unfavourable situations. However, it was also found that the relations-oriented followers performed better in highly favorable conditions, which contrasted with Fiedler's view.

3.3.4 Transformational Theory

The development of the transformational leadership theory is attributed to James Macgregor Burns (Bolden et al., 2003). The theory was first introduced in 1978 and was later advanced by Bernard M. Bass in 1985. The transformational theory proposes

that leaders can delegate tasks to be accomplished by others by motivating and inspiring their workers and followers.

Burns (1978) originally used the term in reference to political leaders, but later extended it to other organisations as well (Bass and Riggio, 2006). Burns has said that transformational leadership is a process by which followers and leaders cooperate to advance and achieve a greater level of morale and motivation. This process is believed to have a profound effect on the employees by transforming their perceptions as well as values and changing their expectations and aspirations. It is based on a relationship of 'give and take'. As the leader's vision and energy are passed on to his/her followers and workers, it will automatically lead to a positive and enhanced productivity. The followers tend to imitate the zeal of the leader and consequently put more effort into the work they are undertaking.

3.3.5 Servant Leadership Theory

Robert K. Greenleaf developed the servant leadership theory in the 1970s. Casida (2007) stated that this theory has been in active use since 1977. According to this theory, a leader should provide or meet the needs of his/her followers. In so doing, the workers and followers will be motivated to work and the organisation will meet its goals and obligations. Hence, the leader, like the workers and followers, also becomes a 'servant' to the organization. The characteristics of a servant leader include having good listening skills, a keen observer and learner at the same time, having the ability to understand the needs of their followers, being persuasive, having a vision and possessing stewardship abilities. In a hospital scenario, a nurse leader who utilises servant leadership could be patient and able to understand the needs of each staff nurse.

Once the nurse leader knows the needs of the followers, he/she can take steps to meet those needs. When those needs are met, the staff nurses will be motivated to meet the requirements of the job. Whilst servant may seem a strange choice of words today it does allow the sharing of the goals of the organization and highlights the role that everyone plays to achieve them.

3.4 The difference between Leadership and Management

After examining different views and theories, it would seem important to clarify the exact difference between management and leadership. According to Alfozan [1997] the significance of management is that there is a task to be achieved that has been made explicit by those at the head of the organization. Further study classifies the management style into two aspects, one focusing on relationships and the other on achieving results (Everard and Morris, 1990). Definitions of leadership are undoubtedly influenced by the studies of management as well as leadership itself. Both are interrelated in that leaders and managers of the organization can emerge as leaders, depending on context. In essence people with authority can be seen as leaders, but this does not exclude those without formal authority (McKenna, 2006). Management and leadership roles are essential aspects of the organization and both are crucial to making a difference when attempting to meet new challenges and deal with complexities that may arise (Tomey, 2009). Indeed, both management and leadership are significant when activity, quality and purpose are considered in terms of any organisation. (Asiri et.al, 2014).

To scrutinize the difference between management and leadership, it would seem appropriate to look at the core qualities and responsibilities. Building relationships must be a key consideration of leaders and will be influential in facilitating all leaders

to successfully lead other people (Kaulio 2008). It is also a factor in enlisting co-operation when change is introduced within an organization, including hospitals. Good relationships can bring motivation and vision, alongside honing skills as well as competence. Whilst a manager may strive hard to achieve the objective task by making a plan, controlling services, enhancing structure and reducing overall risk and cost factors, a leader may focus more on encouraging others to adopt change and innovation, but each have a complex inter-relationship (Kaulio 2008). According to Young-Ritchie, Spence and Wong, (2009) the most appropriate style of leadership allows an organisation to improve its performance and effective leadership is a highly significant factor that contributes to its success.

3.5 Change Management and Leadership Style in the Middle East

In this section leadership is examined with distinct reference to the Middle East. The implementation of change management is dynamically connected to the type of leadership approach in an organization but also the culture in which it occurs (Senior and Fleming, 2006). In the current context of healthcare delivery having the foresight and ability to potently react to change and modification is the main skill set of a successful leadership (Reardon and Rowe, 1998). This is also true in SA.

There are a few important policies which have to be kept in mind when leaders prepare to incorporate change in an organisation (Cameron and Green, 2009). This is because the reaction of people will differ regardless of the amount of change that may be happening (Okpara, 2007). It has been suggested that leaders should be aware that every person has fundamental requirements in their everyday roles, and very

frequently change leads to loss, and people enduring something termed a ‘loss curve’ (Briggs, 1995). Understanding this difference is considered important by authors such as Briggs, as people expect to be managed efficiently and for change to be explained and fear of the unknown addressed as much as possible. (Briggs, 1995). Reardon and Rowe (1988) consider this ability to be associated with strategic leaders who can understand what is required to bring about change at each step of the process.

As mentioned previously, the organisational culture of the Middle East is established on the philosophical bedrock of Islam (Al-Yahya and Vengroff, 2005). People in this part of the world can easily be overwhelmed by unclear change and most may wish to sustain the present situation. This may explain what makes it extra hard to initiate and handle change in SA (Schneider and Barsoux, 2003). Despite these difficulties, Al-Yahya and Vengroff (2005) and Reardon et al (1998) suggest that although revising the culture itself is unlikely and unwarranted, drawn-out and sometimes unstable change processes are not desirable. In places like the Middle East, where imperious leadership styles are very extensive, executing change can be a very difficult challenge (Badawy, 1980).

Looking at the different styles of leadership classified by Reardon et al (1998), a commanding style may be thought to best suit Middle Eastern culture as it is orients towards performance and most of the time has short-term goals with the stress on the belief in learning from one’s own achievements and failures rather than from some other person’s experience. When the final goal accomplishment is the main objective, this approach be more effective than other styles but may not be possible when a multi-cultural workforce is involved. This is an important feature of the present study: to understand the best way to address future leadership development in SA.

3.6 Defining Culture

As well as leadership, it is also not easy to come to an agreed definition of such a complicated term as culture. Indeed, many scholars have failed to define culture in one holistic definition. As far back as 1952, Krober and Kluckhohn listed 164 definitions of culture (Spencer-Oatey, 2012). Searching the literature revealed that the most frequent definition used for culture is Bates and Plog's descriptive definition:

"Culture is a system of shared beliefs, values, customs, behaviours, and artefacts that the members of a society use to cope with their world and with one another, and that is transmitted from generation to generation through learning" (Bates and Plog, 1990, p.7).

Culture can also be defined as integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups (Papadopoulos, 2006).

In Saudi Arabia the culture is shaped by several key and powerful factors, such as religion, tribe, race, level of education and economic status. The Islamic religion of the Arab race mainly shaped the present Saudi culture. The population of Saudi Arabia is essentially a Semitic people who have lived in the same region for thousands of years. As explained earlier they are comprised mainly of two groups; the modernized /urban and Bedouin/ nomadic, each belonging to different tribes. The framework of Saudi people's lives, social context, economic system, roles, regulations and policies are derived and developed from the Islamic teaching: the holy Quran and the Prophet Mohammed's traditions (WHO, 1998).

The cultural mix that now exists is exemplified in the fact that the majority of nurses in Saudi Arabia are expatriates who are recruited from different countries. These nurses come from different cultures, different ethnic backgrounds, different beliefs and values than those of the indigenous Saudi Arabian people. This diversity brings a variety of experiences to the workplace and to the healthcare services. The King Faisal Specialist Hospital and Research Centre (KFSH&RC) in Riyadh, the capital city of Saudi Arabia, is one of the main hospitals in the country. 95% of its nursing staff are expatriates from more than 40 nationalities and cultures which gives some idea of the challenge in providing culturally congruent nursing care to patients from different culture backgrounds (Aboul-Enein, 2002). This is an important starting point for the present study as the dominant culture is also being impacted by outside forces and we see change occurring- such as the recent change in the law to allow SA women to drive. The ethnicity dimension of culture is important as it is concerned with the ideas, customs and social behavior of a particular people or society (Papadopoulos 2006). This is at heart of this study and SA culture has already been described, and will be explored again in subsequent chapters.

Beyond ethnicity the culture of the workplace may be very influential in helping to set the tone and allow the solving of common problems within an organization; it can also contribute in setting the direction of its members. It is believed that a positive workplace culture (that may include how ethnic diversity is accommodated) may enhance motivation and coordination (Mbigi, 2005). Aboul-Enein (2002), for instance, argues that the immersion of a nurse's culture into another's is achieved by integrated nursing leadership development that supports and identifies cultural performance criteria. In SA, the healthcare profession is facing more issues than other industries. The leaders and managers must realize the importance of domestic culture,

expertise, planning, skills, necessary resources and other essential things to manage the healthcare services more effectively and efficiently (Felemban, O'Connor, & McKenna, 2014).

The word culture is regarded as one of the most difficult and complicated in the English language to define. Nevertheless, culture can be analysed in a similar way to leadership using two different approaches; the positivist way considers culture as a "variable" operating inside organisational activity, whereas the method of applying various modification/ social constructionism is described as "interceptive" studies. It also seems appropriate to consider both culture and leadership briefly within the territory of social constructionism. According to McMillan & Schumacher, the outlook of any research can helpfully be explained by adopting this constructivist approach (2001).

The major philosophy of constructivism is that every person develops their own facts of existence when classifying their experiences, which are then shared with others with the help of language (McMillan & Schumacher, 2001). This suggest that shared culture, for instance, will be regularly developed through communication that rearranges the divisions for and understandings of, shared experience (McMillan & Schumacher, 2001). Geertz considers that any cultural knowledge to be explored though research must be correlated with a considered interpretation of views, behaviours and 'thick' descriptions (Geertz 1973). According to her, the aim of research with a cultural dimension is to find out the shared cultural insights which mirror the way the representatives of a cultural knowledge are contained from doing and saying both implicitly and explicitly (Sackmann, 2003).

It is defined as the “problem of the intentionality of human action” by Czarniawska (Czarniawska 2004: 7) which can be settled by a descriptive approach of knowing. According to Mir and Watson these realities are the product of diverse situations, mindsets and understanding mechanisms – such as everyday interactions, but also in more formal interviews and focus groups (Mir and Watson 2000). This is my rationale for studying leadership and culture using a constructivist approach to help develop my research idea and it has supported my belief that it provides the tools I require.

Many noteworthy anthropologists agree that “culture is the basic and central concept of their science“ (White 1959: 227). It is possibly Clifford Geertz who is considered to be the most passionate supporter of analysing culture by utilizing a constructivist [interpretive] method of research (Geertz 1973). He asked others to study culture in a non-reductionist and relaxed non-judgmental way in order to gain ‘thick description’ and this has stimulated researchers to a greater understanding of the meanings of symbolic practices (LaCapra 1988). According to this author “an entire way of life mediated in symbols“ is the definition of culture (LaCapra 1988: 377). Previously LaCapra was a critic of functionalist concepts, particularly concerning the concepts of sociology that reduced complex issues such as culture to behavior alone. In earlier days, many anthropologists advanced more complex studies of culture from the theoretical adaptation of Malinowsky and Radcliffe-Brown’s scholarly traditions (Chilcott 1987).

Consequently, it is postulated here that if leadership is positioned and established within an appreciation of culture and context, then the existential place of philosophers like Geertz (1973) and Giddens (1984) seem to be highly acceptable. They express culture as an array of symbols, meanings and practices that are the product of synergy

of members in the group (Brannen and Salk 2000). For example, the definition of culture by Ong is:

> 'Culture change cannot be understood as developing in accordance to any prearranged logic (of development, modernization or capitalism). It can be understood as an agitated, paradoxical and varied conclusion which associates modification in existence, relations of struggle and dependence, including the involvement in the reality itself.' (Ong 1987: 2-3).

In light of the above it can be understood that descriptions used in the study of culture will not be unblemished, orderly and uncomplicated. The literature in this field is complex and dense but also challenging and provokes a response. There are certainly similarities between defining and researching culture and defining and researching leadership. Barker has explored some of these issues and has stated that many early theories of leadership, administration and management were accommodated inside logical positivism of cause and effect which is not relevant to the present thinking about the complex character of life and everyday reality (Barker 2001: 491).

The study of how leadership remains lodged in social operations becomes very crucial if the cultural context is believed to be related to the process of research. This is the reason that leadership and culture are now seen as social processes that emerge from the relations and associations between organization goals and their representatives (Uhl-Bein, 2006: 655). 'The fallacy of misplaced things' theory proposed by Wood emphasises this facet of modern leadership. Wood states that leadership is better comprehended as a process instead of a thing or a skill or property (Wood 2005: 1103).

This process approach seems more applicable in analysing the cultural context of Middle Eastern communities such as Saudi Arabia. Here the theory of leadership

begins to stand out separately from the usually dominant Western approach, where the character of leadership reality is "here, now, immediate and discrete" (Whitehead 1967 quoted by Wood 2005: 1103). The core belief in the process ideology is that "process is the concrete reality of things" (Griffin 1986 quoted by Wood 2005: 1104). The process analysis depends on open, modifying and the advancing of human experience, and where "society and life are perceived as productive developments" (Wood 2005: 1104). This is certainly true for SA where the culture is constantly changing and developing.

For Chia, the spotlight of process leadership research is on evolution and enhancing not just precipitous presence of living (Chia 1996). From this angle, one can say leadership is not a thing present in characteristics or a fixed facet of a particular social actor or in "the self-governing personal with a safe faultless characteristic at the core of the social universe" (Alvesson and Deetz 2000: 98) instead it is the unequal ground on which a leader must function.

When it comes to literature on the progress of modern leadership it is suggest that we need to stop thinking of the human world as completed structures and finished systems (Price C. 2007) Wood also argues that leaders, organisations and followers are just superficial things; it is action that matters in the end (Wood 2005: 1104). For this reason the study of cultural context and process is highlighted again and again in this thesis; thereby assisting in the development of more compatible meanings, explanations and reasoning in this study of nursing leadership in SA. A further relevant definition of culture to be considered is that offered is by Clifford:

> 'A culture is an open-ended, innovative conference of subcultures, of inmates and foreigners, of differing behaviors; a "language" is the interplay and

> struggle of regional dialects, professional jargons, generic commonplaces, and the speech of different age groups, individuals, and so forth (Clifford quoted by Meyerson 1991: 259).

According to my personal view, two constructs in the afore-mentioned quote are very important in building and describing of culture. Firstly, that culture is made up of subcultures, and the second one is the importance of language in the development, comprehending and meaning of culture. For Yinger (1960) the concept of subculture stands out as of more importance than culture yet has been considered less by sociologists and cultural anthropologists. According to Yinger, subcultures are more close-knit and often survive inside the bigger world of national culture. Similarly, other definitions of subculture state that a society consists of a large number of subgroups, every group with its own distinctive ways of analysing and doing. Such cultures within a culture are named as subcultures (Blaine Mercer quoted by Yinger 1960: 625). These may be specified on the basis of social background, racial, professional, residential, beliefs, languages, ethnic, provincial differences. Importantly, the presence of subcultures in organisations was observed by Sackmann (2003) as key when considering an individual's role and professional identity, hierarchy, departmentation and management.

At this point, it is pertinent to discuss the importance of levels of analysis in the study of culture and leadership. In order to obtain certainty in organisational research, especially in conception and aptness of the formulation of theories, the levels of analysis play a very important role. One way of classifying research studies is to consider whether they focus on the micro or macro level (Albert et al. 2000). Analysis on an individual, group or organizational level is considered as micro or lower level

of analysis. On the other hand, macro level is an analysis which is collective or aggregate, that is industry, region, sector or nation. According to Corley et al, there will be always the notable change of opinion and discussion over the action of a concept when it is used at the lower or individual level and when applied at higher or collective level (2006).

On many occasions research on leadership and culture is positioned on one level of analysis but the reality tends to be more complicated and dispersed by many levels of analysis such as individual, society, industry, organization, group and culture etc. As Adler and Kwon argue, even though the mechanics of research are made uncomplicated by diminishing ourselves to a single level of analysis, the real nature of an organization is molded by the constant coactions of the individual, group, unit of business, corporate, and inter-firm levels (Adler and Kwon 2002: 35). Hospitals are very complex organisations with sub cultures and ethnic groups within. This makes it important to consider what is possible in understanding such cultures from a single study.

The observation of the division between micro and macro levels of analysis was also made by Burrell and Morgan. The main discrepancy usually drawn between these paths focus on the problem of level of analysis: whether this is on the whole or only a part of the social system or an individual institution (Burrell and Morgan 1979: 53). This is an interesting dilemma when researching a complex topic such as leadership and culture.

The pattern of functional (e.g. trait or type) research available concentrates mainly on the micro, individual level of analysis. Those research methods that have focused more on organizational context or task –focused outcomes place more importance to macro,

holistic, cultural or societal levels of analysis. Each are important, however, and have added to the knowledge around the topic of leadership in the workplace.

3.7 Nursing Leadership and culture

3.7.1 Why culture matters

The core element of the human life is culture according to Wibbeke (2009), who suggests that we do not exist without our social and cultural context. They go on to argue that it is culture that makes people different and unique as it signifies tradition, norms, and belief. Working internationally, culture is what is noticed first. Everyone has a different cultural background, but they come together to learn, share, communicate and interact. Sometimes, cultural conflicts create barriers in work and communication but as culture will remain an integral part of the human's life it should be accepted and understood. It is particularly important to respect each other's culture while working across cultural and national boundaries.

3.7.2 Confirming the relevance of culture

As mentioned earlier culture encompasses behaviour, values, and customs. Schein (2010) says that culture is a phenomenon which is around us all the time but may be less than obvious. Commonly it includes shared knowledge, beliefs, and social behaviours (Wibbeke, 2009, Dickson et al. 2003)

Types of categorization of cultures include national, organisational, macro-cultures, micro-culture, and sub-cultures (Schein 2010). The critical aspects of this study are concentrated on national and organizational culture (Kitchin, 2010). Both the aspects have already been referred to and will be returned to in the upcoming chapters.

However, there are cultural similarities and diversities in healthcare contexts that must be considered, including societal practices and how these impact in a cultural way in hospital settings as outlined in other studies (Alqahtani, Jones and Holroyd, 2015). The current emphasis on empowering clients, with the intention to take part in healthcare decisions, must also take into account the cultural norms of health care professionals, and should recognize how society can perpetuate built-in disadvantage. This present study is intended to reveal much about the culture of nursing in SA and how this influences an individual nurses' identity, lifestyle and new connections with others both within and outside their own culture (Guta and Karolak, 2015).

Al-Sayegh (2013) has determined that it is important for nurses to comprehend their views, value system and beliefs, and by so doing their own cultural awareness starts with developing an understanding of their personal value base and beliefs. In a study by Frewen, Chew, Carter, Chunn and Jotanovic (2015), cultural competence was seen as the capacity to give care effectively which has taken into consideration people's behaviors, beliefs. Cultural competence must be looked at as an aspect within healthcare services and not isolated, it also should be considered as an important component of overall excellence in health care delivery. Issues of health care quality and satisfaction are of particular concern for people who frequently come into contact with the health care services and the professionals from various cultures. Efforts to improve cultural competence among health care professionals and organizations could contribute to improving the leadership and quality of health care for all consumers. According to the national survey of the U.S. healthcare leaders conducted by the search firm Witt/Kieffer, respondents viewed diverse leadership as a valuable business builder. They associated it with improved patient satisfaction, successful decision-making, improved clinical outcomes, and stronger 'bottom line'

(Witt/Kieffer, 2011). The issue of cultural competence will be returned to in the subsequent chapters in relation to the underpinning framework for this study.

An example of the importance of culture is research that showed how Saudi female nurses may wish to work in male units themselves, but the cultural norms and social circumstances prompt them to request a move to a female unit (Almutairi, McCarthy and Gardner, 2015).

It is possible, however, that this problem can be addressed should aspects of Saudi culture be introduced to health professionals intending to work in Saudi Arabia and care for Saudi patients (Al-Shahri. 2002).

Being socially mindful is the exemplification of abstaining from stereotyping. Social mindfulness "is the in-depth investigation and self-examination of one's own professional background and culture" (Monteiro and Fernandes, 2016). This helps the individual to understand the importance of their own cultural background as well as the importance another person’s own background is to them.

Saudi Arabia as any other country has its own cultural norms and values, to comprehend such cultural aspects a particular training must be prepared and delivered to nurse leaders who come from different parts of the world to bolster their cultural knowledge about SA. Some authors argue that, when providing care to Muslim patients' it is important to remain unobtrusive and protection of the patient’s rights ought to be regarded, and nurtured by a health professional, ideally someone of the same gender, which meets the needs of the Muslim culture. Cang-Wong et.al, (2009) Furthermore, highlights that there are still several significant gaps in understanding how culture affects leadership in international healthcare circles, such as SA. As other

researchers indicate, leaders should understand the meaning of culturally competent leadership when working with mixed cultures (Murphy, & Adelman, 2009).

Additional cultural characteristic unique to SA, are further affected by the wide enlistment of medicinal guardians, requiring administrators to be able to navigate this cultural norm effectively (Rassool, 2000). It also means having a deep understanding of the roles of family ties, the Saudi Constitution, Shariah law, the Arabic vernacular, social norms, and Islamic views on prosperity and daily life (Rassool, 2000).

According to Doring et.al (2015), nurses with appropriate training in cultural competencies can generate patient care in an individualized way that promotes patient adherence and safely and effectively incorporates their cultural practices. Informing users about the use of therapeutic means that are relevant to their culture may also be useful for treating the disease and promoting health (such as diet or understanding the importance of adherence to medication regimens), issues which are important to promote as a nursing leader. In accordance with the present study it is known that nurses with cultural competencies generate patient care in an individualized way that promotes better patient adherence and safely and effectively incorporates their cultural practices (Guo et.al, 2015).

3.8 Leadership and Management in Nursing

The study of leadership has been done from the fields of military, education, healthcare to management. As it is always a demand to increase the performance in all organisations, one way for this to be achieved is with effective leadership performance. Erkutlu, (2008) and Al Hosis (2009) has found that nurse leaders are motivated to achieve their vision. They demonstrate competence and skills and

challenge resistance in their path. Effective skills of leadership are required in nursing in order to meet many different but co-existing daily challenges. The total numbers of nurses in leadership positions is unknown (and would be difficult to define) but the global figures of nurses per country are variable. One example of statistics of nurses per 100,000 of population are listed in figure 8. As a general point of note Saudi Arabia is not in the highest quartile of this table.

Global distribution of healthcare Nurses

Rank	Country	Nurses density per 1000
1	San Marino	95.48 / 1990
15	Germany	9.72 / 2003
19	U.S.A.	9.37 / 2000
27	Japan	7.79 / 2002
60	U.A.E.	4.18 / 2001
88	**Saudi Arabia**	**2.97 / 2004**
104	Egypt	2.00 / 2004
106	Syria	1.94 / 2001
111	Turkey	1.70 / 2003
190	Bangladesh	0.14 / 2004 WHR 2006

Fig 9. **(**Reference: https://www.slideshare.net/isuliman/health-stats-ksa)
(Global distribution of healthcare Nurses. WHR, 2006)

3.9 Leadership Styles in Nursing

Over the years, nursing experts, as well as other disciplines, have come to understand that there are different ways or styles of leading people (O'Brien, 2011), and that the style of leadership impacts a nurse's sense of empowerment, work efficiency and job-

related stress (Germain and Cummings, 2010). Although the present study is anchored in SA, it is critical to understand that the context and purpose of this research venture is not limited to one leadership theory. To embrace the nursing discipline and become its proponent, an understanding of the history, culture and theoretical language of the knowledge and practice of nursing leadership is required (Meleis, 2011). The following sections discuss the impacts of different theories on the context of nursing leadership.

3.9.1. Transformational Leadership in Nursing

Academics have shown that effective ways of working, including transformational leadership, have enhanced the performance of organisations, (Casida and Parker 2011). Transformational nurse leaders are said to inspire, fill with energy, and stimulate their followers. This leadership style also promotes awareness in leaders about the interest of their employees. In the cross-sectional study, Salanova, Lorente, Chambel and Martínez (2011) examined the relationship between transformational leadership in nurse supervisors and staff nurses. The engagement of a transformational leadership style allowed these individuals to establish a close and dynamic relationship with their employees. The relationship built positively on levels of trust, openness, and empowerment of both groups of employees.

3.9.2 Transactional Leadership in Nursing

The academic research in this field centers on the transformational leadership style which focuses on supervision, organization and performance enhancement. It employs rewards, or sometimes negative punishment, to enhance staff performance on a day to day basis. Chaudhry and Husnain (2012), Casida et al. (2012), Casida & Parker (2011), and Gunther et al. (2007), have reported many benefits, which are a

result of active transactional leadership techniques. The three most primary features of the transactional leadership are motivation, concentrated in followers, and support. Importantly there is also a focus on maintaining the status quo rather than driving change.

3.9.3 Differences between transformational and transactional leadership

From the point of leading academic studies (e.g., Zagorsek, Dimovski and Skerlavaj, 2009; Salanova et al., 2011), the key differences between transactional and transformational leadership in nursing management are important. The net effect of this distinction in leadership style is frequently neglected, however, and is important according to Zagorsek et al. (2009) who call for more concrete workplace outcomes. The difference between these two styles of leadership are summarised in Figure 8.

Additive effect of Transformational and Transaction Leadership

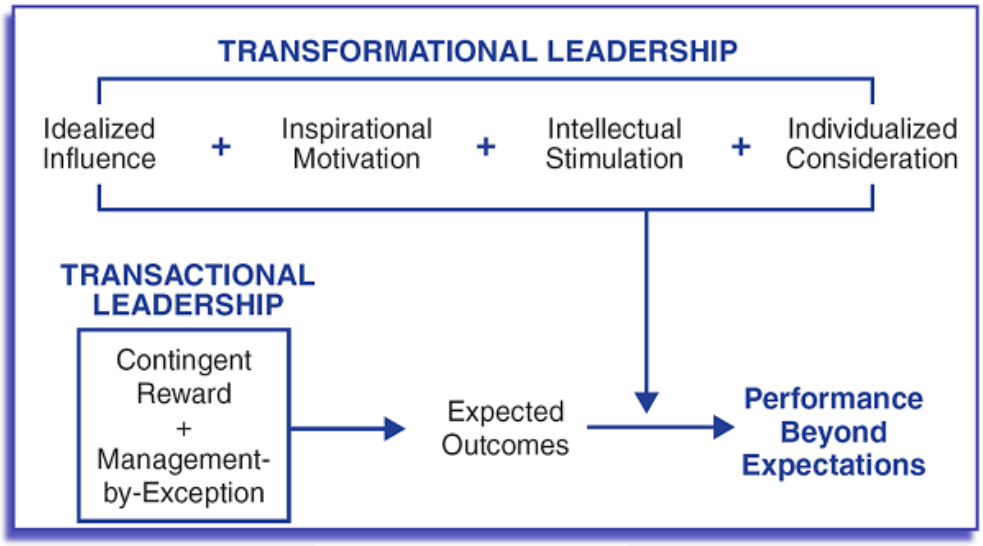


Figure 10. (Reference: https://www.slideshare.net/chaudhariglalit/leadership-theories-10310926)

Transformational leadership is summarised here as a way of leading with subordinates to discover required changes and to create a path to guide change through inspiration and to execute change with the agreement of committed members.

Transformational Leadership follows some basic facts:

1. Idealized Influence:

Transformational leaders embody ways of working and attitude that exemplify a role model for their followers.

2. Inspirational Motivation:

The leader motivates followers with inspirational work plans and their behavior.

3. Intellectual Stimulation:

The leader has ability to encourage creativity and new ideas, and prepares followers for upcoming challenges, and makes them come up with creative solutions to problems.

4. Individualized Consideration:

Leaders pay close attention to each individual's needs. Leaders spend their time in learning about these particular needs, motivations, hopes and aims of their followers.

Transactional Leadership suggests some different styles to consider in comparison. Transactional leaders focus on performance, organization, and supervision, they also promote consents by subordinates through both rewards and punishments.

Further, we can explain transactional leadership by these attributes:

1. Contingent Reward:

This is a motivation-based system used to reward those subordinates who meet their specified goals.

2. Management- by-Exception:

Management by exception is a way of work where the leader's attention will be focused only on those areas in need of action.

Transformational leadership and transactional leadership both work together in some situations and can achieve results that may extend beyond the expectations of a single approach.

3.9.4. Laissez-Faire Leadership in Nursing

This style of leadership differs as it is less action focused. Few research studies have indicated whether the Laissez-Faire leadership style can blend the authority and creative style of the previous leadership styles. One exception is the work of Skogstad et al. (2007). The main objective of their research was to determine the Laissez-Faire Leadership effect on employee role conflicts, co-worker conflicts, and ambiguity in an organization. The 2,547, heterogeneous sample was comprised of Norwegian employees, in which fifty-eight percent were employed in the work of the department and twenty percent had responsibility as superiors. The laissez-faire leadership style was measured using the MLQ instrument. On the other hand, the measurement of constructive leadership and employee-centered leadership was measured with other six-item scales.

To judge whether any role ambiguity and conflict had any effect, these scales were used, alongside the Bergen Conflict Inventory. Using correlation, the researchers

suggested the association between laissez-faire leadership with role conflicts and reports of role ambiguity in the workplace. This style, whilst important, is not one to consider effective in most situations, and it is suggested would not be a good fit to the culture of SA.

3.9.5. Effective Leadership in Nursing

Recent research in the field of nursing management and work environment states that most nurse leaders function as strong advocates for both professional and personal concerns – i.e. the task (patient care) and the people carrying it out (nursing staff), (Tomey 2009). The advocacy role carried out by nurse leaders can help in the creation of a working environment that is positive and encouraging. With the general interpretation of the nurse leaders as multidimensional this extends the perceived importance of the role (Tomey 2009). This range of influence varies from managing daily workloads to suggesting modern education programmes, to encouraging professionalism in their particular field. Nurse leaders can also promote outreach to encourage family and community support in patient care situations. Despite such efforts, there are still organisational factors to contend with such as professional hierarchies, and bureaucracies that can add to the challenge of nurse leadership (Gunther et. al, 2007).

3.10 Leadership Practice in Multicultural Environments

Perhaps one of the most challenging aspects of this study is multicultural leadership, and one of the most complex environments is that of a busy hospital. This, in turn, generates the important challenge of recruiting and retaining skilled nursing leaders; which will, in the end, also enhance the quality of nursing care. The next section of

the literature review will return to highlight the multicultural environment of Saudi Arabian healthcare. The section will once again highlight the influence of Islam in the culture of Saudi Arabia and the impact on expatriate staff working in Saudi Arabia.

3.10.1 Multicultural Environments

Today's nurse leaders need to know the factors for dealing with issues within the multicultural workforce. The cultural dimension encompasses belief, symbols, customs, and behaviour, which are transferred from one generation to other (Almutairi and McCarthy, 2012). The culture of the society is established via the educational system, religion, race, environment, and economic status. As we are living in the age of globalization and internationalization, many of workplaces are now occupied with multicultural teams of people. Leaders in these places should not have the only prime focus on technical performance and economic control, but also should attend to the organisation and be able to pinpoint the impact of multicultural issues (Adler, 2008). Leaders also need to focus on the factors that influence the behaviour of workers, including working in mixed and multi-cultural teams.

As staff prefer to work in different workplaces or specialisms, it is obvious that there will also be diversity in how they feel about working with different languages and cultures. Diversity in spoken language is a major challenge in SA hospitals that nurses and patients both need to tackle and cope with. A generation of nurse leaders who lack the skills of diversity management may find it a problem to deal with the multicultural environment (Suliman, 2009). Not taking the issue of cultural diversity seriously warrants attention as ignoring this is likely to affect the performance of the nurse, due to multicultural teams.

As already mentioned the culture of Saudi is a blend of Arabic and Islamic culture. To aid expatriate nurses to become comfortable with Saudi culture, Almutairi and McCarthy (2012) did a cultural analysis of SA hospitals. The analysis suggested that 67.7% is the rate of expatriate nurses, from a different cultural background, who feel they have to compromise in some way to fit in to SA. Due to such high levels of staff diversity in SA, there are obvious high risk of misunderstandings and cultural conflicts. However, with cross-cultural awareness, expatriate nurses can be empowered with knowledge of the cultural heritage of SA. This will ultimately improve the outcomes of their efforts. The impact of multicultural education has been shown to positively enhance the creativity among workers (Leung, Maddux, Galinsky and Chiu, 2008).

3.10.2 Nursing Leadership in a Multicultural Workforce

The nurse with effective professional skills, and cultural awareness, can expect the opportunity to work in other countries. In Southeast Asia, Kanchanachitra et al. (2011) have studied the movement of staff in global health services. The results of the study suggest that there was no lack of healthcare staff, but that low-income countries have reported more distribution issues, especially in rural areas. The study also highlighted that even when there was an availability of highly trained nurses, there was often a lack of coordination among the heath care staff members. This point came into more focus in international health trade which included Malaysia, Thailand, and Singapore. This international medical trade also attracts medical tourists which requires cultural awareness as well. The practice of education in cultural difference is needed to train nurses, who often come from The Philippines and Indonesia. The studies into the

multicultural workforce were conducted by MoH hospitals and have some resonance with the SA situation (Kanchanachitra et al., 2011).

3.10.3 Transformational Leadership in a Multicultural Workforce

Nurse leaders need to be equipped and supported to make a choice about the style of leadership required according to the environment they are working with. One of the most appropriate styles of leadership is the transformational model described earlier (Harrison, 2011). This form of leadership links subordinates with organisational leaders through a common vision, and individual motivation (Visagie and Linde, 2010). The vision of each individual is shared with the leaders that ultimately encourage subordinates to go beyond their self-interest, and ideally may cross cultural boundaries. Applying this style in a multicultural context clearly requires traits of self-confidence, freedom from indecision, determination, co-ordination, and understanding the needs of subordinates (Harrison, 2011). When an organisation adapts to a transformational style of leadership, leaders need to be able to motivate and unite team members in a positive way and with a sense of shared belief (Nyberg, Bernin and Theorell 2005).

In (Figure 10) advice is provided for how to succeed as a cross-cultural leader in the Middle East. This simple diagram captures many of the characteristics of transformational leadership theory but also requires cultural knowledge and experience.

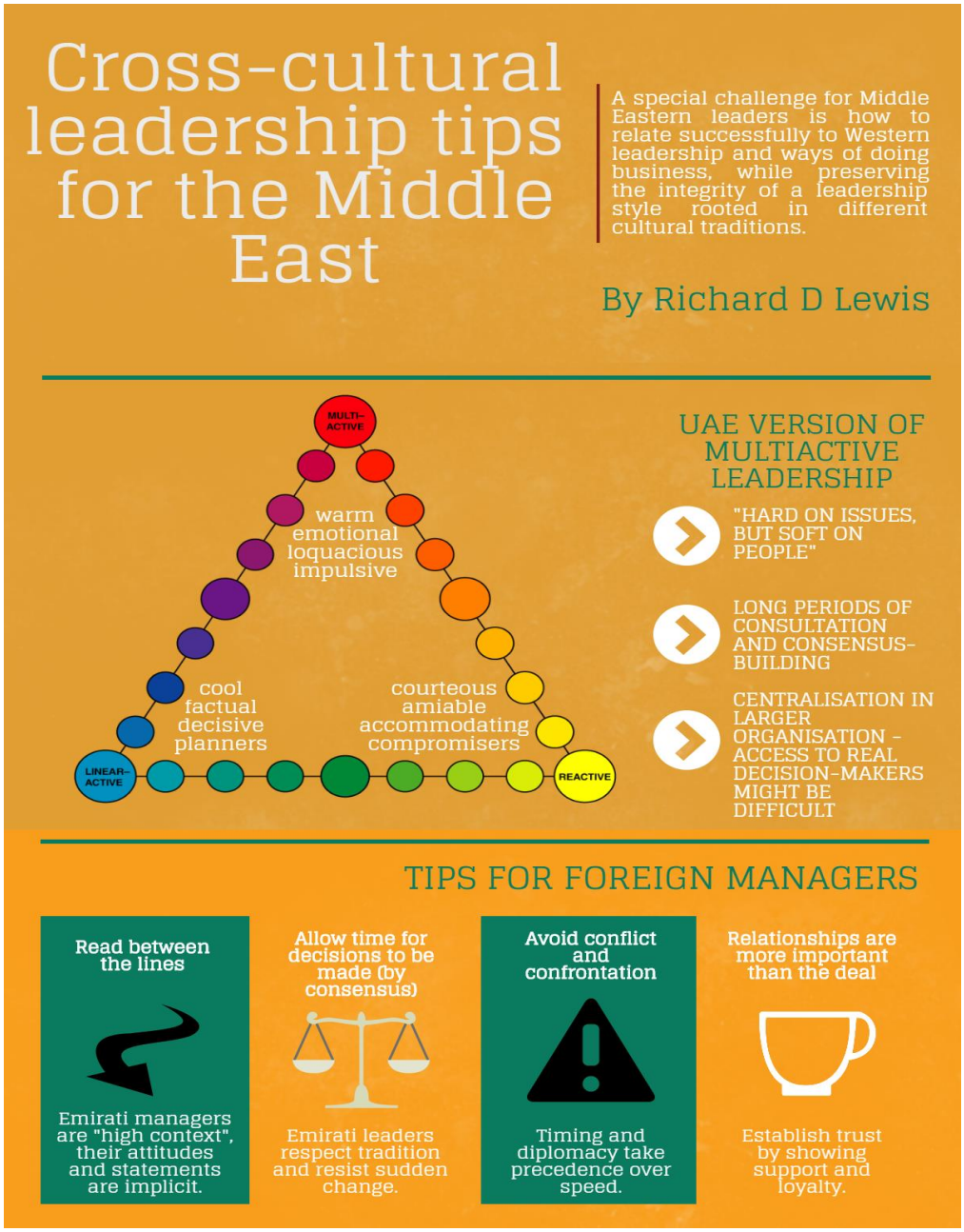


Figure 11. (Source: Accessed at 25APR 2017 from http://www.crossculture.com)

The Middle East is the home for a ‘myriad’ of nationalities. This mixing of people is the ‘Middle-East model’, driven by economic opportunity, and attracting labor / talent from under developed countries. This helps the Middle East to support its dream of growth.

However, this vast diversification opens up new challenges as each nationality has particular values, sensitivities and perceptions and in order to achieve the most out of

this wealth of labor, they are to be handled with care. One of the challenges for Middle Eastern leaders is to apply the western leadership (which has proven itself and has a long track record) to this culturally diversified pool of skills (Suliman, 2009).

Three leadership styles popular in the Middle East are worthy of brief mention: multi active, linear active and reactive and represent a spectrum of behaviors. Leaders from UAE (the most advanced economy in Middle East), generally, adopt the multi active leadership style. This is because of the inherent cultural and diversification issues that UAE face. These leaders tend to focus on priority issues and remain lenient on disciplinary issues. They 'sleep' on problems and focus on consultation and consensus (but often with lack of support from the top most decision makers), sometimes they make decisions impulsively (Suliman, 2009).

Some important tips provided to foreign leaders to yield most out of the UAE skilled pool:

a. Read between the lines i.e. focus on the 'high context' environment among Emiraties.
b. Allow time for consensus and include all to reduce surprises and sudden changes
c. Use diplomacy to avoid confrontation and /or conflict even if it takes longer to decide.
d. Establish trust by support and loyalty.
e. Value the relationship over the deal

This is an interesting example of culturally appropriate advice, and is based on pragmatic knowledge rather than research. The nurse leaders making use of transformational leadership have the ability to draw on such advice to help transform

the attitudes of staff members, says Suliman (2009). This is the approach that may lead to success in transforming SA healthcare organisations. They also require skills in inspirational trust, confidence, creative problem solving, and an awareness of local challenges. The leaders exercising such skills, and drawing on sources of advice, training and appropriate leadership styles, are more likely to be successful.

3.11 Summary

The chapter has explored theories of leadership in the context of multi-cultural environments and has emphasized the value of transformational leadership. The chapter has been focused on scanning the literature also on other leadership theories, and has examined the role of culture which should be inculcated as awareness by nurse leaders in SA to achieve the best success. Encouragement happens only by making staff feel that they are being listened to and ensuring that their needs and requirements are viewed as equally important. Awareness of the style of leadership needs to be linked with the needs of the organisation at large. The leadership styles that have been explored in this chapter include transformational, transactional and laissez faire. Some relevant research has been introduced and the benefits of training and awareness of multi-cultural teams examined. Importantly it was found that a negative workplace culture has resulted in more stress for those undertaking a leadership role. It also has been discussed that the outcomes of a leader's satisfaction, and willingness to put in extra efforts, can impact on the role satisfaction and patient care. The chapter has adopted the perspective of both the Saudi system and global level leadership on the practice environment. In conclusion, it can be seen that more research is needed to understand what leadership training is needed to support nurse leaders working in SA. The study is now introduced that seeks new answers to this challenge.

CHAPTER FOUR: Methods

4.1 Research Methodology

It is crucial to employ the most appropriate methodology to answer any research question. Leadership styles has been explored largely by employing quantitative questionnaires which serve to analyse and measure elements of leadership style. Alban-Metcalfe and Alimo-Metcalfe (2000) recommended that more qualitative research needs to be conducted to explore the constructs associated with leadership in different organizational settings.

This research is designed to do just that and thereby add to the body of knowledge concerning nursing leadership in Saudi Arabia, and how, in particular, it impacts on organizational culture in the hospital setting. It does not attempt to produce statistical information regarding the leadership traits of nurse leaders. Due to the subject matter and context of this study a qualitative methodology has been selected and the research is conducted in the setting of one large ethnically diverse Ministry of Health hospital. This is an obvious and natural setting to research how specific leadership practices are implemented in a specific organisational culture. A qualitative methodology is considered appropriate to explore the variety, complexity, depth and richness of experience of nurse leaders and, most crucially, the significance of the meanings generated by these experiences.

To fulfil the aim of the research, a qualitative design adopting semi-structured interviews and focus group sessions was employed.

Determining which investigative techniques to utilize is crucial when seeking to establish the research outcomes to be achieved. It is usual for researchers to utilize two types of research techniques; namely an essential and an auxiliary research strategy. The 'essential strategy' for research is concerned with the accumulation of direct information gathered by studying reviews, interviews and similar, whereas a 'secondary strategy' for research gathers information that is current within articles, websites, diaries, books, the internet and so forth. Research shows that auxiliary techniques for information accumulation can actually have a greater legitimacy and consistent quality when they are coordinated alongside essential strategies for gathering of information (Pervez, 2005). Data that can be assembled from these secondary information sources may occasionally be sufficient in exploring an issue (fao.org, 2012).

The research method is the choice of the techniques best suited to conduct a study; whether qualitative or quantitative. The research design is concerned with what techniques are actually used such as observation, opinion s from surveys, descriptive interviews or experimental approaches (Gill & Johnson, 2002).

In this research, a qualitative design employing a semi-structured interviews and focus group discussion / meetings also took place afterwards to gather more information for the purpose of answering the research question.

4.2 Theoretical Framework and Research Questions

When conducting any research study, it is particularly important to understand the specific theoretical framework used by the researcher. Understanding the theoretical framework makes it possible to explain, predict, and understand phenomena which

occur. It also makes it possible to challenge and extend the existing knowledge and literature available on a specific topic within the parameters of the specific theoretical framework. Therefore, it is the structure of the theoretical framework that helps to support the theory behind a particular research study.

The theoretical framework for this research study is largely based on the cultural competence model, according to Papadopoulos (2006, p. 10), which implies there are four components necessary for a person to be able to develop cultural competence. The first component is cultural awareness. The second component is cultural knowledge, the third cultural sensitivity and the fourth and final component is cultural competence. Each of these will be further elaborated to ensure the theoretical framework by which this research study is conducted within is understood.

By being able to understand our own cultural identity as well as how it impacts our own personal beliefs about health care behaviors and practices, are essential elements of the individual being able to understand and learn the differences between multiple cultural identities (Papadopoulos, 2003). For this reason, the research will seek to look at the level of personal cultural awareness nursing staff have of their own cultural identity.

The final component of this model is cultural competence. The ability to demonstrate cultural competence requires healthcare workers to be able to apply this in their interactions with patients, their families, and other staff members. Without being able to apply their awareness of their own cultural identity, knowledge of the cultural identity of those they are serving, and to do so in a manner that is sensitive to their needs and culture, are not capable of being culturally competent (Papadopoulos, 2003).

It is this four-component model of cultural competence which underpinned this research study. It is through this framework, that data were collected to determine how culturally competent the nursing staff in Saudi Arabia are, including nursing leaders (Gerrish and Papadopoulos, 1999). As a result, it is the desire of this researcher that the research study is able to help further expand this theoretical framework so that SA nurse leaders can provide the highest quality of care that is also culturally competent to their patients.

The primary goal of this study was to reach an understanding of what indicators leaders and staff members would use that would enable them to perceive whether someone was a competent nurse leader within the cultural setting of SA. This would include what expectations they would have of someone in that role and what would be deemed to be acceptable practice. The study also aims to outline what training would need to be put in place in order that someone could fulfill the necessary requirements of being a culturally competent nurse leader.

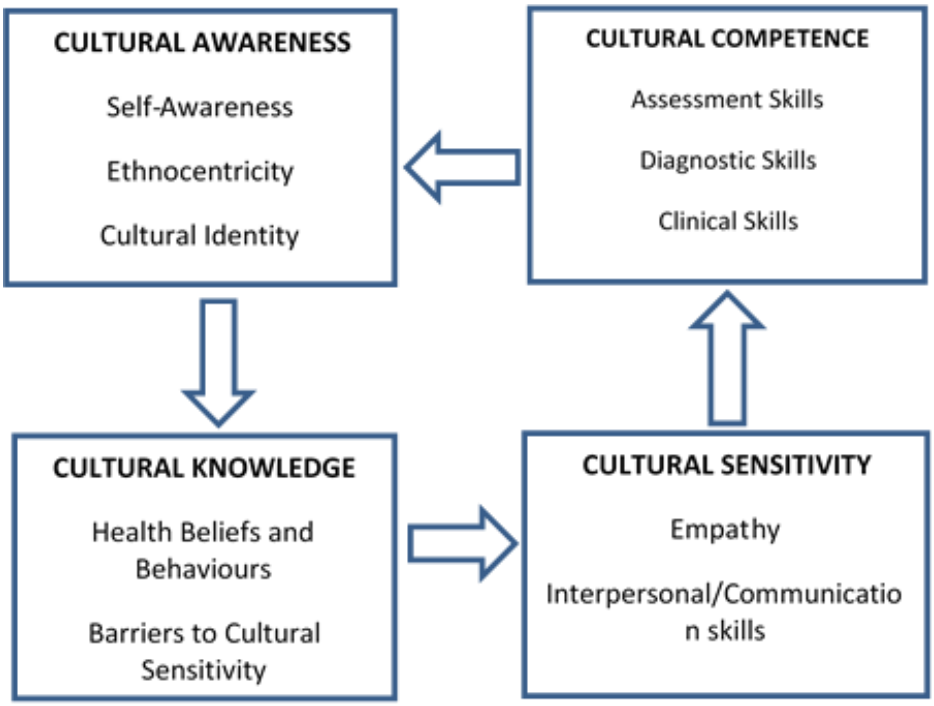


Figure 12. (Papadopoulos, Tilki and Taylor Cultural Competence Model. 2006)

The cultural competence model, according to Papadopoulos (2003), implies four components necessary to develop cultural competence:

Cultural awareness is the first stage in the cultural competence model. It commences with an exploration of one's personal value base and beliefs. Understanding the nature and construction of cultural identity, as well as its impact on people's health beliefs and practices, are described as essential elements of a learning platform (Papadopoulos, 2003). In this stage, the focus can be on identifying what level of cultural awareness nurses, or other professionals, have.

The second stage is concerned with **cultural knowledge.** This stage can be reached through meaningful contact with people from different ethnic groups. Contacting such people aids and enhances knowledge about their health beliefs and behaviours as well as expanding a person's understanding of the problems they may encounter. This knowledge is required in order to understand cultural similarities and differences (Papadopoulos, 2003).

Cultural sensitivity is the third stage**.** An important element of this stage is how professionals may view people in their care. Considering subordinates and colleagues as true partners is an essential component of cultural sensitivity and a crucial element in anti-oppressive practice. Equal partnerships involving trust, acceptance and respect as well as facilitation, advocacy and negotiation can help to achieve cultural sensitivity (Papadopoulos, 2003).

The achievement of the fourth stage, **cultural competence,** requires the synthesis and application of previously gained awareness, knowledge and sensitivity.

Using this model, the research questions are listed below to help locate the present study within the previous literature review and this theoretical framework.

4.2.1 Research Questions

These questions provide the focus of the present study and draw on what is already known about nurse leadership, and my own knowledge of SA culture and the ambition to improve nursing care management:

- What is the nature of the relationship between culture and the leadership style of SA nurse leaders in practice?
- What are the qualities that nurses in SA need in order to be identified as culturally competent nurse leaders?
- What training do nurse leaders in SA need in relation to their present role?
- How does the changing nature of healthcare in SA impact on their role and leadership style?
- How might training and development best be delivered?

These questions are considered in light of the relevance of cultural competence as a concept and its usefulness in helping to make the findings useful to the SA context.

4.2.2 Employment of Cultural Competence Model to SA nurse leaders

The Papadopoulos, Tilki and Taylor's (1998) model for assessing cultural competence development was employed in order to assist in discussion of the data in the current study in order to determine how culturally competent SA nurse leaders might be, and what training they may need, to develop their leadership style within this unique cultural setting. It is suggested in this model that culturally competent leaders need to develop both culture-specific and culture-generic competences. Culture-specific

competence refers to the knowledge and skills that relate to a particular ethnic group and that would enable leaders to understand the values and behaviours operating within a particular culture. In this case we are concerned specifically with SA. Cultural-generic competence is the acquisition of knowledge and skills that are applicable across many ethnic groups (Gerrish and Papadopoulos 1999). This is a secondary benefit of the study and may also be useful.

It is hoped that the insights gained during this study will also add to the further development of this theoretical framework within SA nursing leadership development. The methods used in the study are now described.

4.3 Research Methods

The present research analysis aims to elucidate pertinent information regarding the subject topic, using semi-structured interviews and focus group discussion. Qualitative approaches are important as they enable analysis of a specific group/ population by means of them revealing their feelings and thoughts concerning the research subject under scrutiny. The qualitative approach is also challenging (especially as it involves language and some researchers, such as myself, do not speak English as their main language). The qualitative research method can include surveys, semi-structured interviews, observation, focus group discussion and telephone conversation (McDowell & MacLean, 1998).

Exploratory research can demonstrate and evaluate various ideas, contrasting with the quantitative / experimental method of research. Importantly, it takes place during the course of open-ended questions asked to main participants (Becker, 2007).Therefore,

a qualitative data collection technique was used to understand the leadership practices of nurse leaders and the organizational culture of one Saudi Arabian hospital setting.

This data for this study was collected by the researcher himself, who then collated the relevant data and information and analysed the procedures and opinions of the participants. It can be said that SA hospitals or healthcare companies might have the finance to extend this knowledge base and continue with this research by conducting, for example, larger satisfaction surveys of employees (Saunders, Thornhill, & Lewis, 2009).

4.4 Study Setting

The study was carried out in Riyadh, the capital and the largest city in Saudi Arabia. For the purpose of this study, one of the biggest MOH medical cities in the Riyadh region was selected. The study site was the King Saud Medical City (KSMC), commonly known as Shomaisy Hospital after the area in which it is located. KSMC is a medical complex composed of six different hospitals: 1) General, 2) Paediatric, 3) Dental, 4) Diabetic, 5) Rehabilitation and 6) Obstetrics and Gynaecology. The KSMC is considered the oldest and the main referral MOH hospital in the Riyadh Region. This Medical City receives its budget and regulations directly from the central MOH. The total population of nursing staff in KSMC is 2,758.

This study site was selected based on its evident relevance in terms of size and the varied cultural backgrounds of the staff. Access was negotiated first with MOH's training and education department and secondly with the chief nurse in KSMC who gave permission for the study to take place. Ethical permission was also gained from the School of Healthcare Sciences at Cardiff University (see Appendix F, G, I).

All the Nurse Directors comprising the 6 hospitals in the KSMC were included in the study and representatives of nurse leaders, head nurses and staff nurses were also selected for participation.

4.5 Sampling

This study utilized a purposive maximum variation sampling approach. The selection was made to ensure that the sample represented different settings and a wide range of experiences and views. The sample size in qualitative research is not determined by fixed rules, but by factors such as the depth and duration of the interview and what is feasible for a single interviewer (Britten, 1995). Although it is theoretically possible to carry out qualitative research on large samples, qualitative researchers find themselves obliged by time and resource limits to trade breadth for depth (Murphy et al., 1998).

A snowballing technique also guided this phase with nurse leaders and staff nurses to determine a variety of cultural backgrounds, ages, gender, specializations, places of work and qualifications. The sample finally consisted of three groups: nurse directors (n=8), head nurses (n=23) and staff nurses (n=15). As mentioned earlier the initial group also included all six Nurse Directors from the different hospitals within KSMC. With a total of 46 participants involved in the interviews, 30 of these participants were equally distributed amongst six focus groups. The remaining 16 subjects were interviewed separately. The selection of participants was based upon their experience and hierarchical status within their field of practice.

Participants have met the eligibility criteria as they are currently working in the selected hospital, and have at least an associate degree in nursing science (Diploma).

The research targeted nurse leaders and managers who have a minimum of six months experience in their current position with twenty-four hours accountability and responsibility for operational processes. The research also targeted staff nurses who have been working not less than 6 months in one department, and who have at least an associate degree in nursing science.

In the next table (Table 3) some biographical data of the sample are listed. However, those senior nurses in the sample were allocated a number to represent each level. This was because the numbers were smaller and there was a need to protect their identities, prevent disclosure and maintain confidentiality of identifiable data. The highest nursing grade is number 1.

Interview and focus groups participants' biographical data (Table 3)

Participants	No.	Gender	No.	Nationality	No.	Age range	No.	Level of Qualification	No.	Position	No.
Approached	65	Male	17	Saudi	14	22-30	16	PhD	1	Nursing Managerial Level 1	1
Agreed	51			British	1	31-36	9	Master	9	Nursing Managerial Level 2	1
Cut-short	5			Pilipino	12	37-41	9			Nursing Managerial Level 3	1
		Female	29	Indian	8	42-47	6	BSN	17	Nursing Managerial Level 4	4
Completed Study	46			Pakistani	1	48-53	4			Nursing Managerial Level 5	5
				South Korean	2			Nursing Diploma	19	Head Nurse	19
				Jordanian	7	54-60	2			Staff Nurse	15
				Egyptian	1						

4.5.1 Data Collection

This study utilized in-depth individual interviews as well as performing 6 focus groups with staff nurses and some head nurses in an attempt to further understand the relationship between leadership practices and SA culture. Data saturation occurs when "the researcher is no longer hearing or seeing new information. Unlike quantitative researchers who wait until the end of the study to analyze their data, qualitative researchers analyze their data throughout their study" (Siegle, 2006, p.11).

Use of personal influence

The researcher initiated first contact by writing letters and making follow-up telephone calls. However, this did not generate a sufficient response to act upon and so personal face to face contact was then employed. The first step was to build up close contact with a couple of key influential individuals and persuade them of the importance of the research proposed. This is not an uncommon technique amongst social scientists and ethnographers and can be a successful means of obtaining genuine and pivotal data. The researcher was fortunate in that having worked alongside key important people in the past, and having a history of mutually supportive working relationships, they were not averse to being helpful and agreeing to meet and discuss the research proposal. Indeed, they very generous with their time, and frequently allocated even more time to meet than had been requested. Another factor to note is the researcher has relatives who hold high government office and this may have been influential in the positive response of others to agree to meet with him.

As a result of these two factors a ‘troublesome errand’ became far less troublesome and once the co-operation of some nurse leaders and staff nurses had been obtained and they had agreed to participate they were willing to recommend and endorse the researcher to others. In this way, some nurse leaders volunteered themselves and actively approached the researcher to enlist in the study. Once the research was approved it was rare for individuals to be unhelpful. Only one individual declined for the meeting to be recorded, so in this instance the researcher took written notes. However, if anything this may have resulted in an even more open dialogue and data was gleaned that perhaps wouldn’t have been during a recorded meeting. Overall, those interviewed were generous with their time and the researcher was confident that questions were answered honestly, candidly and in a straightforward manner. In general, they were also willing to elaborate on points that were made and issues that were raised.

4.6 An inductive strategy

The data and information examination process for this study utilized a subjective or inductive qualitative approach. This approach encompasses a variety of current thinking but is based on people responding to questions about their situation and views of the world (Elliott, Fischer, & Rennie, 1999). The meetings that were led were planned carefully prior to them taking place. This approach is one that has some fluidity that enables the researcher to gather a wealth of information, some of which will then suggest areas for future study (Gall, Gall and Borg., 2010),. With respect to the present research, I had made use of a range of different academic sources, books and articles (as described in the earlier literature review chapter) so new information that could be gathered and considered and utilized as appropriate. Towards the end his

facilitated the development of critical themes and suggested areas for further examination and possible conclusions (Elliott, Fischer, & Rennie, 1999).

Qualitative research is used to evaluate and reveal trends in opinions, behaviour and thought and delve deeper into the main issue under consideration. Methods include individual interviews, group discussion and observation / participation (Saunders, Thornhill, & Lewis, 2009). An inductive approach most likely to include quite broad research question or questions that will define the scope of the research analysis and is mostly associated with qualitative research. This method requires the analyst to start with an entirely open mind without defined ideas of what will be assessed. The main purpose of this is to generate a new theory grounded on the information or data. Once all the necessary information has been gathered the researcher should then examine other theories to establish what they have in common and what would be a new area of study within a particular body of knowledge (Saunders, Thornhill, & Lewis, 2009).

Within a qualitative approach theories are not made, or conclusions drawn, until nearing the end of the research process (Kitzinger, 1995). The inductive approach is also known to as a “bottom-up” method of understanding, in which the analyst utilizes observations to create an idea or to define a method to enable study of the phenomenon that is being researched (McCaston, 2005).

Nevertheless, the investigative approach of explorative research is recognized as a legitimate technique of research (Saunders, Thornhill, & Lewis, 2009) It is generally understood that the main 2 approaches to research are those that use a subjective methodology [qualitative research] and those that use a statistical approach [quantitative research]. In this study it was decided that a quantitative approach would not be used as it would not give sufficient scope to the topic and would require

extensive informational study appraisal (Elliott, Fischer, & Rennie, 1999). The researcher instead used an inductive or subjective approach in order to access views on leadership qualities and cultural factors when employees join the healthcare workforce in Saudi Arabia. It is also a subject that the health authorities in Saudi Arabia would recognize as a useful topic and one that would be viewed as of obvious relevance, so examples from key individuals would be useful. A qualitative approach would also enable me to experience this type of data collection and to build on previous work undertaken in this area. (Patton, 2002).

4.6.1 In-depth interviews

The researcher started by conducting a series of in-depth single interviews, which enabled him to navigate the interview and direct the interviewee through the research questions whilst also allowing the interviewee the opportunity to discuss the particular subjects that they considered relevant to their own situations (Fielding and Thomas, 2001). The in-depth interviews provided the flexibility needed to enable the interviewer to undertake additional enquiries into the research subject to order to gain richer qualitative data. This is important in guaranteeing the trustworthiness and transferability of the resulting research data. Thought was given to ensure that the questions were relevant rather than abstract so they could be relevant with the situational social processes and meanings of nurse leadership in SA (Mason, 2007).

The in-depth interviews were conducted in person and were audio recorded to allow the interviewer to fully focus on the interview with less distraction than would be the case if note-taking. Recording data audibly also enabled the researcher to file and retrieve the data at any future time.

4.6.2 Focus Groups

The researcher also facilitated and moderated 6 focus groups with staff nurse participants who shared a common characteristic central to the topic (Krueger and Casey, 2000). Each group consisted of 5-7 participants who could interact in a group to generate insight into understanding shared experiences and social norms regarding the relationship between the organisational culture and leadership style. In addition, factors were discussed that they thought would serve to produce a good nurse leader. Focus groups can help to uncover factors that influence opinions or behaviour (Krueger and Casey, 2000). It was arranged that the 5-7 participants would be gathered for focus groups in the meeting room in the main building in KSMC.

A pilot study was conducted prior to the data collection phase to ensure the feasibility of the study methods and to clarify any issues with conducting the study within a specified time frame.

Interview methodology

This review concerns the semi-organized meetings, including a description of the methodology employed in the meetings, the setting of the meeting and the participant members. It also describes the course of the meeting, interpretation and translation strategies. The meeting involved a discussion between questioner and interviewee with reference to achieving certain targets. The questioner used prompts and encouraged the members to personalise their sentiments and refer to their own circumstances and to describe how they contended with the conditions in which they were working. He also facilitated them to decipher how their opinions had been

formed and any under-lying meaning they could deduce (Cohen, Manion, Morrison, & MyiLibrary, 2010).

Participants were able to put forward their arguments and perspectives and speak openly about the topic. This was facilitated by the fact they were permitted to speak in their first language. This meant that any nuances in their views were not lost. The reactions of group members were also noted. This contrasts with the mere accumulation of information in other methods, such as surveys (Patton, 2002). Some other noteworthy data can be gained by examining the perspectives of members in some further depth, however, the data gathered can be subjective and personal as it may be time consuming to collect it as well as hard to interpret reliably. To avoid this the focus of the interviews and groups were kept to the topic of nursing leadership in SA (Kitzinger 1995).

The semi-structured interviews and focus group discussion / meetings were both developed using guidelines suggested by relevant and accessible surveys previously undertaken in the field. The interviews were, for the most part, conducted in English. The starting point was a discussion with the interviewee of their understanding, capabilities and experience concerning the subject of the research. We commenced with broad questions and then moved on to more exacting questions to obtain sufficiently concentrated data required for this type of research. An important consideration was seeking a way that I would try to guarantee openness for both members and researcher during the meeting. The way in which the meeting was conducted was pertinent to achieving this openness. When members of a group meeting were selected the time of the meeting and the convenience for the potential participants was also carefully considered.

Prior to the meeting taking place individuals were informed of the purpose. They were also advised that the meeting would take around 40 - 70 minutes. Individuals were reassured that their identity would not be revealed or deduced when the research content was written up and confidentiality was to be guaranteed. There would also be no investigation or adverse consequences of any revelations made during the meeting. Consent was obtained by participants prior to the meeting and this included that they were willing for any recording gadgets such as voice recorders and sound tape recorders to be used (see Appendix C, D).

Some parts of the meetings were structured o the questions to be asked (Patton, 2002). Others were more free-flowing and dictated by the interests of the participants whilst still trying to maintain the focus of the study. It was considered vital that participants 'had a voice' and able to put across their point of view and so be empowered. This also meant that the researcher was more likely to get participants to elaborate on their views and achieve a greater understanding of the reality of their experiences. Some individuals stood out as having opinions and experiences of note but all individuals were able to bring something new to the debate and all opinions were treated as worthy of consideration. However, it must be acknowledged that some individuals may have been inhibited when discussion takes place in a social context and group discussions can be difficult to evaluate. Group gatherings, it can be said, are particularly useful when it comes to considering a wide range of responses and feelings concerning an issue before, perhaps, focusing on a certain aspect to investigate further (Kitzinger, 1995).

Qualitative interviewing

The alternative of the researcher talking to those who are working in the field being researched in an interview or focus group is the ethnographic approach. This may be considered less refined and may take more time to obtain data as a meeting or a one to one interview will yield (Shaoming & Huifen , 2011). However, this data will be different as it is more descriptive.

Researchers who lead 'purposeful' interviews or focus group meetings describe them as having one of two key components, "ethnographic" and "emic" (Shaoming & Huifen , 2011). They describe two contrasting ways in which such meetings can be conducted. From one viewpoint, it is recommended that questioners do not contribute their own ideas and avoid any attempts by participants who ask for their opinion. This approach is based on the assumption that both questioners and respondents are "faceless and invisible" and that this will prompt a significant amount of unwanted data. This also has the disadvantage that much of the data will be less valuable. For this reason, it is now held that researchers should use an interpretive method of focused questioning and take part in a genuine discussion between equals, with 'give and take' on both sides to facilitate a true understanding of the topic under discussion. This type of meeting will, therefore, yield more genuine and dependable data as individuals are enabled to express and clarify their opinions through dialogue (Shaoming & Huifen , 2011).

In light of the above, the researcher decided to proceed with an open/interpretive method when conducting interviews with those recruited for this study. Further detail regarding this decision now follows, together with what constitutes effective interviewing.

There are various factors to consider when utilizing interviews and focus group discussion as research strategies. In the first place, they may be setting delicate. Given that my focus is on undertaking research in a specific setting (SA) it would indicate that meetings organized in the same setting under scrutiny would be most appropriate. Such meetings between participant and researcher are particularly useful when attempting to illustrate and translate the perspectives of people and their different world perspectives and contrasting social practices (Kitzinger, 1995).

This is my own favoured research approach as it also yielded data that covered what was said and the way in which it is said and so foster participant's subjectivity. Focused discussion has the potential to capture differences and heterogeneity and subsequently to be a more tried and tested strategy for research into culture or multifaceted issues. Fontana and Frey (1994) laid strong emphasis on the requirement for understanding the dialect and culture of the respondents as a means of conducting successful research interviews. The researcher has the benefit of being able to speak the dialect, and to understand the local social vocabulary to enable him to establish mutuality with respondents and a fuller understanding of their contributions (Fontana and Frey 1994). Finally, the researcher, wanted to undertake the meetings, as prompted by Straddle, with the utilization of local dialect in order to reduce the ethical concerns and raise the self - esteem of participants.

Data were collected during two trips home to SA and were set up and ethical approval and other permissions agreed in advance. Whilst this was successful it was also challenging to arrange everything at a distance, and also to attend all my classes in Cardiff.

4.7 Data analysis

To achieve familiarity and comprehension, the researcher read the transcribed documents thoroughly and repeatedly as well as listening innumerable times to the recorded interviews. This is a necessary process for data analysis. Subsequently, the researcher summarized the transcribed texts and produced a reduced script with socio-demographic data highlighting pertinent points made by each participant. This technique enabled the researcher to capture the individual accounts and personal meanings of their nursing experience in relation to gender, marital status, tribal affiliation, employing hospital, service sector and educational background. To aid data analysis, the researcher attempted to use the NVivo which it claims features new and improved functions. Unfortunately, this software did not prove helpful, so the researcher used code-based manual analysis of the data, using Microsoft Word to avoid any possibility of failure of NVivo software while dealing with scripts.

Coding was used as a technique of data reduction and a way of interacting with, and thinking about, the data. Patton (2002) emphasized that "analysis is the interplay between researchers and data, so what qualitative descriptive theory offers as a framework is a set of coding procedures to help provide some standardization and rigor to the analytical process" (p. 127). The intent of the analysis was to reveal categories and obtain themes. Upon completion of each interview, data was organized into initial categorise with segmented information reflecting emerging competencies. This process is called coding (Creswell, 1998). With a combination of a well-defined research question, clearly stated research objectives and semi-structured in-depth interview techniques all the topics suggested by the literature were covered and the

researcher was enabled to complete the data reduction phase of the analysis (see Appendix J and K).

4.7.1 Analysis and writing approach: Thematic analysis

Thematic analysis is a method for identifying and interpreting patterns of meaning across qualitative data (Braun and Clarke, 2006). In data analysis, the researcher used thematic analysis approach described by Boyatzis (1998), who said "thematic analysis enables scholars, observers, or practitioners to use a wide variety of types of information in a systematic manner that increases their accuracy or sensitivity in understanding and interpreting observations about people, events, situations, and organizations" (Boyatzis, 1998, p. 5). Thematic analysis is an inductive method for coding qualitative information and it has included procedures like discovering themes and sub-themes, organizing or sorting important themes, building hierarchies of themes and linking and building themes into relational connections. Using these procedures, the researcher read and reread and coded the data to answer the research questions of the study. The researcher encountered some difficulties when undertaking this initial examination of the data as some responses were brief and lacked depth. Therefore, it was suggested by the researcher supervisors to review the study approach, collect additional data and to make the interview and focus group prompts more conversational.

The researcher decided to proceed with conducting interviews and focus groups in the way that was suggested and to find evidence to confirm this was the best way to proceed. This was successful and responses became more extensive and the researcher had more information to work with during the analysis. Researchers may deduce a thematic pattern by various routes but in general a theme emerges that is an expression

or sentence that encapsulates what really matters in a unit of information or alerts us to its implications. The transcript of each interview was marked every time the study participant state or describe a feeling, or a thought or action they had, during their daily work events. The action, thought or feeling was paraphrased to succinctly document the behavior. This is the first step in a process described by Boyatzis (1998) as thematic analysis. Thematic analysis provides researchers with a way to organize and analyze qualitative data. The end result is an organized pattern of descriptive information.

A further explanation behind my inclination to begin with high level thematic examination is that, unlike content investigation which may start with predefined classifications, thematic examination enables themes to emerge more openly out of the information collected. Such themes may emerge as possibilities or even plausible explanations as to what is occurring in a given situation. Thematic analysis as an independent qualitative descriptive approach is mainly described as "a method for identifying, analyzing and reporting patterns (themes) within data" (Braun & Clarke, 2006: 79). At this point it seemed appropriate for the researcher to illuminate the comprehension of the connection between subjects and accounts given by them of leadership in SA.

From this high-level analysis of the transcripts the researcher moved to a more focused approach bearing in mind the dimensions of leadership as previously discussed, the cultural context of SA and the cultural competence dimensions described earlier. The researcher started to transcribe the interviews, and obtain the sense of the whole through reading the transcripts several times. Then he developed themes (Appendix K) and proceed to the next stage of data analysis. Open coding, under the

classifications of generating initial codes, defining and naming themes, reviewing themes, and searching for themes. The final stage of data analysis was related to reporting the result of the previous stages. This stage is especially highlighted as the final opportunity of data analysis in thematic analysis. in addition, the researcher tried to use his creativity for presenting the result. It is noted that high quality data analysis depends on gathering high quality data, therefore the researcher tried to conduct data gathering in such a way that any data would be suitable to present interesting findings. After data gathering and transcribing and paying particular attention to respondents' emotions besides their behaviors, the researcher tried to immerse himself in data in order to obtain the sense of the whole through reading and rereading (Polit and Beck, 2003).

In order to be able to thematically analyse these different sources of data I used the six-phase process for thematic analysis suggested by Braun and Clarke (2006). These phases are; 1) Familiarizing myself with the data and identifying items of potential interest 2) Generating initial codes 3) Searching for and developing themes 4) Reviewing potential themes 5) Defining and naming themes 6) Producing the report.

In the first phase, I familiarized myself with the data by immersing myself in the dataset by reading and re-reading the data in the transcribed interviews and listening to the audio recordings of the interviews and focus group interviews. (I had listened and transcribed the audio recordings as part of the study).

Thus, I was able to become familiar with the content of the dataset very well. During this phase, I gradually started to identify, and record, potentially interesting features of the data, relevant to the research questions. The second phase in the thematic analysis process was systematically coding the data to generate initial codes. A code

is a label that captures something interesting about the data: codes in thematic analysis are very like initial codes in grounded theory according to Charmaz, (2006). During this phase I also aimed to identify potentially meaningful extracts from the data and ended this phase with the compilation of a list of codes, and collation of all the data relevant to each code. In the third phase I began searching for, or developing sub themes, the researcher shifted to a wider focus and used a broader pattern while searching and development of sub themes across the coded data. Afterward, similar codes were clustered together and organized into main themes. The researcher in this phase relied on his own analytic judgement about what is meaningful and important for answering the research question. Some codes and themes were discarded, because they did not fit the developing an analytic narrative. A theme identifies a meaning patterned across the dataset, which is important for illuminating the research question (Braun and Clarke, 2006).

The fourth phase was reviewing potential themes, the researcher checked that the themes captured the important features of the coded data relevant to the research questions, then the researcher read through of the whole dataset to check that themes worked in relation to the study goals. I ended this process with a final set of themes. The fifth phase was the process of defining and naming. In this stage I selected data extracts that would be used in the final report develops and builds the analysis into a form that addresses the research questions. I tried to give themes names that are informative and engaging, and used short data quotes that captured the essence of a theme used. Producing the report was the last phase of a Braun and Clarke's (2006) process. In this phase, I had the opportunity to refine the analysis and determined the order in which the themes were to be presented. In the end, I tried to tell the rich and

complex story of this process of text analysis that helps to describe the relationship between the Saudi culture and nursing leadership practice.

As the researcher, I completed this process with a set of main themes and sub themes that are discussed in the following chapter.

4.8 Ethical considerations

When gathering data in the pursuit of any research it is important to consider the ethical issues that may arise and how to protect the individual when disclosures are made. It is vitally important to consider the moral implications of any research and this would include the obligation to ensure that the rights of any research participants have been protected and their anonymity guaranteed. As participants were invited to participate in the study (Appendix A) and asked to sign a consent form that outlined their role in the study and assured them of their anonymity (Appendix B, C, D). All participants were guaranteed full protection of information exchanged during the interview process. Creswell (2002) suggests protection of information can be achieved by coding all interview documentation. A respectful manner is also vital when undertaking qualitative research as without the trust of participants, data collection will be very limited.

A moral code can be considered to exist globally but the application of this code must be formalized and proven to be upheld. This code will undoubtedly include the protection and consent of respondents when recording equipment is used and subsequently analysed. Regarding this it is noteworthy to consider statements of assent and protection (Gill & Johnson, 2002). To explain this issue, the respondents needed to be in full possession of the facts regarding the aim of the research and how the data that was produced was going to be used and disseminated. They needed to have the

opportunity to ask questions of the researcher and fully explore any issues relating to their participation so consent would be fully informed. They also needed to have concrete reassurance that their confidentiality would be protected and that they could freely give their consent to participate or decline (Campbell and Smith, 2010).

I was also guided by a comprehensive Cardiff University ethical framework that all postgraduate students must abide by and I had the opportunity to be guided by the School Research administrator and to talk through, and be made aware of, ethical issues that required consideration so any pitfalls could be avoided.

In this review of the key ethical issues, I reflect that my first thought was of the sensitivity of the topic and the need to guarantee the confidentiality of what was discussed in the meetings. To this end all respondents were clearly informed as to the purpose of the research and how the findings would be used and disseminated. They were guaranteed that anonymity would be protected, and their confidentiality would be upheld both regarding themselves and their colleagues (Neuman, 2003). Only when I was clear they fully understood the research and they were absolutely reassured what would be the outcome of them sharing information about themselves and their colleagues, did I proceed to obtain their consent. When this was obtained, and the meetings commenced, I continued to give reassurance and answer any questions that arose regarding this issue. In the midst of a meeting I was careful to respond sensitively and without judgement to the views put forward and answers given. Occasionally I sought clarification about the responses of a participant, but I was diligent in not allowing my own views to encroach on the proceedings. To the best of my abilities I protected the participants from these during the planning and execution of my field work.

To fulfill the ethical principle of protecting study participants from any harm arising from their involvement in the study approval for this study was obtained from the General Directorate of Medical Research, MOH in SA and from the Research Ethics Committee of Cardiff University School of Healthcare Sciences (SOHCS). Each participant was given a 'Participant Information Sheet' (PIS) which explained the purpose of the study; set out their rights; confirmed whether they had chosen to participate; introduced the interview approach and focus group process; explained the consent procedure for consenting and the use to which the data was to be put (see Appendix A, B, C, D). It also explained that information given by participants would be anonymous and that confidentiality would be ensured. It provided the researcher's contact details for any enquiries and a further contact in the School was given that the participant could contact if they had any complaints or issues with the study/researcher.

The PIS clearly stated that, by completing the interview and focus group discussion, the participant was giving permission for his/her information to be used for research purposes. The researcher also made sure that the PIS provided enough information for participants to make an informed decision. The participants were advised about the voluntary nature of their participation in the research and the fact that they had the option to refuse their consent without any consequences (Neuman, 2003).

Interviews and focus groups were carried out in rooms within the hospital and a digital recorder was used to ensure accuracy. All were conducted in English, to prevent the need for translation, and they were transcribed at a later date; and checked for accuracy by listening again to the recordings.

4.8.1 Confidentiality

To ensure confidentiality, only the researcher and his academic supervisors have access to the data regarding the names and demographic information of participants (Neuman, 2003). The results were presented in an anonymous form so that no individual response was identifiable. A statement of confidentiality was included in the Participant Information Sheet. Electronic data and paper documentation was securely stored using SOHCS at Cardiff University and will remain there until its destruction occurs at the end of the holding period.

4.8.2 Reflexivity

It is important that some degree of reflexivity is incorporated and acknowledged in this method chapter due to the researcher's background and his position as the Director of Nursing Training and the Acting General Director of Nursing in MOH, SA. Reflexivity entails the researcher being aware of how his presence affects the process and outcomes of research based on the premise that 'knowledge cannot be separated from the knower' (Steedman, 1991). In carrying out qualitative research, it is impossible to remain completely outside of our subject matter as our presence, in whatever form, will probably have some kind of impact.

Different researchers will approach a study situation from different positions or perspectives. This might lead to the development of different, although equally valid, understandings of the situation under scrutiny. Whilst some may see these different ways of knowing as a reliability problem, others feel that these different ways of seeing provide a richer, more developed understanding of complex phenomena such

as cultural influence on nurse leaders in SA (Glesne, 1999; Merriam, 1998; Russell and Kelly, 2002).

To overcome possible bias in this study the researcher tried to mention any preconceptions he had with a separate verification group of nurse leaders. This group participated in one meeting and helped with a discussion of the analysis and identification of current views on leadership and training needs, as well as discussing possible implementation strategies for such training.

The researcher also kept a reflective diary and completed this following each interview and focus group, to reflect on whether his position may have influenced data collection. This reflection was included as part of the analysis (See Appendix J).

4.8.3 Research validity and reliability

Legitimacy and quality are vital for the dependability of any research study and I have learned this during my studies at Cardiff University. The researcher is charged with employing a dependable research method (qualitative or quantitative) and to gauge the authenticity of information and nature of the subject being explored. Legitimacy requires that any gathered information comes from a genuine source and the variety of different methods enhance quality (Fischer, et al., 2008). Analytical legitimacy is concerned with reality and established on the premise of such quality. Quality is also demonstrated to examiners by the precision or consistency of the information and the defense of the topic under scrutiny. It is difficult for researchers to always ensure the issue of quality, however, given the subjective nature of the qualitative information obtained and as the researcher was always reliant on the participants, and what they said during our discussions (Fischer, et al., 2008).

The aggregate information that was accumulated and collected from all the sources, such as semi-structured interviews and focused group discussions, was considerable. The content was then analysed thematically and summarized in main and sub-themes in order to understand the relevance of leadership style, culture and Saudi Nursing leadership; and to strengthen the conclusions and the results of the research.

4.9 Limitations

Generally speaking the limitations of any research are those of time and space. This was a challenging experience but a very relevant topic so I felt motivated to continue, even though I was dealing with a second language. This was not a limitation as such, but it did challenge me to write in a way that was clear to all.

How qualitative data analysis is undertaken is particularly significant when questions of reliability are posed. Data collection made at the time, such as notes and tape recordings may be very hard to interpret after the event and its interpretation may appear to be highly subjective when the researcher has blended again into the midst of a group. This was certainly true for me but Creswell (2009) examines well the challenges of data collection in such an environment.

In order to clarify my position, I will explain how my thinking was altered in the course of my research experience. Maybe as a matter of primary importance, one ever present research limitation is the personality of the analyst and the part that this plays in the research process at different phases. It is a fact that no perfect strategies exist but nevertheless the researcher attempted to make a design fit his specification for a method that may help answer the questions he was posing and the answers he was

seeking. This study was exhausting and difficult, though, the researcher tried to be very careful and try avoids errors when undertaking research.

Being a student from SA meant that language conveys considerable significance in a study conducted in the English language, while the researcher (me) and the investigated (respondents) are non-English. Practically speaking, and regardless of how compelling both researchers and respondents are, competency in English is going to remain a challenge as comprehension and familiarity with the language may be variable, and this will result in lack of clarity or meaning at times (McDowell & MacLean, 1998). In addition, interviews tend to occur in different social settings. This is affirmed by Converse and Schuman (1994) who suggest there is no single data collection style that fits each event, or all respondents. As a direct result of all these contemplations I am inclined to consider the conduct of qualitative research for me to have been challenging, but also a unique and fascinating learning opportunity! (McDowell & MacLean, 1998).

4.10 Conclusion

This chapter has summarized the methodological approach to the study and presents an overview of pertinent issues considered when planning a study in SA. The benefits and challenges of qualitative/subjective approaches have been considered, and the ethical and methodological decisions have been described. Semi- structured interviews and focused group discussions were the main research tools used and these were informed by a consideration of ethical issues, research methods, sampling techniques, theoretical background and primary and myself as a researcher working in a second language.

I now present the findings, presenting the views of my participants in a way that answers the research question outlined at the start of this thesis.

CHAPTER FIVE: Findings

5.1 Introduction

This chapter presents the results from the data, including the explication of themes and subthemes that have emerged from this process. With a total of 46 participants involved in the interviews, 30 of these participants were equally distributed amongst six focus groups. The remaining 16 subjects were interviewed separately. The selection of participants was based upon their experience and hierarchical status within their field of practice; this is detailed in Chapter 3. Table 3 shows the characteristics of all participants included in the interviews.

Three main themes emerged from an analysis of all the transcripts created during this study. They are: 1) Gendered Aspects of Nursing in Saudi Arabia. 2) Unique personal leadership qualities. 3) What works?

These will be expanded upon throughout this chapter of findings. In addition to these 3 *main themes* and 24 *subthemes* were identified throughout the data collection and analytic processes. The thematic map of the first main theme, gendered aspects of nursing in SA, shows an overlap with all other themes, and there are also interconnections between all the findings. The symbiotic nature of these themes is significant and the structure of this map is designed to highlight the co-existence of such inter-related thematic findings.

Each theme will be examined herein. The structure of the data presented to illustrate each theme and the relationships that have emerged between them, including the individual subthemes, will help to generate the final outcomes from this study. The

explanations provided will also draw upon verbal excerpts taken directly from participants' perspectives. The below diagram (Figure 13) clarifies themes and sub themes and how they relate to research questions.

Research question	Theme and Subtheme
1- *What is the nature of the relationship between culture and the leadership style of SA nurse leaders in practice?*	• What works? • This works • No superwomen • Working with conflict • Knowing Culture • Language courses for working in SA • How to deal with conflicts • Manager's solutions • Gender aspects of nursing in Saudi Arabia • Status • Culture influence
2- *What are the qualities that nurses in SA need in order to be identified as culturally competent nurse leaders?*	• Unique Personal Leadership Qualities • Respect & Trust • Effective communicator • Challenger • Flexible • Motivational • Role model • Visionary
3- *How does the changing nature of healthcare in SA impact on their role and leadership style?*	• Gender aspects of nursing in Saudi Arabia • Status • Culture influence • Ideal Vs Reality • Played out in practice • Expatriate Vs Local • Refusal • Challenges • Managers' authority and solutions
4- *What training do nurse leaders in SA need in relation to their present role?*	• Language courses for working in SA • Knowing Culture • Education and experience • Culture competence training • Ideal Vs Reality • Training

5- *How might training and development best be delivered?*	• Culture influence • Education and experience • This works • Ideal Vs Reality • Played out in practice • Managers' solutions • Training

Figure 13. Themes and sub themes to research questions.

5.2. First main theme: Gendered Aspects of Nursing in Saudi Arabia

Participants in this study had repeatedly raised the issue of the gender-based segregation inherent to Saudi culture, sanctioned by society and enforced through government structures. Examples of this segregation cited by the participants include the prohibition of interaction between the sexes in public spaces and the assigning of different physical areas for males, females and families. Women are not allowed to interact or work with men they are not related to in most settings; especially in a health care context – unless out of necessity. Participants also brought forward the issue of the prohibition of women from driving cars in SA, with Saudi women dependent upon either close male relatives or expensive private drivers to convey them to work. Although this law has been altered during the course of this study, driving was identified by participants as a key factor in female nurses' absenteeism.

Responses indicate that gender issues appear to be a major concern in relation to nursing leadership, especially in health care settings in Saudi Arabia. A number of participants from various cultural backgrounds endorsed gender differences in SA culture as the primary cause of workplace difficulties in health care settings. The varying responses of respondents were compared and contrasted, using interview and

focus group transcripts. Similarities, differences and patterns amongst the transcript summaries were grouped together, then identified and labelled as pertinent to the theme of gender and presented in the following diagram (Diagram 13. The theme Gender and its subthemes). This is explained in following pages.

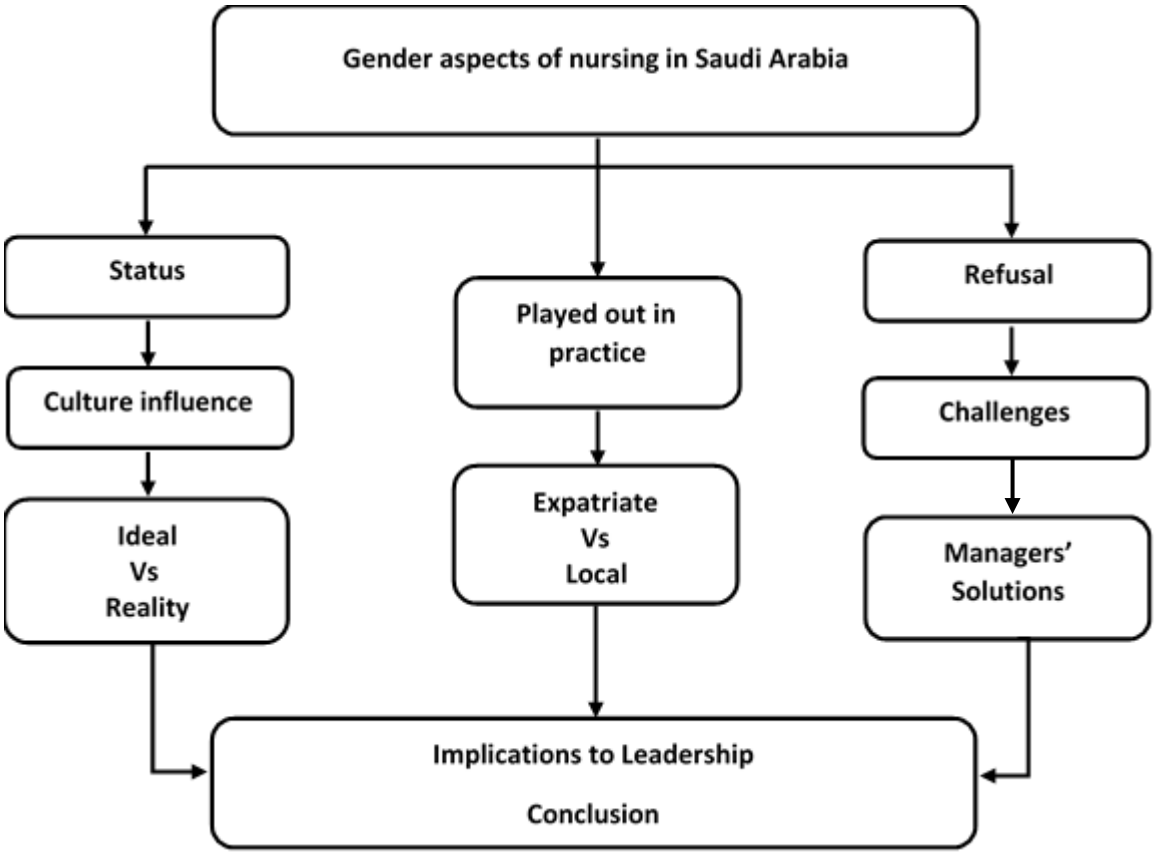


Figure 13. The 1st main theme: Gender and its subthemes

Sub-theme 1: Status

Participants' responses shaped this subtheme, which pertain particularly to nursing hierarchies and their connection to gender in Saudi society and health care. The

nursing profession traditionally has been viewed as "women's work" (Kelly 2016). Some societies, including the SA context in question, actively forbids the mixing of genders in the workplace and women do not direct men in these contexts. Participant P18 stated that although there are changes are taking place in SA culture regarding health care in general and nursing in particular, the image of nursing is still perceived negatively. The community is still not accepting of Saudi females working side by side with male colleagues. The participant also said that this cultural view towards nursing and female nurses affects the reputations of those Saudis who work within the profession. They added that an enhanced awareness regarding nurses and the nursing profession should be promoted within the community in order to remove the stereotypical views held within Saudi Arabia regarding nurses, both male and female:

(P18): *Saudi culture still has a negative image of female nurses and how they work with men. Actually, the reputation of nursing in Saudi culture is generally still low. We need to increase awareness of the nursing profession in society and work to improve the image of nursing in Saudi.*

The culture of this society entails a marked gender preference when considering certain positions, such as leadership roles. This is what Participant P11, a female nurse leader in KSMC, articulated. She stated that men were well represented in leadership positions due to the cultural norms that society held regarding gender differences. It was also clear from this statement that Saudi women do not enjoy the same social benefits and freedoms as Saudi men. Participant P11 referred the origins of this situation in the way that children are raised in SA and that the family shape the thoughts and personalities of the children as they grow up and become a part of society. She also stated that her family raised her to be a leader, as she was taking the

responsibility within her family from early age. However, the community is more disposed to perceive of men as leaders, therefore it is rare to see women in leadership positions:

(P11): *Saudi culture influences leadership greatly; we as Saudis always think that men are better leaders than women. Although some women make better leaders than many men, that maybe originates from the way she is raised in her family and the personality she has developed by leading her family in their own house. But in our SA community, men are more appreciated as leaders and therefore it is rare to see women in leadership roles.*

Along with society's views on the nursing profession, believing it to be a 'female' job, P9, who was a male nurse leader in KSMC, stated that this view is not just relevant in the Arabian region or exclusive to SA culture. He emphasised that this goes back to the beginning of the nursing profession, and from the Western culture where nursing originated. Proffering an interesting point of view, participant P9 described the community as a causative element to the current status of the nursing profession. This participant discussed how cultural norms shaped nurses behaviour, especially female nurses, as the Arab community insists upon full respect for and obedience to the husband. Therefore, female nurses may behave as subordinate to males in the workplace, which will, in turn, also influence their leadership abilities:

(P9): *The concept of the sister comes from the Christian region and the concept of nursing was created or developed by Christianity. Here we have an Islamic culture. There are contradictory issues there. In addition, nursing in general is a feminist profession and in general,*

females in SA or at least, females in Arab communities – they belong to their males. Some level of their freedom should already have been delivered by their male. This has had an impact on female nursing leaders. In general, as regards feminism, if we are speaking of the highest level of nursing in Saudi Arabia, she is a female. If she wishes to leave SA, she has to get permission from her husband. This in turn effects how she deals with other males within her profession.

Sub-theme 2: Cultural Influence

As discussed, cultural influences play an important role in influencing leadership and gender discrimination. Participants' responses present the view that inherited cultural traditions still influence attitudes in SA today, particularly regarding nursing leadership and gender.

Participant P19 stated that the Saudi culture has a strong historical basis; however, these cultural beliefs still shape society's view towards women and their work. He said that women were usually not allowed to work away from home. Nowadays if women are allowed to work at all, they work only with the same sex and do not mix with males. Permitted professions include teaching at all-girls' schools, for example.

(P19): *As we know, the Saudi culture is based on traditional cultural beliefs, because before, women were not allowed to work outside their house. There are still restrictions because if women today do have jobs, they have to be in fields considered appropriate for women – like teaching, but not for the opposite sex.*

Participant P13, who is a female nurse leader in KSMC, believed that the family is more important than society and that the family influences are stronger, as they can empower children and raise them to challenge traditions and cultural norms, and become successful despite negative and pervasive societal judgement. Nevertheless, she also described society's view towards women and towards the nursing profession in similar terms. In SA culture, nursing has been understood as an extension of the physician's role and nursing graduates may not feel so proud of their profession. Saudi nurses distance themselves from nursing because female nurses were viewed as subservient to the physician and second-class citizens in a culture where honour is strongly linked to status and profession. This view remains a constant challenge that resulted in participant P13 struggling to prove herself as a competent leader:

(P13): *I believe that my family have more influence; they empowered me and raised me to be independent. In work, the Saudi culture looked to female as inferior and the nursing profession also was looked at the same way. I struggled to show myself as a competent nurse and as a leader. I can learn and understand and I am no less than any doctors.*

Similarly, Participant P21 shared the view that the culture of SA was responsible for making her feel inferior, which she found to be disappointing:

(P21): *Being a woman, sometimes I feel that the culture of Saudi Arabia considers women to be second-class citizens.*

Participant P21 made a statement describing what may be considered an extreme reaction from the community towards women who do work as nurses: this participant asserted that many Saudi nurses do not marry because men view them with antipathy. It is not just an abstract view held by society; it directly affects the lives of female

nurses in SA as their vocation may deny them the opportunity to marry and build a family. Their work, with male health care providers and the care they provide to male patients, is considered to be a 'black mark' against them. According to participant P21, society may also make judgments regarding behaviour, often assuming personal or sexual relationships taking place between SA female nurses and the other male members of the health team. Such assumptions will inevitably lead to the female nurse in question being viewed as sinful, denying her the chance to marry:

(P21): *Also, we have a lot of Saudi nurses who are single, not married at all. Why? Because the Saudi males dislike marrying female Saudi Nurses. They ask: why are the handling men inside the department? Why they are doing rounds with male doctors? They are building interpersonal relationships with them.*

The same participant P21 offered further anecdotal evidence gained from her experience to support this opinion. She said that families may also prefer their daughters to not work as nurses. She added that it is not only family the female SA nurse will struggle with, but also potentially visitors to their patients. Those visiting members of the public admitted to the public may speak harshly to the nurses and are, at times, verbally abusive towards them:

(P21): *Female nurses are facing resistance from some parents and actually, there is a lot of harsh verbal abuse that they are receiving from visitors. All of these dimensions have a negative impact upon their personality and how they handle their work.*

On the other hand, this participant P16 did not think that SA's culture always had a negative impact on the female SA nurse ability to function, either as a leader or as a

nurse. That being said, the culture in SA is undoubtedly strict and puts a lot of pressure on female nurses as they are prevented from speaking to male health team members on an equal footing:

(P16): *The traditions that SA has may be affecting the development of leadership, especially in female leaders. As you know, the culture here is strict and it may prevent from women moving freely and speaking loudly with the opposite sex.*

Again, we can see how SA culture is viewed as one of the main limiting factors for female nurses. Participant P19 thought that the culture and social norms of SA may prevent women from having any job at all which requires them to work side by side with the opposite gender. The participant added that even if they do have the opportunity to have such a role, culture might still prohibit their advancement into positions of leadership. They justified this view by saying the shift patterns of nursing staff means that female nurses must be outside of their homes for longer than may be considered permissible; particularly if they are working night shifts. Absence from the family home at night may be particularly unacceptable to more conservative families and partners:

(P19): *I think that is one of the features that holds some nurses back from becoming leaders -that it eats up so much of their time. They will be a way for so many hours from home and some are asked to do night shift or evening shift.*

The participant P11 was a Saudi male nurse leader who held a position in nursing administration within KSMC. He described an unfortunate conflict he experienced at work between himself and a female colleague, and he held SA's strict culture

responsible for preventing men and women working together as professionals. Some people in Saudi Arabia believe that female nurses must be restricted from interacting with male nurses on religious grounds. As a result, they often ignore the positions of individuals within the profession, both men and women. Religious and cultural expectations are being enforced upon the workplace and this can result in conflict. It may also lead to a context where male and female nurses are unable to communicate with each other openly and effectively, as seen in P11's interesting account of his experiences:

(P11): *This is a story of what happened to me when I was promoted into nurse leadership in this hospital. A nurse – a female nurse- and I used to communicate well together. I was regularly referring to her, asking about what happened with various patients and so on. As a result of my role, I needed to meet with her daily. After some time I received a call from Legal Affairs, who were launching an investigation into my conduct. They asked me: what kind of relationship do you have with X female? I told them that she is my colleague and my role necessitates regular meetings with her. They informed me that she was complaining that I was harassing her. I asked them what type of harassment. They said it's not verbal, it's not physical, but it's harassment. When I asked them what they meant exactly by harassment, they told me that she is complaining because I was calling her to my office. However, as you can imagine, my door was kept open all the time and there is a secretary outside my office. In addition, it was not a closed area. Nevertheless, she still insisted that it was harassment and that it will affect her as a female. I am working here, I am a male within a majority*

of female workers. So, the Saudi culture is affecting me personally as I cannot communicate personally and equally with female nurses. So, it's not an easy issue for me. I was very shocked by this and have had to be more cautious. Now if I need to call a female nurse I will call two of my secretaries with her because as a result of our culture, it is not easy for a male to speak with a female in a closed room.

Another aspect of the culture that influences female nurses in terms of possible leadership development is that in SA, the covering of a female's face in front of men who are not related to her, is an imposed rule. This is called the Vaile; the Vaile is a very common part of the dress for women in Saudi. Participant P1 is a nurse leader from South Korea. She mentioned that she believes female SA nurses are not reaching their full potential when they are veiled. She also stated that on the rare occasions where Saudi female nurses are seen unveiled, they seem to enjoy this and their true personalities may be seen more visibly:

(P1): *Because we always see each other at work. So outside of work it is a great opportunity for us to see the girls without ''abaya'' [female body covering in SA] and different shapes, different personalities which are not shown in the workplace. Therefore, this experience was a good opportunity for me.*

Continuing to expand the impact of culture on this theme, Participant P7, a Saudi female nurse leader, explains how culture can shape a nurse's behaviour and their reaction to a certain situation. She believes that nurses should provide emotional support to patients as part of the holistic care provided, regardless of the patient's gender. She feels that although empathy and psychosocial care are highly valued by

nurses, SA culture may prevent nurses from actively practising such components of nursing care. In SA culture, it is acknowledged that it is not allowed for a woman to touch a man if he is not a close relative, and vice versa. As the participant, P7 expressed in her statement:

(P7): *Like in ICU, I saw one patient, and really, he wants some Muslim to touch him. Therefore, I just wanted to give him a hug, but I could not. I wanted to cry, because I could not do that.*

Interestingly, participant P23, who came from India, declared that it was not only Arab culture that looks at the female nurse through a lens of discrimination. In India, she asserted, it is common to view female nurses who provide nursing care for male patients as evil women. She continued that society viewed a female going out at night as a bad person, even if she was going to her work place in a hospital to provide nursing care to those in need. She also added that when a nurse deals with patients who needs hygienic care that involves cleaning and showering, the nurse is considered inferior in her country and looked at in this way:

(P23): *When I was small, I was hearing that, 'Yeah, she is a nurse. They look like bad women.' 'Oh, she's going to the night duties'. This is not good. Even today many Hindus see the nursing profession as something bad. They are dealing with waste, things like that. Still now, in India, it is going on - but here I do not know.*

Family shapes culture in SA, according to Participant P2. She considered the family as the basis of an individual's decision-making, especially when considering nursing as a profession. In order for a female in SA to study nursing, or to work in a hospital, she would need the support of her family and to be able to assure them that she will

work within the inscribed boundaries of her community. She needs to make sure of this in order to keep her job:

(P2): *In my opinion, I think it would be possible for Saudi female nurses to join nursing school and work in a hospital only if they promise their family that they will work within the boundary of the traditional culture and within the religious and social norms. I think it would be possible then them to be allowed to join nursing profession, nothing is impossible as long as I do not forget to keep my promise.*

However, the next participant, P29, believes that women should not have full freedom to do whatever they want, but should have the right to make choices in their own lives. She explained that in SA culture, the family plays a significant role in woman choices; including education and work. She also placed responsibility onto the family's involvement in female family members' decisions. In this way, the family is also responsible for gender discrimination as they allow male family members to make decisions freely whilst controlling the choices of the female members:

(P29): *I think if the family lets their daughter make decisions, she will be strong and confident in future, but that does not leave her free. No, no. Sometimes in SA culture, some families discriminate between genders and deal differently with male and female. If this is the case, she cannot really make any decisions.*

Sub-theme 3: Expectations vs Reality

The subtheme was created to collate participants' responses pertaining to the conflict between expectations and reality in the experiences of nursing in general, and female nurses in particular, within the SA context.

Participant P1 stated that when a person commences the studying of nursing, they must be aware that this means providing holistic care to all of those in need, no matter their gender, race or creed. This the same in nursing education everywhere; even in Saudi Arabia. Male and female nurses are made aware that they will have to look after patients of the opposite gender, and work with colleagues of the opposite gender, whilst carrying out care. Therefore, participant P1 questioned: why would nurses who refuse to provide care to patients of the opposite gender take up nursing for study and as a career from the beginning:

(P1): *My question for such nurses is: why are they working as a nurse? When they are studying, they know they are studying nursing. It is about helping the patient whatever their gender.*

Participant P12 attempted to answer this question personally. They articulated that the family plays a key role here; when a woman takes up nursing as a profession, the family may agree for her to study nursing, or whatever she wants to study. Yet when it comes to work, the family then influences and instructs their daughter to work only with the same gender and to provide nursing care to female patients only. These women may then be pressurised to work only in the female departments and never take night shifts:

(P12): *Well, the family sends them to study. Let her study as a nurse but when it comes to the job, she's told to work with females and do not work with males, go with day shift, do not go with night shift.*

The following participant P17 referred to the situation where SA female nurses do not provide nursing care to male patients and do not do night shifts. She believes that the weakness of their English language may be detrimental to their lived experience as nurses. As the world has become interconnected though a process of globalisation, the number of people living and working outside of their native countries is increasing. Therefore, those in the workplace are increasingly expected to interact with people from diverse cultural backgrounds; often this means people who speak different languages, lead different lifestyles, and come from widely disparate belief systems and cultural backgrounds. When SA nurses interact with foreign nurses, they may struggle to operate in English and this is contrary to their expectations. The need for SA nurses to improve their English proficiency may be a further detriment to their potential for leadership development:

(P17): *Compared to our study back home, I think in Saudi Arabia your basic English is not strong. We speak English in our lectures, workshops, and all over is in English. But English is not our mother language, so before studying we have difficulty in talking English but with practice, we can talk not perfectly but we can explain and solve our own problems. Therefore, with studying and practicing I can tell you we have less difficulty.*

Leadership, however, is based on qualification not gender, according to participant P25. They believed that it is ideal to recruit only qualified nurse leaders whether they

are Saudi or not, men or women, as long as he/she possesses good leadership qualities that help to maintain the provision of ideal nursing care to the patients:

(P25): *We need only to put Saudi leaders in position who are qualified. Someone who can stand up for themselves, male or female. If she is a woman, she should really have a voice because sometimes we see leaders qualified in education but their personality is not strong enough to be a leader.*

Participant P4 stressed the difficulty of having good facilities but poor quality of workers. They said that whilst SA has many advanced hospital and modern health care facilities compared with other countries, it needs to further its efforts in the development of manpower in order to provide optimum health care services. She added that, SA staff nurses need to be trained intensively in clinical areas in order to match the capacity of the staff to the quality of the facilities:

(P4): *If you consider the kind of hospital we work in in Saudi Arabia, it is more modern than we had in the Philippines. You really put a lot of effort into building hospitals in Saudi Arabia. The kind of experience you have in the clinical area is not as good as the hospitals. Saudi Arabia is a rich place, therefore more efforts need to go towards the manpower qualities.*

Sub-theme 4: Played in practice

Although more women are assuming leadership roles today than ever before, the notion of a woman as a leader is still a foreign concept to many individuals in SA, male and female alike. In SA, leaders have customarily been men; women have been under-represented at the highest levels of leadership. Nurse leaders' gender appears to be a major issue in ascribing leadership positions; for example, participant P26 referred to the fact that if a nurse leader is female, staff nurses, especially Saudi staff nurses, reacted to them with less commitment and respect. Accordingly, this means that it is more effective in this culture to assign nurse leaders positions to a local male nurse or a Saudi female nurse who possesses strong personality and a firm leadership style:

(P26): *Women in leadership in SA faces difficulties… Could I say since you said about the culture in Saudi Arabia. It is not our fault to be a woman. Sometimes if they see the leader is a woman, the SA staff will not be committed.*

Another participant P17 shared similar opinions. They mentioned how SA staff nurses usually arrive late to work, and they do not provide proper nor complete nursing care. Indeed, many do not seem to like the work; they are often absent and this will affect the health care provided to patients, besides impacting on the nurse leaders of their units:

(P17): *Some SA female staff are lazy. It is very common here they are coming late, so this is a problem. Sometimes they are very lazy they do not want to do the work, this affects the leaders because the whole staff must be*

in work. Those staff come late, suffer from absenteeism and sometimes they do not like to work. They don't like to finish.

It is understood from participant P21 that it is useful, and sometimes crucial, to educate expatriate nurses about the cultural norms of the country, the city or the community that they are moving to. Some cultural practices may be viewed in a certain way, whereas they could be interpreted differently in another culture. As they come from South Korea, this participant explained that she attended some cultural lectures about the situation in SA:

(P21): *Yes. Because they were giving us a kind of a lecture about Islamic society, how they separate males and females and so how they respect, how they avoid eye contact with the opposite gender, what the female needs in order to go out.*

Another participant, P11, who is a male Saudi nurse leader, referred to cultural diversity in the workplace as creating an environment that embraces diversity and equality. This, he believed, not only attracts the most qualified nursing candidates, but also creates an inclusive environment that helps to assure that the standards of nursing care include cultural competency. Cultural differences can affect patient assessment, teaching and patient outcomes, as well as overall patient compliance. Lack of cultural competence is sometimes a barrier to effective communication amongst interdisciplinary teams, which can often trickle down to patients and their families. He emphasised that this cultural diversity encourages best practice and can show society that it is normal for men and women to work together:

(P11): *I believe that every nurse coming from different background will bring with her experience and insights into patient issues. For example, I will*

call my senior staff and l ask them of some issue new to me. Say they are Filipino for example, they will tell me "We have that issue in the Philippines and in our hospital, we do it this way". that is what we call benchmarking. I believe in benchmarking. It is one of the easiest ways to solve an issue. People from other nationalities can change people's mentalities. Like the example that I gave to you of the Saudi Nurse who complained about me to Legal Affairs. I think in a multicultural environment it can become known that it is normal for males to meet with females in a work environment and it is not harassment or anything sexual.

Sub-theme 5: Expatriates Vs locals

The majority of participants stressed the important of effective nursing leadership in ensuring a high-quality healthcare system; and the professional qualities of nurse leaders are considered vital in providing optimum care. Some of these participants noted that the SA culture might be viewed as the source of the inequality they believe that SA or non-western nurse leaders encountered. They believe that Saudi culture venerates Western nurse leaders regardless of their qualifications and this unfair to local nurse leaders.

The following participant, P21 explains why, they believe, SA culture prefers non-Saudi western leaders. They referred to the fact that non-Saudi or expatriates work hard to prove themselves as good quality employees to avoid being fired. Due to differences in contracts, this is not the case for most Saudi employees. When they are assigned a job by the government, it is difficult for them to be fired and so the threat

of dismissal prompts foreign nurses to work even harder. This can, she believes, also encourages complacency in the local SA nurses:

(P21): *For all those expats who come to work in SA as leaders, they are working very hard just to prove themselves and avoid having their contract terminated. Unlike Saudis, they work hard to keep their job because it is not secured, as you know. If you are not good, they will fire you. If you are good, they will promote for leadership positions. So those who are coming from outside are doing a great job and they are better leaders.*

Another statement by the same participant P21 proffers a view that SA culture prefers and respects Western nurses, such as Americans or Europeans, even if they are not qualified to hold the position. This preference is based entirely on their status as Westerners. She added that even if there is a Saudi nurse who has good qualifications and a competing Western nurse who is less qualified, they will assign the Westerner as a leader instead of the Saudi. She supported this point of view with an example about two non-Saudi female nurses, one from India and the other from Canada. These two nurses were competing for a nurse leader position and the Canadian nurse was given the role despite having fewer qualifications:

(P21): *In our culture, they will respect more those who come from western cultures, America or something. They will respect them even if they are not good, they will still like them. At the same time, if there is one Saudi nurse better qualified than the Western leader, he or she will face disrespect. I will tell you a story of an Indian girl and a Canadian girl*

applying for the same position. The Indian girl is better qualified, but they hired the Canadian girl because of her nationality.

As participants continued talking about the expatriate nurse leaders compared with Saudi nurse leaders, participant P15 provided a good example of the differences between Saudis and expatriates, and how these differences would influence their staff. They used to work in a unit as a staff nurse where the leader was non-Saudi; other staff were hesitated to ask her for promotion as they believe she would not take them for a higher position. Yet when the participant was assigned as the nurse supervisor, the staff started asking for promotions and she was able to pursue them:

(P15) *Before I was assigned as nurse supervisor, there was a Filipino girl who was the supervisor. Her staff wanted to ask her for a raise in salary and other things due to working in a critical area. But they were afraid to ask her because they believed she couldn't help them as she was not Saudi. When I took the position, everyone immediately started to speak and ask for these things, because they believed I could secure them. They were trying to ask for increase in salary and ask for extra things for them because they are in critical area. So, they are afraid to ask her because at the same time they are believing she cannot help them. Because she is non-Saudi. Immediately when I take the position everybody started to speak and ask believing I can do it for them. Alhamdulillah, I can bring it for all of them. I think that they believe in Saudis.*

Similarly, participant P7, who was a non-Saudi nurse leader, stated that SA people have stronger personalities than others, which originates from their culture and enables

Saudi staff nurses to speak louder and have more influence upon their leaders. She referred to her experiences as she has worked in SA for a considerable length of time and has an in-depth knowledge of Saudi nurses. This participant asserted that her Saudi colleagues have stronger characters due to SA culture:

(P7): *Based on my experience as a nurse leader, being here in Saudi Arabia has made me a stronger leader. Because the culture of Saudi Arabia is different from our culture in The Philippines. The personalities of Saudis are stronger, like stronger than any other nationalities. We have to be firmer, especially with our Saudi nurses because most of them… you know, sometimes Saudi nurses have their strong personalities that makes non-Saudis afraid. Therefore, I have to be firm and be on the line of the policy so they can follow me on the right path. Because the culture in Saudi Arabia is different from our culture. Especially as the Saudi nurses here in our hospital do not have much experience. They came with no experience, graduated from private institutions.*

Culture can have a detrimental effect on the provision of care, particularly in relation to issues associated with gender. This participant P14 explained the attitude of some Saudi female nurses who are not committed to work and come up with cultural excuses to avoid providing nursing care to patients of the opposite gender:

(P14): *I have experienced that Saudi nurses often come late, and after that, they say that the assignment is just male. So, they tell me: I do not want to take this patient, I am going home!*

On the same point, participant P21 articulated that some female nurses refuse to provide nursing care to a patient of the opposite sex; some male nurses will claim that

it is improper to provide nursing care to a female patient. In fact, there is no written policy preventing a nurse from providing care to a patient of the opposite gender, so nurse leaders should not accept this cultural excuse when it comes to work. She added that Saudi staff nurses discriminate against their patients according to gender. Moreover, she stated that some Arab (non-Saudi) nurses have learned to use the methods to avoid providing nursing care to patients of the opposite gender. She summarised by saying that discriminating patients by gender may cause conflict in the workplace, as she stated:

(P21): *Yes. Because with non-Arab male nurses, there are no such difficulties in handling female patients or male patients. Since male nurses began discriminating between female and male patients, Saudi or other Arab female nurses have started to do the same thing. So, this is a very different cultural issue which has also caused kind of conflict in the workplace.*

Sub-theme 6: Refusal

Building on what was discussed above, cultural norms in SA may provide a cover for some nurses to be less competent and will lead to a refusal to comply. This subtheme will interrogate this issue more deeply. Participant P22, an Arabian non-Saudi nurse leader, talked about how difficult and challenging it is when cultural norms play a role in the workplace. This person emphasised that they do not have many male nurses to look after male patients and the Saudi female nurses prefer to work in an exclusively female environment:

(P22): *Even with the patients here, we are trying to separate the females from the males, which is challenge for us. As a leader, it is a challenge*

because we do not have enough male nurses. Yes, it is a challenge, because we do not have many male nurses and the Saudi female nurses, they are trying to go for the female areas, not in the male patient areas. So, it is a challenge.

Similarly, participant P19 described the situation but with different causes; she cites Saudi female nurses wishing to work in male only units, but the cultural norms and social circumstances prompting her to request a move to a female unit. According to this participant, one of the staff, who is Saudi female nurse, was recently engaged and had the belief that she should obey her future husband, who did not want her to work with male colleagues or to provide nursing care to male patients:

(P19): *One example. Two weeks ago, one nurse, she came to me, she told me, "I want to transfer from my area to the female observation". She was working in the male observation. I was shocked. I asked her, "Why? You have been working three, four years in the male observation". She said, "I am engaged. My fiancé said to me you cannot work with the male patients now".*

Participant P14 also shared the similar point of view and discussed it from a different perspective within his department, ICU. He stated that female nurses often refuse to look after male patients, but in his unit, it has been 2 years since a staff nurse refused to provide nursing care to a patient from the opposite sex. He said that is due to the personality of his staff and connected it to the leadership, which was able to convince his staff about the reality of nursing care:

(P14): *Female nurses are refusing the assignment for male patients. In two years, I have not heard of a refusal of an assignment regarding gender.*

Actually, this is a big improvement. This is according to culture, according to the personality of the staff. If they can understand that a nurse should provide care for any religion, any gender, anytime and save lives, everybody will be happy.

Participant P28 provided a rather shocking example, however, when she described the refusal of one Saudi male staff nurse to provide nursing care to a little child because she was a girl. She rejects the attitude of that nurse as he discriminated against child patients by their gender, and refuses to accept cultural norms as an adequate reason for this. She added that we should provide care to all patients and look at them as patients only who need care nothing else:

(P28): *What came to my mind was an experience I had in the ICUs. While I was working, very often I faced the situation that male nurses refused to have female patients. I used to work in the paediatric ICU where we dealt only with small children. I wonder why the male nurses consider the girls, small girls, in a different way. They are all just patients. We do not discriminate female patients from male patients and vice versa. We just take care of them as a patient and we do not see them in a different way, which is somehow nasty or filthy.*

Participant P4, a nurse leader from overseas, expressed her frustration with some Saudi nurses agreeing to provide nursing care to patients of the opposite sex but refusing to clean private areas and instead asking expatriate nurses to do this. In addition, she said this kind of behaviour affects the nursing services and affects other staff nurses who are usually busy with other patients:

(P4): *Some Saudi nurses, they're really taking care of the patient, but when the patient passes a stool, they don't want to clean it up because they are male and she is female. Or if the patient is male and the nurse is female, they don't clean it even if she is assigned to that patient. Why can she not do the entire job? She is asking another nurse to clean her patient. But remember, the other nurse also has some other duty and she has to take care of her own patients. But this particular cultural aspect is really affecting the other nurse.*

A nurse leader, participant P13, also said that SA female nurses may refuse to deal with male patients and this causes issues with the nursing services in the hospital. As an Arabic but non-Saudi nurse, he defined himself as "us", in opposition to the Saudi staff, indicating SA culture is the particular source of many challenges:

(P13): *The negative, the Saudi female staff do not deal with the male patients this is a big issue. Unlike us – we [non-Saudi staff] can deal, there is no problem.*

Moreover, the following participant P7 said that she observed that Saudi nurses facing considerable language barriers. He added that they might need a good leader to motivate them:

(P7): *I observed myself while visiting the areas, that they have a language barrier. They do not like to work with the patients. At least a good leader can motivate them. You know the culture of Saudi. As I am a female, I have to be straight also with the male nurses.*

Sub-theme 7: Challenges

Some participants have brought up Challenges as a distinct subtheme of the Gender topic. ‘’Wasta”, or ‘collectivism’ in English, is pressure from the community and relatives asking for help. It is a burden, as participant P1 has stated; especially on the Saudi nurse leaders because they are from a culture that is accustomed to asking for favours from fellow Saudis. Participant P1 explained the pressure they receive from the relatives and sometimes from the administration when they refused their requests:

(P1): *Most of the challenges we face are because we are Saudi usually. It takes different forms. Mainly people, relatives of the staff member, will ask for, as we call it, ‘’Wasta’’. They say: “please help our daughter (female staff nurse), move her to a morning shift, do not let her work with male patients or we will go to the Ministry”. They will make complaints: “she is putting my daughter on night shift!” or the female nurse’s husband will complain: “She is making my wife work in the male department”. The non-Saudi nurse leader may not face this as we do or maybe she will face other cultural challenges. This is Saudi culture and the mindset of the administration.*

The SA nursing staff come from different backgrounds and must provide care to patients from different backgrounds. Consequently, one of the challenges facing nurses is language barriers. As participant P11 has stated, the language barrier prevents the provision of holistic nursing care to the patients, and additionally, there are few or no translators. This nurse leader participant said that as the majority of nursing staff who are non-Saudis they will not be as helpful in this matter; additionally, most of the patients are Muslims and most of the expatriate nursing staff are non-

Muslims, so they cannot necessarily help. Therefore, the only solution they use is providing orientation programmes for expatriate nurses to instill in them basic knowledge about the patients, the society and the SA culture. Yet this solution only focusses on the culture and thus the language barrier remains intact:

(P11): *Having a multicultural nursing work force affects nursing care because of the language barriers and we do not have translators. Nursing care is holistic and we need to reach the patient in many dimensions - religious, cultural, social, linguistic. I think diversity is not helping in this issue because of the language barriers. In addition, they are not helping because most of the patients are Muslims; non-Muslim nurses do not know exactly how to look after patients in religious ways. That is why we have a Nursing Orientation Programme for three weeks for non-Saudi nurses. It increases their knowledge about Islam, how the patient can pray, etc. We can answer their questions, but still we have a problem with the language barrier.*

Nursing team members in Saudi Arabia come from different cultural backgrounds, therefore nurse leaders require a high level of communication with their staff and they should understand the cultural differences to avoid clashes. Participant P23 came from another country where the culture is completely different to in SA; she expressed discomfort with SA cultural strains regarding gender segregation and constrictions linked to religion that prevent female nurses from developing proper communication with their male nurse colleagues:

(P23): *They are separating the genders, males and females. Sometimes we are not getting the freedom to talk to the male person or female person. It*

is very difficult. We are not facing this in our country even where there is Muslims and non-Muslims.

Another major challenge presented is that of absenteeism, as illustrated by participant P13 when he said that there is no clear form of punishment for absenteeism from MOH. Therefore, it is difficult to apply administrative sanctions against those who absent. He added that the number of absences in one month amounted to 1400 cases. They only take actions against those who comes late:

(P13): *Based on Saudi culture, there is no clear guidance from the MOH about the punishment or how to control the problem. Can you imagine, 3 months ago there were 1400 absences in one month? They only take action for late-coming.*

The following participant, P11, emphasised how culture and people's behaviours affects the professional relationships between nurse leaders and their staff:

(P11) *I can sit with any Indian female nurses and Filipino female nurses for example, relax, laugh with them and we can speak loudly regarding work but I cannot do that with female Saudi nurses because they will misunderstand me and maybe they will complain about me.*

Participant P21 contributed his opinion about how male and female nurses' circumstances impact upon their job; he also related these circumstances to the cultural norms of Saudi Arabia. He added that gender differences in the workplace commonly come from social factors, which influence the behaviour of both men and women. They may also come from gender stereotypes related to men and women. For instance, a stereotypical assessment is that women belong in their houses while men should

work and provide support to the wife and family. Stereotypes often lead to gender discrimination in the workplace. He concluded by describing the cultural norms that affect female and also male nurses:

(P21): *Yes, there is a total difference between male and female. Why? The female nurse has a lot of family responsibility and other barriers that make her often absent. When I ask a female nurse why you were absent, she says to me:" I do not have a car, I do not have a driver, and I have a family problem". This is Arab culture. It is related to the leadership positions of males and of females. As a male, I cannot close the door to counsel alone with any female staff, even though I am the head of the unit.*

Sub-theme 8: Managers' Solutions

A nurse leader needs to show care towards people and build strong, effective relationships. Their interactions with multicultural staff must lead to the creation of an understanding and acceptance, and leadership ought to be a conduit for new ways of thinking and interconnection. Managers' or leaders' solutions is about overcoming the differences that hinder personal growth and about adapting new practices to enhance the critical thinking necessary to solve problems in nursing.

Participant P13 is a Saudi female who works as a senior nurse administrator in KSMC provided an account of her solving of a serious problem during a terror attack in Riyadh, the capital of SA. The bombing of compound resulted in causalities. She made crucial decisions within that specific situation and was able to adapt her leadership style in direct response to those circumstances in order to treat patients quickly and effectively:

(P13): *For an example, you remember when we had the terror explosions in Riyadh, I made the immediate decision to send all the male nurses to the attack site to help and keep all the female nurses ready in ER to receive the injured. I could not be a democratic leader at such time, it was a crucial situation and a decision had to be made.*

Participant P16 stated her experience and her reading allowed her to adapt to the norms of her host country; she benefitted from clear rules and regulations:

(P16): *Yes, we live in this country and my experience was built up within this context. Besides, reading shaped my personality, I believe. We need to know the rules and regulations and follow them exactly. I'm no superwoman that knows everything but I can do everything I learn the right way according to the hospital policy.*

Participant P4 emphasised the importance of avoiding misconceptions between genders as it can cause conflict within the workplace. Men and women can perceive information differently, which could lead to feelings of exclusion or gender discrimination. Leaders can avoid this problem through training and development initiatives that focus on increased awareness of gender-related issues:

(P4): *Of course, we have to think. From our female side, even in what nationality, when we approach the female, it will be different from the male.*

This nurse leader participant P16, explained that the provision of nursing care should be equal to all those in need without gender discrimination. She stated some characteristics of a successful nurse leader, as being flexible and understanding the

gender diversity of patients. In addition, she emphasised that SA culture is changing. However, culture is resistant to rapid change and this needs time:

(P16): *We are really making them aware that, once you accept this profession, you must be flexible, as you know already that we are dealing with patients whatever their gender: the patient is the patient. Now, you see, there are many changes really, they are happening, because previously there was a division of male and female. However, nowadays, you see we can mingle with the male staff, and we can hear their suggestions, We are having conversations, unlike previously when we were really separated.*

2nd main theme

5.3 Second Main theme - Unique personal leadership qualities

This second theme confirms that leadership emerged as a key skill in these data for nurses at all levels. While this may be somewhat obvious, those whose position gives them direct managerial responsibility in SA need the qualities and skills to be able to offer leadership to their staff and other colleagues, such as healthcare assistants. A range of policies and initiatives mean that the nursing profession has a growing influence on all aspects of healthcare delivery.

The unique personal qualities of leaders, therefore, may play a significant role in preparing culturally competent nurse leaders; this suggestion was derived from some of these participants' feedback. It was provided by data which suggested that nurse leaders' characteristics and attitudes towards their work are important elements in winning the respect and trust of team members and leading the development of clinical practice. Participants have stated that cultural understanding and continual learning about culture might empower and motivate nurse leaders and their staff.

By introducing the structure of each theme, it will be possible to continue to explain the relationships between themes and sub-themes. Moreover, each explanation is provided with a sufficient number of excerpts taken directly from participants' perspectives. The themes that emerged under personal leadership qualities are outlined in the diagram (Diagram 14) below:

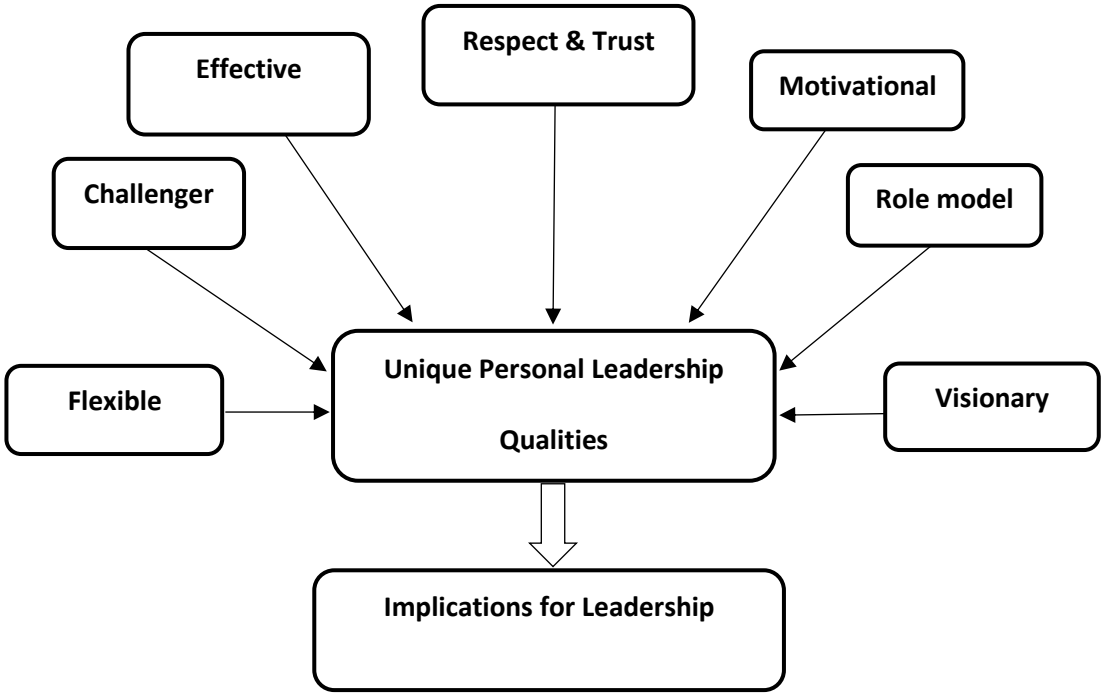


Figure 14. 2nd main theme: Personal Leadership Qualities and sub themes

Sub-theme 1: Respect and Trust

This theme suggests that mutual respect and trust amongst health team members and between managers and employees is crucial. It also suggests the importance of respecting each other's culture. Participant (P4) is a nurse leader who has been working in SA for several years. According to her, it seems to be important for nurse leaders to understand what style of leadership he/she practices, as it may affect the staff, the unit and the institution's outcomes. P4 believes that the nurse leader's self-awareness of their own type of leadership is a valuable asset in the creation of mutual respect between nurse leader and his/her colleagues. It also can actively enhance team collaboration.

Overall, participant P4 concluded that individual leadership style is important as it facilitates productivity and collaboration that cannot be attained without mutual

respect between nurse leader, his/her team, the team members themselves and with the patients:

(P4): *Leadership style is very important in the productivity of the unit. We have to be aware of the type of leadership that we are using because it will affect us. We have to identify which leadership style we should use in keeping with the outcome of the unit. Our self-awareness of that type of leadership leads to good productivity. It also helps to develop mutual respect and collaboration.*

This excerpt suggests that it is important for the nurse leader to show respect for other cultures and to develop and understanding of cultural values and beliefs. This may be one of the first urgent tasks for the nurse in general, and specifically for nurse leaders, who come from different cultural backgrounds. Cultural competency skills are essential to facilitate communication, to demonstrate respect for cultural diversity, and to demonstrate culturally sensitive practice during the delivery of health care, as in the case of the next participant who is a western nurse leader who came from a European culture to SA.

She described her early days in Saudi Arabia, when she was walking into the ER department where many patients and relatives were in the waiting area. However, she came from a different culture and it was normal to take some time to learn and get used to the culture of the new environment she is now working in. Accepting others' cultures, and having the ability to adapt to it, is an important skill. It is clinically important and care-specific to use and understand phrases such as "Thank you" spoken in the client's language, which shows respect and willingness to value language and diversity. This ability provided participant P5 with an understanding of, and

acceptance from, the community as she responded to a situation when a client asked this participant during her round to cover her hair as the SA custom demands. She did not argue with this but directly used her scarf to cover her hair. The client looked directly at her and said ‘’Shokran’’, which is the Arabic word for “Thank you”, as an appreciation for respecting his culture. Although she is from a different cultural background and speaks a different language, she showed respect, understanding and reacted politely by speaking the same language of the patient:

(P5): *I understand the culture and I covered my hair, yes. I do it out of respect, because when I was here for an interview there was a patient in the outpatients and he shouted ‘Why isn't she wearing her hair cover?’ I luckily I had this scarf around my neck so I covered my hair and he just looked at me and said "Shokran" (thank you in Arabic).*

In a similar quotation, participant P5 showed understanding, acknowledgment and respect to the conservative culture she is working in, as she was located at one of the most crowded hospitals in the central area of Riyadh, which serves citizens from the local Saudi culture. KSMC is unlike hospitals that have absorbed some Westernised culture such as King Fahad Medical City (KFMC) or King Faisal Specialist Hospital and Research Centre (KFSHRC); therefore, participant CE was required to wear culturally acceptable clothes, paying close attention to the conservative population she now worked with:

(P5): *So then, I realised because I am not working in King Faisal Hospital and I am not working in King Fahad Hospital, where I can wear very western clothes and walk around, I know that I have to respect the*

culture and the area I am working in and we have a very conservative population here.

Another example is participant P6 who is a senior nurse and emphasised that a leader should apply leadership skills, not just managerial, and claimed that some leaders still cannot differentiate between being a manager or a leader. Participant P6 gave a description of a successful leader which includes being risk taker, and in her opinion successful leaders should take risks and defend their staff, which can lead to greater respect from the said staff. She also describes the feeling of her staff towards her, as they know that she is their advocate and will protect them; they respect her for this. Participant P6 stated a number of qualities that a nurse leader should present such as involving the staff in decision making and also encouraging them to develop themselves:

(P6): *Actually, some leaders must know first what the meaning of being leader is. They need to understand the difference between a leader and manager, because actually in our culture still many leaders are acting as a manager when they actually need somebody to lead them. As a leader, one important feature they should have is being a risk taker. If as a leader, my staff know that I will really protect them and I will be their advocate, they will respect me. If I will work with them, they will really give me more. I have to be as a leader and give them clear assignments and not let them feel confused. I have involved them in any decisions and encouraged them to better themselves.*

As for being respectful, it was also mentioned that culturally competent nurse leaders should be trustful and trusted. Participant P3 believes that trust is a key feature of a

developed institution and services; it also makes the workplace better in regard to atmosphere and job satisfaction. In order to be a trustful nurse leader, however, some personal characteristics have been emphasised: transparency, vision, being equipped with strategies to solve problems, consistency toward patient satisfaction and maintaining group effectiveness. Nurse leaders must apply these characteristics to their work in order to win the respect and trust of team members and lead the development of clinical practice. However, participant P3 still feels that some nurse leaders in SA do not have such qualities:

(P3): *I believe that establishing trust between everybody is one of the key factors in making workplace better. And this trust between every single employee can be achieved by transparency, being passionate, having a proper way of solving problems, consistency and having a vision toward patient satisfaction - which, actually, I don't feel that we have.*

Participant P14 concentrated more on the patients or the clients, and presumed that those clients need to be communicated with properly – newly admitted patients need be oriented about the ward or department they are going to stay in and need to be reassured and guided through their treatment journey. With such strategies, participant P14 believed that the result will be positive and will lead to tangible improvement:

(P14): *Colleagues expect that we are very honest and that we are patient as we give them care. So usually, in some ways, they find that they would like to trust you and they would like you to make them settle into that ward. When you release the barriers, like communication barriers, or if they are very stressed and you make them calm down, you are taking them in the right path in their treatment and you will see a difference.*

Participant P13 shared an interesting point of view about leaders and how they could be effective and influence their followers. She stated that when the leader feels that he/she is not being effective nor respected by staff, this meant that the defect is coming from inside the leader themselves and they should look inward to change it for the better. AB supported her opinion with a verse from the Koran (Muslim holy book):

(P13): *My mother told me that once you see your leadership is ineffective and your followers are not respecting you, it means that you should change your way and your style. As Allah said: (Surely, Allah changes not the condition of a people until they change that which is in their hearts).*

Sub-theme 2: Effective Communicator

The next theme concerns the role of communication in leadership. Participant P5 is a female nurse from a different culture than SA, therefore she emphasises the importance of ensuring clear communication amongst the health care professionals, bearing in mind that different cultures may play a role in understanding and reacting to communication. According to participant P5, the different ways of receiving such information through miscommunication means that the message could be altered and the intention could be lost or misinterpreted:

(P5): *Communication is key and it is ensuring that the communication is clear because with different cultures you know you can say something in one way but if I say it and they didn't quite understand it, you may slightly lose the intention.*

Participant P5 also gives an example of her statement above; she explained a conversation between herself and one of the nurse directors who is from a different

culture. His English was not as good as her own. Participant P5 was communicating with her Saudi colleague, asking her to convey an important message to the office secretary at once, but the Saudi colleague thought she could wait to do it tomorrow, and so she replied to her saying that she will convey the message tomorrow. P5 kept trying to explain to her that she should do it today not tomorrow, but she still did not understand this correctly. She worked this out from her response when she said she would do it tomorrow. In order to avoid misunderstanding and to make things clear, and to happen at the right time, she called someone else to speak to the Saudi colleague and explain to her in Arabic that he should do it tonight, not tomorrow.

Participant P5 articulated that something said in wrong way with one wrong word may lead to misunderstanding; it is, therefore, crucial to communicate and translate very clearly, especially when working in multicultural environment. In this context, an emphasis on effective and accurate communication is key.

(P5): *There was an incident yesterday afternoon. I was speaking to one of my directors of nursing who is Saudi and her English is not as good as mine, so at the end of conversation I said: "You phone up Mohammed (the secretory), and you tell him exactly what happened in Arabic and you give explain exactly what has happened to that patient. She said: "Yes, I will tomorrow". I said "No, no, tonight". Then she said: "Yes, yes, I will do it, I will do it tomorrow." Then I said "No, no, you do it tonight!" Again she said she would to it tomorrow. Therefore, I had to phone someone else to speak to her in Arabic to make sure she was going to do the endorsement. The other member of staff she was very clear that she, the Director of Nursing, would want to do that*

endorsement tonight. So that is a little thing, taking one wrong word in the wrong way. It is challenging to communicate and translate when you are working in a multicultural work environment; you have to make sure that everybody understands and that it is clear. I think that is the key because if there are not clear channels of communication, then clinically everyone suffers.

Participant P6 who is a Saudi female nurse leader, similarly emphasised the importance of communication within health care settings. For her, it was important for nurse leaders to understand their own team characteristics and to endeavour to relate to each team member by identifying their traits and strengths. Sharing basic insights of each team member's characteristics with the entire team facilitates understanding and can encourage a blending of efforts when caring for patients using different methods of communication. In addition, she stressed that doing so may affect one's leadership style.

(P6): *Being a leader that means you are able to take your staff with you to achieve an objective. To reach these levels, then you need to be aware of their needs, sensitive to what they are looking for and have a full knowledge of their culture so as to function within that culture. Of course, you adapt your communication style for each member of the team because they all use different methods of communication. You will change the methods of assigning tasks based on their needs. Also, you change the methods of your assessing the missions or assessing the patient based on their needs. But of course, it will affect your leadership style.*

The same participant P6 contributed further insights. She served in a very senior role for one of the hospitals within KSMC and expressed her worries that this organisation did not set regular meetings to include all nurse leaders and allow them to share that their experiences, including difficulties or obstacles and the solutions they may identify.

She understood that their institution is enormous in scale so she suggested that nurse leaders need to meet once a year at least in order to have an open dialogue regarding to other sectors' roles that might interfere with final outcome of their own institution. This would allow them to share best practice and maximise their clients' satisfaction:

(P6): *Nurse leaders need to communicate with each other on a frequent basis. At least every year, they should meet all the leaders and to hear what is really happening in the hospital. Because unfortunately, as sister SY said, most of them are handling positions but they never go to other areas and they don't know many things. Secondly, they have to work with Civil Services (government agencies such as MOH) which is destroying our hospitals. They have to change it and update things. Yes, I hope all the people working in Ministry do not take their position to benefit only their work.*

Participant P3 is a female nurse leader from South Korea. She has worked in SA for several years now. This participant stated clearly that nurse leaders in KSMC need to get proper training in communication and learn effective communication skills. She stressed that it is not only about speaking English or for the non-Arabians to speak Arabic. It is also about learning how to listen and communicate clearly with the clients who are valuable to the institution – after all, the service is really all about them:

(P3): *Nurse leaders should get training in communication skills. Not only to show others that I can speak English or Arabic. I mean real listening skills and real communication skills with end users who they are not considering as an important, but in fact they are the most important people in maintaining this organisation. So, real communication skills, not about showing off to others but demonstrating real understanding.*

Similarly, participant P4 emphasised the importance of communication. This participant is a female nurse leader from the Philippines; she has been working in SA and particularly in KSMC for several years in conjunction with colleague the previous participant P3. She stresses the importance of communication skills as this facilitates access to the people who hold key positions and can get things done. She also added three criteria that the nurse leaders need in order to make them capable to assessing their staff: good communication skills, good understanding of the processes and practice, and critical thinking:

(P4): *For me, I would like the leader really to have good communication skills. How you will communicate to your staff is important and you need to know how to do it, especially if you are in a key position. Good communication skills, a good understanding of the nursing process, of the nursing practice and a capacity for critical thinking are all necessary for you to be able to judge your staff. Those are the three best criteria.*

Participants P2 focused attention on the written part of communication; she is a head nurse from India where she speaks and communicates in languages other than Arabic. Although English is not the spoken language of SA, many health care organisations

in SA uses English as the language of communication between health care professionals. Yet clerks and people in administration in such organisations use Arabic in all paperwork such as memos, regulations, policies etc. Participant P2 described how she receives memos from the Ministry of Health written in Arabic and not translated into English. She cannot understand this and is dependent on the translation of Arabic staff. She worries that things may be lost in translation:

(P2): *For me, as I am foreigner, the first issue is the language. Those memos from the Ministry are purely Arabic. If it isn't in English, because I have staff that are non-Saudis, they can also read the memos. So how I can trust you if what others are translating is right or wrong? If it is in English, all can understand.*

Participant P7 is an expatriate Indian nurse leader who has come from a different culture to work in this organisation in SA. She was used to particular body language being demonstrated within her country but has discovered that there are different methods of physical communication in SA. She believes that there are body language issues in SA which are inappropriate at times:

(P7): *Yes, of course, I have some expectations. Indians are usually polite and their body language is not so aggressive when they talk with each other. But this is the expectation I have of others. But when I see the communication, the way of communication here and their body language, it's inappropriate sometimes.*

Participant P5 who comes from Europe is also an expatriate nurse leader, but unlike the previous participant, she had found her own way to understand the body language of the host culture and as a way of communication. Although culture in SA, especially

in Riyadh, requires females to cover or veil their faces, Participant P5 was still able to establish communication and understanding to those nurses whose facial expressions she couldn't see. Participant P5 said that she uses body language to communicate with nurses and other health team members. This method of observation allowed her to tell who is listening and who is not. Participant P5 uses smiling as a greeting and she can sense a smile in response now, even if their faces are covered:

(P5): *I found new ways communication with body language. I now look so directly at people and even if they wear the veil and their faces are covered, you can tell if they are listening. I can talk to them and I know if they are shifting and they do not want to listen to me. But it is really in body language and understanding it and speaking directly and smiling and that breaks down culture. It doesn't matter if your face is covered, I will look at the lady on the left and even if she is completely veiled, I will smile at her and I know by her body that she is smiling back.*

Participant P7 also shared her experience as a nurse leader with some of her team members. She was giving feedback and some guidance to staff from the host culture of SA. Those staff pretended to accept her feedback but she said that she could tell from their language, the words they used, and from their body language, that they did not accept what she was advising:

(P7): *It's just talking about any other matter or just guiding them, showing them this is the path. As for me, I'm advising you, this is the path. Go along this path. It will be good for you. Maybe they accept it but their*

method of communication suggests they don't – the words they say and their body language seems to suggest that they don't really respect us.

Participant P5 believed that 70% of the communication process is non-verbal communication and delivered by body language. She has explained further that as a nurse leader, she needs to communicate with her staff, especially the Saudi female staff who cover their faces as a cultural norm. It is a struggle for her to read lips or see facial expression in order to ensure a proper understanding. Although such barriers can have considerable impact on communication, she still welcomes different cultures, and understands this could be attained by clear communication:

(P5): *Here, communication and body language are affected by culture. You know body language is 70% of communication, I think? It is, so if you are not welcoming and different cultures do it in different way of communication. Obviously, I never realized how much you lip-read and of course the girls often have their faces covered. That is a struggle and I do worry about that, but it is ensuring it comes back to that communication again isn't it, when we communicate well and we communicate clearly.*

Participant P2 is a nurse leader who comes from India. She acknowledged that effective communication requires both parties to participate actively. She stressed that effective clinical leaders had to be able to listen to the team and surely, he/she should explain the aim and mission of the unit. JE also emphasised that a leader should appreciate their staff – even the small duties that they do. For participant P2, it is important to listen to team members and take their suggestions and comments for

improving the services provided. This may avoid any negative aspects that can alter the effectiveness of nursing care for the clients:

(P2): *The leader should lead the team and she should communicate their aims and goals. we should appreciate our staff even how they are doing their minute part in the teamwork, we should appreciate them. We should listen and take their suggestions as a leader - if it is positive or can improve our unit. We need to hear from their side also.*

Sub-theme 3: Challenger

Participant P3, a female nurse leader who comes from South Korea, emphasised the challenges that she faces which involve conflict, negligence and unprofessional behaviour from the staff who work with her and who are of different nationalities. Participant P3 spoke about nurses in general when she said that in SA, we are irresponsible. She used the example of asking the staff to imagine that the patient or client is one of his own family members; she used this strategy to motivate the staff to give the maximum care to the patients:

(P3): *I face a lot of problem here. There is conflict, negligence and also unprofessional behaviours from many of staff. It's not limited only to Saudis or any particular nationality. We are generally here are kind of irresponsible. So, whenever I sit with a staff member who is causing problems, I would say, I would actually start asking them a question. I ask them in this way: "Would you accept this for any of your family members?"*

The same participant P3 stressed that it is a challenge for her to be a nurse leader in her current position, but she has learned from nursing to understand human being in a holistic nature. That is what she has used as a coping mechanism, in addition to her own self-awareness. Leading staff from different nationalities and culturally different contexts was a challenge and she adjusted her leadership style to deal with this diversity:

(P3): *Is it really a challenging task being a nurse leader in my area? Nursing is a science, isn't it? So I learned in school about understanding men in a holistic nature. Also, I try to be self-aware about my type of leadership. So, for that, it's really a challenge.*

Participant P2, the nurse leader from India, and from a different cultural and linguistic background. She expressed similar sentiments regarding the challenges she faces in her recent place of work, mainly language barriers, which cause real issues. This participant believed that the healthcare system should provide resources for interpretation. She also demands that all print documents and memos must be selected with respect for the spoken language before distribution, and it should be reviewed for accuracy by individuals from the intended audience. JE stated that when she receives a memo in Arabic and there was no translator, she would have to sign without being sure of what it is about. She also feels the need to be an Arabic speaker to deal with staff and clients:

(P2): *We have the same challenge, the language barrier. For now, I know as a leader I should be bilingual because I don't know the Arabic so the same – simply, this hospital, they are issuing the memos in Arabic and we are signing blindly because sometimes there is no translator, so*

should I sign for that? As a leader, sometimes, especially recently, I faced with the medical supply for my unit, all forms in Arabic. However, I had to sign for that blindly. I need to sign and later on, it is coming into my head. It is very difficult for me.

Participant P1 is an Arabian male nurse leader from Jordan; he does not view SA culture as being so different to Jordan. He believes it is not just about dealing with the culture of the clients; it is about dealing with the community, organisation and most importantly from his point of view, the staff. He justified his opinion, saying that the staff here are not from one single culture, they are multicultural and so as a nurse leader it is important to consider each staff culture separately and deal with it accordingly. Participant P1 considered effective clinical leaders to be skilled at recognising multicultural backgrounds of health team members, accommodating the patients' cultural values, beliefs and practices during all interactions and when planning and providing nursing care. Diversity is prevalent in society and both the patients and staff in our SA healthcare system today clearly demonstrate this fact:

(P1): *From my side, I don't look to the Saudi culture as different from my original culture. But in general, for the nurse manager, it's not only issues of dealing with the patient culture, even within an institute like our institute. We are dealing with staff as a nurse manager. Now, those staff, probably they are not uncultured. They are also multicultural. As a head nurse or supervisor, I am looking after non-Saudi staff and Filipino staff, Indian staff, Asian, South African and western staff. I will deal with all of them in their individual cultures.*

Similar to the previous participant, participant P8 is also a Jordanian nurse leader, who valued the role of nurse leader in being competent in dealing with culture and personal diversity, especially for the staff nurses. They viewed it as a challenge which needed to be addressed in order to build a new culture for the workplace. Participant P8 emphasised that this ability is a skill that should be included in the development of nurse leaders:

(P8): *The nurse manager should be able to deal with all of the cultural and personal diversities of the staff at the same time. This is the challenge and this is how we can build a new culture. It is not only organisation and cultural effect, it is not only the culture outside the environment effect, but it is altogether. These are the skills that leadership that should be gaining.*

Participant P1 demonstrates that they, as nurse leaders and as staff, receive patients from different cultures; those patients need specific consideration with regard to their culture. Participant P1 cited more specific details about the different cultures as he clarified that it was mainly Saudis; but there are patients from India who need special consideration with regard to shaving for certain body parts, for example. These cultural behaviours may seem strange or meaningless to those outwith that culture but they demand sensitivity and awareness. He added this is the challenge, because we should understand and be aware of these differences, although there is no written policy pertaining to such cultural aspects or beliefs:

(P1): *Regarding the patient: we are governmental hospital and that means we receive also non-Saudi patients. Each one of them has a special cultural concept. The Indian patients, they have a problem with the*

shaving, for example. They [nurse leaders] should be understanding. This is also a challenge for them, the nurse leader. It's not written but it's a policy. Well, it's not written policy.

Participant P9 is a nurse from the Philippines. She described the challenges she faced in the department she leads, such as the frequent absenteeism of certain staff nurses and tardiness of some of them. She described this as a challenge because it could lead to a disaster, although she understands and tries to help, she finds the staff do not co-operate:

(P9): *The challenges I find most difficult…for me, it's mostly absenteeism and tardiness and sometimes -- Yes, that's one. I have to challenge myself because mostly our staff now are doing this one, absenteeism. So, one time I encountered one staff member who was frequently absent and I asked her what was the reason for such absenteeism. She told me the reason and she was honest in regards to a family problem. I did try my best to understand and co-operate with her, but I told her "I cannot help you all time even if I understand. If you cause a disaster through your absence, I have to respond." So I told her after this one, your name will be included in the investigation.*

Participant P7, from India, and so has a different cultural background and different assumptions about and interpretations of cultural practices. Participant P7 highlighted the cultural differences and the challenges she faced when she shared her experiences. She was in the focus group discussion and observed two expatriate nurse leaders (Arabs from Jordan) while they were speaking to each other and were sharing opinions. They were using their hands and their vocal pitch was high, which confused

participant P7 as she thought that they were fighting. Afterwards they explained to her that they were discussing and sharing thoughts in a friendly and they were not fighting at all. Participant P7 made assumptions about the way they were speaking due to their tone of voice, as in her culture this would be perceived as such a thing:

(P7): *Sometimes we feel frustrated by the body language. We feel like they are not with us. If we see Mr. X and Ms. Y communicating in Arabic, we do not understand anything, you feel, oh, they're fighting really. But we don't know what they are talking about. Why they are aggressive? Something is going wrong. You feel like that. They speak loudly and even using hands, Saudis and Arabian they are using hands more than actions. They feel aggressive. Yeah, the way you are acting, it's different culture.*

The same participant P7 described another kind of challenge she faced in SA, the religious and cultural beliefs of the Saudi staff, especially females. Some female nurses would refuse to work night shifts, as it is culturally odd for a woman to go out at night, therefore they preferred morning duties; this adds a challenge for the nurse leader. Participant P7 understands that this is a cultural issue but it is a challenge that may put patients' lives and health in danger:

(P7): *There are some religious or cultural beliefs of the SA nurses that are challenging. Yeah, because some of them are saying, "My family is not allowing me to do night duties so I can only come for day duties". Of course, this is a cultural issue but it's really affecting the patient care setting. We cannot optimise the staff levels and the staff are overloading so it is difficult.*

Another participant P9 from the Philippines recognised the different cultural challenges and again states that it is mainly from the Saudi staff nurses. She asserts that her unit is maternity, therefore they do not take male patients nor male nurses so there should be no gender problems or issues. However, there are some issues with female nurses when they refuse to give nursing care or administer medications to the female patients using SA culture as an excuse. They say it is not acceptable in SA culture to administer suppositories to patients. AG describes this as a challenge:

(P9): *And one thing also mostly for them, we are not allowed to accept male patients in maternity, that is nothing. But one thing also I experienced was one Saudi nurse, she told me that that a patient needs to have a suppository. So, she is telling me: "In our culture, we are not allowed to put suppository into another person".*

Participant P10 who is an Arabian female nurse leader from Jordan, mentioned prayer as a religious factor that helps shape Muslim culture and Saudi culture in particular. Muslims are required to pray five times a day. Men are encouraged to pray in the mosques instead of at home to strengthen community bonds, while women are granted a special concession if they wish to pray at home due to their family responsibilities. Depending on lifestyle and work schedules, many Muslims pray at home, in the workplace, or during travel in the car, the train or an airplane, whenever there is the time for it. If the staff leave the workplace to perform prayer, that may affect the care provided. Although this is should not be the case, but it remains a challenge for the nurse leader:

(P10): *It is not only a culture. It is Islamic rules and regulations. We have to go for a prayer. And with us also in Jordan.*

The same participant (P10) expanded upon this, further depicting the religious factors which influence SA culture. They asserted that separating male and female patients adds an extra complexity as it requires recruiting more nurses from both genders to serve clusters of patients by gender. This is extremely difficult as there is still a shortage of male nurses in SA. Indeed, this is a challenge for nurse leaders:

(P10): *Even with the patients here, we are trying to separate the females from the males which is challenge for us. As a leader, it is a challenge because we don't have enough male nurses. The Saudi female nurses, they are trying to go for the female areas, not in male patient areas. So, it is a challenge.*

Participant P11 is a Filipino nurse leader described gender differences as a challenge for nurse leaders in the SA context. In SA, as some cultural beliefs are inherited or religiously interpreted, they certify that a leader should be a man. This cultural challenge is facing nursing leadership especially for female nurse leaders as some male Saudi nurses reject or dislike the idea of being subservient to a female nurse leader:

(P11): *For the leadership style, of course, from our side, from the Filipino side, from the western side, we don't have any problem because we are dealing with both genders. But the Saudis, of course, it is different from the female and from the male. Of course, we have to think. From our female side, when we approach to the female, it will be different from the male.*

Participant P9, who is a Jordanian male nurse, reveals that even he as a nurse leader cannot make the Saudi female nurses provide nursing care for male patients. He used

to be a nurse leader back home in Jordan and he had female staff under his command, and instructing them to look after male patients was not an issue. But the situation is different in SA. Moreover, he explained that the leaders he used to work with were autocratic leaders and he learned this style from them but when he tried to apply it here it was difficult, as he stated that SA staff won't accept this kind of leadership. Accordingly, he was forced by certain factors to change his style of leadership:

(P9: For me, because of my previous experience in Jordan, most of the leaders I worked before used autocratic leadership. Yeah, they were giving orders. They would not listen to us or listen to our concerns or our needs. So, when I came here, most of the time, I was angry: "Why did you do it like this? Why did you do it like this?" I said to the staff, and I listened to them more. So, most of my style changed to democratic. Why? Because here I cannot force female to work with male patient. So, in Jordan, I could order then she would be dismissed if she didn't work. But here, I cannot. So forcefully, I changed my leadership style from autocratic to democratic. What I will do?

Sub-theme 4: Flexibility

Flexible nurse leaders seem to require the ability to change their styles and plans to match the reality of the situation. As a result, they may maintain productivity during all situations. Leaders skilled in this competency embrace change, are open to new ideas, and can work with a wide spectrum of people. Being a flexible nurse leader includes large changes, but also trickles down to everyday activities that are subject to change. The theme of being flexible has been addressed by various participants in different contexts, each of whom stresses the importance of a leaders' ability to adapt. Participant P5 shared her experience with one Saudi female staff member that forced her to become flexible and adapt her leadership style. Sometimes it is necessary to utilise a full range of leadership styles, from 'dictator' right through to 'confessor'. Sometimes the leader needs to be more rigid, dogmatic and directive. When facing issues such as ethics, compliance, legal issues, professional principles and standards, there is a need to be definitive. In some cultures, one might need to take strong, decisive action in order to be seen as a leader, while in other cultures consultation and a democratic approach may be the preferred approach to exercising effective leadership:

(P5): *I suppose yes, I've got a very naughty girl, she is a Saudi nurse and she didn't realise that I had arrived in the building and that I was aware how absent she had been. So, she had just kept coming and going and she arrived in my office after I've been here for 3 months and said that she didn't want to work in medicine anymore and that she wanted to be transferred and if she didn't get what she wanted then you know, she will go to the King or she will go to Dr. X [KSMC CEO]. So, I said*

fine, ok, and at that point I was quite shocked but her attitude was quite strange and her uniform wasn't professional. So, I was quite surprised as I found myself being quite umm autocratic and saying actually no, no, no, this is not what's happening. You are coming to work tomorrow and you are coming with a proper uniform and you are going to do your shift and that's it, finished, ''khalas'' [Arabic word for Finish].

However, there are other times when a different leadership style should be employed. Differing levels of negotiation, inclusion and adaptability can be applied depending on the specific issue. This was the case with the same participant P5 as she stated she used every single leadership style in one situation in order to find a solution:

(P5): *And then she said No. I said, "Well fine, so that is it. Whether you come or not". So, she went from my office and she went to see executive Dr. X and said to him that she had seen me and I was not helping her. Luckily enough Dr. X and I have an agreement. So, he said "No, I'm not going to see you, I want you to go back to Ms. Participant P5 and I want you to work this through and talk about it", so she came back.* ***I*** *have to say I used every single leadership management style dealing with her and her friends!*

Participant P5 shared the result of her flexibility in changing leadership style which was effective and solved this difficult and complex situation as she stated:

(P5): *Then I started to come to support her. I think we shouted, we cried, we hugged, we did everything but she came to work. She came to work and she has now been at work for the last two weeks. I found myself being a mother, being a sister, being a friend, being a chief nurse. She came*

to me lately 2-3 days ago to say "I need to do different Ramadan shift". I said, "Don't come to me, you go back to your head nurse, she is your line manager, go and speak to her". So there I am back to autocratic again. Telling her to go back, but it is nurturing and understanding to use a different management style to have a different way of dealing with some situations.

A general description of a leader might be someone who is flexible and seeks to develop a good relationship with his/her team. Flexibility is thought to broaden and elevate the interests of followers and to generate awareness and acceptance amongst them. Participant P3, the South Korean nurse leader, shared with us an attempt to break ice between her staff and between cultures and as a means of reducing work stress. She as a leader suggested a night out. It is different in SA as there is no nightlife, which is religiously and culturally not accepted. It is preferable for Saudis to enjoy what is called "Istriaha", which is usually a fenced garden with swimming pool and grill facilities:

(P3): *Lately, we have actually gone outside during a weekend because head nurses, supervisors, they are really under extreme stress - different issues that they face every single day. So, they in fact have no other place to vent their stress. So I suggested to head nurses and supervisors: why don't we go out to have fun outside?...So we went outside. We rented a place, what they call an '' Istriaha'' (like a cottage). I don't know the term in English. We gathered all together. We had such fun for around five to six hours. We were swimming and dancing and having different kinds of fun. We really danced and initially, as usual, Filipino guys, as very sociable and friendly people*

so they would want to lead the atmosphere. But later on, Saudi, Arabic and even the Indians and Pakistani groups, they all started to dance. We were singing. We were dancing. We shared different foods. So, I can say that was a unifying experience, where I tried to incorporate myself into the different cultures. incorporate myself into the different cultures, some kind of unification.

Participant P2 articulated the view that flexibility in giving staff the chance to meet up with colleagues from different cultural backgrounds could positively impact the work environment. So as a nurse leader thought it was an opportunity that could help narrow the cultural gap by focusing on the similarities between them, instead of focusing on difference. Looking at commonalities rather than dissimilarities in people can be a good approach to assisting nurse leaders in communicating and leading more effectively:

(P2): *Because we always see each other at work. So outside of work it is a great opportunity for us to see the girls without ''abaya'' [female body covering] and different shapes, different personalities which are not shown in the workplace. Therefore, this experience was a good opportunity for me.*

As many nurse leader participants agreed being close and friendly with other team members is an asset for successful nursing leadership. But other participants, such as P6 believed it is never possible to please everybody; therefore, she stated the importance of sticking to rules, systems and policies of the workplace:

(P6): *As a leader, I have experienced that if I am friendly in work, it will affect the work because you cannot please everyone. If I will be like*

friendly in the work, I will affect the work because I will consider this and that but you cannot please everyone. So I have to work with them regarding policy, the system and the law. But outside the work, we will be really totally different.

Participant P6 acknowledged that the effective nurse leader is an individual who respects the difference between others and avoids personal bias against staff members' nationalities or cultural backgrounds. She also emphasised that there is necessarily a difference between interpersonal interaction in break times or outside of work, and when carrying out care in practice:

(P6): *For me, when I became a head of the department in 2013, I was very, very strict actually in work. Many of the staff were not happy and not satisfied but with time I showed them that I am a leader. I will be like strict in the work - you have to know that this is work. But at lunch I am going to the cafeteria with them like an equal. We are sitting, eating, sharing and sometimes we are arranging to go to restaurant. Sometimes we are going to shop with the group, with different nationality. with the time they realized, ah, so now this is her leadership. In the work I am one way, but outside of the office I am another person.*

On the other hand, participant P13 held a different and interesting opinion; she thought that the leader should be tough when followers are ready and willing to listen, and conversely should be flexible when followers are stubborn. She used an Arabic proverb to support her idea:

(P13): *In my opinion the leader should be using the old Arabic proverb: "Hold Mouwayh hair" (be strict if others are flexible and be flexible if others are strict). I mean, be always in the middle way.*

The contradicting opinions of participants greatly enriched this study. Participant P9 mentioned that some leaders may not have the knowledge and may not accept others' opinion or views, therefore, staff should be more knowledgeable than their leaders and should establish respect between each other to get work done:

(P9): *But we should have the strength and be more knowledgeable than them. So, we have to have this one, respect to each other. Even they are superiors, they should accept our opinions and views regarding what we want to do regarding leadership.*

Sub-theme 5: Motivational

Ultimately, the goal of any healthcare organisation should be to enhance the quality of patient care. Good nursing leadership is invaluable in this. Good leaders should encourage staff to gain a better understanding of patients, their needs and their values. According to Participant P2, these strategies could help lead to increased patient satisfaction, and more effective nurse-patient relationships. It could also help to motivate the staff and increase their commitment to organisational goals, and thus deliver patient care with greater effectiveness. Participant P2 stated that some staff need to recognise that their ultimate goal should be to provide effective nursing care to the patient and every nurse should think and understand that clearly:

(P2): *As a leader for my unit, I am making two types of schedule. It is affecting the patient. But some staff do not realise this, they are thinking of themselves only. As a leader, we should go with the patient. As a leader, I should prioritise the patient and so should the staff. The staff they don't understand why I am strict with them regarding my schedule.*

Participant P1 stated that staff motivation can come through constructive feedback and that this should be used to encourage and support team members. He said that during his time as a nurse leader in Jordan before coming to work in SA, it was difficult for him to give constructive feedback. But he has found the situation to be different for him here with the non-Arabic staff. This highlighted the fact that culture was playing a huge part in the reception of such feedback:

(P1): *Before I came to work in Saudi Arabia, I was in a management position and it was risky for me to give someone constructive feedback or any*

feedback at all. When I came here, I realised the situation is different within the non-Arabic culture. They take the feedback in an easy manner and they directly appreciate it. This encouraged me to investigate the effect culture had upon this.

Participant P6 mentioned the differences in how people perceive corrective advice and guidance in different cultures, as some would perceive it as a criticism. She also suggested that it was useful and important to select the right words when you want to show your support and guidance and avoid what might be perceived negatively. She believes that humans in general do not like feedback, and she herself used to dislike it when someone said to her that what she is doing was wrong. She continued and explained that was in the past but now she has changed and become more confident and accepting of feedback or even criticism. She learned to use supportive language to provide feedback for her staff:

(P6): *Actually, this is an important question and I think if you give us the time, we will not stop talking about it. But we will be honest. We are human. We do not always accept feedback. That's why we have to work on how to deliver the critique or the message. I personally don't like anyone telling me that I'm wrong. But because I have worked on myself and now I am confident because of the critique. Due to my strength and confidence, I started to welcome feedback. We have to make sure to point to good word and take the time to criticise our staff properly. In my department, we are always using a system like 'point for improvement' and we are always looking for something to improve. Now we are changing the language, staff will respond to feedback: "Okay, we will do this, we will improve ourselves".*

Participant P2 supported the idea that effective leaders achieve superior results because of their ability to motivate followers, arguing that people who embrace such leadership have staff with higher levels of satisfaction, motivation and performance. She claimed that by targeting staff weaknesses and giving them the support they need, in addition to delivering her experience to others, this can be achieved:

(P2): *Because we are leading, we cannot expect that all the staff will be same level. So we have to go with their weak points and we should accept them that way, then we will give support to them. As a leader, I go to the C group, ask what problems are occurring and provide support to help them improve. So later, from this experience, I can improve them so that they can support my group B or group A.*

As a kind of motivational act, participant P6 stated that it is good to convince your staff that you are also keen to improve yourself so that they view you as a role model. Eventually, they will accept your advice for improvement. It is obvious, from her perspective, that motivational leaders become motivational by demonstrating their own motivation. The leader motivates him or herself by continually looking for ways to help others improve their lives and achieve their goals. They become the kind of person others want to get behind and support in every way:

(P6): *I will tell my staff that I want to improve myself, I want to see if I will listen to the other people, and tell them that when I want to change a weak aspect, I start to change myself. Why? Because we have assignments called group work. In the group work, there was fighting about my idea. But with time, I started to learn when I am listening. I started to collect many ideas from others and we made it better. We got*

a score of A. Why? Because we were listening to each other and learning from each other in a different way. That's why I always try to change myself to change other people and it's my rule as a leader now. I had one really hard-headed member of staff who always thought he was right but with time, he really changed. So, this is a good thing.

Participant P5 articulated empowerment as a key concept of leadership, in addition to communication and understanding:

(P5): *Well, I suppose it is the whole concept of leadership is about empowerment, isn't it? It is about having difficult conversations, important communication. We need workshops about communication and understanding; I suppose those will be key for leadership development.*

On the other hand, participant P15 indicated that the defect is not always in the system, it appears because there is less support from the leaders. Therefore, leaders need to be supportive in order to enable staff to achieve the optimum service:

(P15): *You can't beat the system. You cannot choose the system. If you have support from the leaders, you can really change the system, you are not happy. There are many, many thinks in the system that aren't our reality. So, if you have support, you can achieve it.*

Sub-theme 6: Role modelling

Participants indicated that in order to motivate others, we need to start seeing ourselves as role models and function as a good example to team members. Effective leaders will generate opportunities for professional self-development for junior staff. The role

modelling behaviour of senior nurses during this process is critical in transmitting appropriate professional values from one generation of nurses to the next. Nurse leaders in practice settings have opportunities to influence and even create new environments in which professional practice can flourish. Participant P1 suggested that nurse leaders have a major responsibility in changing behaviour to provide an environment that supports the preparation of positive, expert nurses. It is part of a nurse leader's role to serve as a model in providing effective socialisation experiences that impart appropriate values, beliefs, behaviours and skills to staff:

(P1): *The leader has either a positive or negative influence upon the work place. They have a great influence on the nursing, the direction and the atmosphere of the workplace. They can either encourage teamwork or destructive work. They can emphasise clear agendas. Of course, this is the influence of the leader.*

Participant P5 believed it was easier to highlight leadership through the demonstration of leadership qualities rather than by issuing orders to your staff. As stated by P5, leaders need to have managerial goals, rules and regulations and they need to be visionary. She emphasised that leadership is not the same as management:

(P5): *And also, as leaders you need to be able to manage. So leadership and management certainly are different. Once you have set managerial goals, rules and regulations, then you can be a set out a strategy for visionary leadership.*

Participant P8 believes that the starting point of motivational leadership is seeing yourself as a role model - as an example to others. One key characteristic of leaders is that they set high standards of accountability for themselves and for their own

behaviours. They assume that others are watching them and setting their standards according to what they see from their leader. Participant P8 acknowledged the importance of being a role model, considering it as the primary quality of a nurse leader:

(P8): *I think we should first of all be a role model for our nurses. We should know their needs, listen to their needs, to listen to what obstacles they are facing. So if we understand these issues, later on we can work on that. We can influence and minimise any obstacles in front of them. If you want to encourage them or be a role model for them, you should do a brief assessment on what is going on with them.*

Once again participant P5 stressed the importance of communication, as she stated that it is essential for nurse leaders to be trained on how to be effective leaders and how to be a role model for the staff:

(P5): *Nurse leaders need to be trained in communication, yes, and all levels of that communication. They need to know how to communicate in different ways. It's about being both a role model and clinically credible.*

Sub-theme 7: Visionary

Linked with the previous theme the data also suggested that participants felt leaders should be able to inspire passion and commitment to the mission of their organisation by communicating its vision. The subjects emphasised that leaders need to be competent whilst retaining the ability to develop and communicate a vision. Participant P1 may be considered to have some qualities of a visionary nurse leader – this is apparent from his participation in and contributions to the vision of the Ministry of Health in SA. Participant P1 first describes the MOH as lazy in terms of leadership; containing vision only in their papers but never in practice. He also registers the widespread anxiety about MOH resources and suggests this is having an impact upon the hospital's morale:

(P1): *There are some differences within the same culture. In general, unfortunately I feel that within the Ministry of Health, there is a loose leadership style or lazy leadership style when it comes to meeting the objectives. They have great objectives or leadership visions on paper but unfortunately during the application, this is missed. The other issue is that they are very concerned about resources – the profits of even governmental hospitals. They are losing a lot of resources and we don't know exactly why this is happening. This is affecting the culture within the hospital.*

Leadership has a critical role in shaping the conditions for staff to deliver quality care. Implementing a vision requires an awareness of the workplace culture. Moreover, it is important to focus the activity necessary to achieve the vision. Participant P5 articulated the importance of sharing the vision of the organisation with other team

members, as she shared the responsibility for achieving this vison with her team members:

(P5): *Oh, I think it is not me that does the job. I am the leader yes, however - I have team beneath me and it is that team who does the job. I help them facilitate that but it is the team that make me look good. So if have done that job well and that team do their jobs…we all have different personalities and ways of doing things but if we all look at the rules and regulations and follow them consistently then we will all have the same vision of doing the right thing for the patient. No one person can do it on their own. It is the team approach.*

This continuing communication was raised as an essential leadership behaviour. It needs to focus on promoting and ensuring that the vision is understood. Participant P12 stated that in order to attain one's vision, it is essential to have the right authority and the right power as an influencer:

(P12): *Actually, with the power I can do what I can. Yes, I can do my job. The right authority and the right power can influence me to do my vision, my planning, my strategy, my goals and everything. Now, if there is no authority and no powers, everything will be lost.*

In contrast, participant P1 emphasised the need of the leader to concentrate on all the staff needs and articulated a need to be sensitive to their goals but also their abilities and limitations. He also stated that leaders should be culturally sensitive. Furthermore, he presumed that the leader ought to change his/her communication methods and assign tasks or techniques based on those staff needs:

(P1): Do you want to be a leader in this position? Okay. That means you should be aware of their needs, sensitive to what they are looking for and competent in dealing with them. Of course, you will change your communication style based on those needs. Also you must change the methods of your assessing the missions or assessing the patient based also on their needs.

Implications of the findings on the unique personal qualities of the leader to leadership.

It was concluded that unique personal qualities of the leader are an essential asset for competent leadership. It starts with building trust between team members, staff, colleagues and patients; this relies on the leader's ability to build and maintain the trust and respect through their daily actions. Leaders' traits, behaviour, leadership style, and skills all serve to shape culturally competent leaders. Being a role model was described as the most important element in creating such leaders. An effective leader must also have a thorough knowledge of motivational factors for others. They need to be self-motivated in order to be an efficient and effective leader.

Competency in leadership takes time and effort; these efforts encompass some leadership characteristics and duties that show traits for the leader. Such leaders need to be able to meet and nurture the psychological needs of their followers, sharing and involving them in decision making. The data also revealed that good communication plays a major role in shaping effective leaders. Understanding cultural diversity and being ready and able to tackle challenges in this matter appears to be an important skill for efficacious leadership. Being unafraid to challenge is another quality which enhances nurse leadership.

3rd main theme

5.4 Third main theme: What Works?

This theme and its subthemes (Diagram 15) examine what works and also what may not when leading nursing in SA. It builds on the previous themes and demonstrates both successful and less successful strategies used by leaders in the cultural context to develop outcomes and actions. It would be expedient to first work out what it is about leaders' and staff's current situation that they are happy with, before looking at what they would change if they could look at. This section will examine such effective strategies from a variety of perspectives

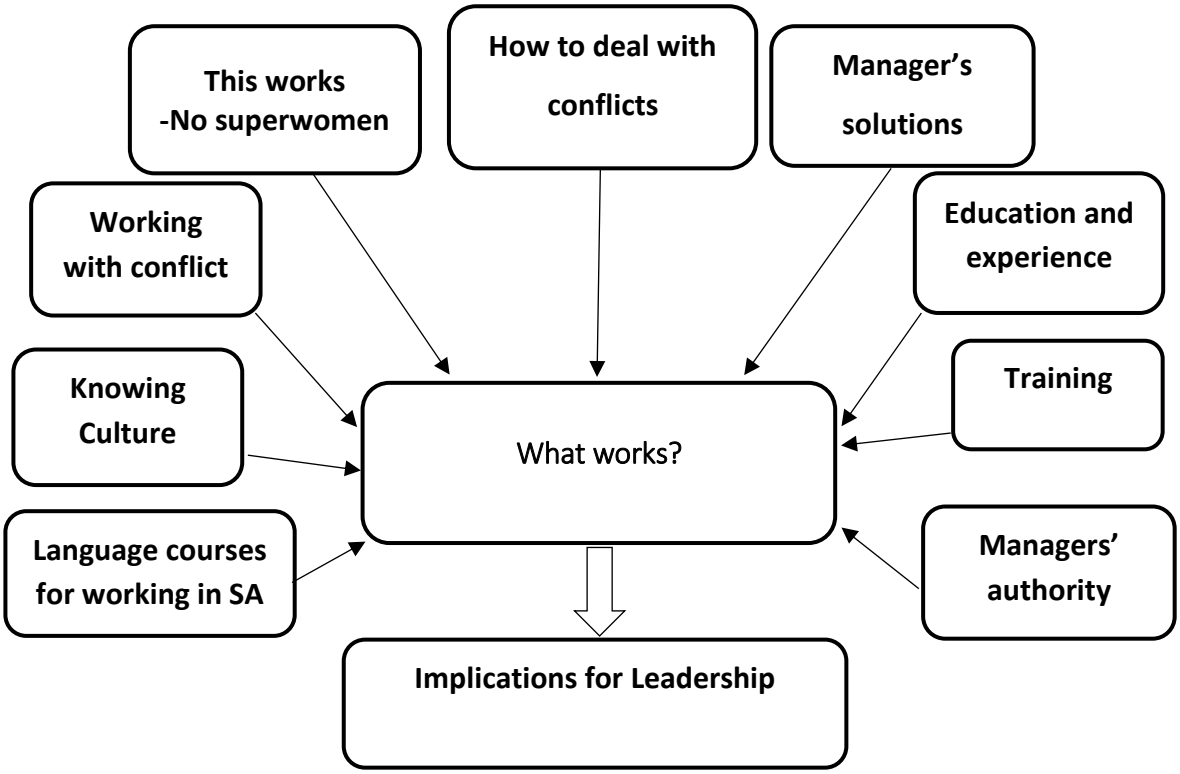


Figure 15. 3rd main theme: What works

Sub-theme 1: How to deal with conflicts

This section outlines some of the obstacles experienced by participants and their solutions. These differ amongst the people who took part. Participant P5, who is an English nurse leader, believes that nurse leaders should always challenge difficult behaviours. She has given an example of some of the challenges she has faced and how she empowers the nurse leaders to challenge and change behaviours that could affect patients' health. This includes teaching nurse leaders to say no to doctors when there is harmful behaviour, such as a lack of hand washing pre/post conducting a physical examination of a patient. In general, she emphasised that nurse leaders should challenge difficult behaviours which affect the profession of health care services or are contrary to the rules and policy of the organisation. As she was, at the time of the interview, relatively new to the department, she hoped that all nurse leaders in the KSMC will become empowered to develop a challenging leadership approach:

(P5): *Nurse leaders should do it, challenging difficult behaviours that are not right. So for instance, hand washing, and empowering nurses and nurse leaders to say to a doctor: "Actually no, could you wash your hand please before you see that patient?" That's the kind of leadership I'm hoping to develop.*

Different issues presented themselves to participant P10, who is the head of a very large ER department containing 80 beds and approximately 310 staff. Such a complex department is naturally going to encounter some fraught situations. He explained that Saudi female nurses need to be given special consideration because they cannot drive and there is no proper public transportation, so they have to group themselves to share a taxi or minibus and as a result, require the same work schedule. This nurse leader

fixed this issue by ensuring they had a say in their timetable. He faced another issue with Saudi female staff, in that they cannot work with staff as they need to stay home with their husbands and families. Therefore, he faced a serious shortage during one holiday when the whole group of nurses did not show up. After that day, he managed to find a solution to avoid such shortage by assigning non-Saudi female nurses during holidays. That solution worked within the department:

(P10): *Most of them, because of the transportation issue in the Saudi Arabia, the females cannot drive. Sometimes they are grouping together, for example, three or four girls with one driver. So they are working together. I cannot separate them and I cannot put them on different duties. It's really a problem. One time I changed their schedule because I have shortage at the weekend, Friday and Saturday. I told the charge nurse to please arrange it fairly for all. What happened that weekend was that none of them came because they don't have a driver at the weekend. Yes it affects the workload of other nurses. From that time, I am trying to put the non-Saudi off during the weekdays and Saudis at the weekend, as much as we can.*

One of the solutions suggested by participant P5 was providing local knowledge for the managers and staff about the rules and regulations of their host organisation in order to equip them with necessary tools to be knowledgeable about what is right and what is not. These include knowing the right procedures for absenteeism and also the disciplinary policies for such derelictions of duty. This extended to the Head Nurse of the departments knowing how to make an order for supplies and other such procedures:

(P5): *Umm, I think it is the same in my country. They need to know the rules and regulations. You know, they need the tools. They need to know, they need everything in front of them. They need to know what they can do about the absenteeism. They need to know about disciplinary policies. They need to know all of those processes. They need to know to order supplies and how to handle the general housekeeping of wards, et cetera.*

Participant P5 explained that in order to benefit from leadership, it is essential to empower leaders and provide them with the skills needed to manage conflict amongst her/his staff. Besides, by empowering them they will have the tools to encourage greater team spirit, appreciate their colleagues and develop all staff accordingly:

(P5): *Those are the skills you need to give them. You need to help them to empower themselves. What we came back to is how to manage conflict, how to challenge, how to value, how to engender good team spirit, and how to appreciate staff. That is the leadership quality I aspire to. Then you put that down at a clinic level and develop them accordingly.*

Developing Head Nurses was believed by participant P14 to be a key solution for developing leadership more generally. As she related, the development of head nurses will eventually lead to the development of leadership of the organisation. A managerial nurse in KSMC organisation, she agrees that there is a need to do a lot of work in order to achieve this goal:

(P14): *Yes, we will soon be developing a Head Nurse course. We will be developing leadership for our supervisors and I will be doing a lot of leadership work for my Directors of Nursing.*

Another participant P23, suggested that nurse leaders should learn the local cultural values and use them to gain the knowledge and understanding necessary to gain respect for all cultures. This develops leadership that is culturally competent:

(P23): *So, I have to culturally cross all these barriers and get the right principles around leadership into all other cultures.*

Participant P17 raised communication as an important aspect that provides nurses and health care professionals with a solid tool to interact effectively with each other. She seemed to equate appropriate communication between health care providers with having a proper common language, which is English in this case:

(P17): *Well, again the culture issues come down to communication, which what I have said before. It's about making sure that they can speak English, and they can communicate effectively.*

Participant P9 continued to clarify the ways in which communication is vitally important and a solution that may help resolve conflict. It is an essential component for proper health care delivery. Nurses need to deploy a kind and gentle speaking tone, regardless of the spoken language, in order to demonstrate care and a well-balanced response. Despite her stressing the importance of spoken English, she also indicated that body language and tone are equally important:

(P9): *It again comes down to whether or not they can speak Arabic and whether they respond well if they can communicate. However, if a nurse is kind and her voice is soft and gentle, it doesn't matter what language she is speaking. You communicate, as I said, through body language and by showing them that you care. So again, it is communication, it is making sure that I can speak Arabic and we have our common language.*

Training was identified by another participant as an important element of the procedures or solutions that can work to develop effective nursing leadership. P19 stated that nurses need relevant courses in addition to their built-up experience in order to produce effective nurse leaders:

(P19): *Then you need to have the right management courses and give them the tools to do their job. You know, you cannot do it by experiential learning, you need to do the experience and the theory at the same time so you do the two together.*

Others believed, however, that the whole concept of leadership was about empowerment; as participant P7 said, leadership is empowerment that includes good communication and understanding to allow everyone to fulfil their roles:

(P7): *Well, I suppose it is the whole concept of leadership, isn't it? It is empowerment, it is having difficult conversations, intense communication, workshops around communication and understanding. I suppose they are key for me.*

Sub-theme 2: This works

From participant P5 prospective, it is not helpful for effective leadership to assign inexpert or newly graduated colleagues in leadership positons. She as a leader herself refutes the idea that nurses or graduates with a Master's degree should be promoted or given a leadership position simply because they have achieved an advanced degree. According to participant P5 those new graduates need to work in practice with patients to gain good experience and to learn the real working situation for the staff and clients:

(P5): *And often they have moved up for positions they are not ready for, I found that a lot in Saudi- you've got people are out of their depth. And I am very clear that those who come back in with Master's degrees just don't get positions up here. No, actually they need to work on the shop floor and then of course they will fast track quicker to that promotion but they need to have the experience on the shop floor first. The experiential learning has to be part of that person.*

A good understanding of culture can lead to a better service through the development of appropriate and effective communication which is accepted by the community, according to participant P15 She emphasised that different cultures attach different interpretations to communication, verbal or otherwise:

(P15): *Communication is key. It is about ensuring that the communication is clear, because with different cultures, you know, you can say something in one way but if I say it and they didn't quite understand it and slightly you lose the intention.*

Absenteeism is a problem that most of the leaders complained about, particularly in conjunction with the Saudi staff. A number of participants from the nurse leaders, including many of them who are Saudi, blame Saudi staff nurses for their regular absences.

Participant P1 believes that they as leaders are responsible for this kind of behaviour, or as he called it, a "culture of absenteeism". He justifies this, saying the senior nurses will threaten the junior nurses who come with enthusiasm to work hard, but then they are confronted by the older staff who diminish their enthusiasm:

(P1): *In fact, we create the culture of absenteeism as organisation. This is not the staff's fault. This is the organisation's fault. I have seven new staff. When they arrived at work the first time, they were excited to work. Then they meet the older staff, who tell them not to work so much, encourage them to be lazy so they aren't chosen for things. They tell them that they are protected by law and only the Prime Minister can kick them out. This is an organisational fault. It is not only their fault.*

As a senior nurse leader, Participant P24 recommended thorough interview and vetting processes. She recalled that in her college, applicants had to be interviewed to gauge the sincerity of their interest. But those who graduate from private colleges are not exposed to such a process. They are more worried about securing a job and earning money than really viewing the role as a vocation. This leads to incompetency:

(P24): *And this is one factor. We have other factors, like how they select nurses to work. Before, I remember in my college, they interview to see if you are really interested or not. Now, because most of them are graduated from private colleges, they don't care. Only for money. Their*

purpose is only money, that's why they have graduated a lot of staff who are really not competent.

Participant P24 also suggested to get to the root of the unprofessional behaviour of some nurses, mainly Saudi Arabian nurses, as the situation was not so marked five years ago. She also blamed the Chief Executive Officer, and the Chief Nursing Officer, for not supporting or trying to establish a system to prevent such behaviours. She pointed out that the CEO did not even allow other departments, such as the legal department, to place sanctions upon nurses who do not meet their responsibilities. She linked all of these issues back to the leadership of the institution:

(P24): *So, the third factor relates to the CNO and the CEO. They are supporting these things. They blame the ministry. If I were CNO and CEO, I would sit and work out the root of the issue because if we go back just five years, we can see that the Saudi nurses were qualified, competent, and could be leaned on. But now it's different, so why? Because we cannot see any support from the CNO and CEO. They are not trying to find a system. They have not involved departments like legal affairs, who can stop this behaviour. Yes if we go back to the root, it's all about the leader and how they manage this institution.*

Absenteeism of staff nurses seems to be a serious issue facing nurse leaders in this medical city. Participant P5 also has commented that in addition to being absent, they frequently arrive late and are allowed to get away with this. She stated that this attitude ought to be challenged and that ignoring it is condoning the behaviour. She also suggested that the attitude should be challenged and not merely ignored. Participant

P5 suggested that as part of their managerial duties, a leader should challenge this behaviour by sitting with those who are regularly absent and explaining to them what nursing is about:

(P5): *I think it's about ensuring we have full understanding, because I think the absenteeism and that side of things, they have been left to get away with it. They arrive late and nobody challenges their absenteeism. Nobody has brought them to task. Nobody has done that. They've been late to get away with it, so nobody has challenged their absenteeism nobody has brought them to task nobody has done that. It is the rules and regulations that need to be set down and that is part of management, that is the managerial side of my job. I need to give them passion and make them understand what nursing is.*

Sub-theme 3: This Works, but no superwoman!

Understanding staff circumstances, especially for Saudi female nurses, was essential for a participant who said that those young nurses have their own children to look after as they run their houses and still come to work full-time. This is a difficult challenge which must be considered as Participant P23 said:

(P23): *Some of the Saudi girls here do need real help, because they are struggling with their own identities regarding where they are in the world. Social media is bombarding them - bombarding them completely – and the culture has its own expectations of them. I have some Saudi girls who have 3 or 4 children, they run a home and they still come to work and work full-time. I couldn't do that.*

Participant P5 shared the sentiment that these women cannot be superwomen and have to be treated with respect. She related that being understanding of staff circumstances is key in creating a proper work environment. Leaders and head authorities need to understand staff limitations and adapt the system to provide a chance for such nurses to both work and look after their families, by offering them part time jobs or flexible working:

(P5): *When my children were small, I worked part-time and you know, these are the conversations I have had with CEO. We now need to adapt the system so that we can give these nurses what they want. Why can't they work part-time? Why does the ministry say no, you have to work a full time? Give them a break, they are not super women!*

Sub-theme 3: The Manager's Solutions

Participant P4 believes that establishing trust is key for the development of the workplace; when team members feels trusted and they also show trust in their colleagues, it will have a positive impact. She thinks, however, that this has not yet been achieved in her workplace:

(P4): *I believe that establishing trust between everybody is one of the key ways to make the workplace better. This trust between every single employee can be achieved by transparency and consistency, which actually, I don't feel that we have.*

Appreciation is one of the easiest ways for managers to maintain a high standard in the workplace. Participant P3 explained how important appreciation is. According to her, it is more important than financial compensation. It is actually what staff nurses

and nurse leaders need; they need to feel appreciated, trusted. They need to be supported to get the best out of them: as simple as that.

(P3): *I think a word of appreciation will really make huge difference. It's not always about financial compensation. Sometimes, for example, if I say to the CNO or CEO that I will resign, then their first question will be about money. I'm not aiming for money in any other place because I'm kind of a task-oriented person, not money-oriented. So if my work or if my effort is being appreciated, even with one trustful word, it would really make me work harder. But without support or without trust, I don't think the workplace will improve.*

Sub-theme 4: Working with conflict

Participant P3 highlighted some conflicts which exist in SA and especially in MOH hospitals. This is because of SA's culture and the misinterpretation of religion, which leads to discrimination as some male and female staff nurses avoid providing care to those of the opposite sex:

(P3): *Yes. Because non-Arabic male nurses, there are no such kind of difficulties in handling male or female patients. Since the male nurses started to discriminate female patients, also Saudi or some of the Arabic female nurses started to do the same thing, which is to take care of the male patients, which is not what we're supposed to do. Yeah, this is very much a different cultural issue, which also causes conflict in the workplace.*

Participant P15 has also faced similar conflict when staff, even from the same gender, have used culture to avoid providing nursing care to a bedridden patient. This was due to the nature of the care needed, which was to apply a catheter to prevent him from urinating himself. P15 was able to solve this problem by delegating this task to a different team member:

(P15): *I have one example about this one - we have a lot of bedridden cases and the application of the condom catheter for patient so they don't wet themselves. So, in this example, we are really having trouble managing the staff. We have to understand that it's their culture but the patient – what about the patient? So I delegate it to other staff.*

The participant P3 created a way of convincing negligent staff to provide a better care and adapt to the hospital rules and regulations. She did this by asking her staff from different nationalities to imagine that the clients or the patients are a member of their family. This forces them to question: are they going to treat them unprofessionally?

(P3): *I here face a lot of problems, conflicts and negligence and unprofessional behaviours from many amongst the staff. It's not limited to one nationality. Generally, we are quite irresponsible here. So whenever I sit with a staff member who is actually having a problem, I would actually start by asking them a question. I ask them in this way: "Okay. When any of your family is in the hospital, say it's here in KSMC, and one of the nurses or doctors comes to you and gives you no explanation about the treatment process, diagnosis or any kind of plan, how do you feel? How would you intervene for your family? If*

the nurse never answered you or gave you the wrong answer, she would be being very rude, very unkind to you."

The same participant continued her statement by adding that staff always respond that they would never treat their family members unprofessionally. They respond by saying that they will provide proper professional nursing care to their clients:

(P3): *So if this is the situation you're facing in KSMC when you bring your one of the family members, is it acceptable to you? They often say no. I then ask immediately: Okay, since it is unacceptable to you, do you really believe this is acceptable for others? They say no. Okay then, what is the reason that you continue to behave in this way, which is very ignorant or unprofessional? Do you want to maintain this attitude or do you want to change? Then they answer yes. They say: "This is really unacceptable. I will never accept that any of the staff will treat my family members in that way, disrespectful. I feel that I need to change."*

Participant P1 highlighted the Islamic culture in SA as sometimes seeming contradictory to the profession of nursing care, as females are separated and it was accepted in the community that women 'belong' to their men. This results in them needing permission when they travel, which affects the ability of female nurses to provide proper care for male patients or even interact with male members of the health care team:

(P1): *Here we have an Islamic culture. There are contradictory issues or points between them. Nursing is in general a female profession and in general, the female in Saudi Arabia, or the female within the Arabic*

communities, they belong to their male. Their levels of freedom should be delivered by their male. This has had an impact on the nursing female leader.

The Islamic faith is also a source of challenge for expatriate nurses who come from different countries where religion does not have the same impact upon public life as in SA. This is nurse leader participant P21 opinion about what is not working in the nursing profession in SA. She believes that faith is totally up to the individual. The situation in here is so different and it is a significant challenge for nurses from abroad:

(P21): *From my side, it's absolutely about the challenge because the way people -- especially in Saudi Arabia, they have been raised from the childhood; it is absolutely affected by the religion, which we don't actually have in my own country. So whatever they think or decide, everything is actually based on their religion or guidance. So I can say this is a challenge because in Korea we don't have a specific national religion. Whatever people believe is up to them, unlike here, so when we came here the first time, the things that were normal for us were totally unacceptable in Saudi culture. For me to overcome such differences between my culture and also the Saudi culture was absolutely a big challenge.*

One of the solutions suggested by participant P26 was that the leaders should have control over his/her leadership style to be able to manipulate it into different styles to deal with a certain situation in a way that does not affect negatively the work process:

(P26): *The nurse leader should manipulate their leadership style to meet the needs of these different people.*

Participant P12 show an interesting method for dealing with some of her staff. She stated that as a female, she can understand her female staff and she can easily find if they are telling the truth or not. She shared her experience with one of her staff who came to her asking permission to leave work because of a family problem but P12 read the female staff member's eyes and sensed she was not telling the truth, so they told her to go back to work:

(P12): *Female to female, we can understand who is a liar and who is telling the truth. One staff member, she comes and tells me: my husband has a problem, he needs me to leave everything and go to see him. I can read her eyes. She's a liar. Go out and continue your work.*

Sub-theme 5: Knowing culture.

Participant P29 provided an example of a policy used in other countries that could help preparing nurses for cultural differences. Participant 29 said that whilst we do provide orientation for new staff about SA, the KSMC should consider the other cultures of staff and patients:

(P29): *Actually, anybody will go to the other countries. They have really to read a lot to prepare themselves because they will face something different, this is number one. And the rule of the hospital or the other countries who are going to receive these people, they have also to give them at least little orientation about their culture. The good things we are doing it here, but still l think we have to consider the other culture because we're already dealing together.*

Participant P29, who is a Saudi nurse leader, elaborated more about the importance of cultural awareness and how it is essential for staff nurses and nurse leaders to learn about others' cultures. This allows you to be prepared to avoid causing accidental offence to others. Participant P29 brought up her experience as a nursing postgraduate student in Sweden, where the culture is very different to SA:

(P29): *As a Saudi people, it is accepted and appreciated for you to touch patient's hands. But when I was outside SA, the patient got angry and pushed my hand. This not all of Europe but I'm talking about Swedish people. She kind of kicked me and started talking in her language, which I didn't understand. But then one senior nurse said to me that you are not supposed to touch anyone until you have permission from them. This was something really shocking for me. So, we have to read more about the cultures and how to deal with people because we are different really.*

Similarly, Participant P13 agreed on the importance of understanding one another's culture, especially understanding a patient's beliefs and values in order to respectfully provide a professional and culturally competent level of nursing care. He continued by stating that such cultural differences are key challenges for SA nurse leaders:

(P13): *The second one is also regarding the patient. We are a governmental hospital so that means we receive also non-Saudi patients, and each one of them has a special cultural concept. This should be understood. This is also a challenge for them, the nurse leader. It's not written but it's a policy.*

Participant P11 spoken about the importance of the language as way of communication and the importance of understanding each other, the patient and the health care provider. P11 said it is possible to have patients who do not understand Arabic nor English, and in this case you need someone who can translate for you both:

(P11): *When you don't have anyone with the same language as the patients, there are issues of translation. Not necessarily all the patients are able to speak English or able to speak Arabic.*

Participant P11 further highlighted an important issue as he described the situation within Arabian cultures regarding the stigmatisation of others. They generalise from only one experience and extend it to the whole nationality. He gave examples:

(P11): *It is also about the issues of culture -- in all and in general -- about Arabic culture. It's not only in the Saudi, about the stigma of the people. We are building up and growing up with stigma that he's Asian, he's Indian and we become prejudiced like that. All the Filipinos think in this way. All Indians think in this way.*

Participant P27 says that cultural diversities can lead to unity. Staff can learn from each other and begin to act similarly. As a solution, participant P27 believes that nurse managers should deal with a new professional culture, replacing unwanted or challenging alternative cultures:

(P27): *Well, it's not necessarily the truth. It's maybe projected onto them: oh, you have an Arabic speaker: He will come late. He will do this and that, etc. The nurse manager should be able to deal with all of these diversities on the same time and this is the challenge. The issue how*

we can build a new culture. It's not only organisation and cultural effect.

Sub-them 6: Education and experience

Experience and education may help a lot in preparing nurses to understand human psychology and provide the tools needed to produce holistic nursing care; that was the opinion of Participant P18, the nurse leader from the Philippines:

(P18): *In our preparation for nursing, we have understood human psychology, we have learned holistic nursing. This is understanding man in all aspects of his being. So that prepares us. It's education and also our environment; experience also is a good teacher.*

As more Saudi nursing graduates come into field, then more preparation and orientation seems to be needed. Participant P4 suggested that those newly graduated nurses need to have a special training programme in order to prepare them before giving them a job in hospital and allowing them to deal directly with patients. He also endorses a specialist training centre for them:

(P4): *For newly hired Saudi staff, we need to make an orientation programme before deploying them in the area. As you get the job, go. There should be a specific training centre for them and let them train and come to work.*

Participant P22 suggested that education and nursing curricula should include topics about each culture, especially the one you work in. Many of the textbooks are specific only to Western contexts:

(P22): *This may be an opportunity for more research. From my experience, I'm not trained to deal with the cultural diversity. This is a fact. I've already finished my Bachelor's and my Master's and we just copied from textbooks from the United States and from UK. All the students with my class, they know about the issues and sensitive culture of Native Americans, more than the issues of our culture. This is the problem.*

This participant also suggested that the Saudi Council of Healthcare specialities, which provide examinations for nurses to get their license, should include a section about cultural sensitivity in order to assess nurses' understanding about cultural diversity:

(P15): *Now, the other sides of the problem…when anyone of us start to train on the NCLEX, we start to learn about the American culture because we would like to pass the exam. But when we learn about the Saudi prometric exam, they didn't mention anything about the cultural sensitivity. This could be a suggestion for Saudi Council to put this in as a part and a preparation course for the nurse.*

Participant P15 also mentioned that it is necessary to have cultural programmes for nurses at a national level, in order to give them a general idea about the Islamic cultural background that shapes the SA culture:

(P15): *Now, I expect that all the nurses, they don't need to speak Arabic but at least they should be prepared on the cultural side. In our hospital, they have some programmes in Islamic cultural background. They have some activities, but it's not organised on the national level to be for all*

nurses coming from outside, even within the Arabic community. They should be trained on this sensitivity. But this is the fact.

Participant P8 has also posited a significant suggestion, using the UK and USA as an example, where those who want to work in one of those two countries, need to pass an English language exam and score a reasonable number of points in order to have the opportunity to be recruited as a health care provider:

(P8): *If you just allow me, I will mention something from experience. Really, we are dealing with different people and we have a lot of challenges here. We have non-Saudi staff working in our hospital. Actually, I was like wondering why they are not developing many things like, as you see in America or UK, before you will come to study or to work, they will ask you to prepare for TOEFL or IELTS.*

Sub-theme 7: Language courses for nurses working in SA

Participant P8 continued and added other examples, such as Korea and the Scandinavian countries, where it is compulsory to attend a one year language course as a preparation for nurses who wish to work there. She suggested that courses in the Arabic language should also be requisite for those who want to work in SA;

(P8): *In Korea and Japan or all the Scandinavian countries, they will not allow you to continue the Bachelors or work until you take one year of their language. So since we have here our patients, most of them they are Arabic. Why not prepare the staff who are non-Saudi? At least one year free, with no work, for them to study the language and then they can deal with the patient.*

Participant P1 also said that Ministry of Health hospitals have only 'loose leadership', which leads to unachieved objectives, this is what he said about these hospitals, which provide free healthcare to everyone:

(P1): *This is the first concept. There are some differences within the same culture. But in general, unfortunately, I feel within the Ministry of Health, there is a loose leadership style or lazy leadership style and they aren't meeting the objectives. They have great objectives or leadership vision on paper, but unfortunately during the application, this is missed.*

Participant P26 also argued that wasting resources and the absence of accountability towards hospitals supplies and organisation budget leads to defects in the nursing leadership:

(P26): *Within Saudi Arabia, you can feel that in the Ministry of Health hospitals, they are losing a lot of resources and we don't know exactly why this is happening. This is affecting the culture within the hospital unit. For example, when you write down every syringe, every cannula you give to patients in governmental hospitals, then the nurse will have the concept of how many resources he/she used for this patient. But when the nurse just goes to the store and you take a lot of syringes together with you, then you don't care how many syringes you consume. This will affect the culture. This is accumulated within the government hospitals.*

One female Saudi nurse leader, participant P6, also explained that absenteeism is a major problem as mentioned earlier. Unlike other hospitals where they have a strong

system that prevents such behaviour, there are no punishments for staff. Moreover, she supported her opinion with an Arabic paradigm relating punishment with behaviour and the relation between both, meaning that if there is punishment, people will behave, and if there is no punishment people will not behave.

(P6): *Some hospitals they are so strict with their staff, they have a system, all the staff they are following the rules. Like, for example, we have a lot of absenteeism. Why don't they deal with our problem? It means they can control. Here there is an Arabic paradigm: "Who is safe from punishment, he'll behave badly''. Really, we don't have a strong punishment.*

Sub-theme 8: Training

The majority of the participants agreed that training in all fields is an important aspect for the development of health care workers and services. Participant P5 placed the leader in the position of responsibility to communicate on a human level, making sure that the message is delivered clearly and it was understood by the followers:

(P5): *So that you communicate correctly, so it does not matter what colour, creed, culture or whatever; if you talking to them properly and on a human level, then they understand what you are saying and the job is done.*

Participant P3 also believed that random selection of leaders with no obvious criteria or qualification, nor unique traits for those leaders, is the reason for the deterioration of leadership and health care services within SA. Assigning leaders without knowledge of rules and policies will eventually lead the organisation to failure:

(P3): *Here we can see that leaders are selected randomly without even giving them any courses, they don't even know simple things about the rules or policies. I don't know how they will deal with the staff. They just want to fill up the gap, throw in anybody just to lead this unit or this area, while actually we can see many things are deteriorating. This hospital was better in 2006 because now they want to select anybody, even if they aren't qualified or capable. So how to lead these people? Unfortunately, as my colleague says, there are still some foreign people who are not qualified whilst there are many competent Saudis who could be doing it.*

While some participants stressed the importance of cultural education and understanding through providing training courses, participant P12 emphasised the self-directed learning of nurse leaders. Nurse leaders need to read about the culture that they are going to settle in and work with. He also recommends that health team members should certainly know about each other's culture:

(P12): *I will give an example. The other nurses who are coming to the Gulf or Saudi Arabia, they are interested in reading about the Saudi culture while the Saudi nationals are not interested in their culture. When you go to Sweden you are interested to read about Swedish culture. But when you receive Swedish nurses to your country, they are not interested in them. If you would like to survive, you should manipulate your skills to be able to survive or to be able to live in this situation. This is exactly what's happened with us.*

Participant P13 stresses the importance of understanding staff needs, adapting one's leadership style, supporting staff in achieving their objectives, leading them through the challenges and taking them to a higher level. Furthermore, participant P13 emphasised the adoption of an effective communication style and changing the method of assessment to satisfy both staff and patients:

(P13): *Being a leader that means you are able to take your staff with you to achieve an objective. To reach these levels, then you need to be aware of their needs, sensitive to what they are looking for and have a full knowledge of their culture so as to function within that culture. Of course, you adapt your communication style for each member of the team because they all use different methods of communication. You will change the methods of assigning tasks based on their needs. Also, you change the methods of your assessing the missions or assessing the patient based on their needs. But of course, it will affect your leadership style.*

In addition to his previous statement, participant P13 said that he believed transformational leadership is the key for survival in the work atmosphere. It is not enough to resolve a dilemma, a transformational leader needs to be able to adapt his leadership style to urgent situations in order to select the suitable way method of leadership with managerial intervention:

(*P13):* *Yes. In my point of view, to survive, not to pass, to survive: you should have transformational leadership. Otherwise if you stay, then I came here with more transactional just only focus on the task and that's it. If*

I stay within my leadership style for four or five years, I will not survive. I will just -- even destroyed or come back to be a staff.

On the other hand, participant P21 believes it is more effective and highly recommended for leaders' development to have regular meeting with authorities from the Ministry of Health and other colleagues from other institutions in order to share experiences. He explained that he has been working in SA for several years and never had such meeting or group discussions:

(P21): *Sharing information with another leader in another institution. Since I started working here, I've never met any leader or anyone from a place related to the Ministry of Health. They are not, we are not, doing meeting with, for example, another hospital to know their experience. Maybe they have successful experiences.*

In conjunction with the previous statement, the participant P8 shared the experience she had when she had the chance to meet with other colleagues from other cultural backgrounds. They had some discussions of what kind of problems they have faced in their work and how they solved them. Sharing such experiences, even if there are some differences, helps in improving the institute and health services provided:

(P8): *I had an experience. Sometimes you are facing a problem, which is kind of a problem or barriers with you and your institution. But when you have meetings with different people from different backgrounds, then you will find how they are solving this problem. So using the other backgrounds and experiences to improve the institution, it's helping.*

Sub-theme 9: Managers and Authority

A different system of hiring could be the reason for absenteeism, as referred to by participant P11. He explained that their organisation had three types of job systems: they are the civil-service system for Saudi employees; civil-service for non-Saudi employees (where job security is high and accountability is low); and the Health Operation Programme (HOP), where most of the employees are non-Saudi but there are some Saudi staff (job security is low and accountability is high). Participant P11 compared the ratio of absenteeism for Saudi staff in both job systems and stated that it is lower in the HOP system, where the leader can take action and apply sanctions to Saudi employees:

(P11): *To be fair, it's partly from the differences in the labour work. If all staff are working within the same level, no one will be able to have the power to do that. The problem is we have three levels of work in the city. We have the first chapter on the civil service which is for Saudi staff, and we have the second chapter which is for the non-Saudis in the civil service. Then have the health operation program. In the third one, for example, the third one, either Saudi or non-Saudi, they have the same level of work. In this way you can see simply, the Saudi staff on the HOP, they don't have any absences or they're absent within the normal level. But the highest absences are coming within the first group, because if they have absent, they know they have been covered within the regulations and this is the different for that. If you would like to split a culture within your unit or your organisation and you should*

deal with these issues or you should make it all within one regulation to make it work as for example, the same of King Fahad Medical City.

Participant P1 related that culture was the main source of negative impact on leadership and eventually the quality of service provided by the organisation. He described some of the cultural values that staff from certain nationalities hold towards other nationalities because of their race. P1 gave an example when he described the staff coming from India display a great respect for host culture of their new workplace. Those staff consider the Arabs to be leaders even when they have neither experience nor qualifications, just due to their race:

(P1): *Ones' values could affect the others'; it is partly from the stigma of the people, stereotyping or racism. For example, the Indian people look for Arabs as superiors even if they are just managers. They have been born to be managers. The problem is then when a senior nurse with 20 years experiences looks to a junior nurse as superior and gives them a role as a manager. Or if they get an order that is wrong but because their values that they should respect the manager they let it pass. This is important. This is a negative side.*

Participant P3 suggested that nursing has a bad reputation in some parts of the world, like India where she comes from, therefore it is important to work hard with the media and the community to correct this misconception of nursing, so as to show how humanistic and important the nursing profession is:

(P3): *When I was small, I was hearing that, yeah, she is a nurse. They look like bad women. Even today many Hindus see the nursing professions as something bad.*

Participant P19, said that the Head of Development, benefitted from the group discussion and decided to add a cultural training in orientation course for the new staff in KSMC. As she stated, it was only few slides about culture in SA included in the orientation course for the newly assigned staff, but she decided to expand this:

(P19): *Okay. First of all, thank you for this interview because it's really given me the idea to add on our orientation. We need to include other cultures and religions because actually I am the Head of the Development department and we are only discussing the culture of Saudi Arabia and religion. But really after this meeting now, the idea it's come to me that I will select all the countries that we have here and will make like at least three to four slides talking about their like religion and culture.*

On the other hand, participant P1 who is a nurse leader, has a very interesting view about what kinds of training works and what does not. He stated that training should be based on society's needs and should consider that society's geographical location. He clarifies by saying that training should not just be copying text books from other cultures as the SA culture is so specific:

(P1): *When I look to our CNO, the new CNO, coming from an European country after 35 years of experience and she wasn't in a position to be a Nursing Director. While we are in this age, our communities are highly developing communities but we are a young society. Our training needs should be satisfying that, satisfying the issues of culture, satisfying that our focus on the paediatric care more than the geriatric care, for example. It should also consider our status as an unsafe zone*

within the Middle East. The training should be focused on this. We should not copy the box from Europe on geriatric care; we spend one year of geriatric care where we have less than patients in this group.

While previous participants emphasised training in communication, Participant P16 believed it is more important to provide not only lectures about leadership as he stated, but brainstorming, regular meetings with other health workers from different departments and group discussions to share best practice:

(P16): *Yeah. And even leadership courses. We need a workshop, training with the actual scenarios. We don't want lecture only. We need to be brainstorming regularly. Unfortunately, we don't have this. If there is regular meeting with the friends, group discussions are great.*

As well as communication training programmes, participant P21 suggested that nurses and nurse leaders need to have leadership and management training courses. They would also need courses in how to solve problems in workplace and finally, training in open communication between leader and followers:

(P21): *For Saudi, of course, first of all the leadership management. Also, problem solving and then, open communication between the leader and his/her subordinates.*

Participant P3 believes that training in communication skills would be very helpful because it provides nurse leaders with necessary skills of listening and showing interest, not just learning how to speak languages by rote. The communication skills should be practiced mainly with end users who are the clients, as she said that those are the most important people for the organization:

(P3): *For me, communication skills are important but not only to show others that I know how to speak English or I know how to speak Arabic, no. I mean real listening skills and real communication skills with end users who they don't consider to be important but are the most important people in maintaining this organisation. Real communication skills, not showing off to others, but real, understanding communication skills.*

In addition to the previous participant, this participant P10 emphasised the importance of training in communication skills for the health team members and especially for those who are leading, in order to maintain a good understanding of each other. She would also train staff and leaders about nursing processes and critical thinking:

(P10): *For me, I would like the leader to have really to have good communication skills. How you will communicate to your staff is important and you need to know how to do it, especially if you are in a key position.*

Participant P27 also mentioned communication as the first topic for training for her staff and nurse leaders. She additionally suggested that transparency in work is important, as well as training health team members to respect each other:

(P27): *For me, first is communication skills. Second, is transparency in the workplace. And third is respect to each other. So as a leader, I benefit from this.*

Communication training again was mentioned by participant P2, considered to be of first importance beside nursing ethics and thorough knowledge about policy and procedures of the organization:

(P2): *First, communication. Second, ethics. Laws, plus policies and procedures of the hospital where they work.*

Participant P3 added to this theme, that clinical knowledge and skills were vital for members in the organisation. She added to this suggestion that almost all of the team members do not have the necessary clinical skills and knowledge:

(P3): *I want to have one more, add one more. Clinical knowledge and skills. Almost all of them, unfortunately, don't have the necessary clinical skills and knowledge. When it comes to any kind of serious event, the managers actually cannot really decide what went wrong and what is the best solution. So when they discuss about root causes and try to come up with an action plan, they will grab something in the sky, not in reality.*

Participant P2 suggested that it may work if the MOH opened a window for communication with other organisations. This would allow her nurse leaders to exchange updates, discuss solutions and suggest new ways of development. She also commented on the role of the job system and how it let those who do not respect their job be questioned and sanctioned:

(P2): *Yes. They have to make open communication at least every year; they have to meet all the leaders and to hear what is really happening in the hospital because unfortunately most of them are handling positions but*

they never got to the area and they don't know many things. Second thing, they have to work on Civil Services, which are destroying our hospitals. They have to change it.

The same participant P2 also suggested providing Arabic language course for one year for those staff and leaders who do not speak Arabic:

(P2): *On the other hand, they have to provide one-year Arabic language for foreigners.*

Participant P22 nominated communication in one understandable language as essential to avoid getting lost in translation where memos come in Arabic, which is not spoken by many health care members as they use English to communicate in all health sectors and among the workers and the health team members:

(P22): *For me, as I am foreigner, the first issue is the language. Those memos from the Ministry are purely Arabic. If it is in English, all can understand.*

5.5 Summary

Nursing leadership in Saudi Arabia has been highly influenced by globalization and the multinational workforce of the modern world. The role of nursing leadership as a source of power that can lead people and health organisations into success is becoming increasingly important. However, the required leadership skills and behaviours need to be considered in depth within the unique context of Saudi Arabia. Solutions for conflict, obstacles and problems differ among participants; some believe that the nurse leader should challenge difficult behaviours that affect the provision of health care services or affect the rules and policy of the organisation. Others suggest providing

local knowledge to the managers and staff about the rules and regulations of their host organisation in order to equip them with the required tools to be knowledgeable about what is right and what is not. These include knowing the right procedures to be taken during challenging situations.

Empowering nurse leaders and providing them with the necessary skills to manage conflicts within teams and amongst her/his staff was suggested as an essential method to develop nursing leadership in SA. In addition, giving them the tools to engender team spirt, appreciate their colleagues, and develop their staff accordingly whilst learning local cultural values will provide nurse leaders with a respect for all that will support their care provision. Developing the communication skills of nurse leaders was repeatedly emphasised. Lastly, training in all fields was viewed to be an important element of the solutions that can work to develop effective nursing leadership in SA.

5.5.1 Summary of Findings to Research Questions:

1) What is the nature of the relationship between culture and the leadership style of SA nurse leaders in practice?

Answers: In the Middle East and Saudi Arabia in particular, leadership styles have been claimed to be held back by national cultural values, but it is currently unclear how SA nurse leaders are negotiating the balance between national cultural values and modem influences, and how the values they uphold may influence their leadership roles and practices. In order to develop leadership in the SA context, there is a real need to understand better nature of the relationship between culture and leadership. Thus, this study investigates to what extent and how the nature of culture influences the leadership process of SA nurse leaders.

Culture refers to the beliefs and values that have existed in an organization for a long time, and to the beliefs of the staff and the foreseen value of their work that will influence their attitudes and behaviours. Nurse leaders usually adjust their leadership behaviour to accomplish the mission of the organization, and this could influence the employees' performance at work.

In this study, it was indicated by the respondents that culture may be responsible for the discrimination between genders, as male members are free and do what they want whereas the female members of the SA community are prevented from most aspects of public life. Some Saudi female nurses prefer not to deal with male patients and some male Saudi nurses prefer not to care for female patients. These cultural norms and customs have led to gender separation, especially in relation to nursing care. With a society that considers the male and female spheres and responsibilities to be so distinct, women managing men or male nurses treating female patients have become contradictory to the norm.

Another issue is that the limited mobility of women in SA; having no free will to other things like driving. In addition, women in SA, whether Saudi or not, must cover their hair and neck, as well as their arms and legs. Participants also explained that these cultural norms, and some other inherited traditions, may lead to delays in nursing leadership development in Saudi Arabia. Moreover, leadership styles of nurse leaders may also influenced by cultural issues as to language, nationality, and education of SA nurse leaders. Overseas or foreign nurses do not always fully understand the Saudi culture and language. Hence, problems arise that prevent adequate patient care and that have an influence on the performance and challenge of leadership.

Nursing practice in Saudi Arabia is significantly affected by traditional, socio-cultural factors, which will colour the nurse's view of his or her profession. Any one of these factors can create and increase problems for Saudi nurses, and the nurses themselves do not have the resources needed to facilitate cultural change in the workforce. This in turn leads to difficulties for those in leadership, as motivating and managing such a disparate staff base that experience such dissatisfactions is challenging.

To summarise, SA nurse leaders must recognize that choosing the right leadership style for the current situation tends to improve the likelihood of success. Typically though, most leaders use a primary style in their management approach. Cultural traditions and values play a role in a leader's style. According to the "International Journal of Cross Cultural Management," leadership traits result partly from cultural norms and partly from the needs of the leadership job. Cultures differ regarding the use of power. People who act to maximize their personal gain behave as individualists. Collectivists, on the other hand, are expected to act to help the community. By acknowledging these differences, leaders improve their ability to function while conducting working on a more diverse setting.

2) What are the qualities that nurses in SA need in order to be identified as culturally competent nurse leaders?

Answers: The development of a multicultural background provides the workplace and leadership with broader understandings and greater abilities which will enhance both that workplace and society at large. In SA, nursing is considered to exist in one of the most complex work environments. Thus, recruiting and retaining expert nursing

leaders is essential to enhancing the stability of nursing care and to improving nursing leadership in multicultural environments.

To be culturally competent the nurse needs to understand her/his own world views and those of the patient, to avoid stereotyping and misapplication of scientific knowledge. Cultural competence includes obtaining cultural information and then applying that knowledge. Knowledge of cultural information is very essential for delivery the quality of care and it improves health outcomes.

In addition, nurse leaders need to express compassion and care towards all patients and instill in their staff a desire to treat all patients equally. Nurse leaders must interact with diverse cultural backgrounds in staff and patients, helping his/her staff and colleagues to adapt to the norms of the host country. This implies that competent nurse leaders need to avoid misconceptions between genders and to understand that men and women perceive information differently. He/she needs to possess critical thinking capacities to overcome any difficulties he/she may face in their career. A nurse leader also needs to be well educated and trained, likewise an experienced one, in order to develop their personality and their ability to deal with crucial problems. Also, nurse leaders need confidence to make decisions instantly, and to stand up for what they believe to be right.

Likewise, culturally competent leaders must possess essentially the quality of being trusted leading towards a successful leadership. However, building and maintaining trust is hard to establish, thus, a leader's behaviour plays a key role in building trust and maintaining them. Aside from being trusted, the nurse leaders must respect the

cultural diversities of the all the clients and to be respected by them. Earning respect takes time and effort in SA; this effort encompasses some leadership characteristics and duties that demonstrate these traits. Participants shared that when employees respect leaders, they are more likely to work harder to accomplish a shared goal that they believe in. It was also presented that leaders are requested to recognise that employees are people and they have psychological needs, such as the feeling of respect, which must be met and nurtured in order to enhance performance. It is the job of leaders to make decisions but the competent leader should involve his staff and colleagues in making decisions. By demonstrating such qualities as being respectful, nurses and nurse leaders are more likely to influence their leadership and show cultural competency.

Moreover, other qualities of nurse leaders to be culturally competent, one must be an effective communicator. Effective communication is essential within the group or organizations. It is one way of understanding patients. Nonverbal communication is the major aspect of communication that should be used and understood carefully. Other participants believe that nurse leaders should be required to develop proper and effective communication with each other and with other health care professionals to overcome misunderstandings or faulty assumptions, which could result from different cultural expectations and backgrounds.

As a culturally competent nurse leader, he/she must be a great challenger and flexible enough to face those challenges in life and at work most especially when surrounds with many people with diverse cultural backgrounds. Participants asserted that effective and competent leaders are better place to meet organisational goals and to do

this; they need to guide their staff effectively. Fostering good communication and building trust is intrinsic to that goal, as is a flexible approach that considers the needs and culture of each member of the team. However, participants did identify the difficulties in doing this with a culturally diverse staff.

Lastly, nurse leaders must be role models to young people. Staff are led by example; and where the leader goes their colleagues should follow. Being a role model is perceived as critical to developing competent leadership. Participants emphasised that leadership is not merely about management, but being aware of the backgrounds and experiences of individual members of staff. It was additionally highlighted that a good leader directly contributes to the ethos and efficacy of the workplace.

These data suggest that creating an environment where workers can achieve their peak performance is a necessary for attaining the leaders' vision. Such positive actions make the vision more realistic for team members. Some participants' views regarding the leaders' vision and visionary leaders emphasised the characteristics of such leaders and some of the qualities that enable such leaders to achieve vision. Other participants simply emphasised that vision may not provide sufficient motivation and a leader should have a good understanding of his/her team; this will enable him to know what motivates them and drive change forward in the SA context.

3) How does the changing nature of healthcare in SA impact on their role and leadership style?

Answers: The government of Saudi Arabia has made healthcare a top priority in its development plans. Consequently, the Kingdom is implementing radical changes in

the structure and function of its healthcare system to enhance the quality of care and efficacious service delivery through its NTP 2020. Organisational change is among the major challenges that face healthcare organisations, and many factors affect their ability to be ready to adopt the change desired. Among these important factors are the significant role of the attitude of the leadership that is responsible for the change. Moreover, nursing leaders in SA face a myriad of challenges which are unexpected and prevent leaders from managing their teams and achieving their goals. Some of these obstacles also affect the leader on a personal or direct basis, especially for those who are working in a different culture and operating within a multicultural workplace. Cultural challenges were repeatedly emphasised as difficult and these complexities demand exceptional abilities to achieve resolutions.

In addition to this, because of globalization and the multinational workforce, nursing leadership in Saudi Arabia has been highly influenced by other cultures, their role as a source of new power and thinking can lead people and health organisations into successful change is becoming increasingly important. However, the required leadership skills and behaviours need to be considered within the unique context of Saudi Arabia. Solutions for conflict, obstacles and problems differ among participants; some believe that the nurse leader should challenge difficult behaviours that affect the provision of health care services or affect the rules and policy of the organisation. Others suggest providing local knowledge to the managers and staff about the rules and regulations of their host organisation in order to equip them with the required tools to be knowledgeable about what is right and what is not. These include knowing the right procedures to be taken during challenging situations. Thus, the nurse leader should participate in the positive changes currently happening within SA's culture and

to contribute usefully to this process within nursing, as well as generally in Saudi society.

4) What training do nurse leaders in SA need in relation to their present role?

Answers: As a nurse leader in a healthcare organization in SA, they should be able to access training workshops on leadership with reflections of the impact of working in a culturally diverse society. Since then SA surrounded with many foreign nurses, nurse leaders must be equipped with knowledge and tactics on how to handle those conflict arises in the organization. Empowering nurse leaders and providing them with the necessary skills to manage conflicts within teams and amongst her/his staff was suggested as an essential method to develop nursing leadership in SA. In addition, giving them the tools to engender team spirit, appreciate their colleagues, and develop their staff accordingly whilst learning local cultural values will provide nurse leaders with a respect for all that will support their care provision. Developing the communication skills of nurse leaders was repeatedly emphasized. Lastly, training in all fields was viewed to be an important element of the solutions that can work to develop effective nursing leadership in SA.

5) How might training and development best be delivered?

Answers: Training workshops were deemed important to all nurse leaders in SA due to the many problems that arise. Some of the participants in this study also suggested having new Head Nurse Courses as further leadership training opportunities for other head nurses. Others suggested conducting a more relevant orientation program prior to the beginning of his/her clinical work. This orientation program could cover culture alongside all rules and regulations must be known by the staff and other head nurses,

so they can abide these rules and regulations in the healthcare setting in a culturally competent way.

Another suggestion is that training and development on cultural competence might best be delivered when the Human Resources Department organized a specific schedule such as teambuilding and leadership workshops to employees of the organization. This might be the best in order to develop camaraderie and a harmonious relationship with other staff and or employees including those foreign nurses who are now working there. Regardless of gender or culture, the training provided is likely to be more effective if it is free.

CHAPTER SIX: Discussion

6.1 Introduction

The last chapter provided the findings gained from all data that were collected and analyzed relating to culture competency and nursing leadership in Saudi Arabia. This chapter will review and discuss the research findings in respect to the research questions. It will also discuss the findings of the current study and compare and contrast these with the existing literature and the conceptual framework. The present study critically focuses on the four main components of the cultural competency model (Papadopoulos, Tilki and Taylor, 1998): cultural knowledge; cultural awareness; cultural competence; and cultural sensitivity. It highlighted the linkages between these four components, explained and discussed in respect to the main questions of the research and to participants' responses organized into themes and subthemes. Natural overlaps between research questions will be noted whilst also addressing how each of the questions have been addressed separately. This chapter will make clear how the findings from the present study enhance understanding of cultural competence in nursing leadership in Saudi Arabia. In addition, the chapter makes reference to the implications of the study findings for nursing leadership practice and leadership training in Saudi Arabia. Finally, recommendations from the study and a nursing leadership training program are proposed.

This discussion includes an explanation of the three main themes identified from the outcomes of the research study. The first main theme relates to gender aspects of nursing in Saudi Arabia; this theme consisted of eight sub-themes. The second main theme focuses on personal leadership qualities, and consisted of seven sub-themes.

The third main theme explores what works and consists of eleven sub-themes. Focusing first on the question of gender and according to the outcomes of the study, the participants have repeatedly raised the problem of the gender-based segregation inherent to Saudi culture, enforced through government and sanctioned by society.

There was a total of 46 participants involved in the interviews within this study, and 30 of these participants were distributed across six focus groups. Hence, the outcomes reveal combined responses of all the participants, as well as those included in the interviews. The gender-based segregation found throughout Saudi Arabia which was previously mentioned, was also compounded by a culture of poor communication, blame, and lack of resources within the nursing profession, a finding which is also supported by Alahmadi (2010).

This study employed Papadopoulos Cultural Competence model as its theoretical framework (Zaidi et.al, 2016) to provide some awareness of the role that cultural knowledge, cultural competence, cultural sensitivity and cultural awareness play in nursing roles in SA. According to this model the cultural identity, self-awareness, ethnocentricity, heritage adherence, stereotyping, ethno history, diagnostic skills, health beliefs and behaviors, interpersonal and communication skills, respect, appropriateness and health inequalities are all important considerations. Therefore, there are cultural similarities and diversities in healthcare contexts that must be considered, including societal practices and how these impact in a cultural way in hospital settings as outlined in other studies (Alqahtani, Jones and Holroyd, 2015). The current emphasis on empowering clients, with the intention to take part in healthcare decisions, must also take into account the cultural norms of health care professionals, and should recognize how society can perpetuate built-in disadvantage.

This study reveals much about the culture of nursing in SA and how this influences an individual's identity, lifestyle and forces new connections with others both within and outside their own culture (Guta and Karolak, 2015).

6.2 Papadopoulos cultural competence model

According to Papadopoulos' (2006:10) cultural competence model, there are four stages: "Cultural Awareness, Cultural Knowledge, Cultural Sensitivity and Cultural Competence (Niroz and Semuhungu, 2010). The central orchestrate in the model is cultural awareness, which begins with a person's evaluation of their own beliefs and values. The possibility of improvement of social lifestyle and also its effect on people's prosperity, feelings and practices are viewed as key sheets of a learning stage. Social data (the second stage) can be achieved in different ways. One of the key ways is through meaningful contact with people from different ethnic groups. This increases the individual's knowledge about their beliefs and behaviours, and increases the individual's level of understanding around the problems that people from the other culture face (Papadopoulos, 2006). Through sociological examination, it is possible to see emerging issues concerning power, for instance, the use of power and control, or to make connections between cultural positions and other characteristics. Anthropological data empowers us to appreciate the traditions and self-personality practices of different parties consequently enabling us to consider comparable qualities and differentiations. A fundamental part of achieving social affectability (the third stage), is the way that specialists see people in their care. Unless clients and health team members carefully understand the culture of each other, the understanding and sensitivity of cultural care will be difficult to achieve. Therefore, it is necessary for a mutual level of respect and acceptance to exist between nurses, clients, and co-workers and clients, which makes way for negotiation, acceptance, trust, negotiation

and facilitation between all the parties. The fourth stage, cultural competence, is achieved when the individual is able to apply their previous awareness, knowledge and sensitivity to people of different cultural backgrounds, specifically as it applies to the issue of assessing needs, diagnosis, and providing and managing care within the healthcare setting. The result is also a broader understanding of areas of inequality and human rights, which helps to bring about changes within the patient-provider relationship as suggested by Papadopoulos, Tilki, and Taylor (1998) and Papadopoulos, Shea, Taylor, Pezzella, & Foley (2016).

Al-Sayegh (2013) has determined that it is important for nurses to comprehend their views, value system and beliefs, and by so doing enhance their own cultural awareness starts with developing an understanding of their personal value base and beliefs. In a study by Frewen, Chew, Carter, Chunn and Jotanovic (2015), cultural competence is seen as the capacity to give care effectively which has taken into consideration people's behaviors, beliefs. The responses of the participants in this study indicated gender issues as one of the main concerns in terms of implementing effective care giving, which could be linked with being able to provide effective nursing leadership in Saudi Arabia. As discussed above, cultural norms in SA can provide a cover that leads to a refusal to comply. Hence, also according to these participants, an explanation of this situation is possible to link to different causes; an example cited is that Saudi female nurses may wish to work in male units themselves, but the cultural norms and social circumstances prompt them to request a move to a female unit, an issue identified by others (Almutairi, McCarthy and Gardner, 2015).

The outcomes of this study have revealed some of the cultural factors in Saudi Arabia culture when patterns and difference across the transcripts were grouped together and

labeled under the theme of gender. The outcomes revealed that large numbers of expatriate nurses appear to have limited knowledge about, and may have an issue with, providing culturally competent care in this country. One of the participants of the study, who had worked in SA for a considerable length of time and has an in-depth knowledge of Saudi nurses, asserted that her Saudi colleagues have stronger characters due to the SA culture. However, on the other hand, these data also revealed that non-Muslim nurses do not always know how to look after patients in a religiously appropriate way. This is the main reason they have a Nursing Orientation Programme for three weeks for non-Saudi nurses. This may increase knowledge about Islam, and how the patients can pray, but the findings from this research study also suggest the need to expand this training, especially around the topic of nurse leadership.

According to Papadopoulos, Tilki and Taylor (1998), creating social ability, attendants' impression of social skill is introduced as Cultural Awareness, Cultural Knowledge, Cultural Sensitivity, and Cultural Competence. Social mindfulness starts by distinguishing the components that have framed one's own particular social qualities, in this way the social foundation is investigated and social personality is resolved. To have the capacity to recognize social contrasts one needs to think about one's work with multicultural patients and call attention to those components of shared traits. Additionally, the meaning of culture given by Papadopoulos demonstrates that it is characterized by the shared understanding of the different lifestyles of people, which integrates beliefs, thoughts, values, language, interchanges, ethics and markedly communicated arrangements, like societies, skills, manners and attire. This understanding is particularly important in being able to answer the research question: “What are the qualities that nurses in SA need in order to be identified as culturally competent nurse leaders?”. For example, if nurse leaders do not understand the

definition of culture they cannot be considered culturally competent. The findings showed also that shared values and ideas are important in facilitating communication which may help nurses and other healthcare professionals to interact effectively with each other. It is indicated that communication used during the course of interaction with people from diversified cultural backgrounds helps to share thoughts and beliefs. Ultimately, some balance of cross-cultural knowledge and communication skills seems to be the best approach to cultural competence education and training for nurse leaders and health care professionals, a conclusion that helped address the research question: "What training do nurse leaders in SA need in relation to their present role?".

6.2.1 Cultural awareness and nursing leadership in SA

As revealed in this research cultural awareness includes the level of awareness a leader has about his or her own cultural background and identity. Participants came to a shared agreement that the health system in Saudi Arabia is mainly staffed by Non-Saudi health professionals, with nurses recruited from all over the world. Therefore, inadequate cultural awareness by nurses and nurse leaders can render the leadership ineffective, caring for patients and health care services. It is possible, however, that this problem can be addressed should aspects of Saudi culture be introduced to health professionals intending to work in Saudi Arabia and care for Saudi patients (Al-Shahri. 2002). It will also need reinforcing in further training, such as new leadership courses (once again these insights helped to address the research question about the training needs of SA nurse leaders).

Any individual who expects to work abroad ought to know about the assorted variety of cultures with which individuals live, be receptive, and grasp the complexity of social contrasts. Other cultures may believe that the ways we teach and behave are the

norm and could be considered as a standard. Be that as it may, once implanted in a culture dissimilar to our own, it is hard to envision that things we see are not unusual for those that live within that culture. These findings indicate that nurse leaders in SA should know about the diverse social implications, and health team members should be able to understand and give credit to specific cultural practices, although it is suggested here that this has not always been achieved. Being socially mindful is the exemplification of being socially equipped, which perceives separation and abstains from stereotyping. Being socially mindful, then, is simply being mindful of other's differences. It involves a 'social mind' that recognizes the needs and wishes that other people may have in the present moment. The kind of prosocial behavior we associate with social mindfulness requires that people both see what others may want, and act accordingly; so, it is a two-step process (Monteiro and Fernandes, 2016).

It may be understood from this study that examination of the participants' views bolsters the significance of social attention to encourage the working and connections to gain mutual understanding and provide comprehensive care. A linkage to the data in this study can be seen. For instance, Saudi female nurses wanted to work with male nurses whenever they are required, but due to social and cultural norms of Saudi Arabian society, they will not be allowed to work with a male nurse. Additionally, the family barriers and responsibility on female nurses to comply with cultural norms, often leads to job dissatisfaction and may later influence the quality of care provided.

The data from this research study suggested that nurses felt there was a need for a level of understanding of cultural awareness and flexibility to be present in nursing leadership, however, generally there was a low level of the cultural awareness demonstrated by nursing staff themselves. Even although these health care

organizations did provide an orientation programme for new workers which introduce Saudi culture and Islam, to help prepare nurses to work as leaders with the level of cultural competence required, the data suggests this has not been done as effectively as they would have liked. There is obviously a need to enhance such efforts in the nursing profession generally in SA, the process of enacting changes appears to be slow amongst nursing in the country, including leaders.

6.2.2 Cultural knowledge of nurse leaders in Saudi Arabia

In this study, it was discussed that social communication is one way of looking for and acquiring cultural knowledge about assorted social and ethnic gatherings. It was also suggested that healthcare providers should not generalize about Saudi individuals, yet rather see them as having different requirements, dialect, instruction, customs, convictions, practices, and social settings. A "one size fits all" way to deal with human services practices won't work, in the same way that individualizing health care services is essential. It was emphasized by participants that it is not possible to generalize a patient as a result of his or her perceived way of life. Saudi Arabia, as any other country, has its own cultural norms and values, to comprehend such cultural aspects training must be prepared and delivered to nurse leaders who come from different parts of the world to bolster their cultural knowledge about SA and answers two of the research questions - What training do nurse leaders in SA need in relation to their present role?, and How might training and development best be delivered?. Some authors argue that, when providing care to Muslim patients it is important to remain unobtrusive and protection of the patient’s rights ought to be regarded, and nurtured by a health professional, ideally someone of the same gender, which meets the needs of the Muslim culture (Cang-Wong, Murphy, and Adelman, 2009).

Throughout this research study, there were a number of times where the participants acknowledged a need for a greater understanding of different cultures, specifically for those who are looking to be, or who already are, undertaking nurse leadership roles. For instance, some participants suggested that nurse leaders should learn the local cultural values of the society he/she is working with and use this to gain the knowledge and understanding necessary to gain respect for all cultures. As a result, this increase in knowledge and understanding will help to develop leadership which is culturally competent. In addition, the findings indicated that the personal level of understanding and knowledge of other cultures and the need to address co-workers and patients in accordance with their specific cultural identity is essential.

It was discussed that nurse leaders, in order to be culturally competent, also need to be aware of the staff lifestyles, being sensitive to their culture and have a full knowledge of their cultural world so as to function well within that culture. As addressed by these participants, cultural knowledge may lead the nurse towards providing culturally competent health care to the patient. Parallel with the findings, is the definition of cultural competence by Andrews and Boyle (2003:15) as they define it is a "...complex integration of knowledge, attitude and skills...". This process may lead to the developing and sharpening of nurse leaders' cultural knowledge, and helping them to work effectively within the cultural context, either on an individual or community level, with diverse cultural backgrounds.

6.2.3 Cultural competence of nurse leaders

It is important that nurse leaders have an awareness of cultural beliefs so that they are able to guide others in the provision of effective nursing care and be able to communicate with patients and relatives in a meaningful way. The findings in this

research study has supported that many in nursing supervisor roles have an understanding of the need to be culturally competent, not only when working with patients, but also when working with and supervising nursing staff. For instance, according to one of the participants who is head nurse: "*I am looking after non-Saudi staff and Filipino staff, Indian staff, Asian, South African and western staff. I will deal with all of them in their individual cultures"*. However, the understanding by nursing supervisors is not always carried over to the nursing staff. There was an acknowledgement by nursing staff of this need, but more as a struggle they faced than really an understanding of the different cultures. For this reason, the supervisors need to help nurses from all backgrounds to gain a higher level of understanding of their own culture as well as the culture of those they work with and care for. Doing so will help these nurses to gain cultural competence.

Furthermore, Alqahtani et.al (2015) highlights that there are still several significant gaps in understanding how culture affects leadership in international healthcare circles, such as SA. As findings indicate, leaders should understand the meaning of what culturally competent leadership is when working with mixed cultures. It was clear this is a complex issue and like all complex issues requires preparation and support. A leader should be able to think out of the box and be prepared to take risks. As located in the findings, in SA culture, many leaders are acting as managers, whereas the nurses actually need somebody to lead them, someone, who can inspire and engage them and help them turn the vision into reality. Data in the present study strongly indicates that a leader should be a risk taker, a role model and an example for followers. It was emphasized that a leader should apply leadership skills, not just undertake a managerial role. One participant went on to explain that some leaders who still cannot differentiate between being a Manager and being a Leader. Some of them

strongly felt that a successful leader is one who is prepared to take risks and also defend their staff. This protective characteristic will earn them the respect of the team. Another participant describes a leader as one that at all times defends their team and staff and advocates their cause. In addition to vouching for the team, other participants also believe that a leader should involve the team in decision making and encourage them to grow career-wise.

Issues arising from each theme are now discussed.

6.3 First theme: Cultural diversity challenges and gendered aspects of Nursing in Saudi Arabia

6.3.1 Cultural influence and diversity

The current nursing environment in SA is very complex with the advancement of Saudi nursing as a self-governing indigenous master workforce. Genuinely, medical specialists and patients in SA come from diverse language and social backgrounds (Rassool, 2000). As a result, there is a large influence from different social settings and struggles outside of the medical arena which affects the patient nurse relationship. Furthermore, there is a need for highly skilled nursing supervisors and leaders who are able to manage a diverse workforce. Also, medical organizations in several parts of SA have a diverse nursing staff as well as patients, requiring the administrator to have a high level of social capability. Additional cultural characteristic unique to SA, are further affected by the wide enlistment of medicinal guardians, requiring administrators to be able to navigate this cultural norm effectively (Rassool, 2000). It also means having a deep understanding of the roles of family ties, the Saudi Constitution, Shariah law, the Arabic vernacular, social norms, and Islamic views on prosperity and daily life (Rassool, 2000).

As per the first main theme, the participant's responses shaped the sub theme pertaining to nursing hierarchies where the connection with gender in healthcare in Saudi Arabia was also seen. Well trained nurses with cultural competence are more capable to provide nursing care that incorporate patient's cultural practices and promotes his/her adherence in that care (Doring et.al, 2016). Informing users about the use of therapeutic means that are relevant to their culture may also be useful for treating the disease and promoting health (such as diet or understanding the importance of adherence to medication regimens), issues which are important to promote as a nursing leader. In accordance with the present study it is known that nurses with cultural competencies generate patient care in an individualized way that promotes better patient adherence and safely and effectively incorporates their cultural practices (Guo et.al, 2015). As mentioned, cultural practices vary according to communication patterns and social stratum and nurses need to be aware of these. There is still variety within a culture. Therefore, the patient is not able to be categorized solely on the perceived culture they belong to, or by single practices, values, or beliefs associated with the culture. It is essential for the nurse to exercise true cultural competence by taking the time to get to know and understand their patients and to understand their lives and how their culture influences them (Demorest et.al, 2017). This is also true for nurse leaders who are required to understand cultural differences in their staff (including those from the same group).

Hence, the responses in the present study showed that nursing in SA is functioning in a complex and nuanced context and that nationality plays a significant role; especially when intersected with gender. In SA, there is currently a necessary and substantial reliance on overseas (expatriate) nurses to meet the health needs of the population. In addition, there is a critical need for all Saudi nurses to be sensitive to patients' cultural

and religious needs. The researcher, as in previous research, found from the participants' feedback that expatriate nurses do not always fully understand the Saudi culture and language (Alqahtani et.al, 2015). Therefore, from the perspective of SA nurses, problems may arise that prevent adequate patient care that is related to leadership. According to the outcomes of the present study, respondents also showed how staff can respond very differently to their nursing leaders, depending on whether they are Saudi or foreign. Thus, improving the qualifications and the leadership situation, and future potential, of Saudi nurses is critical (Demorest et.al, 2017).

6.3.2 Challenges facing nurse leaders in SA

The analysis of the study signified that conflicts and misunderstanding with patient and other healthcare team members through lack of cultural skills in how to cooperate within the appropriate culturally way, could lead to an increase in levels of tensions and conflicts. These can threaten the quality of healthcare services provided. Therefore, when recruiting foreign nurses to work in SA, attention should be given to their cultural competence, and they should be prepared to work in the SA healthcare environment. The sensitivity of culturally diverse workforce needs to be improved by training and development of cultural competencies**,** and answer the research question about what training do nurse leaders in SA need in relation to their present role?. Nurses must acknowledge and understand differences which define patients from various settings of culture (Karout, et al., 2013). After careful review, the researcher would recommend that nursing in Saudi Arabia should seek to address areas of concern within the culture of the nursing field to address the current needs for cultural care using proven methodologies. This is particularly challenging for organizations within SA, as they go up against a number of different factors than other types of organizations. However, it would also require SA nursing to be well equipped with

the training and resources necessary to be able to care for patients in a culturally sensitive manner going forward, thereby also addressing the research question about the training that nurse leaders need in SA need in relation to their present role.

In SA, the healthcare profession is facing more issues than other industries. The leaders and managers must realize the importance of domestic culture, expertise, planning, skills, necessary resources and other essential things to manage the healthcare services more effectively and efficiently (Felemban, O'Connor, & McKenna, 2014).

6.3.3 Expatriate Versus Local Nurses

Expatriate nurses face particular problems in relation to working as leaders in SA healthcare. Saudization is taking place – part of this is related to replacing experienced medical and nursing expatriate staff with Saudi nationals. This could result in a loss of expertise and cultural diversity in the SA healthcare system, a nursing shortage and the employment of nurses who are inexperienced. These issues may impact upon nursing leadership both negatively and positively. For many people in SA, including participants of the current study, the view of nursing as a profession is not seen as favorable compared to other career paths. Because of these poor views of nursing, there have been a number of obstacles related to gender, and there has been a huge dependence on the use of outside medical overseers. This has resulted in a huge controversy within SA. For instance, in 2011, more than 66% of the expatriate medical staff in healthcare organizations were removed from their positions (Felemban, O'Connor, and McKenna, 2014, p. 2). Such cultural diversity within health care professionals, resulted in a significant social impact and created a number of implications for healthcare staff who seek to provide care for patients. Participants

commented on the advantages of working with people from other cultures and how this enriched their working environment. It was discussed in the current study that SA would be to look to other countries that have already been able to develop healthcare services with adequate supervision, like Australia, South Africa, Malaysia, the United States of America, and the United Kingdom. In order for nursing in SA to be improved it is vital this area of concern is addressed, and diversity in culture maintained, whilst an understanding of cultural differences understood (Felemban, O'Connor, and McKenna, 2014).

The needs of employees coming from varied cultures also differ, which also raises their instincts of feeling valued at the workplace. It is the duty of the management to take care of the needs of the people belonging to different cultures in order to lessen the atmosphere of tensions and issues. Maintaining and providing a peaceful environment at work helps in increasing the abilities and skills of employees. All the organizations and institutions have to work in bridging the gap between communication without differentiating between “them” and “us” and maintaining solidarity at the workplace.

Cultural competence must be looked at as an aspect within healthcare services and not isolated, it also should be considered as an important component of overall excellence in health care delivery. Issues of health care quality and satisfaction are of particular concern for people who frequently come into contact with the health care services and the professionals from various cultures. Efforts to improve cultural competence among health care professionals and organizations would contribute to improving the leadership and quality of health care for all consumers. According to the national survey of the U.S. healthcare leaders conducted by the search firm Witt/Kieffer, respondents viewed diverse leadership as a valuable business builder. They associated

it with improved patient satisfaction, successful decision-making, improved clinical outcomes, and stronger bottom line (Witt/Kieffer, 2011).

Recent research studies indicate that retention of staff in an organization depends to a great extent on the work culture prevalent within the organization. A healthy and positive work culture automatically attracts and retains staff and helps them grow in their career paths. It has been proved that over 90% of staff who leave an organization do so mainly owing to the incompatibility with the leadership style. Most often, in such cases, the leadership style was found to be domineering and dictatorial in nature. This generally the leadership practice that nursing leadership within Saudi healthcare organizations, a style that staff from other cultures may not be able to identify with and is directly related to the research question about the nature of the relationship between culture and the leadership style of SA nurse leaders in practice. This view is also supported by Alqahtani, et al, (2015) who comments that staff from different cultures may be unable to identify with the prevailing culture of the organization.

Obstacles faced by SA culture which greatly impacts the field of nursing is the need to maintain a high level of separation between men and women. As a result, when there are patients receiving care in a hospital setting, it is customary for patients of different genders not be on the same unit. In addition, they are not to be cared for by staff of the opposite gender. Complicating the situation further is the use of therapeutic guardians for the majority of female patients. While female staff can treat female patients, it is not culturally accepted to interact with the male therapeutic guardian who has accompanied the patient to get care, except for instances of an extreme emergency. This is also seen elsewhere throughout SA culture, where women are not allowed to travel alone outside of the home, and are reliant on male family members.

This has greatly influenced the field of nursing in SA, and as a result, there is a huge obstacle of being able to provide quality care while still observing the cultural norms of the host country. It is therefore recommended that specific guidelines be put into place to help ensure there is adequate medical care provided for patients regardless of gender of the patient or the staff providing care, which can still be sensitive to the cultural needs to have minimal social interaction between opposite genders.

On the other hand, some participants emphasized the importance of providing proper orientation and training programs to educate expatriate nurses about the cultural norms of SA and relates to two of the research questions about the training that nurse leaders in SA need in relation to their present role and how best might such training and development best be delivered. Some expatriate nurses may view some SA cultural practices in a certain way whereas they could be interpreted differently in their culture. For instance, eye contact during social interaction is considered important and it can be interpreted in different ways according to the culture. In the current findings, avoiding direct eye contact with the opposite gender in SA was described as sign of respect whereas in other cultures it could shows a person's interest and engagement with other's conversation. In a study investigating the importance of different rules within social relationships, results indicated that among respondents from the U.K. and Italy, the rule 'Should look the other person in the eye during a conversation', was rated more important when compared to respondents from Japan and Hong Kong (Argyle et, al. 1986).

For instance, this study has discussed the refusal of some SA female nurses to provide nursing care to a patient of the opposite sex; some SA male nurses will claim that it is improper to provide nursing care to a female patient. Although, there is no written

policy preventing a nurse from providing care to a patient of the opposite gender, some nurse leaders, especially expatriates, accepted this as a cultural excuse. Some of the nurse leaders who participated in this study preferred expatriate nurses to work with, in fact, they emphasized that Saudi staff nurses discriminate against their patients according to gender. Moreover, they stated that some Arab (non-Saudi) nurses have learned to use the methods to avoid providing nursing care to patients of the opposite gender. Such practices may cause conflict in the workplace and affect nursing leadership. *"Because with non-Arab male nurses, there are no such difficulties in handling female patients or male patients. Since male nurses began discriminating between female and male patients, Saudi or other Arab female nurses have started to do the same thing. So, this is a very different cultural issue which has also caused kind of conflict in the workplace" (P21).*

The study also revealed that due to SA cultural values, some Saudi female nurses were restricted from looking after male patients; and some male Saudi nurses, due to the same cultural values are not allowed to care for female patients. These cultural norms and customs have led to gender separation, especially in nursing care. With a society that considers the male and female spheres and responsibilities to be so distinct, women managing men or male nurses treating female patients become contradictory to the norm. However, if there is a shortage in staff, they will ask foreign nurses to provide nursing care to patients, regardless of their gender. Furthermore, this study viewed that cultural competency skills are most important in the nursing profession as it helps the system to communicate well, and to promote an awareness of cultural diversity and sensitivity in the delivery of nursing practice In this regard, nursing leadership roles are viewed as important to create liaison, trust, transparency, vision, problem solving strategies and coaching skills, all of which can help the understanding

of cultural diversity and competency among all (Dauvrin and Lorant, 2015). According to the findings of this study, there was a lack of cultural competence and awareness in SA nursing frameworks; examples of this include Saudi female nurses having less communication with male nurses and vice versa. This may adversely affect the quality of healthcare services and a lack of shared ideas and knowledge. Therefore, the current study reveals that implementation of cultural competence leadership strategies in SA healthcare organizations should lead to more effective patient care and perhaps have a positive impact on the entire healthcare system.

It was discussed in the current study that there are differences between some of Saudi staff nurses and expatriate nurses. One of the participants criticized some SA female nurses and described them as lazy and other descriptions that would adversely affect the quality of health care provided and nursing leadership in their units; "*Some SA female staff are lazy. It is very common here they are coming late, so this is a problem. Sometimes they are very lazy they do not want to do the work, this affects the leaders because the whole staff must be in work. Those staff come late, suffer from absenteeism and sometimes they do not like to work. They don't like to finish" (P17).* It appears that the cultural background of the healthcare provider can have a detrimental effect on the provision of care, particularly in relation to issues associated with gender. In the current study, while discussing the theme expatriate vs. local, it was revealed nurse leaders have censure towards the attitude of some female SA nurses as they not committed to work and come up with cultural excuses to avoid providing nursing care to patients of the opposite gender. "*I have experienced that Saudi nurses often come late, and after that, they say that the assignment is just male. So, they tell me: I do not want to take this patient, I am going home!" (P14).* Therefore, it is important to develop culture competence training programs that help nurse leaders and healthcare

professionals understand cultural preferences and characteristics of the host community – a finding that once again helps to answer the research question about how such training and development should be delivered. Culturally, health professionals in SA are increasingly diverse, viewing the world and the people they see through many different lenses. However, health care providers should learn skills around cultural competence leadership and patient-centered care. Such skills can be a compass for exploring, respecting and using cultural similarities and differences to improve nursing leadership and quality of care and patient outcomes.

6.3.4 Managers' solutions

Administrators and managers in SA need to be able to take initiative in their leadership roles in order to provide the best level of care and supervision to nursing staff. The administration also needs to take the initiative to provide adequate nursing training and educational modules for staff regarding their specific job roles and for professional development, as well as addressing the concerns of providing culturally sensitive care within SA which again addresses the research question about what nurse leaders in SA need in relation to their present role and how might training and development best be delivered. Nursing leaders should also help to further develop other leaders to be able to provide proper care for patients as well as coaching them how to oversee nursing units. For administrators, this will also mean recognizing when unit directors neglect to oversee staff and prepare them to provide care for patients, and as a result work with unit directors to ensure they have adequate coaching to address the concern before replacing them with a different staff member. As a result, the higher qualified candidates will be able to support and help to nurture those staff members who are lacking in specific areas so that they can improve in their skills and competencies (Alshammari, 2014).

This research study revealed that maintaining and establishing trusting and respectful relationships among the leader and nursing staff will help to create a positive impact on the healthcare system, as well as improve communication at all levels. However, it was indicated that appreciation is one of the key motivators which is lacking in the SA nursing system. Furthermore, managers must also provide the financial and non-financial rewards such as salary incentives, letter of appreciation, acknowledgement, recognition and others which leads to more motivational influence among the nursing staff. These issues were raised by participants in this research.

The findings from this study suggests that managers also need to have the ability to negotiate and communicate with staff, patients, and guardians in order to avoid any negligence, conflict of interest, or unprofessional behavior. It is also important for managers to ensure there are adequate levels of rules and regulations which are clearly defined for the nursing staff in written policies. Lastly, it is important for management to exhibit an ideal leadership style to be able to have personal cultural knowledge and to then be able to coach and deal with different situations amongst staff. The study reveals that education and experience knowledge helps nurse leaders to understand the cultural values of the community which provide them with effective strategy to ensure comprehensive nursing care. Furthermore, the study signifies that competent nurse leaders must provide the programmes designed for newly qualified nurses, and orientation programmes for those newly hired nursing staff members before deployment to clinical settings. This may comprise specific training and development courses again helping to answer the question about how best might training and development be delivered. Arabic language courses for non-Arabic speakers could be important to improve communication and helps to understand the local culture. For instance, if the nurses who come from overseas understand the Saudi culture and speak

Arabic language that would help them to easily adapt to the changes they encounter and accomplish the organization's goals (Mutair, 2015).

6.3.5 Gendered aspects in SA

There was a general agreement among participants that in SA cultural norms and customs have led gender separation, nursing profession was addressed in the findings as the most strongly gender segregated of all occupational groups. This idea was supported by literatures, it is being understood that one of the key features of nursing in the health care industry is its strongly polarized occupational segregation (Farren & Kaye, 1996) which the findings from this study suggest remains in the present day. This polarization position places gender, politics and power as central to nurses and nursing. The effects of this polarity can be seen in aspects of workplace culture, such as occupational violence, workplace oppression, and in current debates such as those addressing the leadership practices of nurses and recruitment into the profession as some participants mentioned earlier in analysis chapter. As well, gender been viewed as a concern especially in nursing leadership positions as reflected by the participants' feedback. Many participants from both genders in the current study agreed that leadership positions are greatly over-represented by men (Brown 1998), which is still prevalent in practice today. This means that gender, particularly aspects pertaining to disadvantage and privilege, needs to remain firmly on the nursing agenda.

Some of the participants focused on the issue regarding the implications arising from the prohibition of interaction among the sexes in the public spaces. It is identified that in Saudi society females are not permitted to work and intermingle with males, especially in the healthcare setting. Some of the respondents also brought up the issue of the prohibition of women driving cars in Saudi Arabia to convey them to work.

These findings have demonstrated that SA law is a key factor in female nurse's absenteeism and derives from cultural practices. For nurse leaders, this poses particular challenges as it is difficult to challenge existing cultural practices without challenging the host culture itself (Slim and Saunders, 1996). It might be suitable to add here what could be considered a historical change in SA, and after years of struggling, only recently and to be exact on 26th September 2017, King Salman, the ruler of SA, issued a royal decree allowing women to obtain driving licences and women can drive by the summer of 2018. And while this may not be a direct change to the healthcare field in SA, it has brought about significant amount of change within the country that will likely impact on healthcare industry as well – an example of how these data help to answers the research question about how the changing nature of healthcare in SA impact on their role and leadership style.

Gender separation was a major issue highlighted in the findings, however, nursing requires working closely with patients, including those of the opposite sex. This was also seen within the data collected for this research study. For instance, many SA nurses struggle with caring for patients of the opposite gender, as well as many SA patients prefer to be cared for by same gender nursing staff. As a result, many SA nurses have had to face this obstacle when providing care for patients and when trying to lead and manage work. Another example is how the influence of family has shaped an individual's decisions, especially as it pertains to pursuit of education and a career path.

There is also a lack of respect for nursing as a profession in SA, and as a result, many view other professions as preferred to the nursing profession, and have a weak view of nursing, particularly female nursing. With that being said, nursing as a profession

has been documented in Islamic culture since the 18th century, in midst of the early circumstances of the prophet Mohammad, female care givers in that era were accepted and appreciated to provide nursing care for injured people (Rassool, 2000). Rufaidah Bint Sa'ad Al Ansariyah is seen as principle muslim master medicinal overseer, who developed essential nursing schools to instruct women on the skills necessary for providing nursing care (Rassool, 2000). Although nursing has often been viewed negatively by many within the SA culture, there is support for nursing as a profession throughout Islam which should be acknowledged. In addition, these data have supported the need for members of all cultures to recognize nursing as a legitimate career option, and should be treated as such, by the nurses, patients, as well as the general public.

It was also raised in the findings that culture of SA society entails a marked gender preference when considering certain positions, such as leadership roles. It is commonly believed in SA as in many Arab and Muslim countries men are very much presented in leadership positions due to the cultural norms that society held regarding gender differences. It was also brought to discussion that Saudi women do not enjoy the same social benefits and freedoms as Saudi men. Participants referred the origins of this situation to the way children are raised in SA and that the family shape the thoughts and personalities of the children. Some female nurse leaders stated that although they have the experience, ability and qualities to be a leader. However, the community is more disposed to perceive of men as leaders, therefore it is more rare to see women in leadership positions. The women in SA and the nursing profession were considered to be somewhat ‘mediocre’, which led to their struggle of making such people fight hard to showcase their skills as leader and nurses. This outlook can be

changed when the people are provided with proper education making them believe that they are no less important than a doctor (Demorest et.al, 2017).

In addition, the study findings emphasized that gender behavior and expectations appear to impose a real limitation for women who are in leadership positions. Several participants viewed women nurse leaders to be in the unfortunate situation as not being able to demonstrate a strict leadership style due to their nature. The expectations for a gender-congruent woman seem to be counter to the wielding of power, while the wielding of power by men seems to be consistent with gender expectations. This once again demonstrates how SA culture influences thoughts and behavior about leadership style. It was suggested that as long as women are believed not to fit the effective-manager profile, female managers should be cautious about demonstrating a feminine orientation that could reinforce perceptions of incompetence in the minds of organization decision makers (Alimo-Metcalfe, 2004).

6.4 Second main theme: Unique personal leadership qualities

6.4.1 Personal leadership qualities

According to the second main theme, leadership which encompasses cultural competence is a key skill for all of the nurses working in a healthcare setting. This can perhaps be seen as obvious because those same nurses often provide direct leadership responsibility where their qualities and skills combine to offer leadership to their colleagues and staff. In this study, however, there is a wide range of initiatives and policies where the nursing profession can be seen to have more and more influence on all aspects of healthcare delivery. For example, findings continued to clarify the ways in which communication is vitally important and a solution that may help resolve

conflict and it stands as an essential component for proper health care delivery. Nurse leaders according to the findings, need to deploy kind and gentle speaking tone, regardless of the spoken language, in order to demonstrate care and understanding. Despite her/his stressing the importance of spoken English, it was also indicated that body language and tone are equally important. This theme provides the understanding of personal leadership qualities which might have played an important role in preparing culturally competent nurse leadership, and addresses the research about the qualities that nurses in SA need in order to be identified as culturally competent nurse leaders. When defining the personal leadership nurse qualities, it is clear that this starts with the need to develop leadership skills appropriate for nursing. For this, they need to use skills of observation that must be developed by training their attention to detail. Their communication must be clear with objectives and aims allied to the application of scientific knowledge that align with practice needs, certain details will become clearer and more evident in some situations such as emergency or acute care versus chronic conditions such as diabetes management. Guo et.al (2015) determine that observation, in basic terms, means information is obtained by the nurse about a patient, and she uses her senses of sight, hearing, smell and touch as instruments of identification. The same principles can be applied to leadership. A good evaluation of the individual staff member is an integral part of the everyday actions of the nurse that leads. This sense of awareness comes from noticing situations and problems that arise over time, with constant observation demonstrating that many situations can be avoided and problems solved with greater success (Demorest et.al, 2017). These successes of a nurse leader do not depend only on cultural competence but it is important to ensure that certain qualities are required for SA nursing leadership regardless of those leaders own cultural background.

The current study findings indicated that a nurse leader who demonstrates a number of specific qualities are more likely to influence their leadership and show cultural competency. Additionally, participants describe nurses who have competence with respect to culture as being those who can easily improve the nursing skills by using communication skills and secondly, by acquiring knowledge on various aspects of nursing. A competent nurse is required to offer continuous and effective care based on the cultural needs of their patients (Sheldon and Hilaire, 2015). The most detailed definition of competence of culture with respect to nursing preparation is attaining the skill of being able to execute the nursing system with a variety of people in the context of diversified cultures, manners, and upbringings (Douglas, et al., 2011). These skills have importance for effective nursing leadership as well as for the delivery of culturally competent nursing care, as raised by participants from this study.

It was concluded from the research findings that unique personal qualities of the leader are an essential asset for culturally competent nursing leadership, and helps to further clarify what the qualities that nurses in SA need in order to be identified as culturally competent. Such nurse leaders care for all staff in the health organization, showing an intense consciousness of multiplicity, a solid base of skills and knowledge in multicultural nursing and awareness of other cultures. The unique qualities of such leaders start with building trust between team members, staff, colleagues and patients; this relies on the leader's ability to build and maintain the trust and respect through their daily actions. Leaders' traits, behaviour, leadership style, and skills all serve to shape culturally competent nurse leaders. Being an effective and skillful communicator, role model, visionary, trustworthiness, respect and other qualities was described as important elements in creating such competent leaders. An effective competent leader was described to have motivational skills for himself and to motivate

others. Competency in nursing leadership requires some investment and exertion; these efforts contain some leadership qualities and obligations that show qualities for the leader. Such leaders should have the capacity to meet and support the psychological requirements of their subordinates, sharing and including them in setting the organization's goals.

6.4.2 Effective communicator

The current study findings indicated clearly that nurse leaders in SA require proper training in communication and in learning effective communication skills. It was argued that it is not only about speaking English for Saudis or for the non-Arabians to speak Arabic. It is also about learning how to listen and communicate clearly with colleagues and clients who are valuable to the institution – after all, the service is about them (Al-Hazmi and Windsor, 2013). Hence, according to these findings, the leader should lead the team confidently and should communicate their aims and goals with clear understanding of cultural differences. They should also listen and take suggestions as a leader, including positive or negative comments, but being aware that all can contribute to improving the department. Culturally competent nurse leaders need to hear from their own side also and be open to learning and change this helps also to address the research question about how the changing nature of healthcare in SA impact on their role and leadership style. They should also appreciate the staff, even asking how they are doing, and appreciating their minute part in the team and its work.

Effective communication was revealed as an important characteristic by the research participants. Many indicated that good nurse leaders have good communication skills with their staff and mentioned this characteristic as important for the nurse leader to

be effective and culturally competent. Unsurprisingly, highly effective communication skills are necessary for nurse leaders to develop connection and supportive relationships with staff. Such relationships require and are fostered by clear and open communication. The participants emphasized the importance of a leader being able to maintain and promote effective communication. As reported in the findings, "*Communication is key and it is ensuring that the communication is clear because with different cultures you know you can say something in one way but if I say it and they didn't quite understand it, you may slightly lose the intention* (P5).

Congruent with such findings, theories put forward by Windsor and Al- Hazmi (2014) have coined the importance of how knowing varied dialects can help nurses communicate with families and women who come from different ethnicities. Furthermore, before acquainting oneself with other cultural norms, it is equally necessary for the nurses to be well aware of their own cultural norms, morals, behavior, rituals, and beliefs, thus helping them learn about the biases that exist. Being well aware of these biases will prevent one from typecasting a particular culture, thereby, helping the nurses broaden their horizon and enhance their skills in accepting a variety of beliefs, and norms essential for working in the health sector. Almutairi et. al (2015) points out that different cultures have varied ways of communication involving different aspects of society, and for those individuals working in nursing or the health industry, it is necessary to imbibe cultural skills. It is thus necessary to access the ability of nurses coming from varied cultures (AlYami & Watson, 2014). This is not just limited to written and oral communication. Non-verbal communication methodologies differ amid different cultures, and thus it becomes immensely important for nurses to get accustomed to this in order to understand and gain social and cultural competence. One example of misinterpretation of non-verbal

communication is meetings held between staff of different genders where non-verbal actions can be misconceived. As mentioned in the findings, some Saudis perceive not looking into the eyes of the opposite gender appropriate or a sign of respect, however, in another culture not maintaining eye contact while speaking can be interpreted as a sign of disrespect.

The findings of this research also indicate that effective communication is essential for the staff, unit, organisation and competent nurse leaders need to ensure effective communication between their colleagues and their staff and with other health team members in order to encourage feedback, discussion, teamwork and, ultimately, improved patient care. Some participants stressed that body language is a major aspect of communication that should be used and understood carefully. Other participants believe that nurse leaders should be required to develop proper and effective communication, and this was essential to overcome misunderstandings or faulty assumptions, which could result from different cultural expectations and backgrounds. However, the findings indicated that even when communicating in the same language, the terminology and body language used in a message may act as a barrier if it was not clearly understood by the receiver.

Effective communication was found to be related to developed interpersonal relationships and are also related to effective leader performance (Heuston and Wolf, 2011). This is important because patient care is optimized through cooperation and collaboration between healthcare staff. Effective communication lines also make possible participation in decision-making processes between nurse leaders and their subordinates. This study findings showed that effective communication with nurse

leaders is an important factor affecting their performance in healthcare services, which confirms the views of Germain and Cummings (2010).

6.4.3 Respectful and Trustworthy

Bennis and Goldsmith (1994) suggest that, "trust is the essential quality that creates a following for leaders…It is the secret of their ability to inspire those who create movements for social change and build the organizations that realize their dreams" (p. 120). The study findings indicated that leaders must be respected and show respect to others, besides being trustworthy, they must also trust staff members. As a result, nurses may be better able to provide quality care when their skills and knowledge are trusted and respected. This, in turn, may lead to empowered nurses who can practice autonomously and feel they are a valued member of the healthcare team. Respect was mentioned as a personal quality of competent leaders by many participants in the current study. The study findings revealed that building relationships and trust are critical leadership qualities that shaped a cultural competent nursing leader, further addressing the research question about the qualities of a culturally competent leader. In addition, it was found that empowering staff depends on respectful and trusting relationships among members of the work setting. One of the participants thinks that establishing trust between everybody is one of the key factors in making the workplace better. And this trust between every single employee can be achieved by transparency, being passionate, having a proper way of solving problems, consistency and having a vision toward patient satisfaction. However, he also believed that such characteristics that produces trust are not available in many of the SA leaders. Previous research also shows that it takes a leader a long time to build trust, yet one brief incident of untrustworthy behaviour can permanently destroy it (DuBrin, 2007).

Respect for the worth of others and trustworthy are values that are frequently identified as traits of the competent leader in this research. Trust, along with fairness and respect, is a key value associated with healthy organizations (Lowe, 2010). In a meta-analysis of research findings on trust in leadership, Dirks and Ferrin (2002) reported significant relationships among trust and job satisfaction, organizational citizenship behavior, job performance, intention to quit, and organizational commitment. Workgroup or team processes such as group identification and support also play a role in the development of trust in the leader (Shamir and Lapidot, 2003).

In this study respect was described as a two-way street, a leader cannot demand respect, she/he must earn it. If a leader treats his/her staff right, give them clear directions and compliment their efforts, then they will definitely acknowledge him/her as a good leader and give respect. The participants stressed involving staff in the decision-making process, as they should feel free to voice their opinions and suggestions and engage in healthy debates over the pros and cons before a final decision is taken, such healthy engagement from both sides of the table will benefit both the individual and the organization (Guo et. al, 2015).

6.4.4 Challenger

One of the qualities that distinguished the culturally competent nurse leaders found in this study was being a challenger. As he/she faces different and multiple difficulties and obstacles, then it requires a competent leader to challenge them in order to achieve organizational goals. Such challenges vary, for instance, the findings in this study indicates difficult behaviors as a challenge that need to be addressed by the nurse leader. It was also described that some challenges that leaders need to face to provide staff with empowerment to challenge and change their own behaviors that could affect

the quality of health care services provided or are contrary to the rules and policy of the organization. The competent nurse leader challenges existing assumptions, structures and processes within the organization. Collins (2001) identified that leaders found in great companies are more committed to doing what matters the most for the values of their company than promoting their own career or prestige or succumbing to the overwhelming challenges they face.

6.4.5 Motivational

In the current study, it was found that good personal leadership qualities include being motivational and able to demonstrate strategies that spreads the motivation spirits among health team members. The findings of the participants' opinions showed that motivational leaders have the ability to encourage their staff to work hard and triggered the optimum quality of health care to be provided to patients. Participants also suggested that culturally competent nurse leaders who are effective, demonstrated an understanding of cultural norms and differences. Similarly, self-motivation of a leader was required in order for a leader to be efficient and effective and only then can the leader encourage others to achieve their personal goals in harmony with the goals of the organization. This finding was supported this saying by: "While leader development focuses on individual-level knowledge, skills and abilities and interpersonal competencies such as self-awareness and emotional awareness, self-regulation and self-motivation …" (Iles and Preece, 2006, p.324),

On the other hand, some participants mentioned the differences in how people perceive motivational exhortation and guidance in different cultures, as some would perceive it as a criticism. It is useful and important to select the right words when the leader wants to motivate others from different cultures and avoid what might be

perceived negatively in such culture. Leaders within the organization are responsible to increase and sustain the motivation, job satisfaction, and job and organizational commitment of its staff. Other studies supported these findings, as the staff attitudes have consistently been found to affect performance and turnover (e.g., Patterson, Warr and West, 2004; Xenikou and Simosi, 2005). This idea was supported by participants as they emphasized that effective leaders achieve superior results because of their ability to motivate followers, arguing that people who embrace such leadership have staff with higher levels of satisfaction, motivation and performance.

6.4.6 Visionary

Leadership has a critical role in shaping the vision of the organization and preparing the conditions for staff to achieve this vision. It was found in the data that implementing a vision requires the leader to have cultural awareness of the workplace culture. Moreover, it is important to focus the activity necessary to achieve the vision. The study findings suggested that vision can create an environment where workers can achieve their peak performance. The participants describe competent nurse leaders as those who are able to inspire passion and commitment to the mission of their organization by communicating its vision. It was also articulated by participants of this study the importance of sharing the vision of the organization with subordinates and other team members, as they also share the responsibility for achieving this vison with team members. Such finding was supported in the literature, according to Nanus (1992), “There is no more powerful engine driving an organization toward excellence and long-range success than an attractive, worthwhile vision of the future, widely shared” (p. 3).

Some participants' views regarding the leaders' vision and visionary leaders emphasized the characteristics of such leaders and some of the qualities that enable such leaders to achieve vision. On the other hand, some participants emphasized that vision may not provide sufficient motivation to followers. One of the participants said that he was disappointed because healthcare authorities in SA set great visions but those visions are written on papers only and not achieved in real world. *"They have great objectives or leadership visions on paper but unfortunately during the application, this is missed. This is affecting the culture within the hospital" (P1).* It was recorded in the findings that a leader needs the power and the right authority to enable him/her achieves the vision of the organization. This continuing communication was raised as an essential leadership behavior, it needs to focus on promoting and ensuring that the vision is understood by all individuals in an organization. It was also found that in order for a nurse leader to attain their vision, it is essential to have the right authority and the right power as an influencer.

6.4.7 Role model

The findings showed that a culturally competent nurse leader should perceive himself as a role model and act like a good example in order to motivate followers and other health team members. It was also revealed that the role modelling behavior of nurse leaders during a situation or a process is critical in transmitting appropriate professional values to others. The participants suggested that the culturally competent nurse leaders in action have a bigger opportunity to influence surrounding health professional to adapt his practice as model. Nevertheless, other participants emphasized that a competent nurse leader can flourish behaviors in the working environment. Competent leaders are viewed as role models for followers, they motivate followers to commit to the vision of the organization, provide intellectual

stimulation. Such competent leaders support motivation and individual consideration, competent leaders who operate as tutor and counsellor to followers (Bass and Riggio, 2006).

Findings also showed that nurse leaders should assume that followers are watching them and setting their standards according to what they see from their leaders. As suggested by many of the participants, the starting point of competent nursing leadership, is when leaders begin to see themselves as a role model. Being a role model, was perceived as an important personal quality of a competent nurse leader and critical quality that participate to the development of nursing leadership in SA – all of the above help to address the research question on how might training and development best be delivered. The findings also support the suggestion that nursing leadership in SA should be energized and bolstered with a specific concentrate on effective, competent, cultural leadership qualities that contributes in development of the profession in the country.

6.5 Third main theme: What works?

The third main theme is about "what works" and it discussed the effective strategies used by nurse leaders in SA to tackle situations. This research identified some challenges and difficulties within nursing leadership in SA which has been influenced by globalization, multinational workers and the combination of different cultures. Solutions for conflict, obstacles and problems differ among healthcare organizations and participants of the current study have different opinions of how a culturally competent leader deal with it; some of the participants believe that the nurse leader should challenge difficult behaviors that affect the provision of health care services or affect the rules and policy of the organisation. Others suggest providing local

knowledge to the managers and staff about the rules and regulations of their host organisation in order to equip them with the required tools to be knowledgeable about what is right and what is not when working within different cultural contexts. These include knowing the right procedures to be taken during situations. The understanding of nursing leadership as a source of power that can lead people and health organizations into success is becoming increasingly important. However, the required leadership skills and behaviors need to be considered in depth within the unique context of SA. Therefore, health organizations should invest in effective nurse leaders that can find the best way to work, challenges should be rewarded, resulting in committed and high performing employees (Germain and Cummings, 2010).

Findings of the current study indicated several aspects that linked to nursing leadership in SA. These aspects seem to have a direct effect on the nurse leaders and test their competencies in the cultural context. For instance, participants emphasized that there are some newly graduated nurses whom are assigned to leadership positions without experience, such aspect was considered as not helpful for effective leadership. One of the participants as a leader herself refutes the idea that nurses or graduates with a Master's degree should be promoted or given a leadership position simply because they have achieved an advanced degree. She underlined that new graduates need to work in practice with patients to gain good experience and to learn the real working situation for the staff and clients.

Another aspect articulated by participants, is absenteeism. This problem is considered one of the problems that almost all nurse leaders interviewed in this study complained about, particularly in conjunction with the Saudi staff. A number of participants from the nurse leaders, including many of them who are Saudi, blame Saudi staff nurses for

their regular absences. In the other hand, one of the participants addressed absenteeism as the leader's responsibility, and they are the one who should be blamed for this kind of behavior, or as he called it, a "culture of absenteeism". This participant continued to explain the reason for calling it cultural absenteeism, in that the Saudi senior nurses will model the culture of absenteeism to the junior nurses. Congruent with this finding, is that nursing managers identified as predisposing conditions for absenteeism, those related to the institution and what was considered a cultural norm associated with working in Saudi healthcare. In this regard, the institutional factors that caused staff members to miss work were perceived by the nursing managers as factors that generated job dissatisfaction (Sancinetti et, al. 2011).

Absenteeism of staff nurses seems to be a serious issue facing nurse leaders in SA. It was also listed in the findings that in addition for some nurses being absent, they frequently arrive late to work, nevertheless, they are allowed to get away with this and no action was taken by nurse leaders against them. Participants asserted that such attitude ought to be challenged and that ignoring it was condoning the behavior.

6.5.1 Cultural Training

Participants suggested that a leader needs to have cultural knowledge and competency in order to tackle certain challenges especially while working within multicultural employees. When there is an interaction of people from different cultures, culture-based misunderstandings could influence their relationships and interactions adversely, as suggested by Sidumo et, al. (2010). It was discussed that for nurse and nurse leaders working in SA it is important to demonstrate a basic understanding of the Arab culture, attitudes, values, beliefs and practices. As it is very important to understand the community beliefs, values and perceptions to be able to deal with

diverse situations and diverse nurses' backgrounds. The understanding of nursing leadership as a source of power that can lead people and health organisations into success is becoming increasingly important. However, the required leadership skills and behaviours need to be considered in depth within the unique context of Saudi Arabia.

Enabling nurse leaders and training them with necessary abilities to oversee clashes inside groups and among her/his staff was proposed as an essential requirement to develop nursing leadership in SA. This specifically addressed the research question on what training nurse leaders in SA need in relation to their present role. Furthermore, providing them with the tools to incite team work, value their associates, and develop their staff, while learning local cultural values will give nurse leaders the ability to be able to bolster their quality in tackling challenges. Developing the cultural competency of nurse leaders was emphasized by the participants frequently. Training in general and especially cultural training was suggested in the study findings to be an important component to equip nurse leaders with the basic elements to develop competent nursing leadership in SA. Inadequate cultural awareness by nurse leaders can adversely influence their interaction with staff or other health team members from another culture. If the nurse leader is dealing with Saudi staff, it is possible, however, that this problem can be addressed through introducing aspects of Saudi culture into nurse leader's training, preparing them to interact effectively with in Saudi culture (Al-Shahri, 2002).

6.5.2 Communication and culture interaction

It was discussed in this research that lack of cultural competence is sometimes a barrier to effective communication amongst interdisciplinary teams, which can often trickle

down to patients and their families and affect the overall quality of health care services. Findings emphasized that cultural diversity encourages best practice and can show the SA society that it is normal for men and women to work together with respect to cultural values and religious boundaries. In some health organization in Riyadh the capital city of SA and especially in the study site, cultural norms held by some community members are obviously unlike some other health organization where the community's interaction with organization culture is limited. The expatriate health care professionals expressed their discomfort as the gender segregation is imposed by the community power and culture influence of SA. It was stated: "*They are separating the genders, males and females. Sometimes we are not getting the freedom to talk to the male person or female person. It is very difficult. We are not facing this in our country even where there is Muslims and non-Muslims"* (P23). This finding was confirmed by previous studies which showed that nursing in SA has the preference for the separation of genders in all spheres of life, including the workplace environment (AlMunajjed, 1997; Mayer, 2000).

In addition, the study explains that in Saudi Arabia, gender segregation is a cultural norm that is evident in almost every public and private institution. Education sectors, including schools and universities, and most places of entertainment, as well as parks, forbid the mixing of the genders. Most of the nursing team members in SA health organizations come from different cultural backgrounds, therefore nurse leaders should have a high level of communication with their staff and they should understand the cultural differences to avoid clashes. Cultural diversity of expatriate female nurses should be considered and a proper orientation to SA culture norms must be provided to new employees from different backgrounds than those in SA. All nurses, in all countries, are expected to exhibit their traditional manners. In this sense, nurses, like

many service and health care workers, are carriers of the culture (Lundberg and Boonprasabhai, 2001). Many expatriate nurses were employed in Saudi hospitals without Arabic language skills which may lead to adverse effect of the process of patient/nurse communication. Misunderstanding can occur between nurses and patients due to the differences in interpretation of the language (Almutairi et al., 2015). Thus, the need for proper training and cultural knowledge has been described by the participants in the current study as a must in order for nurses and nurse leaders to carry on their work effectively (answering the research questions about what training is needed and how should it be delivered).

6.6 Summary of discussion chapter

This chapter discussed the research study findings and linked it to existing literature in order to understand the existing nursing leadership practices in Saudi Arabia and answering the research questions whenever possible. A summary of the study findings in relation to the research questions and objectives is also provided in the concluding chapter but it has been shown that the study did provide data to help answer all research questions that were set at the start. The accomplishments related to a cultural context as implied by the Papadopoulos et al's model requires an exploration of belief systems by individuals and establishment of knowledge, gaining awareness, and sensitivity with regards to the cultural values of the surrounding community. Such skills were described as essential for nurse leaders to gain competence in leading nurses and encourages the best nursing practices in SA health organizations. This study includes important information about leadership and cultural influence in the nursing profession in general and nursing leadership specifically from the perspective of SA. The themes discussed herein provide essential information about challenges, and strategies to tackle leadership and cultural issues in effective ways.

The first main theme of the study which is the gender aspect of nursing in Saudi Arabia indicating subthemes that are status, cultural influence, expatriate vs. local, challenges and managers' solutions. As such, this main theme significantly answers research question one about the nature of the relationship between culture and the leadership style of SA nurse leaders in practice. The study is signifying that employees under the nursing profession have distinct cultural backgrounds and the influence of SA culture that impacts some nurses' behaviors and commitment to a high standard of nursing practice. It was discussed how some nurses utilized the cultural norms to avoid providing care to the opposite gender patients and such behaviors can be inherited to other nurses from different cultural backgrounds. Generally, a number of challenges within nursing leadership was linked to the culture of SA which require the urgent need to develop culturally competent nurse leaders to overcome such challenges and ensure high quality of nursing services among health care organizations in SA.

The second theme is describing the personal leadership qualities with respect to effective communication, challenger, respect and trust, motivational, visionary and role model. By its very nature, the theme addresses the second research question one about the nature of the relationship between culture and the leadership style of SA nurse leaders in practice. The analysis of this theme in the study indicated that leadership needs to develop such personal qualities in order to build professional relationships with nursing staff and other health team members. This was irrespective of cultural competence, however such qualities are necessary and in association with cultural competence training, will help create a positive impact on cultural competency among the culturally diverse workforce.

The third theme is signifying the subject of what works which relates to cultural training, communication, language, manager's authority, dealing with conflicts,

authority and leadership training. Therefore, this theme addresses the fourth research question about the training that nurse leaders in SA need in relation to their present role. In addition, the focus on creation of training that is relevant to changes in the field of nursing in SA also addressed the third and fifth research questions about how the changing nature of healthcare in SA impact on their role and leadership style and how might training and development best be delivered. The study signifies that leadership must try to place regular training workshops, resolve the language issues among the diverse cultural workforce and actively deal with conflict of interest among the nursing staff members. The nursing leadership must develop effective communication skills and cultural competence training to enhance the nursing profession in MOH health organizations in SA.

When nurse leaders facilitate the provision of nursing services in a way that conforms to the cultural values in SA, the more the chances of the healthcare being accepted, successful and more likely to be cultural competent, unlike when the nurse leaders do not consider the cultural norms. The current findings, however, indicate that often the above-mentioned practices may still not be met due to the lack of cultural competency in SA nursing leadership. The study discussion shows that many factors like language, gender, stereotyping, cultural background, awareness, knowledge, competency and interpersonal communication skills are also factors that influence the effectiveness of nursing leadership.

These variations in responses of the participants when compared and contrasted can be categorized into similarities, differences, and patterns amongst their opinions while discussion. It can be stated that combined results of the discussion of the participants' views gave insights into the context of nursing leadership, and that the healthcare

organizations in Saudi Arabia are still influenced by gender aspects. Because of the SA cultural values, many Saudi female nurses would prefer not to deal with male patients, similarly, male Saudi nurses do not like to care for female patients such cultural norms, customs, and habits lead the stark line of gender separation in all fields, but especially in nursing care. The SA society generally considers the sphere of male and female responsibilities to be separate and distinct. The instances of women managing men and that of male nurses caring or treating women are well against the norm. The complexity of healthcare services in SA, necessitate the import of expatriate nurses to care for the patients regardless of the gender norms. The belief that the profession of nursing should consider separating nurses according to their gender is prevalent and a tenacious belief, although the current study has discussed that the SA society has started to become open to the chance of change in the mindset slowly and despite the stereotype of a good leader being always male. The study emphasized that gender should not be a factor in shaping a culturally competent nurse leader.

The results of the current study have revealed that interactions between people with diverse cultural backgrounds can heighten the understanding among such people and help them to improve the knowledge of each other's culture. It was also presented that cultural differences can affect nurse-patient communication as well as the effect of the assessment, teaching, outcomes, and overall patient compliance. Lack of cultural competence is sometimes a barrier to effective communication amongst interdisciplinary teams, which can often trickle down to patients and their families. On the other hand, it was also concluded from this study that cultural diversity encourages best practice and competent nursing leadership. It can show society that it is normal for nurses, men and women to work together with respect and adherence

to the Saudi cultural norms. Culture competency and knowledge play a very important role in nursing leadership and provide guidelines for nurses and other health care professionals to deliver culturally competent care services to patients in different communities or societies.

The results of this research study show that nursing practice in Saudi has its own unique features that challenge expatriate nurses while working in SA. In general, multicultural backgrounds provide the workplace and leadership with broader understandings and greater abilities which will enhance both that workplace and society at large. Therefore, recruiting and retaining expert nursing leaders is essential to enhancing the stability of nursing care and to improving nursing leadership in multicultural environments as in the case of SA. The study discussion has shown that there is a critical need for nurse leaders to be sensitive to cultural norms and religious needs in SA. The study also concludes that expatriate nurses do not fully understand the Saudi culture and language which may result in inadequate patient care and have an adverse influence on nursing leadership. One of the main outcomes of this study is the importance of improving the training and education for nurse leaders in SA regardless of their nationality or cultural background.

Summary of discussion to the research questions:

1) **What is the nature of the relationship between culture and the leadership style of SA nurse leaders in practice?**

In many areas of the world, the leadership style least appreciated by employees was found to be domineering and dictatorial in nature. This has generally been the leadership practice of nursing leadership within Saudi healthcare organizations, and is largely a result of the SA culture, and is a style that staff from other cultures may not

be able to identify with. In addition, there is still a sense of division between how men and women are viewed in SA. For instance, the expectations for a gender-congruent woman seem to be counter to the wielding of power, while the wielding of power by men seems to be consistent with gender expectations. This demonstrates how SA culture influences thoughts on leadership style, and the stereotype many in SA still have of men being a better leader than women.

2) What are the qualities that nurse in SA need in order to be identified as culturally competent nurse leaders?

The meaning of culture is a shared understanding of the different lifestyles of people, which integrates beliefs, thoughts, values, language, interchanges, ethics and markedly communicates arrangements, like societies, skills, manners and attire. This understanding is particularly important in being able to answer this research question; if nurse leaders do not understand the definition of culture they cannot be culturally competent. Culturally competent nurse leaders need to hear from their own side also and be open to learning and change. Lastly, the research concluded that unique personal qualities of the leader are an essential asset for culturally competent nursing leadership, and helps to further clarify what the qualities that nurses in SA need in order to be identified as culturally competent. Some of these included the ability to build relationships and trust are critical leadership qualities that shaped a culturally competent nursing leader.

3) How does the changing nature of healthcare in SA impact on their role and leadership style?

On 26th September 2017, King Salman, the ruler of SA, issued a royal decree allowing women to obtain driving licences and women will be able to drive by summer 2018.

And while this may not be a direct change to the healthcare field in SA, it has brought on a significant amount of change within the country that has impacted changes in the healthcare industry as well. More specifically, it may begin to open the door for more women in SA to enter into the nursing field and work outside of the home. something which is vital for begin able to provide care for women in the SA culture as there is often a division still between men and women in the country, even in providing healthcare services.

4) What training do nurse leaders in SA need in relation to their present role?

Some balance of cross-cultural knowledge and communication skills seems to be the best approach to cultural competence education and training for nurse leaders and health care professionals. The sensitivity of culturally diverse workforce needs to be improved by training and development of cultural competencies. It appears that inadequate cultural awareness can render leadership ineffective; however, this problem can be addressed should aspects of Saudi culture be introduced to health professionals, specifically those coming from other areas of the world, and also need reinforcing in further training, such as new leadership courses. Lastly, the current study findings indicated clearly that nurse leaders in SA require proper training in communication and in learning effective communication skills.

5) How might training and development best be delivered?

It is important to develop cultural competence training programs to help nurse leaders and healthcare professionals understand cultural preferences and characteristics of the host community. Some participants emphasized the importance of providing more

relevant orientation and training programs to help educate expatriate nurses about the cultural norms of SA. Cultural norms should also be a part of all new leadership courses. Other participants indicated a need to provide adequate nursing training and educational modules for staff regarding their specific job roles and for professional development, addressing areas of conflict, as well as addressing the concerns of providing culturally sensitive care within SA, through orientation programs, specific training centers, and development programs. Lastly, one of the best ways for nursing leaders to train other nurses to be culturally competent is by being a role model of what is expected of culturally competent leaders of staff members.

6.7 Limitations of the research

The limitations of this research have been identified as follows:

1. The research sample consisted of nurse managers and their nursing staff from only one health organization in Riyadh, SA. It can be expected that the responses from these nurses may differ from nurses in other organizations and other cities in SA and hence the findings cannot be generalized across all health care organizations in SA.
2. This research was conducted in one Ministry of Health Medical city; private hospitals and other healthcare facilities are not included. Generalizing the findings is therefore limited.
3. The number of participants is small compared to the total number of working nurses in Saudi Arabia, and so provides only a 'snap shot' of the situation, thus the findings are not generalizable across the total nursing population in SA.
4. One single researcher who has undertaken the study and analyzed the findings may have biased the results.

CHAPTER SEVEN: Conclusion

7.1 Conclusion

In Saudi Arabia, the department of nursing and department of training and scholarship in MOH are investing in developing leadership with a vision to develop competent nurse leaders that consequently participate in improving the quality of healthcare services. As a PhD candidate and recipient of a scholarship for the conduct of this research, my work and experience are, hopefully, testimony to the value of supporting leadership in nursing. The findings from this study provide evidence to further justify the need to educate nurses to become culturally competent leaders, given the multi-cultural context in which they are working.

The research outcomes should help to shape strategy and healthcare policy in the Saudi context and provide evidence to underpin the need for culturally competence nurse leaders to embed nursing leadership profession and professional training throughout the healthcare organizations in SA. As a result of educational programmes addressing these issues, it would be expected that there would be a significant increase in nurse leaders' culture competence which would lead to a much more cohesive system with competent nurse leaders who have the ability to understand cultural influences that are associated with staff performance and nursing profession in the country. Nurse leaders and nurses would also be provided with the education and training to work in a cooperative way, achieving more consistent practice through teamwork.

This research concludes that the leadership and cultural competence of training programs needs to be contemporary and of high quality. The placement of experienced competent nurses into nursing leadership positions is also necessary, to enhance the

future direction of nursing and contribute to the continued professional development of nurses and the further professionalization of nursing in Saudi.

7.1.1 Summary of the study findings

The findings from the data of this research study were all designed to address specific objectives and research questions. A brief summary of the findings from the study will be provided below as they relate to these objectives and research questions. As previously established, the objectives for this research study include comparing and contrasting the participants' accounts on what type of leadership style they value in relation to their own cultural background. In addition, research till examine the participants' views and understanding of the relationship between culture and nursing leadership in SA. Lastly, the research managed to access the participants' views and opinions on the factors (skills, characteristics, and training) which make a good nurse leader in SA, and how they might develop further. In order to address each of these objectives, the following research questions were addressed:

6) What is the nature of the relationship between culture and the leadership style of SA nurse leaders in practice?
7) What are the qualities that nurses in SA need in order to be identified as culturally competent nurse leaders?
8) How does the changing nature of healthcare in SA impact on their role and leadership style?
9) What training do nurse leaders in SA need in relation to their present role?
10) How might training and development best be delivered?

The findings of this research demonstrated that SA culture plays a key factor in female nurse's absenteeism and derives from cultural practices. For nurse leaders, this poses particular challenges as it is difficult to challenge existing cultural practices without challenging the host culture itself. The study findings also emphasized that gendered behaviour expectations appear to impose a real limitation for women who are in leadership positions. Several participants viewed women nurse leaders to be in the unfortunate situation as not being able to demonstrate a strict leadership style due to their nature. In addition, it is determined that nurse leaders in SA should know about the diverse social implications, and health team members should be able to understand and give credit to specific cultural practices, yet this has not generally been achieved. Being socially mindful is the exemplification of winding up socially equipped, which perceives separation and abstains from stereotyping.

One finding of the data was the significant distinction between genders is SA culture. The culture of SA society entails a marked gender preference when considering certain positions, such as leadership roles. It is commonly believed in SA as in many Arab and Muslim countries men are very much presented to in leadership positions due to the cultural norms that society held regarding gender differences. One practical example of this in practice is seen in common conversations. In SA culture, it is customary to avoid direct eye contact with the opposite gender in SA was described as sign of respect whereas in other cultures it could shows a person's interest and engagement with other's conversation.

Another finding of the data emphasized that gendered behaviour expectations appear to impose a real limitation for women who are in leadership positions. Several participants viewed women nurse leaders to be in the unfortunate situation as not being able to demonstrate a strict leadership style due to their nature. The expectations for a

gender-congruent woman seem to be counter to the wielding of power, while the wielding of power by men seems to be consistent with gender expectations. This is particularly difficult to establish for women nurse leaders, based on the research data which also suggests that managers need to have the ability to negotiate and communicate with staff, patients, and guardians in order to avoid any negligence, conflict of interest, or unprofessional behaviour. It is also important for managers to ensure there are adequate levels of rules and regulations which are clearly defined for the nursing staff in written policies.

In addition, the research data demonstrates a lack of cultural competence and awareness in the SA nursing context. For instance, this is seen by the Saudi female nurses who have less communication with male nurses which may lead to less value added to the quality of healthcare services, and a lack of shared ideas and knowledge. The current study findings also indicated that a nurse leader needs to demonstrate a number of specific qualities are more likely to influence their leadership and show cultural competency. Additionally, participants describe nurses who have competence with respect to culture can easily improve the nursing skills by using communication skills and secondly, by acquiring knowledge on various aspects of nursing. As a result, this research study indicates that there is a need to implement a culturally competent leadership strategies in SA healthcare organizations. This would lead to a more effective level of patient care and result in a positive impact on the entire healthcare system.

Lastly, the research findings continued to clarify the ways in which communication is vitally important, and suggested a solution that may help resolve conflict as it is an essential component for proper health care delivery. Nurse leaders according to the findings, need to deploy kind and gentle speaking tone, regardless of the spoken

language, in order to demonstrate care and understanding. Despite her/his stressing the importance of spoken English, it was also indicated that body language and tone are equally important. Nursing leaders should understand the meaning of what culturally competent leadership is when working with mixed cultures. It was clear this is a complex issue and like all complex issues requires preparation and support. A leader should be able to think out of the box and be prepared to take risks.

The findings of this research can contribute to improving the quality of nurse leaders as well as bring recommendations to the development of nursing leadership training. The findings of this research will be shared with the Ministry of Health in Saudi in order to assist them in reformulating leadership training programs and policies for improved strategic planning both for the healthcare system and training programs for nurses. The research will also be used by the researcher in his capacity as a nurse leader to inform his department nurse training program. This research suggests some recommendations, which will help to prepare nursing leaders to be culturally competent leaders.

7.2 Recommendations

There are various recommendations which arise from this study which are directly associated with the healthcare services, nursing practice as well as education. It is very important to improve the learning and professional development courses for nurses. Nursing is a degree level profession and for nurses to be able to lead this workforce of the future in SA, it is essential that they are educated to at least bachelor level, but students may not cover cultural issues within their course. Where this is not present, then opportunities to undertake further study must be made available to them. Furthermore, it is strongly suggested that nurse leaders' skills must be enhanced in

respect to management, leadership and cultural competency and provide them with adequate resources and training development courses in order to address the challenges they face in leading healthcare.

Cultural competence leadership in the healthcare profession is achieved partially through role-modeling. Implementation and development of cultural competence management and leadership strategies need an evaluation of inter-professional association and role-modeling leadership within the healthcare service. Recognizing the most effective individuals and cultural training competence can influence a new attitude and a move towards leaders who are sensitive to cultural differences and develop the knowledge and skills to practice in a culturally competent manner. It is actually the nurses who are directly associated and responsible for the management of all patients and so directly have an impact on the quality of care provided.

Leadership and management within the nursing profession needs to be evaluated regularly and leaders provided with adequate resources in order to overcome any deficits. There is the requirement of assessment / appraisal, and hence the opportunity to incorporate within this a suitable cultural competence tool that includes leadership education/ training and development, mentorship, professional coaching, new learning environment and practices which directly address the diverse cultural workforce challenges. It is also important to evaluate the workforce through proper appraisal mechanism, regular feedback for further professional development. Nursing leadership should try to create a culture of mutual respect and appreciation where development is fostered and professional practice discussed and improved.

Nursing authorities in Saudi MOH need to take responsibility on the organizational level to provide regular training programs that will involve the leaders. There should

be implementation of leadership programmes on the personal level that will help change the behavior and motivate nurses. The main goal is the achievement of efficiency and effectiveness and culturally competent staff. They should provide high morals and direct mentoring that will have a positive effect over the health of nurses and ultimately improve the quality of patient care. Cultural competency and cultural awareness programs should be introduced and be incorporated via training and education at all levels. They should be guided to focus more on development of interpersonal skills, how to lead, teamwork, empathy and management should be involved at the micro and macro levels in the organization. The Cultural Competence model by Papadopoulos et al (1998) is useful starting point for shaping the elements of such programmes.

7.2.1 Recommendations for future research

This study may serve as a foundation for other researchers to expand the inquiry of nurse leader competencies as culture continues to gradually change and impact nurse leaders within clinical, financial, and operational departments in a multidisciplinary healthcare facility. Further empirical research will enhance reliability and validity of initial data findings. Studies further quantifying and qualifying the proposed core competencies may yield data pertinent for revision of current education and leadership curricula among nurse leaders. Other research could concentrate on explicating a full set of competencies needed within the framework created for this study.

Further studies may consider a change of methodology from semi-structured interview to a survey format to accommodate potential participants' time and availability to participate in the research. A mixed methodology study is worthy of consideration for further research where quantitative findings on nurse leadership competencies may

correlate to nurse leaders' qualities and cultural considerations. This study focused on nurse leaders within one healthcare institution located in Riyadh. Future studies should consider nurse leaders in other healthcare organizations and other geographic locations in Saudi Arabia.

7.3 Recommendations for Saudi MOH

These research findings have implications for Saudi healthcare practice, nurse education and nursing practice. This section makes recommendations for the related departments in Ministry of Health in Saudi Arabia, and considers future research needs. It considers the importance of developing selection criteria for effective nurse leaders, developing professional training programs, updating the healthcare policy, and developing a professional nursing leadership education program. Enhancing the hospital's existing educational programs about Saudi Arabian cultural aspects. Developing a cultural resource center, including information brochures, literature reviews on health-related topics of the Saudi Arabians and access to relevant Websites. Hiring and promoting professionals from various cultural backgrounds in the health care workforce. Some policy considerations would probably help to the development of nursing leadership in SA and consequently to the health care services.

There is the importance of selection criteria to hire effective nursing staff, either hiring locals or expatriates to be in leadership positions. The following are some suggested characteristics and selection system for the nursing leaders in the healthcare services. It is therefore suggested that MOH should actually consider various aspects to recruit such leaders that will provide an effective and efficient nursing staff in the system.

7.3.1 Characteristics and selection criteria of effective nurse leaders

It is suggested that the Ministry of Health should consider the following characteristics to select, nominate or recruit a leader to provide effective leadership in the healthcare system:

- A high level of educational nursing qualifications (minimum is BSN).
- Deep clinical nursing knowledge (Superior recommendation or Entrance exam).
- Good communication skills.
- Managerial efficacy.
- Working experience in multicultural unit.
- Excellent personal qualities such as strong personality and ethics, cultural awareness, intelligence, trustworthiness, honesty, humanity and kindness, courage, observation, and inspiration.

7.3.2 Professional development

Healthcare organizations should consider how they can enable professional development of their staff, including leadership development. It is the responsibility of nurse scholars and healthcare organizations to continue to assess whether nurses and nurse leaders view professional development as a factor influencing their motivation to perform well. On the basis of this assessment it is recommended that:

- Nurse leaders training needs must be identified across the various levels and access to professional learning made available.
- The importance of creating a friendly working environment and raising awareness of professional practices that supports this be made a priority to

support the attainment of planned goals and working towards high standards in work performance and in achieving optimum care for patients.

- The healthcare organizations need to take the responsibility of providing regular in service professional development training programs to employees who are already nurse leaders.
- Developing and implementing effective nursing leadership programs on personal, mentoring, and motivational behavior for nurse leaders can achieve the goal of developing their organizational effectiveness and providing quality care for healthcare consumers. High personal morals, mentoring, and motivational behavior of the nurse leaders with nurses will positively affect the health and well-being of the nurses, and, ultimately, enhanced quality care of patients.
- Effective leadership professional learning programs need to be incorporated in all levels of nursing education focusing on professional and interpersonal relationships in nursing practice with an emphasis on leadership, cultural competence, teamwork, interdisciplinary collaboration, and the management of nursing care at macro and micro levels.

7.3.3 Recognition of nursing profession

Policy makers also have a key role in promoting the profession of nursing, and raising its profile within the SA.

- Nursing authorities in Saudi MOH should make it a future priority to focus on supporting the development of nursing profession through various management policies that elevate the standards and status of nurses in the healthcare system.

- An important element of the policy makers' role is to ensure an ongoing discussion among healthcare practitioners and doctors to support the respect and recognition that is required for this noble profession by enhancing their image within SA culture. This recognition may motivate and inspire nurses. It may also increase the number of nursing staff through increased interest in joining this profession.

- Culturally, this recognition could enhance the profession by attracting both genders and especially females by giving a better social image of the nursing profession.

7.3.4 Professional learning of the nurse leader

Role preparation for our future nurse leaders begins with leadership and management training, professional learning behavior, and postgraduate leadership and management education before they take up leadership or management positions.

- Once in the role, nurse leaders need access to an in-house organizational leadership and management-training programs to support their leadership development.
- Teaching personal leadership qualities and effective leadership characteristics in all nursing educational levels as nursing institutes (diploma degree), and nursing colleges (bachelor degree) is the first step required to inculcate these qualities and characteristics among future nursing force.

7.4 Suggested leadership training programme

To achieve organizational cultural competence within the health care leadership and workforce, it is important to maximize leadership training. This may be accomplished

through the establishing of a cultural competence training programs for health care leadership development and strengthening existing programs. The desired result is a core of professionals who may assume influential positions in nursing leadership and health care services in general. The professional nursing training programs will enhance and enrich the experience of the nurses in order to develop an effective and efficient nursing leadership, healthy relationship between nurses and their colleagues, and an effective and culturally competent nursing leadership. Nursing leadership courses should be included in all nursing education levels and theoretical and clinical training be specifically updated for nursing leadership training. This research ends with the suggestion for a training program intended to help develop culturally competent nurse leaders in SA. A detailed proposal for this nurse leaders training program is provided in (Appendix K).

7.5 Contribution and impact of the study

Cultural diversity is a reality for most health organizations across the world, including Saudi Arabia. It follows that emphasis should be placed on the content and approach of advanced training programmes that aim to prepare culturally competent nurse leaders, and create an organizational culture which enables those leaders to perform to a high standard. This study was able to identify suggestions for culturally relevant nursing leadership programmes to be developed.

It is intended to publish this work in MOH media and scientific nursing journals to contribute to the nursing evidence base of SA. This study is highly relevant to nursing practice in SA and could be an important contribution to the training of future nurse leaders in Saudi Arabia.

7.6 At the End

In this study, the researcher had the chance to explore Saudi nurses' views and to explore the needs for better nursing leadership, based on their understandings of the situations and their experiences. It has been revealed from the current study that effective and continuous training for nurse leaders is a real need, besides language problems. Further, nurse leaders in SA and especially in MOH hospitals need to have a strong involvement in nursing policy making.

A commonly held viewpoint in this study was that many nursing leadership problems stem from the impact SA culture has on the nursing profession. Therefore, if nurse leaders in SA were better trained about cultural competency in nursing leadership, it might lead to better understandings and reactions towards challenging situations that are often associated with culture. It would also lead to more developed health care services and better work-environment for nurses.

7.7 A final personal reflection

I have been enthusiastic of pursuing studies to the highest level all my life. I was a smart student and received awards during my student days. It started in the middle school as I was the best student and then continued to study at the Nursing & Health Institute where, in my 3rd year, I was assigned to train new students. I then enrolled for the highest qualification for men in nursing in Saudi Arabia at the time, an Associate Degree in Nursing at the College of Health Sciences. When I graduated I was awarded 1st of my group in that year of 1997.

I worked in the Saudi MOH for a couple of years before deciding to undertake a Bachelor's degree in nursing. Bahrain was the only choice because it was near to Saudi, although this was still a real challenge as I needed to work in order to finance my education, and my family, as there were no scholarships offered at that time and it was not possible to work in Bahrain. So, I asked the MOH to transfer my job from Riyadh to a border city close to Bahrain where I was working night shifts and crossing the border to attend university in Bahrain.

Then I went back to work.

Four years later I was awarded a scholarship to do my Master's degree in nursing in Jordan. After graduation, the MOH assigned me to work at the highest nursing authority in Saudi Arabia as the Director of Nursing Education & Training. I worked in this role for 5 years and was then offered a PhD scholarship from the government which is where my recent journey started.

This was my first time to live and study in non-Arabic speaking country, therefore, the language and communication were major challenges as was the scientific writing in English. I found this was both daunting and challenging. Everything in my country was different including the culture, food, lifestyle, and most of all the weather (especially in winter when the cold nights seemed to last forever unlike my sunny and warm home). I started my first days on this journey by meeting my supervisors who encouraged me to read a lot to strengthen my scientific writing skills, and in few months, they asked to prepare a poster illustrating my intended research and participate in a Cardiff University Postgraduate student competition.

Surprisingly I won the 1st prize for scientific posters (Appendix N). To be honest I wasn't able to do this without the continuous guidance and support of my supervisors.

I thought my PhD life would be relatively easy but I was totally mistaken; quickly I became very familiar with the challenges. I had to attend many training courses in different areas related to my study, such as qualitative research methods, interviewing techniques and in leadership and culture, as this is my main area of interest (Appendix M).

I spent months transcribing my interviews and analysing all the data was a daunting task. I had never done anything like this before; so many hours of sitting in one position numbed my mind and body.

I also experienced a family bereavement, as my beloved father passed away and left me with the responsibility of my whole family, my children and my sisters (Saudi culture expects the man of the house to take care of everybody there). Therefore, I brought the family with me to UK and it was one of my most challenging periods in the PhD journey. For my family, everything was foreign and unusual, so I spent time making life easier for them.

Looking back now I can say that my PhD journey has been difficult at times, but it has also made me more resilient, and more aware of the need to work consistently to achieve the goals we set ourselves. In many ways, it has made me the leader of my own research idea. I hope this is also lesson for life in the future.

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APPENDIX A – Invitation Letter

All recruited subjects

Developing culturally appropriate leadership for nursing in Saudi Arabia

You have been invited to take part in a study that aims to understand culture and its relationship to nursing leadership in Ministry of Health (MOH) hospitals in Saudi Arabia (SA) and to identify the future training and development needs of nurse leaders in Saudi Arabia. An information sheet is enclosed with this letter.

I am a senior nurse working in the General Directorate of Nursing in MOH, currently enrolled in the course of Doctorate in Philosophy (PhD) at Cardiff University in Wales (UK) and I am in the process of writing my PhD Thesis. Before you decide whether to take part we would like you to spend five minutes reading this to understand why the research is being done and what it would involve for you. If you would like to discuss any aspect of this research without any obligation to take part, please call Abdulrahman Aldawood on +966568308018 or send an email to (aldawoodaa@cf.ac.uk) if there is anything that is not clear.

Yours sincerely

Abdulrahman Aldawood

APPENDIX B – Participants Information Sheet

Developing culturally appropriate leadership for nursing in Saudi Arabia

What is the purpose of the study?

The primary purpose of the study is to explore your experiences and understanding of the relationship between nursing leadership and culture and to develop culturally relevant nursing leadership training programmes for future nurse leaders in King Saud Medical City (KSMC) in Riyadh the capital city of SA.

Why have I been invited?

You have been invited because you are a nurse leader/staff nurse and have been exposed to the KSMC environment. We would like to ask you about your understanding of nursing leadership and what relationship it may have with culture; how culturally competent nurse leaders are, and what development or training nurse leaders may need in the future with regards to cultural competence.

Do I have to take part?

Whilst your contribution would be valuable, it is up to you to decide to join the study. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving any reason.

What will happen to me if I take part?

If you agree to participate in this study, you will be contacted by Abdulrahman Aldawood to arrange a mutually convenient individual interview or focus group discussion. The interviews will be arranged first followed the focus group. The interview procedure will be clearly explained to you before the interviewing process commences. The interview procedure and questions used in the interview have been developed using expert opinions from the School of HealthCare Sciences, Cardiff University, Cardiff, UK and all the questions will be about leadership, culture, and nursing in Saudi Arabia and how to develop relevant training

programmes. For example (tell me about your experience of nursing leadership from different colleagues with diverse ethnic backgrounds). Interview and focus groups will not include any sensitive questions, and you may skip any questions you feel uncomfortable answering. With your permission, the individual interviews and focus group discussions will be audio recorded using an electronic digital audio recorder. The recorded conversation will be transcribed and stored electronically on a secure password protected computer (and not placed on a server or network) located in the School of Healthcare Studies (SOHCS), Cardiff University. The saved files will not have any data that can identify any study participant. Only the research team will access the saved data. All audio recorded data will be destroyed as soon as the study is completed. We would like to take your consent to allow us to use your participation for data collection.

What will I have to do?

As a nurse leader we would like to you participate in an interview or focus group discussion. The interview or focus group will last four around 30 to 60 minutes. The interview and focus group discussion will be recorded and transcribed for the purposes of analysis. The result of the analysis may be used for publication in the future.

What are the risks of taking part in this study?

No known risks from participation are anticipated in this study.

What are the possible benefits of taking part?

There are no personal benefits but there is a general benefit to increasing knowledge and possibly improving the quality of nursing leadership in SA.

What if there is a problem?

If you have a concern or a problem about any aspect of this study, you may speak to Dr Katie Featherstone, Director of Post Graduate Research, School of Nursing and Midwifery, Cardiff University. Tel: +44 (0)2920 917800. Email FeatherstoneK@Cardiff.ac.uk.

What will happen if I don't want to carry on with the study?

You may stop your participation in the focus group and the interview at any time or decline to participate in future meetings. If you wish us to destroy any previous interview material collected, please email us to this effect and we will do so.

Will participation in this study be kept confidential?

The identity of your organisation will be known, but your identity and place of work (e.g. name of unit) will be protected. We will follow ethical and legal practice and all information about you will be handled in confidence. Audio files will be retained on an external drive kept in a locked cupboard in a locked room and retained for 15 years. Anonymous transcribed data will be securely stored in a file using a coded identification number. This will be held on a secure drive accessible only to the named researcher. If you wish to see a copy of the transcription please let us know.

What will happen to the results of the research study?

The results of this study may be presented at conferences and published in scientific journals. If you would like, a summary of the results can be sent to you after completion of the study.

Who is organising and funding the research?

The study is being organized by the School of Healthcare Sciences, Cardiff University. The study will be carried out by the main researcher Abdulrahman Aldawood in collaboration with supervision from Professor Daniel Kelly and Dr Dianne Watkins. This study is funded by Ministry of Health in Saudi Arabia.

Who has reviewed the study?

The study has been reviewed by the School of Healthcare Sciences Research Screening and Ethical Review Committee in Cardiff (Wales), and by the Research Ethics Committee in King Saud Medical City (KSMC) in Riyadh, Saudi Arabia.

Contact for further information

If you would like to discuss any part of the project in greater detail then please do not hesitate to contact Abdulrahman Aldawood at:

School of Healthcare Sciences, Department of Nursing, Cardiff University

East gate House

35-43 Newport Road

CF24 0AB

Cardiff

Tel: +44 (0) 2920917727

Email: aldawoodaa@cf.ac.uk

Thank you for your time and consideration

Abdulrahman Aldawood

APPENDIX C – Interview Consent Form

Version 1

Title of study: **Developing culturally appropriate leadership for nursing in Saudi Arabia**

Name of Researcher: Abdulrahman Aldawood

Please Initial Box

I confirm that I have understood the study aim and purpose for the above study and have had the opportunity to consider the information, ask questions and to have had these questions answered satisfactorily.	
I understand that I will receive no compensation for my consent to participate in this study.	
I understand that I am free to withdraw at any time without giving any reason.	
I am willing for the interview to be audio recorded and I understand that the audio recording will be used for research and educational purposes only	
I understand that the audio recorded will be used anonymously.	
I understand that all information obtained including the audio recording will remain the property of Cardiff University.	
I understand that all information about me will be kept in a confidential way.	
I understand that use of the recordings may include, but not necessarily be limited to, the following: - A direct quote will be used for research purposes including the final research report, presentations and other academic publications.	
I agree to take part in this study.	

Name of Respondent ……. Date …….

Signature …….

Name of person taking consent …… Date …….

Signature taking consent ……..

When completed 1 copy for participant and 1 for researcher's file.

APPENDIX D – Focus Group Consent Form

Version 1

Title of study: **Developing culturally appropriate leadership for nursing in Saudi Arabia**

Name of Researcher: Abdulrahman Aldawood

Please Initial Box

I confirm that I have understood the study aim and purpose for the above study and have had the opportunity to consider the information, ask questions and to have had these questions answered satisfactorily.	
I understand that I will receive no compensation for my consent to participate in this study.	
I understand that I am free to withdraw at any time without giving a reason.	
I am willing for the focus group interview to be audio recorded and I understand that the audio recording will be used for research and educational purposes only.	
I understand that the audio recorded will be used anonymously.	
Please be advised that although the researchers will take every precaution to maintain confidentiality of the data, the nature of focus groups prevents the researchers from guaranteeing confidentiality.	
I understand that all information obtained including the audio recording will remain the property of Cardiff University.	
I understand that all information about me will be kept in a confidential wayThe recorded conversation will be transcribed and stored electronically on a secure password protected computer (and not placed on a server or network) located in the School of Healthcare Studies (SOHCS), Cardiff University.	
I understand that use of the recordings may include, but not necessarily be limited to, the following: - A direct quote will be used for research purposes including the final research report, presentations and other academic publications.	
I agree to maintain the confidentiality of the information discussed by all participants and researchers during the focus group session.	
I agree to take part in this study.	
Name of Respondent ……. Date ……. Signature ……. Name of person taking consent …… Date ……. Signature taking consent …….. When completed 1 copy for participant and 1 for researcher's file.	

APPENDIX E – Questions Prompt for Interviews and Focus Groups

Prepared by

Abdulrahman Aldawood

I appreciate your participation in this study and I am going to start by asking you about leadership and cultural influences:

1. What influence can a leader have on the atmosphere of the work place?
2. What is it like working in another culture?
3. Tell me how your background has and experience prepared you to be effective in an environment that holds different culture values?
4. Tell me about a situation that you adapted your style in order to work effectively with those who were culturally different from you.
5. What kinds of experiences have you had in relating with people whose cultural backgrounds are different than your own?
6. Can you see any cultural differences in leadership expectations in the workplace?
7. Can you recall a time when you gave feedback to a colleague who was not accepting of others (colleagues/patients)?
8. Did you feel that your cultural background or their cultural affected the way they accepted feedback?
9. Can you recall a time when a person's cultural background affected your approach to a work situation?
10. In your experience, what are the challenges faced by leaders or staff of different culture backgrounds in the workplace? What strategies or what have done you used to address these challenges, and how successful were those strategies?
11. Has culture diversity in workplace played a role in shaping your leadership style? If so, how?

The next few questions are a mixture about your workplace, and examples from your own from experiences.

12. In your opinion, what makes the workplace a good place to be?

13. Give examples of times when your own values and beliefs impacted positively or negatively your relationships with your colleagues.
14. Can you tell me about communication and/or body language in such cultural diverse workplace?
15. Are there any specific religious and/or cultural beliefs of the nurses from different cultural background that have provided challenges in the patient care setting?
16. What efforts have you made, or been involved with, to foster multicultural understanding and cultural competence?
17. What have you done to further your knowledge/understanding about cultural diversity?
18. What leadership skills would you like to see nurses from different cultures develop?
19. From your perspective, what are the learning needs of nursing leaders who have nurses from different culture join their staff?
20. In your area (hospital), if a transitional program, like orientation program for new nurses, were designed to help nurses from different cultures, what competencies/skills/content areas would you want to see included?
21. How have patients in your environment responded to nurses from different culture?
22. What do patients expect of us as nurses, what does this mean for how leaders must organize things in the hospital?

Finally I want you to think about the future and your suggestions for leadership training in Saudi Arabia.

23. How have you encouraged learning and development of employees?
24. What kind of training should we offer for nurse leaders, what topics should we cover in training?
25. What are the three things we need to cover in training?
26. What is the key message you would give the ministry in terms of leadership development in SA hospitals?

Thank you for your time

APPENDIX F - Ethical Approval from Ministry of Health, Saudi Arabia (Arabic).

المملكة العربية السعودية
وزارة الصحة

Kingdom of Saudi Arabia
Ministry of Health

مدينة الملك سعود الطبية
KING SAUD MEDICAL CITY

الموضوع : الإفادة عن إمكانية تسهيل مهمة باحث

سعادة/ مدير إدارة التمريض سلمها الله

السلام عليكم ورحمة الله وبركاته ...

إشارة إلى خطاب مدير عام التدريب والإبتعاث بوزارة الصحة رقم ١٩٩٧٦٣ والتاريخ ١٤٣٤/٥/٢٣هـ بخصوص إجراء عبد الرحمن بن عبد الله الداوود، مبتعث الوزارة لمرحلة الدكتوراه في جامعة كارف البريطانية لبحث بعنوان:

Developing Culturally Appropriate Leadership for nursing in Saudi Arabia.

وحيث أنه تمت الموافقة عليه في اجتماع لجنة الأبحاث والمُنعقدة بتاريخ ١٤٣٥/٧/٦هـ ، نأمل من سعادتكم الاطلاع والإفادة عن إمكانية تسهيل مهمة الباحث في الحصول على المعلومات اللازمة لنتمكن من إكمال اللازم .

شاكرين لسعادتكم حسن تعاونكم ،،،

رئيس لجنة الأبحاث

د. طارق بن صالح الخويطر

عائشة /د.دينا

الرقم ٣٦٨٠٠ التاريخ ٢١/٧/١٤٣٥هـ المرفقات

APPENDIX G - English Translation of MOH Ethical Approval

Kingdom of Saudi Arabia

Ministry of Health

King Saud Medical City

Topic: Facilitating Researcher' Task

Dear Director of Nursing department

Greetings

In regard to your inquiry to allow the facilitation of data collection for the researcher Abdulrahman Abdullah Aldawood who is undertaking his PhD study in Cardiff University in UK entitled:

Developing Culturally Appropriate Leadership for Nursing in Saudi Arabia

We wish notify you that the ethical committee in its meeting on 5th of May 2014 has approved this research to be carried out here and to allow the named researcher collect all the needed information.

Thank you

Head of Ethical committee

Dr. tariq bin Saleh Alkhwaiter

APPENDIX H - KSMC Research Approval

Kingdom of Saudi Arabia
Ministry of Health

المملكة العربية السعودية
وزارة الصحة

مدينة الملك سعود الطبية
KING SAUD MEDICAL CITY

Chief Nursing Officer
King Saud Medical City
Ministry of Health

TO WHOM IT MAY CONCERN

This is to certify that Cardiff University PhD student **Abdurahman Aldawood**, holding social ID # 1028565081, has done a Field Research in our premises from 20th of June to 12th September 2014. He was collecting data from Nursing Staff and Nursing Leaders of various departments within our Medical City.

This letter was given upon his request.

Dr. Hassan A. Alshahrani
Associate Executive Director in Nursing Planning & Development
King Saud Medical City
Riyadh, KSA

Dr. Hassan Alshahrani
Associate Executive Director of Nursing
Affairs - Planning & Development

المرفقات _____ التاريخ ١٨ - ١٢ - ١٤٣٥هـ الرقم ١/١

APPENDIX I – Cardiff University Ethics Approval

School of Health Care Sciences
Head of School and Dean Professor Sheila Hunt

Ysgol Gwyddorau Gofal Iechyd
Pennaeth yr Ysgol a Deon Yr Athrawes Sheila Hunt

Cardiff University
Ty Dewi Sant
Heath Park
Cardiff CF14 4XN

Tel Ffôn +44(0)29 20687552
E-mail E-bost harmerl@cf.ac.uk

Prifysgol Caerdydd
Ty Dewi Sant
Mynydd Bychan
Caerdydd CF14 4XN

14 March 2014

Abdulrahman Aldawood
PhD Student
C/O School of Healthcare Sciences

Dear Adbulrahman

Developing culturally appropriate leadership for nursing in Saudi Arabia

Thank you for submitting your proposal to the HCARE PGR Research Review and Ethics Screening Committee for:

- scientific review;

The Committee has now had the opportunity to review your proposal, and is happy to approve your plans with the following comment.

- This proposal asks a clear question linked to appropriate design and methods. This can be safely approved, where the next step is an application to the HCARE REC and onwards for approval in Saudi Arabia.

Please remember that this Committee is not a research ethics committee (REC), and is therefore not able to give you a favourable ethics opinion. In the view of the Committee your proposal will now need to be submitted for approval to the HCARE REC. The next meeting of HCARE REC is 3 April so you will need to submit your application to me by Monday 24 March at the latest. Further dates will be published on the School website at a later date. You should complete the form attached to the email containing this letter.

If, in the meantime you have any questions then please do let me know.

Yours sincerely

Liz
Mrs Liz Harmer Griebel

Cc Professor D Kelly
Dr D Watkins

Cardiff University is a registered charity, no. 1136855
Mae Prifysgol Caerdydd yn elusen gofrestredig, rhif 1136855

APPENDIX J – Sample Transcript Extract

In depth Interview extract

Duration 01:15:07

Code	Name	Nationality	Position
P	Participant	European	Participant
R	Researcher	Saudi	Researcher

[0:00:00]

R: *Thank you very much for participating in this study, I understand you that you come from UK?*

P: Right.

R: *Can you tell me about your experience, just a little bit?*

R: Yes, absolutely, I have been in nursing and midwifery for 37 years. Um qualified as a nurse and then obviously as a midwife, I am both registered nurse and midwife now.

Worked clinically for number of years, but then moved up into a management position, umm probably about 19 years ago umm when I was back home, and then obviously became a head of midwifery and then moved up to associate chief nurse, deputy chief nurse and chief nurse.

So, I've been to a chief nurse and deputy chief nurse in two organizations. So, my career is very long and it is very varied umm I have really, my specialty obviously is women and children and I had to work very hard to get my other specialties up, but umm I have been very lucky that's you know I've got very good experience at chief nurse level, however, I say having said that, it is all UK based.

And I know the UK system extremely well, which is the NHS. However, I know what the good looks like, I know what safe looks like and I know what quality of patient care looks like, umm so that is where I am at.

R: *Yes, lovely, I will just ask few questions outside my list if you allow me.*

P: Sure.

R: *You told me that you come from UK and you have been working there for long time, do you have had any idea before coming to Saudi Arabia how it is look like or anything about it?*

P: umm, I suppose I didn't, I had just a thought in my mind that it would be very manufactured, I thought that it would be very marked on an American model, I think I thought that it would be big private hospitals, umm and that the care would be very slick and varies.

But when I came for interview here to this particular hospital I was struck by a fact that it wasn't manufactured. Umm and that it was free at the point of access which is what I'm used to but it was open to and it was a Ministry of Health hospital and that it was open for Saudis and also for non-Saudis.

R: *Okay. Great.*

P: That it had numerous problems, umm and had, but it the major trauma center and critical care, so in some way that is why I feel in love with it because I knew that if I came I could actually make a difference.

R: *Ohh, beautiful.*

P: So, it was not that I was going to walk in an organization that already had clear processes and a mapping of the way that patients would come through their facility and at the other side their treatment and it was you know a package of care this is a large organization and it is extremely complex umm and it is not only working through those pathways but it is working through enabling the staff and giving the staff the tools to do their job.

Which is why my thoughts changed and that is why I came to work here in Saudi Arabia.

R: *Yes, and you told me that you have an experience of more than 30 years in UK, can I ask why did you choose to come here what motivates you to come here?*

R: I suppose two things: Making a difference and the 2nd thing would be umm the patient focus, making a difference to patients.

R: *Right, this is from work prospective, but how about the living here with the community?*

R: Ohh, I suppose I am at a point in my career where I wanted to experience a different health system and that was really appealing and it just came at the right in my life, because my children have all

left home and married and my husband and I it is our time to go and do something different in our life.

Rather than doing what have been doing for the last 30 old years. It was an opportunity to do that well, not only to do that personally but also to do that professionally as well. I came here with my husband, he is here with me to, and loving it yes, he is loving it.

R: *Oh, that's great.*

R: *Good, now I will go directly to questions: So what in your opinion the influence can a leader have on atmosphere in workplace?*

P: Oh, gosh that is multi factorial, umm and I think many, many gurus of leadership have looked at this, but for me I think it is been. that person that lead the organization in nursing, for me it is nursing and that person is trustworthy, has the integrity, that the nursing team believe in that individual, that she is a rule model, credible.

And that is really important, and sets that bar, sets the standards at a level, and except the nursing team and that sets the atmosphere umm and that we are here for the patient we are not here for our personal gain.

We are here as nurses to work for the patient, and is that patient experience that it is in our gift and that the atmosphere that the leader should create from all those things.

R: *Beautiful, so you have been here for around 6 months, can you tell me what is it like working in another culture? I mean you came from UK to Saudi Arabia which is obviously a different culture for you.*

R: I think I suppose the 1st couple of weeks, I will describe the as the honeymoon period umm and I was happy to be here and I was looking around and I think I went into a level of shock, you know.

R: *Aha, keep going please.*

P: I was in that period of shock for quite some time for quite few weeks because the difference the culture difference the way that we undertake things, and the cultural difference of how we look after patients and we treat them and packages of care that we deliver.

Now I am at the 3rd phase which I suppose is adopting I think I becoming I am becoming a Saudi, ha-ha.

R: *Ha-ha that is brilliant.*

P: You start to think like a Saudi and no I don't get frustrated if something doesn't happen straight away, umm but I am looking at the culture and the way that `Saudi Arabia is and then it is looking to things.

Now as I know we work around that and how we get that into the culture and do things that is culturally acceptable to ensure that we get end result which is good patient care.

R: *of course, How about the staff you are dealing with in Saudi Arabia, do you find difference in dealing with them compared to those you dealt with in UK?*

P: Yes, very, very different, umm the staff themselves fall into 2 categories as you know; Saudi and non-Saudi, the non-Saudis as like myself are imported to assist Saudis.

You know in the health care system to deliver that care, but then there is the Saudi section and umm and that needs nurturing it needs a clear stair and it needs to be worked through whether or not those girls want to be nurses or whether they don't.

And that is my fundamental question to them, because I have a very difficult time with some of them because they don't understand what is required within the nursing profession umm and I have a lot of absenteeism, I have a lot of individuals have lost their way and that is difficult and of course they are been led by non-Saudis who are making up for their deficit However, I went to the Saudi health care conference and I had a day there and it was a big exhibition here and I listened 3 Saudi girls who told a story about how nursing meant everything to them, that it was their passion and just thought actually.

You know there is a cohort, there is a big cohort of Saudi nurse that really want to be nurses and it is those that I've got to facilitate to grow and that cohort of individuals that don't want to work and don't want to be part of us and are absent and play the system actually let's move you away let's get rid of you, lets think about your possible future of you guys. Umm but let concentrate because I think Saudi nursing can go a really long way and it is my job to facilitate that, I have a very high level.

I have over 30% of Saudi Arabian nurses here and it is my job really to work with them and get the skills because some of them have been very poorly trained and getting them the right bridging course, getting them the right English courses and getting ourselves into a cohesive position where they are going to take nursing forward and take the quality because you know those are the nurses of future, in 10 to 15 years one of those will be doing my job, and they need to know what

good looks like, what safe looks like and what quality of patient care is, and how to look after patients, your import they do that for us because they have been taught in another country, so that is what we were at and that what is my experience so far.

[00:12:01]

R: *Great, can you please tell how back ground and your experience prepared you to be an effective leader as you are in different culture just like this in Saudi Arabia?*

P: I come from a cultural background where my family are Irish and having worked in the UK I have worked with Filipino nurses, Indian nurses, I have worked European nurses, Irish nurses, I have done recruitment overseas to support the hospital I have worked in the UK,

So I have come from a multicultural nursing environment and I think that has helped me adjust and understand, but nursing is language and I think that the understanding you have to bring with care for patient is only way to do it, there is only one way to wash them, you wash them properly, you look after their mouth you make sure that they eat and drink and then you make sure that they had their medication and the medicine.

That is the same whether you are in India, America or the UK. so if you come with that understanding then I think I think that helped, the other thing is that I am not a young thing I am mature and I have a lot of experience behind me so I'm not thrown by people that have their own agendas I'm not worried by difficult conversations, conflict, I ;m not worried about physicians shouting at people it just actually woo, woo, woo, let's just be calm and let's take this forward and that I think is a really strong attrition for leader is that consistency.

R: sure*, so tell me about a situation that happened to you, you told me you've been working with different cultures, that makes you adopted your style as leader in order to work effectively with those who were culturally different.*

P: I suppose yes, I've got a very naughty girl, she is a Saudi nurse and she didn't relies that I have arrived in the building, that how absent she had been, so she had just kept coming and going and she arrived in my office after I've here for 3 months and said that she didn't want to work in medicine anymore and that she just was moving she wanted to be transferred and if she didn't get what she wanted then you know, she will go to the King or she will go to the hospital's CEO so I said fine, ok, and at that point I was quite shocked but her domina was quite strange and her uniform wasn't professional she just came and

... so I was quite surprised so I found myself being quite umm autocratic and saying actually no, no, no, this is not was happening.

You are coming to work tomorrow and you are coming with a proper uniform and you are going to do your shift and that's it, finish, ''khalas'' (Arabic word for Finish). And then she said no, I said well fine so that is it you whether come or you don't. so if she went from my office and she went to see CEO of the hospital and said she been seen Me and that I was not helping her she was that going to facilitate her back into work extra, luckily enough CEO and I have an agreement.

So he said No, I 'm not going to see you I want to go back to (the Participant) and I want you to work this through and talk about rather than just come and jumped to me, let's go through your management process your line management, so she came back. I have to say I used every single leadership management style dealing with her and her friends

[00:16:49]

Then started to come to supported her, I think we shouted we cried we hugged we did everything but she came to work, she came to work and she is now been at work for the last two weeks.

I found myself being a mother being a sister being a friend being a chief nurse and she came to me lately 2-3 days ago to say I need to do different Ramadan shift, I said don't come to me you go back to your head nurse she is your line manager go and speak to her, **so there I am back to autocratic again.**

Telling her to go back, but it that nurturing and understanding that you use a different management style a different way of dealing with same situation differently and culturally.

R: *Beautiful, beautiful, so tell me what type of experience you have in relating with people whose cultural background are different from your own, tell me about it in UK.*

P: Yes, I think every nation has their own real culture treats, in the UK we had a population in of Pakistan and Bangladesh which you have here, they are culturally very different and they're the same in the UK as they are here, it is incredible and I have that same cultural believes you know which is incredible they carry this and they are very strong so you see them.

APPENDIX K– Sample Interview Transcript

Thematic analysis

Example of thematic analysis

Data item	Codes	Subthemes	Themes
Yes, absolutely, I have been in nursing and midwifery for 37 years. Um qualified as a nurse and then obviously as a midwife, I am both registered nurse and midwife now. Worked clinically for number of years, but then moved up into a management position, umm probably about 19 years ago umm when I was in Milton Keynes in Buckinghamshire, and then obviously became a head of midwifery and then moved up to associate chief nurse, deputy chief nurse and chief nurse. So I've been to a chief nurse and deputy chief nurse in two organizations, one in Buckinghamshire and one in Worcestershire. So my career is very long and it is very varied umm I have really, my specialty obviously is women and children and I had to work very hard to get my other specialties up, but umm I have been very lucky that's you know I've got very good experience at chief nurse level, however, I say having said that, it is all Uk based. And I know the UK system extremely well, which is the NHS. However, I know what the good looks like, I know what safe looks like and I know what quality of patient care looks like, umm so that is where I am at.	Profession Management positions Career Experiences Quality of Service Long and varied career Hard work Good experience in chief nurse level I know what good looks like	This works Working with conflict Knowing Culture How to deal with conflicts Manager's solutions Education and Experience Managers' authority	What works?
umm, I suppose I didn't, I had just a thought in my mind that it would be very manufactured, I thought that it would be very marked on an American model, I think I thought that it would be big private hospitals, umm and that the care would be very slick and varies. But when I came for interview here to this particular hospital at KSMC I was struck by a fact that it wasn't manufactured. Umm and that it was free at the point of access which is what I'm used to but it was open to and it was a Ministry of Health hospital and that it was open for Saudis and also for non-Saudis.	Expectations Free access Workplace	Status Culture influence Played in Practice Challenges Managers' Solutions Knowing Culture	Gender aspects of nursing in Saudi Arabia
I suppose two things: Making a difference and the 2nd thing would be umm the patient focus, making a difference to patients.	People-oriented	Cultural Influence	

Ohh, I spouse I am at a point in my career where I wanted to experience a different health system and that was really appealing and it just came at the right in my life, because my children have all left home and married and my husband and I it is our time to go and do something different in our life. Oh, gosh that is multi factorial, umm and I think many, many gurus of leadership have looked at this, but for me I think it is been. that person that lead the organization in nursing, for me it is nursing and that person is trustworthy, has the integrity, that the nursing team believe in that individual, that she is a rule model, credible. And that is really important, and sets that bar, sets the standards at a level, and except the nursing team and that sets the atmosphere umm and that we are here for the patient we are not here for our personal gain. We are here as nurses to work for the patient, and is that patient experience that it is in our gift and that the atmosphere that the leader should create from all those things.	Making difference Leadership in organization Qualities Standards Atmosphere		Unique personal leadership qualities
I was in that period of shock for quite some time for quite sew weeks because the difference the culture difference the way that we undertake things, and the cultural difference of how we look after patients and we treat them and packages of care that we deliver You start to think like a Saudi and Know I don't get frustrated if something doesn't happen straight away, umm but I am looking at the culture and the way that `Saudi Arabia is and then it is looking to things. Now as I know we work around that and how we get that into the culture and do things that is culturally acceptable to ensure that we get end result which is good patient care. Culturally it is that bit around, I suppose it's that opening up and understanding that	Cultural differences Culture shock Cultural norms Inequality of roles	Status No superwomen Culture influence Ideal Vs Reality Played in Practice	Gender aspects of nursing in Saudi Arabia

women are going to be to have a different place in your society and okay they cannot drive and they some would say that they are suppressed but I wouldn't at all. There are some very bright women out there but I think it is culturally changing the way you do things over the next 10 years to appreciate women place in your society, and I think it is handled very well then you will get the best, if it handled badly and you continue to suppress them they will leave and that is what happening some of them are leaving, and they need to go outside the country to study and to experience other cultures so they come back different people	Women in the society Reason to Stay or Leave	Expatriate Vs Local Challenges Managers' Solutions	
You know in the health care system to deliver that care, but then there is the Saudi section and umm and that needs nurturing it needs a clear stair and it needs to be worked through whether or not those girls want to be nurses or whether they don't. And that is my fundamental question to them, because I have a very difficult time with some of them because they don't understand what is required within the nursing profession umm and I have a lot of absenteeism, I have a lot of individuals have lost their way and that is difficult and of course they are been led by non-Saudis who are making up for their deficit However, I went to the Saudi health care conference and I had a day there and it was a big exhibition here and I listened 3 Saudi girls who told a story about how nursing meant everything to them, that it was their passion and just thought actually	Nursing competencies Nursing concerns	Working with conflict Knowing Culture Language courses for working in SA How to deal with conflicts Manager's solutions Education and Experience Training Managers' authority	What Works?
I have over 30% of Saudi Arabian nurses here and it is my job really to work with them and get the skills because some of them have been very poorly trained and getting them the right bridging course, getting them the right English courses and getting ourselves into a cohesive position where they are going to take nursing	Poorly trained Bridging programs Language courses		

forward and take the quality because you know those are the nurses of future, in 10 to 15 years one of those will be doing my job, and they need to know what good looks like, what safe looks like and what quality of patient care is, and how to look after patients, your import they do that for us because they have been taught in another country, so that is what we were at and that what is my experience so far.			
So I have come from a multicultural nursing environment and I think that has helped me adjust and understand, but nursing is language and I think that the understanding you have to bring with care for patient is only way to do it, there is only one way to wash them, you wash them properly, you look after their mouth you make sure that they eat and drink and then you make sure that they had their medication and the medicine. That is the same whether you are in India, America or the UK. so if you come with that understanding then I think I think that helped, the other thing is that I am not a young thing I am mature and I have a lot of experience behind me so I'm not thrown by people that have their own agendas I'm not worried by difficult conversations, conflict, I ;m not worried about physicians shouting at people it just actually woo, woo, woo, let's just be calm and let's take this forward and that I think is a really strong attrition for leader is that consistency. London now is over 50% is multi-racial it is multi culture, they have polish and European and different nationalities and yes you have to adapt your style. I suppose the big thing for me the experience in the UK which I have now brought with me is communication and its understanding that you have decent translation and in the UK they invested quite heavily in translators and ensuring.	Cultural diversity Cultural competencies Positive Attitudes Consistency of leadership Adaptations Experiences	Status Culture influence Ideal Vs Reality Played in Practice Expatriate Vs Local Refusal Challenges Managers' Solutions	What Works?

And if you are talking to those individuals as patients and they understand and you translate correctly then you get the sense and then you get the ability to impact either in their processes or their pathway of treatment or in their care	Communication styles		
… I was quite shocked but her domina was quite strange and her uniform wasn't professional she just came and ... so I was quite surprised so I found myself being quite umm autocratic and saying actually no, no, no, this is not was happening. (Flexibility leadership style) ….found myself being a mother being a sister being a friend being a chief nurse and she came to me lately 2-3 days ago to say I need to do different Ramadan shift, I said don't come to me you go back to your head nurse she is your line manager go and speak to her, so there I am back to autocratic again Yes, I think every nation has their own real culture treats, in the UK we had a population in of Pakistan and Bangladesh which you have here, they are culturally very different and they're the same in the UK as they are here, it is incredible and I have that same cultural believes you know which is incredible they carry this and they are very strong so you see them.	Autocratic Leadership Management style Flexible Leader Leadership transformation Resilience of leadership style Cultural differences	Managers' authority Effective communicator Challenger Flexible Role model Respect & Trust Effective communicator Challenger Flexible Motivational Role model Visionary	What Works? Unique personal leadership qualities
They developed their nurses and thy have done within different cultures however this culture is very Saudi this is going to be ministry of health this is going to be a Saudi culture and I have to do that within this culture environment so it is thinking about each of them individually and giving them the tools which I have said before and getting to be proud and have that passion in their hearts and I think that is the way we will culturally developed. The reason I smiled and hesitate in that question because I had a really interesting conversation with a psychiatrist and he got a	Culturally developed Respect for others Passion Helping people		Unique personal leadership qualities

great insight of understanding of the young nurses that they are here the they are Saudi girls and he said you know some of them do need some real help because they are struggling with their own identities where are they in the world social media is bombarding them			
They could work part time and then when their children got older go back full time and the you pay them per rata, the head count goes up, yes of course however you accommodate them so it is actually thinking about them not only from professional point of view which we have to do and that is why I am here, we need to think about their culture we about the think from a psychological and social point of view and adjust that, because I have spoken to some of these girls who have been really rode to me and I have said would you talk to your mother like that and they said set back and I said I'm your chief nurse you wouldn't talk to your mother like that so let's get to an understanding here so it is that is I hope is the answer to that question for you	Qualities Respect	Respect & Trust Effective communicator Challenger Flexible Motivational Role model Visionary	Unique personal leadership qualities
Sometimes they do bring me down but it is exactly the same as in UK, you know I will have a nurse who is belligerent or I will have a nurse that has. You know I've had it when they slapped a patient, I have had where they. you know and you have sometimes nurses that have difficult circumstances and you have to understand those but you do get down days because you are a human being and as leaders you have to make sure that you are supported and that you have mechanisms to offload and The hospital CEO has been a great support and he insured that I had a good mental. There is a uniform policy but nobody but it in place, nobody is monitoring it nobody is telling them actually it is not acceptable for you to have a face full of makeup and gold dripping off your arms and you looking after patients, it is not acceptable. I always find that you have to give them some good feedback as well as some bad feedback to help cushion that blow and helped them rebuild or say look actually this isn't the job for you let's move you on. It does, and I said to you the male I gave feedback to, was devastated but I was honest	Negative qualities Policies and standards	Status Culture influence Ideal Vs Reality Played in Practice Expatriate Vs Local Refusal Challenges Managers' Solutions	What Works? Gender aspects of nursing in Saudi Arabia

with him and his biggest worry was not so much about the feedback, it was his loss of dignity. So that's very cultural and that is very middle eastern culture, gulf region culture that is not just Saudi culture but as long you are clear, concise, honest and you triangulated your evidence. Actually you've gone round and you've realized that they have done that and you've got other examples you've concrete evidence and you can show them and say look and that is the feedback you've to give everybody doesn't matter what their culture, but you know every culture has different temperament and sometime it gets bit fiery, but I think if you keep calm an clear then you can then give the messages that need to be but the biggest pace having done that is the rebuild afterwards ether they leave you and go or help them rebuild and you give them the tools. So negatively that impacted on me because I struggled with it but positively impacted on me because I had good conversations and in the UK I did a lot of work on the DNR process and when I worked as chive nurse I got that out around the whole of the health economy, so all the GPs were making sure their patients had that choice to have a DNR you know, please do not resuscitate me don't jump all over me just let me die with dignity and peace. Those are the things I feel passionate about and they impact on the way I work and they have to cross barriers of culture and diversity we have to work around and the conversation that I know had with clinicians here we need palliative care bath ways so, the choice will be with patient and the family, if that patient need d to pass and he have cancer let them have the choice and I feel passionate about that. So that was an example for you.	Positive and negative feedbacks Gender differences on leadership Passion		
Yes, I do, I you know I manage by working around I love smiling a lot of feeling of people been valued for what they do and that comes	Management strategy	Leadership styles	What Works

from nurturing and I did that in the UK and I'm doing exactly the same that I'm doing in here. ---have done that job well and that team do the job they all have different personalities and different way of doing that, but you know going back to the rules and regulations as long as we are consistent and we are all saying the same messages and we are all got the same vision of doing the right thing for the patient then that is where it, no one person can do it in their own and it is the team approach and everybody has that tricks or puzzle and if everybody puts that effort in then these tricks and puzzles are done. Credibility is that all of the leadership team work clinically once a month, they work in the shop floor they are not just seen in their office dictating and that are on high If the staff are happy, then know why they are coming to work and they valued and if they are happy and valued and work in a team, you got productivity. I once managed in the UK two maternity hospitals exactly the same 2000 deliveries in each one and the caesarian section were really high in one and really low in the other and the difference was because the staff of the hospital with low caesarian section were happy and worked as a team, that is all it is, if the staff are happy they happy to come, if you think about it work is the 2nd place a person spend time in.	Teamwork Collision of cultures, Cultural inconsistency, Cultural conflict Cultural clash Happiness Productivity	This Works Knowing Culture How to deal with conflicts Manager's solutions Managers' authority	
Communication is key and it is ensuring that the communication is clear because with different cultures you know you can say something in one way but if I say it and they didn't quite understand it and slightly you lose the intonation. Yes, I think so, you know body language is 70% of communication is it?	Major Concerns	Challenges towards effective leadership How to deal with conflicts Leadership qualities Effective communicator	What Works Unique personal leadership qualities
Saying hello to the staff and valuing them but I also working clinically alongside and I can't work every day because this is not my job, but I can do 2 or 3 hours once a month to work alongside them and work in different areas, so that I can hear them and sees them and that what a lot of chive nurses are doing in the UK I do it out of respect, because when I was here for interview there was a patient in the	Valuing people Greeting the staff		

outpatients and he shouted why isn't she wearing her hair cover and I luckily I had this scarf around my neck so I covered my hair and he just looked at me and said ''Shokran'' (thank you in Arabic) So they are happy it is a lot of hard work but you can get it, you can get a happy team and take all those cultural issues, you have to take them with you.	Respect		
….think it is the culture shift to professionalism, we are a healthcare organization we are not all sitting around chewing gums and on our mobile phones it needs to come from those leaders and come down and I don't think that the structure or the, you know it does impact yes, I mean they have the facilities and think if you have good facilities it does help, nut you can create that without, you can create it. … culturally acceptable and the patients knows that when they get there	Structure Facilities Culture change	Professionalism Played in Practice	What Works?
I think it is that, empowerment, knowing what they know it is the professionalism it is empowerment it is knowing what good patient care is? And it is doing it, and it is challenging difficult behaviors that are not right, so for instant, hand washing, and embowering nurses and nurse leaders to say to a doctor actually no, could you wash your hand please before you see that patient. So, it is that leadership I'm hoping to developed	Empowerment What good care Concerns for nurse leaders Challenging difficult behaviours Leadership development	Leadership skills This works Working with conflict Knowing Culture	What Works? Personal Leadership Qualities
… they need to know the rules and regulations. You know the need the tools they need to know, they need everything in front of them. They need to know what they can do about the absenteeism they need to know about disciplinary policies they need to know all of those processes. They need to know to order supplies and how to the general house keeping of wards etcetera. Those are the skills you need to give them and then you need to help them to embower them which is what we came back to is how to manage conflict, how to challenge, how to value, how to engender good team spirit, and how to appreciate their staff and that is	Knowledge need Rules Regulations Absenteeism Disciplinary policies Orientation program	How to deal with conflicts Manager's solutions Managers' authority Trainings	

the leadership quality I aspire to and you then you put that down at a level and develop them accordingly. You know, what the safe number of staff to have on a shift, this really basic stuff, it is real managing of the ward and managing of the environment. …developing a head nurse course we will be developing leadership for our supervisors and I will be doing a lot leadership work for my directors of nursing --- As leaders you have to ensure that your nursing team are fit for purpose, and that they really are fit for purpose, that their competencies are there they are clinically credible and that actually they treat people with human respect	Providing skills Empowerment Manage conflict Leadership qualities Leaders development Nurse directors Leadership trainings Nurse competencies		
It depends, I mean we obviously have categorized, you have to have the basics when they get the promotion of head nurse leadership, you know you become charge nurse and head leadership. And then you need to have the right management courses and give them the tool to their job. You know, you can't do it by experiential learning, you need to do the experience and the theory at the same time so you do the 2 together.	Professional growth Management courses Learning by doing	Training needs Training needs	What Works?
Well, I suppose it is the whole concept of leadership, isn't it. It is empowerment, it is having difficult conversation huge communication it workshops around communication and understanding, I suppose those will be the key for me. yes, and all levels of that communication, how to communicate in different ways and what that means, umm. Number 2 I suppose is being a role model and clinically credible I thought there are three things that make a good leader intelligence, experience and emotional intelligence.	Leadership trainings Coverage of the trainings Communication Intelligence Experience Emotional intelligence	Language courses for working in SA Manager's solution	

APPENDIX L – Proposal for a Culturally Competent Nurse Leader Training Programme in Saudi Arabia (CCNLTP)

Introduction

The professional training that is rendered to the nurses helps in enabling them to generate efficiency and effectiveness in their nursing leadership skills, strengthen the bond between nurses and their co-workers, thereby developing effective cultural competency in delivering leadership. It has been created in response to the research questions addressed in this thesis and offers a way forward to develop nurse leaders in SA.

It is recommended to include nursing leadership in this proposed curriculum along with theoretical and clinical training. This is a new proposal to develop a Nursing leadership programme in MOH in SA, and presents key material and suggested formats.

It is contemplated how the advanced training course in leadership can help enhance the capabilities of the nurses to meet the day-to-day challenges that are put across in health care sector. At the end of the training, those who have managed to complete it successfully will be endowed with skills which would help lend growth to health care industries through the improved outcome of patients and efficient operational functionality.

The focus lies on improving the sustainability of practices which are patient centric. This nursing leadership training program highlights the importance of behavior models which empowers the nurses to identify their core competencies and nursing philosophies, enabling them to expand when leading a team. The competencies and

skills acquired during the course expand to a wide spectrum of rural, urban as well as small or large clinical environment.

The programme comprises of indulging in interactive learning activities, mentoring under professional and able coaches as well as on-site leadership programmes. Also, the team is exposed to carry out transformational projects on health, putting into practice skills on leadership learned during the programme, giving an opportunity to develop personal development through training.

The overall proposal has been discussed with the MOH and they have agreed to consider funding the programme on my return. In the future, there may be the opportunity to evaluate its success.

Influencing Factors

The outcomes of an organization including providers as well as patients are largely affected by the leadership practices carried on by the health care leaders, whose effect can be both positive as well as negative. It is paramount to understand the factors which play a role in enhancing nursing leadership, ensuring an unobstructed supply of competent nursing leaders in the future, inspiring the outcomes for both patients and providers in health care.

Through precise educational activities which include modelling and practice, helps in developing leadership skills. Though there is very few evidence which affirms on the methodology used and factors included which would help enhance the value of nursing leadership used at present and mentor in identifying future leaders in health care. In order to develop a healthy work environment both for the providers as well as augmenting patient care calls for a vigorous study and research on intrusions to be conducted for developing feasible nursing leadership in future.

Leadership and Nursing

The nurse leader needs to be adaptable to the circumstances and situations put forth and adopting the specific characteristics when needed to explore their leadership skills. Furthermore, in addition to leadership qualities, they also need to implore other set of skills which includes the importance to act with integrity, setting realistic goals, encouraging the morals, communicate with clarity and regularly, motivate others and their team to put their best foot forward, also recognize and appreciate the successes of team. These actions would further be echoed back by colleagues who would provide exponential care to patients irrespective of which nursing leadership style they follow.

Each nursing department comprises of individuals who serve varied roles required to meet the specifications of patients. The group need not function as a team, though we come across RNs, CNAs and LPNs scheduled to work together, their working may not be always together. The nursing staff may work as a team in order to meet common set goals or be distributed to varied other departments to head in different directions to explore their leadership skills. A nursing leader's leadership skills play a very great role in determining the success or failure of a team, which is solely based on their strengths and weaknesses in inspiring their fellows to perform well.

Another important point to be noted is, no achievement can ever depend on a person alone, it is on the team. The success depends on the strength and support of team together who help in inspiring and impressing others to grow together, paving a way to success by collective efforts. A leader who does not value the experiences of teams and their ideas are considered to as a dictator by the team. Although this may showcase the strength of the leader, it also highlights their weakness in maintaining team atmosphere.

Candidates

The Culturally Competent Nursing Leadership Training Program (CCNLTP) will accept and prepare registered nurses employed from various countries of the world to work in the prevailing set-up of nursing units in Saudi Arabia. The program is intended for registered nurses chosen based on their experience in patient care unit and willing to gain proper training in the field of culturally competent nursing leadership.

Ideal candidates would have a bachelor degree and must have effective communication skills and commitment to high standard of customer focused quality nursing care. The candidates must prove eligibility and show complete evidence/s of qualification upon the recruitment process. They are required to possess all specified mandatory qualifications. Those with desirable qualifications have the possibility of being listed as priority amongst the field of applicants.

Qualifications – Mandatory

1. Bachelor of Science in Nursing
2. Registered with the Nurses Regulatory Board relevant to the country of origin.
3. Minimum of 2 years' experience in nursing.
4. Basic Life Support provider.

Objectives

The program aims to provide a bridging course designed to improve leadership qualities, cultural competence, nursing care, managerial quality and to enhance resource utilization in MOH health care organizations. Role preparation for our future nurse leaders begins with leadership and cultural competence training, professional learning behaviour, and postgraduate leadership and management education before they take up leadership or management positions. They will get in-house

organizational leadership and management and cultural competence training to support their leadership development. This program is helpful in teaching personal leadership qualities and effective leadership characteristics for all nursing educational levels to inculcate these qualities and characteristics among the future nursing force.

By the time these nurses join the healthcare organizations as nurse leaders, they will have the capacity to apply these characteristics and qualities as part of their job responsibilities. The professional nursing training programs will enhance and enrich the experience of the nurses in order to develop an effective and efficient nursing care environment, healthy relationship between nurses and their leaders, and an effective management system.

Duration:

Lasting for full-time, six (6) days period, the program covers 44 credit hours, corresponding to 24 theoretical and 20 clinical hours.

Methods of Teaching:

Through lectures, discussions, audio-visuals, situation demonstrations, coaching, individual and group works, clinical immersion and exchange programmes in the future, this program addresses the theoretical concepts and clinical skills needed to function in the nursing leadership position.

Evaluation Criteria:

Going through different levels of evaluation, the candidates are assessed based on pre- and post-tests; active participation in classroom and practical sessions; and completion of assignments, case analysis, and presentation.

Particularly, the candidates will be evaluated with appropriate weighted percentage:

- Attendance and Participation 10%
- Quiz 10%

- End of Module Exam 35%
- Clinical/Practical Performance 35%
- Assignment/Case Presentation 10%

100%

At the end of the training attendance will receive a certificate

Course Description:

In response to this enormous demand for nursing leadership skills, a training program is required for nurses to assist MOH hospitals in meeting their human resource needs for safe, effective and accessible care. Nursing leadership training program ensure that all skills required, especially those recruited from abroad are kept up to date and up to the current state of this rapidly changing qualities in the nursing care units that the Kingdom of Saudi Arabia adopts in its Ministry of Health hospitals.

This course introduces candidates to the role and responsibilities of a nurse leader. Leadership skills are discussed within the broader framework of system change and quality improvement. The emphasis is on working with interdisciplinary teams to create and shape effective health care delivery systems responsive to the needs of individuals and families.

During the training program candidate will:

- Combine clinical training and cultural competency theory together, in addition taking part in practice based assignments.
- Mentoring by professional trainers who help engage in forums of discussions, seminars, webinars, mentor through interactive calls and share their experiences.
- Evaluate execution of the training

- Generate a viable action plan, aiding in implementation of programme in organizational practices
- Study financial, clinical and organizational measurement in order helping in evaluating the programme efficiencies.

How Does this Training Programme Work?

A team of experts is appointed for conducting the programme, where the participants will have to go through this training. Coordinator designated for conducting the programme is provided with tools used for planning and augmenting ways how the course will be conducted over a period of time. These tools are provided to the participants as well. The training programme will help the participant to achieve the following:

- The participants will be provided access to complete training programme topics, which include staff education, financial, clinical and organizational approaches for evaluation purposes.

- Participants will receive assignments and topics which would help in the implementation of essential elements in achieving cultural competence.

- At the end will be conducted a review based on the action plan developed. This would be reviewed and discussed by a niche professional which is an important step in turning into a niche designated site.

Who Should Attend?

Anyone who belongs to various disciplines like rehab, social work, pharmacy, medical, etc. can avail for this program. If they are a clinical professional, a manager or administrator, a nurse clinical leader or a direct care staff they can attend.

APPENDIX M – Curriculum Outline

Title: **Culturally Competent Nurse Leader Training Program (CCNLTP)**

Objective: To provide a bridging course helpful in teaching cultural competency, personal leadership qualities and effective leadership characteristics for all nursing educational levels to inculcate these qualities and characteristics among future nursing force

Candidates: Registered nurses from various countries of the world.

Duration: 6 days.

Part I: Theoretical Component

Credit: 24 hours

Module/ Session	**COURSE CONTENT**
Module I/Session I	• The theories and principles of leadership and management functions in relation to SA culture • Explore Saudi cultural values, beliefs, and behaviours • Leadership theories and management processes
Module II/Session II	• Developing Cultural Competency in the workplace • Develop cultural Competency by examining assumptions and cultural competency best practices. • Leadership and management concepts and principles
Module III/Session III	• Linguistic Competence • Knowledge of culturally and linguistically diverse populations • Adapting leadership practice for culturally and linguistically diverse populations

	• Promote the capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse groups including persons of limited Arabic/English proficiency.
Module IV /Session IV	• Professional and interpersonal relationships in nursing practice with an emphasis on leadership. • Dealing with challenges situations • Interdisciplinary collaboration. • Leaders and managers in action using cultural awareness
Module V/Session V	• Organizational structure and culture • Workplace health and safety • Decision making
Module VI /Session VI	• Conflict management • Change management • Emotional intelligence • Maintaining resilience as a leader

Part II: Clinical Component

Credit: 20 hours

Module/ Session	**COURSE CONTENT**
Module I/Session I	• Integrating various management and leadership concepts and principles into practical experiences organized in different settings. • Submission of individual and group projects that reflects mastering levels of different management and leadership concepts and skills.

	• Focuses on the development of participants in the role of beginning nurse managers/leaders in a clinical practice setting.
Module II/Session II	Cultural awareness can help nurse leaders to: • Acknowledge how culture shapes their own perceptions • Be more responsive to culturally diverse colleagues • Be more sensitive and accessible as a leader, mentor or supervisor • Be alert to cultural differences and similarities that will present opportunities and challenges to working in a multicultural environment, including health and safety. • Influence the next generation of public health professionals to be culturally aware as a prerequisite toward achieving cultural and linguistic competence. • Cultural awareness includes being conscious of organizational culture and its implications for policy, practice, teaching, research, and community engagement.
Module III/Session III	• Provide participants with basic concepts and theories needed for effective management of client care. • Problem-solving strategies, decision making and critical thinking skills are developed as management process on patterns of health care practice and delivery are critically evaluated. • Regular meeting with colleagues from different cultures, group discussion. • Regular Workshops with realistic scenarios.

APPENDIX N – Training Completed

Doctoral Academy
Cardiff University
Record of Student Participation
Date Printed: 05.11.17

Student Name: Aldawood Abdulrahman Abdullah
Academic School: SONMS
Student Number: 1155438

Knowledge & Intellectual Abilities — 6 Points Domain A

Developing Systematic Literature Searches - Health & Social Care Topics	03/12/2014	3 hrs	1 Points
Developing Systematic Literature Searches	28/01/2013	3 hrs	1 Points
Critical Appraisal of Research Papers: Qualitative	27/11/2012	3 hrs	1 Points
Word: Working with Long Documents, Microsoft	15/11/2012	4 hrs	1 Points
EndNote: An Introduction to Managing your References	15/10/2012	2 hrs	Points
Starting Out: Induction Event for New Researchers	12/07/2012	4.75 hrs	2 Points

Personal Effectiveness — 2 Points Domain B

Planning and Writing Your Thesis (Sciences)	21/10/2013	1.5 hrs	0.5 Points
Seven Secrets of Highly Successful Researchers	13/02/2013	3 hrs	1 Points
Planning and Writing Your Thesis (Sciences)	29/10/2012	1.5 hrs	0.5 Points

Research Governance & Organisation — 2.5 Points Domain C

Research Ethics in Social Science Research	29/10/2013	5 hrs	2 Points
Plagiarism: The Scientific Journal Editor's View	25/10/2012	2 hrs	0.5 Points

Engagement Influence & Impact — 3.5 Points Domain D

Mock Viva (Sciences)	09/12/2014	2 hrs	0.5 Points
PowerPoint: Enhancing Your Presentation, Microsoft	13/06/2013	2 hrs	0.5 Points
English for Research Writing (for non-native speakers of English) - Friday Series	15/03/2013	2 hrs	0.5 Points
English for Research Writing (for non-native speakers of English) - Friday Series	08/03/2013	2 hrs	0.5 Points
English for Research Writing (for non-native speakers of English) - Friday Series	01/03/2013	2 hrs	0.5 Points
English for Research Writing (for non-native speakers of English) - Friday Series	22/02/2013	2 hrs	0.5 Points
English for Research Writing (for non-native speakers of English) - Friday Series	15/02/2013	2 hrs	0.5 Points

TOTAL POINTS: 14

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Welcome Abdulrahman Aldawood

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Here you can see all your historical bookings. Firstly, there are those sessions that you have successfully attended. There are those you did not attend: no show. There are the sessions that you have been rejected from attending, and finally those sessions which you or staff cancelled.

Attended sessions - You have attended these sessions

09/12/2014(Tuesday) / 17:00 - 19:00
Mock Viva (Sciences)
Hadyn Ellis Building, lecture theatre

03/12/2014(Wednesday) / 09:30 - 12:30
Developing Systematic Literature Searches - Health & Social Care Topics
Training Room 2, Julian Hodge Study Centre

29/10/2013(Tuesday) / 10:00 - 15:00
Research Ethics in Social Science Research
Hadyn Ellis Building, Room 0.27B

21/10/2013(Monday) / 14:00 - 15:30
Planning and Writing Your Thesis (Sciences)
Hadyn Ellis Building, Lecture Theatre

13/06/2013(Thursday) / 14:00 - 16:00
PowerPoint: Enhancing Your Presentation, Microsoft
Training Room 1, Julian Hodge Study Centre

15/03/2013(Friday) / 10:00 - 12:00
English for Research Writing (for non-native speakers of English) - Friday Series

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rssdp.cardiff.ac.uk/index.php?sect=sessions&go=past

15/03/2013(Friday) / 10:00 - 12:00
English for Research Writing (for non-native speakers of English) - Friday Series
Room 3.10, Graduate Centre

08/03/2013(Friday) / 10:00 - 12:00
English for Research Writing (for non-native speakers of English) - Friday Series
Room 3.10, Graduate Centre

01/03/2013(Friday) / 10:00 - 12:00
English for Research Writing (for non-native speakers of English) - Friday Series
Room 3.10, Graduate Centre

22/02/2013(Friday) / 10:00 - 12:00
English for Research Writing (for non-native speakers of English) - Friday Series
Room 3.10, Graduate Centre

15/02/2013(Friday) / 10:00 - 12:00
English for Research Writing (for non-native speakers of English) - Friday Series
Room 3.10, Graduate Centre

13/02/2013(Wednesday) / 13:00 - 16:00
Seven Secrets of Highly Successful Researchers
Shared Lecture Theatre (E1.21), Biosciences Building

28/01/2013(Monday) / 09:30 - 12:30
Developing Systematic Literature Searches
Training Room 1, Julian Hodge Study Centre

27/11/2012(Tuesday) / 13:30 - 16:30
Critical Appraisal of Research Papers: Qualitative
Room 3.19, Graduate Centre

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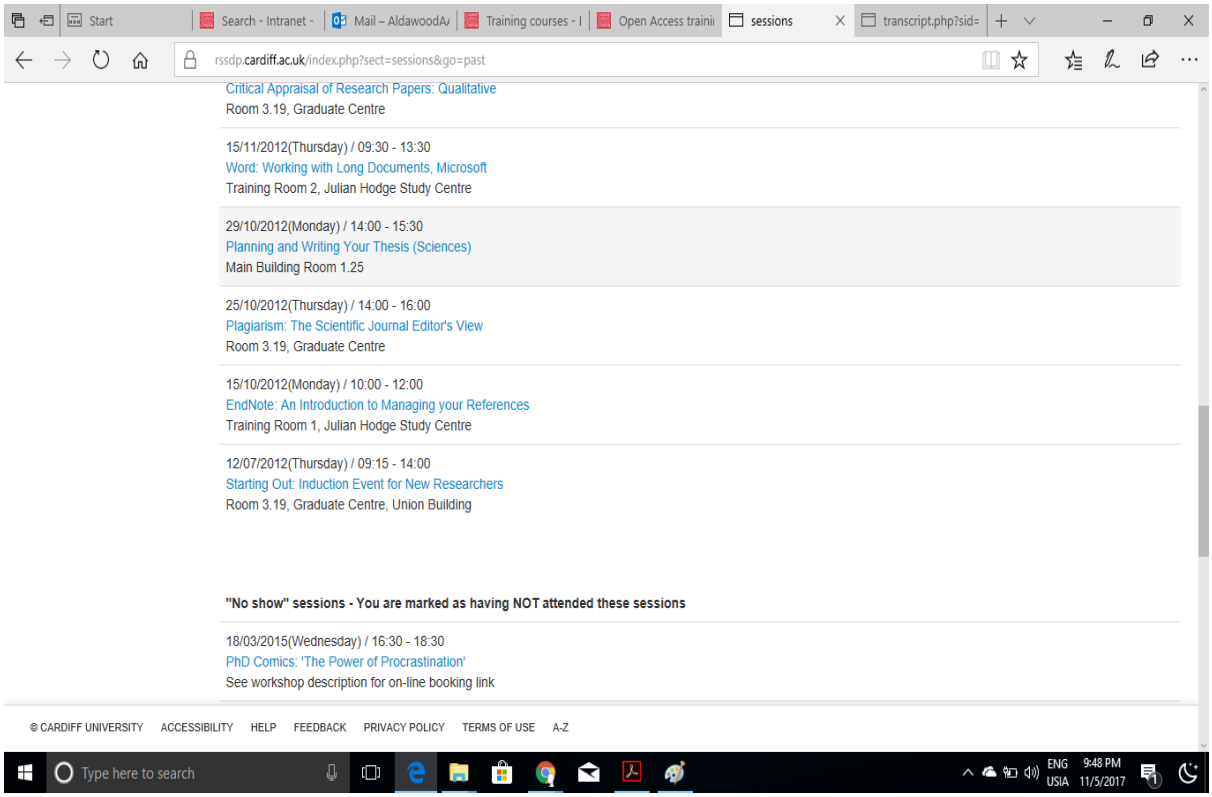

Critical Appraisal of Research Papers: Qualitative
Room 3.19, Graduate Centre

15/11/2012(Thursday) / 09:30 - 13:30
Word: Working with Long Documents, Microsoft
Training Room 2, Julian Hodge Study Centre

29/10/2012(Monday) / 14:00 - 15:30
Planning and Writing Your Thesis (Sciences)
Main Building Room 1.25

25/10/2012(Thursday) / 14:00 - 16:00
Plagiarism: The Scientific Journal Editor's View
Room 3.19, Graduate Centre

15/10/2012(Monday) / 10:00 - 12:00
EndNote: An Introduction to Managing your References
Training Room 1, Julian Hodge Study Centre

12/07/2012(Thursday) / 09:15 - 14:00
Starting Out: Induction Event for New Researchers
Room 3.19, Graduate Centre, Union Building

"No show" sessions - You are marked as having NOT attended these sessions

18/03/2015(Wednesday) / 16:30 - 18:30
PhD Comics: 'The Power of Procrastination'
See workshop description for on-line booking link

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Training Courses attended during PhD

COURSE TITLE	DATE	LOCATION
ESSENTIAL INTERVIEWING SKILLS	01/05/2013 3 days	Riyadh
ESSENTIAL SKILLS FOR EFFECTIVE TRAINING ADMINISTRATION	03/04/2015 3 days	Riyadh
LINKING TRAINING TO ORGANISATIONAL GOALS	09/04/2015 1 day	Riyadh
CULTURAL AWARENESS TRAINING	10/11/2016 3 days	Riyadh
TRAIN THE TRAINER	21/11/2016 3 days	Riyadh

CARDIFF UNIVERSITY
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وزارة الصحة
Ministry of Health

Nursing in Saudi Arabia

- The nursing profession in Saudi Arabia is experiencing a chronic shortage of Saudi staff nurses and leaders.
- Nursing staff are the largest group among all healthcare professionals and are responsible for delivering the highest percentage of patient care (Oulton 2006).
- The nursing system in Saudi Arabia relies a great deal on expatriates nurses, recruited from over 52 countries (Suliman, 2009).

Research Question

What types of culturally sensitive leadership programs need to be applied to nurse leaders

Purpose:

This study aims to assess to what extent nurse leaders in Saudi Ministry of Health are culturally competent.

Nursing Leadership Development

Effective Leadership development will have an impact on performance (Melum 2002)

Nurse leaders who had access to empowerment factors experienced less emotional exhaustion and more dedication to organizational goals. (Goddard & Laschinger 1997).

The placement of a well-educated Saudi nurse to the chief nurse position is needed and should result in the continued professional development of the division

Background

The challenges for Saudi Arabia are to increase its proportion of local nurse leaders who will be able to lead a multinational staff to deliver a culturally-sensitive high quality service (Aldossary et al., 2008, Fielden, 2012).
The World Health Organization has made many recommendations regarding the need for Saudi-trained nurse leaders.
They have identified the need for appropriate leadership training and education for Saudi nurses as crucial for the country to improve its health services (WHO, 2006).