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How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?

by

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ABSTRACT

Leadership behaviours play a key role in achieving organisational success. Leadership is commonly perceived as a world-wide concept throughout different countries; however, the way in which it is conceptualised and operationalised is viewed as culturally specific. Existing leadership research often overlooks the impact of context (Bryman et al. 1996; Denise and Yitzhak 2001; Osborn et al. 2002) and culture (Hofstede 2001; House et al. 2004) on leadership and its effectiveness. Leadership research is mainly the product of models and constructions developed in Western cultures, while little is understood about leadership in other cultures (Tsui 2004). Dickson et al. (2012) argue that most leadership models have a North-American bias, an orientation which has caused many academics to recognise the importance of investigating leadership approaches and characteristics in non-Western contexts. The current research aims to identify, characterise and explain the dynamics of leadership behaviours as these are understood and operationalised by the managers of hospital emergency departments in Saudi Arabia.

A constructionist research philosophy is adopted in this research. This study employs qualitative research methods to investigate the leadership behaviours used by managers in hospital-based emergency departments. The research employed a purposive sampling method to recruit participants from five hospital emergency departments located in three urban cities in Saudi Arabia. A total of 30 participants were recruited for the study between May and September, 2015; data were gathered via semi-structured interviews. The participants were 15 managers and 15 medical staff. Managers included the heads of emergency departments, their deputies and head nurses. Medical staff included physicians and nursing staff. Data were analysed using thematic analysis techniques.

The findings which emerge from this study are grounded in the data. The themes explored were: a) rewarding leadership, b) responsive leadership, c) role-modelling, d) democratic leadership, e) staff-development leadership, f) recognition leadership, g) supportive leadership, h) lenient leadership and i) strict leadership. Managers use these leadership behaviours to address several contextual factors in emergency departments, including pressure, stress, over-crowding, staff-related conflicts, staff-patient-related conflicts, responding to unexpected situations and disciplining staff members who make mistakes that might harm staff or patients. It was found that these different leadership behaviours are mainly influenced by the context of the emergency department and the culture of Saudi Arabia, based on Islamic religion and social norms.

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DECLARATION OF AUTHORSHIP

I am Badr Khalaf Aldhmadi declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signed: .....

Date: .....

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Dedication

To Khalaf Aldhmadi (1938-2010).

To Surba Alzwaimel may Allah grant her good health and a long life.

Definitions and Abbreviations

WHO: World Health Organisation

MOH: Ministry of Health

ED: Emergency Department

ER: Emergency Room

TFL: Transformational leadership

Chapter 1 Introduction

This chapter explains the context of the current research. It begins by introducing the topic of emergency medicine and its distinctive characteristics and challenges, as well as the dominant model of emergency-care delivery in various countries including Saudi Arabia. Then, the chapter moves on to identify the important role of leadership by introducing dominant models in the leadership literature. It includes a definition of leadership behaviours for this research. It highlights the rationale of this research, followed by the research question, aim and objectives. The chapter concludes by describing the structure of the current thesis.

1.1 Emergency medicine

The practice of emergency medicine entails a process of investigation and cure that is directed towards addressing unexpected harm or sickness (American College of Emergency Physicians 2008). There are diverse attributes involved in the practice of emergency medicine, including the initial diagnosis, therapy and evaluation processes. Moreover, it includes handling the disposition of patients in need of urgent medical, psychiatric or surgical procedures. Emergency medicine is often applied within the spheres of freestanding or traditional hospital-based emergency departments (EDs), but is also applied in diverse medical fields including disaster sites, emergency medical-response vehicles and urgent care clinics, among others (ACEP 2008).

The Anglo-American model is considered to be a widely used model for emergency care delivery, since it “brings the patient to the hospital” (Dykstra 1997). This model proposes that a patient needs to be transferred to the emergency department of a hospital or healthcare organisation to be provided with high quality healthcare services. Emergency care delivery starts before the patient is admitted to the hospital, since the patient first interacts with paramedics and medical professionals in the emergency department (Arnold 1999). Based on this model, emergency medicine is a separate discipline of medical science that is managed and administered by emergency physicians. This model is actively used in a wide range of developed countries including Australia, Canada, the United States and the United Kingdom (Arnold 1999).

For developing countries such as Saudi Arabia, emergency medicine is viewed as a specific field related to medicine. This is because it is dependent on particular sets of information and knowledge, and therefore it requires physicians who are specialists in the field. Emergency medicine society at national levels is prevalent in many countries and therefore, it is responsible

for providing residency training and certification. Emergency medicine as a speciality allows emergency specialists to improve the efficiency and effectiveness of emergency healthcare departments and other patient-care systems. An emergency medicine system is beneficial in improving health outcomes for patients who are seriously ill, on life support or critically injured. Sound administration systems may not be found yet (Arnold 1999).

The fundamental aspect of emergency medicine to provide high quality patient care and healthcare services in emergency departments (EDs). The emergency department comprises a room or area that is set aside for receiving and treating patients who arrive, at short notice, seeking care for various medical conditions, ranging from simple to the most complicated medical conditions. It should be properly equipped with the necessary medical tools and staff, including doctors and nurses, who are well trained in dealing with urgent medical conditions that require immediate attention. It provides twenty-four-hour emergency care that is incorporated within the general health delivery system of the hospital, especially concerning its structure and operations (Australian College for Emergency Medicine 2012). The emergency department is structured and divided into different medical care areas that the patient is expected to go through systemically to receive treatment. Medical-care areas include triage, a consultation room, resuscitation, a patients' waiting area, a medical or surgical area, a major operating room, a minor-procedures room, an observation unit, a twenty-four-hour pharmacy and an injection room. In essence, the emergency department is often regarded as the accident and emergency department (A&E) or emergency room (ER).

The World Health Organisation (2013b) has reported that, globally, approximately five million people per annum encounter death due to wars, while millions more suffer injuries in road related incidents or road-traffic accidents (RTAs). Other sources of harm to people include poisoning, drowning, burns and falls, assaults or self-inflicted injuries. From a broad perspective, injuries account for close to 9 per cent of global mortality, as all countries are affected by health hazards. Such deaths are associated with first contact with emergency departments requiring quick and effective response from emergency-department teams.

The emergency services in Saudi Arabia face a major challenge, with increasing numbers of patients visiting emergency departments. For example, it is estimated that over twenty-one million visits were made to Saudi hospital-based emergency departments in 2014 (Ministry of Health 2014). These visits include links to different types of diseases, such as diabetes mellitus, parasitic or infectious diseases. Moreover, such visits are also associated with poisoning, falls and road-traffic-accident (RTA) injuries. Further, the numbers of RTAs have increased dramatically over the last few decades. Official statistics show that they are one of the main causes of injuries

and deaths among young Saudis (Ministry of Health 2013). Saudi Aramco (2012) reports that about 20 people die every day due to RTAs, and more than 7,000 people lost their lives in traffic accidents among the 39,000 injured in 544,179 crashes in 2011. Consequently, this results in an increased burden for emergency-department managers. To meet this challenge, the Saudi Ministry of Health aims to boost emergency services' efficiency in order to meet the need during normal circumstances as well as during disasters (World Health Organisation 2013a). Leadership can play a critical role in meeting these challenges.

The emergency department is an ever-changing, highly regulated, high-stress and complex environment. It needs effective leadership practices to maintain professional emergency-care practice to create a motivating and peaceful environment for medical and nursing staff. However, to date, little research has been undertaken to investigate what effective leadership looks like in this setting, and almost none in Saudi Arabia. This research project addresses this gap.

1.2 Leadership

Leadership is a crucial factor of success in complex organisations, especially when they are multi-layered and have multiple goals and objectives. Northouse (2013 p5) describes leadership as the "process whereby an individual influences a group of individuals to achieve a common goal". Due to the evolving needs of the healthcare industry, analysis of the role of leadership in these increasingly complex systems of organisation has become progressively more relevant. There are various models for the role that a leader plays in an organisation.

The earliest studies of leadership styles were undertaken by Lewin et al. (1939), who examined various styles of leadership, including democratic, authoritarian and laissez-faire models, and their impact on group outcomes. Democratic leaders focus on developing relations with their subordinates through open communication channels, motivating them to take part in the decision making process and identifying clear goals and objectives (White and Lippitt 1960). Authoritarian leadership models are based on the maintenance of strict control over members of the organisation through direct regulation and the implementation of rules and regulations, with dissent often being dealt with strictly and severely (Lewin et al. 1939). Laissez-faire leadership models involve a degree of withdrawal by the leader, into the background, resulting in group members developing higher levels of independence and self-determination (Bass 1990).

Several studies in the 1940s-1960s used contemporary analysis of models of leadership. These include, among others, the Michigan leadership studies (Tannenbaum and Schmidt 1973), Ohio

state leadership studies and McGregor's Theory X and Theory Y (McGregor 1960). In these studies, the emphasis was more on a leader's behaviour rather than his/her personality characteristics, as healthcare systems progressed from personality-based practice to systems-based practice, and the use of tools similar to Blake and Mouton's managerial grid (Blake and Mouton 1968; Blake and McCanse 1991) to explore the managerial practices of leadership, whether it was task-oriented or relation-oriented leadership behaviours in organisational settings.

Over the last few decades, the focus of leadership research has moved towards the interaction between leaders and followers. Leadership has been examined in connection with all aspects that could affect leadership effectiveness, including subordinates, peers, work situations and culture (Avolio et al. 2009). Leadership is currently seen as a dynamic, collective, social, strategic and universal process in different models for both general and private domains, and for profit as well as non-profit organisations. Consequently, more attention is paid to leadership research by large organisations in order to satisfy the demand for leadership development, which leads to positive work outcomes.

In the early 1980s, a new paradigm of leadership, termed transformational leadership, emerged and attracted the attention of leadership research (Northouse 2013). The popularity of transformational leadership can be attributed to its concentration on inherent motivation and follower advancement, fitting the requirements of today's work groups, whereas followers need leaders who are inspiring and empowering in order to succeed in times of uncertainty (Bass and Riggio 2006), which is similar to the context of emergency medicine. It was introduced and developed to expand the transactional model, defined as agreement over exchanging rewards among leaders and subordinates, depending on the performance of followers, in order to achieve expected outcomes (Antonakis et al. 2003). The term transformational leadership was developed theoretically by Bass, who defines it as an approach whereby a leader and a follower elevate one another by raising their motivational, influential and inspirational levels so as to achieve more than what would normally be expected (Bass 1985).

Different contemporary models of leadership have been proposed in recent years. These comprise, among others, servant leadership (Greenleaf and Spears 2002) and authentic leadership (Walumbwa et al. 2008). Servant leadership involves paying attention to followers' needs and placing them first, while authentic leadership is concerned with ethical, genuine and real leaders, as the name of the theory implies.

An analysis of the literature related to culture and leadership demonstrates that culture and its implications play an essential role in influencing the ways in which leaders behave, act, and respond to situations in their societies (Hofstede 2001; House et al. 2004). Hofstede (2001)

asserts that culture represents the common patterns of mentality for individuals of any particular nationality. House et al. (1999 p13) indicates that culture comprises "shared motives, values, beliefs, identities, and interpretations or meanings of significant events". Therefore, leadership meanings and effectiveness are contingent upon the culture in which they occur. This issue raises a critical question in relation to the relevance of Western leadership models in organisations from other nations because of inherent cultural differences. Yet, little is known about leadership understandings and practices in Saudi culture. The current thesis aims to address this gap.

1.3 Leadership behaviours

This study is concerned with leadership behaviours. Behaviours "are specific actions, which occur in a particular setting at a particular time" (Smith and Bond 1998 p65). Leadership actions, as understood in this study, denote the behaviours of leaders (emergency managers, deputies and head nurses) in interactions with their followers (emergency physicians and staff nurses) in an organisational setting (emergency departments). However, there can be a leader-follower relationship between emergency managers and their deputies, as well as between emergency physicians and staff nurses, when interacting in certain situations in emergency departments.

1.4 Study Rationale

Although the leadership field has witnessed significant progress over the last few decades, leadership research is still mainly the product of models and constructions devised in Western cultures, particularly in North America and Western Europe, and little is understood about the use of these models in other cultures (Tsui 2004). These models have been tested in various other cultures and organisational settings but without giving adequate consideration to the contextual e.g. organisational setting (Bryman et al. 1996; Denise and Yitzhak 2001; Osborn et al. 2002) and cultural factors e.g. national culture (Hofstede 1993), that affect the value and importance of perceived leadership behaviours. Osborn et al. (2002) suggest that existing research is not invalid but rather incomplete because it overlooks the impact of context on leadership and its effectiveness. Several leadership scholars have expressed concerns over the validity and generalisability of these models across cultures, since there are some key characteristics of Western cultures that are significantly different from those of other cultures (Hofstede 1993; Dickson et al. 2003; House et al. 2004; Avolio 2007; Tsui et al. 2007; Metcalfe and Metcalfe 2008). Dickson et al. (2003) and Dickson et al. (2012) argue that most leadership models have a North-American bias, which has made some researchers recognise the importance of investigating the

idiosyncrasies of leadership approaches and orientations in different nations. Further, recent leadership models developed in the United states including charismatic and transformational reflect what is known as “heroic leadership” because these models focus on white male senior and top managers (Metcalfe and Metcalfe 2008). The research undertaken by Global Leadership and Organisational Effectiveness (GLOBE) provides strong evidence that effective leadership behaviours and prototypes are culturally determined, and thus Western models of leadership may be ineffective or understood differently in other settings and cultures, especially in nations that differ from Western cultures (House et al. 2004). As a consequence, many scholars in the field of leadership and organisational behaviour call for applying an inductive rather than a deductive approach, described as “indigenous” or “context-specific” research in novel settings, to move from a superficial understanding towards a more detailed understanding of leadership (Tsui 2004; Avolio 2007; Gelfand et al. 2007; Tsui et al. 2007). This research employs an inductive approach to address this gap in order to identify leadership behaviours and understand the contextual characteristics of emergency department and cultural forces that influence leadership behaviours and effectiveness.

1.5 Research question

This study seeks to answer the following research question:

“How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?”

1.6 Aim

The purpose of this research is to identify, characterise and explain the dynamics of leadership behaviours as these are understood and operationalised by the managers of hospital emergency departments in Saudi Arabia.

1.7 Objectives

The present research aims to reach the following objectives:

1) To identify, describe and explain the types of leadership behaviours in use, as perceived and enacted by emergency-department managers;
2) To identify, describe and explain the types of leadership behaviours enacted by emergency-department managers, as perceived by emergency-department staff.

3) To identify shared patterns of leadership behaviours between emergency-department managers and their staff.
4) To examine the influence of the emergency-department context and Saudi national culture on leadership behaviours.

1.8 Structure of the thesis

This section presents the layout of the thesis. It is divided into eight chapters including the current one.

Chapter one provides the general background to the research, including emergency medicine and leadership, followed by highlighting the rationale for the research project. The chapter presents the research question, aim and objectives. Chapter two critically evaluates the literature on leadership, including its definition, distinctions between leadership and management, and constructions of leadership from a historical perspective. Then, the chapter investigates the influence of context and culture on leadership behaviours. Chapter three presents the context of the study with respect to Saudi Arabia, including a discussion around Saudi Arabian history and culture. It also includes a debate about the influence of Islam, social norms and tribal values on leadership behaviours. Chapter four critically evaluates empirical research undertaken in the area of critical and emergency settings, highlighting the theoretical frameworks and methodologies used in these studies and the findings and limitations of previous empirical research. Chapter five sets out the research methodology, including a discussion of the philosophical assumptions made for the current research. Then, the chapter discusses the study design as well as the reasons for adopting qualitative research. It also describes the data-collection methods and analysis methods employed, followed by a discussion of the rigour and trustworthiness of the findings. Chapter six presents the findings of this research. Chapter seven presents a discussion of the findings in relation to the research question and an examination of the findings in relation to the leadership literature, followed by highlighting the research contribution from theoretical, methodological and practical perspectives. In addition, the chapter points out the research's limitations. Chapter eight draws conclusions from the research and revisits the research question, aim and objectives.

1.9 Conclusion

This chapter has shown the background to the present study. An overview of emergency medicine and the important role of leadership in organisational settings have been considered. The chapter

has highlighted the rationale for conducting this research, followed by presenting the research question, aim and objectives. The chapter includes an outline of the structure of the present thesis.

Chapter 2 Leadership

This chapter critically examines the current state of knowledge in the leadership literature. It begins by discussing definitions of leadership and includes a discussion of the difference across leadership and management. Subsequently, consideration is given to leadership models and constructions from a chronological perspective. The chapter concludes by investigating the important role of culture and context in leadership behaviours and effectiveness. This conclusion also includes some thoughts on the physician-nurse relationship. Specific leadership literature, relevant to critical and emergency care settings, will be discussed in chapter 4.

2.1 Leadership definitions

Burns (1978 p2) holds that "leadership is one of the most observed and least understood phenomena on the earth". The concept of leadership has received considerable interest in the literature worldwide and the subject is studied in many disciplines including healthcare (Northouse 2013). The notion of leadership is prevalent in every society and it can be regarded as vital to the operation of organisations. However, the key characteristics of leadership may be perceived differently in different national cultures. Thus, House et al. (2004) suggest a need to understand how leadership is perceived and exercised in various cultures.

Stogdill (1974 p7) states that "there are almost as many definitions of leadership as there are persons who have attempted to define the concept". Leadership may be viewed as a trait or a behaviour, though some perceive it from group-process or relational viewpoints (Bass and Bass 2008; Northouse 2013). Rost (1993) examined publications from 1900 to 1990 and found that there were more than two-hundred different definitions of leadership. Yukl (2013) points out that definitions of leadership are often confusing and unclear due to the reference to words like control and management, as well as supervision, to define similar concepts.

Definitions of leadership evolved systematically during the 20th century. In the first three decades, leadership was conceptualised as the control and centralisation of power and authority (Frank 1911; Moore 1927). By the 1930s, leadership was viewed from personality perspectives, emphasising the qualities as well as the characteristics of a person who is a leader possesses, with a developing perception of leadership as being a matter of influence as opposed to control and power (Nash 1929; Cleeton and Mason 1934; Tead 1935). In the 1940s, the group approach appeared and leadership was defined as a behaviour that encompasses directing group activities

(Copeland 1942; Hemphill 1949). In the 1950s, leadership was viewed as a relationship that develops mutual goals and the notion of effectiveness came to the forefront (Homans 1950; French 1956). Remarkably, in the 1960s, there was agreement among leadership scholars (Northouse 2013); leadership was described as behaviour that influences individuals working towards mutual goals (Seeman 1960). In the 1970s, an organisational behaviour approach emerged and leadership was defined in the following way: "initiating and maintaining groups or organisations to accomplish group or organisational goals" (Rost 1993 p59). Burns's (1978 p425) description of leadership, which Northouse (2013) argues should be regarded as a significant notion, states that "leadership is the reciprocal process of mobilizing by persons with certain motives and values, various economic, political and other resources, in a context of competition and conflict, in order to realise goals independently or mutually held by both leaders and followers".

There was an explosion of scholarly works to describe the nature of leadership in the 1980s. In this decade, leadership was understood as an issue of influence and transformation. The term influence was examined closely in attempts to identify the differences between leadership and management. Leadership was defined as a mechanism of transformation, which happens when individuals interact with other people in a manner whereby leaders as well as subordinates elevate each other to achieve a greater degree of inspiration and enthusiasm (Burns 1978).

Northouse (2013) argues that despite the different methods by which leadership has over time found itself conceptualised, four aspects can be recognised as being at the core of this concept. According to these components, leadership: (1) is a process that (2) involves influence on others; (3) it happens within a group context and (4) encompasses the accomplishment of mutual goals. On this basis, Northouse (2013 p5) suggests the following definition: "leadership is a process whereby an individual influences a group of individuals to achieve a common goal". He contends that leadership is a complex concept and, therefore, leadership continues to have different meanings for different people.

2.2 Leadership vs Management

Leadership is a concept comparable with management (Northouse 2013), although they are functionally and conceptually different. The term influence is an important element of both leadership and management, as both require liaising with individuals to achieve certain organisational outcomes. Nevertheless, leadership is different from management, whose focus is on reducing chaos in organisations in order that they may function more efficiently and effectively. As identified early on by Fayol, the key functions of management involve planning,

organising, staffing, coordinating and controlling. Kotter (1990) argues that the functions of leadership and management vary (Table 2-1). While the primary purpose of management involves ensuring organisational stability and efficiency, the main leadership role concerns the need to create innovation and development. Therefore, a manager's job involves looking for efficiency and consistency, unlike leadership that seeks flexible, innovative as well as productive development. Yet, both are important for organisational success (Kotter 1990).

Table 2-1 Comparision between Management and Leadership processes

Process	Management	Leadership
Creating an agenda	Planning and Budgeting • Establish a plan • Set a timetable • Allocate resources	Establishing Direction • Develop a vision of a distant future • Set strategies
Developing human networks to achieve an agenda	Organising and Staffing • Establish structures • Make job placements • Delegate responsibility and authority • Provide rules and procedures • Monitor implementation	Aligning People • Communicate goals • Seek commitment • Build teams and alliances
Execution	Controlling and problem-solving • Develop incentives • Generate creative solutions • Take corrective action	Motivating and Inspiring • Inspire and energise • Empower subordinates • Satisfy unfulfilled needs
Outcomes	A degree of predictability, order and consistency	Useful change and movement

Source: Kotter JP (1990) *Force for Change: How Leadership Differs From Management*. New York: Free Press

There are many scholars who agree with Kotter (1990) when he suggests that leadership as well as management are distinguished concepts, without assuming that leaders and managers are different types of people. Bennis and Nanus (1985) argue that management refers to the accomplishment of activities and mastering daily work routines, while leadership refers to influencing others and developing a vision for change.

In a similar vein, Rost (1993) made a significant distinction when comparing leadership as well as management. Rost (1993) argues that leadership relies on multiple forms of influence to create connections between leaders and followers, whereas management relies on power as a single form of influence. Leadership incorporates methods for creating joint goals and objectives, unlike management, which is concerned with organising tasks to ensure that a job is fulfilled. Together, leaders work with people to generate and foster tangible development, while managers work with people to make and offer products. Managers may be leaders only when they have this type of influence relationship with their followers, based on non-coercive ways of interaction.

Zaleznik (1981) provides a different perspective, arguing that leaders and managers represent different identities. That is, leaders and managers are essentially contrasting groups of individuals. With low emotional involvement, managers act in response to situations as well as favour working with individuals to resolve issues, providing limited options. Leaders, however, have high emotional involvement, seeking to shape ideas as an alternative to being responsive to them. Leaders act to extend choices to problems-solving and to stimulate followers' thinking processes to generate innovative ideas.

Leadership and management concepts still overlap, in spite of the clear differences between them (Northouse 2013). This is because both processes of leadership and management involve influencing a group of people to work towards goal achievements. For example, managers may find themselves involved in a leadership process when they attempt to exercise their influence on a group to achieve a particular goal. In the same way, leaders may be involved in the managerial activities identified earlier to influence a group of people to achieve an organisational objective. Moreover, Yukl (2013) contends that most leadership scholars seem to agree that managers need to lead so that they can achieve success in modern organisations. Leadership is conceptually distinct, but, a complementary construct to management that can be exercised by managers (formal leaders) or followers (non-formal leaders), with the main emphasis being on leadership as a concept that involves influencing people to reach shared objectives.

2.3 Constructions of leadership

The literature on leadership theories presents several approaches that have contributed to a general awareness of this phenomenon. Concepts of leadership have progressed in complex ways over time. At present, the leadership domain does not just consider a leader's traits or styles of behaviour, but also additional further aspects that influence leadership behaviour, including subordinates and the work environment, as well as the national culture, which have been explored in a range of settings, such as public and private contexts (Avolio et al. 2009). The current section presents chronological insights into the predominant approaches in leadership (see Table 2-2 for a summary of the main constructions of leadership).

2.3.1 Trait theory

The Great Man theory was the earliest attempt to study leadership scientifically and was developed early in the 20th century. This theory proposes that some individuals have inborn traits and personality aspects so that they become superiors and therefore natural leaders (Jago 1982; Bass 1990). It assumes that, historically, there have been heroes with personality traits, features and superior qualities that let them have influence over others. The theory also argues that leaders are born with certain leadership traits. For instance, Stogdill (1948) identified a set of traits which are thought to be characteristic of leaders, including "intelligence, alertness, insight, responsibility, initiative, persistence, self-confidence and sociability" (Northouse 2013 p23). However, the list of traits that has emerged from research on trait leadership is extensive, because each study suggests various qualities. The trait concept of leadership has also received considerable criticism due to the limited evidence-based research to support its conclusions (Northouse 2013). Moreover, Organ (1996) suggests that society and circumstances are more important in forming a leader and hence no individual is destined to become a leader from birth.

2.3.2 Models of leadership styles and effectiveness

Due to the criticisms of the trait approach of leadership which holds that leaders have leadership qualities from birth, research on leadership behaviour emerged to suggest that effective leadership depends on behaviours that can be learnt, focusing on what leaders actually do and how they behave (Derue et al. 2011). Stogdill (1948) found that it is imperative for leadership research to study more than leaders' traits. Consequently, several studies have been undertaken to examine leadership behaviours. Some of the earliest work was undertaken by the Ohio State University during the final years of the 1940s (Stogdill and Coons 1957; Stogdill 1963; Stogdill

1974). A few years later, a series of studies was conducted by the University of Michigan to explore how leadership functions (Katz and Kahn 1951; Cartwright and Zander 1960; Likert 1961, 1967). In the early 1960s, Blake and Mouton (1964) conducted a further study to discover the way in which managers engaged in task as well as relationship orientations in workplace settings (Blake and Mouton 1985; Blake and McCanse 1991). Research investigating leadership behaviours concluded that leadership involves two wide-ranging types of practices: task-oriented and relationship-oriented (Northouse 2013). Task-oriented leadership enables the achievement of objectives and provides assistance to group members to accomplish their objectives. Relationship-oriented leadership supports followers and allows them to have self-comfort, as well as being comfortable with the group and the overall working environment. Explaining the way in which leaders integrate both types of behaviours to affect group members' performance and achieve objectives is a fundamental aim of leadership researchers.

Bryman (1992) and Yukl (1994) argue that the association between leadership behaviours as well as work outcomes has not been sufficiently explained in leadership style research. Moreover, studies on leadership style have also not been able to achieve their aim of identifying an effective form of leadership that is valid in almost every situation due to contradictory research findings. Further, this approach suggests that a high task and high relationship style is the most influential leadership practice, but this may not be valid in every situation and is supported by little research (Yukl 1994, 2013). Yukl (2013) states that most of the research findings on leadership behaviours have been inconsistent and inconclusive since research has failed to identify a stable association between leadership behaviours and results. Moreover, this inconsistency in research findings can be attributed to different situations that require different types of leadership behaviours.

2.3.3 Situational and contingency approaches

The situational or contingent method of leadership has been emphasised due to the concerns expressed regarding the style approach, which has failed to identify a consistent range of leadership behaviours that are effective to all contexts. Situational leadership suggests that varying circumstances necessitate varying forms of leadership behaviours. Explaining the process by which situational leadership occurs was the aim of situational models. Several theories were proposed in the 1970s and 1980s, including situational leadership theory and contingency theory.

Table 2-2 Summary of the main constructions of leadership

Leadership approach	Main research and Time	Aim	Major findings / propositions
Trait theories	(Stogdill 1948)	To find a list of innate traits that determine leaders	A set of leadership traits including: intelligence, alertness, insight, responsibility, initiative, persistence, self-confidence and sociability.
Behaviour theories	1. Ohio State Studies (Stogdill and Coons 1957; Stogdill 1963; Stogdill 1974)	To examine how leaders act in a group or organisation	1. Initiating structure (organising work, giving structure to the work environment, defining role responsibilities and scheduling work activities. 2. Consideration (building friendships, trust and respect) 3. These behaviours were seen as distinct and independent, representing two different continua. 4. Effectiveness varies according to the context.
	2. University of Michigan Studies (Katz and Kahn 1951; Cartwright and Zander 1960; Likert 1961, 1967)	To examine the effects of leadership behaviours on the performance of small groups	1. Employee orientation. 2. Production orientation. 3. These behaviours were seen as distinct and independent, representing two different continua.
	3. Blake and Mouton's Managerial (Leadership) Grid (Blake and Mouton 1964; Blake and Mouton 1985; Blake and McCanse 1991)	To explain the ways in which leaders can use leadership behaviours in order to help them reach organisational goals	1. Concern for production. 2. Concern for people. 3. The Grid Model predicts seven main leadership styles when leaders operate with different combinations of the two leadership behaviours.

Leadership approach	Main research and Time	Aim	Major findings / propositions
Situational and contingency theories	1. Situational leadership model (Hersey and Blanchard 1969; Blanchard et al. 1985; Hersey and Blanchard 1988; Hersey and Blanchard 1993)	To explain the process of situational leadership	1. Involves two leadership styles: directive and supportive, it suggests that each has to be employed in any given situation as appropriate. 2. Leaders are required to assess the competence and commitment of their staff in order to determine the degree of their directive and supportive behaviours needed for a specific situation. 3. Leaders should vary the amount of leadership behaviours to meet the changing demands of followers whose skills and motivation differ over time. 4. Effective leadership behaviour depends on development levels, which are concerned with followers' competency and the commitment required for achieving a particular activity at any given time.
	2. Contingency theory (Fiedler 1964; Fiedler and Chemers 1974)	To provide a framework for effectively matching leaders and situations	1. Different contexts call for different forms of leadership behaviours. 2. Leaders are not able to lead in all situations. 3. Leaders should be appointed in contexts that suit their leadership behaviours; otherwise, they will not be effective when the context changes. 4. Involves two leadership styles: task motivated and relationship motivated. 5. Includes three situational elements: leader-member relationships, task structure and position power. 6. Situational elements, together, define the best leadership behaviour for a given situation in an organisational setting. 7. Task-motivated leaders will be effective, regardless of whether the situation is convenient or not. 8. Relationship-motivated leaders will be effective when the situation is moderately favourable.
Relational theory	Leader-Member Exchange theory (Dansereau Jr et al. 1975)	To examine the relationship process between leaders and followers	1. Leadership effectiveness is achieved when the leader develops a separate dyadic relationship with each follower. 2. Fostering a constructive relationship between leader and subordinates will generate mutual and incremental influence.

Leadership approach	Main research and Time	Aim	Major findings / propositions
New-genre theories	1. Charismatic leadership (House, 1976)	To analyse the characteristics of historical leaders who were able to motivate followers to extraordinary levels of devotion and commitment	1. Personal characteristics: self-confidence and the need to have influence over others. 2. Behavioural characteristics: Role model, image-building and task articulation.
	2. Transformational leadership (Burns 1978; Bass 1985)	1. To examine the link between leadership and followership 2. To distinguish between transactional and transformational leadership 3. To extend traditional leadership models	1. The full-range of leadership model, including transformational, transactional and laissez-faire leadership styles. 2. These leadership styles represent a single continuum. 3. More attention is paid to followers' needs. 4. The model supports leadership effectiveness, influencing followers to make extra effort and show commitment, satisfaction and contribution. 5. Charisma is just one of the significant component of transformational leadership; it is not enough alone (Yammarino 1993).
	3. Servant leadership (Greenleaf and Spears 2002; Liden et al. 2008)	To examine the concept of servant leadership and build a framework to understand its complexities	1. Antecedent conditions (context and culture, leader attributes, follower receptivity). 2. Leader behaviours (conceptualising, emotional healing, putting followers first, helping followers to succeed, behaving ethically, empowering, creating value for the community). 3. Outcomes include a positive influence over follower performance and growth, organisational performance and societal impact.
	4. Authentic leadership (Walumbwa et al. 2008)	To articulate ethical dimensions of leadership	1. Four factors (self-awareness, internalised moral perspective, balanced processing and relational transparency). 2. Influential factors (positive psychological capacity, moral reasoning, and critical life events).

The situational model was established by Hersey and Blanchard (1969). It has subsequently undergone several revisions (Blanchard et al. 1985; Hersey and Blanchard 1988; Hersey and Blanchard 1993). It was inspired by the 3-D management style model set out by Reddin (1967), who argued that it is not realistic to posit a single leadership style as being effective in different situations. Rather, the effectiveness of wide range of leadership practices relies on the situational circumstances. Based on that assumption, Hersey and Blanchard (1969) developed their model in an attempt to explain situational leadership. However, the core assumptions described by situational approach have not been confirmed by substantial evidence to show how leaders match their behaviours to followers' development levels (Vecchio 1987; Fernandez and Vecchio 1997; Vecchio et al. 2006). Moreover, the model lacks clarity in its conceptualisation of development levels because the combination of commitment and competence to shape the four different levels is not clarified (Graeff 1997), though it has undergone several refinements. Further, the model fails to take into consideration the effect of demographic characteristics on the leader-follower instructions provided (Northouse 2013).

Similar to situational theory, contingency theory attempts to match leadership behaviours to particular situations for effective leadership (Fiedler and Chemers 1974). Expanding situational theory, this theory proposes that different contexts call for different forms of leadership behaviours. Additionally, it implies that leaders are not able to lead in all situations. Leaders should be positioned in a context that suit their leadership behaviours; otherwise, they will not be effective when the context changes. Contingency theory, developed by Fiedler (1964), hinges on analysing the leadership styles used by several leaders working in different settings. Leaders' behaviours were evaluated within the contexts in which leadership occurred. Contingency theory was grounded in empirical generalisations to identify the best and worst leadership styles for a particular organisational setting.

Despite the use of predictive methods to match different leaders to different contexts that are appropriate for their leadership behaviours, this theory lacks explanatory power. Contingency theory is not able to illuminate entirely the reasons why people who have specific leadership behaviours are highly influential in certain circumstances compared to others – "the black-box problem" as Fiedler (1993) calls it. The theory also fails to address how an organisation can deal with this issue if there is a bad fit between leader and situation in a given setting (Northouse 2013). The theory suggests that it is not necessary for leaders to modify leadership behaviours so that they can meet the requirements of a particular situation; rather, it requires changing the situation in order to fit a leader's behaviour, which is problematic.

2.3.4 Relational theory

While previous leadership theories emphasised leaders' traits and behaviours or situational leadership, Leader-Member Exchange theory offered different insights into leadership research with its primary focus being on the connection between leader and followers (Claudia and Chester 2000). The theory indicates that leadership is a process and emphasises the way in which leaders interact with their followers (Dansereau Jr et al. 1975; Gerstner and Day 1997). Leadership effectiveness is achieved when a leader establishes a separate dyadic connection with their followers (Graen and Schiemann 2013). It proposes that building constructive relationships between leaders and subordinates will generate mutual and incremental influence (Uhl-Bien 2006). Nevertheless, Leader-Member Exchange theory fails to consider how social as well as cultural contexts affect both leaders and followers (Avolio et al. 2009).

2.3.5 New-genre leadership

There was increasing disillusionment among leadership scholars concerning leadership theories and related research in the 1980s (Bryman 1992; Avolio et al. 2009). However, a major shift in leadership occurred in 1985 as a result of work initially done by Burns (1978). Burns developed the concept of transforming leadership, which takes a broader look at leadership and has expanded and revitalised leadership research. Burns tried to find a link between the role of leadership and followership. In addition, transformational leadership was differentiated from transactional leadership. Burns (1978 p19) states that transactional leadership "occurs when one person takes the initiative in making contact with others for the purpose of an exchange of valued things". Mutually beneficial transactions, as Burns argues, form the basis of leader-follower relationships in transactional leadership. On the other hand, transformational leadership "occurs when one or more persons engage with others in such a way that leaders and followers raise one another to higher levels of motivation and morality" (Burns 1978 p20). Burns (1978) suggests that followers are influenced and transformed by transformational leaders and motivated to transcend personal interests for collective interests.

While Burns' work was developing, House (1976) published work on charismatic leadership. House's work was based on analysing the characteristics of historical leaders who were able to motivate followers to extraordinary levels of devotion and commitment (House 1976). Three sets of characteristics that exemplify charismatic leaders were identified (Chemers 2000). These include personal characteristics similar to high levels of self-confidence and the need to have influence over others. Behavioural characteristics involve being a role model, image-building and task articulation. Situational influences include managing high levels of environmental stress.

In the mid-1980s, the transformational leadership paradigm developed by Bass (1985) emerged in order to satisfy the need to extend traditional models (Avolio et al. 2009). It is a model that supports leadership effectiveness and can have a great effect on followers, making them willing to make extra effort and show commitment, satisfaction and contribution (Bass 1985). Bass's new model of leadership was expanded to comprise the full range of leadership, incorporating transformational, transactional and laissez-faire leadership. The notion of transformational leadership adds two key dimensions to the early research on leadership behaviours in organisations including vision and emotion (Koene et al. 2002).

There are four intrinsic behaviours of transformational leadership, called the 4 I's: i) idealized influence, ii) inspirational motivation, iii) intellectual stimulation and iv) individualised consideration (Bass 1985). Firstly, there is charisma or idealized influence, whereby the emotional elements of leadership are presented. According to this behaviour, leaders act as great role models and demonstrate high principles of both moral and ethical conduct that attract the attention of their followers who try to emulate them. In addition, such leaders have a clear sense of vision and mission, in that followers have a strong belief in them and hence they profoundly respect, admire and trust their leaders. Therefore, transformational leaders put the needs of their follower's front-of-stage and let them take precedence over their personal needs. They consistently share risks with their subordinates and are held to account if they do not do the right things. Their expectations are clearly communicated to their subordinates, so that they too have the desire to meet those expectations as well as to demonstrate a strong commitment towards the accomplishment of collective goals and a shared vision (Bass and Avolio 1994).

Secondly, with regard to inspirational motivation, leaders should promote high standards for expectations and demanding challenges to their subordinates via clear and positive communication and motivation. Such leadership characteristics is designed to inspire subordinates in order that they will show their commitment and become a part of the collective vision of the organisation (Bass 1985). Effective leaders need to demonstrate enthusiasm and optimism, as well as to stimulate a team spirit. Meanwhile their followers should be engaged in pursuing a bright future for the organisation by envisioning making their own positive contributions to that organisation.

Thirdly, there is intellectual stimulation, meaning that transformational leaders encourage and motivate their followers' efforts to engage in problem solving and to develop their innovation and creativity through questioning assumptions and adopting new strategies when approaching long established situations (Bass 1985). Creativity is a significant part of this model and individual followers' mistakes are not to be publically criticised. Leaders need to involve their followers in

the process of manipulating difficulties and finding appropriate resolutions to situations in order to rouse their followers to produce new ideas and find creative ways to approach problem solving. In addition, leaders should encourage their followers to test out new methods, even if those methods and ideas are different from the ideas of their leaders (Bass 1985; Bass and Bass 2008).

Finally, there is individualised consideration, where leaders are aware and attentive to each individual's need for accomplishment and advancement (Bass 1985). Leaders perform as coaches or instructors who attempt to help develop their followers effectively until they reach their full potential. Leaders provide a supportive environment that offers continuing learning opportunities and they understand the different needs and wants of individuals while being accepting of their dissimilarities. Communication, in such case, is a genuine two-way exchange of knowledge and information. The relationship between leaders and followers is embodied such that followers are not seen just as employees and their leaders are conscious of each individual's concerns. Careful listening by leaders, to their followers' needs, is important. The delegation of certain tasks is a key tool for leaders in the process of their followers' development. Leaders have to supervise these delegated tasks in order to provide their followers with appropriate support and direction when needed as well as to evaluate their followers' development (Bass and Avolio 1994).

However, transformational leadership has been criticised for its lack of conceptual clarity (Tracey and Hinkin 1998) and "heroic leadership" bias (Yukl 1999; Alvesson and Spicer 2012; Tourish 2013). Moreover, it is argued that the Multifactor Leadership Questionnaire (MLQ) utilised for measuring leadership styles is not valid because of the high relationship among transformational factors, so they are not distinct factors (Tejeda et al. 2001; Van Knippenberg and Sitkin 2013). Furthermore, the model omits other forms of effective leadership behaviours. Very recently, four research studies undertaken by Antonakis and House (2014) to examine the construct validity of instrumental leadership show that the impact of transformational leadership is vastly overstated when instrumental leadership, which involves environmental monitoring, strategy formulation, path-goal facilitation, and outcome monitoring, is omitted from the model.

Over the last two decades, several contemporary leadership concepts have been presented. These include servant leadership (Greenleaf and Spears 2002; Liden et al. 2008) and authentic leadership (Walumbwa et al. 2008). Like previous theories focusing on leadership behaviours, servant leadership emphasises a leader's behaviours. A servant leader is attentive to followers' needs and puts them first. According to Liden et al. (2008) servant leadership involves nine components: i) emotional healing, ii) creating value for the community, iii) conceptualising, iv) empowering, v) helping subordinates grow and succeed, vi) putting subordinates first, vii)

behaving ethically, viii) relationships, and ix) servanthood. Emotional healing refers to a leader's sensitivity to, and understanding of, their follower's individual concerns. Creating value for the community denotes a leader's real awareness of the requirement for a leader to serve society. Conceptualising represents the leader's deep understanding of the organisation including everyday jobs in order to be able to provide needed support for followers. Empowering characterises leader's encouragement of their followers, in terms of detecting and resolving organisational problems, while giving those followers the autonomy to determine the way to undertake their assignments. Helping subordinates grow and succeed signifies leaders who show real interest in their followers' professional advancement through the supporting and monitoring of those followers. Putting subordinates first means that leaders clearly communicate to followers the message that meeting their organisational needs is their most important priority. Behaving ethically refers to and describes leaders who show openness, fairness and honesty when dealing with followers. Relationships are about knowing followers and authentically trying to build a strong relationships with those followers, as well as supporting them. Servanthood represents leaders who want followers to see them as a servant, whose priority is to help others, to the level that they will, if necessary, sacrifice their own interests for the sake of others (Liden et al. 2008).

Meanwhile, the most recent leadership theory, authentic leadership, is concerned with the concept of leadership authenticity encompassing being genuine and having a real leader, as the name of the theory implies. It was first recognised during research on transformational leadership theory, but given little articulation (Burns 1978; Bass 1990; Howell and Avolio 1992; Bass and Steidlmeier 1999). Authentic leadership was conceived from within the domain of positive psychology (Seligman 2002; Walumbwa et al. 2008). Therefore, authentic leadership has been defined as "a pattern of leader behaviour that draws upon and promotes both positive psychological capacities and a positive ethical climate, to foster greater self-awareness, an internalized moral perspective, balanced processing of information, and relational transparency on the part of leaders working with followers, fostering positive self-development" (Walumbwa et al. 2008 p94). This definition shows four key components of authentic leadership: i) self-awareness, ii) relational transparency, iii) balanced processing, and iv) an internalised moral perspective. Self-awareness represents leaders' understanding of themselves, including their own values, motives, the complex nature of personality, strengths and weaknesses, as well as the way in which they influence others. Relational transparency denotes leaders who display themselves in a genuine manner when interacting with others. Kernis (2003) notes that this behaviour is expected to enhance trust between leaders and followers since leaders embrace open communication style to share information with them and display true views and emotion. Balanced processing characterises leaders who promote objective analysis by considering and

collecting every relevant piece of information, as well as carefully listening to any opposing views prior to any decision making. An internalised moral perspective is about self-regulation, through which leaders use their own internalised values to guide them when facing community and organisational pressures, a perspective which consequently makes leaders take decisions that are consistent with their internalised values (Walumbwa et al. 2008).

Like servant leadership, authentic leadership emphasises the ethical perspective of leadership. In contrast, authentic leadership is leader-focused, whereas servant leadership is follower-focused. Nevertheless, both theories have their shortcomings in terms of lacking conceptual clarity concerning a common definition to determine the core dimensions of the process for servant leadership (van Dierendonck 2011) and moral components of authentic leadership (Northouse 2013).

In summary, leadership research, historically, has tended to be leader-centric and to treat followers in such a way that they have an inactive role in the leadership process and results such as trait, behavioural and situational approaches (Shamir 2007). These different approaches characterise followers as passive players, who neither behave nor effectively respond to the different behaviours exercised by leaders (Burak and Bashshur 2013). According to Uhl-Bien et al. (2014), this is because leadership was not understood as a process socially and relationally co-constructed by both leaders and followers when they interact with each other. However, the contemporary leadership models including transformational and servant leadership, emphasise followers' needs as well as their active role in leadership processes. Transformational leadership considers the role of followers in the leadership process since they can influence a leader's behaviour through their participation in vision- and goal-setting (Bass 1985). Transformational leaders are concerned with mutual goals, and to this end they drive themselves and their followers to go beyond self-interest for the greater good (Kuhnert 1994). Likewise, servant leadership gives special consideration to followers' needs. Servant leaders empathise with their followers. They provide support and empowerment to followers. They emphasise followers' advancement and encourage them to reach their maximum potential (Greenleaf 1991). Liden et al. (2008) argue that servant leaders not only increase the level of followers' self-esteem but also build their leadership abilities.

2.4 National culture and leadership behaviour

Currently, the leadership literature indicates a dynamic connection between a country's culture, an organisation's culture and the way in which leadership acts. Various definitions of culture have been offered over the decades. In the mid-1950s, Herskovits (1955) recognised culture as an

understanding which individuals within a particular society arrive at and as a learnable element for new people. In addition, Herskovits asserts that peoples' regular as well as environmental contexts, including processes of thinking, the political system and the worth of belongings, can be influenced by the culture. Hofstede (1980 p260) defined culture as ''the collective programming of the human mind that distinguishes the members of one human group from those of another''. Highlighting the role of history, Hampden-Turner and Trompenaars (1993) assert that the mutual history shared by a particular community can shape a collective stance and perspective.

Recently, culture has often been depicted from shared-value perspectives. Culture incorporates a range of common values accepted by specific members of a community and these values influence their life patterns (Adler 2002). Moreover, Adler (2002) indicates that, over time, these shared values impact on social expectations, assumptions and ethical principles mirrored by specific societal rules and traditions. In similar vein, but focusing more on the organisational level, Schein (2010 p18) defines culture as ''A pattern of shared basic assumptions learned by a group as it solved its problems of external adaptation and internal integration, which has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems". House et al. (1999 p13) in their study about the influence of national culture on leadership behaviours, known as the GLOBE study, suggest that culture is the ''shared motives, values, beliefs, identities, and interpretations or meanings of significant events that result from common experiences of members of collectivities and are transmitted across age generations''.

Although various aspects of culture have been emphasised, common features can be found. These involve an emphasis on shared understandings between individuals of a particular society, thoughts diffused from one generation to another including words and metaphors, within institutional contexts, as well as the fundamental cognitive aspects preserved by a given society (Dickson et al. 2012).

As can be seen, values play a significant role in shaping both organisational and national cultures. Values and traditions pertinent to a particular culture can affect leaders' attitudes and behaviours in several diverse methods (Lord and Maher 1991; Adler 1997; House et al. 1997; Fu and Yukl 2000). This is because leaders maturing in a specific society will be expected to internalise the social values of that society. Consequently, social values can affect leaders' dispositions as well as behaviours in unconscious methods (Yukl 2013). Moreover, social values can be mirrored in manifest social norms and in the methods via which individuals develop their relationships with others. Social norms influence appropriate practices of leadership. They may also be formalised as social laws and rules that influence the use of power (Yukl 2013). While some leaders may not

internalise certain cultural norms because they grow up in different cultures, most leaders will adapt to social norms about acceptable behaviour because deviation from social norms can lead to decreased respect as well as increased social pressure from different people in an organisational context. Furthermore, the exercising of socially unacceptable behaviour is expected to weaken a leader's effectiveness (Yukl 2013).

Along with the national culture, leadership behaviours are influenced by other situational factors. These include the type of organisation (public or private), the type of industry (education or health service) and the characteristics of managerial positions (level of manager and authority). While some situational factors may have comparable influence across national cultures, other situational factors can interact with national culture in complex ways (Yukl 2013).

While some leadership behaviours are not clearly reinforced by dominant cultural values and traditions, it does not necessarily mean they are fruitless. House et al. (1997) argue that leaders who have little experience with a specific kind of leadership behaviour may not understand how effective it can be. Yukl (2013) contends that people are more likely to follow new practices of leadership when they learn that those practices are highly effective.

It is important to note that cultural values and traditions may change over time, and this is similar to organisational culture. This is because several types of change, including economic, political, social, and technological forces, can influence values relevant to a particular culture. For example, nations where socialism is being replaced by capitalism are likely to witness a move towards stronger individualism and performance-orientation values because of the influence of economic, political and social changes (Yukl 2013).

2.4.1 Dimensions of cultural values

Several studies have been undertaken to characterise culture (Hofstede 2001; House et al. 2004). One of the most popular in this area is the research by Hofstede (1980; 2001), who made important progress regarding the use of this concept of culture in organisations. He analysed more than 100,000 questionnaires from respondents from more than 50 countries. It was found that culture differs in relation to five key factors: power distance, uncertainty avoidance, individualism and collectivism, masculinity and femininity, and long-term-short-term orientation. Power distance refers to the degree that people in a society with greater restricted power assume and accept regarding the unequal allocation of authority. Uncertainty avoidance indicates the level at which people within a particular culture are anxious when there is a lack of clarity. Individualism means a tendency for a weakly-built community structure that people are anticipated to be concerned about themselves and the people who are close to them.

Collectivism indicates a tendency to possess a strong social structure in which people consider more their families or others with whom they are closely linked, who will give them support in order to receive total loyalty from them. Masculinity denotes an aspiration for individuals within a community to be courageous, successful, self-confident and decisive, while simultaneously stressing tangible motivations for achievement. Femininity indicates a tendency to be self-effacing and responsive, showing consideration to vulnerable people, and defending one's own living standard. Hofstede (2001) suggests that, in organisational contexts, masculinity is related to tough cultures while femininity is related to tender ones. Long-term orientation refers to a society which supports austerity as well as determination in contemporary education to make people ready for the future. Short-term orientation represents a tendency to preserve glorious traditions and norms, whereas social transformation is seen as doubtful.

In a similar vein, the GLOBE research undertaken by House et al. (2004) represents another key effort to examine the influence of culture on organisational leadership (Northouse 2013). The project was in essence intended to increase the understanding of cross-culture leadership, as well as social effects on leadership effectiveness. The GLOBE study included 62 societies and more than 160 researchers participated. The project applied qualitative and qualitative methods together to achieve the study's aim. Quantitative data were collected through questionnaires from more than 17,000 managers, representing more than 950 organisations. Qualitative data were collected through interviews and focus groups, as well as document analysis. Several results have been generated concerning the factors of cultural values and desired leadership behaviours.

The GLOBE research identified nine cultural factors. These factors incorporate: uncertainty avoidance, power distance, institutional collectivism, in-group collectivism, gender egalitarianism, assertiveness, future orientation, performance orientation and human orientation (House et al. 2004). Uncertainty avoidance signifies the degree to which a community is dependent upon conventional social standards and rituals, as well as techniques for avoiding uncertainty. Power distance indicates the level that people anticipate and accept regarding inequality in authority. Institutional collectivism refers to the degree that a society or an organisation encourages societal or institutional collective action because they perceive that it is associated with common advantages to society instead of one's own self- interest. In-group collectivism measures the tendency of people to stress superior, dedicated, contented and cohesive relationships with their families and organisations. Gender egalitarianism indicates a social tendency to support sex similarities and reduce function variations between the genders. Assertiveness is associated with the level at which people within a particular culture are self-assured, determined, forceful, or contentious in their relationships with others. Future-orientated leadership describes the extent that people engage in long-term activities, including planning as well as investment. Performance-

orientated leadership indicates the level at which societies or organisations support and help individuals to excel and achieve more. Human-orientated leadership is associated with the level at which a society supports individuals who are sympathetic, obliging and equitable regarding others, and employ a friendly approach such as self-sacrifice, consideration and kind-heartedness (House et al. 2004).

For leadership behaviours, six global leadership behaviours were identified by the GLOBE research: charismatic and value-based, team-oriented, participative, human-oriented, autonomous and self-protective (House et al. 2004). Charismatic leadership indicates the level of providing encouragement and stimulation to people who are anticipated to show great work performance as determined by the basic values they possess. Team-oriented leadership means the construction of a cohesive group, as well as focusing on mutual goals between individuals within a group. Participative leadership indicates leaders who make people participate in decision-making processes. Human-oriented leadership refers to leaders who are supportive, considerate, compassionate and generous; it includes showing self-effacement as well as empathy. Autonomous leadership emphasises self-governance, independence, as well as distinctiveness. Self-protective leadership refers to leadership behaviours which maintain peoples' well-being and security. Self-protective leadership includes displaying self-interest, self-protection, face-saving and procedure-oriented traits. The findings reveal that effective leadership prototypes and behaviours are perceived differently across cultures (House et al. 2004).

2.4.2 Leadership behaviours across cultures

To date, the GLOBE project is considered to be one of the most influential studies that investigate how culture affects the perceptions of effective leadership behaviours (Northouse 2013). The findings reveal that effective leadership prototypes and behaviours are perceived differently across cultures, while there are certain attributes that can be universally endorsed as desirable and undesirable. In the Middle East, for example, the important characteristics of effective leadership were found to be personal features, including preserving one's reputation as well as position. Independence and family were valued. It was also found that charismatic, team-oriented and participative leadership were not seen as very important characteristics of leadership. Countries within the Middle East scored high on in-group collectivism and power distance, higher than average on human orientation and lower than average on uncertainty avoidance, but low on future orientation and gender egalitarianism.

In terms of globally desired and undesired attributes of leadership, the GLOBE project has revealed interesting findings. Worldwide, several desired characteristics of leadership are

described in a format whereby ideal and exceptional leaders are those who are high in integrity, are charismatic/transformational and have relational skills. In contrast, globally endorsed undesired features or barriers to effective leadership include attributes such as antisocial, malevolent and self-focused.

2.5 Leadership and context

The context in which leadership is enacted has been paid little attention in leadership research (Denise and Yitzhak 2001; Osborn et al. 2002). Context is defined as "the interrelated conditions in which something exists or occurs".[1] Several contextual factors have been documented in the literature that affect leadership behaviours, including environmental factors, organisation characteristics, technology and hierarchical leader level, to name a few. All these contextual factors vary from one setting to another and are perceived as vital elements to understand leadership (Osborn et al. 2002). Lord et al. (2001) argue that, when examining leadership, a given environment may restrain the kinds of behaviours which can be commonly attributed as effective. Both Denise and Yitzhak (2001) and Osborn et al. (2002) argue that leadership is embedded in the context in which it operates; leadership effectiveness relies on the contextual circumstances. Thus, they encourage more contextualisation of organisational research by incorporating context into research methods and reporting.

2.5.1 The physician-nurse relationship and leadership

Central to the context of the present research is the emergency department setting characterised in chapter 1. An area of the literature that has considered culture in relationship to leadership is the physician-nurse relationship. In a health care context, such care is usually provided by the interaction of medical physicians and nursing staff, who function interdependently as a team. However, this interaction has been traditionally characterised in terms of authority and power dispensed through structural and hierarchical relationships (Tellis-Nayak and Tellis-Nayak 1984; Campbell-Heider and Pollock 1987; Gjerberg and Kjølsrød 2001; Mackintosh and Sandall 2010; Liberati 2017). Physicians are commonly perceived as leaders, with nurses as subordinates (Hughes 1988). In other words, leadership is dominated by medical practitioners whereas nurses take followers' roles and are seen as dependent and passive actors, a situation defined as a 'dominant-subservient relationship' (Gjerberg and Kjølsrød 2001). This kind of relationship limits nurses' autonomy and involvement in leadership and increases the traditional dominance of

[1] Merriam-Webster (2017) *Meriam-Webster English Dictionary*. Available from: https://www.merriam-webster.com/dictionary/context [Accessed 23 Oct 2017]

physicians in taking leadership roles. Thus, this process of domination may diminish the benefit of collegiality and a team approach. Issues affected include consultation, referral, better-quality and safety of patient care and reduced health care expenditures, in a given health care context (Feiger and Schmitt 1979; Watkins and Wagner 1982; Verschuren and Masselink 1997; Mackintosh and Sandall 2010). Campbell-Heider and Pollock (1987) argue that shifting this style of relationship by increasing nurses' roles and autonomy, has been resisted by the members of medical profession.

There are various influences that shape the nature of this physician-nurse relationships, based on authority and hierarchy, between physicians and nurses. Campbell-Heider and Pollock (1987) maintain that the physician-nurse relationship is influenced by organisational obstructions formed by social presumptions. For example, while the team style of patient care delivery is promoted by the professions of medicine and nursing, these professions do so for different reasons (Helena 1983). In medicine, the extended function of nursing is still viewed from a hierarchical perspective; nurses are seen as servant and assistants working under the power and influence of a medical practitioner, who is considered as the team leader. In contrast, nursing profoundly differentiates between medical and nursing care; therefore, nursing staff support the decentralisation of power and flexibility in leadership for health care teams. However, physicians view that power must be given to a single person within a health care team, in order to ensure effective provision of health care and ultimate responsibility, both clinically and legally, for patient care (Campbell-Heider and Pollock 1987). In essence, the socialisation process of medical practitioners, as argued by Campbell-Heider and Pollock (1987), reinforces the concept of physicians being the 'captain of the ship'. In the same context, nurses are encouraged to inform physicians of their notes of patients so that physicians could be recognised during the subsequent examinations. Moreover, physicians' medical knowledge and expertise provide additional higher status over nurses since special knowledge, or the so-called 'secret knowledge', can generate value, advantages and justified rights (Murphy 1980).

Tellis-Nayak and Tellis-Nayak (1984) note that nurses are aware of the influence of cultural stereotypes in preserving their nursing role as subordinate within the health care contexts. According to Campbell-Heider and Pollock (1987), nurses consider that the physicians' arguments for resisting decentralisation of authority are inappropriate. This is because nurses do not suggest they should shoulder authority for the medical care of patients; nurses undertake authority when it comes to the nursing care of patients (Baker 1983). To illustrate, medicine traditionally emphasises diagnosing and treating disease, whereas nursing emphasises responses to illness when they handle the personal experiences and everyday problems encountered by patients (Campbell-Heider and Pollock 1987; Salhani and Coulter 2009). In addition, nurses spend much more time in direct and unstructured contact with hospitalised patients, when taking care of

them, than physicians do; a situation which renders physicians to be dependent on nurses for obtaining patient-related information. Thus, nurses' closeness to patients may relatively reinforce their position in relation to medical practitioners, who can lack awareness of the developments of a patient's situation (Svensson 1996). Therefore, social assumptions and stereotypes are key contextual forces that influence the nature of the typical relationships between physician and nurses relative to leadership enactment in health care settings. Since this study is undertaken in the context of Saudi Arabian hospitals' emergency departments, where health care is delivered by the interaction of physicians and nurses, it is important to understand the social culture of physician-nurse relationships and their impact on leadership.

2.6 Conclusion

The current chapter has conducted a critical evaluation in relation to the present knowledge in the leadership field. It has offered a discussion of leadership definitions and the differences between management and leadership. A discussion around the development of leadership models and constructions from a historical perspective has also been presented. The chapter has explored the influence of culture at the levels of national and organisational context on leadership behaviours, as well as effectiveness. An investigation into leadership concepts and practices is needed to explore and understand leadership behaviours within the context of emergency departments operating in the culture of Saudi Arabia.

Chapter 3 Context

This chapter presents the cultural background to the current research. It begins with a brief outline of the country of Saudi Arabia and then moves on to introduce the history and culture, political context, economy and development plans, Saudisation policy, Saudi healthcare system and its challenges, and social norms. The chapter then provides an overview of the Islamic perspective of leadership from the Quran and prophetic traditions to identify the influence of Islam on leadership behaviours in Saudi Arabia.

As noted in the previous chapter, culture has a profound influence on leadership. Hofstede (2001) and House et al. (2001) argue that institutions operate within social and cultural contexts, and these have a considerable impact on workforce attitudes since they shape their values as well as the way in which they socially connect with others in workplace settings. Therefore, taking into consideration the socio-cultural context in which the present research is embedded is essential. Saudi Arabia is an Islamic country whose population mainly comprises Muslims. To understand the Saudi Arabian historical background as well as its political, economic and social development, it is necessary to appreciate that Islam represents a comprehensive approach to life (Haddara and Enanny 2009). Thus, Islam influences many values and behaviours. In general, Islam penetrates every aspect of the Kingdom of Saudi Arabia (Mellahi et al. 2001; Metcalfe and Mimouni 2011). Understanding leadership from an Islamic perspective will help in understanding leadership processes and dynamics in this society.

3.1 History and culture

The culture of Saudi Arabia is an expansion of Arab culture, including accommodating the holy mosques in Makkah and Madinah, whereby the country occupies an exceptional position as a spiritual place for Muslims (Metcalfe and Mimouni 2011). For this reason, it receives millions of pilgrims every year from all around the world. On the Arabian peninsula, early civilisation was grounded on economic exchange and cultural interaction with different societies in the Fertile Crescent, stretching from Iraq to Turkey, Egypt and, later, the Roman Empire (Metcalfe and Mimouni 2011). The desert had a profound influence on the early lifestyle of Saudi Arabian people. This harsh setting demands a high degree of independence and adaptability. While some Saudis moved into farming and stayed near water sources, other Saudis developed a nomadic lifestyle, continually moving from one place to another, looking for water as well as pasturage. This duality of lifestyle led to a unique culture combining Bedouin tribes and dispersed oasis settlements (Metcalfe and Mimouni 2011).

Over the period of 610 CE, the prophetic message of the oneness of Allah (the God) was announced by the Prophet Muhammad (Peace be upon Him) (Armstrong 2002). This led to the establishment of the first Islamic government in Madinah, as the capital city and to the unity of the Middle East countries. However, in the middle of 600 CE, the Arabian Peninsula lost part of its status when Ali, the fourth Caliph, transferred the headquarters of his government from Madinah to Kufa in Iraq. Yet, Makkah and Madinah retained their significance as the centre of spiritual life in the region. Later, subsequent heads of the Islamic state in Iraq and Damascus lost control of the united Muslim world. Consequently, most of Arabia returned to tribal law (Metcalfe and Mimouni 2011).

In the middle of the fifteenth century, the Saud dynasty controlled Aldiriyah, a small city near the capital city of Riyadh. In the eighteenth century, the Saudi rulers made an alliance with Muhammad bin Abdulwahab, a reformist religious man who sought the re-emergence of clear monotheism, to reinforce their political authority (Metcalfe and Mimouni 2011). This led to the spread of monotheism throughout most of the Arabian Peninsula. In the nineteenth century, the Saud dynasty controlled great parts of the peninsula. In 1927, King Abdul-Aziz was declared king of the Najd and Hijaz regions. A few years later, the country declared itself an independent Islamic country.

3.2 The Kingdom of Saudi Arabia

Saudi Arabia is an Islamic country that occupies most of the Arabian Peninsula of Western Asia. Having been unified in the early 1930s, Saudi Arabia was formed as an independent country. The country accommodates the two holy mosques of the Muslim faith, at Makkah and Madinah, while greatly influencing politics in the Middle East, especially due to its oil wealth (Walston et al. 2008). The country borders Kuwait, Jordan and Iraq to the north, while the Gulf, the United Arab Emirates (UAE), Qatar and Bahrain are adjacent to its eastern frontiers (Mufti 2000). Additionally, Saudi Arabia borders Oman to the southeast, the Red Sea to the west and Yemen to the south (Albejaidi 2010). Riyadh is the capital city, Jeddah is the principal port and the Eastern Province contains the country's rich oil resources. Saudi Arabia is divided into thirteen central regions: Riyadh, Qassim, Tabuk, Madinah, Makkah, Northern Borders, Jawf, Hail, Baha, Jizan, Asir, Najran, and Eastern Province. Saudi Arabia is currently experiencing exponential population growth rate of up to 2.7% per annum (Ministry of Health 2014). The Ministry of Health (2014) indicated that the country had a population of 29,994,272 people, of whom 30.8% were under the age of 15 years, 66.2% between 15 and 64 years, and 3% of the population 65 years and over. The majority of the population of Saudi Arabia is of Arab origin, while the country also has an Afro-Asian minority (Gazzaz 2009).

Saudi Arabia has strong cultural ties with the Arab Gulf States, including the United Arab Emirates, the Sultanate of Oman, Kuwait, Bahrain, and Qatar. These countries are members of the Cooperation Council for the Arab States of the Gulf, known as the Gulf Cooperation Council (GCC), which was established in 1981 and is located in Riyadh. These countries share a regional culture called “Khaleeji”, denoting Gulf culture. Partrick (2013) argues that Khaleeji culture has formed an identity whereby its adherents define themselves quite differently from other Middle East Countries.

3.2.1 Political context

The political system of Saudi Arabia operates under Islamic and monarchical control (Mellahi et al. 2001). The royal family and the king dominate political power. The king has the highest authority in the country. The kingdom has a national constitution that is largely drawn from the Holy Quran, which conveys God’s words as revealed by the Prophet Mohammed, as well as Sharia, Islamic law. Further, the Prophet Mohammed provided the Sunnah, which acts as a life symbol reflecting his public activities and his behaviours, as well as what he allowed, advocated or tolerated. Therefore, the Sunnah and the Holy Quran established the foundations for Sharia law in the country. Within this context, leaders are expected to find solutions to conflicts using discussion and conciliation (Mellahi et al. 2001). Atiyyah (1999) observed that preserving peaceful contexts in organisations and workplaces, as well as reducing conflicts as much as possible, is a key task of leaders in Saudi Arabia. The kingdom maintains a high level of cultural homogeneity that is expressed through its shared Arabic language, including strong adherence to the Sunni school of Islam (Al-Farsy 1990).

3.2.2 Economy

The discovery of large oil reserves was a major element of change for the Saudi economy in the 1930s (Saudi Aramco 2018). Petroleum reserves are estimated to account for up to 80–90 per cent of financial revenues (WHO 2013a). The country has the second largest petroleum reserves globally estimated at 22.1% (Organisation of Petroleum Exporting Countries 2014). The country has, therefore, experienced rapid economic development due to exploration for and discovery of oil in commercial quantities that have a positive impact on every aspect of life (WHO 2006). Various development projects have depended on capital from the petroleum industry, while the country pursued economic growth by employing foreign employees.

Five-year strategic development plans were initiated in 1970 by a Saudi government aiming to improve the socioeconomic aspects of life, including infrastructure, agriculture, industrial and

commercial needs and future national priorities. These development plans have consequently led to substantial growth in education, training, health and the social services. In 2005, the country transformed the eighth plan from a five-year plan into a long-term strategy to 2024, with the aim of making full utilisation of the nation's workforce. Very recently, the country launched Vision 2030 (Saudi Vision 2030 2016), a national project, to support the economy through reducing the country's reliance on petroleum as well as increasing employment prospects to meet the demands of a growing population. This vision aims to transform the economy of Saudi Arabia by facilitating the growth of the private sector, long-term capital investment, openness to foreign investment and utilising the country's geographic position (Saudi Vision 2030 2016).

3.2.3 Saudisation Policy

The concept of Saudisation entails a national policy that was developed as the fourth development plan between 1985 and 1989. The aim of Saudisation is to reduce the dependence on foreign labour and create more work opportunities for Saudi people. Saudisation focuses on creating an environment that is conducive to the development and training of Saudi people, and the Saudis attaining their full potential while also securing job opportunities. It is worth noting that this policy has helped the Saudi government to increase the employment rate of Saudi nationals over the last two decades, despite the budget constraints experienced by government agencies leading to the unsustainability of job benefits. Consequently, the private sector and other governmental sectors, such as teaching hospitals, the Ministry of Defence and the National Guard, are geared up to being major sources of employment due to the decreasing demand from the government sector. In addition to the increase in Saudis nationals participation in the workforce generally, women have been motivated to seek opportunities in areas that had long been considered male preserves, including business and the law (WHO 2013a). It is anticipated that, by 2030, a significant contribution will have accrued from Vision 2030, especially the Saudisation policy expected to add more than six million Saudis to the workforce (Saudi Vision 2030 2016).

3.2.4 Saudi Arabian healthcare system

The Saudi Arabian healthcare system offers free-of-charge healthcare services to its citizens. As a national healthcare system, it started providing free services when the Ministry of Health was established in 1954. The healthcare system has received considerable attention from the Saudi government since the establishment of its first strategic plan to support growth in several governmental services, due to increasing revenues from oil sales. The system has undergone a comprehensive transformation, based on subsequent national development plans (Albejaidi

2010). The government managed to establish the infrastructure required for hospitals and primary healthcare facilities. Despite the country relying on expatriate medical personnel and services when working on developed health services, the government has made great investments in terms of workforce developments and providing scholarship opportunities to Saudis to help them follow their careers within the medical domain (Jannadi et al. 2008).

The Ministry of Health in Saudi Arabia has complete responsibility for supervising healthcare facilities offering services in the country. These include both public health facilities and private ones. In Saudi Arabia, healthcare services are offered based on three main sectors, involving the Ministry of Health, the private sector and other sectors within government, including teaching hospitals, the Ministry of Defence and the National Guard. The Ministry of Health accounts for 60.2% of health service delivery, 17.7% of health services are provided by other governmental sectors and the private sector provides 22.1% of health services in the kingdom (Ministry of Health 2014). The Ministry of Health operates approximately 270 hospitals across the country. The Saudi healthcare administration upholds national priorities based on eight important values. These values are justice, societal involvement, initiative, teamwork, productivity, putting the patient first, honesty/ transparency, equality and professionalism (Ministry of Health 2014).

Currently, chronic shortages in healthcare workforces are being experienced in many countries around the world, including Saudi Arabia. The kingdom is experiencing scarcities of medical staff, including nurses and physicians. The Ministry of Health (2014) has reported that Saudis account for 60.8% of the healthcare workforce, estimated at 174,881 employees. However, the greatest proportion of Saudi employees comprises allied health professionals (72.6 %), plus physicians (23.3%) and nurses (37.2%). Other healthcare employees are expatriates from various countries in the Middle East, Asia and the West (Ministry of Health 2014).

The Saudi healthcare workforce has various backgrounds, levels of education, nationalities and levels of experience in the medical field (Aldossary et al. 2008). It is worth noting that the diversity among healthcare staff presents a major challenge, especially to nursing or medical managers and organisation directors within the sphere of healthcare. Thus, they are forced to adopt strategies for coping with diversity in the rapidly changing and growing healthcare environment. Therefore, leaders within the medical field experience various issues with such a mixed workforce, including recruitment, selection, high turnover rates and retention challenges, as well as cultural differences (World Health Organisation 2017).

3.2.5 Social norms and leadership

As discussed in section 2.4, culture exerts a profound influence on the practice of leadership. It can be argued that Saudi cultural values and social attitudes to leadership vary significantly from those found in the rest of the world in terms of how leadership is understood and enacted (At-Twaijri 1989; Ugur and Mahmoud 1999). This variation can be attributed to the strong influence of both Islamic and tribal values, beliefs and characteristics, along with the high growth in petroleum revenues (Mellahi et al. 2001). Thus, two key interrelated factors influence the practice of leadership in Saudi Arabia: Islam and tribal and family traditions. However, most tribal and family values are shaped by Islamic traditions which, in reality, make it difficult to draw a clear distinction between the two.

The prescriptions given by Quranic principles and prophetic traditions offer guidance to leaders in how to conduct their work affairs. Islamic teaching and values emphasise compliance with leaders and encourage followers to challenge leaders who show a deviant behaviour (Beekun and Badawi 1999; Metcalfe and Mimouni 2011). Leaders, in authority, are acknowledged as doing the right things and showing socially appropriate behaviours, whereas followers display compliance and respect to leaders (Mellahi et al. 2001). Islamic values place strong concentration upon forgiveness, tolerance, kindness and mercy (Mellahi et al. 2001). It is argued that Arab and Islamic values stress brotherly and friendly relationships, cooperation and harmony (Atiyyah 1999). Thus, leaders should avoid or suppress conflicts (Atiyyah 1999; Mellahi et al. 2001). Overall, it is expected that leaders behave moderately, be forgiving and consultative, abide by promises they make, be honourable, humble, honest and patient, show appropriate appearance as well as possess a belief in asceticism (Khadra 1984; Abdalla and Al-Homoud 2001).

Arab culture has long been characterised as traditional, socially oriented and male-dominated (Badawy 1980; Abdalla 1997), with high power distance, high context that signifies strong dependence on personal relationships, and collectivistic (Nydell 2002; Al-Omari 2003). Likewise, House et al. (2004) describe Middle East culture in relation to leadership as reflecting a high level of in-group collectivism and power distance, a relatively high level of uncertainty avoidance, being higher than average in human orientation and low on future orientation and gender egalitarianism. Similarly, Hofstede (2001) characterises Saudi Culture as having a high power distance, high masculinity and uncertainty avoidance, and being just above average in indulgence, while low in individualism and long term orientation. Metcalfe and Mimouni (2011) suggest that a high power distance reflects bureaucratic organisations along with excessive managerial

structures, favouritism and special advantages. As for being high context and collectivistic, Arab culture involves high reliance on personal connections, resorting to direct and indirect communicative skills to deliver a particular message. They use their administrative and interpersonal skills to create cohesive working groups. The associations between managers and their staff can be seen in moral terms, e.g. family ties. Managers emphasise status as well as face-saving for others. Family and community are given more importance than the individual (Metcalfe and Mimouni 2011). House et al. (2004) contend that Arab culture maintains community and group interests more than an individual's personal interests.

Tribal traditions or community values are primary principles guiding people's stances and behaviours. For example, in decision-making, consultation with one's community as well as family members is encouraged, along with showing strong devotion to them, which may, in turn, encourage authoritarian behaviour with non-kin, be that other tribes or strangers (Abdalla and Al-Homoud 2001; Mellahi et al. 2001). Abdalla and Al-Homoud (2001) assert that tribal leaders, who are called Sheikhs, tend to centralise power and deal with all the responsibilities, considering themselves protectors, caregivers and fathers of their communities. Metcalfe and Mimouni (2011) suggest that collectivist behaviour is likely to result in decisions based on consensus rather than resorting to voting. Abdalla and Al-Homoud (2001 p512) argue that "the concept of consultation, a counterpoise of autocratic rule, has a special value in Islamic tribal societies as it is strongly recommended by the Koran and emphasised by Bedouin traditions", see Figure 3-1.

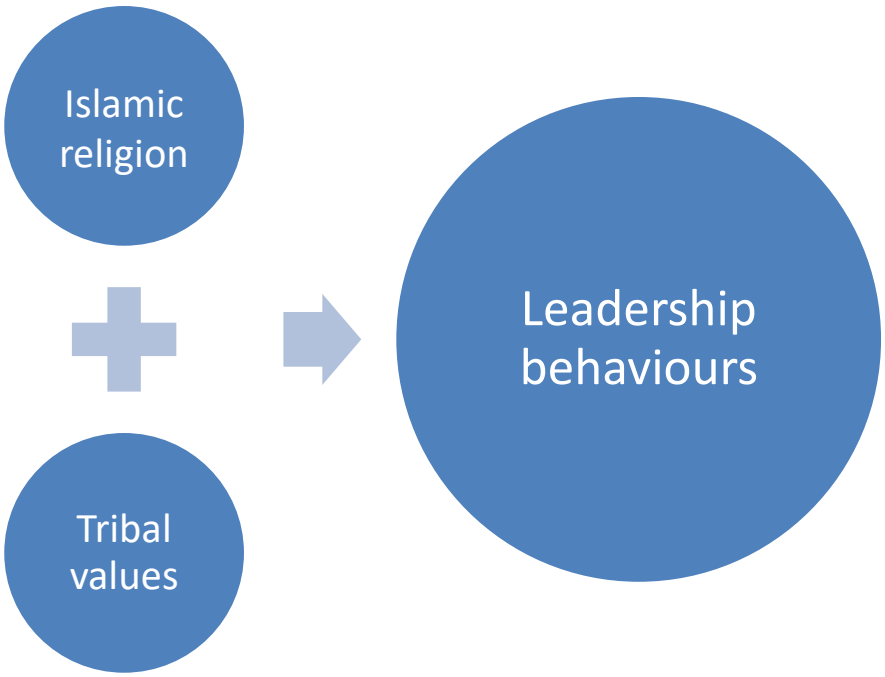


Figure 3-1 Factors that are influential on leadership behaviours in Saudi Arabia

Although there is a lack of previous rigorous research on leadership in Saudi Arabia and Arabian Gulf cultural context (Abdalla and Al-Homoud 2001; Metcalfe and Mimouni 2011), research on the prevailing leadership generally presents contradictory results. On the one hand, a number of research findings show that the predominant leadership styles used by Saudi managers are consultative and participative (Al-Jafary and Hollingsworth 1983; Ali and Al-Shakis 1985; Ali 1989). Moreover, Robertson et al. (2002) suggest that many Arab countries, including Saudi Arabia, hold strong work beliefs regarding humanistic, organisational and participative decision making , which principally derive from Islamic work ethics. Meanwhile, Ali (1993) found that Saudi managers have a tendency to adopt an authoritarian style irrespective of work-related factors, including hierarchical level, organisational sector and size of the organisation.

In an attempt to illuminate these conflicting results, Ali (1993) argues that Saudi leaders do not tend to practise consultation in a genuine sense; instead, they exercise consultation in a false sense, labelled as “pseudo consultative style”, attempting to differentiate between consultation in Saudi culture and that identified in Western culture. Likewise, Muna (1980) supports this argument, maintaining that leaders may discuss options with their followers but followers have no part to play in the ultimate decisions. Atiyyah (1999) observed that Saudi managers operate their organisations in a similar way to conventional tribal structures, whereby paternalistic authoritarianism, which relies on social skills to encourage people to complete assigned tasks, is practised. For example, before resorting to disciplinary action, managers use unofficial friendly practices as well as societal pressures as ways to influence people (Mellahi et al. 2001).

Ali (1993) points out that the emergence of a pseudo-participative style in Arab culture can be attributed to the influence of Western management philosophies and the benefits of utilising participative approaches, because management textbooks in Saudi Arabia consider this approach as an ideal form. Thus, managers suffer from a problem of duality in thinking and practice, since they tend to demonstrate admiration of ideal forms while they recognise that these forms are contradicted by the reality (Ali 1993). Indeed, in medical and business schools, management and leadership textbooks used in Saudi universities are imported from the West, particularly from the United States. Moreover, leadership development and training programmes run for different organisations, including those in the healthcare sector, to advance employees’ leadership skills teach Western models and theories, which may significantly influence managers’ thinking and practices of leadership.

The next section discusses the Islamic perspective of leadership in order to understand how social norms are shaped by Islam, which influences day-to-day life in Saudi Arabia.

3.3 The Islamic perspective of leadership

To understand the Islamic view of leadership, there should be a brief overview about the doctrine and Sharia law, which are central elements that constitute Islamic religion (Haddara and Enanny 2009). Islamic doctrine is the foundation on which Islamic law is established. The doctrine contains a number of main principles whereby people can engage in Islam, such as a belief in the oneness of God. Islamic law incorporates all the principles and regulations that organise worship, ethics and relationships, such as the relationship between a Muslim and God, as well as between a Muslim and society. The doctrine legitimates the law, and in this way they have a strong and inseparable connection. This means that Islamic doctrine forms the core beliefs of Muslims by which they follow as well as implement the law with intrinsic motivation (Haddara and Enanny 2009). Consequently, the Islamic doctrine and law guide Muslims' attitudes and behaviours.

In Islam, leadership can be described as a key everlasting concept. There are several words employed to describe a leader. These include Amir, Khalifah, Immam, and guardian (Beekun and Badawi 1999; Abdalla and Al-Homoud 2001; Haddara and Enanny 2009; Randeree 2009). An Amir literally means "Prince" and comes from the term "Amarah" that refers to command and order (Haddara and Enanny 2009). A Khalifah denotes "Khilafah", which can be used to refer to either a successor or a vicegerent. And an Imam denotes "Imamah", derived from the term "amma", referring to "faced towards" (Haddara and Enanny 2009). In addition, Haddara and Enanny (2009) note that an Imam describes a man who leads a group of people when performing a prayer, guides individuals and can generally be utilised to indicate a leader. Moreover, a leader is called a guardian in Islam, which implies responsibility and protection of the community against tyranny and oppression.

وَجَعَلْنَا مِنْهُمْ أَئِمَّةً يَهْدُونَ بِأَمْرِنَا لَمَّا صَبَرُوا وَكَانُوا بِآيَاتِنَا يُوقِنُونَ[2]

"When they became steadfast and believed firmly in Our messages, We raised leaders among them, guiding them according to Our command." (Haleem 2005 32:24)

[2] All Quran verses in Arabic included in this research have been retrieved from the King Saud University (2017) *KSU electronic moshaf project*. Available from: http://quran.ksu.edu.sa/ [Accessed 5 Dec 2017]

Chapter 3

Leadership in Islam is an obligation as well as a shared responsibility. This is because leadership can be voluntarily exercised by an individual on behalf of others (Haddara and Enanny 2009). Islam commands people to employ leaders and follow them. It also instructs any group of Muslims, who number more than two, and want to perform a particular duty, to choose a leader for them. This indicates that leadership plays a key role in the everyday lives of Muslims. The Prophet Muhammad (pbuh)[3] said:

إِذَا خَرَجَ ثَلاثَةٌ فِي سَفَرٍ فَلْيُؤَمِّرُوا أَحَدَهُمْ

"When three persons set out on a journey, they should appoint one of them as their leader." (Sunnah.com 2017 8:5)

For Muslims, the Prophet Muhammad (pbuh) is the ideal leader to follow, whom Allah (God) describes in the wholly Quran as "Uswatun hasana", which means the most beautiful pattern of conduct.

لَّقَدْ كَانَ لَكُمْ فِي رَسُولِ اللَّهِ أُسْوَةٌ حَسَنَةٌ لِّمَن كَانَ يَرْجُو اللَّهَ وَالْيَوْمَ الْآخِرَ وَذَكَرَ اللَّهَ كَثِيرًا

"There has certainly been for you in the Messenger of Allah an excellent pattern for anyone whose hope is in Allah and the Last Day and [who] remembers Allah often." (Haleem 2005 33:21)

Leadership involves trust (Beekun and Badawi 1999; Haddara and Enanny 2009). Leaders are given responsibilities to lead individuals, organisations as well as societies (Haddara and Enanny 2009). Leadership implies "psychological contracts" between leaders and their followers (Beekun and Badawi 1999). Leadership responsibilities include guiding followers according to Islamic principles. Hence, in Islam, the emphasis on leadership incorporates performing good deeds for the sake of God, the society and humankind (Beekun and Badawi 1999).

وَجَعَلْنَاهُمْ أَئِمَّةً يَهْدُونَ بِأَمْرِنَا وَأَوْحَيْنَا إِلَيْهِمْ فِعْلَ الْخَيْرَاتِ وَإِقَامَ الصَّلَاةِ وَإِيتَاءَ الزَّكَاةِ ۖ وَكَانُوا لَنَا عَابِدِينَ

"We made all of them leaders, guiding others by Our command, and We inspired them to do good works, to keep up the prayer, and to give alms: they were Our true worshippers." (Haleem 2005 21:73)

[3] The phrase of Peace be upon him (pbuh) is used by Muslims whenever the Prophet Muhammad is mentioned.

Islam recognises that leadership is exercised on different levels. Islam insists that people practise leadership from the simple level of family to more complex levels, such as organisations, societies and nations. This means that leadership is shared and every person is expected to exercise leadership in everyday life. The Prophet Muhammad (pbuh) said:

كُلُّكُمْ رَاعٍ وَمَسْئُولٌ عَنْ رَعِيَّتِهِ فَالْإِمَامُ رَاعٍ وَهُوَ مَسْئُولٌ عَنْ رَعِيَّتِهِ وَالرَّجُلُ فِي أَهْلِهِ رَاعٍ وَهُوَ مَسْئُولٌ عَنْ رَعِيَّتِهِ وَالْمَرْأَةُ فِي بَيْتِ زَوْجِهَا رَاعِيَةٌ وَهِيَ مَسْئُولَةٌ عَنْ رَعِيَّتِهَا وَالْخَادِمُ فِي مَالِ سَيِّدِهِ رَاعٍ وَهُوَ مَسْئُولٌ عَنْ رَعِيَّتِهِ

"Beware. Every one of you is a shepherd and everyone is answerable with regard to his flock. The Caliph is a shepherd over the people and shall be questioned about his subjects (as to how he conducted their affairs). A man is a guardian over the members of his family and shall be questioned about them (as to how he looked after their physical and moral well-being). A woman is a guardian over the household of her husband and his children and shall be questioned about them (as to how she managed the household and brought up the children). A slave is a guardian over the property of his master and shall be questioned about it (as to how he safeguarded his trust). Beware, every one of you is a guardian and every one of you shall be questioned with regard to his trust."
(Sunnah.com 2017 33:24)

Haddara and Enanny (2009) argue that the notion of multi-level leadership in Islam transforms the entire community into one team. Armstrong (2007) notes that the term "Muslim Umma" implies Muslims' unity, harmony and collective duties.

Leadership in Islam is about accountability. Leaders are held accountable not only to their followers but also primarily to the God. These accountabilities can be seen in the next verse:

وَقُلِ اعْمَلُوا فَسَيَرَى اللَّهُ عَمَلَكُمْ وَرَسُولُهُ وَالْمُؤْمِنُونَ ۖ وَسَتُرَدُّونَ إِلَىٰ عَالِمِ الْغَيْبِ وَالشَّهَادَةِ فَيُنَبِّئُكُم بِمَا كُنتُمْ تَعْمَلُونَ

"Say [Prophet], 'Take action! God will see your actions—as will His Messenger and the believers—and then you will be returned to Him who knows what is seen and unseen, and He will tell you what you have been doing." (Haleem 2005 9:105)

Consideration is a significant concept in Islam and leaders are encouraged to practise it. Consideration is considered to be an effective approach of leadership. It is expected that being considerate will enable leaders to bring people together in order to obtain mutual goals and benefits. It involves kind-heartedness, understanding, compassion and mercy. It also

encompasses showing appreciation for followers' performance and rewarding them justly for their efforts.

فَبِمَا رَحْمَةٍ مِّنَ اللَّهِ لِنتَ لَهُمْ ۖ وَلَوْ كُنتَ فَظًّا غَلِيظَ الْقَلْبِ لَانفَضُّوا مِنْ حَوْلِكَ ۖ فَاعْفُ عَنْهُمْ وَاسْتَغْفِرْ لَهُمْ وَشَاوِرْهُمْ فِي الْأَمْرِ ۖ فَإِذَا عَزَمْتَ فَتَوَكَّلْ عَلَى اللَّهِ ۚ إِنَّ اللَّهَ يُحِبُّ الْمُتَوَكِّلِينَ

"By an act of mercy from God, you [Prophet] were gentle in your dealings with them—had you been harsh, or hard-hearted, they would have dispersed and left you—so pardon them and ask forgiveness for them. Consult with them about matters, then, when you have decided on a course of action, put your trust in God: God loves those who put their trust in Him." (Haleem 2005 3:159)

Islam indicates the significance of the concept of consultation. Haddara and Enanny (2009) point out that, in the Quran, consultation is stated two times. Firstly, consultation is revealed as an order to the Prophet (pbuh), as appears clearly in the above verse. Secondly, it is described as an essential duty for leaders in order to obtain different perspectives and advice that will help them achieve mutual objectives, as revealed in the following verse:

وَالَّذِينَ اسْتَجَابُوا لِرَبِّهِمْ وَأَقَامُوا الصَّلَاةَ وَأَمْرُهُمْ شُورَىٰ بَيْنَهُمْ وَمِمَّا رَزَقْنَاهُمْ يُنفِقُونَ

"Respond to their Lord; keep up the prayer; conduct their affairs by mutual consultation; give to others out of what We have provided for them." (Haleem 2005 42:38)

Patience is an important leadership characteristic in Islam. There are several verses in the Quran that point out that a leader must show patience, endurance and forbearance in times of pain and adversity. It also involves dealing calmly with problems.

وَلَنَبْلُوَنَّكُم بِشَيْءٍ مِّنَ الْخَوْفِ وَالْجُوعِ وَنَقْصٍ مِّنَ الْأَمْوَالِ وَالْأَنفُسِ وَالثَّمَرَاتِ ۗ وَبَشِّرِ الصَّابِرِينَ

"We shall certainly test you with fear and hunger, and loss of property, lives, and crops. But [Prophet], give good news to those who are steadfast." (Haleem 2005 2:155)

Justice or fairness is a significant dynamic characteristic of leadership in Islam. It means equality and balance. Each Muslim, whether leader or follower, must endeavour to develop and show justice. Justice safeguards leaders from behaving in a partial manner with followers or for personal gain.

يَا أَيُّهَا الَّذِينَ آمَنُوا كُونُوا قَوَّامِينَ لِلَّهِ شُهَدَاءَ بِالْقِسْطِ ۖ وَلَا يَجْرِمَنَّكُمْ شَنَآنُ قَوْمٍ عَلَىٰ أَلَّا تَعْدِلُوا ۚ اعْدِلُوا هُوَ أَقْرَبُ لِلتَّقْوَىٰ ۖ وَاتَّقُوا اللَّهَ ۚ إِنَّ اللَّهَ خَبِيرٌ بِمَا تَعْمَلُونَ

> *"You who believe, be steadfast in your devotion to God and bear witness impartially: do not let hatred of others lead you away from justice, but adhere to justice, for that is closer to awareness of God. Be mindful of God: God is well aware of all that you do." (Haleem 2005 5:8)*

Humility is a significant leadership characteristic in Islam, which leaders must strive to practise. It is mentioned several times in the Quran and the prophetic traditions. It shows that people must never let their ego get the better of them. Leaders must not show pride and arrogance towards people. Leaders as well as followers must acknowledge their faults and weaknesses to develop humility.

وَعِبَادُ الرَّحْمَٰنِ الَّذِينَ يَمْشُونَ عَلَى الْأَرْضِ هَوْنًا وَإِذَا خَاطَبَهُمُ الْجَاهِلُونَ قَالُوا سَلَامًا

> *"The servants of the Lord of Mercy are those who walk humbly on the earth, and who, when the foolish address them, reply, 'Peace';" (Haleem 2005 25:63)*

Beekun and Badawi (1999), Muslim scholars, rely on two major definitions of leadership. First, leadership refers to "the process by which the leader seeks the voluntary participation of the followers in an effort to reach organisational objectives" (Beekun and Badawi 1999 p6). This definition describes leadership from a social reciprocity perspective. Likewise, Toor (2008 p26) describes Islamic leadership as "the process in which the leader seeks to achieve certain organisational goals by garnering the support from relevant stockholders, primarily followers, while fully complying with Islamic teachings and principles". Second, leadership encompasses the process of persuading people in order to achieve organisational goals with high levels of willingness and enthusiasm; leadership is a human and motivational activity that brings people together to achieve different goals and objectives (Beekun and Badawi 1999). These definitions are compatible with the Western definition of leadership given by Northouse (2013), because these definitions indicate that leadership is about social influence processes and the voluntary participation of followers to achieve shared objectives. However, Islamic definitions of leadership emphasise the importance of conforming to Islamic traditions and principles, which can be considered as the main difference between Islamic and Western definitions of leadership. Moreover, Beekun and Badawi (1999 p7) note that "management activities such as planning, organising, and decision making are dormant cocoons until the leader triggers the power for motivation in people and guides them toward their goals". Thus, this description differentiates between leadership and management. It also points out that a leader is not necessarily a manager, while a manager is not necessarily a leader.

3.3.1 Moral principles in Islamic leadership

For a deeper understanding of the notion of leadership from an Islamic perspective, the main moral principles or values that regulate leadership behaviours in Islam need to be discussed. Islamic principles include Iman, Islam, the consciousness of God "Taqwa" and Ihsan (Beekun and Badawi 1999).

3.3.1.1 Iman

Iman refers to faith in Allah (God). The Prophet Muhammad (Pbuh) said of Iman: "*It is to believe in Allah, His Angels, His Books, His Messengers, the Last Day, and in the Divine Decree, its good and its bad" (Sunnah.com 2017 47:6).* Therefore, Muslims have faith in the angels, Holy books, messengers, life after death, and destiny as well as human accountability. A person who has a strong Iman will consider him/herself, as well as all his/her personal possessions, as belonging to God. It also includes conquering one's ideas, thinking, ego and passions before God. Iman involves a belief in the hereafter and in an individual's complete accountability for his/her deeds. Thus, a leader with a strong Iman will neither avoid nor neglect his/her responsibility for his/her actions and behaviours. Moreover, s/he will always attempt to recognise and do good deeds.

آمَنَ الرَّسُولُ بِمَا أُنْزِلَ إِلَيْهِ مِنْ رَبِّهِ وَالْمُؤْمِنُونَ كُلٌّ آمَنَ بِاللَّهِ وَمَلَائِكَتِهِ وَكُتُبِهِ وَرُسُلِهِ لَا نُفَرِّقُ بَيْنَ أَحَدٍ مِنْ رُسُلِهِ وَقَالُوا سَمِعْنَا وَأَطَعْنَا غُفْرَانَكَ رَبَّنَا وَإِلَيْكَ الْمَصِيرُ

> *"The Messenger believes in what has been sent down to him from his Lord, as do the faithful. They all believe in God, His angels, His scriptures, and His messengers. 'We make no distinction between any of His messengers,' they say, 'We hear and obey. Grant us Your forgiveness, our Lord. To You we all return." (Haleem 2005 2:285)*

3.3.1.2 Islam

Islam is built upon the concept of Iman. In Arabic, the term Islam means peace and submission. Islam signifies the achievement of peace with Allah, within oneself, and with the creation of Allah, by being willing to submit to Allah. Beekun and Badawi (1999) suggest that Islam will encourage Muslim leaders to submit their ego to Allah, while preventing them from seeing themselves as supreme. The Prophet Muhammad (Pbuh) said of Islam:

> *"It is to bear witness that there is none worthy of worship except Allah and that Muhammad is the Messenger of Allah, to establish the Salah, to give Zakah, to fast*

Ramadan, and to perform Hajj to the House if you are able to bear the journey." (Sunnah.com 2017 47:6)

3.3.1.3 The Consciousness of God: "Taqwa"

Leadership in Islam encompasses the consciousness of God, "Taqwa". It means that individuals are always mindful of God, to guard them from taking the wrong path. Taqwa includes strengthening people against the desire to misbehave (Haddara and Enanny 2009), and ensuring that each action taken satisfies Islamic principles. In order to have Taqwa, people have to devote every kind of action they do to the God. Haddara and Enanny (2009) suggest that people who are aware of the God have many features pertinent to leadership, including being generous, having self-control, being forgiving and keeping their promises, as well as persevering. Thus, good actions and deeds are not only performed because these may lead to leadership effectiveness, but also, and most importantly, because these good actions will achieve the pleasure of the God (Beekun and Badawi 1999; Haddara and Enanny 2009), which is considered an inherent and spiritual motivating factor apart from any materialistic rewards (Ahmad 2009). Consciousness of God promotes sensitivity to followers' needs.

الَّذِينَ يُنفِقُونَ فِي السَّرَّاءِ وَالضَّرَّاءِ وَالْكَاظِمِينَ الْغَيْظَ وَالْعَافِينَ عَنِ النَّاسِ ۗ وَاللَّهُ يُحِبُّ الْمُحْسِنِينَ

"Who give, both in prosperity and adversity, who restrain their anger and pardon people—God loves those who do good." (Haleem 2005 3:134)

3.3.1.4 Ihsan

The term Ihsan denotes excellence. Ihsan implies a person who performs according to his/her own full potential. Islam instructs Muslims to attempt to give an excellent performance when performing any task. Haddara and Enanny (2009) suggest that Ihsan involves having a greater degree of awareness of God. The Prophet Muhammad (Pbuh) said of Ihsan: *"It is to worship Allah as if you can see Him, for although you cannot see Him, He can see you"* (Sunnah.com 2017 47:6). Beekun and Badawi (1999) suggest that Ihsan motivates leaders and followers to carry out their responsibilities carefully, display additional commitment and push themselves beyond the call of duty; they are willing to make sacrifices in the performance of their tasks. Ihsan is about showing awareness of the God's existence, while believing that the God watches every action that a person does (Haddara and Enanny 2009). Thus, leaders are always required to apply Ihasn through showing good behaviours when interacting with others in order to have God's satisfaction and rewards.

إِنَّ اللَّهَ يَأْمُرُ بِالْعَدْلِ وَالْإِحْسَانِ وَإِيتَاءِ ذِي الْقُرْبَىٰ وَيَنْهَىٰ عَنِ الْفَحْشَاءِ وَالْمُنكَرِ وَالْبَغْيِ ۚ يَعِظُكُمْ لَعَلَّكُمْ تَذَكَّرُونَ

"God commands justice, doing good, and generosity towards relatives and He forbids what is shameful, blameworthy, and oppressive. He teaches you, so that you may take heed." (Haleem 2005 16:90)

The discussion above shows that Islamic doctrine, laws and moral principles provide Muslim leaders with moral incentives to adhere to several leadership accountabilities emphasised by the Quran and the prophetic traditions. These leadership accountabilities highlight that leadership is an obligation, a collective duty and a duty of trust. The Quran and the prophetic traditions underscore that leadership involves role-modelling, guiding, protecting and treating followers fairly. These religious precepts also emphasise shared leadership, consultation, consideration of followers' needs, compassion and mercy, patience, justice and humility.

In summary, this section is a discussion of meaning and processes of leadership from an Islamic perspective, as revealed in the holy book of Quran and from prophetic traditions. The section indicates that Islam permeates all aspect of Saudi life, including practices of leadership. Such a linkage between religion and leadership practices within Islamic organisational culture may not be seen in other organisational environments located in other cultures within secular realms (Egel and Fry 2017). This is because Islamic doctrines and laws permeate day-to-day life and interaction with others. It shows that Islam sees leadership as a vital construct, which is multi-faceted and complex. It is defined as an important concept needed for every group of people to bring them together cohesively in order to realise mutual concerns and objectives. It is a collective duty that is available to nearly everyone. Leadership in Islam is about trust, accountability and role-modelling. It also involves several forms of consideration, including kindness and leniency, compassion and mercy, and understanding. Islam includes showing patience and tolerance, displaying justice and humility as important aspects of leadership. Consultation is also depicted as a fundamental construct in Islamic leadership. Leadership behaviours in Islam are shaped by four primary principles: Iman, Islam, consciousness of God and Ihsan. These principles provide a spiritual sense of both responsibility and accountability. An Islamic view of leadership indicates that Muslims' activities and endeavours are founded on their faith and hopes (Ahmad 2009; Egel and Fry 2017). Thus, it is important to consider the influence of the social, religious and cultural context because these may carry different meanings for leadership behaviours, as approached in the current research question.

As argued in the previous chapter, national culture has a strong influence in shaping leadership meanings, values and behaviours. Hofstede (1980 p260), describes culture as ''the collective

programming of the human mind that distinguishes the members of one human group from those of another''. In Saudi Arabia, Islam shapes the culture of Saudis, along with social norms, Arab and tribal values. Although strongly influenced by Islam, these different interrelated factors provide unique interpretations and understandings of the concept of leadership. These distinctive understandings are moulded by Islamic teachings and instructions emphasised in the Quran and the prophetic traditions, which are the main guiding sources for Muslims to conduct their daily life affairs, including work.

Adler (2002) points out that culture incorporates a range of common values accepted by specific members of a community and these values influence their life patterns. These shared values impact on social expectations, assumptions and ethical principles (Adler 2002; Yukl 2013). Within Saudi culture, Islamic teachings emphasise several values. These values include: a) trust, b) forgiving, c) tolerance, d) patience, e) kindness, f) consultation, g) shared responsibility, h) accountability, i) consideration, j) humility, k) brotherly and friendly relationships, l) cooperation and harmony, and m) fairness. In general, Arab culture is characterised as traditional, socially oriented, male dominated, high power distance, high context, collectivistic. Managers-staff relationships are expressed in terms such as brotherly and family ties. Tribal values emphasise consultation with relatives and people from the same tribal group (in-group) while authoritarian behaviour is directed towards strangers (out-group). With the centralisation of power, leaders are seen as protectors, caregivers, and father of their communities. These different values strongly influence leadership behaviours in Saudi Arabia (At-Twaijri 1989; Ugur and Mahmoud 1999; Mellahi et al. 2001; Metcalfe and Mimouni 2011) since these values guide leaders' behaviours when enacting leadership in an organisational context (Schein 2010; Yukl 2013).

House et al. (1999 p13) shows that culture include ''shared motives, values, beliefs, identities, and interpretations or meanings of significant events that result from common experiences of members of collectivities and are transmitted across age generations''. In Saudi Arabia, leaders are expected to possess a belief in asceticism (Khadra 1984; Abdalla and Al-Homoud 2001) since they ultimately seek to achieve the pleasure of God through showing good deeds when interacting with followers. This intrinsic motivation is deeply moulded by the basics moral values in Islam, which are, Iman, Islam, the consciousness of God (Taqwa) and Ihasn. Thus, culture may not only explain the meanings and interpretations of leadership but also the basic motives for leaders to enact particular leadership behaviours. It can be argued that many Muslims are essentially motivated by their faith.

Bass (1997) maintains that Western models of leadership may be understood and enacted through specific patterns of thinking, underlying values, views and behaviours in other different cultures. This perception indicates that the underlying processes and dynamics of leadership are different from one culture to another. In Saudi Arabian culture, Islamic values and social norms may facilitate the enactment of several elements in different new-genre models of leadership including transformational, servant and authentic leadership through different underlying values, motives and behaviours. For instance, Islamic values emphasise ethical and moral conduct, which is also highlighted in different leadership models such as the idealized influence for transformational leadership, behaving ethically for servant leadership and internalised moral values for authentic leadership. These different models suggest that leaders may display ethical behaviours that are consistent with their own core values in order to influence others. Moreover, Islam encourages leaders to be sensitive to followers' concerns and needs through displaying a) consideration and kindness, b) consultation, c) forgiveness, d) tolerance, e) patience, f) cooperation and g) harmony. These different values may reflect different leadership models such as individualised consideration for transformational leadership, emotional healing, empowering, helping subordinates to grow and succeed, relationships and servanthood for servant leadership and balanced processing for authentic leadership. In addition, the collectivistic value that characterises Saudi culture may encourage leaders to transcend their own interests for the sake of others. This kind of sacrifice and altruism has been stressed in transformational and servant leadership models (Bass 1985; Liden et al. 2008).

3.4 Conclusion

This chapter has presented the cultural context in which the present research is embedded. The chapter includes an overview of the history and culture of Saudi Arabia. It highlights the political and economic contexts. The chapter also presents an outline of Saudisation policy and the Saudi healthcare system. It discusses the factors that can influence leadership behaviours enacted in organisational settings, including social norms, tribal values and Islam. A discussion around fundamental moral principles in Islam and their influence on leadership is highlighted.

Chapter 4 Literature review

The current chapter presents a literature review of empirical research conducted in the areas of critical care and emergency settings. It highlights the major leadership models used, the methodological orientations, the similarities and differences in findings, and later the influence of context and culture in which leadership takes place.

Leadership behaviours play a pivotal role in today's complex health-care systems, especially in a critical care setting such as emergency medicine (LaSalle 2004). This environment is extremely dynamic, chaotic, stressful and highly regulated. Emergency departments need leaders who can use effective leadership behaviours to influence different staff and maintain standards of professional practice, as well as create a productive healthy environment. Therefore, this chapter will conduct a review of the literature aimed at synthesising and analysing the studies that have examined leadership behaviours in emergency and critical care work environments. A preliminary search and screening of several data bases, including CINHAL, MEDLINE, PsychINFO and Web of Sciences, shows limited empirical research conducted to investigate leadership in emergency departments within health sectors (Table 4-1). The facilities provided by each database were utilised in order to perform an effective search of the literature. For example, research techniques such as "suggested subject term" or "headings" were employed to identify specific terms used for emergency departments. Hand screening of the retrieved articles indicates that the majority of retrieved articles are neither empirical research nor focused on leadership as a main topic of investigation (Table 4-1). Due to the limited amount of empirical research conducted in emergency departments, it was decided to include similar healthcare environments, such as operating rooms, anaesthesia and critical care units in this review. These settings share some common features with emergency departments, such as complexity, providing care for unstable patients and life-threatening diseases.

Table 4-1 Literature search to show limited empirical research conducted on leadership in emergency departments

Database	Period covered	Key words	Total
CINAHL	2000-2018	Lead* and (MH "Emergency Service") or emergency* or trauma* or accident* Narrow by SubjectMajor: - leadership	81
MEDLINE	2000-2018	Lead* and (MH "Emergency Service, Hospital") Narrow by SubjectMajor: - leadership	39
PsycINFO	2000-2018	Lead* and DE "Emergency Services" or emergency* or trauma* or accident*	71
WEB of SCIENCE	2000-2018	Lead* and emergency*	151
Total			342

4.1 Search strategy

The following electronic databases were searched for peer-reviewed research articles: CINHAL, MEDLINE, PsycINFO and Web of Science. In order to conduct a comprehensive literature review, the PICO method was utilised to create a literature search strategy. For the PICO search strategy, P (population) refers to medical and paramedical staff working in emergency medical settings or anaesthesia, operating rooms and intensive care units, I (intervention) refers to leadership behaviours, C (comparative intervention) is not included in this review, similarly O (outcomes) is also not included in this review. Effective keywords and their synonyms were identified to develop search-strategy lists and thus retrieve the most productive results (Appendices A and B). Then, keywords were entered and combined in a Boolean search engine using title and abstract with truncations to retrieve relevant and specific results (Table 4-2). The electronic databases were searched via the University of Southampton's interface. Reference lists of identified journal articles were manually searched to find other relevant studies.

4.1.1 Inclusion and exclusion criteria

Inclusion and exclusion standards were set out to provide information in relation to the scope and relevance of the articles being reviewed.

Inclusion criteria:

1. Studies published from 2000 to 2018.
2. Studies reported in English and Arabic.
3. Studies in critical healthcare settings (emergency, operating room, anaesthesia and intensive care units), and the participants in these studies must work in a health service.
4. Qualitative, quantitative and mixed-methods studies.
5. Peer-reviewed articles.

Most of the accessible evidence on healthcare leadership development dates from the past eighteenth years.

Exclusion criteria:

1. Studies that evaluated leadership development programmes.
2. Studies published before January 2000.
3. Studies in which leadership is not the focus of investigation.
4. Studies outside emergency medical or critical care settings, e.g. medical units.

Table 4-2 Search results

Database	Period covered	Total
CINAHL	2000–2018	8,919
MEDLINE	2000–2018	108,640
PsycINFO	2000–2018	13,672
WEB of SCIENCE	2000–2018	6,841
Total		138,072

The results were further refined using effective key words and search strategies relevant to each database (see hits, Table 4-3). The results for each database were then personally screened in order to find relevant studies (see full records, Table 4-3). Sixty-one studies were identified after duplicates were removed (Table 4-3). Then, the aims, methods, sampling and results of these studies were carefully revised for their selection of papers using the PICO template to assess the relevance of the retrieved studies (Bettany-Saltikov 2012) (Appendix C). For critical appraisal, the Mixed Methods Appraisal Tool (MMAT), version 2011 (Pluye and Hong 2014), was used to assess the methodological quality of the studies (Appendix O). The MMAT allows researchers to critically appraise studies with diverse research designs, including qualitative, quantitative or mixed methods studies, which fit the inclusion criteria. Although Whittemore and Knafl (2005) argue that the ideal criteria for evaluating methodological quality have not been established, the MMAT was selected because it was rigorously developed based on a theory, a literature review, a pilot study, workshops and consultations with experts (Pluye and Hong 2014). Only nineteen journal articles (see Table 4-3) were found that fit the inclusion criteria and these are included in this literature review. Fourteen studies were conducted in a critical care environment, while five studies were undertaken in an emergency setting. The researcher alone screened and reviewed these articles.

Table 4-3 Search results after screening

Database	Period covered	Hits	Full record / titles and abstracts
CINAHL	2000–2018	258	35
MEDLINE	2000–2018	2,224	43
PsycINFO	2000–2018	946	22
WEB of SCIENCE	2000–2018	162	38
Final list (after removing duplicates)	2000–2018		61
Included articles			19

The following review offers a synthesis of the literature on several theoretical models that link different leadership behaviours with various organisational outcomes. The discussion will broadly start by reviewing the literature on critical care settings. Then, the discussion will focus narrowly on the literature on emergency departments.

4.2 Leadership styles in critical healthcare settings

Leadership behaviours in critical healthcare have been investigated based on several models and outcomes. These include transformational or charismatic leadership, participative and supportive leadership, authentic leadership, task-oriented and relation-oriented leadership and contingent leadership. Various outcomes have been linked to these behaviours including, but not limited to, job satisfaction, leadership effectiveness, extra effort, organisational commitment and staff retention. The review shows that quantitative methodologies dominate the literature. The predominant quantitative methods used in these studies include descriptive and correlational

methods. Most of these studies employ purposive more than random sampling techniques, which is a key drawback, since purposive sampling may limit the generalisability of these studies. The following review explores the literature in relation to various leadership models and outcomes, grouping studies around the different theoretical frameworks of leadership considered (see Table 4-4 for a summary of research articles).

4.2.1 Transformational Leadership

The existing research on leadership has used quantitative correlational methods to investigate how transformational leadership links to different outcome standards. For instance, these standards include job satisfaction, organisational commitment, productivity, staff retention, effectiveness and extra effort. With the current shortages in the healthcare workforce, staff satisfaction is one of the most important outcomes of leadership practice as it is associated with increased staff commitment and retention (Bratt et al. 2000; Loke 2001; Kanste 2008; Giallonardo et al. 2010; Abualrub and Alghamdi 2012; Spence Laschinger et al. 2012; Wang et al. 2012; Moneke and Umeh 2013; Wong and Laschinger 2013; Bormann and Abrahamson 2014). Furthermore, transformational leadership has been linked to effective leadership (Casida et al. 2012; Zhang et al. 2012) and employees' extra effort (Salanova et al. 2011). Researchers have used different measures for transformational behaviour including the Leadership Practice Inventory (Kouzes and Posner 2012) and the Multifactor Leadership Questionnaire (Bass 1985).

Various research e.g. (Loke 2001; Wang et al. 2012; Moneke and Umeh 2013) has been conducted to examine the influence of leadership behaviours on job satisfaction using the Leadership Practice Inventory and different scales for job satisfaction. These studies have found a positive association between transformational leadership behaviours and job satisfaction, organisational commitment and productivity. Moneke and Umeh (2013) conducted research in the United States and found a significant correlation between perceived leadership around behaviours encompassing challenging the process, inspiring a shared vision, enabling others to act and modelling the way and job satisfaction. Moreover, a significant link was reported between enabling the heart, organisational commitment and job satisfaction. Similarly, Loke (2001) indicated a statistically significant association between transformational leadership behaviours including challenging the process, inspired a shared vision, enabling others to act, role modelling, encouraging the heart and employees' productivity, job satisfaction and organisational commitment. Managers perceived that they actively exercise enabling others to act while staff perceived that their managers keenly exercise modelling the way. Together, managers and staff rated inspiring a shared vision as the least likely behaviour used that managers engage in.

Likewise, Wang et al. (2012) found a significant association between nurse leaders' transformational behaviours and job satisfaction. In addition, nurse managers are moderately perceived by registered nurses as transformational leaders.

Although these studies reveal significant findings, they have some weaknesses. Moneke and Umeh (2013) research was conducted in one hospital and only 112 out of 204 respondents completed the questionnaire that was used for data analysis. The questionnaire was accessed online and this could explain the low participation rate, which may increase the bias in the result. The study undertaken by Wang et al. (2012) used the Chinese version of the leadership practice inventory-observer, which might have affected the clarity and familiarity of the items measured. Thus, the translation of leadership-practice inventory items into Chinese could negatively influence the validity and reliability of the questionnaire. In addition, the research did not examine how nurse managers perceive their own leadership styles so that they could be compared with staff perceptions in order to assess the consistency of the results.

Different studies have investigated the influence of various leadership behaviours on job satisfaction and accomplishment using the Multifactor Leadership Questionnaire (MLQ), which evaluates transformational, transactional and laissez-faire leadership behaviours (Kanste 2008; Abualrub and Alghamdi 2012; Bormann and Abrahamson 2014). Kanste (2008) found that all transformational leadership behaviours plus contingent rewards from transactional leadership are significantly related to personal accomplishment. The study reported a negative relationship between emotional exhaustion and depersonalisation. Moreover, management by exception-active behaviour may increase personal accomplishment, while the passive form of management by exception as well as laissez-faire were negatively related to personal accomplishment. Abualrub and Alghamdi (2012) also found a significant association between transformational leadership components and nurses' job satisfaction. In contrast, the study found a significant but negative correlation between transactional leadership factors and job satisfaction ($r = -0.14$, $P < 0.01$). The study found that leaders display transformational instead of transactional leadership behaviours, as perceived by their staff nurses. Yet, Bormann and Abrahamson (2014), who undertook a quantitative correlational study to examine the association between leadership styles as observed by staff nurses and their job satisfaction, found that both transformational and transactional behaviours are positively associated with staff nurses' job satisfaction. However, the study revealed a negative link between management-by exception passive and laissez-faire leadership styles and job satisfaction.

Nevertheless, one criticism of much of the literature on transformational leadership is the overuse of the Multifactor Leadership Questionnaire (MLQ). Tracey and Hinkin (1998) have questioned MLQ's validity because of the high correlation among the components of transformational leadership; they are not distinct factors. The study by Kanste (2008) involved a limited number of participants from critical care settings (14%). It is noteworthy that there are inconsistent findings in these studies, because Kanste (2008) and Bormann and Abrahamson (2014) studies revealed a positive association between both transformational and transactional leadership behaviours and job satisfaction, while Abualrub and Alghamdi (2012) found transformational leadership only has a positive association with job satisfaction but negative effects were found in relation to transactional leadership and job satisfaction. These inconsistent findings demonstrate that taking the context and culture of leadership into account is vital because these influence the effectiveness of observed leadership behaviours.

Few studies have been carried out to examine the effectiveness of transformational leadership (Casida et al. 2012; Zhang et al. 2012). Effectiveness has been measured by investigating the association between transformational leadership and several indicators of leadership effectiveness, including culture, performance and value congruence. Casida et al. (2012) used a descriptive, exploratory research design to investigate the correlation between leadership, culture and performance. The findings indicated that nurse leaders in critical care departments were perceived by their nursing workforce as less transformational leaders than those in non-critical care units. Likewise, the ratings of staff nurses in critical care units on the least favourable factors involved in transactional leadership behaviour (passive-management by exception), as demonstrated by nurse managers, were significantly greater than non-critical staff nurses' ratings.

Zhang et al. (2012) undertook a three-stage research project including in-depth interviews, a pilot survey and a final survey to study the influence of transformational leadership on leadership effectiveness in crisis situations, such as the earthquake that struck China in 2008. The results indicated that transformational leadership has a significant association with value congruence and leadership effectiveness, especially when leaders display a high level of emotional control. Value congruence, which is defined as "the extent of agreement between the leader's value system and the members' value system" (Zhang et al. 2012 p4088), potentially plays a mediating role between leaders and their followers in the correlation between transformational leadership and leadership effectiveness. However, this study did not identify which departments participants were from. Although validated, they used a self-developed questionnaire, which needed to be tested in various kinds of situations, to measure emotional control and leadership effectiveness.

The term ‘effectiveness’ in leadership is vague because there are no clear objective measures to determine leadership effectiveness (Yukl 2013).

Salanova et al. (2011) carried out a cross-sectional research project using structural equation modelling to investigate the association between transformational styles of managers and followers’ extra effort, through which the self-efficacy and work engagement of staff nurses mediate this relationship. The findings revealed that the self-efficacy and work engagement of nursing staff fully mediate the relationship between transformational leadership and followers’ extra effort. The findings also revealed a strong association between transformational leadership and work engagement. However, the participants were only from one hospital, with 280 of 364 staff nurses participating. Similar to previous research, this study used a translated Portuguese version for all the scales including the multifactor leadership questionnaire (MLQ) and a self-constructed scale which might affect the clarity of items.

Overall, the preceding literature review reveals two predominant models of transformational leadership that have been used in these studies, including the leadership challenge (Kouzes and Posner 2012) and the full range of leadership (Bass 1985). With respect to the leadership challenge model, leadership behaviours, such as challenging the process, inspiring a shared vision, enabling others to act, encouraging the heart and modelling the way, are positively related to job satisfaction, productivity and organisational commitment (Loke 2001; Wang et al. 2012; Moneke and Umeh 2013). For the full range of the leadership model, which measures not only transformational behaviours but also transactional and laissez-faire behaviours, it has been found that transformational leadership behaviours encompassing idealised influence, inspirational motivation, intellectual stimulation and individualised consideration have a positive correlation with personal accomplishment, job satisfaction, performance and extra effort (Kanste 2008; Salanova et al. 2011; Abualrub and Alghamdi 2012; Casida et al. 2012; Bormann and Abrahamson 2014). Value congruence, self-efficacy and work engagement mediate the association between transformational leadership with leadership effectiveness and followers’ extra-role performance. However, the findings of these studies indicate an inconsistent relationship between transactional behaviours, including contingent rewards, as well as active and passive management-by-exception with job satisfaction. For example, Kanste (2008) found that only contingent rewards behaviour has a positive link with personal accomplishment and a negative link with emotional exhaustion and depersonalisation, while Bormann and Abrahamson (2014) indicated both contingent rewards and management-by-exception active/passive are positively related to job satisfaction. In contrast, Abualrub and Alghamdi (2012) found a significant negative connection between transactional leadership behaviours and job satisfaction. These inconsistencies in the

reported findings highlights the impact of the context and culture in which leadership takes place since these studies were conducted in different clinical settings and in different countries, including the United States, Finland and Saudi Arabia.

4.2.2 Participative and Supportive styles

Bratt et al. (2000) undertook a study to explore the factors influencing job satisfaction. The study involved 1,973 staff nurses from paediatric intensive care units drawn from 65 institutions in the United States and Canada. Self-reporting questionnaires were used for job stress, nursing leadership, group cohesion and nurse-physician collaboration, and two measures of satisfaction concerning professional job satisfaction and organisational job satisfaction. The results revealed a strong influence of leadership on job satisfaction. Nurses who perceived their managers as having a participative style had higher job satisfaction than those who had different perceptions. Supportive leadership as well as providing a cohesive work environment had a positive influence on job satisfaction. However, they used a cross- sectional descriptive design which recorded the participants' views at a single point in time, which may vary at other times, although the participant rate was 70%.

4.2.3 Authentic Leadership

Several studies have shown a significant association between authentic leadership behaviours and job satisfaction using the Authentic Leadership Questionnaire (ALQ) (Giallonardo et al. 2010; Spence Laschinger et al. 2012; Wong and Laschinger 2013). Recently, Wong and Laschinger (2013) have indicated that authentic leadership behaviours, which incorporate balanced processing, relational transparency, an internalised moral perspective and self-awareness, are significantly and positively associated with increased staff job satisfaction. Authentic leadership also has a significant and positive relationship with job satisfaction and performance because it has a positive influence on structural empowerment. Moreover, Spence Laschinger et al. (2012) show that authentic leadership has an indirect influence on job satisfaction by reducing bullying and emotional exhaustion. In addition, authentic leadership, workplace bullying and emotional exhaustion directly influence job satisfaction, which consequently leads to decreased intentions to leave. Furthermore, Giallonardo et al. (2010) revealed that new graduate nurses are more engaged and satisfied with instructors displaying greater amounts of authentic leadership. It was also found that authentic leadership influences job satisfaction through nurses' work engagement.

However, there are some limitations to these studies. First, response rates are low and this may be due to the constraints of a mailed survey. Second, the majority of participants were part-time or casual staff, which may cause bias. Third, these studies used a cross-sectional method along with a small amount of participants working in critical care settings. Last, the authentic leadership model is a new part of leadership research which is still under development, and therefore its moral element is not clearly explained (Northouse 2013).

4.2.4 Task-oriented and Team-oriented leadership

In a literature review, Parker et al. (2011) included ten papers that examine the effective leadership behaviours of surgeons in operating rooms. They classify the studies into three categories according to the principal methods used: 1) observation, 2) questionnaire and 3) interview. Seven categories of leadership behaviour are identified, including maintaining standards, managing tasks, making decisions, managing resources, directing and enabling, guiding and supporting, communicating and coordinating. These categories of leadership behaviour are then carefully aligned with the general models of effective task (maintaining standards, managing tasks, making decisions, managing resources) and team leadership (directing and enabling, guiding and supporting, communicating and coordinating). The results of this review indicate that effective leaders should focus on both task-oriented and team-oriented leadership.

4.2.5 Summary

The review shows that transformational, authentic and participative styles have a positive relationship with job satisfaction, while extra effort is only positively connected with transformational leadership, and this could be attributed to the fact that it is an item in the MLQ. Contingent rewards and occasionally active-management by exception (transactional) and task-oriented behaviour are positively connected with leadership effectiveness. In addition, staff working in critical care settings perceive their leaders as more transactional than transformational when compared with those in non-critical settings (Casida et al. 2012). Passive-management by exception and laissez-faire are seen as ineffective leadership behaviours.

4.3 Leadership styles in emergency medical settings

Although still scant, there is a growing body of quantitative research investigating various leadership behaviours in emergency medical settings (Yun et al. 2005; Raup 2008; Lin et al. 2011; Ghorbanian et al. 2012; DeVivo et al. 2013). Different leadership behaviours including contingent

leadership, empowerment, transformational and transactional, task-oriented and employee-oriented leadership were investigated to examine their relationships with leadership effectiveness, staff satisfaction, staff retention and patient satisfaction.

4.3.1 Empowerment leadership behaviour and leadership effectiveness

Yun et al. (2005) conducted a scenario approach using a confounded factorial design to examine contingent leadership (empowering vs directive) and the effectiveness of trauma resuscitation teams (simple and complex injury; expert and inexpert groups). The results show that when a patient's medical condition is simple and staff members are experts, empowering leadership, defined as leaders who encourage people to take part in the decision-making process, is more effective. In contrast, when a patient's medical condition is complex and group members are inexpert, directive leadership is more effective. More learning opportunities are provided with empowering leaders than with directive ones. Moreover, DeVivo et al. (2013) recently undertook quantitative research to describe the perception levels of empowerment, which include opportunity, information, support and resources, among nursing staff working in emergency departments. The results indicate that a moderate level of empowerment perception among staff nurses was found (21.25 out of 30). However, the first study was conducted in only one trauma centre, while the second study used a convenience sample from a particular geographical area, which limits the generalisability of the findings.

4.3.2 Task-oriented and employee-oriented leadership with unit performance and staff satisfaction

Lin et al. (2011) explored the relationship between emergency managers' leadership behaviours, emergency units' performance and emergency medical staff's work satisfaction. Leadership behaviours were grouped into two broad categories: task-oriented and employee-oriented leadership behaviours. Task-oriented behaviours encompass specifying goals understandable by subordinates, standardising workflows, being sensitive to subordinates' work needs, reacting effectively to subordinates' work situations, giving appropriate feedback to subordinates on work performance. Employee-oriented behaviours contain clearly expressed expectations and feelings to subordinates, encourage subordinates to be creative and active, are considerate of subordinates' perceptions about what they care about, consult subordinates for their opinions before making decisions, and are easy-going with and comprehensible to subordinates. The findings indicate that there is a positive association between task-oriented leader behaviour and emergency department performance. Indicators of emergency department performance include:

performing emergency care functions well, capably achieving the goals of patient emergency service requirements, emergency teaching/research, high quality of emergency patient care, meeting the needs of emergency services for patients and their families, reacting well when faced with an emergency situation, and meeting the needs of patient and families well as compared to other hospital-based emergency departments. A positive association was also shown between both task- and employee-oriented behaviours as well as emergency nurses' work satisfaction, while no indication of statistical significance was found between leadership behaviour and emergency department physicians' work satisfaction.

4.3.3 Transformational and transactional leadership with job satisfaction and staff retention

Ghorbanian et al. (2012) surveyed 21 managers and 87 emergency medical technicians employing the multifactor leadership questionnaire (MLQ) (self & rater) and job descriptive index to study the association between managers' leadership styles and emergency staff's job satisfaction in Iran. The findings indicated that the highest mean score for leadership behaviours was related to transformational leadership among both managers and technicians, while a laissez-faire leadership style was related to the lowest mean score. Both transformational and transactional leadership styles showed a significant association with job satisfaction. This is partially consistent with an earlier study done by Raup (2008), who used the multifactor leadership questionnaire (MLQ) to determine the predominant behaviours exercised by nurse leaders in emergency departments and explore leadership's impact on nursing staff turnover and patient satisfaction. The study found that transformational leadership was predominantly used by emergency nurse managers (80%), as validated by their staff. However, the study failed to find significant associations between transformational, transactional and laissez-faire leadership with staff retention and patient satisfaction. Furthermore, these two studies do not show what specific elements of transformational leadership behaviours versus non-transformational are exhibited more by emergency managers. In addition, these studies do not explain why transformational leadership is the predominant style in emergency departments. Moreover, the second study may have lacked a proper research methodology because it could not find a significant relationship between the variables and the response rate was low, which could be as a result of using an online survey.

4.3.4 Summary

Effective leadership behaviours are perceived slightly different in emergency medical departments compared to other critical care settings. Within emergency departments, although transformational leadership, supportive behaviours and empowering are extremely important, task-oriented behaviours along with transactional and directive behaviours are positively connected with both job satisfaction and leadership effectiveness. However, in other critical care settings, transactional, task-oriented leadership behaviours are less effective and may not lead to organisational outcomes such as followers' satisfaction, commitment and performance compared to transformational, people-oriented and participative leadership behaviours. Only one study (Yun et al. 2005) shows the situational factors that determine effective forms of leadership behaviours, but it is restricted to empowering and directive behaviours. It is also noteworthy that managers in emergency departments perceive themselves as transformational rather than transactional leaders, as perceived by their staff (Raup 2008; Ghorbanian et al. 2012). In contrast, critical care nurses perceive their managers as more transactional than transformational leaders (Casida et al. 2012). According to Yukl (2013), the findings from research based on surveys are weak and inconsistent, but a more explicit picture is painted when combined with other methods.

Table 4-4 Summary of research articles

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Abualrub and Alghamdi (2012)	The impact of leadership styles on nurses' 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 intention to stay at work.	Convenience sample of 308 Saudi nurses from six public hospitals in western Saudi Arabia. Response rate was 51.3%.	A quantitative correlational design. The Multifactor Leadership Questionnaire (MLQ-5X), Job Satisfaction Survey (JSS), McCain's Intent to Stay Scale and a demographic form.	Nurses had moderate satisfaction with their jobs. Nurses had a higher level of satisfaction with leaders who demonstrated a transformational leadership style, and those who were more satisfied with their job had a greater intention to stay at work. A transformational leadership style and a transactional style accounted for more than 30% of the discrepancies related to job satisfaction.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Bormann and Abrahamson (2014)	Do Staff Nurses' Perceptions of Nurse Leadership Behaviours Influence Staff Nurses' Job Satisfaction? The Case of a Hospital Applying for Magnet Designation	To examine the relationship between staff nurses' perception of nurse managers' leadership behaviour and staff nurses' job satisfaction in a hospital on the Magnet journey and the influence of nurse managers' leadership styles on staff nurse job satisfaction.	115 staff nurses purposively selected working in a not-for-profit acute care hospital in the southern United States.	A quantitative descriptive and correlational survey method. The Multifactor Leadership Questionnaire (MLQ-5X), Job Descriptive Index (JDI) and a demographic questionnaire.	Managers' transformational and transactional leadership styles had a positive association with followers' job satisfaction and satisfaction with opportunity for promotion. Managers' passive management-by-exception and avoidant leadership styles had a negative association with followers' satisfaction with work, promotion, supervision and co-workers.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Bratt et al. (2000)	Influence of stress and nursing leadership on the job satisfaction of paediatric intensive care unit nurses	To explore factors that influence nurses' job satisfaction, including nurses' attributes, characteristics of the PICU, and nurses' perceptions of the work environment across a multi-institutional population of PICU nurses.	1,973 staff nurses were drawn from 65 paediatric acute care institutions in the United States and Canada. Response rate was 70%.	A quantitative cross-sectional descriptive study. Self-reporting questionnaire. Two measures of satisfaction related to professional job satisfaction and organizational job satisfaction.	Leadership was a strong predictor of work satisfaction. Nurses who perceived their manager exhibiting a participative style had greater job satisfaction than did nurses who had different perceptions. Nursing leadership that is observed to be supportive and providing a cohesive work environment has a positive impact on job satisfaction.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Casida et al. (2012)	Elaboration of Leadership and Culture in High-Performing Nursing Units of Hospitals as Perceived by Staff Nurses	To examine the relationship between leadership, culture and performance.	Purposive sampling. 278 staff nurses, critical care SNs (n =18) and non-critical care SNs (n = 19) units in four acute care hospitals in the northeast region of the United States. Response rate of 69.5 %.	A descriptive, exploratory research design. The Multifactor Leadership Questionnaire (MLQ-5X), the Denison Organizational Culture Survey (DOCS).	Staff nurses rated their leaders lower as TFL leaders in critical care units than those in non-critical units. The critical care staff nurses' ratings of the least favourable components including the passive management-by-exception exhibited by nurse managers were significantly greater than non-critical care staff nurses' ratings. Staff nurses in Magnet hospitals observed their nurse managers as TFL leaders and slightly as transactional leaders, more than their counterparts in non-Magnet hospitals.
DeVivo et al. (2013)	Perceptions of Empowerment Among ED Nurses	To describe the perceptions of empowerment among ED nurses within one large health care system.	Six hospital emergency departments with 240 emergency nurses; 170 (71%) were returned.	A quantitative descriptive study design. Conditions of Work Effectiveness Questionnaire CWEQ-II and a background questionnaire.	A moderate level of empowerment among registered nurses was found.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Ghorbanian et al. (2012)	The relationship between managers' leadership styles and emergency medical technicians' job satisfaction	To explore the relationship between managers' leadership styles and emergency medical technicians' job satisfaction.	21 managers and 87 emergency medical technicians working in 23 locations in Isfahan city, Iran.	A descriptive and cross-sectional study. Multiple Leadership Questionnaire and Job Descriptive Index.	Amongst both managers and technicians, the highest mean score related to a transformational leadership style. Avoidant leadership behaviour had the lowest mean score. A positive association was shown between both transformational, transactional leadership and job satisfaction. A significant correlation between a laissez-faire style and job satisfaction was not found.
Giallonardo et al. (2010)	Authentic leadership of preceptors: predictor of new graduate nurses' work engagement and job satisfaction	To examine the relationships between new graduate nurses' perceptions of preceptor authentic leadership, work engagement and job satisfaction.	170 registered nurses working in an acute care setting, Canada. Random sampling from the College of Nurses of Ontario (CNO) registry list. Response rate of 39%.	A quantitative predictive non-experimental survey design. The Authentic Leadership Questionnaire (ALQ), Utrecht Work Engagement Scale (UWES), part B of the Index of Work Satisfaction scale (IWS), and a demographic questionnaire.	New staff members get involved with preceptors displaying a great amount of authentic leadership. Nurses reported greater engagement and satisfaction with greatly authentic leaders. Authentic leadership influences job satisfaction through work engagement.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Kanste (2008)	The association between leadership behaviour and burnout among nursing personnel in healthcare.	To explore the association between leadership behaviour and burnout among nursing personnel in healthcare.	900 staff nurses and nurse managers were randomly selected from different healthcare institutions across Finland. 660 nurses responded (73%) and 627 were included. 119 nurse managers and 508 staff nurses.	Quantitative correlational study design. Multifactor Leadership Questionnaire (MLQ) and Maslach Burnout Inventory – Human Services Survey (MBI-HSS).	Transformational behaviours and only contingent reward from transactional leadership indicated a positive correlation with personal accomplishment and showed a negative link with emotional exhaustion and depersonalization. Management-by-exception active leadership behaviour might raise personal accomplishment. Passive management-by-exception and laissez-faire leadership were positively associated with emotional exhaustion and depersonalization, and showed a negative link with personal accomplishment.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Lin et al. (2011)	The role of leader behaviours in hospital-based emergency departments' unit performance and employee work satisfaction	To explore how the behaviour of a hospital-based emergency department's (ED's) leader might be related to ED unit performance and ED employees' work satisfaction.	120 hospital emergency departments in Taiwan. 10 in medical centres, 32 in regional hospitals and 70 in district hospitals. Non-proportional probability sampling. 1,344 completed questionnaires.	Quantitative survey design. Three survey questionnaires on leadership, unit performance and employee satisfaction.	Task-oriented behaviour showed a positive association with performance. Task and employee-oriented behaviours reported a positive association with nursing job satisfaction. A significant relationship between leadership behaviours and medical doctors' job satisfaction was not found. Medical doctors' job satisfaction was related to structural aspects such as accreditation.
Loke (2001)	Leadership behaviours: effects on job satisfaction, productivity and organizational commitment	To explore the relationships between five leadership behaviours identified by Kouzes and Posner and the employee outcomes of registered nurses practising in the general wards, intensive care units and coronary care unit in an acute hospital.	Convenience sample of 100 registered nurses and 20 managers from an acute-care tertiary hospital in Singapore. 100% response rate for managers and 97% for employees.	Quantitative descriptive and correlational study. Demographic questionnaire, leadership practice inventory (self & observer), Job-in-General scale (JIG), productivity scale and organizational commitment scale.	Managers perceived themselves highest when enabling others to act, while employees perceived their managers highest when role modelling. Inspiring a shared vision was the least exercised behaviour as indicated by leaders and staff. The results indicate a positive relationship between all transformational factors and staff productivity, job satisfaction and organisational commitment.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Moneke and Umeh (2013)	Factors Influencing Critical Care Nurses' Perceptions of Their Overall Job Satisfaction – An Empirical Study	To explore the factors influencing critical care nurses' perceptions of their overall job satisfaction.	A purposive sample of 204 registered nurses working in critical care units in a public healthcare organisation, New York, the United States. Of 137 respondents, 112 included for final analysis.	A quantitative correlational design. Leadership Practices Inventory, the Organizational Commitment Questionnaire, and the Job in General scale (JIG).	Statistically significant relationships between leadership behaviours and organisational commitment and job satisfaction. A significant link between enabling the heart, organisational commitment and job satisfaction.
Raup (2008)	The Impact of ED Nurse Manager Leadership Style on Staff Nurse Turnover and Patient Satisfaction in Academic Health Centre Hospitals	To determine what types of leadership styles are used by ED nurse managers in academic health centre hospitals and examine their influence on staff nurse turnover and patient satisfaction.	15 managers and 30 nursing staff working in different emergency departments out of 98 potential hospitals. The United States.	A quantitative correlational design. The Multifactor Leadership Questionnaire, a 10-item researcher-administered survey for nurse manager roles, and a demographics survey.	The leadership style mostly used by nurse managers was transformational leadership as perceived by managers and their staff. Statistically significant relationships between leadership behaviours, staff turnover and patient satisfaction were not found.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Salanova et al. (2011)	Linking transformational leadership to nurses' extra-role performance: the mediating role of self-efficacy and work engagement	To examine the relation between supervisors' transformational leadership and staff nurses' extra-role performance as fully mediated by staff nurses' self-efficacy and work engagement.	Convenience sampling of 17 nurse managers and 364 staff nurses. 76.9% response rate for staff and 100% for managers. Portuguese.	A cross-sectional quantitative method. Structural equation modelling was used for data analyses. The Multifactor Leadership Questionnaire, Self-Constructed Scale, Utrecht Work Engagement Scale and four items to measure extra effort.	A complete mediation model whereby transformational leadership explains extra-role performance via self-efficacy and work engagement. An association between transformational leadership and work engagement.
Spence Laschinger et al. (2012)	The influence of authentic leadership on newly graduated nurses' experiences of workplace bullying, burnout and retention outcomes	To test a model linking new graduate nurses' perceptions of their supervisor's authentic leadership behaviours to their experiences of workplace bullying and burnout, and ultimately to job satisfaction and turnover intentions.	342 staff nurses working in acute care hospitals. 38% response rate. Ontario, Canada.	A quantitative cross-sectional design. The Authentic Leadership Questionnaire (ALQ), the Negative Acts Questionnaire (Revised), Maslach Burnout Inventory – General Survey (MBI-GS), (Hackman and Oldham, 1975) job satisfaction scale and Kelloway et al.'s (1999) turnover intentions scale.	Authentic leadership negatively correlated with workplace bullying. Workplace bullying positively correlated with emotional exhaustion. With indirect influence, authentic leadership correlated with job satisfaction via bullying and emotional exhaustion. Authentic leadership, workplace bullying and emotional exhaustion showed significant links with job satisfaction, which correlated to less turnover intentions.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Wang et al. (2012)	Transformational leadership: effect on the job satisfaction of Registered Nurses in a hospital in China	To describe the relationship between the transformational leadership of nurse managers and job satisfaction.	Stratified random sampling of 238 registered nurses working in a tertiary hospital. Response rate of 95.20%. China.	A quantitative descriptive correlation survey. Leadership Practice Inventory, Job Satisfaction Scale and a demographic survey.	Transformational leadership was moderately associated with staff nurses' job satisfaction. Transformational leadership was significantly associated with job satisfaction.
Wong and Laschinger (2013)	Authentic leadership, performance, and job satisfaction: the mediating role of empowerment	To report a study conducted to test a model linking the authentic leadership of managers with nurses' perceptions of structural empowerment, performance and job satisfaction.	Random sample of 600 registered nurses from acute care hospitals. Response rate of 48%. Ontario, Canada.	A quantitative non-experimental, predictive survey. Authentic Leadership Questionnaire, Conditions of Work Effectiveness Questionnaire, Global Job Satisfaction Survey and General Performance scale.	A significant and positive relationship between authentic and staff structural empowerment. Structural empowerment enhanced job satisfaction and self-rated performance.

Author(s) & year	Title	Aim(s) of study	Sample & country	Methods	Major findings
Yun et al. (2005)	Contingent Leadership and Effectiveness of Trauma Resuscitation Teams.	To Investigate the leadership and effectiveness of teams operating in a high-velocity environment, specifically trauma resuscitation teams.	134 staff members working in a Level I trauma centre. 68.7% response rate. United States.	Scenario approach using a confounded factorial design.	Empowering behaviours showed greater effectiveness when there was strong trauma severity with inexperienced team members. Directive behaviours indicated greater effectiveness when there was strong trauma. Directing delivered fewer learning opportunities than empowering.
Zhang et al. (2012)	Transformational leadership in crisis situations: Evidence from the People's Republic of China	To examine the effect of transformational leadership on leadership effectiveness in the context of the 5.12 earthquake that struck China on 12 May 2008	Snowball sampling. 146 groups with 146 leaders and 526 members from hospitals in a disaster area in China. Response rate of 70.5% for subordinates and 78% for leaders.	A quantitative descriptive survey. Different items of surveys were used to measure transformational leadership behaviour Podsakoff et al. (1990), value congruence Posner (1992), leader-member exchange Liden and Maslyn (1998). Emotional control and leadership effectiveness measured using a self-developed questionnaire.	Relationships were found between transformational leadership, value congruence and leadership effectiveness. Possible mediating role of value congruent between leaders and their subordinates in the association between transformational leadership and leadership effectiveness. Significant influences between transformational leadership and leaders' emotional control and the interaction of transformational leadership and leader-member exchange with value congruence.

4.4 Conclusion

While these studies indicate interesting findings regarding leadership behaviours and their relationship to some selected organisational outcomes, generally, in critical care units and particularly in emergency units wherein lies the main focus of my study, researchers have not examined leadership behaviours in much depth. It is still not clear how the leadership phenomenon is understood and practised in such settings, because much of the research to date has been descriptive and correlational in nature. There is also a lack of understanding of leadership processes and dynamics. It seems possible that these results are due to an excessive reliance on quantitative methods. One key drawback of this approach is that leadership surveys have intrinsic limitations (Conger 1998; Berson 1999; Hunt 1999; Antonakis et al. 2003). Yukl (2013) argues that the findings from research based on surveys are weak and inconsistent because this approach fails to take into account both context (Bryman et al. 1996; Osborn et al. 2002) and culture (Hofstede 2001; House et al. 2004; Schein 2010). Most of the studies reviewed were carried out in the United States, Canada, China, and Western Europe, where leadership processes and dynamics are better understood compared to Saudi Arabia, where the current study takes place. Therefore, a study that applies a qualitative approach, which is sensitive to both the context and culture in which leadership is taking place, is needed so as to better understand the orientations and dynamics of leadership behaviours.

Chapter 5 Methodology

5.1 Introduction

This chapter presents arguments to justify the adoption of a constructionist world view and a qualitative approach for the present research, it gives a thorough account of the research steps and procedures. The chapter begins with discussion of the research philosophy and paradigm, identifying researchers' positions with respect to different philosophical assumptions. This is followed by a discussion around the selection of the research design and a semi-structured interview method. The chapter includes a description of the sampling process as well as the steps taken to obtain access and approvals. In addition, this chapter explains the processes followed for a pilot study of the research question protocols, and for the main data-gathering stage. The last two sections of this chapter discuss the techniques used for data analysis and the procedures followed to promote rigour and trustworthiness in the findings.

5.2 Research philosophy and paradigm

A paradigm refers to several fundamental principles which direct the activities of the researcher. It deals with ultimate and primary principles representing beliefs and viewpoints in which the world's characteristics and a person's position within the world are described, while a context regarding the potential links to the world and its divisions is also outlined (Guba and Lincoln 1994; Neuman 2006; Morgan 2007). Weaver and Olson (2006 p460) describe a research paradigm as "patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished". Put simply, a research paradigm defines appropriate methods for undertaking an investigation. It also represents a foundational theory that delineates an investigator's world characteristics, which in turn offers unique ways to understand a particular phenomenon under examination throughout an investigator's interactions within that world. Burrell and Morgan (1979) suggest that a researcher can select a paradigm from several different alternatives that represent the main world views of the scientific community.

Investigators' fundamental beliefs and theoretical orientations shape their perceptions about the natural context of the social world, as well as appropriate means of investigation. To understand these beliefs, assumptions in relation to different essential and interrelated principles, including ontology, epistemology and axiology, must be revealed. These various principles delimit a paradigm. Ontology indicates the nature of the world. Epistemology refers to the acquisition of

knowledge, and what counts as knowledge. Axiology represents the role of values. Since these principles are interrelated, the assumptions revealed concerning a certain principle must be consistent with others. Accordingly, assumptions revealed about these principles guide the investigator's preferences concerning the ways and techniques of producing knowledge (Guba and Lincoln 1994).

Commonly, there are two different key research paradigms, i.e. positivism and constructionism (Guba and Lincoln 1994; Neuman 2006; Creswell 2013). Positivism and constructionism represent divergent world views about the nature of the world. Thus, they incorporate incompatible beliefs with respect to ontology, epistemology and axiology. The next part discusses how to differentiate between different philosophical beliefs and argues for "social constructionism", which is the paradigm employed in this research.

5.2.1 Ontology

Ontology is concerned with two interconnected questions. First, it is concerned with the "nature of reality" (Guba and Lincoln 1994 p108; Creswell 2013 p20). Second, it refers to the investigator's beliefs in relation to how the world works (Guba and Lincoln 1994). It is about defining whether the phenomenon under investigation is independent of our knowledge and perceptions, or if it is dependent on and a result of them. For social reality, there are two key perspectives: realist and relativist (social constructionism) (Morgan 2007).

A realist approach assumes that the world and the social reality exist as external to human actors. In addition, it postulates that reality is independent from cognitive structure. In contrast, a relativist approach posits that the social reality is the product of social actors' perceptions. Relativists suggest that reality is multiple and constrained by the context (Guba and Lincoln 1994; Creswell 2013). That is, as argued by Carsten et al. (2010), reality is neither single nor universal: rather, it is understood through individuals within their social, organisational and cultural environments. People, through their actions and interactions, construct the reality. Unlike a realist view of reality, which aims to be objective, a relativist approach assumes that reality is both subjective and changeable. The relativist approach attempts to understand the process through which reality is constructed.

The current study recognises the impact of the social, organisational and cultural contexts in which this study is being conducted on leadership behaviours. This study seeks to understand how emergency department managers and their staff construct leadership within the context of hospital-based emergency departments and Saudi culture. Additionally, leadership is both a controversial and a socially constructed concept (Carsten et al. 2010; Fairhurst and Grant 2010).

As discussed in the second chapter, the concept of leadership is complex and multifaceted. Moreover, the perceptions of effective leadership are vague and may differ from one culture to another. Thus, the reality depicted in this research cannot be other than subjective.

5.2.2 Epistemology

Epistemology is concerned with the nature of knowledge (Bunniss and Kelly 2010). It focuses on the relationship between the knower and what is known; how the researcher comes to know the reality; the study of knowledge; and what is deemed to be truth regarding attained knowledge (Guba and Lincoln 1994). It, thus, reveals the investigator's beliefs in respect of suitable methods for investigating the world. Positivism and social constructionism, which are sometimes positioned under an interpretive approach or framework by some scholars (Creswell 2013), reflect the philosophy of epistemology. Positivism and social constructionism represent very different viewpoints of epistemology. Put simply, positivism relies on people accepting that there are objective facts about the world. In contrast, social constructionism relies on people accepting that there are no objective facts about the world.

5.2.2.1 Positivism

The positivist approach assumes that knowledge about phenomena under investigation is valid when it can be measured and observed. Researchers who adopt a positivist approach to research endorse a philosophical position in which the reality is independent and objective (Guba and Lincoln 1994; Neuman 2006; Morgan 2007). Thus, objects are assumed to hold stable meanings and these meanings are not dependent on the investigator's perceptions (Crotty 1998). For positivists, facts are viewed from conclusive and accurate perspectives as right or wrong. Knowledge is presented as numbers and figures. Information about phenomena already exists and the responsibility of the researcher is to collect and summarise it. This is because they adopt an objective stance through which positivists are required to isolate their perceptions and values so that they do not influence the object. Thus, a positivist approach is typically associated with quantitative research, since it adopts a rigid form of research enquiry. However, positivists tend to simplify the world by applying inflexible processes that cannot capture its complexity (Crotty 1998). Moreover, Crotty (1998) states that what we experience in day-to-day life varies greatly from the social world seen by people adopting a positivistic approach.

5.2.2.2 Social constructionism

A constructionist world view stands in contrast to a positivist world view in asserting the importance of discovering the subjective meaning of an individual's experience. Researchers

adopting a constructionist approach endorse interactive and subjectivist assumptions (Guba and Lincoln 1994; Schwandt 2007; Creswell 2013). That is, constructionists view knowledge as created in interaction between researcher and research participants, whereby the findings are literally produced through research. Burr (2015 p2) argues that we must be cautious about accepting the idea that "our observations of the world unproblematically yield its nature to us, to challenge the view that conventional knowledge is based upon objective, unbiased observation of the world". Thus, it is difficult to depict the social world without examining the way in which individuals utilise language, symbols and meaning to build social practice (Klenke 2008).

Guba and Lincoln (1989) spell out several key conventions about social constructionism. First, truth involves relative consensus among social actors; truth is not related to objective reality. Second, facts contain no meaning unless they reflect a certain value framework, whereby an objective evaluation of propositions cannot be conducted. Third, causes and effects cannot be established unless they are imputed. Fourth, to understand a phenomenon, it has to be examined within its context. Therefore, findings, problems and solutions generated by constructionist research cannot be generalised from one context to another. Fifth and last, data produced by constructionist research do not hold greater value or power; however, these data only denote an additional construction to be considered in the move toward consensus (Guba and Lincoln 1989). Overall, constructionists perceive the world as multifaceted and interrelated. They assert context sensitivity. The situational and structural aspects of the social world are paid special attention by constructionists so as to understand a phenomenon along with its related complexities in a specific setting (Klenke 2008).

Social constructionists hold that knowledge and reality are socially constructed through human interaction (Berger and Luckmann 1966; Burr 2015). Concepts are created, not discovered. Social processes define the reality, which reflects subjective experience of day-to-day life (Andrews 2012). People define the reality which makes sense to them.

Crotty (1998) suggests that constructionist enquiry examines the way in which behaviours are formed and assumes knowledge and meanings are contextually constructed by social actors. Burr (2015) suggests that knowledge is maintained through social processes and such knowledge calls for various types of social actions (Burr 2015). Burr (2015) maintains that history and culture shape peoples' knowledge and common understanding of the world, as well as the concepts they use. Furthermore, knowledge is not only the product of particular history and culture but also reflects specific social as well as economic strategies that predominate in a specific period of time. Social constructionists suggest that knowledge is maintained through everyday interactions between people during social life, in which collective forms of knowledge and understanding

come to be constructed (Burr 2015). Knowledge is sustained and transmitted through language, which is of importance to social constructionists. Knowledge pertaining to a particular culture guides people's actions to counter social events (Burr 2015).

In line with the discussion above, Berger and Luckmann (1966) note that knowledge is constructed by human interactions within society, and this gives it significance for that society. They argue that the distribution of the workforce, the rise of further complex shapes of knowledge and financial overflow, which refers to the profit on production capital invested, bring about expert knowledge. This expert knowledge is developed by individuals who completely dedicate their efforts to this subject matter. Consequently, these experts demand a unique position and full authority in relation to that knowledge.

Berger and Luckmann (1966) assume that society exists as both objective and subjective reality. On the one hand, objective reality emerges through the interaction of individuals with the surrounding socio-cultural environment. Consequently, this socio-cultural environment influences people and leads to routinisation and habitualisation (Andrews 2012). Thus, repeated social behaviours form patterns and are recreated with less effort. Over time, the meanings of habitual actions are strongly fixed in the social world and come to be regular practices which create a general "stock of knowledge" (Berger and Luckmann 1966; Andrews 2012). This is then institutionalised and legitimised by society. Coming generations see this knowledge as objective, though it is constantly reconstructed through people's interactions with each other (Andrews 2012).

On the other hand, society encounters subjective reality through socialisation processes. Socialisation processes are twofold: primary and secondary (Berger and Luckmann 1966). Primary socialisation takes place during childhood, while secondary socialisation occurs due to the division of labour and related social distribution of knowledge in which sub-worlds may emerge (Berger and Luckmann 1966). The socialisation process happens through significant others, which refers to important individuals in one's life, whereby an individual is given an identity and a position in the social world (Burr 2015). The objective reality of a particular social world is facilitated by significant others, who give it meaning as well as make it significant for people living in that social world, which in this process, people internalise the objective reality of the social world (Berger and Luckmann 1966; Andrews 2012). This socialisation process is achieved by means of language (Berger and Luckmann 1966; Burr 2015). Berger and Luckmann (1966) argue that language is key for sustaining, changing and restructuring the subjective reality, which involves thoughts and notions that can be easily transmitted to other people. Thus, this reality is generally taken for

granted because these notions becomes shared and are not required to be defined whenever applied during day-to-day communication (Andrews 2012).

Constructionist enquiry can inform leadership research well because leadership is deemed to be socially constructed phenomenon (Conger 1998). Accordingly, the current research considers the world as complex, dependent and subjective. This research attempts to discover the subjective meaning of an individual's experience as it is lived and assessed by social actors. Thus, this research adopts a constructionist worldview.

To clarify the researcher's position, the researcher accepts and follows the basic axiom of Berger and Luckmann (1966). Berger and Luckmann (1966) argue that societal, structural and institutional facets of the world are constructed by people's interpretative and cognitive structure. It is, thus, of importance to acknowledge the underlying structures in constructing the reality. In line with this argument, the current research question asks: "How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?" The research question focuses on identifying leadership behaviours as well as examining contextual and cultural facets that may produce particular conceptualisations. Therefore, the research question considers the context as secondary to the individual's cognition and meanings, and related to rather than detached from reality. In the current research, leadership is seen as a situated concept. To illustrate, social interpretations of leadership acts depend heavily on the situational circumstances surrounding those acts. Social constructionists tend to examine leadership from an attributional perspective and from the viewpoints of individuals who practise it (Fairhurst and Grant 2010). Grint (2000 p3) highlights that "what counts as a situation and what counts as the appropriate way of leading in that situation are interpretive and contestable issues, not issues that can be decided by objective criteria". Therefore, the researcher considers social constructionism to be an appropriate paradigm that fits well with the characteristics of the leadership concept being studied.

5.2.3 Axiology

Axiology represents research values and ethics (Klenke 2008). Positivists seek value-free and unbiased research since they avoid being connected with the phenomenon being investigated. Positivists seek to discover causal links, relationships among variables and to follow a systematic process of observation (Neuman 2006). However, constructionists admit that their research is value-laden and involves considerable values; researchers interact with the matter being studied (Creswell 2013). Constructionists seek to explore the subjective meanings of social behaviours and meanings, which are socially created based on relative value (Neuman 2006).

The axiology in this research is value-laden. The study aims to understand how different leadership behaviours of emergency departments' managers are conceptualised and operationalised through the lens of emergency departments' managers, as well as by their staff, who are social actors as they experience as well as construct leadership. Accordingly, it is of importance to consider participants' views, conceptualisations as well as resultant behaviours, since they construct and form the leadership concept. For that reason, this research will pay attention to the interplay between the researcher and the study's participants. In the present study, the investigator plays a role in the process of the study. The researcher's involvement in the investigation process is key for understanding and interpreting leadership behaviours of emergency departments' managers in a society, which is the Saudi Arabian cultural context (Burr 2015).

5.2.4 Methodology

The last question to be addressed in relation to the research philosophy and paradigms is concerned with methodology. Methodological questions focus on the most appropriate methods for obtaining knowledge about the world (Denzin and Lincoln 2011; Creswell 2013): how the researcher can generate data in respect to the social realm (Guba and Lincoln 1994). The answer to how the researcher can acquire knowledge of the external world is constrained by ontological, epistemological and axiological assumptions. Methodology, thus, refers to the selection of appropriate research methods, which should be compatible with the previous responses given by the researcher in relation to ontological, epistemological and axiological assumptions (Denzin and Lincoln 2003).

The type of knowledge to be obtained influences the selection of methodology. According to Burrell and Morgan (1979), it is necessary to be close to the matter being investigated so that the social world can be understood. Therefore, the methods selected must permit the subject under investigation to disclose its nature throughout the investigation process. It is argued that a qualitative methodology permits the researcher to draw near to the subject being investigated; it allows the researcher to gain rich knowledge about the subject matter (Klenke 2008). Burr (2015) suggests that qualitative methods are a rational and suitable means for constructionists because constructionism emphasises the social meanings of accounts. Moreover, because constructionists agree on the constructive force of language, interviews are proposed as qualitative research methods for collecting data as they enable the researcher to analyse interview transcripts and record naturally-occurring conversations (Burr 2015).

5.3 Research design

According to Creswell (2009 p3), research design refers to "the plan and procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis". Research design involve various decisions that are informed by the researcher's worldview assumptions. It involves interpretations of procedures along with data collection and analysis methods, which turn these methods into practices (Creswell 2009).

5.3.1 Objectives

The research design used in the present study seeks to obtain the following key objectives:

1. To examine individual participants' thoughts and views in order to identify, describe and explain leadership behaviours exercised by managers in hospital emergency departments;
2. To compare and contrast participants' accounts of different leadership behaviours;
3. To identify shared patterns across different participants' accounts;
4. To identify contextual and cultural factors that influence leadership behaviours.

5.3.2 Qualitative approach

The selection of the methodology is determined by the sort of knowledge required. Thus, the selection of methodology was guided by what has been argued above regarding ontology, epistemology and axiology. Silverman (2013) maintains that research can be defined in a broad sense as qualitative or quantitative, or in a narrower sense as phenomenology, a case study or grounded theory, among other things. In line with the philosophical and methodological stance of this study, the present study adopts a generic qualitative approach (Merriam 1998). A generic qualitative approach can be described as "those that epitomize the characteristics of qualitative research but rather than focusing on culture as does ethnography, or the building of theory as does grounded theory" (Caelli et al. 2003 p2). Merriam (1998 p11) maintains that researchers who engage in generic qualitative research, "simply seek to discover and understand a phenomenon, a process, or the perspectives and worldviews of the people involved".

Several definitions have been proposed for qualitative research. Strauss and Corbin (1990) broadly define qualitative enquiry as an approach that does not involve any type of statistical and numerical methods to generate data. Denzin and Lincoln (2011) maintain that qualitative research is naturalistic and interpretive enquiry in which the social realm is turned into several representations in order to increase its visibility by using research methods such as interviewing. A further definition of a qualitative approach is given by Creswell (2013), who describes it as a means to examine and understand the meanings people ascribe to problems. Qualitative

investigators use emerging approaches to enquire into and investigate problems. Data are collected in natural settings that are sensitive to individuals as well as the contexts being studied. Data are analysed inductively to find patterns or themes. The closing written report includes the participants' expressions, the researcher's reflections and detailed depictions of the issue being investigated. It also indicates the way in which the study contributes to the current field of knowledge (Creswell 2013).

Quantitative methods, including surveys, correlational and experimental research studies, have dominated leadership research over the last few decades (Lowe and Gardner 2000; Gardner et al. 2010; Mumford 2011). These methods provide opportunities for examining current leadership models and are particularly useful for testing hypotheses with large samples, which allows the development of causal links as well as replicability across settings (e.g. Tosi et al. 2004; Lyons and Schneider 2009). Nevertheless, on their own, they are poorly suited to investigate contextualised understandings, multi-level perspectives and cultural influences because of their inherent limitation of seeking to understand that meanings individuals, leaders and followers, ascribe to significant incidents in their lives, as well as success or failure in their organisations (Klenke 2008; Stentz et al. 2012).

Both context (Bryman et al. 1996) and culture (Schein 2010; Yukl 2013) are essential aspects when studying leadership, and these have received comparatively less attention from quantitative researchers. Thus, several leadership scholars (Bryman et al. 1996; Conger 1998; Bryman 2004; Parry et al. 2014) have called for the application of qualitative research methods to better understand the complexity of leadership and make more sense of quantitative research findings, because such methods provide opportunities to explore and understand the impact of context-specific forces (Parry et al. 2014). Bryman (2004), Yukl (2013) and Parry et al. (2014) argue that qualitative research methods are practically useful in understanding leadership processes and dynamics because they offer a detailed sense of the context that Influences leaders' behaviours.

The use of qualitative methodology is seen as appropriate for the present research on leadership for a number of reasons. First, it is sensitive to the context in which the phenomenon (leadership) occurs. Second, it gives an opportunity to discover processes that people experience and thus to reveal the thoughts and behaviours influencing their responses. Finally, qualitative research enables theory-building, because existing models and theories may be inadequate for the population and sample in this study, and they may also not capture the complexity of the leadership phenomenon being examined.

The literature reveals a need for a qualitative approach that provides participants with ways to talk about perceptions and opinions, as well as reflect upon their work experience, unlike

quantitative survey methods, which make people respond to fixed items. A qualitative approach produces insights based on individuals' understandings and perspectives, which can complement and illuminate previous findings of quantitative research. Pope and Mays (2006) and Miles et al. (2014) contend that qualitative findings are useful to supplement and validate previous quantitative research.

5.3.3 Whose voices should be heard?

The target population is managers and clinical staff working in hospital emergency departments in Saudi Arabia. It was necessary to select samples from a number of different operational groups to represent the population of emergency departments in Saudi Arabia, and thus obtain multiple perspectives on the meanings and contextual influences of leadership behaviours. Hence, the following three groups were selected: managers, physicians and staff nurses. This was also done to include various types of participants and embody different backgrounds and experiences concerning nationality, gender, professional role, position and workplace. Further, the diversity of sampling groups was anticipated to enhance assurance in the results generated by qualitative research, because this reinforces precision, validity, stability and trustworthiness (Miles et al. 2014).

In this research, four methodological decisions were taken in order to answer the research question: "How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?" The first concerned the selection of a qualitative design to explore and understand the area of interest. The second was the adoption of semi-structured interviews as a method for data collection. The third was the selection of a purposive sampling method for identifying research informants. The fourth was the selection of thematic techniques to analyse the data.

5.3.4 Interviewing

Qualitative interviewing methods provide participants with opportunities to talk so that the researcher can obtain their views on the concepts being studied. Bryman et al. (1996) argue that interviewing is a key instrument for data collection in qualitative leadership research when a study seeks to explore leadership practices and orientations through inviting leaders or individuals to discuss them. Qualitative interviewing was of interest because it delineates the context of behaviours and provides an opportunity to explain the meanings of those behaviours (Seidman 1998).

A face-to-face (FTF) technique was used to interview research participants. This technique is typically seen as the "quintessence" of qualitative research (Klenke 2008). Seymour (2001) argues that the face-to-face interview is generally perceived to be an appropriate technique to get actively involved with informants in a way that reduces the gap between researcher and participants, and thus increase the efficiency and quality of data-collection activities.

The type of interview method determines the time and freedom given to informants to talk about experiences and opinions during the interview process. In qualitative research, there are three types of interviews: unstructured, semi-structured and structured, which exist on a single continuum (Klenke 2008). In an unstructured interview, a wide subject can be introduced by the investigator, who neither guides nor restricts the discourse but instead gives informants the freedom to speak. While in a structured interview, the investigator guides the interview since there are certain topics and questions to be explored throughout it. Therefore, semi-structured interviews, which sit along this continuum, covering concepts derived from the literature, are a suitable type of interview technique. According to Bryman (2004), semi-structured interviews are the main technique used for data collection in qualitative leadership research. Semi-structured interviews ensure that data gathered would align with the research question (Britten 1995). Britten (1995) also asserts that it is profoundly important for researchers to be open to new concepts and thoughts, which could not have been expected at the beginning of the research.

Semi-structured interviews are employed to obtain answers to known questions (Morse and Field 1996). The present research aimed to attain knowledge based on informants' perceptions and understandings. This was needed to help the researcher build up an understanding of what different forms of leadership behaviours might mean to the participants. A semi-structured technique, whereby open-ended and close-ended questions are combined, offers greater flexibility to a researcher seeking to probe, rephrase and add extra questions when needed to obtain useful and relevant data (Parker 2005).

5.4 Setting

5.4.1 Study settings

The study was carried out in three different urban cities in Saudi Arabia: Riyadh, Qassim and Hai'l. Riyadh is the capital city of Saudi Arabia, with a population of more than five million. Riyadh contains the largest number of hospitals in the kingdom, including 47 governmental hospitals. Qassim is a city located in the centre of Saudi Arabia, northwest of Riyadh and bordered by Hai'l Region to the north, with a population of around one million people. Qassim has 18 governmental

hospitals. Hai'l is the largest city in the northern part of Saudi Arabia and has a population of more than six hundred thousand. Hai'l has 11 governmental hospitals. Hail is the city where the researcher resides and works. The selection of different cities is anticipated to add confidence to the findings because it allows comparing and contrasting cases, which reinforces the conceptual soundness of the research and increases the confidence that the emerging theory is generic (Miles et al. 2014).

5.5 Sampling strategy

The sample size is generally small in a qualitative enquiry, since the aim of qualitative research is to understand rather than generalise (Creswell 2013; Miles et al. 2014). Miles et al. (2014) recommend that boundaries should be established to define what needs to be investigated, considering the constraints imposed by resources and the time-frame, as well as to construct a framework for revealing and approving basic processes of the investigation.

5.5.1 Selection of hospitals

The Ministry of Health Annual Statistics Book for 2014 reports the numbers of hospitals in the MOH, other-governmental and private sectors as 270, 42 and 141, respectively (Ministry of Health 2014). Therefore, the selection of hospitals was based on a purposive sampling technique to make sure that the selected institutions were within the following frame of inclusion and exclusion criteria:

5.5.2 Inclusion criteria

- Governmental hospitals belonging to the Ministry of Health (MOH), which are accessible to the whole population;
- Hospitals that offer all types of emergency care (e.g. for minor and major injuries);
- Hospitals with an adult emergency department;
- Hospitals with a bed capacity of 250 or more;
- Hospitals located in urban areas.

5.5.3 Exclusion criteria

- Hospitals that provide only emergency care for patients with minor injuries;
- Other governmental hospitals which provide emergency care for a specific population, e.g. military hospitals;

- Hospitals with a bed capacity of less than 250;
- Private hospitals.

The inclusion and exclusion criteria were set out to guide the selection of hospitals based on the research question: "How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?" Governmental hospitals are included to meet the aim of the research question, which is concerned with public hospitals that are accessible to all people. To guarantee that the hospitals selected were located in urban areas, it was necessary to include hospitals that offer all types of emergency care and have a minimum 250-bed capacity. For local sociocultural reasons, it was important to ensure that the selected hospitals had an adult emergency department that was accessible to men; it would be difficult for the researcher to gain entry to independent paediatric or female-emergency departments.

In light of the inclusion and exclusion criteria and for convenience of access, five out of 270 governmental hospitals (Ministry of Health 2014) in Saudi Arabia were selected. These hospitals are: 1) King Fahad Medical City, Riyadh (governmental hospital), 2) King Saud Medical City, Riyadh (governmental hospital), 3) King Fahad Specialist Hospital, Buraidah, Qassim (governmental hospital), 4) King Saud Hospital, Unizah, Qassim (governmental hospital) and 5) King Khalid Hospital, Hail (governmental hospital).

5.5.4 Target population

Morse and Field (1996) suggest that sampling determination in qualitative enquiries relies on a number of criteria. These include the identification of informants who are able to report and contribute well to the investigation, as well as the selection of adequate numbers of informants so that the researcher can build complex understandings of the subject matter being investigated. The study sample, therefore, included both managers and their staff. Heads of emergency departments, deputies in emergency departments and head nurses were selected to represent leaders. Meanwhile, physicians and registered nurses were selected to represent emergency-department staff. Six participants were selected from each setting (Table 5-1). The participants in each setting included the head of department, a deputy in the department, the head nurse, a physician and two staff nurses. Males usually dominate managerial positions in Saudi Arabia. The sample included both Saudi and non-Saudi staff who occupy managerial, medical and nursing roles in emergency departments, as shown in the demographic characteristics of the participants (Table 5-2). As inclusion criteria, managers had to have had at least six months' experience of working in an emergency department, while ED staff had to have had three years' working

experience and at least six months experience in their present emergency department to ensure they had adequate experience to reflect upon in order to obtain meaningful data.

Table 5-1 Study sample

Sampling group	KFMC-R[4]	KSMC-R[5]	KFSH-Q[6]	KSH-Q[7]	KKH-H[8]	Total	Male	Female
Heads of ED	1	1	1	1	1	5	5	0
Deputies in ED	1	1	1	1	1	5	5	0
Head nurses	1	1	1	1	1	5	4	1
Physicians	1	1	1	1	1	5	5	0
Staff nurses	2	2	2	2	2	10	1	9
Total	6	6	6	6	6	30	20	10

Table 5-2 Demographic characteristics of participants

Nationality	ED Head	ED deputy	Head nurse	Physician	Nurse	Number	Male	Female
Saudi	2	3	3	1	2	11	9	2
Egyptian	3	1	0	2	0	6	6	0
Filipino	0	0	1	0	8	9	1	8
Pakistani	0	0	0	1	0	1	1	0
Jordanian	0	0	1	1	0	2	2	0
Indian	0	1	0	0	0	1	1	0
Total	5	5	5	5	10	30	20	10

[4] King Fahad Medical City in Riyadh
[5] King Saud Medical City in Riyadh
[6] King Fahad Specialist Hospital in Qassim
[7] King Saud Hospital in Qassim
[8] King Khalid Hospital in Hai'l

5.6 Access and permissions

5.6.1 Identification of ethical issues

Field research is subject to approval by an institutional review board in order to make certain that the researcher adheres to ethical principles (Klenke 2008). These mainly involve obtaining ethics approval from professional or academic institutions grounded in principles of informed consent, voluntary participation, confidentiality and anonymity, protection from harm, and maintenance of the well-being of participants. Therefore, ethical approvals for this study were requested from the Faculty of Health Sciences Ethics Committee at the University of Southampton and the institutional review boards at all the selected hospitals in Saudi Arabia in order to gain access.

A study of leadership behaviours has to take into account the sensitivity of the topic, since it may induce powerful emotional responses when talking about kinds of destructive leadership behaviours. The researcher sought to ensure the psychological well-being of the informants by referring them to available sources for professional assistance if needed. Another issue is that it may affect the relationship between staff and leaders who participate if participants' answers are revealed. Therefore, staff who would be asked about their managers' leadership behaviours were clearly advised that their answers would be kept private in order to protect their data and thus minimise the effects of participation. Moreover, they were assured that their answers would not be talked about or discussed with managerial staff.

Before commencing the work, as discussed earlier, there was a need to obtain ethical approval from various institutions. It was necessary to get ethical approval from the Faculty of Health Sciences Ethics Committee at the University of Southampton. The process of getting the study approved by such a committee requires the researcher to provide a comprehensive research proposal that contains an outline of the study, the conceptual framework, a brief literature review, the methodology and a timeline for the project. It was also necessary to attach various forms, such as a participants' information sheet and a consent form to get ethical approval. An application was then made for ethical approval. This approval was granted by the University of Southampton Faculty of Health Sciences Ethics Committee on 25 March 2015 (Appendix E).

5.6.2 Consent

All participants in this study were given a participants' information sheet (Appendix F). Every participant was given an informed consent form to sign before taking part in an interview (Appendix G). The participants' information sheet and informed consent form covered the research's purpose, the research procedure and the right to drop out from the research project

without penalty or loss of benefits. The researcher made sure that every participant had read and understood them before signing a consent form and conducting the interview.

5.6.3 Confidentiality and anonymity

A number of procedures were followed to protect the participants' confidentiality and anonymity, although complete anonymity could not be guaranteed (Lincoln and Guba 1989). The names of individual participants were not recorded during the interviews. Data transcripts use pseudonyms so that participants cannot easily be personally identified. The names of the hospitals are not mentioned in any way that makes them identifiable. In Saudi Arabia, there are many other hospitals similar to those included in this study, which thus helps to maintain confidentiality and anonymity for both hospitals and informants. A coding scheme including alphabetical and numerical codes was developed to allow the researcher to link individuals to their corresponding data sets.

5.6.4 Gaining access to selected hospitals

Upon arrival in Saudi Arabia on 1 May 2015, the researcher set up lines of communication and made introductory visits to the prospective hospitals. This was undertaken to establish a rapport and identify the formal requirements to undertake research in these institutions. It was found that the researcher had to apply for ethical approval from the Saudi Ministry of Health, since all the hospitals are governmental ones. However, King Fahad Medical City in Riyadh is the only governmental hospital that has its own ethics research committee.

Consequently, the researcher had to employ two strategies in order to access the selected institutions for research purposes: First, start a communication process with the Ministry of Health to apply for ethical approval; at the same time, the researcher needed to apply for ethical approval from King Fahad Medical City. Obtaining permission from the Ministry of Health took around four weeks. Written permission to access each hospital was eventually granted (Appendix H).

5.6.5 Approaching selected hospitals

The researcher organised second visits to all the prospective hospitals after obtaining the official approvals needed for admission and then started the selection of research informants. The researcher met several people in every hospital, such as the director of the continuous education department, the director of the research department, the medical director and the head of the emergency department, who were approachable as well as helpful. In each hospital, a coordinator

was appointed in order to assist in reaching possible informants and undertaking interviews. A list of the medical workforce, including physicians and nurses, was delivered by the coordinator to the researcher. The selection of physicians and staff nurses in every department was based on work experience. According to the inclusion criteria, physicians and staff nurses had to have three years' working experience, with at least six months in their current emergency department. For the researcher's convenience and safety, staff working a morning shift were recruited for the study. The selection of a morning shift ensures the availability of emergency department managers. Also, all the managerial departments in a hospital work during the morning shift, which increases the researcher's safety if something goes wrong during interviews. All the prospective informants at the different hospitals were given complete freedom to either participate in or withdraw from the study. Initial communication with prospective informants was made by the coordinator, who informed them about the forthcoming investigation and provided them with a participant information sheet. When prospective informants agreed to participate in the study, interview appointments were arranged.

5.7 Interview protocol

An interview protocol includes various questions to be explored throughout the meeting time (Klenke 2008). It offers some structure as the researcher develops his/her questions and sequences of questions, as well as making decisions about which to pursue in more detail in the interview (Patton 2002). An interview protocol was designed to elicit information in relation to topics around the concept of leadership behaviours. The interview protocol included several open-ended questions aiming to identify informants' perspectives on leadership orientations, contextual factors influencing leadership behaviours, effective and ineffective leadership behaviours, facilitators of and barriers to effective leadership behaviours, relationships between managers and their staff, and motivational factors.

Probing is a technique used to clarify and gain more details, especially when the researcher is attempting to understand the meaning that participants ascribe to an original question (Klenke 2008). Therefore, the researcher employed further prompts to motivate informants to speak and give additional clarifications. The researcher also organised the questions in a rational array. Informants were questioned by employing nearly similar expressions. The interview protocol was slightly modified to fit with the specific experiences of different informants. Interview protocols were designed in both English and Arabic, as well as utilising easy expressions that fit with every type of informant (Appendix I).

As part of developing a rapport, the interviewer started each interview by thanking the participants for agreeing to take part in the research and briefly explained the nature and aim of the research, as well as asking the participant if they needed additional information. Then, each interviewee was asked a few questions, such as “Tell me about your yourself”, to encourage them to open up and talk (Klenke 2008). To limit social desirability affecting participant’s answers, they were asked questions about leadership practices in general terms, such as “Can you tell me about leadership approaches? What leadership behaviours and strategies are used in this department?” or “Can you think of a time when you wish a manager had used a different leadership behaviour?” During the course of the interviews, interviewees were encouraged to give examples of incidents that occurred in their departments so as to obtain a better understanding and increase the credibility of their responses.

5.8 Pilot study

A pilot study was undertaken in Hail General Hospital from 10–21 May 2015 to obtain information, improve the project and assess its feasibility (Polit et al. 2001). The pilot study was used to pre-test and evaluate the interview questions and processes, including their clarity and timing. The study included a convenience sample of five participants: the head of the emergency department, two physicians, the head nurse and one staff nurse. Participants’ information sheets were distributed and given to potential participants. The participants’ information sheet given to the prospective informants included information about the study’s purpose, the informant’s right to participate or withdraw from the study at any point of time, and confidentiality. Participants were requested to sign an informed consent form prior to conducting the interviews. Interviews were conducted at their facility during working hours, at the participants’ convenience. At the end of every interview, the researcher asked the participant about the interview process and the clarity of the research questions.

The pilot study provided the researcher with an opportunity to generally evaluate the interview process, review and refine the questions included in the interview protocols. Moreover, participants’ answers were evaluated so that the researcher could make sure that the collected data addressed the research aim, objectives and question. Thus, this small-scale study allowed the researcher to modify, reorder and refine the questions involved in the interview protocols, so that informants could clearly comprehend the questions when undertaking the main investigation. For instance, two questions about participants’ definition of leadership were combined and a new better understood question was formulated. The pilot study indicated that senior managers take more time during interviews than staff. Managers often took an average of one hour and a half while staff took about one hour. This might be attributed to the greater experience that managers

have. The pilot study was an opportunity for the researcher to practise his interviewing skills as well as to increase his self-assurance in advance of undertaking the main investigation.

5.9 Data collection

The main data-collection phase, which consisted of 30 interviews, took place between 21 June and 20 September 2015. A total of 30 interviews were conducted. All hospitals provided the researcher with a private venue to undertake prearranged meetings with informants to ensure privacy and reduce interruptions. Meetings were scheduled based on informants' working circumstances. One to two interviews were planned per day. All fieldwork was undertaken on weekdays only. As the study took place in Saudi Arabia, weekdays start on Sunday and end on Thursday.

Since all interviews were undertaken by the investigator, it was important to create a relaxed atmosphere for the informants and encourage them to speak freely. Hence, the interviews were undertaken in their organisational settings, in a private place familiar to them. The investigator made sure to stress participant's confidentiality, preserve a friendly style and establish a relationship. In order to create a comfortable environment and make a connection, in every meeting, the investigator attempted to arrange the seating to avoid any object, e.g. a table, being in the middle between the investigator and the informant. Informants could have coffee, tea and/or a bottle of water if they wished. Prior to the start of each interview, the investigator asked the informant whether s/he was ready for the interview. The invistigator greeted and expressed his gratitude to every informant for taking part in this research. Almost everyone appeared lively throughout the interviews and gave an importance to the subject matter being debated. Overall, the informants showed collaboration and provided rich and interesting information.

Participants were requested to write their names and sign and date a consent form before starting the interviews. The researcher made sure that every participant had enough time to read the participants' information sheets and were encouraged to ask questions. The researcher also prompted the informants to ask for an explanation when any question was not well understood. Participants' names were not recorded before or during the interviews.

The researcher attempted to ask questions according to the prearranged protocol and to commit to the timeframe set for each meeting. Expressions and terms used for the questions during interviews were similar only if the informants came from a similar group e.g. managers or staff. However, the sequence of questions was flexible so that the researcher could probe informant's answers. The researcher attempted to keep the discussion informal in order to prompt the study informants to speak freely. The investigator used several probing questions during the interviews,

including “Can you please tell me more”, “Can you please explain” as well as “Please give an example”. These different probing questions were employed as a technique to prompt informants to give more details on a particular question or topic.

Most of the interviews lasted between 60 and 90 minutes on average. Managers tended to take more time than physicians and staff nurses during the interviews. This could be because managers tend to give further details when they talk about issues they have encountered in their work experiences. Managers typically have more experience and can elaborate and explain how they do things. When each interview was completed, the researcher expressed thanks to the informant for participating in this study.

Interviews were conducted and transcribed in either Arabic or English. To illustrate, interviews were undertaken in Arabic when the participant’s native language was Arabic, while participants who do not speak Arabic were interviewed in English. Arabic is the first language for most of the interviewees and the researcher. The researcher conducted only one interview with each informant. Each meeting was digitally recorded. The recording device used in the interviews caused the informants neither to hesitate nor be distracted. An audio-recorder might inhibit participants’ readiness to talk comfortably, which is a reported drawback of using a tape-recorder. The researcher, however, did not notice any problems relating to the audio-recorder. Rather, informants talked spontaneously and paid no attention to the recording device, though they occasionally mentioned names during the interviews in spite of continuous reminders.

5.10 Data analysis

Qualitative approaches have significant overlaps in terms of procedures and techniques (Holloway and Todres 2003; Guest et al. 2012). A wide-ranging philosophy such as person-centeredness and a certain open-ended starting point are shared in these methodologies. In general, a critical position towards positivist standpoints is held by researchers who use qualitative methodologies to look for meaning in the accounts and/or actions of participants. This is because of their disappointment with quantitative methodologies, which fail to capture the experiences and perspectives of participants whose lives, behaviours, thoughts and feelings are being examined (Holloway and Todres 2003). Moreover, qualitative researchers have a mutual concern and consideration for the different types of contexts in which research is carried out.

5.10.1 Thematic analysis

Thematic analysis is seen as the basis of qualitative analysis (Braun and Clarke 2006). Braun and Clarke (2006 P79) define thematic analysis as “a method for identifying, analysing, and reporting

patterns (themes) within [the] data, it minimally organises and describes data sets in [rich] detail". The advantage of using thematic analysis is its flexibility, which stems from its theoretical freedom, permitting it to be applied across diverse theoretical and epistemological approaches. Braun and Clarke (2006) argue that thematic analysis can be seen as a method in its own right.

5.10.2 Deductive vs inductive thematic analysis

There are two key methods to identify themes or patterns in thematic analysis, inductive and deductive. An inductive method indicates that the identified concepts have an extreme relationship with the data generated (Patton 1990). The inductive procedure has a connection with grounded theory. An inductive analysis entails the way in which data are coded without adapting these codes into a predetermined conceptual framework. It also involves no attempt to adjust the emergent codes to suit the investigator's analytical interests. Thus, inductive data analysis can be described as data-driven. In contrast, deductive analysis deals with themes that fit into a predetermined theoretical framework or the researcher's analytical interests. This form is then analyst-driven. In addition, a deductive form of thematic analysis is inflexible since it provides fewer opportunities for the researcher to move beyond the pre-existing theoretical framework. In this research, an inductive approach was employed as it offers the flexibility needed to provide rich descriptions of the data, and thus helps the researcher builds up an understanding of the phenomena being examined, based on participants' experience (Lodico et al. 2006).

5.10.3 Processes of inductive analysis

The analysis of the qualitative data gathered started with data generation and continued throughout the period of the research. A thematic analytical technique entails several steps, encompassing transcribing data, reading transcripts several times to obtain initial knowledge about the data, producing preliminary codes, extracting themes, revising themes, determining and labelling themes, and lastly writing up the paper (Braun and Clarke 2006). Texts were analysed as a proxy for individuals' experiences of behaviours, as represented in the texts, which were generated by personal interaction with the research participants (Guest et al. 2012). The analysis also involved constantly moving backwards and forwards through the entire data set, coded extracts of the data and analyses of the data produced.

5.10.3.1 Step one: becoming familiar with the data

Data were collected through audiotaped, face-to-face semi-structured interviews. This provided the researcher with prior knowledge of the data gathered. Braun and Clarke (2006) suggest that

the researcher immerse him/herself in the data to acquire a comprehensive understanding of the entire data set. And the entire data set was read prior to coding. Then, repeated reading of the data was undertaken to search for meanings and patterns.

Transcription of verbal data

Data collected from interviews were personally transcribed to support thematic analysis. The transcription of the interviews started after the beginning of the data collection and was completed a few months later, after the end of the data-gathering period. While the process of transcription is time-consuming and frustrating, it is a significant method to start familiarising oneself with the data (Riessman 1993; Bird 2005). Careful attention was paid during the transcription process to ensuring a rigorous and thorough account of all verbal utterances. There were some occasions on which some spoken words were not recognised, in spite of moving backwards and forwards to listen repeatedly to and recognise them. These were put in brackets in order to be able to go back and listen to them again. Overall, the transcription process gave an initial detailed understanding of the data gathered.

5.10.3.2 Step two: generating initial codes

This stage started after reading the transcripts to gain a thorough understanding in respect to the knowledge and concepts that the data might generate. This step included the production of initial codes. Boyatzis (1998 p63) describes coding as “the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon”. Codes were used to organise the data into meaningful groups (Tuckett 2005). Therefore, each interview was carefully read, line by line, in order to identify codes (Appendix J). The content of the entire data set was coded using highlighters, with notes written on the texts. Codes were identified based on the texts, which means the texts themselves influenced the coding scheme (Appendix K). Each code identified was then defined based on its meaning in the text (Appendix L). Codes were organised in alphabetical order to simplify the refining process. The coding process involved identifying as many codes as possible. This was undertaken to ensure the codes identified were comprehensive. Furthermore, a table was created for each interview in order to make consistent comparisons. Each transcript was compared with previous transcripts and the entire data set to highlight the similarities and differences between each one, and to recognise new codes. All repeated pattern ‘codes’ in more than one interview and across the entire data set were collated together in a categorisation process (Appendix M).

5.10.3.3 Step three: Searching for themes

This stage started after coding and collating the entire data set. An extended list containing all the various codes found through the whole data set was created. The categorisation process involved organising these varying codes into possible thematic frames, as well as grouping all related codes and quotations to each characterised theme (Braun and Clarke 2006). A table was then created in order to gather all similar codes together. This allowed moving codes in order to sort them into overarching themes. At the end of this stage, several candidate themes and sub-themes were identified.

5.10.3.4 Step four: Reviewing themes

This step involved the refinement of identified themes to make sure there were enough data to support them. According to Braun and Clarke (2006), reviewing themes entails two levels: the first is reviewing a theme at the coded extract level, and second is reviewing a theme along with the whole data set. To perform these steps, all the collated data extracts for each theme were read to see if they formed a coherent pattern. Moreover, the entire data set was read in relation to the identified themes to ensure they reflected the meanings apparent in the data set as a whole and to include all codes left in the early analytical steps. Tables of refined themes were developed and an understanding of what the different themes were was gained by the end of this step.

5.10.3.5 Defining and naming themes

This step included describing and refining the identified themes in order to get their essence, as well as to delineate distinctive features of every theme. To do this, there was a need to go back to collected quotations relevant to every theme in order to organise them into coherent and consistent accounts (Braun and Clarke 2006). An extended analysis of each theme was undertaken. In addition, a thorough description of every theme was written up. This was undertaken to identify what each theme tells us as well as to ensure that there was not too much overlap between themes. As part of the refinement process, several sub-themes were identified. Braun and Clarke (2006) believe that sub-themes give structure to large complex themes and are useful for representing a hierarchy of meanings within the data. By the end of this step, each theme was defined and named.

5.11 Translation

The analysis of the interview transcripts involved a translation process from the source language (Arabic) to the target language (English), since most of the participants in this research were

Arabic speakers. The investigator and informants have both Arabic language and culture in common. Hence, Arabic was used to undertake a large part of the interviews. Moreover, the findings needed to be translated and disseminated in English. The translation process posed a challenge because meaning matters in qualitative research (Al-Amer et al. 2016). Temple and Young (2004) argue that the meaning of a particular notion can differ from one language to another. The integrity of the results relies on the reliability of the translation process, because inaccurate translation in thematic analysis may negatively affect its reliability (Twinn 1997). Moreover, researchers need to integrate the sociocultural context during analysis and translation process (Twinn 1997). Thus, qualitative research requires the researcher to pay special attention to accuracy when linking data interpretations with the sociocultural environment in order to convey the messages of participants.

Squires (2009) acknowledges that researchers may encounter translation challenges throughout the investigation process. Squires (2009) notes that challenges can appear during data analysis and reporting, since the researcher is required to translate data generated by interviews into another language. This is evident in the current research. Challenges were encountered during the process of coding analysis through to the dissemination of findings concerning metaphors and connotations of texts.

In the first stage of analysis, codes were literally translated from Arabic into English. Each code was then defined according to the participants' definitions in order to enhance the accuracy of the translation and maintain the meanings intended by the participants. Moreover, each interview transcript was not fully translated from Arabic into English, only selected quotes were translated. This was done to allow the researcher to stay in close contact with the source language and preserve the meaning of the texts translated between the first and second languages.

In qualitative research, the use of direct quotes is important because participants' experiences can be presented and the researcher's interpretations and claims can be supported (Corden and Sainsbury 2006; Al-Amer et al. 2016) . Yet, the translation of quotes verbatim poses a challenge as some participants use cultural metaphors and poetry to express specific meanings. For example, one of the participants recited a poetic verse that refers to a well-known Muslim scholar: "*If a beloved person came with a sin, their good deeds should come with a thousand intercessors."* This was translated literally into English. However, an English speaker might not easily grasp the intended meaning. Therefore, the researcher used a footnote to explain the intended meaning to the reader. Moreover, the original Arabic text was put in the footnote, too. This was done in order to preserve the participant's own voice and word as much as possible. Lakoff and Johnson (1980)

and Simawe (2001) contend that conveying the original meaning of metaphors and notions from one language to another is challenging, since it is derived from a specific culture.

5.12 Data-analysis software

The researcher used a software program called MAXQDA Plus 12 to help organise, manage and store the data collected effectively, although the analysis processes were done manually, in their entirety, using a word processor. This software was selected because it is sensitive to different languages and thus supports both English and Arabic scripts (Appendix N). All the codes and categorisations initially identified manually were then transferred into this software. Creswell (2013) suggests that the use of a qualitative computer program offers a simple means for storing data as well as easy and quick access to codes assigned by the researcher. Moreover, it helps to support the rigour and validity of research because the examination of data can be more comprehensive and rigorous (St John and Johnson 2000). For example, it enables the researcher to do a thorough examination of all data extracts related to a theme.

5.13 Rigour and trustworthiness of the findings

A number of criteria have been proposed in the literature for assessing the rigour and trustworthiness of qualitative data and findings. One of the proposed criteria to evaluate the rigour of qualitative research is that of reflexivity (Creswell 2009; Jootun et al. 2009). In addition, Creswell (2013) suggests that Lincoln and Guba's standards are prevalent in qualitative research. The four criteria are: credibility, dependability, confirmability and transferability. Therefore, reflexivity, together with the four criteria from Lincoln and Guba (1985), were adopted to assess the rigour and trustworthiness of the present study's findings. This section will discuss reflexivity and then go on to highlight briefly the Lincoln and Guba's standards of rigour and trustworthiness regarding qualitative research.

5.13.1 Reflexivity

The term 'reflexivity' has been described as illusive since it is difficult to reach in order to find out its meanings (Colbourne and Sque 2004; Dowling 2006; Berger 2015). Moreover, the processes that can clearly explain how to do it are seldom addressed (Mauthner and Doucet 2003). Carolan (2003 p8) maintains that "Reflexivity is a term that is widely used, with a diverse range of connotations, and sometimes with virtually no meanings". However, reflexivity plays a crucial part in increasing the rigour and credibility of qualitative research (Jootun et al. 2009) since data are co-constructed through the interaction of the researcher and study participants (Gilgun 2005).

Reflexivity shows the role that a researcher plays in the research process including their influence on the study under investigation during the process of data collection, analysis and interpretation, through critically analysing the influence of the researcher's role and values on the study (Gouldner 1970; Rice and Ezzy 1999). Creswell (2009 p196) notes that "the role of the researcher as the primary data collection instrument necessitates the identification of personal values, assumptions, and biases at the outset of the study".

Reflexivity has been defined as "the process of a continual internal dialogue and critical self-evaluation of researcher's positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome" (Berger 2015 p220). In qualitative studies, researchers must 'position themselves' by being aware of their personal values, biases and experiences, which they convey to the investigation (Creswell 2013; Berger 2015). As positionality plays a key role in the process of reflexivity, it is primarily essential to identify my position as a researcher to enable reflexivity.

According to Berger (2015) and Creswell (2013), a researcher's position is related to many personal aspects that a researcher brings to his/her study including, among other things, gender, culture, language and religion. Creswell (2013) maintains that, firstly, the researcher needs to talk about his/her past experiences, e.g. schooling, work and family structure. Secondly, the researcher needs to explain how these past experiences influence the researcher's understanding and interpretation of the phenomenon being studied.

Reflexivity has been described in terms of insider and outsider perspectives (Dwyer and Buckle 2009; Burns et al. 2012; Berger 2015). Insider refers to the commonalities shared between the researcher and the study participants such as culture, professional affiliation, role and experience (Dwyer and Buckle 2009). Outsider refers to differences between the characteristics of the researcher and the researched in relation to personhood and relationship position (Dwyer and Buckle 2009). These varying positions can influence the collection and analysis of qualitative research.

The researcher's position can profoundly influence the study in a number of ways (Berger 2015). First, it may influence access to the study setting, since a researcher who is seen by participants as sensitive to their situations may gain more willingness from the participants to reveal their experiences. In addition, the researcher may have more awareness in respect to the potential co-operative and informative resources. Next, it can form the nature of relationship between the researcher and their study's participants, which will consequently influence the data that respondents want to reveal. Lastly, the researcher's background and worldview may influence his/her understanding of the world, practice of language, questioning and the selection of lenses

in order to filter the data gained from the study's respondents and to construct sense of the data. Therefore, researcher's position can form the research's results and conclusions (Berger 2015).

In the context of this research, my position fluctuated between being an insider and an outsider. I am a Saudi national, male, Muslim, working permanently as a lecturer in the department of health services management at the University of Hail, Hail city, Saudi Arabia. I live independently with my family, my wife and son in Hail city; where I was born, grew up and am now working. In terms of schooling, I undertook my primary, secondary, and high school education in the city of Hail. My scientific background involves three academic degrees attained from different countries. I have a diploma degree in nursing from the Health Institute for Boys in Hail city. During this course, for training purposes, I visited and worked in the main hospitals in Hail city: King Khalid Hospital and the Hail General Hospital. It was in this period that my interest in emergency medicine was developed. Moreover, I have a bachelor degree in nursing from the Applied Science Private University in Jordan. In addition, I hold a master degree in health services management from Griffith University in Australia. My interest in leadership grew during my master studies. I am currently pursuing my PhD studies in the Faculty of Health Sciences at the University of Southampton in the United Kingdom. Overall, since I grew up, live and work in Saudi Arabia, I am familiar with Saudi culture and speak Arabic as my first language. My training experiences during the diploma and bachelor degrees have helped me to understand the health care setting and system in Saudi Arabia as well as the context where this study is conducted, e.g. hospital-based emergency departments. This familiarity with both Saudi culture and health contexts has enabled me to understand participants' experiences and facilitate the way through which I can understand and analyse the data. However, since this study was also conducted in four other hospitals in Qassim and Riyadh, it is worth mentioning that I had not been to these hospitals before initiating the data collection process. Because I work as an academic, and was away of Saudi from 2005 to 2009 and 2012 to 2018 pursuing my studies, I have no relationships with hospitals' managerial, clinical or nursing staff. Yet, being a Saudi national, an academic with a medical background, working outside the authority of the Saudi Health Ministry, has helped me to build a rapport with both local and international managerial, medical and nursing staff during the period of data collection. Moreover, my situation has enabled me to gain trust and cooperation during recruiting and data collection processes. Therefore, I consider myself as an insider when it comes to culture, language and scientific background, but as an outsider in terms of relationships and work career.

My status as a Saudi national and an academic may give me a kind of power and privilege or credibility in the eyes of international staff, with whom I share neither national culture nor Arabic language. This is because they may think that I may know some people within their hospitals, or within the Ministry of Health, and that their participation in this study may negatively impact their

work in the future. Nevertheless, participants were assured that their answers will not be disclosed to any managers, colleagues or other professional staff. Moreover, I fully introduced myself to the study participants; for example, who I am, where I come from and my work affiliation. I provide this personal information in order to increase their awareness of my identity and thus enhance trust and potential me/them relationships. This personal initiative encouraged participants to speak freely and accurately when they were interviewed.

To conclude, I am fully aware of all the potential biases and other influences that may affect the research process and outcomes. In the context of the current research, I do not deny the potential impact my identity may exert on the research process; however, I attempt to decrease that influence by being aware of it. This awareness is of importance in order to understand respondents' experiences and can also assist in the way that I understand and scrutinise the data; thereby aiding my efforts to address the research question, aim, and objectives. In order to avoid potential personal biases, I attempted to distance myself from the data to prevent my own biases that could influence how I interpreted the findings especially in terms of what leadership behaviours count as effective. This was undertaken by adopting the Lincoln and Guba's standards of credibility, dependability, confirmability and transferability to maintain the rigour and trustworthiness of the current research findings.

5.13.2 Credibility

In this research, multi-perspective interviews with managers and staff, for the same phenomena, were used to increase the credibility of the findings. The inclusion of multiple sites from different cities in Saudi Arabia was also done to enhance the credibility of the findings.

5.13.3 Dependability

This involves an enquiry audit, which is defined as having an external researcher not involved in the research process assess both the processes and findings of the research study. Supervisory meetings with my PhD supervisors were considered to compensate the external researcher.

5.13.4 Confirmability

An audit-trail technique was used to achieve confirmability. An audit trail is a detailed description of the research steps that have been undertaken from the beginning of the research project to the development and writing-up of findings.

5.13.5 Transferability

A thick-description technique was used. It is defined as a way of providing a sufficient description of the phenomenon being studied so that it can be evaluated, and a conclusion drawn which is transferable to other times, settings, situations and people. Lincoln and Guba (1985) contend that the issue of transferability can be addressed when investigators present sufficient descriptive data to allow comparisons.

5.14 Conclusion

The current chapter has conducted a discussion to justify the adoption of a constructionist world-view and a qualitative approach to the present research. The chapter has provided a thorough account of the research steps and procedures followed. The chapter began with a discussion of the research philosophy and paradigm, identifying the researcher's position with respect to different philosophical assumptions. This was followed by a discussion around the selection of the research design and a semi-structured interview method. The chapter has included a description of the sampling process, as well as the steps taken to obtain access and approvals. In addition, this chapter has offered an explanation of the processes involved in the pilot study for the research question protocols and the main data-gathering stage. The last two sections of this chapter have highlighted the techniques used for data analysis and the procedures followed to promote rigour and trustworthiness in the findings.

Chapter 6 Findings

This chapter reports the qualitative findings from the thematic analysis of semi-structured interviews conducted with 15 emergency department hospital managers (5 heads of department, 5 deputies and 5 heads nurses), and 15 medical staff (5 physicians and 10 nurses) from the emergency departments, across five public hospitals in Saudi Arabia. The objective of this chapter is to identify and characterise the study findings. The coding scheme for quotation is illustrated in Table 6-1.

Table 6-1 Coding scheme for quotation

Int	H	HD	D	P	HN	RN
Interview	Hospital	Head of the department	Deputy	Physician	Head Nurse	Registered Nurse
M/F	SA	EG	FI	PA	IN	JO
Male/Female	Saudi	Egyptian	Filipino	Pakistani	Indian	Jordanian
For example: Int.1, H.2, HD, M, SA, refers to Interview number one from Hospital number two, the interviewee is the Head of the Department, the gender is male and the nationality is Saudi.						

This chapter sets out key themes and subthemes (Table 6-2) that emerge from the interviews to help in addressing the following research question:

Q. “How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?”

Table 6-2 Summary of key themes and subthemes

	Main themes	Sub-themes
1.	Rewarding leadership	None
2.	Responsive leadership	1. Corrective action to clarify staff mistakes 2. Direct action and responding to unexpected situations
3.	Role model leadership	1. Showing patience, tolerance and serenity 2. Respect for others
4.	Democratic leadership	1. Consultative leadership behaviour 2. Consensus 3. Delegation
5.	Staff development leadership	None
6.	Recognition leadership	None
7.	Supportive leadership	1. Flexibility and understanding 2. Staff protection and defending
8.	Lenient leadership	1. Containment 2. Alerting
9.	Strict leadership	1. Autocratic behaviour 2. Reporting to higher authorities

In order to distinguish between key themes and tease out the main differences, it was useful to develop an operational definition for each theme (see Table 6-3). Table 6-4 presents the number of participants who commented in each leadership behaviour.

Table 6-3 Operational definition for each theme

Main theme	Definition
Rewarding leadership	An advantage given by leaders to followers including money, overtime and days off to compensate task achievements and extra performance.
Responsive leadership	A direct leadership intervention to events or situations in order to prevent or solve problems.
Role model leadership	A process of displaying inspiring leadership behaviours in order to influence staff and encourage them to imitate these behaviours in the workplace.
Democratic leadership	The process of giving weight to staff members' opinions and making them able to take part in decision-making and leadership process through consultation, consensus, and delegation.
Staff development leadership	Leaders who want to improve their staff's skills, abilities and qualities through the provision of different educational opportunities.
Recognition leadership	Leaders who praise, thank, and appreciate their staff for their performance and achievements.
Supportive leadership	The process of identifying and addressing staff needs at the level of workplace, as well as, in personal and family life, by showing flexibility and understanding, and protecting and defending staff in order to nurture their morale and emotional wellbeing.
Lenient leadership	The perceived understanding, tolerance and avoidance of taking disciplinary actions and punishing staff who make simple mistakes with solving problems within their department.
Strict leadership	The process of using authority to impose decisions or applying disciplinary procedures on staff members who commit repeated or harmful mistakes.

Table 6-4 The number of participants who commented in each leadership behaviour

Main theme / definition	Heads of EDs n=5	Deputies n=5	Physicians n=5	Head nurses n=5	Staff nurses n=10	Total
Rewarding leadership	5	5	4	5	5	24
Responsive leadership	4	4	5	5	8	26
Role model leadership	4	5	4	3	9	25
Democratic leadership	5	5	5	4	9	28
Staff development leadership	5	5	4	4	7	25
Recognition leadership	5	3	2	4	8	22
Supportive leadership	5	4	3	5	7	24
Lenient leadership	5	5	5	5	9	29
Strict leadership	5	5	5	5	10	30

6.1 Overview of themes and subthemes

The present research has generated several different categories of leadership behaviours enacted and deeply valued by staff working in the Saudi hospital-based emergency departments. These findings have been organised into several themes and subthemes. This section will introduce and highlight what each theme and subtheme captured.

First, rewarding leadership is a leadership behaviour that shows leaders who give an advantage to their staff to compensate task achievements and high performance. The current research found that emergency department managers use different types of rewards in emergency departments. These rewards include overtime, giving days off, extra time off, extending holydays, allocating staff their preferred place of work for a short time, working fewer hours, and providing educational opportunities. These different types of rewards were found to effectively influence emergency staff, since those rewards generated their cooperation during the difficult times frequently present in emergency departments. In addition, it was found that these rewards decreases the emotional, mental and physical burden on emergency staff which results from the stressful environment, since they provide times to rest and reinstate energy during demanding situations.

Second, responsive leadership is about a direct leadership intervention to events or situations in order to prevent or solve problems. Responsive leadership has two subthemes: i) corrective action to clarify staff mistakes and ii) direct action and responding to the unpredictable situations that typify EDs. As the name of each subtheme implies, the first subtheme shows leaders who take corrective action when discovering something wrong done by staff in order to fix it. This leadership behaviour is used by emergency department managers to clarify to staff their task-centric mistakes as soon as they are discovered, in order to avoid a reoccurrence of the problem. The second subtheme shows leaders who take a direct leadership intervention by providing practical support to solve problems and to tackle unexpected events in emergency departments. This leadership behaviour involves communicating with higher management personnel to seek support during disasters e.g. bringing extra medical and nursing staff to ED and prioritising patients' treatment according to the severity of each medical case. These leadership behaviours were found to be valued in emergency departments because they help emergency department managers to control problems that are out of the staff members' control. Moreover, it can help ED managers to tackle problems inherent in emergency departments such as increased cases admitted due to disasters, which lead to over-crowding, pressure and may trigger conflicts between staff members or even patient-staff conflicts.

Third, role model leadership involves a process of displaying inspiring leadership behaviours in order to influence staff and encourage them to imitate these behaviours in the workplace. The major theme of the role model leadership was found to be linked to several leadership behaviours including, for example, respect, punctuality, showing commitment to work duties, saying the right words, behaving well towards others, wearing suitable outfits for a good appearance, showing concern for staff and asking as well as knowing about their situations and sharing their special occasions. These different behaviours of role modelling were seen to be important in ED to encourage staff to comply with organisational and professional standards. Role modelling has two subthemes: i) showing patience, tolerance and serenity and ii) showing respect for others. These subthemes indicate that an emergency department is a stressful and pressured workplace, where emergency department managers regularly practice patience, tolerance and serenity as well as showing respect for others, in order to minimise the effect of such a stressful environment. These behaviours were found to increase staff cooperation and enhance relationship with each other, as well as the quality of patient care delivery; such behaviours can generate a peaceful environment in ED. The concept of role model leadership reflects Islamic values that prevail in Saudi culture.

Fourth, democratic leadership is about giving weight to staff members' opinions and making them able to take part in decision-making and the leadership process through consultation, consensus, and delegation. As the definition implies, democratic leadership involves three subthemes: i) consultation (shura), ii) consensus (Igma'a) and iii) delegation. All three are concepts derived from Islamic teachings and tribal values that reflect democratic leadership. Consultation was seen to be important in emergency departments as it helps managers to get staff members' views and ideas; this co-operation is of value as the personnel in emergency department are composed of several teams and individuals who come from different nationalities and scientific backgrounds. Consultation was used to organise work and assign responsibilities, develop new polices within the department to improve staff performance, and to identify and discuss staff issues and departmental problems. Consensus was also reported as an effective leadership behaviour in emergency departments because ED managers can assess the viability of a proposed decision. Consensus involves the use of a voting system if there is no general agreement. Delegation presents the act of assigning a particular authority or duty to another employee. Delegation was seen as a valued way to counter the complexity of emergency departments, since it involves different sections and medical teams. In general, consultation, consensus and delegation were perceived as collective processes that increase staff cooperation, teamwork and sense of value in emergency departments.

Fifth, staff development leadership signifies leaders who want to improve their staff's skills, abilities and qualities through the provision of different educational opportunities. This leadership

behaviour includes teaching or organising lectures for staff to correct misunderstandings and deficiencies related to medical knowledge and skills or to keep up with scientific advances in their respective specialities. Staff development leadership also involves facilitating educational opportunities such as attending seminars, workshops and conferences. Staff development was perceived as a valuable and mutually beneficial process for both staff and emergency department. For staff, their development helps them to grow both scientifically and professionally. For emergency departments, staff development helps in improving the quality of emergency care provided since staff can apply what they have learnt in emergency situations.

Sixth, recognition leadership shows leaders who praise, thank and appreciate their staff for their performance and achievements. In addition to praising, thanking and showing appreciation, recognition was found to include several behaviours such as smiling, greeting, talking up staff achievements, and giving a present or appreciation certificate. Recognition was found to be significant in emergency departments since it increases the concept of competition between emergency staff, as well as maintaining and increasing effective staff performance. Recognition was also found to be strongly influenced by Islamic teachings. It was seen as an effective intrinsic motivation for staff.

Seventh, supportive leadership describes the process of identifying and addressing staff needs at the level of their workplace, as well as, in personal and family life, by showing flexibility and understanding, and protecting and defending staff in order to nurture their morale and emotional wellbeing. Supportive leadership has two subthemes: i) flexibility and understanding (Altafahum) and ii) staff protection and defending. Flexibility and understanding involves solving staff issues at their workplace such as work duties that may cause family, social or cultural problems. It also involves identifying and solving financial and residential issues of staff. This leadership behaviour was used by emergency department managers as an approach to minimise the effect of stress and pressure on staff in emergency departments and, as a result, leads staff to respond effectively during difficult situations, which are frequent in EDs. Flexibility and understanding was seen as effective in EDs and can create a satisfactory and friendly environment. Staff protection and defending was also seen to be valuable in the context of emergency departments since it involves complex interactions between different medical staff during the diagnostic and treatment processes of patient care. The complexity of a patient's early investigation and treatment may create disagreement between staff since emergency departments typically involve interdisciplinary teams. This makes it significant to emergency department managers to defend and protect their staff to make sure that their staff continually take the right decisions regarding patients' treatment and care, so as to avoid disciplinary actions that may affect emergency staff. This behaviour was perceived to increase staff retention in emergency departments. It also helps

in creating a family environment in the emergency department. In general, flexibility and understanding, and staff protection and defending, which shape supportive leadership, were strongly influenced by Islamic values and social norms in Saudi culture.

Eighth, lenient leadership is about showing understanding, tolerance and avoidance of taking disciplinary actions and punishing staff who make simple mistakes by solving problems within their department rather than escalating them to more senior management. Lenient leadership has two subthemes: i) containment and ii) alerting. Containment behaviour was seen as important in emergency departments because it can control latent or potential staff problems caused by stress without harming them psychologically and legally. Containment involves solving staff conflicts or staff-patient conflicts that occur in emergency departments because of stress and pressure environments by discussing and explaining the issue with the individuals in conflict, in order to find a solution that satisfies both parties. Containment involves a manager's absorption of sudden negative behaviour that may emerge from their staff due to work pressure or psychological or social circumstances. This leadership behaviour was reported to increase staff retention and enhance teamwork in emergency departments. Alerting is about making staff aware of their faults and its consequences to give them opportunities to improve their negative behaviour. Containment and alerting leadership behaviours are strongly shaped by Islamic values and social norms in Saudi Arabia.

Ninth and last, strict leadership (Alsarama) indicates the process of using authority to impose decisions or applying disciplinary procedures on staff members who commit repeated or harmful mistakes. Strict leadership has two subthemes: i) autocratic behaviour and ii) reporting to higher authorities. Autocratic behaviour is about taking individualistic decision-making process where managers do not refer to their staff when making decisions. Autocratic behaviour was used to punish staff who show deviant behaviour or who failed to meet organisational obligations. This is because emergency departments were seen as critical environments where staff must be disciplined and committed to professional and organisational standards. It was also reported that autocratic behaviour was used by emergency department managers at times of disasters in order to make staff do extra work and exert control. Reporting to higher authorities is about communicating with higher management authorities regarding departmental problems. This leadership behaviour was seen effective to punish staff who made repeated mistakes, exhibited offensive behaviour and made harmful medical interventions. As will be considered, strict leadership is influenced by social norms in Saudi Arabia.

Having introduced and provided an overview of the key themes, each will now be explored in detail.

6.2 Rewarding leadership

One of the key themes identified in the interviews was that of rewarding leadership. Participants defined rewarding behaviour as an advantage given by leaders to followers including money, overtime[9] and days off to compensate task achievements and extra performance. Rewarding leadership behaviour was found to include several behaviours identified during coding activity: compensation, rewards, financial incentives, reward and punishment policy, as well as annual evaluation, days off and overtime. Emergency-department managers used conditional rewards to motivate their staff based on the level of task performance and achievement. The aim of this behaviour was to reward the extra effort done by emergency department medical and nursing staff in order to encourage them to maintain it. This behaviour was commonly used at different sites and was mentioned by all types of participants with twenty-four out of 30 participants mentioned rewarding behaviour. To be specific, all types of emergency department managers emphasised their use of this behaviour and the majority of emergency medical and nursing staff indicated that rewarding behaviour was used by their managers and perceived effective. This behaviour is consistent with the notion of contingent rewards discussed in the full range model of leadership (Bass and Bass 2008), whereby leaders establish productive exchanges with their followers and spell out clear expectations, as well as setting up rewards in order to meet those expectations.

The heads of emergency departments mentioned their use of this behaviour to reward their staff. They indicated their use of different methods to motivate their staff both financially and to build morale. Financial incentives are given through annual evaluation and overtime, while morale incentives are applied by giving short-term incentives such as staff extra time off or extending holidays, such as “long weekends”. These incentives were provided to reward staff because of their efforts during task performance. Rewards were given based on the levels of performance and achievement. That is, the better a staff member performs in relation to a leader’s expectations, the more they obtain rewards. Moreover, conditional rewards were used to encourage underachieving staff to perform better in order to obtain better types of rewards and benefits. It was identified by the study participants as being particularly important to encourage staff to respond to emergency situations, when there is a need to stay longer in the department due to unexpected situations, or to break off their holidays in order to cover staff shortages due to sickness or emergencies. Thus, it is the unpredictable nature of emergency departments that

[9] Payment for overtime, which means time worked in addition to one’s scheduled working hours.

makes leaders rely on the giving of rewards (so-called rewarding leadership) to obtain staff members' cooperation and effective performance.

> "*We have an annual evaluation when I try to give staff the maximum possible, perhaps an increase in salary of 5%. I give the staff 100% and 20%, all the rewards I have, and this is made clear. Because you do this and that, you deserve this because you are good. I give underachieving staff rewards based on their achievement, I give them a lower percentage so that they know there are differences between staff in terms of rewards, I tell them you are good but you there are these things that you should do in order to get more rewards, so hopefully you will improve. Another way is to give staff extra time off, if I have staff who are diligent, work hard and help me in difficult situations when there are staff shortages, I give them extra time off." Int.1, H.1, HD, M, EG (translated from Arabic)*

Participants commented that fairness plays an important role for the effectiveness of contingent rewards. They perceived that being fair when distributing rewards to staff who deserve them is important to avoid staff being frustrated. To put it in another way, rewarding was perceived as fruitless without fairness. To avoid disappointment, they believed that rewards should be given based on the performance level of each employee.

> *"If there are any advantages, they must be distributed to all employees according to the productivity of each one." Int.19, H.4, HD, M, EG (translated from Arabic)*

Deputies and head nurses also indicated that they use rewarding behaviour as a motivational factor to encourage staff who do good work and work hard. They indicated the influence of rewarding behaviour on physicians and nursing staff working emergency departments, where they have to work with a high volume of patients who present with serious injuries that may engender stressful behaviours. Unlike the heads of emergency departments, the deputies and head nurses focused more on morale incentives, such as allocating staff their preferred place of work for a short time or giving extra break hours or time off to counter the psychological and physical burdens put on their staff. Similar to the heads of emergency departments, they think that this behaviour encourages their staff to change their holiday's schedules in order to overcome staff shortages caused by emergency situations that may prevent staff attending and doing their duties. As reported by the deputies and head nurses, the emergency department environment is highly stressful and pressured context, where it calls for rewarding leadership behaviours such as allocating staff their preferred place of work for a short time or giving extra time off for break to minimise the emotional, mental and physical burdens on their staff. These different burdens come from the context of emergency departments since emergency

departments' staff are subject to frequently working in an overcrowded environment and dealing with stressed patients and relatives as the emergency department is the first gate of admission to a hospital.

> *"We use most of the methods, in emergency work you work under pressure, psychological pressure, and pressure because of the high number of patients, and emergency physicians always experience the first shock from patients who may be irritable because of pain so you cannot count on them or their behaviour, we give these staff morale incentives that differentiate them from others. It means, for example, that if you work hard for us we will give you your favourite place where you want to work for one or two days, we will give you two or three hours break to relax, because our work always involves conflicts with patients or physicians who come from other departments." Int.2, H.1, D, M, SA (translated from Arabic)*

> *"Sometimes we provide incentives, I mean distinguished staff have priority in terms of holidays, priority in terms of educational courses, and someone who is distinguished in their evaluation has priority to be put in the places s/he chooses, and priority for the cases they undertake; these are motivational methods in terms of performance. Whenever you are distinguished, you get more benefits than others." Int.10, H.2, HN, M, SA (translated from Arabic)*

Emergency staff also indicated the use of rewarding behaviour by their emergency department managers to motivate staff to keep good performance. Consistent with view of the managers, they revealed methods for rewarding, including receiving financial incentives, given extra time off and working fewer hours. These rewarding methods can minimise the effect of working in high pressure workplace that characterises emergency departments, which results in physical and mental exhaustion for the ED staff.

> *"For an emergency physician, it is very difficult to work twenty-six days or twenty-four days and take only six days off. The head of the emergency department tries to give extra time off and to satisfy people with the number of working hours." Int.27, H.5, P, M, EG (translated from Arabic)*

In addition to the previous rewarding methods, emergency staff indicated that their managers provide educational opportunities to empower them as compensation for high performance. It was also found that head nurses tend to use rewarding behaviours to encourage their staff to cooperate and respond when they are requested to come in to work when they are on holiday in order to deal with an unexpected situation in the emergency

department. This shows mutual expectations regarding rewards between different types of emergency managers and their staff including physicians and nurses.

> *"During evaluation if they see that staff are very good they give them very good evaluation ratings and they are praised for specific jobs that were done well and there are compensations to motivate nurses to work hard, such as giving them educational training to make them future leaders in the department." Int.18, H.3, RN, M, FI*

> *"They give us more time off if they are pulling us in on our days off, then they give us more time off, and then you take that time to rest, and yeah that's it." Int.23, H.4, RN, F, FI*

In summary, all of the managers talked of using the rewarding leadership behaviour, as did many of the staff. Emergency department managers commented that this behaviour will encourage staff to maintain good performance. Moreover, participants suggested that this behaviour would lead to more cooperation between managers and staff, particularly when there were, for example, sudden shortages in staff numbers or in times of large-scale emergencies when staff were requested to work extra hours and provide more help.

Emergency department managers (heads of ED, the deputies, and head nurses) differed in their use of rewarded leadership behaviour. For example, it was apparent that the heads of emergency department used both financial and morale incentives as conditional rewards. However, the deputies and head nurses used only morale incentives or compensations, e.g. extra day off, to reward staff accordingly.

Whilst many workplace settings can be stressful, the demands of the ED in Saudi make this especially the case due to the serious nature of patient illness and trauma that present combined with the unpredictability of patient flow. The analysis shows that emergency departments are characterised by various participants in this research as dynamic and pressured environment that affect staff performance emotionally, mentally, and physically. Emergency department managers seem to use different reward methods to minimise such effects. These reward methods not only include formal monetary means as a token marking high performance, but also holistic methods such as giving days off, extra time off, extending holydays, allocating staff their preferred place of work for a short time, working fewer hours, and providing educational opportunities. These reward-giving methods are considered as valuable in such volatile context by both emergency department managers and their staff. For emergency department managers, these types of different rewards ensure effective staff performance, reduce mental, emotional and physical pressures on their staff, and most

importantly generate staff cooperation during difficult times in the department. For emergency staff, these kinds of rewards work well since they give them time to restore energy and ensure that high and extra performance are compensated.

6.3 Responsive leadership

Responsive leadership behaviour was defined as a direct leadership intervention to events or situations in order to prevent or solve problems. This theme is comparable to the concept proposed in the full range model of leadership - management by exception (Bass and Bass 2008), in which leaders closely monitor the performance of followers and predict problems so that they can take corrective action accordingly. The aim of this behaviour was said to respond to and solve unexpected problems in the emergency department following the monitoring of work performance. This behaviour was emphasised by head nurses in their leadership role and physicians in their staff role more than other groups of participants. Responsive leadership behaviour emerged from a number of leadership behaviours identified during coding activities. These included respond, direct or corrective action, break the rules, intervene, reactive, take action, direct behaviour, direct action. These were then grouped into two sub-themes: corrective action to clarify staff mistakes and direct action and responding to unexpected situations.

6.3.1 Corrective action to clarify staff mistakes

Participants described corrective action as a leadership behaviour used when discovering something wrong done by staff in order to fix it. Managers including heads of departments, deputies and head nurses indicted their use of this behaviour in order to explain to staff their mistakes when doing their tasks as soon as they are discovered. Correcting these mistakes was discussed in terms of telling staff about the nature of their mistakes and explaining the appropriate methods to deal with the situation to prevent its occurrence again. Situations involved misunderstanding of task requirements, interpersonal conflicts that may have occurred between staff due to work pressure and deviance from organisational rules and policies. Thus, as described by the participants, it is the stressful environment characterising emergency departments that may recurrently cause problems between staff; an issue which make leaders resort to corrective action to clarify staff mistakes in order to solve problems rapidly.

> *"Occasionally, a problem occurs between a nurse and a physician during work because of tense environment. The nurse supervisor may come and say that a problem happened, and we intervene to clarify that there was a mistake in the way of dealing with that point to prevent it from occurrence next time…" Int.20, H.4, D, M, EG (translated from Arabic)*

Corrective action was used to persuade emergency staff to comply with organisational rules and policy when a staff member shows a deviant behaviour such as lack of punctuality. It was stressed that corrective action should always be used when a problem arose from staff in order to explain to them the implications of the situation on their performance and consequently on the emergency department. Corrective action, thus, is understood by managers in emergency departments as an educative, rather than a punitive, strategy.

> *"…but she is not following or she is not doing the right thing. So, the head nurse should also correct her, if she is for example she is not following the rule that you have to come early 15 minutes before the time and she is always coming late, you have to correct her, because you have to come here at least 15 minutes just to check if there is any new memos any new information that you have to read before the time of your duty and you have signed assignments also that you have to check before you start your duty so like that if you notice that she is coming always late so you have to correct" Int.28, H.5, HN, F, FI*

The physicians and nurses mentioned the use of corrective behaviour by their emergency department managers. This corrective leadership behaviour was described to be used to solve conflicts between staff and to explain what mistake was done and what should be done instead to prevent staff from doing the same mistake in the future.

> *"We had a problem happened between two physicians in the emergency department, everyone knows that problem. It was relevant to the management and policy of this department, and relevant to patients themselves. The head of the department directly intervene to solve this problem" Int.27, H.5, P, M, EG (translated from Arabic)*

> *"He is telling to that staff ok this is what happen, in my opinion this is what had happened and this should be done, he is just correcting you so that problem will not arise…" Int.24, H.4, RN, F, FI*

6.3.2 Direct action and responding to unexpected situations

Managers of emergency departments usually encounter unpredicted events during their day-to-day work. They used direct action, which was described as a direct leadership intervention through providing practical support to solve problems, to tackle unexpected events that go out of staff member control or caused by increased cases admitted to emergency departments due to disasters, which lead to over-crowding, pressure and may trigger conflicts between staff members or even patient-staff conflicts. Such events may also go out of managers' control so they need to

report to the higher authorities in the hospital. These events made it necessary to managers to respond and intervene in order to solve these problems. Therefore, it is the unpredictable nature of emergency departments that demands leaders to respond rapidly in order to constructively solve sudden problems faced by their staff.

> *"The supervisor is considered responsible completely on all physician present in the unit… he has to intervene to solve any problem and be in touch with me. If it is out of his control, I will intervene to solve it" Int.25, H.5, HD, M, EG (translated from Arabic)*

One of the participants commented that there would be times when an emergency department could not tolerate a massive disaster since it is operated with a particular, limited number of physicians and nurses. Thus, emergency department managers must directly interfere by either calling for extra efforts from the medical and nursing staff within the emergency department or contacting the medical director in the hospital in order to bring more staff from other departments to handle such event.

> *"The management always intervenes to support. If there is, for example, a huge disaster and many cases coming, the number of physicians here may not be enough. So the emergency department management call other physicians or communicate with the medical director to bring in physicians from other wards to help"* Int.20, H.4, D, M, EG *(translated from Arabic)*

Head nurses characterised the emergency department as unstable, crowded with limited bed capacity. Therefore, taking a direct action to solve unexpected events was seen to be of importance. Direct action included communicating with higher authorities to arrange for support in terms of providing extra medical and nursing staff and distributing patients to other departments due to limited bed capacity in the emergency department. This leadership behaviour helped in speeding up treatment or task completion processes and prevented over-crowding in ER.

> *"… As an emergency, we have to be warm-blooded, as we say in our language, being cool does not work, because you do not know what is coming? Emergency department is different from other wards; I have, for example, only 50 beds, while in the surgical ward for example has 50 beds but they know it is impossible to receive 51 patients" Int.16, H.3, HN, M, JO (translated from Arabic)*

Physician and nurses also had a shared perception that direct leadership action was commonly used in emergency department, not only by managers but also by senior staff members. There was agreement that this behaviour supports medical and nursing staff in

terms of speeding up treatment process and solve problems such as over-crowding caused by disastrous events. There was also agreement that communication with higher management authorities was a significant direct action to get their support in order to cope with challenging events.

> *"Of course, ER is always a problematic area. We have to intervene to find solution and to prevent it to become worse. One of these problems is overcrowding, if the number of patients exceed the capacity of the ER. We have different measures we can do to try to manage large number of patients. For example, some patients do not need to wait and be seen in detail because they are not severely ill, we can allocate part of the beds for them instead of having a patient stay for long time. When the patient comes, they will be completely diagnosed in the bed and medical analysis is taken if needed, based on this we evaluate their condition, they can stay in the waiting room or if they are good and they do not need extra treatment, we can give them the necessary medications and discharge them. This way will accelerate treatment process. If we cannot solve the problem because of crowdedness, where there is not enough beds to admit patients in the hospital, we communicate with the management to inform them we need to accelerate this process. They can do rounds on patients who are hospitalised to see if there are patients who can be discharged so that the ED patients can be admitted instead of them or can be referred to other hospitals" Int.15, H.3, P, M, SA (translated from Arabic)*

> *"… This hospital is large, we always have crowdedness and no beds are available. Patients start to make noise and so on, we always see one of the ED managers to intervene and try to make the situation easy and try to provide facilities such as bringing extra beds so that we can continue working" Int12, H.2, RN F, SA (translated from Arabic)*

The quotes above show that emergency department managers tend to use various strategies to intervene and overcome disastrous events that cause overcrowding and delay of treatments. These strategies include prioritising treatment of the patients according to the severity of their medical conditions and communicating with other departments within the hospital through the relevant management personnel to find beds for patients who need hospitalisation. When the beds in the emergency department and the other departments in the hospital are busy, the physicians will be instructed by the management of the hospital to see the patients in all the wards of the hospital to evaluate their medical conditions and find out if there are patients who can be discharged so that patients in the ED can be admitted to

replace those being discharged. In addition, if there are no beds available for patients who need hospitalisation due to the hospital being full, the management will contact other hospitals within the city to distribute those patients for admission. This typical kind of situation that can occur in EDs shows that leaders not only need to intervene promptly but they also need to advocate for support and cooperation from higher management authorities to jointly overcome such difficult events.

6.4 Role model leadership

Role modelling behaviour is inherent in Islamic teachings and instructions of effective leadership (Beekun and Badawi 1999). It is named “guduah” or “auswah hassanah” and denotes a role model and a person who is taken as an example. Participants defined having a role model as a process of displaying inspiring leadership behaviours in order to influence staff and encourage them to imitate these behaviours in the workplace. These behaviours, as described by the participants during interviews, included showing patience, tolerance, serenity, respect for others, approachability, listening, humility, breaking barriers, and fairness. These behaviours were identified during coding activities and participants always linked these types of leadership behaviours to being a role model in the emergency department. There was consensus among participants that being a role model is an effective leadership strategy to influence different staff to achieve organisational goals. These include being committed to work, providing efficient and effective healthcare, maintaining strong relationships with and between staff based on mutual respect and cooperation with each other. Role modelling is a dominant leadership behaviour in recent leadership models although labelled differently in different models. For example, role model is comparable to the concepts of setting a strong role model for charismatic leadership (House 1976), idealized influence (Bass 1985) and modelling the way (Kouzes and Posner 2012) for transformational leadership.

Most heads of emergency departments reported that leadership is a social-influence process. Social-influence signifies the leaders, who can influence people in order to change their behaviours. Participants reported that it is an effective leadership approach for leaders to exercise desirable behaviours themselves within the emergency department. This influences others to copy the same behaviours and thus achieve commitment and organisational goals. Respect was seen an essential aspect of leadership behaviours that should always be shown to staff.

> *“Leadership means having influence and being a role model. Basically, it is all the methods that you use based on respect … you cannot ask people to come in early while if you do not do so. You cannot ask them to see every patient if you do not do so …*

leadership in general means that you have objectives, you influence people in a social and artistic way… ." Int.7, H.2, HD, M, SA (translated from Arabic)

This participant continued to say that practising desirable behaviours within the emergency department was a method used to convince staff to practise them themselves. It was seen as important to exercise such leadership behaviours in order to overcome difficult times in the emergency department, especially if there was a lack of staff for some reason. It was also identified as challenging to request staff to do certain tasks if the leader does not do them him/herself.

"He has to lead by example, especially because our work has difficulties and problems. After Ramadan, someone said to me, for example, 'Are you working nights?' he saw me working a night shift. I said, 'Yes, what is the problem?' One of my colleagues working in another hospital said, 'You are crazy to work the afternoon shift,' because he only works the morning shift. In the team we have, all are consultants, we are professionals, we are not administrators. We must have the same working conditions, I work weekends and afternoons. You cannot work only in the morning and bring in people to work at night, they must see you on the night shift … leading by example is the first." Int.7, H.2, HD, M, SA (translated from Arabic)[10]

Another participant, a head of an emergency department, indicated the importance of leading by example to influence other staff and make them adopt similar behaviours to others, colleagues and patients, within the emergency department. This included being punctual and showing commitment to work duties, saying the right words, behaving well towards others and even wearing suitable outfits for a good appearance. It was also seen as important to show concern for staff and asking as well as knowing about their situations, even those who may not be available in the workplace for some reason. It was seen as important to be in contact with staff and share their special occasions. These behaviours will make staff see their leaders as role models and like spiritual fathers. This will lead staff to respect their leaders as long as leaders are perceived to be fair with all members of staff. These leadership behaviours were perceived as key to making changes at the level of individuals and to constantly improve their conduct in the emergency department.

"I think the most essential point for any manager to be successful is that you have to be an example. You need to be an example for staff in terms of attendance, the way you

[10] During Ramadan, Muslims staff can break their fasting during night shifts because Muslims can only eat between sunset and sunrise.

deal with staff and what you say, the way you deal with trainers, the way you speak with people and your appearance, being on time and asking about staff person by person, asking about people who are not available, with or without a reason. Communicate with them, even on special occasions. There are many things that one may feel are trivial, but they make a difference. I try to be an example for them, as they are your children who should see you as a leader and father so that this place succeeds. I think all my colleagues respect and appreciate me or appreciate the place or the managerial person, they feel that this person is fair and can be a father to us or an example for us; this is the most important point. I can say briefly that you must be an example for your staff. You must be a good example for your staff in everything you do, even my talk with patients. When I say, 'How are you?' I sit down with a patient and talk with him while one of the trainers sees me, the next time the trainer will do the same thing. You feel that you have changed a person's way of dealing with others … I consider this the most important strategy for success for any manager." Int. 13, H.3, HD, M, SA (translated from Arabic)

In addition to other behaviours linked to being a role model, it was perceived vital for leaders to be available in the workplace to provide help and assistance to emergency staff. It was reported that leaders should have better skills and knowledge than others so that they can deliver the needed support. This contributes to being seen as a role model.

"A leader to be a role model must have a good appearance, be well-spoken and have the knowledge to support others, because it is not possible to have a senior leader whose knowledge is the same as other people present or less than theirs. His administration, technical and medical knowledge must be better than other people around him so that he can support them… .) Int.19, H.4, HD, M, EG (translated from Arabic)

One of the deputies expressed his deep deference when describing and comparing leaders who were perceived as role models. This is because leaders show a great commitment to work duties and punctuality in terms of attendance at work.

"…commitment to work to a great extent. It means two leaders both act as role model for their staff in terms of commitment and attendance. You may even feel sad for them because of their huge commitment. They are excellent examples for us in the workplace… ." Int.8, H.2, D, M, SA (translated from Arabic)

A head nurse indicated the importance of being perceived as a role model in the emergency department in order to influence staff to comply with both departmental and organisational rules. Similar to other managers, it was seen as effective to practise desirable behaviours and do the

right things in order to encourage staff to do the same. Furthermore, it was reported as vital to be close and in contact with staff in order to foster relationships based on mutual respect.

> *"…by having good communication with all the staff under her leadership. For me, a good way to have a good relationship with staff is proper communication. If you have good communication and a relationship with mutual respect, if you set a good example to your staff and if you yourself follow the rules, the staff also will not mind following the rules of the hospital and the rules of the unit." Int.28, H.5, HN, F, FI*

Consistent with other participants, physicians and nurses indicated the effectiveness of being a role model whereby leaders practice all that they preach in the workplace. This is seen as an influential method to make staff emulate a leader's behaviour when dealing with patients, their companions and other colleagues within the emergency department. Thus, emergency staff emulate leaders' behaviours with others, as they perceive these behaviours being used successfully by their leaders when facing difficult situations that might negatively affect their feelings and consequently lead to bad clinical decision-making.

> *"Practical leadership is when leaders are part of the team, they implement what they say themselves. If a leader wants us to take 100% care of a patient, they too should give 100% care to a patient. If they want us to deal well with a patient, the patient's companions and other medical staff, they should behave well first. As you might say, leadership is by example, it means that they are examples for others." Int.9, H.2, P, M, JO (translated from Arabic)*

It was commented that leaders who are perceived as role models are expected to do the right things, which in turn leads staff to identify with them and do what is expected by the leaders. Being a role model entails being a careful listener to staff, taking ideas from staff, showing commitment at work, providing practical help when needed and responding to emerging problems.

> *"In practice, for me, a leader will do the right things so that his staff will follow him, he also has a sense of command and is able to commit to more goals after this one, a good listener may do so that his followers will help him too, I think only that matters in practice." Int.5, H.1, RN, F, FI*

> *"Listen to your colleagues, be in the middle, do not just go to one point only, then be a good example; a leader who is good listener to their staff and you know what to do with your staff merely by being like that. Our leaders distribute the workload fairly among the staff, then if they are like I said and there are any problems they should be solved the*

same day, and like that if you accept any suggestions made, and ideas, it will be much better for you because you listen to them." Int.24, H.4, RN, F, FI

Two subthemes have been attributed as elements of role model leadership behaviours in emergency department: showing patience, tolerance and serenity; and respect for others.

6.4.1 Showing patience, tolerance and serenity

Showing patience, tolerance and serenity was defined as the ability of leaders to demonstrate constructive responses underpinned by calmness, tolerance and patience towards difficult situations, caused by either staff or, mainly, patients and their relatives that may generate undesirable emotional reactions and results. There was a consensus among most of the participants that this behaviour is effective and widely used by leaders in the emergency departments to maintain a peaceful environment within it. All types of emergency department managers adopted these behaviours and encouraged their staff to do the same in order to minimise the negative effects of pressure and stressful situations on the clinical decision-making process and the relationships between leaders and staff and among staff.

Emergency departments' managers including heads of emergency departments, deputies and head nurses indicated that the emergency department is a stressful setting where leaders must be able to remain calm in order to help them engage in proper, polite and ethical behaviour towards other people. This enables leaders to deal with staff and patients and to solve departmental problems that are likely caused by patients and their companions. It was believed that emergency departments need leaders who are able to remain patient and tolerant so that they can avoid negative interactions that might subsequently lead to undesirable results that affect leaders, their staff, patients and the overall healthcare provided. Confrontational reactions due to problems caused by other people were seen as negative behaviour and could lead to failures of leaders in emergency departments because this is to be expected in such stressful environment. Therefore, it is the high stress environment characterising emergency departments, which provides showing patience, tolerance and serenity leadership behaviour a particular significance and meaning in this setting.

"An emergency manager must have the features of politeness, good behaviour and ethics so that they are able to solve departmental problems. It does not work to bring in an emergency physician who is nervous, they must be quiet … they must be patient because you have to be patient with the people you see." Int.1, H.1, HD, M, EG (translated from Arabic)

"Be cool-minded is what I say if a patient is getting aggravated; he may be 100 per cent wrong, but even then you should be cool to deal with him, you should not lose your temper, not to say I will go, I will not see him. Now, if a doctor is shouting at a patient for some reason, maybe he is right, but he should listen to the patient; he should not use the same language as him, in the same way as him. His manager should take him to his office, he should cool him down, offer some tea, coffee, or other beverage, and then he should listen, he should never be a bad-tempered person." Int.26, H.5, D, M, IN

"Leaders must be broad-minded and tolerate everything coming their way, not confrontational, because confrontations always fail the leader." Int.4, H.1, HN, M, SA (translated from Arabic)

The quotes above reveal that tolerance is an important leadership characteristic in EDs since those EDs are frequently exposed to hostile patients who may say bad words or behave poorly because of the severity of their medical condition. An important function of leaders in emergency departments is to ensure that emergency staff can respond constructively to such situations by showing patience and tolerance as well as through attending to patients and avoiding confrontations. When an emergency department staff starts being nervous and tense, leaders should take them out of that environment by taking the staff to their office, for example, to listen and cool them down.

Physicians and nurses agreed with emergency department managers, deputies and head nurses that leaders must remain calm in order to be able to maintain a peaceful environment and make constructive decisions. Physicians indicated that this is an effective approach to solve day-to-day problems effectively. Nurses revealed that leaders' serenity influences them since it makes them focus during care delivery; thus, it is important to deliver reliable patient care in emergency departments. Consistent with other participants, it was said that a lack of patience and tolerance might lead to increasing occurrence of problems. Therefore, leaders must be able to show patience and tolerance.

"You have to be quiet whatever happens around you, you will probably make the wrong decision if you lose your temper… ." Int.21, H.4, P, M, EG (translated from Arabic)

"Sometimes we are anxious because of the situations of patients, also because of the behaviours of the relatives of patients. But we try to do our best, we do our best to save the patient for the sake of the patient. At times we are calm if the doctors are calm when giving their orders; calm means not cranky." Int.30, H.5, RN, F, FI

6.4.2 Respect for others

The second subtheme put under the major theme of role modelling is showing respect to others. This subtheme defines leaders who constantly display kindness, care, humility and being approachable to emergency staff. All types of participants in all hospitals pointed out this leadership behaviour. Participants perceived respect as a process that can result in reciprocal influence between leaders and staff. In other words, when leaders show respect to their staff, staff too will show respect to their leaders. Thus, emergency staff may increase their cooperation in the department, in addition to their commitment and devotion to work duties. Furthermore, showing respect to others was seen as a key leadership behaviour when forming relationships with emergency staff. In contrast, participants believed that a lack of respect might lead to a failure of leadership, because it damages the foundations of the relationship via which leaders and staff interact with each other.

Heads of emergency departments mentioned the importance of showing respect to staff in order to make them feel they are valued in the workplace. It was perceived that paying attention to staff by listening to them, treating them equally, involving them in the leadership process, giving advice to them and recognising their achievements were important behaviours that help leaders express and gain respect at the same time. Moreover, leaders who were perceived as friendly, whereby staff have easy access to talk to them, and show humility in the workplace could gain acceptance and respect from their staff. It was commented that having a close relationship with staff might not only increase relational bonds but also reinforce mutual respect. It was also reported that showing respect to staff might greatly increase their cooperation and performance in the emergency department.

> *"These are the main things we expect we use. It means you listen, you coach, you engage, you respect. These are the basic things I am trying to do it with them, we respect them, we appreciate what they do and we listen to them… we respect everyone, residents, housekeepers, we sit down with them, eat with them, talk to them, so that they feel important to the area. There is no closed door so that you cannot come without permission or an appointment." Int.7, H.2, HD, M, SA (translated from Arabic)*

> *"Employees do their jobs to the fullest if respect is shown to their personality and humanity." Int.19, H.4, HD, M, EG (translated from Arabic)*

Deputies and head nurses described the importance of showing respect to emergency staff in order to gain their cooperation in the workplace, especially at challenging times. Respect was viewed to be a key leadership behaviour to make emergency staff work efficiently and always

willing to provide help to their leaders, regardless of their positions within the emergency department. Respect was also described as the basis of the relationship between staff in the emergency department because they always need to cooperate with each other. In addition to leadership behaviours that bring about respect, leaders who are knowledgeable and have clinical skills were more likely to be respected by emergency staff. This is because leaders will be able to offer the necessary medical support to deliver appropriate medical treatments in different situations that arise in emergency departments. It was seen that knowledge and clinical skills might positively influence leadership capabilities. However, leaders who have expertise power with lack of respect for others were described by participants as ineffective because they may not be able to gain respect and thus cooperation of others.

> *"I still have the conviction that the extent to which you respect the people around you, whether they are doctors, nurses or other staff, is the extent to which they make your work successful. I always say to doctors, and there was a consultant who told me this when I was doing my internship year, that if you want to be a smart doctor read books and save them in your memory, from the first to the last pages,[11] but if you want to be a successful doctor, respect the staff who are with you. You will see them work well in times of disaster and find your work gets done quickly, they will work with you more efficiently, cooperating with you at times of disaster, even if they are not working in the same area as you, you will find they come to help you. So I see respect as the first point between colleagues." Int.2, H.1, D, M, SA (translated from Arabic)*

One of the head nurses described how respect is gained through showing humility and equality with staff, regardless of their position, being kind to staff, and the use of polite and proper language for communication with them. Respect can be expressed by stressing brotherhood and modesty. Like other participants, it was believed that showing respect might enhance the relationship between leaders and staff.

> *"Respect is possibly ... When I speak with anyone here, honestly, I say I am an elder brother and my level is less than yours is. It means there are no barriers between us, whether Saudi or non-Saudi." Int.4, H.1, HN, M, SA (translated from Arabic)*

[11] The participant uses a metaphor to describe how to be a smart doctor rather than a successful one by only reading and revising books and being able to save in their memory the medical information that these books contain. The original source in Arabic is the following: [اذا كنت تبغى تكون دكتور شاطر رح اقرأ بالكتب اقرأ من الجلدة الى الجلدة واحفظ]

When the participant was asked to explain the reasons behind showing kindness and politeness as a means of showing respect to others, he replied that this is a very influential strategy that is used to influence staff in the emergency department, compared to the use of power and force.

> *"Because this style; sorry, we are not in an old era of ignorance whereby everything must be imposed by force. I think respect affects them more than power." Int.4, H.1, HN, M, SA (translated from Arabic)*

Physicians and staff nurses expressed the importance of showing respect for others in terms of kind-dealing and polite language between emergency leaders and their staff. It was also said that respect must be shown to all types of staff working in the emergency department. Respect must be given to their scientific background, related knowledge and skills, nationality and culture. Physicians and staff nurses indicated that emergency leaders use this behaviour not only to gain the respect of their staff but also to strengthen their relationship with the staff. Respect for others leads to mutual respect and facilitates staff cooperation in spite of pressure and the heavy workload characterising the emergency department as described by the participants. Thus, it was seen as effective and can facilitate staff cooperation in the emergency department. One of the physicians also commented that nurses may see themselves less than physicians in terms of rank and knowledge although nurses have special knowledge that physicians do not have. Therefore, physicians should respect nurses for their scientific and professional knowledge. This point also shows that physicians perceive themselves as leaders and nurses as their subordinates.

> *"Always, respect makes the person in front of you respect you back … for example, when I work with a labourer, I do not work like a physician with a labourer, I do not say go or do not go, rather I say please bring this. They will feel a little barrier has been broken down; then, if you ask them to do something later on, they will do it without any problem. Nursing is the same; they feel they are nurses and you are a physician. In Egypt, they say being a physician is the highest thing, but being a physician is not the highest thing. Being a physician is the highest thing possible, yet a nurse knows things that I do not know…" Int.21, H.4, P, M, EG (translated from Arabic)*

> *"Usually what makes this unit works, even given how toxic this unit is, is respect for each individual and nationality, or even culture, from both doctors to nurses and managers to nurses, so it starts from there." Int.18, H.3, RN, M, FI*

A staff nurse indicated that leaders who show respect to others, in terms of being friendly, cooperative and modest, have good relationships with their staff and this may contribute to

reinforcing a cooperative relationship among emergency department staff. Furthermore, it may lead to increased staff retention and better performance.

> *"…the friendship that we have among the staff is a good relationship, that's why we are motivated; and our leaders are very approachable and cooperative and kind, and so we are motivated to stay and to work." Int.30, H.5, RN, F, FI*

6.5 Democratic leadership

Democratic behaviour, as defined by the participants, is the process of giving weight to staff members' opinions and making them able to take part in decision-making and leadership process through consultation, consensus, and delegation. This is consistent with White and Lippitt (1960) definition of democratic leadership; democratic leaders focus on developing relations with their subordinates through open communication channels, motivating them to take part in the decision making process and identifying clear goals and objectives. Democratic behaviour is also called participative or empowering leadership, which involves a leader's use of decision procedures that allow followers to have some influence over decisions that will affect them (Yukl 2013). Democratic leadership is similar to the concept of consultation and consensus, which are both deeply embedded in Islamic religion and they are considered as a form of effective leadership:

> *"Respond to their[12] Lord; keep up the prayer; conduct their affairs by mutual consultation; give to others out of what We have provided for them" (Haleem 2005 42:38)*.

Consultation refers to the term "shura", while consensus refers to "Igma'a" in Arabic. The former denotes consultation and the later denotes consensus or general/majority agreement.

There was a shared perception that emergency department managers regularly practice this type of leadership behaviour. While Arabic speakers' participants said shura and Igma'a during their interviews, participants who speak English language used democratic or consultation and consensus. Democratic leadership behaviour involves several behaviours identified during the coding process. These behaviours included democracy, meetings, listening, brainstorming, voting, consultation, discussion, participation, involvement, delegation, taking suggestions, ideas and opinions. These were then categorised into three sub-themes: consultative leadership behaviour, consensus and delegation.

[12] Their refers to Muslims

6.5.1 Consultative leadership behaviour: "Shura"

The participants defined consultative leadership behaviour as the process of discussing a decision or a procedure with staff members in order to get their advice or opinions about it before making a decision. Most emergency department managers, including heads of departments, their deputies and head nurses, revealed their use of this consultative behaviour. Heads of emergency departments usually undertake consultation through meeting with staff members to get their views and ideas. This includes organising work and assigning responsibilities, developing new polices within the department to improve staff performance, and identifying and discussing staff issues and departmental problems in order to solve them. Emergency department managers indicated the importance of consultative leadership behaviour as the emergency department is a multidisciplinary setting where people from different scientific backgrounds come to work in one place. They described this behaviour as both effective and a collective process. They also used this behaviour as a technique to identify different views and thoughts, and to reinforce their decision-making process.

> *"With regard to organising physicians' work, I use consultation. For example, when I make the rotation schedule, I consult people. I mean I go to each doctor or I arrange a meeting, a weekly meeting, to see who can cover the medical care room and who will be a medical physician in the future; who wants to stay in GP to see cold cases; who wants to be in the surgical and accident room. We form a committee from them to take their opinions and organise the work according to the interests of everyone in order to let them benefit scientifically and benefit the place he is assigned to. When you work with things you like, you will perform better." Int.1, H.1, HD, M, EG (translated from Arabic)*

> *"If we want to develop a treatment book, which is about emergency protocols, the head of the department will not do this alone. I take the opinions of everyone because they have different specialities. For example, I want to improve performance, so if I see a problem in the performance of the nursing staff I want to improve their performance; I cannot do it alone, I must consult the nursing supervisor and the nurses because when a decision is taken collectively it will be free of deficiencies." Int.19, H.4, HD, M, EG (translated from Arabic)*

Almost all deputies and head nurses had comparable perceptions and indicated their practice of consultative behaviour. They pointed out that this behaviour as effective and participatory. They mentioned that this behaviour enables the exchange of ideas between managers and staff members. In addition, it was said that consultative behaviour encourages staff, not only in terms of implementing instructions but also to think and build creative ideas to solve problems. They

pointed out the significance of listening to staff members to identify their problems and hear their thoughts, and thus let them be involved in the decision-making process. Democratic behaviour was also understood as giving staff members the right to express their views, to accept and refuse instructions, and to do things that are in line with the hospital's policies and procedures. It was considered to be a cooperative behaviour that supports teamwork within the emergency department. The deputies and head nurses indicated that the use of consultation will facilitate the implementation of new policies and procedures in emergency departments, since staff can feel that they are part of the decision making process.

> *"Imposing opinions does not lead to efficiency when compared to participatory opinion-forming. When I come to consult you, how do we do this? You can give me your ideas and I listen to you, and you listen to me and we will come up with a result, but if I impose my opinion, this means your opinion is not important and you just implement it, that's all. This will create a barrier for people who can think, you would see doctors just implementing instructions as ordered by the head of the department, but when doctors realise that their opinions are important and they can participate, then you will see that everyone has ideas. I have ideas and you have ideas, I lived in one environment and you live in another environment. You have seen and had experience in other hospitals, and I have had experience in other hospitals. This means we can gather ideas from various sources and come up with new ideas, and this is why we use it." Int.2, H.1, D, M, SA (translated from Arabic)*

> *"Everyone has the right to make suggestions, the right to do what they think is correct, but based on the policy and procedure of the hospital. It is democratic in the sense that they are not obliged to do what they do not want to do, it is still they who decide. For example, when exchanging duties they still have the right to be informed..." Int.28, H.5, HN, F, FI*

Most physicians and nurses described the use of consultative leadership behaviour among emergency-department managers. Like emergency managers' perceptions, consultative leadership behaviour was usually undertaken through meetings when managers consult their staff members to identify departmental, clinical or personal problems that they encounter during work activities. Emergency medical and nursing staff indicated that their managers listen to their concerns and consider their views. They described this behaviour as a collective process that lead to better results and increased cooperation and respect between managers and staff.

"Usually, managers in this department behave in such a way that you are respected, your views are listened to, before they give you, what I call this, their ideas or judgements in a certain bed, so usually they assess first what happened, they investigate, they ask the other person about an incident, and after that they will also consult with other leaders, such as other charge nurses, before they give you their decision on a certain thing." Int.18, H.3, RN, M, FI

6.5.2 Consensus: "Igma'a"

The second form of leadership behaviour categorised under democratic leadership behaviour was consensus. Consensus leadership is derived from Islamic values which denotes a general agreement. Igma'a was the word used by the paricipants who speak Arabic language, while consensus was mostly used by other participants who speak English as a second language. However, consensus leadership behaviour was described by participants as a either a general or largely accepted opinion or decision among a group of people, managers and staff members. In other words, a decision is taken based on the largest number of people who are requested to select and agree on one alternative among several. Many participants, including emergency department managers and their clinical and nursing staff, identified this leadership behaviour. For emergency department managers, this behaviour was seen as important in order to reach agreed decisions that are accepted by most of the people involved. Managers used this behaviour not only to listen to their staff, identify and discuss their problems, and take their views on certain issues, but also to make staff members feel that they are responsible and important to the department. Consensus was used to find out about the appropriateness of a proposed decision, which can be changed if there is little agreement. Managers also indicated that they resort to a voting system when there is no general agreement in order to identify the most desirable decision. That is, voting is used to reach major consensus.

"Decisions are taken collectively most of the time and we use modern communication media. Every decision is taken according to the people responsible for it and interested in it. For example, we wanted to change the working time to 7 o'clock, someone came and said if you decide it yourself, write and sign a paper, staff will be forced to come in at 7 am, which is easy for me, but I said no. I said that people must agree before Ramadan;[13] they must feel they are responsible. They are neither sheep nor slaves to whom you just say come in at 7 am. We let people vote, who wants to change, and what are the pros and cons of this decision, what are your opinions? And many said indeed we have no

[13] The ninth month of the Muslim year, when Muslims have no food or drinks during the day.

problem at all. Based on a vote, people wanted to come in at 7 and so we changed." Int.7, H.2, HD, M, SA (translated from Arabic)

"We are very free to do this because this is the main job of a leader, he should provide the circumstances whereby the subordinates are free to discuss the issues which they have in daily practice in the department, so we have a daily morning meeting where all the doctors who were in duty in the last 24 hours describe their problems, so in this way we discuss with each other how problems can be solved, in this way or that way, he takes the opinions of us all. A second thing, the most important thing, he does not mention the names of those who are not present, and if someone has made a big mistake he does not mention the person but he will describe the problem, so he will ask for opinions. This is what happens with some doctors, they ask for your opinions, what they should do, so everyone will say we should do it like this, we should counsel him, we should punish him, or we should or should not cut his aaagh! We have to pass a complaint up to the higher authorities, so in the end, after half an hour, we reach a major consensus, and we get to follow that." Int.26, H.5, D, M, IN

"As a head nurse, when there is a unit meeting and I propose something, which some people agree with it and others not, we take a vote to find out what to do or, for example, you offer a certain choice and you see there is no response, so you do not continue, you change it, then there is no problem." Int.22, H.4, HN, M, SA (translated from Arabic)

A physician indicated the use of consensus leadership behaviour by the head of his department in order to solve disagreements between staff regarding working time. The physician viewed this type of leadership behaviour as effective and a collective problem-solving process. The head of his department also told this story.

"There was a disagreement a while ago about the start of working time, whether it should be 7 am or 8 am, because we used to start work at 9 am during Ramadan, but they find it could be difficult for physicians. This issue was under discussion and there was research for a solution, who wanted to start at 7 am and who wanted to start at 8 am; and there was a vote. At last, it was decided to start at 7 am, even for a simple issue like that the decision was shared." Int.9, H.2, P, M, JO (translated from Arabic)

Overall, democratic behaviours through consultation and consensus not only solve departmental and staff members' problems but also increase the level of relationship between managers and staff through involving them in the decision-making process. As believed by the participants, this

behaviour leads to staff satisfaction and increases their sense of responsibility, as well as their sense of being an important part of the team.

Whilst democratic behaviours were perceived as effective and can lead to better results and increased staff satisfaction among managers and their staff, the lack of it was perceived ineffective and can lead to decreased staff satisfaction, which may result in more staff who want to leave.

> *"The consultant who is responsible for education took two or three decisions without referring to the department, why did not he let us contribute? He does not have the right to take decisions without consulting his team members, not just the head of the department. I can fire him from his position, it is easy for me, I would not feel any guilty in firing him. Our goal is to take all our decisions by voting, or reaching consensus at least." Int.7, H.2, HD, M, SA (translated from Arabic)*

The absence of democratic behaviours could lead to tensions and disagreements among staff members. It was also viewed that individualistic decision-making processes are likely to lead to making wrong decisions.

> *"Imposing opinions leads to conflicts, even if it is not overtly explicit it will be internally implicit, it cannot be accepted." Int.2, H.1, D, M, SA (translated from Arabic)*

> *"I always see leaders who take individualistic decisions fail. Not always but most of the time they do not take correct decisions." Int.14, H.3, D, M, SA (translated from Arabic)*

Staff nurses also indicated that leaders should not only decide based on their own views but also should consider and take the views of others. A decision that can be seen as effective by a leader may not necessarily be seen so by others who have different views, and this may have a negative impact on them.

> *"When considering ideas, you should consider not only your ideas, you should also be saying, what is this? You must be elastic, you should not focus only on one thing, you should consider others too." Int.5, H.1, RN, F, FI*

> *"…because if you are only believing in your own judgement, sometimes your decisions will not be good, and that will affect others…" Int.24, H.4, RN, F, FI*

6.5.3 Delegation

Delegating is a particular type of democratic leadership behaviour. Participants defined delegation as the act of assigning a particular authority or duty to another employee. This subtheme emerged from repeated mentions by participants of leadership behaviours such as delegating and assigning. There was a consensus that this form of leadership behaviour is valued in emergency departments.

All emergency-department managers indicated their use of this behaviour to distribute leadership responsibilities to their employees. This was to ensure that there is a leader in every area within the emergency department who can run, manage and solve problems arising. It can be said that emergency-department managers recognise the complexity of their department and believe they cannot lead all time and be everywhere. Thus, they identified the usefulness of delegation, not only to control the department but also to create leaders in every area within the emergency department. Therefore, a key skill in leaders is to create leadership in others at all levels.

> *"The way I manage the department is that we have something called macro and micro duties; I intervene in big things which is the fundamental operation management; this is for me. While small things like everyday work, the number of available beds, physicians' schedules, attendance and absent sheets for physicians, patient referrals from one place to another and dealing with patient complaints, every area is responsible for dealing with such these things." Int. 13, H.3, HD, M, SA (translated from Arabic)*

Emergency-department managers reported that they select some employees and give them authority to lead based on several criteria, including years of experience in the hospital and their behaviour with colleagues and patients. Put it differently, leaders develop their own self-awareness of their staff members' strengths, which are used to promote their involvement in leading the team.

> *"I select them based on experience, years of experience, work in the hospital, their behaviour with their colleagues and also with patients. I personally select them because they have particular leadership attributes, they are selected based on these. I then give them tasks to achieve; when they achieve them, I delegate and give them other tasks… ." Int.25, H.5, HD, M, EG (translated from Arabic)*

Deputies and head nurses mentioned the use of this behaviour to delegate responsibilities to staff in order to lead different areas and tasks. There was a common agreement that leadership is not the responsibility of particular individuals, based on rigid instructions, but rather it is distributed across the department with intervention from department managers or deputies to solve

problems when needed. Leadership responsibility was given to staff, along with accountability. Designated leaders were given less workload or were placed in a lighter area in order to be able to have time to solve problems arising. Notably, there seems to be some consistency in leadership behaviours between the head of the department, his deputy and designated leaders, with more influence from the head of the department on other leaders, who try to engage in the same behaviours.

> *"…on every shift we have one; for example, in the evening, we have six doctors on duty – one will be the leader, so he does not have much demanding work. For example, he might be involved in triaging, so he is the leader of that situation. In the same way, if any problems arise he is the one on the evening or the night shift to solve these problem; so we have these three teams to cover the times concerned. We have morning, evening and night shifts, and on every shift we have one leader who will work on behalf of our chief, he will do the same as me doing everything my boss does." Int.26, H.5, D, M, IN*

Participants described this behaviour as vital to decentralise leadership, and thus to have leaders in every area of the emergency department; where more than two people are available, one of them leads the other. It is also reported that leadership is not going to be effective and fruitful unless it is available to every group of people in the emergency department.

> *"Leadership is important, when it is always active with no centralisation, you cannot cover everything every minute and every hour. We always put a leader in every area, even if we are few. If they are two, one of them is responsible. If they are three, one of them must lead the others. And this is one of the successful things we have in our department" Int.4, H.1, HN, M, SA (translated from Arabic)*

Participants suggested that it is important to delegate leadership responsibilities in order to accelerate working processes and prevent delays in emergency departments. It was also reported that there should be a direct communication with other formal leaders to provide support when needed because they have official authority in the hierarchical system. When one of the participants was asked to explain his answer, he replied:

> *"To prevent working stoppages. If you put everything on one individual, there will be weakness and delay at the same time. You should give power to others, with direct communication if anything happens. I always think centralisation delays work." Int.4, H.1, HN, M, SA (translated from Arabic)*

Some physicians also indicated that different emergency-department managers use delegation to assign some of their responsibilities to other employees, who are given substantial freedom to

perform these responsibilities. According to the physicians, delegating work responsibilities is usually based on staff's skills and capabilities. They perceived this behaviour as effective, as it decreases the workload on managers and leaves them with considerable time to concentrate on the long-term running of the department.

> *"Department leaders always try to assign some responsibilities. This means delegating responsibilities to every specialist, according to their wants, and what they are successful at. Our previous and current managers try to give each doctor some responsibility so as to minimise the daily burden on managers and let them focus on strategic management for emergencies. I think this is one of the good qualities that leaders in this department have. They prefer not to interfere in every small and big thing... ." Int.9, H.2, P, M, JO (translated from Arabic)*

Staff nurses identified the effectiveness of this behaviour in the emergency department. It was reported that the emergency department consists of many individuals and several teams and each team has to have a leader and take some leadership responsibility. In addition, it was indicated that it is challenging for managers to lead all the time all over the department since an emergency department is a complex setting composed of large numbers of staff who operate in different areas within the department. This is consistent with the managers' views mentioned above. It was also emphasised that delegation may help to increase working efficiency and the effectiveness of patients' treatment processes.

> *"We have a total of, I guess, about 70 staff, so staff are assigned and distributed to each area as determined by our head, he distributes the staff and decides who will be assigned to the medical-check room, the surgical-check room or our store to check for the expiry of supplies, who will be responsible for requesting store supplies, things like that. So, of course, although he is a leader, our head, we cannot just put all the responsibilities in his shoulders, he has to distribute some of his workload to his staff, so that is kind of, what I mean is, this strategy has a very good impact because although most of the staff are non-Saudi, they still follow instructions." Int.6, H.1, RN, F, FI*

In summary, the main objective for delegation behaviour was to share leadership responsibilities with staff and to boost the leadership capabilities of emergency medical and nursing staff. It was not only intended to increase the efficiency and effectiveness of care delivery but also to facilitate changes and improve the overall running of the emergency department.

6.6 Staff development leadership

Staff development refers to leaders who want to improve their staff's skills, abilities and qualities through the provision of different educational opportunities. Interviews revealed that staff development is perceived as an effective leadership behaviour in terms of promoting staff knowledge and skills in order to deliver better healthcare in the emergency department. It was perceived as an effective leadership strategy to motivate emergency department staff to increase their performance in the workplace. Moreover, staff development was used to strengthen the relationship between leaders and emergency department staff. This theme emerged from several leadership behaviours reported during participants' interviews including provision of education, training, teaching, lectures, continuous education activities, conferences, workshops, scientific courses. About 25 participants, from all the hospitals, mentioned different patterns of staff development during their interviews. Staff development leadership reflects some leadership behaviours, which have been identified in current leadership literature, including individualised consideration (Bass 1985) for transformational leadership, and commitment to growth of people (Spears 2002) for servant leadership. Individualised consideration incorporates teaching as well as showing high concern for different individuals' needs for success and development (Bass and Bass 2008). Commitment to growth of people denotes treating each follower as a unique individual who have intrinsic values with commitment to helping each follower to grow personally and professionally (Spears 2002).

Emergency department managers mentioned their use of this behaviour to either advance or correct understandings and skills in relation to clinical care provided in emergency departments. This was achieved through meeting clinical staff, in the emergency department, on a regular basis in order to discuss any difficulties experienced regarding diagnostic or treatment issues for particularly complicated medical conditions. It was also achieved through organising lectures inside or outside the emergency department to increase staff's understanding of certain serious subjects in the workplace. The aim of this leadership behaviour was to identify the correct diagnosis procedures for complex conditions so that medical staff can follow these when experiencing similar situations. Commonly, all emergency department managers had the perception that promoting staff development is an effective behaviour that is used to enhance staff's understanding and skills in order to keep up with scientific advances in their respective specialities.

> *"I am responsible for the scientific training of physicians. We regularly run training courses in the emergency department. For example, we have a meeting every week, in the morning, where most of the physicians gather, and we discuss complicated cases*

that we study in the department on the same day. This means that if any physician is facing a difficulty in diagnosing a certain medical case, we can discuss it together, look at the results, see what investigations were done, the diagnosis of the case and what plan of treatment was devised for the patient. If there are any deficiencies, we call a consultant physician and start to organise lectures again to correct any misconceptions or deficiencies in the treatment process, this is for education. Secondly, we have also training courses provided by Health Affairs[14] or the Ministry or the educational centre that we have in our hospital organised by physicians. We put three or four physicians every week to attend these lectures." Int.1, H.1, HD, M, EG (translated from Arabic)

"First is scientific motivation. It means you must offer educational development for those people. You must provide them with certain programmes and lectures. People must know that they are not standing still, that there is more development. Everyday there is a change to something in medicine. They must keep up with events; we call it journal club lectures." Int. 13, H.3, HD, M, SA (translated from Arabic)

Another emergency department manager expressed that leaders must desire to develop emergency staff clinically for the sake of the department and the staff themselves. It was perceived as a mutually beneficial process. Moreover, it was seen as important not only to provide education opportunities for staff, but also to encourage them to develop themselves in order to advance their careers, which in turn will be reflected in improvements to their clinical performance in the emergency department. Furthermore, it was reported that leaders must be able to make staff feel that professional development is important for themselves through communication, determination and encouragement.

"The principle of development is that you have to develop yourself. We have paramedics who are not working in the emergency department, they work on the door. They leave and bring patients. I request them to look at the schedules and shifts. They can see patients, just for themselves, for development. If the leader has no desire to develop his/her team and make them feel it is important, we will not develop. I give you an example; I spoke with our specialists here and told them that after three years they must be consultants. How? You have to do anything. I told them that I would not accept or have specialists after three years. You must work to develop yourselves. Revise and take the board exam so that you become a consultant. Now, all of them are reading because

[14] The General Directorate of Health Affairs is the representative agency of the Ministry of Health in each city in Saudi Arabia.

the exam is in two or three months, and I will give them a chance next year and the year after." Int.7, H.2, HD, M, SA (translated from Arabic)

Deputies reported that staff development occurs through meeting regularly with emergency staff to discuss and analyse shortages and mistakes in medical interventions that have occurred in the department in order to raise awareness of proper intervention techniques for medical staff and prevent reoccurrences of similar issues. It also occurred through the provision or organisation of scientific lectures in order to promote staff abilities, skills and experience in certain medical interventions. It was commented that emergency managers frequently provide educational opportunities to their staff and try to encourage them to attend lectures, seminars or conferences, either within or outside the hospital or the city of the hospital. It was seen as an ongoing process.

"There is scientific supervisory part; there must be some kind of training and follow-up training, especially for new doctors, and we arrange continuous education activities to develop the capabilities, skills and scientific expertise of physicians who practise emergency medicine in the department. This is done on a regular basis for people who practise emergency medicine inside the department, they can also attend seminars and conferences in the region or outside it. All of these are organised and supervised by the head of department." Int.20, H.4, D, M, EG (translated from Arabic)

Head nurses perceived educating staff as an effective leadership behaviour to strengthen staff knowledge and skills in relation to emergency medicine and related matters through providing them with training courses. This was done to overcome shortages of knowledge and capabilities that may lead to deficient medical interventions. This behaviour is associated with responsive leadership behaviours in section 6.2, because leaders can exercise leadership development behaviours when they discover problems due to a lack of knowledge of certain medical subjects, with provision of related courses to overcome such deficiencies.

"One of the problems is when staff, for example, make a mistake when giving certain medication. The staff member types a notification of the mistake, an OVR[15] that a problem has occurred which is not supposed to occur. We call the staff member and ask him/her about the problem and what happened. We listen to the answer of the staff member and we study his/her current weaknesses. If, for example, the staff member has a problem with calculating dosages or lacks information about medications, we allocate

[15] OVR is a medical abbreviation for an occurrence variance report. It is an internal form used to document the details of an occurrence/event, an investigation of it and the corrective actions taken.

courses in this subject for him/her, which will also support him/her with a number of credit hours." Int.10, H.2, HN, M, SA (translated from Arabic)

When this participant was asked about the reasons for meeting staff and providing courses, he replied that the aim is to develop staff and prevent the occurrence of similar events again.

"It is done on the basis of development of the employee, and to avoid any errors of this kind next time." Int.10, H.2, HN, M, SA (translated from Arabic)

Physicians and staff nurses reported that emergency leaders must always try to facilitate training and educational activities for their staff. This was undertaken in order to keep their staff up to date with scientific advances. Moreover, it was done to let staff acquire various skills needed in the emergency department. Staff development will lead to improvements to the healthcare services provided to patients because the knowledge and skills attained can be applied in the workplace. Managers who pay attention to staff development were appreciated. Like other participants, staff development was seen as an ongoing process. Physicians and nurses indicated that the emergency department is open all the time and receives all types of diseases and injuries; therefore, emergency staff members need to be continually trained, educated and informed about the latest advancements in medical knowledge and practices.

"Well, I always say that in leadership there is always room to improve, and improvement should come from the Ministry of Health, from time to time lots of courses are organised for emergency care management and for advanced life support, plus some courses for hospital risk management, policies and procedures, and disaster management. They are organised because this is an ongoing process. Our department works 24 hours per day, so we need more trained people, more than ever we want them to have the latest information and the latest knowledge. So we keep these things in our minds, we try to ensure all our leaders get updated with the latest courses. So sometimes they go to Riyadh, sometimes they go to our educational department's[16] three-day workshops, five-day workshops and one-day workshops. They attend, learn new concepts and then they come and apply them in our department." Int.3, H.1, P, M, PA

"They actually encourage us to attend courses and symposiums to become more effective staff. So actually, we are attending some nurses now, some ER staff are already on an ETLS course[17] and many more courses are on the way. Of course they are always

[16] Continuing education department is available in most of the large size Saudi Hospitals located in urban areas such as those included in this study.
[17] ETLS refers to Emotional Trauma Life Support training course.

encouraging us to keep the patients happy and contented with the service we are giving, they give us lectures sometimes, and they always remind us to consider or treat the patients' right." Int.30, H.5, RN, F, FI

"If you have a lack of skills they allow you to go on certain education or training courses, or to conferences, to make you more effective." Int.18, H.3, RN, M, FI

When this staff nurse was asked to describe his feelings about this leadership behaviour, he replied that this behaviour makes staff feel pleased and content.

"It is good and I feel happy. I even notice that some staff are also happy." Int.18, H.3, RN, M, FI

In summary, this theme shows emergency managers' tendency to develop their staff through teaching and facilitating educational opportunities. It is perceived as effective leadership behaviours that lead to enhanced staff knowledge and skills. This behaviour leads to increasing staff satisfaction and performance at the workplace.

6.7 Recognition leadership

Recognition leadership behaviour refers to leaders who praise, thank and appreciate their staff for their performance and achievements. This theme emerged from several leadership patterns identified during the coding process, including praise, thanking, recognition and appreciation. These were then grouped together to form recognition as an overarching theme. Leaders who recognise staff performance and achievements through thanking, praising and appreciation were seen as effective because they motivate their staff to increase their performance and promote the concept of competition between emergency staff. Competition meant that every staff member wants to perform better than others because of leadership recognition of their successful efforts. Recognition was viewed to be an intrinsic motivational influence.

Emergency department managers reported that recognition is an effective leadership behaviour because it motivates their staff to maintain and increase their valuable performance in the emergency department. Along with praising, recognition could be exercised through smiles, greetings staff who perform their tasks well in the workplace. It also included talking up their achievements within the emergency department and with respective administrative authorities. This was reported to maintain and enhance staff members' reputations. It also led to raising the level of competence of emergency staff, which in turns increases staff performance and cooperation with other colleagues within the emergency department. Recognition might encourage staff, who do less well than expected, to exert better performance in order to make

achievements comparable to other colleagues. It also made emergency staff like what they do and respected the environment in which they work. Emergency department managers provide recognition after their observation and assessment of staff performance and activities in emergency departments.

> *"As I have said to you, motivation is always very important. When I come to a morning meeting, for example, I say to the group that today I did something called auditing, something similar to assessment, of some patients' investigation papers and found that doctor [name of the doctor] got a score of 100 per cent. Of course, he must be available and attend the meeting and this is good for him. I say to the group that there was a case coming with a heart attack, and a doctor was available and did cardiopulmonary resuscitation in the right way, and so, thanks be to God[18], the patient is now doing well in the intensive care unit and the staff there are starting to remove the ventilator from the patient. Of course, I must say the full name of the doctor … I say to the group that this doctor [name of the doctor] achieved this and that, we assigned some tasks to this doctor and he achieved them within the time line, and so we would like to give him a present at the end of this month. Make sure that if you are a member of this team and you do not have achievements like this that you will try to have similar achievements because you need to enter the same circle, where physicians have these achievements. This is a method that I follow and I see its benefits because I have felt there is more competence. Why? Because a physician may finish his/her work but he/she does not quickly leave the department, he/she waits to help another doctor until he completes all the cases and then he/she leaves … Motivation generates in them a spirit of love." Int.25, H.5, HD, M, EG (translated from Arabic)*

Deputies and head nurses in the emergency departments identified that recognition is an important motivational leadership strategy that increases staff performance in the workplace. They indicated that recognition can be exercised through praising and making staff feel they are valued in the department. In addition, recognition could be used by giving a present or appreciation certificate to staff who show excellence every month and so they were called "the star of the month". They also described that recognition is important when staff show punctuality, commitment and excellence when performing their tasks. This leadership behaviour helped leaders to encourage their staff to maintain a high level of performance. Recognition

[18] "Alhamdulillah" is commonly used expression by Muslims for thanking the God when something pleasant happens (الحمد لله).

leadership can be used as a complementary leadership behaviour after exercising rewarding leadership (section 6.1), which involves compensations.

> *"When you compensate them, praise them as well, tell them they do their best for us, the department would not work well without them. You will find they want to work and perform, so this is motivational for the doctors as well" Int.2, H.1, D, M, SA (translated from Arabic)*

> *"Declare your appreciation to good staff, this means there should be praise and thanks to good staff, clarify that they do their best and thank them, this works. Thanks be to God, we have established this environment now." Int.4, H.1, HN, M, SA (translated from Arabic)*

> *"We have something called the star of the month. This gives them motivation." Int.16, H.3, HN, M, JO (translated from Arabic)*

Physicians gave less emphasis to recognition leadership behaviour than staff nurses, who value this leadership behaviour, although physicians identified this behaviour as an effective and influential method for motivation. It was also indicated that praising and appreciation were parts of Islamic teachings, which supports and rewards the use of such leadership behaviour. Therefore, this behaviour was identified as a deeply influential method that makes staff feel pleased with themselves and their performance because their leaders acknowledge what they have done. It was reported that physicians exercise this behaviour when they take leadership roles. Physicians reported that recognition can simply be practiced through saying good, positive, encouraging words to staff and thanking them for their effective performance.

> *"Of course, praise and good words. Sometimes I have a trainer or a resident physician, for example, I say good words to them. It makes them happy. It is excellent for them that a consultant says to them that they are very good. Praise, give thanks and a reminder that The God will reward them if they have good will. Of course, we are religious people and so religious talk really affects us." Int.15, H.3, P, M, SA (translated from Arabic)*

> *"It is supposed that I always give you something back to motivate you. A human soul is always as one.[19] There are many things for motivation, but there are rewards. It means you work well; a reward is not necessarily money. You say good, what you have done is excellent, that's it, that is a reward … even the Prophet, peace be upon him, said good*

[19] The participant uses an expression to say that all human beings are psychologically similar.

> *words.[20] At least good words will give you satisfaction. It does not mean, for example, that you are bad and he says you are good… ." Int.21, H.4, P, M, EG (translated from Arabic)*

Staff nurses indicated that emergency leaders use this behaviour to appreciate their performance. They appreciated leaders who give thanks, praise and appreciation for their efforts. This behaviour is viewed to charm staff and encourage them to improve their performance. It could also be seen that this behaviour encourages staff to encounter difficult situations that require problem-solving skills.

> *"When you do something, they will come to you and say thanks, you did your best today. These words are enough, even if they do not nominate me. These words suffice because he appreciates my work and effort." Int12, H.2, RN, F, SA (translated from Arabic)*

In summary, recognition leadership behaviour is seen as effective by all types of participants across all hospitals. Although it is perceived as simple acts that leaders use, it is seen as a deeply influential leadership strategy that motivates staff not only to maintain a high level of performance but also to increase their performance in the emergency department. This is because, particularly for Muslim leaders, recognition is seen as part of Islamic principles that rewards people who show thanks and give praise and appreciation to other people for their good deeds and performance as narrated by the prophetic tradition "a good word is charity". Recognition seems to generate a psychological influence whereby leaders gain acceptance from their staff as well as motivate them to keep up standards and make extra effort. It can be said that leadership behaviours related to recognition such as thanking and saying good, positive and encouraging words are important in public sector organisations, where financial rewards are not easily available as a form of incentive. Recognition leadership behaviour reflects a specific behaviour available in leadership literature, which is encouraging the heart (Kouzes and Posner 2012). Encourage the heart means that leaders motivate their followers on their achievements and successes by giving praise for well performance, using celebrations, showing appreciation and encouragement to others.

[20] The participant tries to quote a verse from the prophet Mohammad, which is "*It is also charity to utter a good word*" (Sunnah.com 2017 2:14). It means that talking to someone in a decent way will be rewarded by Allah (The God).

6.8 Supportive leadership

Supportive leadership, as defined by the participants, denotes the process of identifying and addressing staff needs at the level of workplace, as well as, in personal and family life, by showing flexibility and understanding, and protecting and defending staff in order to nurture their morale and emotional wellbeing. Put it differently, supportive leadership denotes emotional and morale support whereby leaders show concern for staff wellbeing and circumstances, at the levels of work and personal life, and thus provide the necessary support. Overall, supportive leadership was reported to increase the quality of relationships among leaders and staff, maintain staff cooperation and team cohesion, as well as to encourage staff to improve their performance in the emergency department. It was also used to meet the demands of the unpredictable environment that distinguishes the emergency department, where constant help and cooperation between leaders, individuals and interdisciplinary teams are key to maintain an efficient and effective working environment. Empathy, the sensitivity of an individual to the feelings and concerns of other social members (George 2000), is described as a prosocial behaviour, which is perceived vital to cohesive team function (Thoits 1989). George (2000) suggested that the formation of empathetic behaviour as a team norm would cause relationships to be built and the social support network of the team to be formed. There was a consensus among all participants that this is an effective leadership behaviour. The absence of this behaviour may raise a barrier to effective leadership.

This theme was constructed from several leadership patterns identified during the analysis, including morale support, morale incentives, morale encouragement, psychological support, understanding staff needs and circumstances, flexibility, defending, and protection. These were then grouped into two subthemes: flexibility and understanding, and staff protection and defending.

6.8.1 Flexibility and understanding: “Altafahum”

Flexibility and understanding were defined by the participants as understanding and willingness to accept staff circumstances in the workplace or social situations and attempting to solve them. It is about showing sympathy and kindness. That is, the capacity to feel and share other’s situations and thus respond accordingly.

Most emergency department managers, including heads of departments, deputies and head nurses, indicated their practice of flexibility and understanding behaviour. Managers tended to be flexible and understanding and to manage work duties that might cause family or social struggles for their staff. They tended to solve these problems at work in order to help staff

work comfortably by eliminating pressure. By being flexible and understanding and solving problems to improve the working conditions of the staff, managers were viewed to be able to build a sense of cooperation. Thus, staff were likely to be willing not only to increase their effort at work but also to respond to their managers at any time when there is a need to perform certain duties, even if they are called in to work during their time off. Thus, supportive leadership is connected with rewarding leadership (section 6.1) because these different leadership behaviours seem to be used to achieve a similar purpose, which is to encourage staff to respond effectively during demanding situations.

> *"One of the physicians has a personal problem at home and his family are with him; as you know, we have three shifts, morning, evening and night. The night shift causes problems with his family. The physician met me at the office and told me: I have these problems when I work the night shift, so could we try not to have too many night shifts for me. I told the physician it was no problem at all. I started to rearrange his schedule; we put him on evening shifts and some morning shifts. The physician started to be psychologically much better. If I call him at any time, he will never be late because he feels there is a good response and cooperation between us. Because I try to solve his problems, if I work one day and there is a physician absent because of sickness, what can I do? I have to call a physician who is on holiday to bring him in … If I did not help him in that way he would not respond to my call." Int.25, H.5, HD, M, EG (translated from Arabic)*

The quote above shows that emergency department managers are flexible in terms of modifying work duties to minimise their effect on staff members' social and family lives. However, this flexibility is not only used to decrease work pressure that may cause social or family issues, but also to give staff moral responsibility to give back and respond effectively to their managers during difficult situations, which is common in emergency departments, even if they are not on duty.

It was reported that identifying personal and work-related problems of staff was key to providing the required support. This could include providing support for several types of personal problems, such as financial hardship and residential or family issues. It was perceived that this behaviour increases staff retention and reassures staff that their leaders are mindful of their situations. This might lead staff, in turn, to feel comfortable and work better in order to show their appreciation for their leaders who try to solve the difficulties they experience. For example:

> *"First, leadership looks to the comfort of employees. It looks at all their problems and seeks to be psychologically reassuring so that they can do their work, because whenever*

they feel that their hospital and departmental leaders take care of their interests, I think this will be a driver and motivate them to prove themselves in the workplace. This is the approach I adopt, I try to offer all means of psychological comfort to every new physician coming into the department so as to help them perform well in the workplace, whether they have accommodation problems, problems with their documents in the registry here in the Saudi Commission[21], or financial problems. We try to solve all kinds of problems with, of course, the support of hospital management so that physicians feel that there are people supporting them and trying to offer all means of comfort to them to perform their duties with support. For a female physician, who has children and needs nursery care, we opened a nursery in the hospital to solve this problem to allow her to work and knows that her children are secure, and thus she can work with peace of mind. This is the strategy I adopt." Int.19, H.4, HD, M, EG (translated from Arabic)

The practice of flexible and understanding behaviour would lead to building a satisfactory and friendly environment among emergency staff. Managers' attention to their needs formed a kind of stress release and stimulated their enthusiasm as well.

"Second, the head of department does an important thing, he ensures there is a satisfactory atmosphere at work in the department so that all the doctors are very happy, because he makes the duty rosters according to the problems which they have at home and in society, yet they want to do their duty. So, he helps them; this is the most important thing, we have that help according to the doctors' problems, which could affect the working of the organisation, by giving relieve to concerned doctors, this is our main concern and he generally does not communicate small things to the higher authorities, he tries to solve them at his level and keep the doctors happy." Int.26, H.5, D, M, IN

In contrast, being inflexible and not understanding staff concerns would result in less productivity and more complaints, absences and staff turnover. All head nurses mentioned the importance of exercising flexibility and understanding behaviour to increase staff performance, which could reflect positively by delivering better patient care. The head nurses also perceived this behaviour as a morale-boosting influence that will make emergency staff feel comfortable, ease their mental and physical stress and make them more committed to applying the organisation's rules and regulations. The participants mentioned

[21] Saudi Commission for Health Specialities (SCFHS). SCFHS is the responsible agency for supervising and evaluating training programs, as well as setting controls and standards for the practice of health professions.

kindness and fairness as attributes linked to flexible and understanding behaviour. It was indicated that leadership flexibility and understanding of staff issues can reduce pressure and stress; factors that frequently characterise emergency departments.

> *"It is normal to be flexible, because if there was strictness in everything it would be impossible to get good productivity. If staff are not shown courtesy once or twice, you will be shocked the third time and you will receive a lot of complaints, either transfer requests or absences and sick leave." Int.4, H.1, HN, M, SA (translated from Arabic)*

> *"You influence your staff in a psychological way; you give them support and comfort them. They take what they want, it means you give them their rights, if you are kind to them they cannot break or exceed the rules. This is the most common type of nursing leadership in the ER particularly because the ER is stressful area for both physicians and nurses. As a manager, if you increase the pressure on your staff, this will reflect negatively in the care provided to the patient, and you want something opposite to that. You should give your staff space to be comfortable and you must be flexible. There are some rules that work for other nurses working on other wards, but these rules do not work here in the ER. For example, vacations, we know that the December vacation is very important for Christian people. But you understand for example, that 80 per cent of the staff nurses are Christian, I cannot give a vacation to all of them. You want to be fair so say you took a vacation last year so other staff can take it this year. You do not want to upset anyone because they are all your staff. Pregnant nurses, for example, you cannot pressure them and you cannot say: take a vacation for nine months, because you will lose a staff member. You try to give her lighter work so that she does not experience psychological and physical stress." Int.16, H.3, HN, M, JO (translated from Arabic)*

There was agreement between most emergency department medical and nursing staff across all settings that their managers are attentive to solving problems according to their internal and external concerns that might affect working conditions. They described their managers as flexible and understanding in terms of taking into consideration staff's circumstances and needs when solving problems, although their solutions may go beyond organisational regulations. They also indicated that their managers perceived their high performances and the different circumstances and needs of different staff who come from different cultural backgrounds to work in this setting. Emergency staff commented that they appreciate this behaviour as they have a sense that their work efforts are being valued. Understanding these concerns allowed managers not only to solve their problems but also to build good relationships with their staff and enhance staff interrelationships.

"The ER leader is very friendly, he believes in his doctors, he believes in teamwork. And he understands that all the people, all the doctors and all the staff, come from different places, different parts of Saudi Arabia and different countries, and from different cultures; he makes them all into one crew and lets them work under one umbrella in harmony, that's why I think he is doing great work according to the doctors' needs; he addresses their problems and when he has to be strict he is very strict, but most of the time he is soft, he is understanding, caring and listening." Int.3, H.1, P, M, PA

It was perceived important for emergency department managers to understand and feel the situations of others by showing empathy. This includes presenting high consideration to employees' needs and concerns.

"Of course, it is called empathy in English … with all team members or with all people. You let the person in front of you feel that you take care of him/her … like you are a sympathetic brother … love and cherish for example." Int.21, H.4, P, M, EG (translated from Arabic)

"Yesterday, my shift was in the morning, I rang them to say I could not come in and needed to take time off. The hospital's system does not allow you to time off unless you request it a week in advance, you can't just ring in and then take time off. When they gave me time off, it meant there was consideration, she works every day and is not absent but suddenly she is exhausted, why do we not consider her? This is a good thing." Int12, H.2, RN, F, SA (translated from Arabic)

Understanding staff's circumstances and needs involved considering external factors that may affect the functioning of staff during work time. External factors include social, cultural or religious circumstances. Emergency medical and nursing staff indicated that their managers always attempt to resolve their concerns to let them work in comfort and increase their productivity. They also reported that their demands are always met as long as they do not affect work circumstances in the emergency department.

"When Dr… [the head of the department] makes the schedule for the coming month, a staff member will come and say please give me two days off at that time because I am travelling on those days and I will continue working without time off on the remaining days; another one says I am going for Umrah[22] so please give me these two days off. He

[22] The non-mandatory lesser pilgrimage made by Muslims to Mecca, which may be performed at any time of the year.

is trying to satisfy everyone according to their desires, but at the same time, he does not want to affect the work of other people. Everything is always for the sake of his staff." Int.21, H.4, P, M, EG (translated from Arabic)

It was indicated that managers tend to balance between staff needs and departmental needs in order to ensure both staff satisfaction and normal functioning of emergency department. It is stressed that staff needs are always put first.

"If you are requesting a vacation, there are requests from every one of us, so he is trying to grant all our requests; our head nurse wants to approve all our requests but sometimes you know he cannot approve everything but he does try; so what I mean is, if he tries to approve those requests it is because you are not making important requests. But you know he is also trying to balance the staff and retain them in the ER; so he is thinking about his staff but also thinking about the area, it is a balancing act." Int.17, H.3, RN, F, FI

6.8.2 Staff protection and defending

This subtheme captures a leadership behaviour that shows managers' support and protection for staff in order to keep them from being harmed when dealing with complex situations or experiencing unfair disciplinary actions. This subtheme emerged from several leadership behaviours identified during coding activities, such as protecting staff, security, defending staff, taking responsibility. Work in the emergency department was seen as complex and involved interdisciplinary teams to deliver patient care. Occasionally, emergency physicians may require to consult different specialists in order to correctly diagnose a clinical case. However, disagreements may occur between emergency physicians and specialists regarding the degree of severity of patient conditions, leading to undesirable clinical decisions, which may result in the loss of patient lives, with the emergency physician taking full responsibility of. Thus, it was perceived that providing support to emergency staff is important to let them feel protected and secure when dealing with serious conditions that need further investigation. This support was given when a leader takes responsibility for a clinical situation involving providing assistance and giving reassurance to staff. As a result, this increased the quality of the relationship between leaders and staff. It also maintained a family working environment whereby staff feel encouraged to do their work well while support and protection is given.

"For example, there was a chest pain case the day before yesterday and the patient was sweating. A doctor came here and was worried because another doctor said it was not a serious condition. She came to inform me and I went to see the patient and found it was

a serious condition. She was afraid that the patient might die in front of her and I told her to bring the case so we could diagnose it together. The patient came, I called the cardiologist, and the patient was moved to the coronary care unit. This support makes the doctor like you and increases the compassion and mercy between you. She will know that there is someone like her big brother or father to support her, she will feel encouraged." Int.1, H.1, HD, M, EG (translated from Arabic)

The terms of father, mother and family to describe leaders and work relationships were widely shared among all types of participants. This could reflect the influence of national culture, in terms of high human and collectivistic values (Hofstede 2001; House et al. 2004), on leadership behaviours practiced by emergency department managers.

The participant continued to explain that the aim of using this behaviour was to serve both patients and staff. It helped to deliver effective treatment processes that save patient lives. In addition, it offered protection and security to physicians against managerial and legal punishment relating to wrong diagnostic decisions.

"The first behaviour with the patient differs from the behaviour with the physician. The physician looks at patients from two perspectives, the first is to save lives and the second is to protect themselves. If a patient dies due to a wrong medical decision, the physician will be penalised managerially and legally. However, a patient only needs someone to make a diagnosis. I use two things with the doctors; I assume responsibility for patients and, at the same time, I take responsibility for saving patient lives, those I become responsible for. This is what the physicians want." Int.1, H.1, HD, M, EG (translated from Arabic)

Participants reported that it was important to use this behaviour in the emergency department in order to increase the levels of security and mutual trust between leaders and their staff, which leads to staff retention. This was because emergency staff usually work with different medical personnel from other departments, resulting in disagreements regarding certain medical decisions that may affect the safety of both patients and emergency staff, who may not be confident enough in decisions taken by certain specialists. In addition, emergency staff may experience conflicts with patients and their families who become irritated and emotional, which may prompt undesirable reactions towards clinical staff.

"Whatever you offer to staff, rewards or certain jobs or facilities for them and their families, if you do not offer them a secure place and work security they may soon leave. The most important thing is to get the trust of staff by providing job security, security in

their work and for them in the place they work in." Int. 13, H.3, HD, M, SA (translated from Arabic)

Deputies have a strong perception that the complex environment of the emergency department made it important for them to take responsibility and protect their staff from erroneous complaints, whether they come from patients or other clinical or managerial staff within the hospital. These complaints may expose emergency staff to unfair disciplinary or legal action. This was because they believed that they were responsible for staff safety and well-being. Moreover, it was also performed to ensure that staff rights were maintained. This behaviour was identified as effective and could lead to reinforcing the relationship with their staff. It could also make staff show strong loyalty towards their leaders and more devotion in the workplace.

"I always tell myself that a successful leader is one who is able to take responsibility and protect others, otherwise, you mustn't let them lead. Our profession is prone to complaints and subject to fines; if you are not able to protect them, do not take an action against them, and try to protect them as much as possible. People will blame you and you will be exposed to problems, but you protect them because they are under your responsibility. Whenever you increase your protection for them whenever they like you more and work more diligently." Int.2, H.1, D, M, SA (translated from Arabic)

Most of the head nurses agreed with emergency department managers and deputies. Again, a leader was perceived as a parent or a guardian who must look after and shield his members. They perceived that it was important to show understanding, protection and sympathy to emergency department staff. One of the head nurses went further and commented that leaders must take responsibility for staff mistakes and safeguard staff against managerial disciplinary actions.

"A leader is like a spiritual father of staff who look to him in every big and small matter; he should always support them strongly and cover for them. A leader does not withdraw his responsibility and say it is not his business. Many things happen here and no one is able to disturb my staff. Always, if there is a punishment, I take responsibility for their mistakes" Int.4, H.1, HN, M, SA (translated from Arabic)

He continued to say that this behaviour was used to support his staff regardless of blame from other people. It was perceived that being a leader means defending staff from harm as much as possible, even if the leader has to take total responsibility for their mistakes. This was because there was a feeling of shared responsibility over certain mistakes and it was unfair to put this on

the shoulders of staff alone. This behaviour would make staff strive to avoid repeating mistakes because of the leader's support and protection.

> *"The first thing is to support him. At the same time, I totally believe that if he feels I take responsibility for his mistake and warn him, he will not repeat it. Indeed, I remember there was a supervisory team that came here from the infection control department and there were a few comments. They wanted the names of two people who were responsible for these sections, as I said there is a leader for each section; I refused to give them the names of the people responsible for those sections and gave them my name instead. One of them blamed me for this but I said it is normal, because they are some of the best people I have. It is not correct to put the blame for mistakes on them; they may not be responsible for those mistake. I am the one who appointed them as leaders in this department and I must take responsibility for mistakes." Int.4, H.1, HN, M, SA (translated from Arabic)*

When asked to explain the outcome of this behaviour vis-à-vis the staff, he commented that this behaviour would make staff make an extra effort.

> *"I saw they were sad because I was exposed to a reprimand and then I saw they made an extra effort. These things happen. Indeed I can say it is totally gone now." Int.4, H.1, HN, M, SA (translated from Arabic)*

Physicians identified the effectiveness of being supportive and sympathetic towards emergency staff. There was a perception that leaders who display emotions try to ensure staff well-being and the overall interests of the team and the department. It was reported that when leaders show support, in terms of protection and security, emergency staff would increase their performance in the workplace.

> *"Of course, the most important thing is to ensure the safety of your medical team. This is one of the most important things you do to ensure your team's productivity." Int.15, H.3, P, M, SA (translated from Arabic)*

A physician told a story where a lack or absence of this leadership behaviour during conflicts that may happen between staff and patients or their companions was reported ineffective in emergency department. In emergency departments, patients or their relatives occasionally insult physicians or nurses. Emergency staff members were seen as vulnerable to encounter angry and aggressive clients. Thus, the absence of this leadership behaviour to protect staff in situation where emergency staff, particularly expatriates, were attacked could pose

frustration among them and might lead them to leave the work because they feel "humiliated" as described by the physician. For example:

> *"One of the patient's attendants misbehaved with one of our doctor, and the security was called but they stood silent they did not take any prompt action so there was small quarrel between the patient's companion and the doctor. The doctor felt so much humiliated with that event and nobody came to help him. I know him personally, he was such a nice doctor, very kind towards his patients, very soft spoken, he resigned! He left not only the city but this country and he never came back so we lost very reliable, very precious, very skilful doctor so at that time I felt there was lack of positive leadership behaviour which made the doctor leaves the country and definitely our patients have great lost; they lost a doctor" Int.3, H.1, P, M, PA*

Staff nurses indicated the use of this behaviour by emergency department managers to maintain staff rights and protect them from unfair actions. It was assumed that being a Saudi leader makes it easier to communicate with other departments as well as to provide protection to staff against possible harm, whether this was from patients or other staff in the hospital.

> *"For example, our head nurse is, I can say, a leader who protects us. If we have a problem with shouting patients, something like that, he will try to fix it for us, to defend us. I have been here for four years already, I have seen four charge nurses, for me this one is better, and he is better because he is from this country, he can defend us from the inside and from the ward. I know you know it is different for us non-Saudis, they will listen, especially in the departments. Inside they will listen more to Saudi people more than to non-Saudis, so for us, for me, our head nurse is like that, he will do everything to defend us, his staff." Int.5, H.1, RN, F, FI*

It was indicated that this behaviour makes them feel pleased and proud of their leaders. It was also reported as an effective leadership strategy when someone understands the situations of staff members and is supportive to create a relationship with mutual trust. In contrast, leaders who take no supportive action to confront managerial personnel in order to protect their staff were perceived as weak and will have a poor relationship with their staff.

> *"They are happy because the head nurse is a true leader. She defends them. She will defend her nurse, she will not get angry immediately, or ask why you do it like that, why don't you do it like this. We have tried that already before, a head nurse that we have before, that is because it is another nationality and they immediately react like that when there is a complaint, she is afraid and will try to hide and she will scold you*

immediately, even if she does not know yet the reason why, so immediately when upstairs starts calling, when line managers start calling she will not give any answer, she will not defend her nurse." Int.29, H.5, RN, F, FI

6.9 Lenient leadership: "*Alleen*"

Lenient is defined as allowing a lot of freedom and not punishing bad behaviour in a strong way; not harsh, sever, or strict; exerting a soothing or easing influence; of mild and tolerant disposition; especially indulgent (Merriam-Webster 2017). Alleen is an Arabic word, which denotes easiness, kind-hearted, tolerance and forgiveness. Alleen is literally translated to English as either leniency or softness or gentleness. However, leniency is a complex and multifaceted concept. It involves various alternative expression including gentle, kind, kindly, easy, sparing, merciful, tender, human, tender-hearted, kind-hearted, indulgent, permissive, forgiving, easy-going, tolerant, patient, compassionate, forbearing, understanding, magnanimous, generous, and charitable. Lenient leadership is based on empathy. Alleen is an embedded leadership value in Saudi culture that stems from the Islamic religion as this Qur'anic verse reveals:

"By an act of mercy from God, you [Prophet] were gentle in your dealings with them—had you been harsh, or hard-hearted, they would have dispersed and left you—so pardon them and ask forgiveness for them"(Haleem 2005 3:159)

Participants defined lenient leadership as the perceived understanding, tolerance and avoidance of taking disciplinary actions and punishing staff who make simple mistakes with solving problems within their department. In other words, they did not escalate problems to a higher managerial level. Lenient leadership behaviour was used to make a positive change in employees' behaviours at the workplace through showing a degree of flexibility and understanding of their faults to offer them an opportunity to change these undesirable behaviours.

Lenient leadership was a shared pattern among all type of participants and across all different hospitals identified during the coding analyses process. While participants who are Muslims used the word Alleen, none Muslim participants tended to use the words soft, flexible, friendly solution or describe events that reveals leadership behaviours related to leniency. It was an emerging concept that was constructed from several codes. These codes included containment, flexibility, understanding, alerting, empathy, prevent problems, soft, helping, cooperation, team, teamwork and team spirit. These behaviours were categorised into two subthemes: containment and alerting.

6.9.1 Containment "*Alihtwa'a*"

Alihtwa'a was the original Arabic word used by the study participants and is literally translated to English as containment. In Arabic, Ihtwa'a denotes hugging or embracing the problem; limiting its consequences. Similarly, in English, it is defined as the act, process, or means of keeping something within limits; the act of preventing the spread of something (Merriam-Webster 2017). It is a psychological term used to express the human need for another human being in order to help him/her vents his/her troubling feelings arising from stress and subsequently adjust, re-balance and manage him/herself. In other words, containment, as identified by the participant, is an immediate leadership response to distressing emotional reactions in order to control and satisfactorily resolve an arising problem caused by stress. Containment is a particular form of lenient leadership behaviour used by managers who try to control arising staff problems caused by stress without harming them psychologically and legally. Containment was described as absorption of one's anger through listening and discussion in order to help an individual stay self-possessed.

> *"Absorption is discussion and making people calm." Int.19, H.4, HD, M, EG (translated from Arabic)*

Managers who used this type of leadership behaviour solve problems by increasing the level of agreement with and between people in conflicts through listening and discussion. As part of lenient leadership behaviour, managers solved problems within the emergency department and did not inform higher authorities about those problems, so that they could protect their staff from punishment and its related negative outcomes. This was because managers perceived these problems as simple and to be expected in a stressful context like an emergency department. These problems usually occur due to staff-patient or staff interpersonal disagreements during the treatment process. In addition, managers recognised the importance of containing problems that may emerge suddenly from their staff due to work pressure or psychological or social circumstances. Understanding these factors, which may affect the performance of clinical staff and induce undesirable and unusual reactions during work time towards other staff or patients, allowed managers to contain these problems. This leadership behaviour was used to create trust between managers and staff, help staff feel secure and to retain them in the emergency department. George (2000) maintain that when constructively resolving conflicts and establishing a relationship of cooperation and trust between members, the leader contributes to the collective motivation of team members. All types of emergency departments' managers used this behaviour.

"If there is a respectful physician, who has good attitudes with you, does his work well, and you always behave well with him. One day this physician came and was stressed, under pressure and shouting, in this case I would not change my good behaviour towards him although he changed his normal good behaviour; I absorb his anger because he has done many good things. If a beloved person came with a sin, their good deeds should come with a thousand intercessors.[23] This physician has always been respectful but he must have had psychological issues or circumstances that made him slip out of his normal behaviour." Int.1, H.1, HD, M, EG (translated from Arabic)

One of the emergency department deputies mentioned the use of containment leadership behaviour by the head of the department when patients or their companions were not satisfied due to a long stay in the emergency department. This situation created a kind of tension in the department and causes disruption to the staff while doing their tasks. To prevent the situation from getting worse, the manager could contain the problem by explaining the departmental circumstances, what has led to the delay in treatment, to the patients or their relatives so that they understand the situation and thus remain quiet. Prati et al. (2003) suggest that regulation of emotion is useful to maintain social roles in which individuals who uphold strong self-awareness in team interactions may often be able to solve important issues. The deputy perceived that the use of this behaviour would help staff to concentrate on their tasks.

"Sometimes, clients become angry because of staying a long time in the waiting room or they come with a patient who thinks they should be seen before other patients. This tension affects the work of the physician present in the room because he cannot focus on his patients. At the same time, there will be a conflict so the head of the department intervene to contain the angry person, calm him down and try to explain to him the circumstances in the emergency department." Int.20, H.4, D, M, EG (translated from Arabic)

A physician indicated that the head of his department used this behaviour to solve conflicts that arise between emergency staff when a physician, for example, sees fewer patients than others or

[23] The participant quotes a poetic verse, which refers to a Muslim scholar called Imam al-shafi'i. The poetic verse implies that when a good staff member, who constantly shows good actions, changes his/her behaviour and suddenly shows negative one, the leader should not react similarly. Instead, the leader should show patience and always remember the good deeds that the staff has done in order to forgive and tolerate him/her. The original Arabic text recited by the participant is " اذا اتى الحبيب بذنب واحد جاءت محاسنة بألف شفيع"

leaves more patients to the next physician who comes in duty in the next shift. This created stress and tensions. Again, the physician perceived that containment behaviour helps emergency managers to retain their staff when they solve problems at the first attempt at the departmental level, without directly exposing staff to official punishment. Prati et al. (2003) suggest that emotionally intelligent leaders evaluate team members' emotional situations not only to motivate them but also to discourage detrimental interactions; the leaders create a supportive environment for team members by managing conflicts and encouraging supportive members' interactions. Although containment is a kind of lenient leadership, the participant describes it as a firm intervention. In this situation, firmness meant an immediate response to resolve the apparent problem.

> *"He intervenes firmly, if this does not work and if you repeat it, it will reach management personnel. We could solve it between us now, but if we wrote an incident report and sent it to management personnel, there would be a salary cut and penalties. If a situation like that is resolved without reaching the management, this on its own is a good thing to retain staff who work with him." Int.27, H.5, P, M, EG (translated from the Arabic)*

The same physician continued to say that the containment leadership behaviour used by the head of the department is effective in terms of retaining emergency department staff and building a sense of teamwork within the department. This was done when the manager clarified to the staff their mistakes, the effect of their mistakes in such a stressful department and explained to the staff their responsibilities. This behaviour would lead to more acceptance from staff of their manager. Thus, the containment behaviour feeds into a team culture.

> *"The effect on staff is that everyone knows his tasks. Of course, we are one team and we have a team leader who is the head of the department. We all help each other. We do not want to put extra work on others, this is the idea. Staff understand this lesson; we are one family … that was good behaviour from the head of the department so that the situation did not go out of the emergency department and he gained the acceptance of the people working with him…" Int.27, H.5, P, EG (translated from Arabic)*

Containment behaviour was also used by head nurses to solve conflicts that occur between staff and patients due to misunderstandings. A head nurse described his intervention to solve a problem by listening to both parties, a patient and a staff nurse, to get the right information about how the problem arose. This was undertaken to identify the main cause of the problem and thus protect, and not harm, the staff member if the problem was not intentionally caused. Understanding the simple issues that may arise from patients during

clinical care because of misunderstandings made managers use containment behaviour to find a solution that makes both patient and staff satisfied.

> *"For example, a nurse was working in the checking room and there was a patient dealt with badly by her because when the nurse removed her gloves, they fell straight in the rubbish bin; the patient felt irritated but this was not done deliberately by the nurse. When the complaint came to me, I went to ask the nurse what happened and went to the patient to ask him/her as well. I felt the nurse did not do anything wrong. In the meantime, the patient misunderstood the nurse; it meant you could not blame the patient. I changed the workplace for the nurse after getting her agreement and I told the patient that I would put her in another place. I made all of them content; the nurse continued her work and the patient was comfortable. This is one of the simple things that happens in the department." Int.16, H.3, HN, M, JO (translated from Arabic)*

In summary, containment leadership behaviour is a psychological kind of influence. It is used to respond positively to troubling emotions resulting from stress through listening and discussion with respective staff in order to release their stress. An important characteristic of containment behaviour is that it is exercised to control emotional reactions caused by stress and pressure in the context of emergency departments. Thus, this theme is characterised as reactive since the role of containment behaviour is to stabilise the situation and makes relevant staff able to re-balance their emotional state. Containment behaviour reflects paternalistic leadership behaviours, which seem prevalent in collectivistic cultures such as Saudi Arabia.

6.9.2 Alerting

The second behaviour identified under this category of lenient leadership is alerting. Alerting means making staff aware of their faults and its consequences. Participants considered this form of leadership behaviour as the last solution to solve problems within the emergency department and not report them to higher authorities. This behaviour was used when medical or nursing staff were observed to be careless when dealing with other staff or were not committed to their duties. Managers perceived this behaviour as a corrective activity to improve staff behaviour. Thus, this behaviour is related to responsive leadership (section 6.2).

> *"…the second solution, if the problem continues or gets worse, we can possibly make a decision to alert them or report the event to the hospital manager." Int.19, H.4, HD, M, EG (translated from Arabic)*

> *"If for example some staff are not doing as well as others, perhaps, she does not have a good interpersonal relationship with other colleagues, you have to call her attention. So, if you are senior and the other one is junior, the junior will learn if the senior does not teach her, so you have to call her attention; each one of us has a responsibility to correct or teach anyone anything that you know, you have to give to other staff also." Int.28, H.5, HN, F, FI*

Emergency staff also indicated the use of this alerting behaviour by their managers. They also expressed their use of this behaviour when they were assigned leadership responsibilities. Similar to managers' perceptions, this behaviour was exercised to manage staff who cause a problem to other staff working inside or outside the emergency department, or staff lack of punctuality and who are not committed. Emergency staff perceived this alerting behaviour as effective because managers could give their staff few opportunities to improve their ways and avoid losing them, and thus affected the functioning of the department. This behaviour can be defined as a warning-not-harming leadership behaviour.

> *"…if there is a staff member who has made a mistake, I will tell him once or twice; the third time I will write a letter and ask the nursing office to investigate them, because I gave them chances. For example, a staff member who is not regular according to his schedule, or who causes a problem with other departments…" Int.11, H.2, RN, F, SA (translated from Arabic)*

> *"I feel it was a good action. First, the head of the department told the staff member not to do it again. Second, his work did not stop because investigation would stop the staff member from working and penalise him, and so on. This means the staff member was warned and, at the same time, he was not harmed. If the staff member was warned and harmed, the head of the department would lose one of the staff, so our department would be damaged, instead of having ten hands we would become nine hands… this loss would affect other doctors, others in the team, and affect the way we work. This is what we want; you should warn not harm as much as possible." Int.21, H.4, P, M, EG (translated from Arabic)*

6.10 Strict leadership: "*Alsarama*"

Alsarama is the Arabic word mostly used by participants to describe strictness. Alsarama means brave, harsh, decisive and taking firm decisions. Alsarama is literally translated to English as strictness. Strict behaviour was described by participants as the process of using authority to impose decisions or applying disciplinary procedures on staff members who commit repeated or

harmful mistakes. Strict behaviour was used to make staff members comply with organisational policies and procedures. It emerged from several patterns identified during coding activities. These were autocratic behaviour, strict leadership, investigation, authority, forcing, reporting, documentation, punishment, understanding department's circumstances. These codes were categorised into two subthemes including: autocratic behaviour and reporting to higher authorities. Unlike lenient leadership behaviour, where managers avoid taking disciplinary action and try to solve problems within the department, strict behaviour entails taking disciplinary actions and managers may solve problems within or outside their departments, by informing higher authorities, based on the degree of the problem. Managers perceived this behaviour as an eventual solution exercised when lenient behaviour seemed not useful. Almost all participants indicated the use of this behaviour by emergency departments' managers.

6.10.1 Autocratic behaviour

Autocratic behaviour was defined by the participants as using authority to impose decisions in which a leader exercises power with little or no input from staff. That is, this behaviour usually takes individualistic decision-making process where managers do not refer to their staff when making decisions. This behaviour was used to discipline staff members when they deviate from their task responsibilities or when there is a failure to meet organisational obligations. This behaviour is consistent with theory X in which careless and inconsiderate employees promote the use of autocratic style of management (McGregor 1960). Moreover, this behaviour fits with active-management by exception transactional leadership to ensure staff compliance with rules and regulations (Clarke 2013). All heads of emergency departments and their deputies mentioned this behaviour.

> *"… The first is individualistic decision, when there is a physician who did a mistake. This does not require me to do departmental meeting to discuss with every person, it is enough to discuss it with the person himself. This remains a phenomenon in failure to attend the weekly meeting; this is one of the problem we suffer from. A physician works morning sometimes, evening or night duties other times. This results in a kind of exhaustion and leads them to be lazy to attend our weekly meeting. Of course, time by time the physician did not attend, he would have defect in departmental policies and this need a decision; individualistic decisions are taken when there is staff behaviours against the departmental policies." Int.19, H.4, HD, M, EG (translated from Arabic)*

Autocratic behaviour was used when staff members were not committed to their work in spite of giving spoken warning and frequent advices. They also added that unexpected disaster events

might demand them to practice this behaviour in order to request their staff, who just finish their duties at the time of the disaster, to stay longer in the department to help other staff members to undertake their tasks. Yet, it was indicated that emergency care managers must not only rely on strict behaviour to force staff to comply with their decisions, rather they must role model (section 6.3) their behaviour in order to persuade staff to work for extra hours e.g. when there is a sudden disaster at the end of a working shift. Thus, the unexpected situations that are common in emergency departments make leaders resort to autocratic behaviour to control such difficult events.

> *"We never impose decisions on them unless it is for the sake of the patient. I remember one example when I impose decision on myself at the end of the shift to continue working because there was a disaster when I was going to hand out the duty to the next doctor. The disaster was a bus accident, which had 10 or 12 people. I did not just hand out my duty and go, the situation demanded me to stay, and I stayed about 6 hours. If it was happened to another doctor I would enforce him to stay to help until the situation gets easier and then they can go." Int.2, H.1, D, M, SA (translated from Arabic)*

In line with heads of emergency departments and their deputies, head nurses also had similar perceptions with respect to autocratic behaviour. They indicated that autocratic behaviour was used when staff members committed repeated mistakes and were not following rules and regulations. In addition, they pointed out that emergency department is critical place where people are required to be more dedicated and disciplined. Moreover, this behaviour was viewed to be necessary to not only impose decisions and apply disciplinary action on careless employees, but also to not let other staff imitate and make similar mistakes in the future.

> *"…Unfortunately, there is people who do not deserve help. We had a few of them in the past and we were able to overcome this situation consensually in that our department is critical place and receive cases 24 hours. Our department is not the same of other department where there is a space to relax, our department is stressful. I personally feel your situation, but your situation in this department does not let me provide help more than what I did. I wish you do not blame me because I take a certain procedure, because if the mistakes continue and I try once or twice and there is no result, I have to apply punishment, because if I continue not minding their mistakes, one of the good staff members will see them and go the same way." Int.4, H.1, HN, M, SA (translated from Arabic)*

Physicians held similar perceptions with emergency department managers. Interestingly, they perceived autocratic behaviour as achievements-oriented process although it could lead to increased tension between managers and staff members. Whilst the intention of exercising this behaviour might be to improve work circumstances, staff could feel disappointed as they think it is a direct criticism toward them.

> *"… Our previous head of department used more strict behaviour, which led to many achievements for the emergency department, but there was also personal matters appearing in leadership. Our previous head of department was intense, which means he wants everything to be quickly completed, people feel his speech is headed towards them personally, but it was not. It was oriented towards work improvements only." Int.9, H.2, P, M, JO (translated from Arabic)*

Nursing staff believed that this behaviour was used to increase staff commitment and improve their conducts. Moreover, they indicated that managers are sometimes required to be "strong" and use this behaviour in order to deal with individuals who are not doing their responsibilities as anticipated and not complying with departmental rules. They also commented that being autocratic in terms of applying disciplinary procedures could ensure staff apply safe procedures when doing their assigned tasks.

> *"Autocratic in some situations, as I observe … nurses they have hard time dealing with, managers have hard time dealing with them, they need to be autocratic in a sense that these nurses do not work as they are expected to do, so they need a strong hand on them." Int.18, H.3, RN, M, FI*

6.10.2 Reporting to higher authorities

The second form of strict leadership behaviour was reporting to higher authorities. It entailed communicating with higher authorities regarding departmental problems. These problems include staff mistakes that cause harm to other colleagues or patients. These were previously described as "red lines" in the major theme of lenient behaviour where managers have to change their lenient behaviour to strict behaviour in order to handle harmful interventions. All types of emergency department managers agreed that they report harmful mistakes done by staff members, including physicians or nurses to higher authorities in order to apply procedural actions. All types of emergency departments' managers including the heads of emergency departments, the deputies and head nurses described their use of this behaviour when their staff disrespect other colleagues or make wrong medical interventions that cause harm.

> *"When a doctor insulted another doctor, a doctor came from another ward and insulted a doctor here in the emergency department. There were many options to take but I chose the legal one quietly. There was quietness and there was a system in this matter in which the doctor was taken out from the shift to go, another doctor was brought to cover the area, we described the event that occurred, we made a complaint and we are following up the matter… The problem may end by terminating that doctor." Int.7, H.2, HD, M, SA (translated from Arabic)*

Reporting to higher authorities was perceived as important to discipline staff who make harmful mistakes toward other colleagues or patients. Moreover, this behaviour was used to discipline staff who repeated mistakes when doing tasks although they were previously advised.

> *"… strict in way you can raise the OVR (Occurrence Variance Report). You can warn… issue a warning letter first at the departmental level even if it is second time. Then you can tell the higher officials that I have issued him the warning letter because he has repeatedly and intentionally been doing that problem, even my counselling… it is a decision of them about what to do." Int.26, H.5, D, M, IN*

Head nurses indicated that reporting to higher authorities for investigation and punishment is needed when staff members make medical mistakes that affect patient care due to lack of proper intervention that follow certain procedures set down in the department. Similarly, they also invoked this behaviour when staff members behave offensively towards other colleagues.

> *"For example, there was a problem between two female nurses; a quarrel which culminating in a beating during the night shift when I was not available. But I received a report about the event from the charge nurse. I called the nurses, investigated them and I submitted my report to the follow up department, and I put a copy in the computer. The follow up department called them and investigated them and they decided that those nurses do not work in the same place and they were penalised according to the hospital's procedural polices." Int.16, H.3, HN, M, JO (translated from Arabic)*

Emergency staff including physicians and nurses indicated that emergency managers use reporting to higher authorities when the issue was related to medical errors and deficiencies in patient care delivery that lead to loss of patient's life. Likewise, they perceived this behaviour as effective in improving staff attitudes and commitment, when used by managers to deal with and punish staff who commit frequent mistakes. However, the absence of this behaviour was viewed as an example of weak leadership and as a result; staff might easily break the regulations set by an organisation.

"If it is at higher level, life of some patients like that, then the higher inquiry is prepared by the hospital. There is a hospital committee, which conducts inquiries sometimes from Sho'on[24] or Health Ministry. They conduct the inquiry and if someone is found guilty then he is penalised according to the severity of his mistake." Int.3, H.1, P, M, PA

In summary, strict leadership seems to reflect authoritarian leadership models, which are based on the maintenance of strict control over members of the organisation through direct regulation and the implementation of rules and regulations, with dissent often being dealt with strictly and severely (Lewin et al., 1939). Strict behaviour was used to discipline staff who make repeated mistakes, harm colleagues or patients, commit harmful clinical mistakes, and show carelessness towards work duties. Unlike lenient behaviour, strict behaviour often took individualistic-decisions making processes whereas managers might solve the problem within or outside the emergency department by reporting to higher authorities. Lack of strict leadership was viewed by staff to be ineffective and could lead to inefficient work environment. Strict leadership was used as the last resort to influence and improve deviant staff behaviours.

6.11 Summary

The current research findings show that emergency department managers exercise various sets of leadership behaviours in emergency departments. Broadly, these leadership behaviours are: i) rewarding leadership, ii) responsive leadership, iii) role modelling leadership, iv) democratic leadership, v) staff development leadership, vi) recognition leadership, vii) supportive leadership, viii) lenient leadership and ix) strict leadership. Although many of these leadership factors may seem similar to the concepts in Western literature, and can be found in a range of contexts, the findings from this study show that many of these concepts are, at times, understood and enacted differently. Two of the reasons for this fluid outcome are: i) the dynamic influence of the unique characteristics of emergency departments and ii) the peculiarities of Saudi culture.

Leadership is embedded in the context in which it operates; leadership effectiveness relies on the contextual circumstances (Denise and Yitzhak 2001; Osborn et al. 2002). As shown in figure 6-1, the idiosyncrasies of the context of emergency departments seem to shape many unique leadership behaviours as well as their effectiveness in which many broader concepts in leadership literature are understood and enacted; as was found in this study. As indicated by the study's

[24] General Directorate of Health Affairs is the representative agency of the Ministry of Health in each city in Saudi Arabia

participants, these unique features of emergency departments include: a) unpredictable or unexpected situations, b) instability, c) emerging staff shortages, d) receiving high volumes of patients in a very short space of time, e) tension, f) work pressure that may induce interpersonal conflicts between staff, staff and patients or staff and their patients' companions, g) chaos, h) overcrowding, i) high stress environment and j) complex settings that involve multidisciplinary teams (Figure 6-1). These contextual factors in emergency departments shape several distinctive leadership behaviours identified in this study. These leadership behaviours include: i) giving days off, ii) allocating staff their preferred place of work, iii) selecting the type of work to carry out, iv) assigning staff to a lighter working areas, v) giving staff extra break time (rewarding leadership), and vi) direct action to respond to unexpected situations (responsive leadership). Moreover, these contextual factors in emergency departments shape leadership behaviours such as: a) showing patience, tolerance and serenity, b) respect for others (role modelling leadership), c) consultation, consensus and delegation (democratic leadership), d) staff protection and defending (supportive leadership), e) containment (lenient leadership), and f) autocratic behaviour, and reporting to higher authorities (strict leadership).

Overall, because the current research was conducted only in emergency departments, some of these leadership behaviours found in this study may not be found in more normal settings e.g. medical or surgical departments, since these behaviours strongly correspond to the distinctive contextual factors of emergency departments. For example, while the concept of rewarding leadership can be found in normal departments, it can be said the specific leadership behaviours relevant to emergency departments such as giving extra time off, allocating staff their preferred place of work for a short time or working fewer hours etc. as a reward for exceptional performance are specific to emergency departments. This is because those specific leadership behaviours, which are relevant to rewarding leadership can minimise the emotional, mental and physical burden on emergency department staff; a burden caused by the busy, unpredictable and pressured environment that distinguishes EDs from other normal departments. Another example of leadership behaviour specific to EDs is that of showing patience, tolerance and serenity, which emergency department managers intentionally practice it through role modelling in order to encourage their staff to adopt such behaviour in emergency departments. Showing patience, tolerance and serenity has a significant meaning and value in emergency departments. This is because such behaviour can decrease tensions and pressure that characterise emergency departments and thus create a peaceful environment that helps both emergency managers and their staff focus while doing their tasks, taking effective decisions and facilitating care delivery.

Figure 6-1: Specific contextual factors influencing leadership behaviours in emergency departments

In similar vein, the current findings show that national culture strongly influences leadership behaviours in emergency departments; several leadership behaviours identified in this study are moulded by the Saudi culture. These leadership behaviours include the concept of role modelling leadership, consultation, consensus (democratic leadership); recognition leadership; flexibility and understanding, and staff protection and defending (supportive leadership); containment and alerting (lenient leadership); and strict leadership. All these approaches to ED leadership reflect and are strongly shaped by the dynamic forces of social norms, tribal values and Islamic teachings. For example, as indicated in chapter 3, Islamic teachings consider role modelling as an effective characteristic of leadership. Another example is that of consultation, which is considered as an effective leadership behaviour that reflects both Islamic instructions and tribal values.

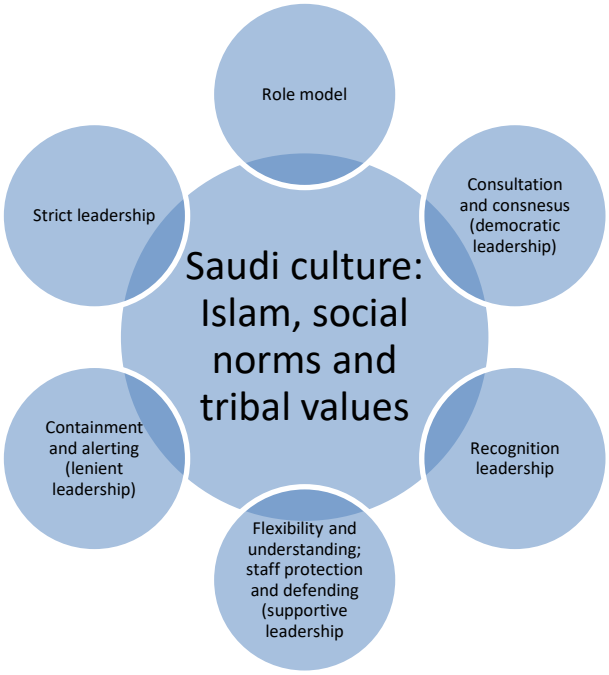


Figure 6-2 Specific cultural factors influencing leadership behaviours in emergency departments

6.12 Conclusion

The present chapter has revealed the study's findings. It has addressed the research question by reflecting on how different leadership behaviours are conceived and practised from the standpoints of both emergency department managers and their staff. It has presented several leadership behaviours including rewarding, responsive, role modelling, democratic, staff development, recognition, supportive, lenient and strict leadership accompanied with several outcomes. It has also shown different contextual and cultural factors that shape these different leadership behaviours. The analysis of the findings revealed that leadership behaviours are complex and dynamic phenomenon. In addition, the analysis captures the multiple meanings and perspectives attached to leadership behaviours because these findings are based on participant's understandings and the analysis connects leadership behaviours with the context in which they occur. The analysis shows that there are a number of leadership behaviours that resonate with the context in which they are situated, a point which will be explored more fully in the coming chapter. The links between the revealed leadership behaviours with the dominant leadership models and the implication of both the context and culture on shaping leadership behaviours will be examined and discussed in the next chapter.

Chapter 7 Discussion

The present research aimed to identify, characterise and explain the dynamics of leadership behaviours as understood and operationalised by the managers of hospital emergency departments in Saudi Arabia. Congruent with the research aim, the current research intended to answer the following research question: "How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?" This chapter will critically examine the research findings in relation to the research question, and more broadly, in relation to existing research in the field of leadership. This examination will be undertaken by comparing and contrasting the research findings with the existing literature. In addition, this chapter will examine the finding in relation to the local context of emergency department and the wider cultural context.

Complex organisations require varied leadership roles. Hart and Quinn (1993) suggest that, within a span of minutes, leaders may call for kindness or forgiveness in one situational role; and determination and vitality in another; roles which require flexible and adaptive behaviours in order to be effective. The findings of this research revealed several leadership behaviours, which were frequently displayed and deeply valued. These included rewarding leadership, responsive leadership, role modelling, democratic leadership, staff development leadership, recognition leadership, lenient leadership, and strict leadership. The different leadership behaviours revealed in this research will now be examined and compared to different leadership behaviours acknowledged in the dominant leadership models. Throughout the discussion, the contextual and cultural factors that shape the current leadership behaviours will be discussed.

7.1 Rewarding leadership

A major theme identified in the current study is rewarding leadership, which was commonly indicated by all types of participants, including emergency department managers and emergency staff, and which was practiced across all settings. The participants identified that rewarding leadership involves an advantage or reward given by leaders to followers, which may include money, overtime or days off, allocating staff their preferred place of work for a short period, selecting the type of work to carry out, assigning staff to lighter working areas, and giving extra break times to compensate task achievements and extra performance. This leadership behaviour was seen as an effective form of leadership in the emergency departments because it is very busy and pressured workplace. These kinds of rewards may hold real respite value as they resonate with staff in a meaningful way and motivate those staff to maintain effective performance.

Rewards were given based on the performance level of each member of staff. The findings suggest that the practice of rewarding leadership motivates emergency staff to maintain effective performance, increases their cooperation with their managers, and may lead staff to perform extra tasks when required at challenging times in emergency departments. This enhanced performance is because rewarding leadership was indicated as a morale-boosting influence in which emergency department leaders enacted to encourage their staff to meet unexpected situations in emergency departments; "a typical characteristic" in emergency departments. Such situations in emergency departments include staff who may be required to stay longer or breaking off their holidays to cover emerging staff shortages due to sickness or sudden ED emergencies that requires staff to come in to deal with it. As indicated by emergency department managers, receiving high volumes of patients in a very short space of time puts psychological and physical burdens on emergency staff and may consequently affect staff behaviour and induce undesirable actions. This encourages managers to enact rewarding leadership to motivate staff to do more and make sure they are not overburdened; a condition which would almost inevitably lead to loss of performance. However, from the emergency staff's perspective, these rewards only work if the right kinds of motivators are used; that is those that are valued by the staff recipients.

The rewarding leadership behaviour reported by participants in the present study is consistent with the notion of contingent rewards discussed in the full range model (Bass and Avolio 1994), whereby leaders establish productive exchanges with their followers and spell out clear expectations, as well as setting up rewards to meet those expectations. Bass and Bass (2008) argue that contingent reward is a constructive transaction, and suggest that a leader allocates a task or obtains a follower's agreement on what needs to be done, and then arranges for material or psychological rewards in exchange for an assignment that is carried out satisfactorily. Bass and Bass (2008) suggest that material rewards may include an increase in pay, as well as receiving awards and financial incentives, while psychological rewards may involve positive feedback, praise and approval. Bass and Bass (2008) also note that contingent rewards are transactional when leaders use material rewards, and are transformational when leaders use psychological rewards. In the current research, however, it was found that emergency department managers use both material and psychological rewards for transactional rather than transformational motivation. This multiple use is because managers seek short-term motivation, rather than the long-term motivation. The latter long-term motivation characterises transformational leadership, which uses psychological rewards to appeal to higher needs and values, thereby enhancing self-actualisation and personal growth.

Bass (1997) argues that the transactional and transformational paradigms are conceptually universal across cultures, but the behaviours reflecting these concepts may differ noticeably from

one culture to another. That is, differences occur because the same concepts may involve specific patterns of thinking, underlying values and views or actions that vary across cultures (Bass 1997). The current findings in this study may support that contingent reward is conceptually universal; there is evidence that rewarding leadership is conceptually congruent with the definition of contingent rewards, which implies the use of different forms of material and psychological rewards to enhance performance. The findings suggest that emergency departments' managers provide contingent rewards by using both materialistic and psychological rewards. Leadership behaviour that reflects material rewards, which is mostly used by the heads of emergency department because of their given authority, indirectly involves money through giving good ratings for annual evaluations and overtime. Specific leadership behaviours displayed in this culture include psychological rewards, which are used by all types of managers; examples include giving days off, allocating staff their preferred place of work for a short period, selecting the type of work to carry out, assigning staff to lighter work-load areas and giving extra or longer break times.

Contingent rewards have been found to have a positive association with job satisfaction and personal accomplishment and a negative association with emotional exhaustion and depersonalisation in critical care settings (Kanste 2008; Bormann and Abrahamson 2014) and in emergency departments (Ghorbanian et al. 2012). The findings of this current research support the results of previous research as the current data suggests that rewarding leadership may lead to increased staff job satisfaction and decrease the psychological and physical burdens put on emergency staff. The findings add that rewarding leadership may also motivate staff to deliver and maintain extra performance.

This finding is contrary to that of Abualrub and Alghamdi (2012), who found a negative relationship between transactional leadership including contingent rewards and job satisfaction. The data was obtained from the perspective of nursing staff only, although their research was undertaken in Saudi Arabia with a sample from different work settings including emergency departments, intensive care wards and coronary care wards, operating rooms, and recovery rooms. Abualrub and Alghamdi (2012) employed quantitative methods using the Multifactor Leadership Questionnaire (MLQ) to measure contingent reward items. Items include "provide others with assistance in exchange for their efforts, discuss in specific terms who is responsible for achieving performance targets, make clear what one can expect to receive when performance goals are achieved, and express satisfaction when others meet expectations" (Avolio et al. 2004 p104). In contrast, in the current research, rewarding leadership emerged from repeated patterns of compensation and rewarding activities when managers as well as their staff describe their experiences in the emergency departments. A possible explanation of the discrepancy between

findings is that the MLQ items do not require a leader to state the specific terms of the contingent rewards. In the current research, the specific contingent rewards are revealed in the everyday leadership behaviours because of the dynamic nature of emergency departments' environments. Therefore, the research participants of Abualrub and Alghamdi (2012) might not recognise what was motivating and satisfying for them in these various settings when they were responding to the fixed answers in the MLQ. Moreover, within leadership research that adopts quantitative methodology, sampling is often drawn from one organisation or many organisations or many settings within an organisation without considering the potential impact of settings on the interest variables (Denise and Yitzhak 2001). This variation between settings may undermine the effectiveness of a particular leadership behaviour because the context of leadership plays an essential role in determining its effectiveness. The present research findings show that the high pressure and volatility characterising emergency departments make rewarding leadership that offers recognition and respite from demands associated with managing the pressured environment as an effective model to ensure effective performance of emergency departments' medical and nursing staff.

The findings of this research suggest two contextual factors that may shape and promote the enactment of rewarding leadership. The key contextual factors are: i) a sudden increase in the number of patients due to unexpected events, and ii) staff shortages due to various emergencies. Together, these contextual factors call for rewarding leadership in order to motivate emergency staff to deliver extra performance and to preserve effective functioning in emergency departments. Thus, it could be argued that these contextual factors, which might not exist in other healthcare settings, may reinforce the effectiveness of rewarding leadership in emergency departments.

The findings also shed light onto specific rewarding leadership behaviours used in this context of emergency department, which have not been identified in previous research. Such behaviour includes assigning good ratings for annual evaluation and overtime, days off, allocating staff their preferred place of work for a short period, selecting types of work to carry out, assigning staff to lighter workload areas and giving extra or longer break times.

Although the specific rewarding-leadership behaviour models identified in this research seem to resonate with emergency department staff, it can be said that these rewards are based on subjective managerial criteria; a model where a fair rewarding system can be difficult to attain. Literature shows that managers working in the public sector are constrained by organisational rigidities that limit managers' potential to reward their staff (Rainey et al. 1995; Kim 2010; Chen 2012; Brewer and Walker 2013). Kim (2010 p40) notes that "for a long time, the public sector has

been recognised as having rigid structures, formalized job guidelines and responsibilities, inflexible reward systems, and many constraints". These organisational constraints seek to ensure the protection of public employees from unacceptable and partial personnel behaviours and, therefore, encourage fairness and equity in the treatment of all staff (Brewer and Walker 2013). However, organisational constraints, which can occasionally be called 'red tape' (Rainey et al. 1995), are somewhat negatively defined as "rules, regulations, and procedures that remain in force and entail a compliance burden for the organisation but have no efficacy for the rules' functional object" (Bozeman 1993 p283). Yet, although it can be seen as a burden on managers, these constraints are relatively important as they are designed to guarantee impartial managerial attitudes and behaviours when exchanging rewards with different staff in an organisational setting.

Within the cultural context of this study, Saudi managers are noted to place a heavy reliance on personal relationships in order to get a particular job done (Nydell 2002; Al-Omari 2003; Metcalfe and Mimouni 2011). This cultural aspect may shape and facilitate the managerial enactment of these specific rewarding leadership behaviours in order to motivate staff when faced with challenging situations in emergency departments. Thus, emergency department managers should be cautious and conscientious in the way they allocate rewards to their staff, since these rewards are not based on objective standards; a situation which, in turn, may lead to unfair distributions of rewards, and therefore may end up being counterproductive.

7.2 Responsive leadership

Responsive leadership has been conceptualised by participants as a direct leadership intervention to events or situations in order to prevent or solve problems. This type of leadership includes two leadership behaviours: corrective action to clarify staff mistakes, and direct action and responding to unexpected situations. These leadership behaviours are valued by all types of participants and across different settings. Corrective action to clarify staff mistakes is exercised when leaders discover a mistake made by a staff member by explaining to their staff the nature of their mistakes and then telling them the appropriate methods to deal with the situation, so that it does not happen again. Other situations may include misunderstanding of tasks requirements, interpersonal conflict between staff due to work pressure, and deviance from organisational rules and regulations. Direct action and responding to unexpected situations is exercised to encounter unpredicted situations that happen during day-to-day work in emergency departments by either providing practical help or seeking support from higher authorities. These kinds of unexpected situations can create chaos, instability, over-crowding, and increased pressure on emergency staff; outcomes which may consequently trigger conflicts between staff members or staff and

patients or their companions. According to the participants, this leadership behaviour leads to the speeding up of treatment and task completion processes, as well as the prevention of over-crowding in emergency departments.

Responsive leadership seems consistent with that of management-by-exception (Bass and Avolio 1994), in which leaders closely monitor the performance of followers and predict problems, so that they can take corrective action accordingly. That is, leaders monitor the performance of followers in order to identify any deviance, mistakes and errors. Bass and Bass (2008) suggest that corrective action may at times involve corrective criticism as well as negative feedback, and disciplinary action. However, the findings of the current study suggest that it is more positive, rather than negative reinforcement, that is perceived to 'work' by emergency departments' managers and the nursing and clinical staff. For example, mistakes are resolved by communicating with relevant staff to explain any implications of mistakes in an emergency department, without taking disciplinary actions. Mistakes can be resolved by offering training opportunities to overcome the shortcomings of a staff member's clinical skills. This positivity may explain the connection between responsive leadership and staff development leadership (to be discussed later). Reason (1997) suggests that management-by-exception active may foster a learning culture when managing errors in organisational settings, because such a leader can provide the opportunity for error recovery and learning from mistakes. Yukl (1999) argues that the Multifactor Leadership Questionnaire (MLQ) scale items for management-by-exception imply intrusive and controlling forms of monitoring, with a lack of any indication as to how the leader corrects those mistakes that are discovered. This view underestimates the positive influence of management-by-exception leadership (Clarke 2013), and runs counter to the findings of the present study.

Overall, the findings relating to responsive leadership may again be explained by the fact that the context of an emergency department, as characterised by the study's participants, is unstable, unpredictable, over-crowded, with the potential and opportunities to trigger conflicts between staff or between staff and patients. These situations require rapid responses from emergency departments' managers to solve and/or prevent these problems. In other words, the context of emergency departments makes corrective actions and effective leadership behaviours of great value for both managers and staff. Osborn et al. (2002) argue that leadership and its effectiveness are largely determined by the context in which it occurs. To illustrate this point, specific leadership patterns that are considered effective in a particular place can be seen as fruitless in a different setting because the context changes (Osborn et al. 2002).

Responsive leadership through direct action and responding to unexpected situations is comparable with management-by-exception active in which "the leaders arranges to actively

monitor deviances from standards, mistakes, and errors in the follower's assignments and to take corrective action as necessary" (Bass and Riggio 2006 p8). The findings from this study around responsive leadership are contrary to previous studies in critical care settings (Kanste 2008; Abualrub and Alghamdi 2012), which have suggested that management-by-exception active is ineffective; although Kanste (2008) suggests it may increase personal accomplishment. However, this finding broadly supports the work of other studies in this area linking management-by-exception-active with leadership effectiveness and job satisfaction in both critical settings (Bormann and Abrahamson 2014) and emergency department settings (Lin et al. 2011; Ghorbanian et al. 2012). It is noteworthy that in their study Lin et al. (2011) characterise elements of management-by-exception implicitly under task-oriented leadership in their study such as reacting effectively to subordinates' work situations, and giving appropriate feedback to subordinates on their work performance. These findings, therefore, need to be interpreted with caution because of the slightly different interpretations of leadership concepts between studies.

The findings of this research illuminate several behaviours used for direct action and responding to unexpected situations; scenarios which seem specific to emergency departments. These leadership behaviours include 1) communicating with the higher management personnel to arrange for access to extra medical and nursing staff from other departments, 2) prioritising treatments of patients according to the severity of their conditions, and 3) communicating with other departments within the hospital through the relevant management personnel to find beds for patients who need hospitalisation. These leadership behaviours are used by emergency department managers to deal with and manage disastrous events that cause overcrowding and delay of treatments in emergency departments.

The findings of this study suggest that the emergency environment, which involves instability, over-crowding, and increased pressure on emergency staff, reinforces management-by-exception leadership to ensure safety related behaviours. The findings suggest several situational factors that influence the use of management-by-exception leadership behaviours, which have not been revealed in previous studies in emergency departments. These factors include staff misunderstanding of tasks requirements, interpersonal conflicts between staff due to work pressure, other conflicts between staff members and patients or their companions, and deviance from organisational rules and regulations.

7.3 Role model leadership

One of the key findings identified in this study was that of role modelling leadership behaviour. It was conceptualised by participants as a process of displaying inspiring leadership behaviours in

order to influence staff and encourage them to imitate these behaviours. The concept of role modelling leadership is consistent with most of the dominant charismatic/transformational and servant leadership models, although they are labelled differently. For example, setting a strong role modelling is a key leadership factor for charismatic leadership model (House 1976), while it is called idealized influence (Bass and Avolio 1994), and modelling the way (Kouzes and Posner 2012) for transformational leadership models; and behaving ethically (Liden et al. 2008) for servant leadership. In these leadership models, role modelling is broadly conceptualised as leaders who exhibit behaviours that they want others to adopt. Bass and Riggio (2006) suggest that through their idealized influence, where leaders show extraordinary capabilities, persistence and determination; subordinates become strongly associated with such leaders, having a desire to imitate what they do and to gain their admiration, respect and trust. Kouzes and Posner (2012) argue that leaders who are role models keep their promises, show commitment, and emphasise the common values they share with their followers. Liden et al. (2008) stress the importance for leaders to be open, honest and fair with their followers, without compromising their moral values so that leaders achieve their targets and goals. Transformational leadership models tend to assume similarity of the underlying processes and their outcomes in all situations, including organisational and cultural contexts, which can actually be missing (Yukl 1999). However, the servant leadership model developed by Liden et al. (2008) suggests that servant leadership behaviours, including role modelling, would be common within the context of healthcare because caring is a predominant behaviour pattern.

The current findings suggest different specific leadership behaviours linked to role-modelling to counter the high stress environments of emergency departments. These favourable leadership behaviours include showing patience, tolerance, serenity and respect for others; all which were seen as particularly appropriate in emergency settings by the study's participants. The findings show that respect for others can be expressed by stressing brotherhood and modesty. The findings also suggest several subsets of leadership behaviours linked to being seen as a role model; these subsets include approachability, listening to staff, humility, breaking down barriers, and fairness. Role modelling in leadership also involves showing commitment to work responsibilities, punctuality, saying the right words, showing care for staff, having better clinical skills and knowledge to support others when needed. Such leaders also strive to maintain good relationships with other staff based on respect and cooperation with each other. Thus, it can be argued that the high stress environment characterising emergency departments shapes role-modelling behaviours. Hence, the findings of the current study challenge the view of transformational leadership models suggesting similarity of the underlying processes and outcomes across different organisational contexts. These findings also support the argument of

Liden et al. (2008) that the norm of caring that characterises health care settings may facilitate the enactment of servant leadership behaviours including role modelling.

The leadership literature suggests that the predominant values in a particular national culture may influence leadership behaviours in organisational settings (House et al. 1997; House et al. 2004). This study's findings suggest that emergency department managers should regularly practice for themselves what they want and expect their staff to do, in order to encourage them to follow desirable behaviour. Role modelling leadership behaviour is congruent with the notion of effective leadership discussed in section 3.3 regarding Islamic teachings and instructions (Beekun and Badawi 1999). In Islam, role modelling is called "guduah" or "auswah hassanah" and denotes a role model and a person who is taken as an example. Islamic teachings support the enactment of humility, fairness, patience, tolerance, and respect for others. This suggests that the enactment of these behaviours by emergency department managers is aligned with Islamic values, which is seen as appropriate in emergency department settings in the hospitals of Saudi Arabia.

This finding generally supports the work of other studies in this area linking role model leadership behaviour with effective leadership. Previous research shows that role modelling is positively associated with many organisational outcomes including job satisfaction, organisational commitment, productivity and staff retention in different settings including critical care (Loke 2001; Kanste 2008; Salanova et al. 2011; Abualrub and Alghamdi 2012; Wang et al. 2012; Zhang et al. 2012; Moneke and Umeh 2013; Bormann and Abrahamson 2014) and emergency departments (Ghorbanian et al. 2012). The findings of the present study suggest that role model leadership behaviour may lead to an increase in followers' compliance with departmental and organisational rules, better clinical decision-making, and increasing both their performance and the cooperative ties between emergency staff in order to encounter difficult situations.

Kouzes and Posner (2012) suggest that intentional role modelling is essential to focusing people's attention, energy and effort on the expected behaviours until these actions become norms of operational practices in the workplace. As argued previously, the context in which leadership takes place shapes effective patterns of leadership (Osborn et al. 2002). The emergency department environment was characterised by participants as a stressful setting, where emergency leaders and staff constantly meet difficult situations that may generate negative emotional reactions. Such reactions are particularly likely when dealing with other colleagues or patients and their relatives. Therefore, the current findings suggest that this kind of setting requires leaders who show respect, patience, tolerance and serenity in order to create a peaceful

environment, to maintain effective cooperative ties with and between emergency staff, and to increase staff performance and retention.

It can be argued that these leadership behaviours are seen as coming from a role model because of the high-stress environment of the emergency department. This contextual factor has not been identified in previous research because of the limitations of quantitative research methodology, which fails to reveal contextual factors. Yukl (1999) contended that survey studies on transformational leadership fail to assess the separate effects of transformational behaviours and to provide the facilitating and limiting conditions because of the high inter-correlation among MLQ items.

It is worth mentioning that the current research findings show that the more medical knowledge a leader has the more the leader is respected by others and may be seen as a role model by medical and nursing staff. That is, leaders can gain respect of others when they have stronger and better medical knowledge than their colleagues. Yet, the findings of the present research indicate that nurses may see themselves as less than physicians in terms of knowledge, as well as professional rank, although it was acknowledge that nurses have special knowledge that physicians do not have. Thus, physicians should respect nurses for their scientific knowledge. This concept shows the inherent cultural stereotypes that regulate physician-nurse relationships, in which physicians perceive themselves as leaders and nurses as subordinates because power is dispensed through structural and hierarchical relationships (Tellis-Nayak and Tellis-Nayak 1984; Campbell-Heider and Pollock 1987). Moreover, Murphy (1980) argues that physicians' medical knowledge and expertise provide additional higher status over nurses since special knowledge, or the so-called 'secret knowledge', can generate value, advantages and justified rights. All of these cultural and social stereotypes are seen as barriers to nurses' autonomy and engagement in leadership roles, as well as team approach, as indicated earlier in chapter 2 (section 2.5.1). Thus, emergency department managers should be aware of this perception to challenge physicians' resistance of sharing leadership roles and responsibilities with nurses and to attempt to empower nurses to increase their involvement in leadership processes, since such conduct can enhance consultation, referral, the quality and safety of patient care (Feiger and Schmitt 1979; Watkins and Wagner 1982).

7.4 Democratic leadership

Democratic leadership is generally seen as effective in Western literature concerning leadership practices. The definition of democratic leadership by White and Lippitt (1960) denotes leaders who focus on developing relations with their subordinates through open communication channels, motivating them to take part in the decision making process and identifying clear goals

and objectives. Democratic behaviour is called 'participative' or 'empowering' leadership, which involves a leader's use of decision-making procedures that allow followers to have some influence over decisions that will affect them (Yukl 2013). Elements of democratic leadership can also be found in transformational leadership models such as individualised consideration (Bass and Avolio 1994) and enabling others to act (Kouzes and Posner 2012). In such leadership, the leader will listen to the views of their staff and use delegation to promote staff development, thereby reinforcing teamwork and cooperation. In this research, democratic leadership was conceptualised by participants as the process of giving weight to staff members' opinions and making them able to take part in decision-making and leadership processes through consultation, consensus and delegation. Democratic leadership was generally seen by participants in this study as an effective, participatory and collective process. The current findings revealed three specific leadership behaviours through which emergency department managers' enact democratic leadership: consultation, consensus, and delegation. These leadership behaviours are consistent with the definition of democratic leadership given by White and Lippitt (1960) and Yukl (2013) and overlap with individualised consideration and enabling others to act as examples of transformational leadership behaviours.

The present study's findings help to identify the specific democratic leadership behaviours deployed in the emergency department settings. For consultation and consensus, specific situational behaviours include a) obtaining staff views regarding work organisation, b) assigning responsibilities by consulting respective staff, c) developing new departmental policies with staff involvement, d) identifying and discussing departmental, clinical, and personal issues facing emergency department staff in order to solve them, e) to assess a proposed decision, and f) to avoid any negative impact of a decision on others. For delegation, emergency department managers distribute leadership within the emergency department to meet the complexity of the emergency department. This delegation is done to ensure that there is a leader at all levels in order to deal with emerging problems.

The findings seem to be consistent with other research which found that certain leadership styles are positively associated with increased job satisfaction, performance, leadership effectiveness, organisational commitment, and staff retention in different cultures and organisational settings. These styles are participative (Bratt et al. 2000), empowering (Yun et al. 2005), employee-oriented (Lin et al. 2011), individualised consideration (Kanste 2008; Abualrub and Alghamdi 2012; Ghorbanian et al. 2012; Bormann and Abrahamson 2014), and enabling others to act (Loke 2001; Wang et al. 2012; Moneke and Umeh 2013). The current study findings indicate that the enactment of democratic leadership through consultation, consensus and delegation may, in particular, lead to effective decision making, build creative ideas to solve problems, enhance

cooperation and teamwork, increase respect between managers and staff, increase the staff's sense of responsibility and their value in the department, speed up working processes, prevent delays, and finally decentralise leadership. While delegation may be widely enacted across different cultures, consultation and consensus in particular may be enacted in Saudi Arabian culture since these two factors reflect Islamic and tribal values. It can be suggested that the notion of democratic leadership and the practice of delegation may come from the influence of Western management and leadership models. These models are taught in Saudi universities as well as in leadership development and training programmes run for different organisations to advance leadership skills. Yet, delegation may also be supported by Islamic teachings because Islam emphasises leadership at all levels, where more than two people are on duty as shown in (chapter 3).

The present study findings are contrary to Hofstede's dimensions of power distance, which are characterised as high in Saudi Arabia, reinforcing acceptance of the centralisation of power and autocratic leadership behaviour (Hofstede 2001). The current findings suggest that the practices of both democratic and autocratic leadership types are used in emergency departments; however, the use of democratic behaviour seems more predominant in various situations than autocratic behaviour, which is seen to be effective only in a limited number of situations (discussed in detail later). According to participants, centralisation of leadership is ineffective, while the practice of autocratic behaviour may lead to decreased staff satisfaction, wrong decision making, generate tension and disagreement, and increase staff's intentions to leave. A possible explanation for these negative outcomes might be that the Saudi culture is characterised as both collectivistic (Nydell 2002; Al-Omari 2003; House et al. 2004) as well as manifesting high power distance (Hofstede 2001; House et al. 2004). The collectivistic nature of Saudi culture may encourage leaders to consult others and seek consensus for decision making to satisfy people involved and maintain group cohesiveness, although they have centralised power reinforced by an organisational hierarchical structure. Metcalfe and Mimouni (2011) argue that high power distance reflects the bureaucratic systems combined with excessive organisational layers. That is, high power distance may not necessarily inhibit leaders to exercise consultative, consensual and delegated forms of democratic leadership, as these behaviours are supported by cultural norms derived from Islamic teachings. It can also be argued that the constant and close interaction between leaders and followers, within emergency departments, may minimise the effect of high power distance and promote more democratic forms of leadership. However, there might be high power distance between emergency departments' managers and those in higher managerial positions, due to limited interaction and communication.

National culture influences the practice of leadership in organisational settings (Schein 2010). The prevailing cultural values in Arab include those which are socially-oriented and collectivist (Badawy 1980; Nydell 2002; Al-Omari 2003). Democratic leadership is consistent with the concepts of consultation and consensus, which are both deeply embedded in Islamic religion and are considered as forms of effective leadership.

Consultation refers to the term “shura”, while consensus refers to “Igma’a” in Arabic. The former denotes consultation and the later denotes consensus or general agreement. While the practice of consultation and consensus is consistent with Islamic values, it is also congruent with tribal traditions, such as consultation that reinforces such leadership behaviours (section 3.2.5). This suggests that consultation and consensus are driven by both Islamic and tribal values. The current study’s findings are in line with those of previous studies showing that consultative and participative leadership style is predominant in Saudi culture (Al-Jafary and Hollingsworth 1983; Ali and Al-Shakis 1985; Ali 1989). This conclusion is consistent with the Islamic view of effective leadership in which leadership is both an obligation and a collective duty (Beekun and Badawi 1999).

Ali (1993) claims that leaders in Saudi Arabia adopt a “pseudo consultative style”. A concept in which managers may discuss options with their followers, who have no part to play in the ultimate decision (Muna 1980). The present study’s findings may neither support nor reject this argument although emergency department managers seem to deeply value consultation and regularly exercise it to reinforce followers’ participation in decision making and increase the sense of cooperation and teamwork; factors which are seen as important characteristics for the success of emergency departments as indicated by different participants in this study. Ali’s claim cannot be generalised since he conducted a quantitative research based on a convenience sample of more than 115 respondents drawn from middle managers in a business sector. This can be regarded as a weak methodological approach because the sampling strategy is neither large nor random to enable generalisation. Within the context of health care and particularly emergency departments, consultation can be seen as a predominant norm in the medical profession. For example, physicians are expected to regularly consult other specialists or consultants regarding the diagnosis and treatment of particular medical cases, in order to take a proper decision relevant to patient care. Thus, physicians are expected to follow specialists’ or consultants’ suggestions when consulting them. Unlike middle managers who may not interact with staff on a regular basis, first line managers such as those included in this present research, regularly interact with their staff during day-to-day operations. Thus, consultation as a prevailing norm in emergency departments and the close interaction between first line managers and their staff may reinforce the true use of consultation. Yukl (2013) indicates that the type of organisations and

level of managers can strongly influence leadership behaviours. However, one limitation of the current study is that it cannot validate the way in which leaders exercise consultation since it was based on interviews. Therefore, there is a need for further research that may apply ethnographic techniques e.g. participant observation (Conger 1998) to accurately describe the way in which emergency departments managers apply consultation with their staff.

7.5 Staff development leadership

Staff development lies at the heart of the transformational and servant leadership models, in which the followers' need for growth and development is emphasised. Specifically, staff development leadership reflects certain leadership behaviours which are noted in the current leadership literature, including individualised consideration (Bass 1985) for transformational leadership, and helping followers grow and succeed (Spears 2002) for servant leadership. Individualised consideration refers to leaders who understand and share each follower's concerns and needs for development and growth to help that follower to increase their potential by giving support, guidance and teaching (Bass 1985). Helping followers grow and succeed denotes knowing the occupational and individual aims of followers, as well as facilitating the achievement of those ambitions and prioritising their development, as well as monitoring and supporting them (Spears 2002). Likewise, the current findings suggest that staff development leadership was identified as practised by leaders who want to improve their staff's skills, abilities and qualities through the provision of different educational opportunities to either advance or correct understandings, as well as to develop skills in relation to the clinical care provided in emergency departments. That is, staff development is done for the sake of employees for their professional advancement linked to the previous models cited above, and also for the interest of the organisation to prevent poorly trained staff undermining departmental performance. The findings suggest that such staff development may be performed through the leaders themselves, by teaching followers according to their individual needs, or by organising lectures, facilitating training opportunities and attending scientific courses inside or outside an organisation. It is worth mentioning that the organisational structure in most of the public hospitals may shape this leadership behaviour since there is a special department called the "continuing education department", which offers different scientific courses to continually improve staff knowledge and skills in their respective specialities. Therefore, emergency department managers are able to offer educational opportunities for their staff.

Bass (1985) and Spears (2002) argue that attending to followers' needs for growth and development helps them reach their fullest human potential and become self-actualised. The findings of this current research suggest that staff development leadership was identified as an

intrinsic motivation in which followers could meet their needs for personal and professional development. Staff development leadership was seen as an ongoing and mutually beneficial process, because this leadership behaviour may lead to a positive impact on the functioning of emergency departments as a result of enhancing followers' knowledge, awareness and skills. The findings suggest that staff development may lead staff to be content and satisfied, as expressed by the emergency staff themselves, because they value leaders who are attentive to their needs for personal and professional growth.

The current data suggests that staff development may be seen as a corrective activity. According to the findings, teaching the staff, and facilitating educational opportunities for them, may be undertaken to meet any deficiencies in knowledge and skills of individual staff members. This finding suggests that staff development may be linked to responsive leadership (management-by-exception) too. This is because emergency department leaders may intervene to teach staff when they perceive shortcomings in staff knowledge and skills in relation to a particular task. Therefore, this leadership intervention shows some of the strategies chosen to deal with problems. Hence, staff development leadership may not link only to individualised consideration of transformational leadership but also link to management-by-exception active of transactional leadership. This association has not been depicted in Bass's model of transformational leadership (Bass 1985), although Bass and Riggio (2006) suggest that management-by-exception active is effective and necessary for some situations when safety is seen as important. That is, in the current findings, staff development takes the form of teaching staff rather than giving negative feedback discussed in management-by-exception of transactional leadership. In other words, the findings showed that the participants consider teaching as a form of corrective action when there are shortcomings in staff skills and awareness.

Having linked staff development leadership with the notion of individualised consideration for transformational leadership and helping followers grow and succeed for servant leadership, the literature review indicated that individualised consideration has a positive correlation with personal accomplishment and job satisfaction, while forming a negative correlation with emotional exhaustion and depersonalisation in critical care settings (Kanste 2008; Abualrub and Alghamdi 2012; Bormann and Abrahamson 2014). Individualised consideration is also positively associated with job satisfaction in emergency departments (Ghorbanian et al. 2012). However, according to the literature review, no study has been conducted on servant leadership for critical and emergency departments. The present study's findings suggest that staff development seems to be connected to perceptions of effective leadership and that it also supports the finding that leaders who show concern for staff development may lead to staff satisfaction, as was indicated by emergency staff in this research. Furthermore, the current study's findings show that staff

development may lead to increased staff performance, reinforce staff appreciation of their managers and strengthen the relationship between emergency department managers and their staff who are working in emergency departments.

The previous studies undertaken by Kanste (2008); Abualrub and Alghamdi (2012); Ghorbanian et al. (2012); Bormann and Abrahamson (2014) on transformational leadership are descriptive quantitative studies, which fail to provide details of any facilitating or limiting conditions (Yukl 1999). This current study's methodology addresses such limitations revealing several contextual factors that influence staff development leadership. These include enhancing staff knowledge and skills regarding a specific medical intervention, correcting shortcomings, keeping staff up to date with scientific advances, advancing staff members' careers, raising staff awareness of new events that may affect their safety in the workplace, and to encourage emergency staff to obtain new skills needed in emergency departments.

7.6 Recognition leadership

Recognition leadership was identified by participants as leaders who praise, thank and appreciate their staff for their performance and achievements. The recognition leadership behaviour shown in this present study reflects specific behaviours available in the leadership literature concerning transformational leadership and transactional leadership, specifically, encouraging the heart (Kouzes and Posner 2012) and contingent reward (Bass and Avolio 1994). Encouraging the heart means rewarding others for their accomplishments through giving praise to followers who do their job well, using celebrations, showing appreciation and encouragement to others. Contingent rewards refers to leaders who establish productive exchanges with their followers and spell out clear expectations, as well as setting up rewards to meet those expectations. While there is explicit congruence between the definition given by participants in this study and encouraging the heart as proposed by Kouzes and Posner (2012), there is implicit association with contingent rewards discussed in the full-range model of leadership (Bass and Avolio 1994). Within the full-range model of leadership, recognition is conceptualised as a result of an exchange process when followers meet the expectation of leaders upon prior agreement. Moreover, Bass and Avolio (1994) suggest that contingent reward is transformational rather than transactional when the rewards take a psychological form of influence such as positive feedback, praise, and approval, as discussed previously in rewarding behaviours (section 6.1). Yukl (1999) argues that there is discrepancy in transformational and transactional leadership because of the ambiguity concerning different constructs' definitions. To differentiate between recognition and contingent rewards, the current study's findings suggest that recognition leadership is enacted by emergency department managers due to observed efforts performed by emergency staff with or without

prior agreement on specific rewards for particular task achievement, as discussed in contingent rewards of transactional leadership. That is, on the one hand, recognition may be used as an independent behaviour to acknowledge specific staff achievement without necessarily prior agreement on specific rewards, although staff may expect their leaders to show recognition. On the other hand, recognition may be used as complementary behaviour to express acknowledgement after giving the agreed rewards as an exchange process in transactional leadership. For this reason, recognition leadership in this study is distinctive and may be related to transformational leadership, or the contingent rewards of transactional leadership, depending on the situation.

Kouzes and Posner (2012) suggest that effective leaders recognise their followers' high performance when doing tasks by praising and celebrating with them as a means of displaying appreciation and providing motivation. Consistent with the literature, this research found that emergency department managers enact recognition leadership through thanking, praising, and appreciating staff for their achievements particularly when staff show commitment, punctuality, and excellence in dealing with difficult situations without being asked to do so in emergency department. This research also found that emergency department managers use smiles and greetings as an expression of appreciation towards emergency staff. The findings indicated that recognition is enacted through talking up staff achievements within the department, as well as with relevant administrative authorities, to enhance staff reputations. Furthermore, this research found that a ritual such as "the star of the month", in which a staff member is given a present and/or appreciation certificate, is used as a means of showing recognition.

Kouzes and Posner (2012) suggest that individuals, in general, naturally expect to be supported and recognised; recognition leads to greater collective identity and community spirit. In addition, the findings of this study show that recognition may lead staff to maintain high levels of performance and increase the levels of competence between emergency department staff. That is, less well-performing staff want to make better efforts in order to be recognised, because they observed that other staff achievements were already being recognised. Moreover, the current study found that recognition makes emergency staff feel that they are valuable members of the emergency department, they like what they do and they respect the environment in which they work. Moreover, the finding suggests that recognition may increase the level of cooperation between emergency staff. The current study findings are broadly consistent with that of Loke (2001); Wang et al. (2012); Moneke and Umeh (2013) who associate positive relationships with encouraging the heart and job satisfaction, organisational commitment and productivity.

Recognition is an embedded leadership value in Islamic culture that is manifested in organisational settings; one of the study participants narrated a prophetic tradition that "a good word is charity". This insight suggests that recognition leadership corresponds to Islamic teachings. This association has an important meaning, particularly for Muslim leaders, because they believe that they will be rewarded by Allah (God) when they enact recognition behaviour, as a means of appreciating others who show good deeds and performance. That is, within Islamic culture, emergency department managers may have an intrinsic motivation to practice recognition leadership in the workplace because it reflects Islamic moral principles. Moreover, recognition leadership was seen by the study's participants to exert a profound influence in motivating emergency staff when that leadership behaviour is complemented with a reminder to them of God's rewards; as one of the participants commented:

> *"Praise, give thanks and a reminder that The God will reward them if they have good will. Of course, we are religious people and so religious talk really affects us" Int.15, H.3, P, M, SA (translated from Arabic)*

7.7 Supportive leadership

In the current study, supportive leadership, as defined by the participants, denotes the process of identifying and addressing staff needs at the level of workplace, as well as, in personal and family life, by showing flexibility and understanding, and protecting and defending staff in order to nurture their morale and emotional wellbeing. Supportive leadership is enacted through flexibility and understanding, and the protection and defending of staff; actions which reflect Islamic and tribal values as well as social norms in Saudi Arabia.

Flexibility and understanding implies emergency managers' tendency to understand internal and external circumstances that may affect their staff commitment in the workplace. This understanding facilitates such a leader's attempts to resolve these problems through arranging and reorganising the staff's duties, according to their needs. The findings indicate that internal factors may involve resolving work duties that may cause a family or social struggle for their staff, while external factors may include social, cultural or religious circumstances. This leadership behaviour reflects social norms in which leaders are expected to show sympathy and kindness towards their followers (Mellahi et al. 2001). Moreover, Atiyyah (1999) maintains that Saudi leaders are expected to be attentive to followers' welfare financially, socially and professionally and followers are expected to reciprocate by displaying loyalty and acceptable levels of behaviour and productivity. The findings suggest that this behaviour leads to a reduction of work pressure, increased staff cooperation, heightened satisfaction and an enhanced sense of their value in the

emergency department. The findings also suggest that flexibility and understanding leadership behaviour build good relationships between emergency managers and their staff, as well as enhancing staff interrelationships. Thus, this is a specific leadership behaviour that incorporates both flexibility and understanding, thereby corresponding to social norms in which social behaviour stresses cooperation, group welfare, and a stable relationship (Mellahi et al. 2001). Moreover, the findings suggest that the absence of this leadership behaviour lead to less productivity, increased complaints, low commitment to work, and increased staff turnover.

The study's findings suggest different contextual factors that may influence leaders to employ supportive leadership. These factors can include personal matters such as financial hardship, residential or family issues, as well as work-related issues such as delayed patient care and inadequate clinical skills. Overcoming staff conflicts in relation to misinterpretation due to cultural factors, resulting from a staff comprised of expatriates from a range of countries and cultures, is another challenge supportive leaders have to meet.

Staff protection and defending was defined by participants in this study as leaders' support and protection for staff in order to keep them from being harmed when dealing with complex situations or experiencing unfair disciplinary actions. This leadership behaviour reflects Islamic and tribal values, as well as social norms in Saudi Arabia. As discussed in chapter three section 3.3, from an Islamic point of view, leadership is trust. Beekun and Badawi (1999) argue that leadership in Islam is a psychological contract between leaders and followers; leaders attempt to provide guidance, protection, and fair treatment to their followers. In Islam, leaders are considered as guardian implying their responsibility to protect the community against tyranny and oppression. Abdalla and Al-Homoud (2001) argue that the tribal values reinforce this behaviour because leaders are expected to carry out responsibilities and consider themselves as protectors, caregivers and father of their community. Leaders are also expected to show compassion and protection towards their followers, in order to create security, a family environment, cohesion and unquestioning loyalty (Mellahi et al. 2001). Therefore, staff protection and defence is a specific leadership behaviour that corresponds to religious and social expectations embedded in Saudi Arabian society.

Consistent with the arguments above, the current findings suggest that emergency department managers enact this leadership behaviour to protect their staff from unfair complaints that may result from the misunderstanding of complex situations. Zaccaro et al. (2001) suggest that leadership is a form of social problem-solving, in which leaders take the responsibility to identify any problems that might possibly disturb their group's and organisational goal achievement. Furthermore, Zaccaro et al. (2001) note that leaders should generate appropriate plans, and

implement appropriate solutions, within a complex social domain. Further, Northouse (2013) reports that leaders monitor the environment in which team members work and may intervene to protect or isolate team members from environmental distractions. According to the findings of the present study, the emergency department environment is identified as complex, involving multidisciplinary teams to deal with complex clinical situations which may trigger disagreements between medical staff. In this situation, emergency department managers feel responsible for supporting and protecting their staff by taking responsibility to further investigate the clinical situation. This leadership intervention is undertaken in order to aid and reassure their staff, and thus prevent undesirable clinical decision-making that may lead to adverse outcomes. One such outcome could be a loss of a patient's life, which may consequently lead to managerial and legal punishment relating to wrong diagnostic decisions. Moreover, the findings suggest that this behaviour is used to protect their staff from patients, and their companions, who become irritated and aggressive due to serious clinical conditions that trigger undesirable verbal or physical behaviour directed towards the emergency staff. In this situation, emergency departments' managers feel responsible to clarify the situation and thus maintain staff rights, as well as protecting them from erroneous complaints that may consequently lead to unfair managerial disciplinary action. The findings suggest that this protective leadership behaviour leads to the building of mutual trust between emergency departments' managers and their staff. Such leadership may also: a) increase the quality of relationships; b) maintain family working environment; c) increase the level of staff security, safety, wellbeing and retention; d) increase staff loyalty and performance; and e) make staff feel pleased and proud of their leaders. In contrast, the findings suggest that the absence of this behaviour leads to increased staff turnover, create poor relationships between emergency department managers and their staff, and increase the staff's perception of weak leadership.

In general, supportive leadership is a widely discussed concept in leadership literature, since the development of early leadership behaviour theories under different labels. Included in a long list are consideration, employee orientation, concern for people, relational orientation from research programmes such as the Ohio State Studies (Stogdill and Coons 1957), the University of Michigan Studies (Likert 1961), and the Blake and Mouton's Leadership Grid (Blake and Mouton 1968). These similar concepts broadly signify leaders who support followers and allow them to have self-comfort, as well as being comfortable with the group and the overall working environment. Supportive leadership is a type of dominant leadership behaviour in the new-genre leadership theories, in which leaders are attentive to followers' needs and attempt to develop quality relationship with followers, by practicing transformational and servant leadership. Thus, supportive leadership may be similar to the notion of individualised consideration, as discussed in

the full-range model of leadership (Bass and Avolio 1994), through which leaders attempt to create a supportive environment and pay a special attention to different followers' needs. Supportive leadership also seems congruent with the notion of enabling others to act because its definition implies that leaders create an environment where others are comfortable with what they do and their efforts are being recognised and can add value to the organisation (Kouzes and Posner 2012). Supportive leadership may be comparable with that notion of emotional healing discussed in servant leadership (Liden et al. 2008), which is about paying attention to the individual interests, safety and welfare of followers; recognising difficulties they encounter and trying to deal with them; making themselves available to others; standing by their staff; and providing the staff with support.

Having linked supportive leadership with various leadership behaviours discussed above, that leadership can now be examined through the prism of the studies identified in the literature review. The current study's findings are broadly consistent with those studies linking job satisfaction, organisational commitment, productivity and staff retention to transformational leadership through the components of individualised consideration (Kanste 2008; Abualrub and Alghamdi 2012; Ghorbanian et al. 2012; Bormann and Abrahamson 2014), enabling others to act (Loke 2001; Wang et al. 2012; Moneke and Umeh 2013), and employee-oriented (Lin et al. 2011). Further, the study's findings suggest that supportive leadership showing empathy and identifying personal and work-related problems of staff is key to providing the required support, which may lead to increases in the quality of relationships among leaders and staff, maintain staff cooperation, and enhance a sense of family bonding, together with team cohesion, when staff encounter difficult and unpredictable situations in emergency departments. The finding suggests that being within a short distance of their staff, helps leaders to identify and be aware of the staff's feelings and needs, and thus, corresponding to them. Moreover, the findings suggest that supportive leadership may decrease the levels of tension and stress experienced by emergency department staff. The present study's findings indicate that supportive leadership is understood and enacted through specific culturally defined leadership behaviours including showing flexibility and understanding "Altafahum", and staff protection and defending.

7.8 Lenient leadership

The findings from the present study suggest that lenient leadership indicates managers' inclination to exercise leadership behaviours that stem from the national culture of Saudi Arabia; a leadership orientation that is based on both emotional and ethical foundations. The national culture of Saudi Arabia is largely influenced by Islamic religion. Lenient leadership is a deeply rooted Islamic leadership concept that is based on values of leniency, gentleness,

kindness, tolerance, forgiveness, care of others and patience. This current research shows that lenient leadership is used to confront various contextual factors, which can be divided into three categories: i) departmental factors, ii) staff-related factors and iii) patient-related factors. Departmental factors include stress, pressure and the complexity inherent in emergency departments. Staff-related factors include misunderstanding, workloads, conflicts between staff, conflicts between staff and patients; factors which, it can be argued, are mostly triggered by stress and troubling emotions. Patient-related factors include patients' and their companions' reactions towards medical staff due to excessive emotional states triggered by the emergency context, and patient-staff misunderstandings. Schein (2010) suggests that most of the observed leadership behaviours inside an organisation simply reflect the national culture in which that organisation is located. In this study, lenient leadership was found to involve two forms of leadership behaviour: containment and alerting.

Containment can be described as an emotion-oriented leadership. Dasborough and Ashkanasy (2002) and Humphrey (2002) stress that leadership, in essence, incorporates emotional practices. Containment leadership behaviour is an emotional regulation process reflecting social norms in Saudi Arabia, where leaders are expected to avoid and suppress conflicts (Atiyyah 1999; Mellahi et al. 2001) in order to maintain brotherly, friendly, cooperative, and harmonious relationships stressed in both Arabic and Islamic values (Atiyyah 1999). Islamic culture, as discussed in section 3.2.5, reinforces the values of forgiveness, tolerance, patience, kindness, and compassion (Khadra 1984; Abdalla and Al-Homoud 2001; Mellahi et al. 2001); all factors which seem to shape containment behaviour.

In this study, containment was defined by participants as an immediate leadership response to distressing emotional reactions in order to control and satisfactorily resolve a developing problem caused by stress. Containment involves controlling staff problems caused by stress without harming them psychologically and/or legally by escalating the issue to higher authorities. Bass and Riggio (2006) argue that leaders encounter, in their roles, threats, crises and uncertainties that lead to stress. This study found that leaders enact containment through communicative behaviour, in which they listen and discuss arising problems with relevant staff in order to reach friendly solutions that satisfy those people involved in a particular conflict. Bass and Riggio (2006) suggest that transformational leadership may contribute to resolving conflicts within teams, by creating a constructive context to determine what is causing the stress, as well as trying to resolve it. The present study's findings suggest that containment incorporates the absorption of one's anger when facing stressful situations that cause negative, undesirable, and unusual reactions; a scenario which is common in emergency departments because of their high-stress environments.

This finding is consistent with that of Zhang et al. (2012) who found that, during crises situations when there is chaos, urgency, and psychological shocks, transformational leadership displaying a high level of emotional control is significantly associated with leadership effectiveness. Thus, it can be argued that the containment leadership found in this study may be a form of transformational leadership behaviour, because it involves emotional control exercised in order to successfully confront stressful and demanding situations arising in emergency settings. Ashforth and Humphrey (1995); George (2000) call for incorporating consideration of the concept of emotions into the study of leadership and transformational behaviour.

The current study's findings help to illuminate the specific trigger issues in the emergency departments of Saudi Arabia that lead to the enactment of containment leadership. These issues include disagreements or misunderstandings between staff and patient/ patient's companion or staff interpersonal disagreements during the treatment process, where work pressure, psychological or social circumstances affect the staff. This study found that containment leadership behaviour may build trust between emergency department managers and their staff, as well as increasing the sense of teamwork, plus levels of staff security and retention. Bass and Riggio (2006) suggest that transformational leaders enhance team cohesion and reduce stress between followers through building supportive relationships between people within a social context. Thus, it could be argued that containment can be a form of transformational leadership that is shaped by both the stressful context of an emergency department and the national culture of Saudi Arabia.

Containment leadership behaviour also seems to be consistent with paternalistic leadership through which a leader is perceived as a father who looks after his family members. Bass and Riggio (2006) argue that paternalism facilitates the enactment of individualised consideration via transformational behaviour in collectivistic culture. Paternalistic leadership has been described as "a style that combines strong discipline and authority with fatherly benevolence" (Farh and Cheng 2000 p91). Benevolence represents individualised concerns towards an individual's welfare. In the current study, the connotations mentioned by the participants of 'one team' and 'one family' signify a strong social structure and collectivistic orientation that characterises Saudi and Arab culture regarding perceived leadership behaviour (Hofstede 2001; House et al. 2001). Hofstede (2001) argues that in collectivistic societies individuals belong to "in groups", which keep them safe in exchange for loyalty. This reflects the socio-structure of the Saudi society because there is a tendency to create and adhere to a strong social structure in which people prioritise their families or others with whom they are closely linked, who will give them support in order to receive total loyalty from them regardless of written rules and regulations (Hofstede 2001). The study's findings

support this argument as the containment leadership behaviour aims to protect staff from punishment and its related negative outcomes by solving problems within the boundary of the emergency department. Therefore, there seems to be an association between paternalistic leadership behaviour and collectivistic-oriented society, such as the one found in Saudi Arabia. Although perceived negatively in Western culture, where it has been termed in ways such as “benevolent dictatorship” (Hofstede 2001; Northouse 2013 p81), paternalistic leadership is perceived to be effective in Middle East culture, Pacific Asia, and Latin America (Uhl-Bien et al. 1990; Martínez 2003; Farh et al. 2006; Pellegrini and Scandura 2006). Thus, these findings support the argument that the effectiveness of leadership behaviour is culturally determined (House et al. 2004).

Alerting is a communicative behaviour and part of lenient leadership behaviour because problems are still solved within the boundary of emergency department without exposing staff to formal punishments. As discussed in the context chapter, Atiyyah (1999) argues that Saudi managers tend to resort to informal means of persuasion and social pressure before turning to punitive action. Alerting is therefore a specific leadership behaviour used by emergency department managers to alert their staff of their faults and the possible consequences. The findings suggest that alerting leadership involves corrective leadership behaviour to improve staff conduct and is used as a last-resort method to resolve a problem within the in-house boundary of the emergency department before the manager takes formal disciplinary action by reporting the matter to higher managerial authorities. The study’s findings suggest a number of situational factors that may lead emergency departments’ managers to take such an action. The factors could include staff who show careless attitudes to colleagues or patients and who are not committed to their duties. According to the findings, this leadership behaviour is seen to be effective because it gives emergency staff few chances to improve their behaviour. It can be said that this leadership behaviour corresponds to social norms in Saudi Arabia and thus reflects social norms within the country.

Overall, despite the effectiveness of lenient leadership through the enactment of containment and alerting behaviours as viewed by the participants in this research, one may question whether there are any negative consequences for such leadership practices. A further question relates to whether these practices are appropriate within public organisational settings? This point is raised because there seems to be an over-reliance in solving problems within the boundary of emergency departments, together with emphasis on social pressure to reach friendly solutions. On the one hand, it can be said that emergency department managers may, in essence, hide or avoid complaints in an attempt to protect themselves from being harmed and questioned by higher authorities in relation to departmental, staff conflicts or staff-patients conflicts. In addition,

increased numbers of complaints referred from emergency departments to higher authorities may undermine the status of those managers as being effective leaders. These issues are of relevance because suppressing conflicts is deemed an effective way of dealing with dissonance in Saudi Arabian culture (Atiyyah 1999; Mellahi et al. 2001). On the other hand, suppressing conflicts within the emergency department may have negative impacts on the delivery of safe healthcare to patients since managers tend to do all they can to protect their staff from legal punishments. This mind-set may mean that a risky error has been neglected. Moreover, suppressing conflicts may make one or both of the conflicting parties accept solutions due to managerial or social pressures though, internally, they are not completely satisfied. Thus, it could be that Saudi managers may tend to be willing to ignore organisational rules and regulations not only to maintain strong personal relationships with their followers to gain unquestioning loyalty but also to keep themselves safe of being questioned by higher authorities about problematic departmental issues.

There has been a considerable disagreement in respect to what defines organisational effectiveness and measurement since such concepts are naturally dynamic and complex (Cameron 1980) and varies from one cultural context to another (Yukl 2013). Therefore, Atiyyah (1999) argues that, in Saudi Arabian public organisations, achieving high levels of effectiveness depends on the creation and maintenance of cooperative, strong leader-follower relationships combined with a conflict-free environment. He also indicates that there is inadequacy of and lack of compliance with formal rules and procedures. This makes leaders use their social skills to persuade followers to perform tasks and run their organisation in a way similar to traditional institutions such as “clans or tribes” (Atiyyah 1999). More importantly, the traditional civil service system and the cultural tradition restrain leaders from applying disciplinary actions when followers show low performance and negative behaviour, in order to prevent the affected individuals to “losing face” or “means of livelihood” (Atiyyah 1999). House et al. (2004) found that, in the Middle East, self-protective leadership is highly endorsed; a model in which leaders emphasise personal features such as preserving one’s reputation and position. Hence, it can be argued that managers in Saudi Arabia are forced to minimise their use of authority in terms of disciplining their staff because of organisational and social constraints; thus, they are inevitably lenient towards their followers. Brewer and Walker (2013) argue that in the public organisational sector, managers are confined by organisational constraints that limit their ability to discipline poorly performing workforce members. Moreover, Yukl (2013) contends that, in any given culture, social norms influence appropriate practices of leadership; norms that may also be formalised as social laws and rules that influence the use of managerial power and authority.

7.9 Strict leadership

As defined by the study participants, strict leadership denotes a leader's tendency to being brave, harsh, decisive, and taking firm decisions by using their authority to discipline staff members who commit repeated or harmful mistakes; such leadership happens with little or no input from their staff. The findings suggest that strict leadership is used as an eventual solution when lenient leadership through alerting behaviour does not work. This finding is congruent with the conclusion reached by Atiyyah (1999) that Saudi managers tend to resort to disciplinary action when informal means of influence are not working. Similarly, the current findings suggest that emergency department managers do, at times, resort to strict autocratic leadership behaviour by reporting an issue to higher authorities to take disciplinary action, when alerting leadership behaviour has not produced an effective result when dealing with a delinquent staff member.

Strict leadership as described by the study participants seems consistent with the early authoritarian model described by Lewin et al. (1939), which involves the maintenance of strict control over members of the organisation through direct regulation and the implementation of rules and regulations, with dissent often being dealt with strictly and severely. It is also consistent with X theory of McGregor (1960) positing that careless and inconsiderate employees promote the use of an autocratic style of leadership. This finding is also congruent with that notion of active management-by-exception transactional leadership discussed in the full-range model of leadership (Bass and Avolio 1994), where leaders employ negative reinforcements to ensure staff compliance with rules and regulations (Clarke 2013). Consistent with McGregor (1960); Bass and Avolio (1994), autocratic leadership behaviour is used to discipline staff who commit repeated or harmful mistakes, who deviate from task responsibilities, disrespect other colleagues, make wrong medical interventions, and exhibit a low level of commitment to their work. The current study's findings indicate that autocratic leadership behaviour is used to influence emergency department staff to comply with organisational policy and procedures. In addition, the findings show that autocratic behaviour is used to discourage other staff from imitating deviant conduct and making similar mistakes in the future. Further, the findings suggest that the context of the emergency department, which was described by participants as critical, may encourage the emergency department's manager to use autocratic leadership behaviour during disasters when the department is under pressure. According to the findings, at times of disaster, autocratic leadership was seen to be effective and achievement-oriented process, although it may lead to tensions because of direct criticisms offered, perhaps, in the heat of the moment.

The current study's findings are broadly consistent with Ghorbanian et al. (2012) and Bormann and Abrahamson (2014), who found that active management-by-exception is positively correlated

with job satisfaction in emergency and critical care departments. In the current study, all types of participants generally identified autocratic behaviour, which involve negative reinforcement, as being effective in specific situations, such as if staff are committing repeated or harmful mistakes, deviating from task responsibilities, disrespecting other colleagues, making wrong medical interventions, and showing a low level of commitment to their work. Yet, this finding is contrary to other studies, which have suggested that active management-by-exception is ineffective in critical care settings (Kanste 2008; Abualrub and Alghamdi 2012). This inconsistency could be attributed to the implication of the socio-cultural environment in which leadership take place because the context determines the effectiveness of a particular leadership behaviour (Osborn et al. 2002). The current findings suggest that an emergency department is critical setting, where staff are required to show commitment and discipline and these demands encourage emergency department managers to enact negative reinforcement (autocratic leadership) leadership behaviour.

The next sections will move on from reviewing each theme independently to discussing together some of the ideas from across the themes identified in the present research.

7.10 The impact of the context of emergency department

The present research findings showed that the context in which leadership is situated strongly influences leadership behaviours and their effectiveness. This is because of the distinctive contextual factors in emergency departments as found in this research. The findings revealed that the context of an emergency department environment is unpredictable and regularly experiences sudden high volumes of patients, tension and work pressure, over-crowding, high stress and interpersonal conflicts. The context of emergency department was also characterised by different types of participant including emergency managers and staff as a complex environment that requires cooperation and teamwork. All of these different situations shape the different leadership behaviours identified by this research and give these behaviours a particular significance and meaning. As argued in chapter 2 (section 2.5), leadership is embedded in the context in which it operates; leadership effectiveness relies on the contextual circumstances (Denise and Yitzhak 2001; Osborn et al. 2002).

The findings showed that there are many leadership behaviours influenced by the unpredictable and dynamic nature of emergency departments. The analysis indicated that rewarding leadership, responsive leadership and supportive leadership are used by emergency department managers to meet the demands of unexpected situations in emergency departments. For example, rewarding leadership behaviours such as allocating staff their preferred workplace for a short time are used

to encourage staff to respond proactively and professionally to unexpected situations. For example, when a staff member shows excellent performance during a disastrous event, s/he will be allocated their favourite place of work for a short time by their managers as means of reward for that performance. When an unexpected situation occurs in an emergency department that causes over-crowding and treatment delays, emergency department managers will directly intervene (responsive leadership) to find solutions that help emergency staff deal with such situations. For example, the leaders will communicate with higher management to bring in more medical and nursing staff from the hospital's other, less busy, internal departments. The study's findings also showed that emergency department managers used flexibility and understanding (supportive leadership) as a strategy to obtain staff cooperation when encountering difficult and unexpected situations in their emergency departments. To illustrate, a manager's flexibility and understanding of staff circumstances give the staff moral responsibilities to respond effectively when they are called to meet challenging events. The findings indicated that leadership flexibility and understanding of staff circumstances make emergency staff respond positively to their managers even if those staff were not initially on duty.

The findings indicated that the pressured and stressful nature of an emergency department also influences several types of leadership behaviour. These leadership behaviours include rewarding leadership, responsive leadership, role modelling, supportive leadership, and lenient leadership. The findings showed that rewarding leadership behaviours, such as giving extra time off, or extending break time can minimise the mental, emotional and physical pressure caused by dealing with large volumes of patients in an emergency department, since such stress reducing rewards give staff a respite value after their high efforts. It was also found that pressure and stress in emergency departments may cause tension and interpersonal conflicts between staff or conflicts between staff and patients or their companions. These situations cause emergency managers to intervene directly to correct staff mistakes (responsive leadership), adopt patience, tolerance and serenity to minimise stress and conflicts and create a peaceful environment (role model), defend and protect their staff against erroneous complaints and unfair disciplinary actions (supportive leadership), and contain problems that suddenly occur from staff due to work pressure or psychological or social circumstances (lenient leadership).

The current research findings indicated that a hospital's emergency department is a complex setting that requires cooperation and teamwork from the involved personnel in order to successfully lead and to deliver effective emergency care. The findings showed that emergency department managers use different types of leadership behaviours to meet the complexity of emergency department and ensure cooperation and teamwork between staff. These leadership behaviours include showing respect for others (role model leadership), consultation, consensus

and delegation (democratic leadership), flexibility and understanding; staff protection and defending (supportive leadership), and containment (lenient leadership). All these leadership behaviours were shown to be of significance in emergency departments because they create and maintain staff cooperation and team work, as well as team cohesion.

The current research was designed to investigate leadership behaviours in emergency departments only. The current research revealed some leadership behaviours that appear strongly influenced by the context of the emergency department. Examples of these leadership behaviours are rewarding leadership such as giving days off, extra time off, extending holidays, allocating staff their preferred place of work for a short time, and allowing a staff member to work fewer hours. Another example is that of direct action and responding to unexpected situations (responsive leadership), showing patience, tolerance and serenity (role model leadership), flexibility and understanding; and staff protection and defending (supportive leadership) and containment (lenient leadership). The current research findings show that these behaviours are highly related to the context of emergency departments; nonetheless, these behaviours may also be found in many busy medical departments, such as those dealing with critical care settings. In contrast, it seems unlikely that these leadership behaviours would be found in 'normal' departments, since 'normal' departments contextually differ from emergency departments. In addition, the leadership behaviours identified in this study may not be seen as effective in in less challenging environments than those frequently encountered in an emergency department. However, this hypothesis needs a further research that adopts a comparative research design to tease out the similarities and differences of leadership behaviours and their effectiveness between dissimilar medical settings.

7.11 The impact of national culture

The findings indicated that a country's culture has a profound influence on leadership behaviours, as revealed in this study. For example, role modelling, consultation, recognition, supportive, and lenient leadership are all factors shaped by Islamic culture which, in turn, legitimises those factors, through Islamic scripts, to be enacted in organisational settings for dealing with others and responding to different work situations. As argued by Hofstede (2001); House et al. (2001) and House et al. (2004) organisations operate within social and cultural contexts, and these contexts have a considerable impact on workforce attitudes, since they shape their values as well as the way in which they socially connect with others in workplace settings. The role of values on effective leadership practices has recently gained increasing interest and attention in the leadership literature and related models e.g. charismatic/transformational, servant and authentic

leadership. As mentioned in the introduction chapter, effective leadership behaviour is culturally determined because of the value systems that underpin each different culture.

Values influence leadership behaviours in several ways, a point made by England and Lee (1974) First, values affect a leader's perception of a situation. Second, they influence the way in which leaders make a decision to solve issues. Third, they influence how leaders build relationships with others. Fourth, values affect people's understanding regarding personal and organisational success. Fifth, the difference between acceptable and unacceptable behaviour is determined by a leader's values. Sixth, a leader's acceptance or rejection of organisational pressures and goals is influenced by their values. Seventh and last, operational performance can be influenced by leaders' values. Hughes et al. (1993) argue that values affect a leader's moral reasoning because they affect decisions in respect to moral, and also immoral behaviour. Rokeach (1968) and Malphurs (1996) suggest that individual value systems shape the nature of people, as well as their approaches and consequently influence their behaviours. The emerging leadership behaviours identified in the present research reflect various values that are deeply rooted in the socio-cultural backgrounds of those leaders.

It can be argued that the leaders' attention to followers' needs, as revealed in this study, is driven by the Islamic religion. Leadership in Islam is about trust (Amanah). Leaders are entrusted to be responsible and accountable not only to their followers but to Allah "the God" in the first instance. Ultimately, leaders seek God's rewards and pleasures through showing good deeds and actions towards their followers. Islamic beliefs and values, as well as social norms, regulate the revealed leadership behaviours and participants frequently embedded their answers in a narrative consistent with these beliefs and values. These socio-cultural mores may explain the leaders' sensitivity towards their followers' needs through the enactment and exercise of rewarding, responsive, role modelling, democratic, staff development, recognition, supportive, and lenient leadership. While these different leadership behaviours can be found in other cultures, it is suggested that the motivations that underpin those behaviours are different and could result in embracing a paternalistic leadership style. This explanation is consistent with spiritual leadership, in which leaders are thought to be motivated by service to God or to humanity, and they therefore view their leadership work as a calling (Fry 2003). Therefore, the culture may not only determine the type of leadership behaviours but also explain the motives of enacting these specific behaviours.

Leadership behaviours identified in this study, such as rewarding, role modelling, democratic, staff development, recognition, supportive, lenient, and strict leadership may be linked with

ethical leadership and associated leadership models, such as spiritual, authentic and transformational leadership. Ethical leadership has been described as "the demonstration of normatively appropriate conduct through personal actions and interpersonal relationships, and the promotion of such conduct to followers through two-way communication, reinforcement, and decision-making" (Brown et al. 2005 p120). Ethical leaders show care, concern for others, and think through the subsequent outcomes relevant to their judgements. The participants in this research perceive the leadership behaviours identified as a normatively appropriate leadership conduct that regulates personal actions and interpersonal relationships. Such leadership behaviours involve normatively appropriate conduct because they are consistent with Islamic teachings, which shape people's day-to-day interactions in Saudi Arabia. Moreover, these leadership behaviours are endorsed to emergency staff through reciprocal communication, reinforcement, and decision-making.

The concepts of supportive and lenient leadership identified in the present study can be linked to some components of servant leadership, which is part of the ethical leadership domain; however, the servant leadership model is understood and applied differently in practice. Servant leadership includes empathy, persuasion, stewardship and building a community (Spears 2002). Empathy refers to a leader who understand others' situations and tries to put him/herself in the positions of others in order to effectively grasp how people feel and think (lenient and supportive). Persuasion denotes a leader who provides clear and persistent communication to persuade others to change, by using gentle non-judgmental argument, as opposed to coercion and force (lenient). Stewardship stands for taking leadership responsibility as entrusted to the leader who carefully manages the people and organisation they are given to lead (staff protection and defending). Building a community is about the development of community, which allows people to feel safe and related to others (flexibility and understanding). The Saudi Islamic culture, which encourages unity, relatedness and sensitivity towards followers' needs, may foster the adoption of servant leadership through supportive and lenient leadership behaviours.

In a similar vein, it is worth mentioning that leadership behaviours such as autocratic behaviour, as well as staff protection and defending, as identified in the current research may mirror the characteristics of paternalistic leadership. Paternalistic leadership incorporates the display of strong power combined with kindness and compassion through the exercise of authoritarian leadership (autocratic behaviour) and benevolent leadership (staff protection and defending) (Farh and Cheng 2000; Farh et al. 2006; Pellegrini and Scandura 2008). In paternalistic leadership, authoritarian behaviour denotes authority and control, while benevolence denotes leaders who show attention and concern for their

followers' individual wellbeing (Pellegrini and Scandura 2008). Paternalistic leadership is seen as effective and common in Middle Eastern culture (Pellegrini and Scandura 2006; Pellegrini and Scandura 2008) The current research identified that autocratic behaviour and staff protection and defending, which are similar to concepts of paternalistic leadership, are exercised in emergency departments and influenced by the manager's tribal values, social norms and Islamic teachings found in Saudi Arabia. Aycan et al. (1999) and Pellegrini and Scandura (2008) argue that, in cultures where paternalism is common, leaders are expected to provide protection for their followers who are, in turn, expected to reciprocate by showing loyalty and deference to their leader. The present research reveals the underpinning motivations that lead to the enactment of paternalistic leadership by specifying not only the behaviours of paternalistic leadership but also the underlying values and beliefs that were not captured in Western leadership models.

The effect of national culture on leadership behaviours is well-established in leadership literature. Leadership effectiveness is culturally determined (Hofstede 2001; House et al. 2001; Schein 2010). Middle-East culture is characterised as human-oriented and collectivist-oriented (Hofstede 2001; House et al. 2004). The former refers to the level at which a society supports individuals who are sympathetic, obliging and equitable regarding others, and who employ a friendly approach such as self-sacrifice, consideration and kind-heartedness. The latter refers to the tendency of people to stress as superior those relationships with their families and organisations that are dedicated, contented and cohesive. Leadership behaviours identified in this research such as the rewarding, role modelling, democratic, staff development, recognition, supportive, and lenient leadership models seem consistent with these categories, because of the influence of national culture on perceived leadership behaviours.

Following social constructionist theory, together with organisational culture and leadership theory, the reality of everyday life is socially constructed through human interactions and is organised around "here" and "now" dynamic phenomena (Berger and Luckmann 1966; Schein 2010). To illustrate, "here" signifies one's body and "now" signifies one's present. Culture implies stability and rigidity in terms of how people should perceive, feel, act in a given society, organisation, or occupation, and in prescribed ways of maintaining "social order" (Schein 2010). The instructions and rules of the social order provide opportunities to predict social behaviour, get along with each other, and find meaning in what people do. Culture supplies language that provides meaning in human day-to-day life. Culture is the basis of social order that people live in and of rules that people should abide by. Culture is a taken-for-granted reality for members of a group. In other words, culture exists in a group's

unconscious though it has strong influences on a group's behaviour (Schein 2010). The current findings support these arguments because leadership behaviours identified in this study seem congruent with the national culture, which is a taken-for-granted reality influencing leadership behaviours and their meanings enacted by emergency department managers.

To understand how national culture influences organisational culture, Schein (2010) proposes four categories of culture: i) macrocultures, ii) organisational cultures, iii) subcultures and iv) microcultures. Macrocultures is a term which refers to countries, ethnicities, religions, and professions, which can be found worldwide. Organisational cultures denote public, private, non-profit, and government organisations. Subcultures imply various occupational groups within an organisation. Microcultures represent microsystems within or outside organisations e.g. emergency departments. Schein (2010) argues that macrocultures are more stable and ordered because they have existed for a long time and that there is a connection between macrocultures and microcultures. Culture is usually the result of the embedding of what a founder "leader" has imposed on a group that has worked out successfully. Culture is created, embedded, evolved, and ultimately influenced by leaders. Simultaneously, with a group's maturity, culture comes to constrain, stabilise, and provide structure and meaning to the group members. Ultimately, culture even specifies what kind of leadership is acceptable. Figure (7-1) shows the dynamic forces of macroculture e.g. national culture, organisational culture and unit culture on leadership behaviours. Notably, macroculture influences all the subsequent categories. The present study's findings show that the Saudi national culture which is dominated by Islamic religion and tribal values (macroculture), influences leadership behaviours such as role modelling, democratic, recognition, supportive, lenient, and strict leadership enacted in emergency department settings (microculture). Organisational culture influences leadership behaviour. For example, staff development leadership is influenced because the contemporary organisational structure for most Saudi Arabian public hospitals include a "continuing education department" for educating the hospitals' workforce in an ongoing way. In addition, the emergency department culture (microculture) influences the enactment of leadership behaviours such as rewarding, responsive, and also role modelling because of the unpredictable, pressured, stressful environment.

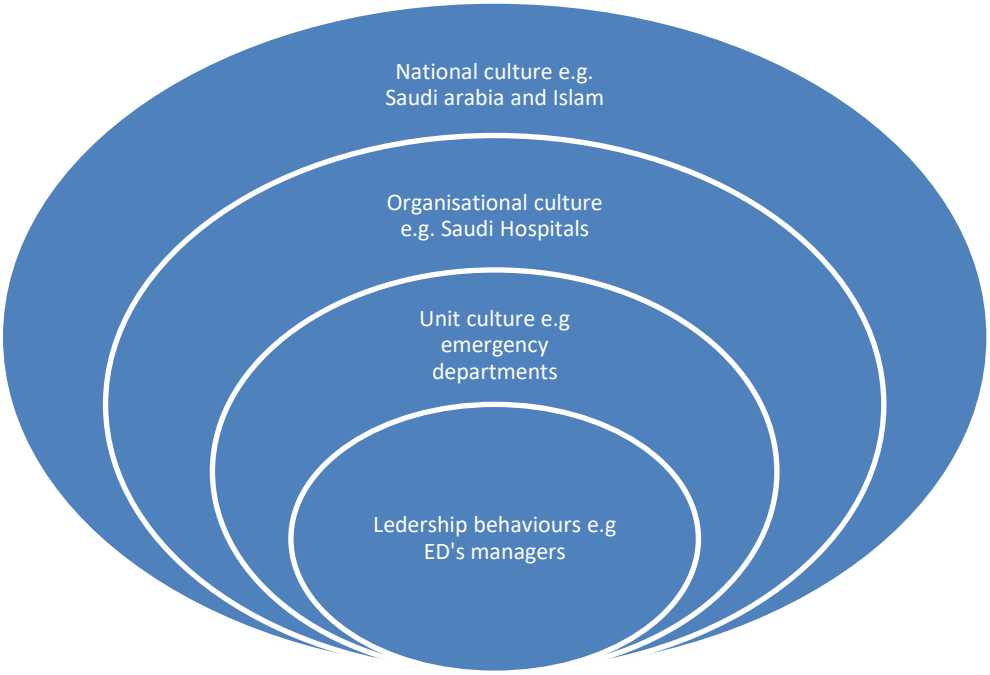


Figure 7-1 Dynamic forces of national culture, organisational culture and unit culture on leadership behaviours.

7.12 The dynamics of leadership behaviours

The current findings indicate that leaders use a complex web of leadership behaviours and may enact a number of different behaviours depending on the context (Anderson and Sun 2017). That is, one particular leadership behaviour may guide the use of other leadership behaviours to adapt for the demands of a particular situation. This section attempts to explain the dynamics of leadership behaviour as understood from the findings (Figure 7-2).

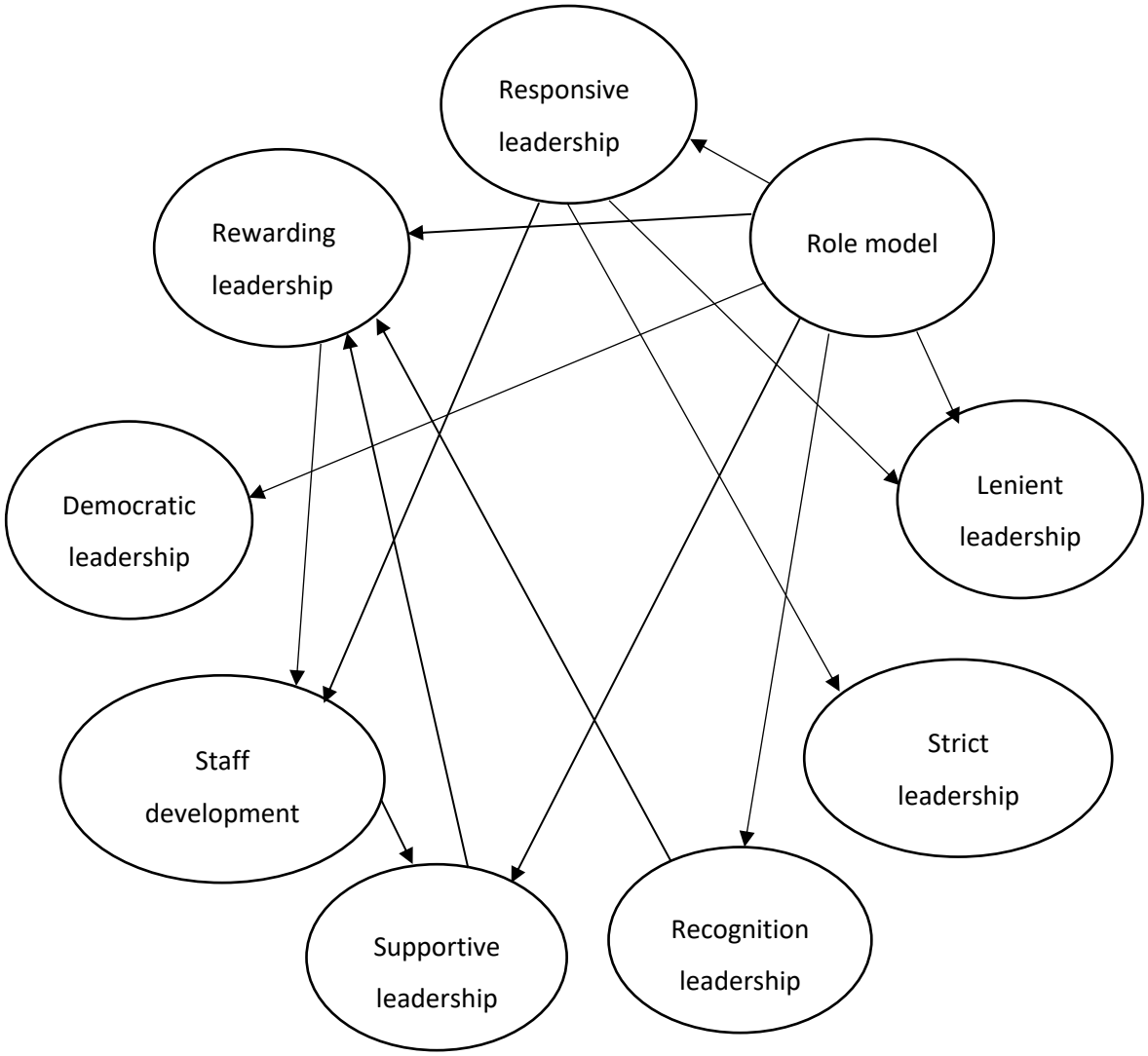


Figure 7-2 The dynamics of leadership behaviours.

The current findings indicate several linkages between different leadership behaviours. The findings suggest a relationship between rewarding leadership and staff development leadership, because leaders seem to offer educational opportunities or training for their staff, as a reward for observed high performance in the workplace. In contrast, staff development leadership may be enacted after responsive leadership when, for example, leaders discover that a medical or nursing staff has a lack of a medical skill or knowledge relevant to a particular medical intervention. In such an instance the leader deals with the situation by either teaching the staff member or offering him/her an educational training opportunity. Responsive leadership may guide leaders to act leniently through containment behaviour or exercise strict leadership by reporting to higher authorities when there are interpersonal conflicts between staff members or patient-staff conflicts, depending on the degree of the problem. Role modelling is related to characteristics such as being fair, responsive, democratic, recognition, lenient, and supportive leadership because when leaders provide fair rewards (rewarding), practical support (responsive), listen to

others' views (democratic), appreciate staff achievements (recognition), satisfactorily resolve an issue (containment), and show concern for others (supportive), they are likely to be perceived as role models, as indicated by leaders themselves and their staff.

Recognition leadership is linked with rewarding leadership because recognition can be enacted after rewarding behaviour as a complementary leadership behaviour. Supportive leadership is connected with rewarding leadership because these different leadership behaviours are used to achieve a similar objective: to motivate emergency medical and nursing staff to respond effectively during demanding situations. Yukl (2013) suggests that leaders may use different leadership behaviours to achieve the same objective. Staff development leadership is linked to supportive and rewarding leadership because these different behaviours involve intrinsic motivational influence; yet they are enacted for different reasons. For example, in the case of an emergency department, staff development leadership is practiced to constantly advance the medical knowledge and skills of staff; supportive leadership is enacted when there is a work-related, personal or family issue affecting an emergency staff member.

To sum up, the findings from this study illuminate specific leadership behaviours that may help in bridging the gap between theory and practice. The current findings not only identify leadership behaviours enacted in Saudi hospitals' emergency departments but also shed light on the meanings ascribed to these different behaviours. Even though the findings of this research may seem similar to Western leadership models, there are key differences in the way these are interpreted and/or enacted, given the influence of culture. For example, supportive leadership seems similar to many concepts in leadership literature including consideration, employee orientation, concern for people, relational orientation (Stogdill and Coons 1957; Likert 1961; Blake and Mouton 1968), individualised consideration (Bass 1985), enabling others to act (Kouzes and Posner 2012), and emotional healing (Liden et al. 2008). Yet, in this research context, supportive leadership was understood differently and enacted through specific leadership behaviours, which included flexibility and understanding, and leaders protecting and defending their staff. These actions are shaped by Islamic and tribal values and reflect social norms in Saudi Arabia.

It can be argued that the high sensitivity of Muslim leaders towards followers' needs is shaped by their belief-system, which is governed by the Islamic religion as discussed in Section 3.3. The doctrine, laws and moral principles of Islam give Muslims' leaders the moral incentives to exercise several leadership behaviours identified in the current research. These leadership behaviours include rewarding, role modelling, democratic, staff development, recognition, supportive, and lenient leadership.

It is worth mentioning that there is a considerable homogeneity in the participants' responses, although this study involves participants from multicultural backgrounds. This homogeneity could be attributed to the influence of Islamic culture, which shapes social norms in Saud Arabia, given the fact two thirds of the participants are Muslims (20 out of 30), who share both a religion and Arabic language in common. Muslim participants may have internalised the values and meanings of their behaviours, albeit in a way that might be unconscious, since they grew up in an Islamic culture.

However, participants from other cultures may exercise these leadership behaviours as they have repeatedly seen these behaviours work successfully for the leaders in emergency departments, without necessarily internalising the underlying values of these behaviours. Schein (2010) argues that when a solution to a problem works repeatedly, it comes to be taken for granted reality, where individuals come to believe that 'nature really works this way'. This process leads to a high degree of consensus within a social unit (Schein 2010). Furthermore, Yukl (2013) suggests that most leaders will adapt to social norms about acceptable behaviour because the deviation from these norms may lead to decreased respect as well as increased social pressure from other members of the organisation. It is expected that the use of socially unacceptable leadership behaviour may weaken leadership effectiveness.

7.13 Study contribution

The current study makes a number of contributions to the existing state of knowledge regarding leadership behaviours in a specific context, at the level of theory and practice as well as taking into account methodological considerations. These contributions will be discussed separately in the next sections.

7.13.1 Theoretical contribution

This research was mainly undertaken to understand leadership in Saudi hospitals' emergency departments, with the aim of addressing the current gap in leadership research, a gap where main models of leadership behaviours overlap, often overlooking contextual and cultural factors that influence the enactment of leadership. Leadership literature has recently indicated that there are strong associations between context, culture and leadership. The literature focuses on the significance of investigating the phenomenon and its impacts on individuals, group, and the overall environment in the context where leaders operate. As discussed in chapters 1 and 2 existing research approaches leadership behaviours using leadership models developed in Western culture, while often disregarding the role of contextual and cultural characteristics in

shaping leadership effectiveness. A growing attention in leadership research has been paid to examining and identifying how leadership is understood and enacted given the influence of the social and cultural context in which organisations are embedded (Bryman et al. 1996; Hofstede 2001; Osborn et al. 2002; House et al. 2004; Avolio 2007; Tsui et al. 2007; Metcalfe and Metcalfe 2008). This literature emphasises the importance of examining the influence of contextual and cultural forces that shape leadership behaviours in an organisational setting. Therefore, the current research contributes an additional construction to leadership literature through empirical examination of leadership behaviours in an emergency department context, located in Saudi culture.

In order to address the current gap in the literature, in which the effects of context and culture has received only limited attention, the current research has generated a conceptual framework (Figure 7-2) of leadership behaviours that can conceptually be linked with the dominant Western models of leadership. The conceptual framework shows how different categories of leadership behaviours are understood and enacted in this organisational and cultural context. The current framework of leadership behaviours is sensitive to the context of emergency department settings and the socio-cultural aspects that reflect the reality of leadership, which depends on motivational, emotional, relational and ethical aspects of leadership underpinned by the unique characteristics of emergency departments as well as cultural and traditional beliefs. This study expands current research into leadership and leadership models by showing not only the specific behaviours practiced, but also the motivations and mechanisms including contextual and cultural forces that shape leadership behaviours enacted in the context of emergency departments in the culture of Saudi Arabia. Contextual factors involve high pressure, stressful, chaotic, overcrowding, and conflicts between emergency staff or between emergency staff and patients or their companions. Cultural factors include social norms, tribal values and the Islamic religion. Moreover, this study expands leadership behaviours in the current leadership models by suggesting specific leadership behaviours that have not been previously identified, due to cultural constraints; for example ‘lenient leadership’.

The present research illuminates some leadership behaviours specific to the characteristics of emergency departments. Examples of reward-based leadership behaviours are giving staff days off, allocating staff their preferred working place for a short time and extending break times as rewards. Showing patience, tolerance and serenity for setting a role model. These leadership behaviours and their effectiveness are derived from the context of emergency department settings which are characterised by the participants of the present study as being unpredictable, overcrowded and stressful settings. Osborn et al. (2002) and Denise and Yitzhak (2001) argue that

leadership is embedded in the context in which it operates; leadership effectiveness relies on the surrounding contextual circumstances.

The current research illuminates the specific leadership behaviours that reflect wider leadership values identified in leadership literature concerning Saudi and Arab culture. The extant leadership literature suggests that Saudi culture emphasises human and collectivistic values (Hofstede 2001; House et al. 2004). This research shed light the specific leadership behaviours that reflect these values including rewarding, responsive, role modelling, democratic, staff development, recognition, supportive, and lenient leadership. Moreover, this research has made a significant contribution to the literature by illuminating the way in which these different leadership behaviours are interpreted and applied in Saudi hospital-based emergency departments.

This study highlights different leadership behaviours that have been linked to many concepts in the traditional and new-genre leadership models. Leadership behaviours identified in this research have been associated with the early developed models of leadership such as democratic and autocratic leadership (Lewin et al. 1939; McGregor 1960; White and Lippitt 1960). Another approach involved consideration, employee orientation, concern for people, relational orientation emerging from research programmes such as the Ohio State Studies (Stogdill and Coons 1957), the University of Michigan Studies (Likert 1961), and the Blake and Mouton's managerial grid (Blake and Mouton 1968). Moreover, the identified leadership behaviours have also been connected with some components of the contemporary models of leadership. These models include contingent rewards and management-by-exception for transactional leadership (Bass and Avolio 1994); idealized influence and individualised consideration (Bass and Avolio 1994) and modelling the way, enabling others to act and encouraging the heart (Kouzes and Posner 2012) for transformational leadership. In addition, the present study's findings have been linked to several components of servant leadership such as behaving ethically, helping followers grow and succeed, emotional healing, persuasion, and stewardship (Liden et al. 2008). Furthermore, the identified leadership behaviours in this research have been linked with paternalistic (Farh et al. 2006) and ethical (Brown et al. 2005) leadership models.

Whilst there are many links to Western leadership models as detailed above, the present study focusses attention that no one leadership model is able to account for the complexities of leadership in this setting. The current research has contributed to the field of leadership by identifying the specific patterns of thinking, underlying values, basic motives, views and behaviours related to Saudi culture that shape and reflect the wider leadership concepts, as reported in the leadership literature. This study, therefore, contributes to the current body of leadership knowledge in a way that makes the well-known look unique while the unique looks

well-known (Whetten 2002; Tsui 2004) through connecting the study's findings with the existing literature on leadership behaviours. Although the key leadership concepts identified in this research may seem similar to the Western conceptualisations of leadership, those concepts are often perceived and driven differently due to the influence of context and culture. This perception suggests that leadership scholars should contextualise leadership research (Bryman et al. 1996; Denise and Yitzhak 2001; Osborn et al. 2002; Tsui et al. 2007; Parry et al. 2014) in order to understand different forces influencing leadership understandings and practices. Thus, we should be cautious in the way we generalise and apply Western leadership models to other different cultures.

7.13.2 Practical contribution

The present study was undertaken to address the gap concerning scholarly debates, professional practices and policymakers through conducting an empirical examination of leadership phenomena in Saudi hospitals' emergency department contexts. This study makes practical contribution to the field because it reveals the collective understandings and orientations of leadership, as well as the difficulties emergency departments' managers experience when leading in such a high-stress environment. This awareness may extend their leadership skills to incorporate relational, motivational, emotional, and ethical orientations found in this study. These leadership orientations are underpinned by cultural traditions, Islamic religious beliefs and organisational constraints and are used to counter the embedded contextual difficulties within the context of this study. The present study provides novel understandings, based on local particularities, of leadership behaviours practiced in the Saudi context. The knowledge and understandings obtained from the current research can be utilised to inform healthcare policy plans concerning leadership development in hospital emergency departments, both nationally and internationally.

The research findings might be interesting for national and international emergency department managers, emergency staff, and potential managers of emergency departments, healthcare practitioners, and policy-makers who wish to better understand the current practices of leadership in the context of hospital emergency departments in Saudi culture. The current research findings highlight leadership concepts and practices in this setting as well as the contextual, organisational and cultural forces that influence these different leadership behaviours. The findings of this research indicate that several leadership concepts documented in the general leadership literature are sometimes named and understood differently, as well as being enacted through specific leadership behaviours driven by specific idiosyncratic contextual, organisational and cultural forces. For example, rewarding leadership behaviours are driven by

the unique characteristics of emergency departments, such as being busy, dynamic and pressured workplace. Another example is that of lenient leadership, which is underpinned by cultural beliefs and organisational constraints as a way of dealing with various conflicts in emergency departments. This research provides local and international managers and healthcare practitioners who are interested in leadership in emergency departments with a more detailed picture and a greater understanding of leadership processes and dynamics in this cultural context. The current study's findings show interested parties not only specific leadership behaviours but also specific patterns of thinking, motives and beliefs that lead to particular leadership practices. This understanding may help local and international managers to recognise the ways in which leaders influence their followers in the context of emergency departments in Saudi culture. Yukl (2013) maintains that leaders will not be able to effectively influence people from a particular culture without a good understanding of that culture. The insights obtained would enable interested parties to determine domains that need more improvement through being aware of the distinctive features related to the different leadership practices. In addition, the findings may help policy makers to identify deficiencies in the management system, as well as recognising organisational forces and constraints that may need reform and development.

7.13.3 Methodological considerations

A qualitative approach was adopted in this research in order to help to understand leadership concepts based on the various views of participants, who construct, operationalise and practice leadership. To the best of my knowledge, this is the first study to investigate leadership behaviours based on both leaders' and followers' perspectives within the context of hospital emergency settings in Saudi culture using qualitative methods. Therefore, this research employs qualitative methodology to study leadership through the adoption of social constructionism to examine the way in which leadership is understood and practiced in hospital-based emergency department settings within the context of Saudi Arabian culture. The study aims to capture these social and cultural meanings. The methodological approach employed in the present research reveals how emergency departments' managers, along with their staff, construct their own reality regarding leadership phenomenon. The research has also examined how and why leadership is being enacted in this sociocultural setting.

As mentioned earlier in the chapter 4, quantitative methodology dominates leadership research. Quantitative methodology falls short in attempts to capture meanings ascribed by the social actors, who engage in leadership. The current research has corresponded to the concerns regarding the adoption of quantitative methodology to study leadership, suggesting preference for a qualitative approach to understand leadership and its related processes (Denise and Yitzhak

2001; Osborn et al. 2002; Bryman 2004; Tsui et al. 2007; Parry et al. 2014). The issues highlighted in Sections 1.4 and 5.3.1, addressing the study's rationale and research objectives relating to the implications of context and culture on influencing leadership behaviours, understandings, and effectiveness, support the researcher's position for adopting a qualitative approach to examine leadership behaviours within the environment of social actors. We might not have been able to explore and understand leadership behaviours enacted in this context, as well as the contextual and cultural forces influencing leadership understandings and practices, if we had chosen a different approach. The findings reveal that the factors influencing leadership behaviours are diverse, complex, and sometimes overlapping. These findings indicate that leadership research within the organisational contexts requires appropriate research methodology in which leadership dynamics and various meanings attached to leadership can be captured. Moreover, because there are diverse definitions of leadership as indicated in chapter 2, the research design used in this study is the key to understanding the various meanings ascribed to leadership

Chapter 8 Conclusion

This chapter presents the conclusions of this research. The study offers knowledge grounded in participants' perceptions regarding leadership behaviours. This research has explored leadership behaviours as understood and operationalised by hospital-based emergency department managers in Saudi Arabia. The research focuses specifically on identifying, describing and explaining different types of leadership behaviours, as well as examining the role of contextual and cultural factors, in shaping these different leadership behaviours. The chapter reviews the research question, aim and objectives, as well as including a discussion of the study's main findings. Highlighted are the limitations of the present study, together with pointers for future research.

8.1 Revisiting the study question, aim, and objectives

The study's question, aim, and objectives were subject to refinements throughout the PhD journey. The research aimed to identify how leadership is understood and practiced by emergency department managers in Saudi hospitals, informed by Saudi culture. The overall research question and aim of this study are identified as follows:

8.1.1 Research question

"How are different leadership behaviours perceived and enacted in emergency medical departments in Saudi Arabian public hospitals?"

8.1.2 Research aim

To identify, characterise and explain the dynamics of leadership behaviours as these behaviours are understood and operationalised by the managers of hospital emergency departments in Saudi Arabia.

A number of objectives were set to meet the overall research question and aim of this study. The following section presents the research objectives, the key findings, and the conclusions reached, drawn from the data collected.

8.1.3 Research objectives

1) To identify, describe, and explain the types of leadership behaviours in use, as perceived and enacted by emergency-department managers;
2) To identify, describe, and explain the types of leadership behaviours enacted by emergency-department managers, as perceived by emergency-department staff.
3) To identify shared patterns of leadership behaviours between emergency-department managers and their staff.
4) To examine the influence of an emergency-department context and Saudi national culture on leadership behaviours.

The present study's findings reveal several leadership practices are being enacted by emergency department managers. These leadership practices are based on the reflections by emergency department managers and their staff on leadership behaviours enacted by managers in emergency departments in the Saudi Arabian context. This reflection stems from the managers' and staff's interactions and relationships with each other. That is, the reflections represent an implicit and explicit discourse between emergency department managers and staff on the role of leadership as practiced by emergency department managers in emergency departments within Saudi culture. In other words, the findings capture the language, views, meanings and values being shared among various individuals in hospital emergency departments in Saudi Arabia.

The study's findings show that leadership may broadly include motivational, relational, emotional, and ethically-oriented leadership practices. This description can be offered because leaders operate within sociocultural contexts, which significantly influence the way in which they behave and interact with others. The dynamic relationship between the contexts of emergency departments, the culture of Saudi Arabia and emergency department managers and their staff produce, occasionally, a distinctive interpretations and meanings in respect to the leadership roles in a Saudi context. This outcome is because of the role of social norms, which define appropriate and inappropriate behaviours. In addition to social norms, this peculiarity stems from the influence of the Islamic religion and tribal values in Saudi Arabia.

Within the context of this research, the findings suggest that the majority of the participants, including emergency department managers and their staff, share similar understandings and practices of leadership. These understandings and practices are mainly inspired by participants' religious values and cultural traditions. Particular emphasis is given to respect, forgiveness, tolerance, kind-heartedness, compassion, brotherly and friendly relationship, cooperation, and harmony. In Saudi Arabia, leadership mainly reflects social norms as it presumably does everywhere. Emergency department managers' views and understandings, as well as mutual

language are strongly influenced by Islamic religion. For example, the motive of emergency department managers to exercise lenient leadership to resolve departmental problems, including stress and pressure, among others, may be triggered by their Islamic background and cultural traditions. This is a taken-for-granted leadership responsibility for emergency department managers. Such leadership orientation was seen to be effective by the study's participants who were working in Saudi culture. However, some components of lenient leadership such as alerting may be considered as ineffective in Western culture, as it involves a kind of paternalistic leadership; the so-called 'benevolent dictatorship'.

In spite of this peculiar conceptualisation of leadership, emergency department managers in Saudi Arabia enact different types of leadership behaviours that may be relevant to the existing behaviours found in Western leadership literature. These Saudi based leadership behaviours include rewarding leadership, responsive leadership, role modelling, democratic leadership, staff development leadership, recognition leadership, supportive leadership, and strict leadership. However, all these different leadership behaviours are still moulded by religious and cultural values, as well as contextual and organisational forces, in the emergency departments. The leadership behaviours identified in this research are consistent with the socio-cultural environment in Saudi Arabia, in that they enable managers to meet different day-to-day challenges in emergency departments.

In this research, the findings show that the unique characteristics of emergency departments play a key role in shaping leadership behaviour and determining its effectiveness. The context of an emergency department has been characterised by the participants of this study as unpredictable, increased workload, busy, over-crowded, conflicts, pressured, and stressful workplace. The study reveals that emergency departments' managers enact several leadership behaviours that are strongly driven by such contextual factors, in order to meet the challenges posed by such an environment. These leadership behaviours include giving days off, allocating staff their preferred place of work, selecting the type of work to carry out, assigning staff to a lighter working areas, and giving staff extra break time as means of rewards (rewarding leadership), and direct action and responding to unexpected situations (responsive leadership). Moreover, contextual factors in emergency departments influence leadership behaviours such as showing patience, tolerance and serenity; and respect for others (role modelling leadership), consultation, consensus and delegation (democratic leadership), staff protection and defending (supportive leadership), containment (lenient leadership), and autocratic behaviour and reporting to higher authorities (strict leadership). These leadership behaviours are deeply valued by the study's participants since they help to maintain effective staff performance, meet unexpected challenges, strengthen manager-staff relationship and create a peaceful environment. For example, emergency

department managers intentionally role model leadership behaviour such as showing patience, tolerance and serenity in order to encourage their staff to try to adopt similar behaviour in their busy workplace. Showing patience, tolerance and serenity has a significant meaning and value in emergency departments because such conduct can decrease tensions and pressure that characterise emergency departments. Thus, showing patience, tolerance and serenity creates a peaceful environment that helps both emergency managers and their staff focus while doing their tasks, taking effective decision and facilitating high quality care delivery in their emergency department. The varying contextual factors identified in this research, which may not be pertinent to other normal, less demanding settings (for example: a medical care unit) may trigger the enactment of these different types of leadership behaviours.

8.2 Limitations of the study

One limitation of the current research is that it was carried out in only five emergency departments for urban government hospitals in three different cities in Saudi Arabia. Therefore, the effectiveness of leadership behaviours identified may not be able to be generalised to any populations of healthcare managers beyond those in the study. Similar research should be carried out in other types of governmental healthcare settings within Saudi Arabia. A second limitation is that the study only focused on the views of emergency department managers including heads of emergency department, deputies, and head nurses as well as emergency staff comprising medical and nursing staff. Future research may also take into account the views of superiors, such as medical and nursing directors, who have direct communication with emergency departments' managers in order to minimise bias. A third limitation in this study is associated with the small number of female participants; a deficit due to leadership roles being almost totally dominated by males in Saudi Arabia. A fourth limitation is the comparative lack of equivalent or near equivalent empirical qualitative research in similar or different organisations and other sectors against which to compare the findings. A next step in this line of research into effective leadership behaviours would be to conduct replica studies with sample of urban and rural areas in other local emergency settings and other local governmental healthcare settings throughout Saudi Arabia. This approach would be able to investigate the generalisability of the effectiveness of leadership behaviours found in the current study. It would also be interesting for replica studies to be undertaken in other countries to examine the generalisability of the Saudi Arabian findings across cultures. This initiative would not be to validate the generalisability of shared meanings but to examine the generalisability of leadership practices which may be driven by different contextual or cultural forces.

8.3 Future research

One aim of the current research was to generate qualitative data that can inform further research in this somewhat neglected area of leadership for hospital-based emergency departments in Saudi Arabia. While this research provides answers about, and insights into, leadership in the context of emergency departments in Saudi culture, it also generates many questions that call for additional research. For instance, this research found that lenient leadership is effective and widely used in the context of this research, future research may examine the effectiveness of leniency in similar or different settings. Future research can be undertaken to examine the analytical generalisability of the current research findings in other parts of Saudi Arabia using

either qualitative or quantitative methods; although the main aim of this study was to understand rather than to generalise. This orientation is because the findings of the present research have been generated from multiple governmental and urban sites, with contributions from people of different cultural and professional backgrounds. Such a population is expected to enhance analytical validity and transferability (Miles et al. 2014). The current study revealed a set of leadership behaviours that can be used to develop an assessment tool to evaluate such behaviours. Locally, future researchers can conduct comparative investigations to examine leadership behaviours in emergency departments in different cities across Saudi Arabia, including East province and Western province, regional hospitals, other governmental hospitals e.g. teaching hospitals or hospital that belong to national guard, and emergency departments in private sectors. Future research may not only compare or confirm the findings of this research, but can also expand the conceptual framework revealed in the present research. Internationally, future research can also investigate the study's findings in other hospital-based emergency departments located in other Islamic countries, including the Arabian Gulf Countries and in the Middle East, since all share a common religion and language.

Appendices

Appendix A Search list strategy

Search list strategy
1. emergency service* (title or abstract) 2. hospital* (title or abstract) 3. Nurs* (title or abstract) 4. Physician* (title or abstract) 5. Medical personnel* (title or abstract) 6. Emergency* (title or abstract) 7. Trauma* (title or abstract) 8. Accident* (title or abstract) 9. Surgery* (title or abstract) 10. Anaesthesia* (title or abstract) 11. Operating room* (title or abstract) 12. Critical care* (title or abstract) 13. Combine 1-12 using “OR” 14. Lead* (title or abstract) 15. Leadership* (title or abstract) 16. Management style or behaviour* (title or abstract) 17. Leadership style or behaviour* (title or abstract) 18. Transformational lead* (title or abstract) 19. Charismatic lead* (title or abstract) 20. Combine 14-19 using “OR” 21. Extra effort* (title or abstract) 22. Motivation* (title or abstract) 23. Leadership effectiveness* (title or abstract) 24. Leadership performance* (title or abstract) 25. Job satisfaction* (title or abstract) 26. Well-being* (title or abstract) 27. Combine 21-26using “OR” 28. Combine 13 AND 20 29. Combine 13 AND 20 AND 27

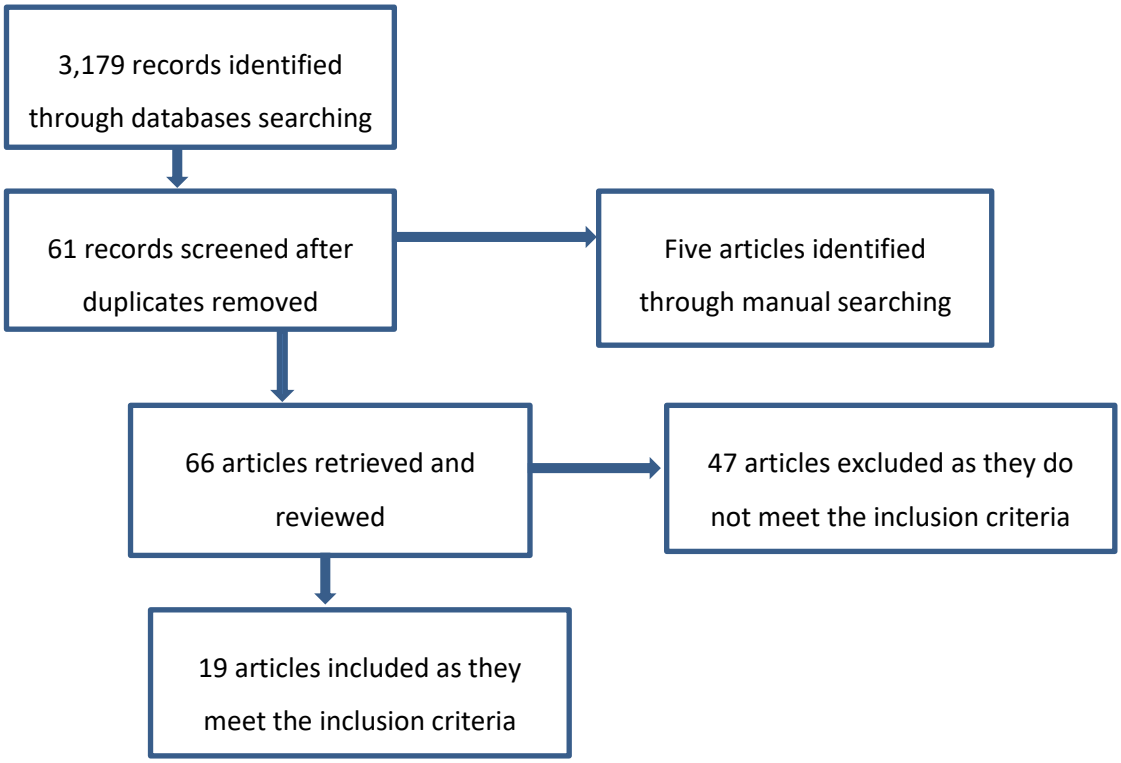
Appendix B Search strategy

Column terms combined with	Condition AND	Intervention AND	Comparative intervention AND	Outcomes AND
OR OR OR OR OR OR OR OR OR OR OR OR OR	1. emergency service 2. hospital 3. nurse 4. physician 5. medical personnel 6. emergency 7. trauma 8. accident 9. surgery 10. anaesthesia 11. operating room 12. critical care 13. Combine 1-12 Using 'OR'	14. lead 15. leadership 16. management style or behaviour 17. transformational leadership 18. leadership style or behaviour 19. charismatic leadership 20. Combine 14-19 Using 'OR'	none	21. extra effort 22. motivation 23. leaders' effectiveness 24. leadership performance 25. job satisfaction 26. well-being 27. Combine 21-26 Using 'OR'

Appendix C Selection criteria

Aim:				
	Inclusion criteria	yes	No	undecided
Participant				
intervention				
Outcomes				
Types of study				
Action (with rational)				

Appendix D Paper search algorithm



Appendix E Ethical approval from the University of Southampton Faculty of Health Sciences Ethics Committee

UNIVERSITY OF Southampton

To Whom It May Concern

22nd April 2015

Project Reference: 12465

Project Title: How are different leadership behaviours perceived and utilised for emergency medical settings in urban public hospitals in Saudi Arabia?

Investigator: Badr Aldhmadi

The protocol for this project was reviewed and approved by the University of Southampton Faculty of Health Sciences Ethics Committee on 25/03/2015

Please contact rgoinfo@soton.ac.uk if you require further information regarding the project.

Yours sincerely

Trudi Bartlett
Research Governance Officer

Research & Innovation Services, University of Southampton, Highfield Campus, Southampton SO17 1BJ United Kingdom
Tel: +44 (0)23 8059 5058 www.southampton.ac.uk

Appendix F Participants information sheet

Participant Information Sheet

Study Title: How are different leadership behaviours perceived and utilised for emergency medical settings in urban public hospitals in Saudi Arabia?

Researcher: Badr Aldhmadi **Ethics number**: 12465

You are asked to participate in PhD research study being undertaken by Badr Aldhmadi, Faculty of Health Sciences, University of Southampton, United Kingdom. Your participation in this research study is completely voluntary. Please read the information below and ask questions about anything you do not understand, prior to deciding whether or not to take part.

You have been asked to take part in this interview in order to attain the necessary information for the research. It is anticipated that there will be only one interview to be conducted.

- **Purpose of the study**

This interview will ask several questions regarding the perceptions and understanding of leadership behaviours as practiced by emergency department managers. The aim of this study is to identify, characterise and explain the dynamics of leadership behaviours as perceived by managers and staff in emergency departments. The results will be used within the final findings of the PhD thesis.

- **Procedures**

If you decide to take part in this study**,** your participation will include the following:

  - Consenting to an interview to be conducted face-to-face
  - The interview will last for approximately one hour
  - The interview will be held at a time and location convenient to you
  - The interview will be audiotaped and saved for future reference.

- **Benefits**

There are no direct benefits to individuals taking part in the study, although it is anticipated that the findings of this study will help identify new information that will be helpful to the health services management.

- **Risks**

There are no known risks (physical, psychological, social or legal) from taking part in the study.

- **Confidentiality**

Any information you give in this study will be kept confidential as required by the Data Protection Act/University Policy, no names will be taken, and all data will be coded by the researcher to ensure anonymity and for the purpose of attaching responses to particular informants. Data will be disclosed only with your authorisation. The findings of this study will not be discussed with hospital management. The interview data will be kept safe on a secure, password protected computer and accessed only by the investigator and his supervisory team.

- **Participation and withdrawal**

Your participation is entirely voluntary and you may withdraw at any time for any reason. You can also refuse to answer any questions you do not want to answer and there is no penalty for not participating in or withdrawing from the study.

- **Complaint**

If you have a concern or a complaint about this study you should contact the Research Governance Office (Address: University of Southampton, Building 37, Highfield, Southampton, SO17 1BJ; Tel: +44 (0)23 8059 5058; Email: rgoinfo@soton.ac.uk. If you remain unhappy and wish to complain formally the Research Governance Office can provide you with details of the University of Southampton Complaints Procedure.

- **Contact details of the researcher**

If you have any questions or concerns about this research, please contact:

Badr Aldhmadi
Faculty of Health Sciences
University of Southampton
Building 67, 2011
Highfield Campus
SO17 1BJ
Tel: +44 (0) 2380595000
Extension: 28204
Email: bka1g13@soton.ac.uk

Academic Supervisor: Dr Jane Prichard
Tel: +44 (0) 2380597956
Room number: 45/2013
Email: J.S.Prichard@soton.ac.uk

Academic Supervisor: Dr Richard Giordano
Room number: 45/2008
Email: r.giordano@soton.ac.uk

Academic Supervisor: Professor Carl May
Room number: 67/E4005

Email: c.r.may@soton.ac.uk

Appendix G Consent form

CONSENT FORM (*v1*)

Study title: How are different leadership behaviours perceived and utilised for emergency medical settings in urban public hospitals in Saudi Arabia?

Researcher name: Badr Aldhmadi
Study reference: 2/2015 v1
Ethics reference: 12465

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet (February 2015 /v1. of participant information sheet) and have had the	☐
I agree to take part in this research project and agree for my data	☐
I understand my participation is voluntary and I may withdraw at	☐
I am happy to be contacted regarding other unspecified research projects. I therefore consent to the University retaining my personal details on a database, kept separately from the research data detailed above. The 'validity' of my consent is conditional	☐

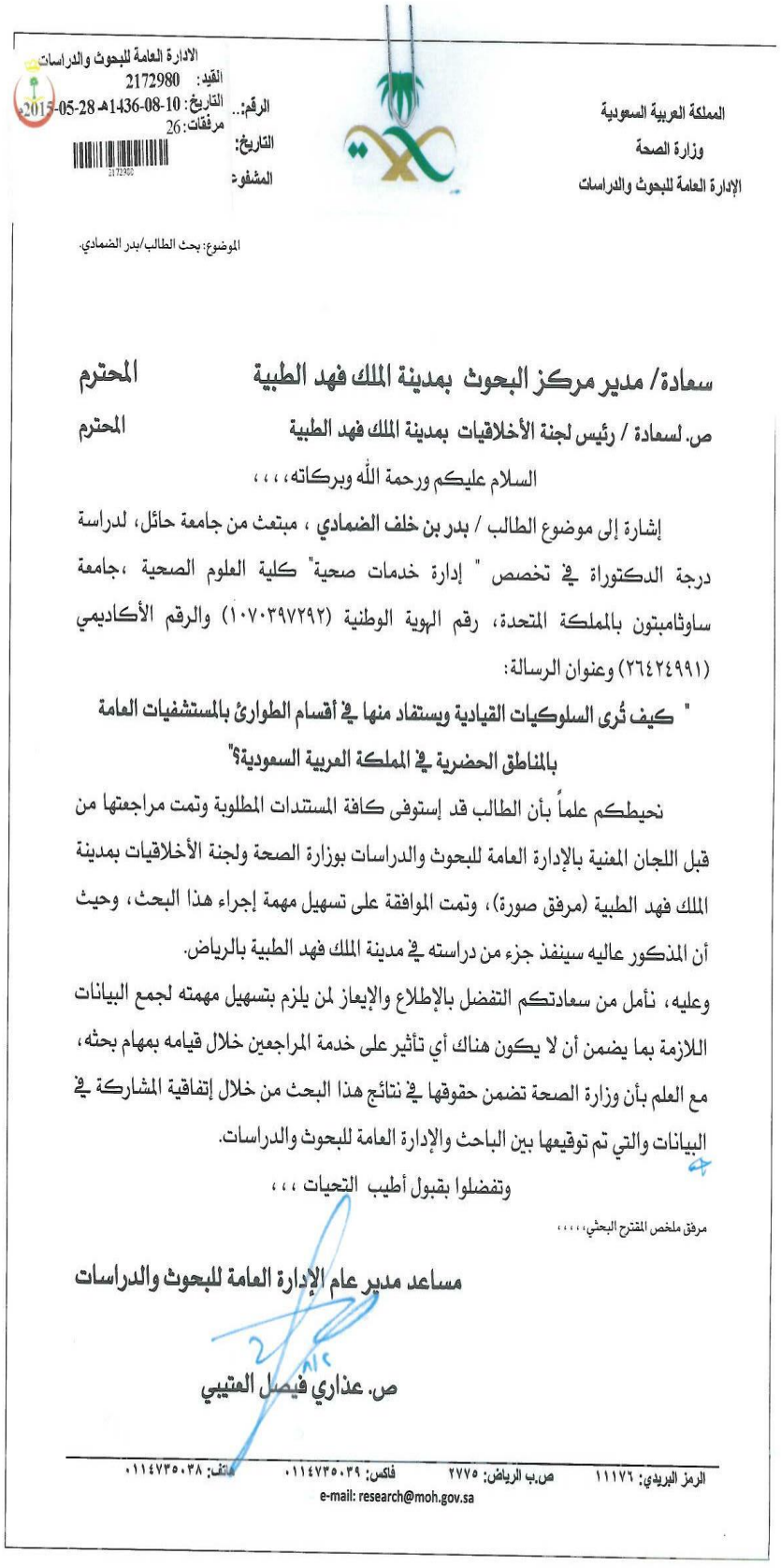
Data Protection
I understand that information collected about me during my participation in this study will be stored on a password protected computer and that this information will only be used for the purpose of this study. All files containing any personal data will be made anonymous.

Name of participant (print name)……

Signature of participant……

Date……

Appendix H Permissions to access hospitals



المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للبحوث والدراسات

الادارة العامة للبحوث والدراسات
القيد: 2172980
التاريخ: 1436-08-10هـ 2015-05-28م
مرفقات: 26

الرقم:
التاريخ:
المشفوعة:

الموضوع: بحث الطالب/بدر الضمادي.

سعادة/ مدير مركز البحوث بمدينة الملك فهد الطبية المحترم

ص. لسعادة / رئيس لجنة الأخلاقيات بمدينة الملك فهد الطبية المحترم

السلام عليكم ورحمة الله وبركاته،،،،

إشارة إلى موضوع الطالب / بدر بن خلف الضمادي ، مبتعث من جامعة حائل، لدراسة درجة الدكتوراة في تخصص " إدارة خدمات صحية" كلية العلوم الصحية ،جامعة ساوثامبتون بالمملكة المتحدة، رقم الهوية الوطنية (١٠٧٠٣٩٧٢٩٢) والرقم الأكاديمي (٢٦٤٢٤٩٩١) وعنوان الرسالة:

" كيف تُرى السلوكيات القيادية ويستفاد منها في أقسام الطوارئ بالمستشفيات العامة بالمناطق الحضرية في المملكة العربية السعودية؟"

نحيطكم علماً بأن الطالب قد إستوفى كافة المستندات المطلوبة وتمت مراجعتها من قبل اللجان المعنية بالإدارة العامة للبحوث والدراسات بوزارة الصحة ولجنة الأخلاقيات بمدينة الملك فهد الطبية (مرفق صورة)، وتمت الموافقة على تسهيل مهمة إجراء هذا البحث، وحيث أن المذكور عاليه سينفذ جزء من دراسته في مدينة الملك فهد الطبية بالرياض.

وعليه، نأمل من سعادتكم التفضل بالإطلاع والإيعاز لمن يلزم بتسهيل مهمته لجمع البيانات اللازمة بما يضمن أن لا يكون هناك أي تأثير على خدمة المراجعين خلال قيامه بمهام بحثه، مع العلم بأن وزارة الصحة تضمن حقوقها في نتائج هذا البحث من خلال إتفاقية المشاركة في البيانات والتي تم توقيعها بين الباحث والإدارة العامة للبحوث والدراسات.

وتفضلوا بقبول أطيب التحيات ،،،

مرفق ملخص المقترح البحثي،،،،،

مساعد مدير عام الإدارة العامة للبحوث والدراسات

ص. عذاري فيصل العتيبي

الرمز البريدي: ١١١٧٦ ص.ب الرياض: ٢٧٧٥ فاكس: ٠١١٤٧٣٥٠٣٩ هاتف: ٠١١٤٧٣٥٠٣٨
e-mail: research@moh.gov.sa

Appendix H

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للبحوث والدراسات

الادارة العامة للبحوث والدراسات
القيد: 2172878
التاريخ: 1436-08-10هـ 2015-05-28م
مرفقات: 26

الرقم:....
التاريخ:
المشفوعات:

الموضوع: بحث الطالب/بدر الضمادي.

سعادة/ مستشفى الملك خالد بمنطقة حائل المحترم

السلام عليكم ورحمة الله وبركاته، ، ، ،

إشارة إلى موضوع الطالب / **بدر بن خلف الضمادي** ، مبتعث من جامعة حائل، لدراسة درجة الدكتوراة في تخصص " إدارة خدمات صحية" كلية العلوم الصحية ،جامعة ساوثامبتون بالمملكة المتحدة، رقم الهوية الوطنية (١٠٧٠٣٩٧٢٩٢) والرقم الأكاديمي (٢٦٤٢٤٩٩١) وعنوان الرسالة:

" كيف تُرى السلوكيات القيادية ويستفاد منها في أقسام الطوارئ بالمستشفيات العامة بالمناطق الحضرية في المملكة العربية السعودية؟"

نحيطكم علماً بأن الطالب قد إستوفى كافة المستندات المطلوبة وتمت مراجعتها من قبل اللجان المعنية بالإدارة العامة للبحوث والدراسات بوزارة الصحة ولجنة الأخلاقيات بمدينة الملك فهد الطبية (مرفق صورة)، وتمت الموافقة على تسهيل مهمة إجراء هذا البحث، وحيث أن المذكور عاليه سينفذ جزء من دراسته في مستشفى الملك خالد بمنطقة حائل.

وعليه، نأمل من سعادتكم التفضل بالإطلاع والإيعاز لمن يلزم بتسهيل مهمته لجمع البيانات اللازمة بما يضمن أن لا يكون هناك أي تأثير على خدمة المراجعين خلال قيامه بمهام بحثه، مع العلم بأن وزارة الصحة تضمن حقوقها في نتائج هذا البحث من خلال إتفاقية المشاركة في البيانات والتي تم توقيعها بين الباحث والإدارة العامة للبحوث والدراسات.

وتفضلوا بقبول أطيب التحيات ، ، ،

مرفق ملخص المقترح البحثي، ، ، ، ،

مساعد مدير عام الإدارة العامة للبحوث والدراسات

ص. عذاري فيصل العتيبي

الرمز البريدي: ١١١٧٦ ص.ب الرياض: ٢٧٧٥ فاكس: ٠١١٤٧٣٥٠٣٩ هاتف: ٠١١٤٧٣٥٠٣٨
e-mail: research@moh.gov.sa

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للبحوث والدراسات

الرقم:.....
التاريخ:
المشفوعات

الادارة العامة للبحوث والدراسات
القيد: 2172770
التاريخ: 1436-08-10هـ 2015-05-28م
مرفقات: 26

الموضوع: بحث الطالب/بدر الضمادي.

سعادة/ مستشفى الملك فهد التخصصي ببريدة، منطقة القصيم المحترم

السلام عليكم ورحمة الله وبركاته، ، ،

إشارة إلى موضوع الطالب / **بدر بن خلف الضمادي** ، مبتعث من جامعة حائل، لدراسة درجة الدكتوراة في تخصص " إدارة خدمات صحية" كلية العلوم الصحية ،جامعة ساوثامبتون بالمملكة المتحدة، رقم الهوية الوطنية (١٠٧٠٣٩٧٢٩٢) والرقم الأكاديمي (٢٦٤٢٤٩٩١) وعنوان الرسالة:

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وعليه، نأمل من سعادتكم التفضل بالإطلاع والإيعاز لمن يلزم بتسهيل مهمته لجمع البيانات اللازمة بما يضمن أن لا يكون هناك أي تأثير على خدمة المراجعين خلال قيامه بمهام بحثه، مع العلم بأن وزارة الصحة تضمن حقوقها في نتائج هذا البحث من خلال إتفاقية المشاركة في البيانات والتي تم توقيعها بين الباحث والإدارة العامة للبحوث والدراسات.

وتفضلوا بقبول أطيب التحيات ، ، ،

مرفق ملخص المقترح البحثي، ، ، ،

مساعد مدير عام الإدارة العامة للبحوث والدراسات

ص. عذاري فيصل العتيبي

الرمز البريدي: ١١١٧٦ ص.ب الرياض: ٢٧٧٥ فاكس: ٠١١٤٧٣٥٠٣٩ هاتف: ٠١١٤٧٣٥٠٣٨
e-mail: research@moh.gov.sa

Appendix H

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للبحوث والدراسات

الرقم:...
التاريخ:
المشفوعا

الادارة العامة للبحوث والدراسات
القيد: 2172636
التاريخ: 1436-08-10هـ 2015-05-28
مرفقات: 26

الموضوع: بحث الطالب/بدر الضمادي.

سعادة/ مدير مركز البحوث بمدينة الملك سعود الطبية **المحترم**

ص. لسعادة / رئيس لجنة الأخلاقيات بمدينة الملك سعود الطبية **المحترم**

السلام عليكم ورحمة الله وبركاته،،،،

إشارة إلى موضوع الطالب / **بدر بن خلف الضمادي** ، مبتعث من جامعة حائل، لدراسة درجة الدكتوراة في تخصص " إدارة خدمات صحية" كلية العلوم الصحية ،جامعة ساوثامبتون بالمملكة المتحدة، رقم الهوية الوطنية (١٠٧٠٣٩٧٢٩٢) والرقم الأكاديمي (٢٦٤٢٤٩٩١) وعنوان الرسالة:

" كيف تُرى السلوكيات القيادية ويستفاد منها في أقسام الطوارئ بالمستشفيات العامة بالمناطق الحضرية في المملكة العربية السعودية؟"

نحيطكم علماً بأن الطالب قد إستوفى كافة المستندات المطلوبة وتمت مراجعتها من قبل اللجان المعنية بالإدارة العامة للبحوث والدراسات بوزارة الصحة ولجنة الأخلاقيات بمدينة الملك فهد الطبية (مرفق صورة)، وتمت الموافقة على تسهيل مهمة إجراء هذا البحث، وحيث أن المذكور عاليه سينفذ جزء من دراسته في مدينة الملك سعود الطبية بالرياض.

وعليه، نأمل من سعادتكم التفضل بالإطلاع والإيعاز لمن يلزم بتسهيل مهمته لجمع البيانات اللازمة بما يضمن أن لا يكون هناك أي تأثير على خدمة المراجعين خلال قيامه بمهام بحثه، مع العلم بأن وزارة الصحة تضمن حقوقها في نتائج هذا البحث من خلال إتفاقية المشاركة في البيانات والتي تم توقيعها بين الباحث والإدارة العامة للبحوث والدراسات.

وتفضلوا بقبول أطيب التحيات ،،،

مرفق ملخص المقترح البحثي،،،،

مساعد مدير عام الادارة العامة للبحوث والدراسات

ص. عذاري فيصل العتيبي

الرمز البريدي: ١١١٧٦ ص.ب الرياض: ٢٧٧٥ فاكس: ٠١١٤٧٣٥٠٣٩ هاتف: ٠١١٤٧٣٥٠٣٨
e-mail: research@moh.gov.sa

المملكة العربية السعودية
وزارة الصحة
الإدارة العامة للبحوث والدراسات

الادارة العامة للبحوث والدراسات
القيد: 21724-42
الرقم:..... التاريخ: 1436-08-10هـ 2015-05-28م
مرفقات: 26
التاريخ:
المشفوعات

الموضوع: بحث الطالب/بدر الضمادي.

سعادة/ مستشفى الملك سعود بعنيزة، منطقة القصيم المحترم

السلام عليكم ورحمة الله وبركاته، ، ، ،

إشارة إلى موضوع الطالب / **بدر بن خلف الضمادي** ، مبتعث من جامعة حائل، لدراسة درجة الدكتوراة في تخصص " إدارة خدمات صحية" كلية العلوم الصحية ،جامعة ساوثامبتون بالمملكة المتحدة، رقم الهوية الوطنية (١٠٧٠٣٩٧٢٩٢) والرقم الأكاديمي (٢٦٤٢٤٩٩١) وعنوان الرسالة:

" كيف تُرى السلوكيات القيادية ويستفاد منها في أقسام الطوارئ بالمستشفيات العامة بالمناطق الحضرية في المملكة العربية السعودية؟"

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وعليه، نأمل من سعادتكم التفضل بالإطلاع والإيعاز لمن يلزم بتسهيل مهمته لجمع البيانات اللازمة بما يضمن أن لا يكون هناك أي تأثير على خدمة المراجعين خلال قيامه بمهام بحثه، مع العلم بأن وزارة الصحة تضمن حقوقها في نتائج هذا البحث من خلال إتفاقية المشاركة في البيانات والتي تم توقيعها بين الباحث والإدارة العامة للبحوث والدراسات.

وتفضلوا بقبول أطيب التحيات ، ، ،

مرفق ملخص المقترح البحثي، ، ، ،

مساعد مدير عام الإدارة العامة للبحوث والدراسات

ص. عذاري فيصل العتيبي

الرمز البريدي: ١١١٧٦ ص.ب الرياض: ٢٧٧٥ فاكس: ٠١١٤٧٣٥٠٣٩ هاتف: ٠١١٤٧٣٥٠٣٨
e-mail: research@moh.gov.sa

Appendix H

Kingdom of Saudi Arabia
Ministry of Health
King Fahad Medical City
(162)

وزارة الصحة
مدينة الملك فهد الطبية
King Fahad Medical City

المملكة العربية السعودية
وزارة الصحة
مدينة الملك فهد الطبية
(١٦٢)

IRB Registration Number with KACST, KSA: H-01-R-012
IRB Registration Number with OHRP/NIH, USA: IRB00008644
Approval Number Federal Wide Assurance NIH, USA: FWA00018774

May 6, 2015
IRB Log Number: 15-211E
Department: External
Category of Approval: EXEMPT

Dear Badr Khalaf Aldhmadi,

I am pleased to inform you that your submission dated May 5, 2015 for the study titled '**How are different leadership behaviours perceived and utilised for emergency medical settings in urban public hospitals in Saudi Arabia?**' was reviewed and was approved. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the head of department or unit in KFMC or an external institution to commence data collection.

We wish you well as you proceed with the study and request you to keep the IRB informed of the progress on a regular basis, using the IRB log number shown above.

If you have any further questions feel free to contact me.

Sincerely yours,

F M
Approved
0 6 MAY 2015
I R B

Prof. Omar H. Kasule
Chairman Institutional Review Board--IRB.
King Fahad Medical City, Riyadh, KSA.
Tel: + 966 1 288 9999 Ext. 26913
E-mail: okasule@kfmc.med.sa

Appendix I Interview protocols

Interview protocol for ED managers

Interview protocol

Study title:
Date:
Place:
Interviewer:
Interviewee:
Brief description of the study:
Questions:

1. Tell me about your responsibilities as an emergency department manager in this organisation.
(أخبرني عن مسؤولياتك ومهامك كمدير لقسم الطوارئ في هذه المنظمة)
2. Tell me about leadership approaches. What leadership behaviours and strategies are used in this position?
(أخبرني عن المناهج والاساليب القيادية. ماهي السلوكيات والاستراتيجيات القيادية التي تستخدم في هذا المنصب)
3. Tell me about emergency team(s), and describe how leadership behaviours are used within the team(s).
(أخبرني عن فريق الطوارئ و عن كيف تصف السلوكيات القيادية المستخدمة في الفريق)
4. How do you think others perceive leadership behaviours in this department? Why?
(كيف يرى الاخرون السلوكيات القيادية في هذا القسم؟ لماذا؟)
5. How effective is leadership? Can you share the factors and strategies that have contributed to leadership success in this position?
(ما هو مدى فعالية القيادة؟ هل ممن الممكن ان تشاركنا بالعوامل والاستراتيجيات التي تساهم في نجاح القيادة في هذا المنصب؟)
6. Can you give me examples about barriers that inhibit leadership success in this position?
(ماهي الحواجز التي تحول دون نجاح القيادة في هذا المنصب؟)
7. What kinds of situations can force leaders to change leadership behaviours? Can you give an example?
(ماهي الظروف او المواقف التي تجبر القادة على تغيير سلوكهم القيادي؟ هل من الممكن ان تطرح مثالا؟)
8. How would you describe working relationship between leaders and staff?
(كيف تصف العلاقة بين القادة و الموظفين؟)
9. Can you give me an example of how leaders work with staff that demonstrates their leadership behaviours?
(هل يمكن ان تعطيني مثالا على كيفية عمل القادة مع الموظفين والذي يوضح سلوكياتهم القيادية؟)
10. Can you give me an example of how leadership was particularly effective because of the leadership behaviours employed at an event?
(هل يمكن ان تعطيني مثالا عن الكيفية التي كانت فيها القيادة فعالة بشكل خاص بسبب السلوكيات القيادية المستخدمة في ذلك الموقف ؟)
11. Can you think of a time when you wish a leader had used a different leadership behaviour or strategy?
(هل يمكنك التفكير في وقت كنت تتمنى فيه استخدام قائد ما سلوك قيادي او استراتيجية مختلفة؟)
12. Tell me how leaders motivate staff to get their full potential?
(كيف يحفز القادة الموظفين للحصول على كامل امكاناتهم؟)

13. Tell me how you define leadership in practice.
(اخبرني كيف تعرف القيادة عملياً)
14. How do you characterise good leadership behaviours?
(كيف تصف السلوكيات القيادية الجيدة؟)
15. How do you characterize poor leadership behaviours?
(كيف تصف السلوكيات القيادية السيئة؟)
16. What qualities of leadership do you think are necessary in emergency departments' managers? Can you give an example?
(ماهي الصفات القيادية التي تعتقد انها ضرورية لمدراء اقسام الطوارئ؟ هل من الممكن ان تطرح مثالا؟)
17. What advice would you give a future emergency department leader about being an effective leader?
(ماهي النصيحة التي تود اعطائها لقائد قسم الطوارئ في المستقبل ليكون قائد فعال؟)

Interview protocol for ED Staff

Interview protocol
Study title: Date: Place: Interviewer: Interviewee: Brief description of the study: Questions: 1. Tell me about your responsibilities as an emergency department staff in this organisation. (أخبرني عن مسؤولياتك ومهامك كموظف في قسم الطوارئ في هذه المنظمة) 2. Tell me about your experience of leadership. What leadership behaviours and strategies are used in this department? (أخبرني عن خبرتك في القيادة. ماهي السلوكيات والاستراتيجيات القيادية التي تستخدم في هذا القسم؟) 3. Tell me about emergency team(s), and leadership behaviours used within the team. (أخبرني عن فريق الطوارئ و عن السلوكيات القيادية المستخدمة في الفريق) 4. How do you perceive leadership style/behaviours used in this setting? Why? (كيف ترى الاساليب والسلوكيات القيادية المستخدمة في هذا القسم؟ لماذا؟) 5. How effective is leadership? Can you share the factors and strategies that have contributed to leadership success in this department? (ما هو مدى فعالية القيادة؟ هل ممن الممكن ان تشاركنا بالعوامل والاستراتيجيات التي تساهم في نجاحة القادة في هذا القسم؟) 6. Can you give me examples about barriers that inhibit leadership success in this position? (ماهي الحواجز التي تحول دون نجاح القيادة في هذا المنصب؟) 7. What kinds of situations can force leaders to change their leadership style/behaviour? Can you give an example? (ماهي الظروف او المواقف التي تجبر القادة على تغيير الاساليب و السلوكيات القيادية؟ هل من الممكن ان تطرح مثالا؟) 8. How would you describe working relationship between leaders and staff? (كيف تصف العلاقة العملية بين القادة والموظفين؟) 9. Can you give me an example of how leaders work with the staff that demonstrate leadership style/behaviour? (هل يمكن ان تعطيني مثالا على كيفية عمل القادة مع الموظفين والذي يوضح اساليبهم وسلوكياتهم القيادية ؟) 10. Can you give me an example of how a leader was particularly effective because of the leadership style/behaviour he/she employed? (هل يمكن ان تعطيني مثالا عن الكيفية التي كان فيها قائداً ما فعالاً بشكل خاص بسبب اسلوبه وسلوكه القيادي المستخدم؟) 11. Can you think of a time when you wish a leader had used a different leadership style/behaviour or strategy? (هل يمكنك التفكير في وقت كنت تتمنى فيه ان يستخدم قائداً ما سلوك قيادي او استراتيجية مختلفة؟) 12. Tell me how leaders motivate staff to get their full potential?

(اخبرني كيف يحفز القادة الموظفين للحصول على كامل امكاناتهم؟)

13. Tell me how you define leadership in practice.

(اخبرني كيف تعرف القيادة عملياً)

14. How do you characterise good leadership behaviours?

(كيف تصف السلوكيات القيادية الجيدة؟)

15. How do you characterize poor leadership behaviours?

(كيف تصف السلوكيات القيادية السيئة؟)

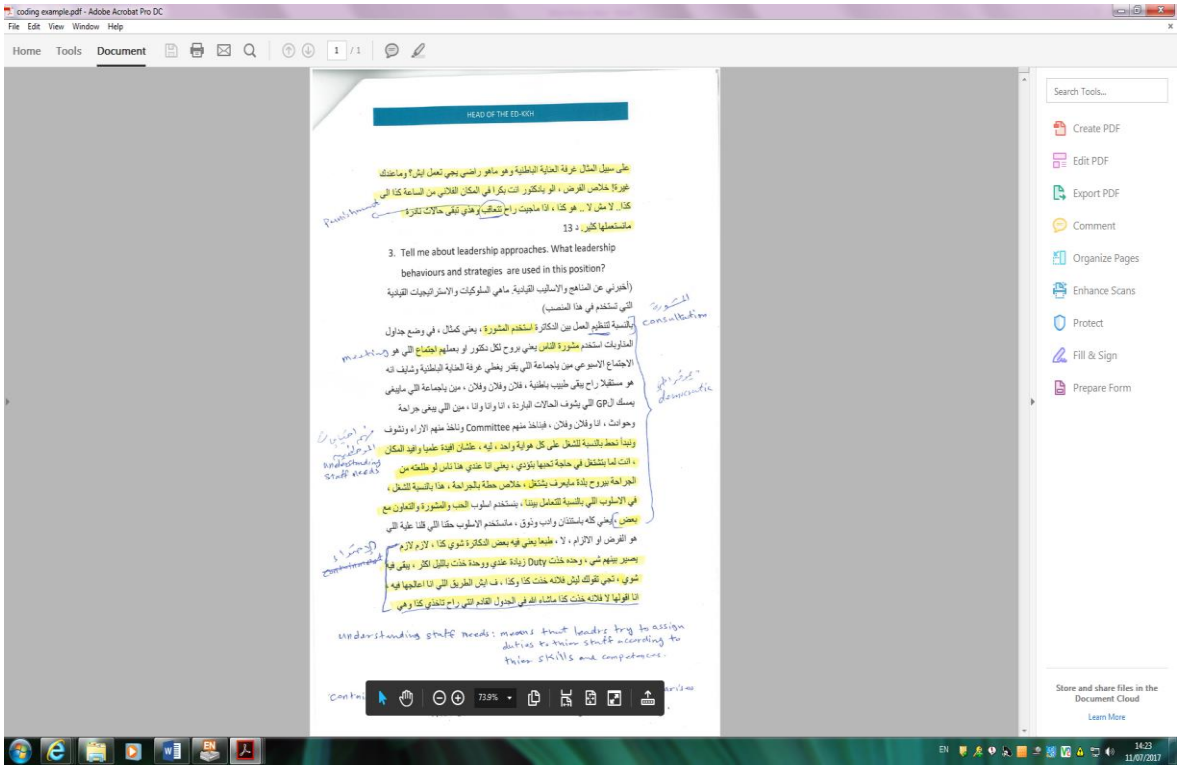
16. What qualities of leadership do you think are necessary in emergency departments' managers? Can you give an example?

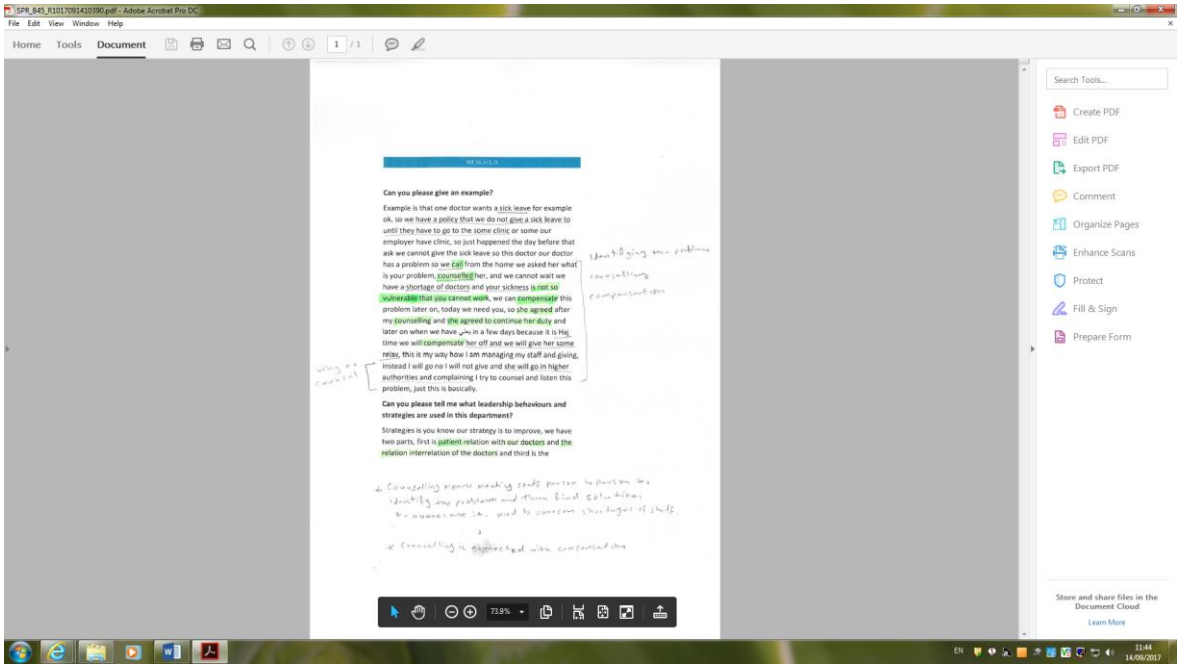
(ماهي الصفات القيادية التي تعتقد انها ضرورية لمدراء اقسام الطوارئ؟ هل من الممكن ان تطرح مثالا؟)

17. What advice would you give a future emergency department leader about being an effective leader?

(ماهي النصيحة التي تود اعطائها لقائد قسم الطوارئ في المستقبل ليكون قائد فعال؟)

Appendix J Example of coding scheme





Appendix K Coding framework

1. Meeting,
2. Education,
3. Delegation,
4. Solving problem,
5. Containment,
6. Communication,
7. Understanding staff circumstances,
8. Helping,
9. Protecting staff,
10. Autocratic behaviour,
11. Consultation,
12. Understanding staff need,
13. Monitoring,
14. Patience,
15. Cooperation,
16. Strict leadership,
17. Staff development,
18. Praising,
19. Engagement,
20. Change,
21. Training,
22. Discussion,
23. Listen,
24. Explanation,
25. Flexible leadership behaviour,
26. Understanding department's need,
27. Organising,
28. Preparation,
29. Flexibility,
30. Coordination,
31. Moral support,
32. Moral incentives,
33. Punishment,
34. Compensation,
35. Identify problems,
36. Respect,
37. Support,
38. Understanding staff personality,
39. Humble,
40. Openness to external environment,
41. Tolerance,
42. Fairness,
43. Being responsible,
44. Rewards,
45. Protecting staff,
46. Connection,
47. Suggestions,

48. Sense of responsibility,
49. Doing rounds,
50. Appreciation,
51. Thanking,
52. Strong,
53. Democratic,
54. Improvement,
55. Observation,
56. Call,
57. Clarifying tasks,
58. Distribution,
59. Teach,
60. Respond,
61. Develop,
62. Empowerment,
63. Team,
64. Recognition,
65. Approachable
66. Teamwork,
67. Accountable,
68. Investigation,
69. Goal,
70. Involvement,
71. Brainstorming
72. Lectures,
73. Direct action,
74. Understanding,
75. Make sure,
76. Role model,
77. Breaking barriers,
78. Balance,
79. Alerting
80. Achieving goals,
81. Vision,
82. Authority,
83. Achieving tasks,
84. Voting,
85. Hierarchical system,
86. Soft behaviour,
87. Moral encouragement,
88. Developing standards,
89. Facilitate
90. Productivity,
91. Negligence,
92. Prioritising,
93. Control,
94. Financial incentives
95. Direct or corrective action,
96. Reporting,
97. Documentation,

98. Intervene,
99. Checking,
100. Taking responsibility,
101. Consideration,
102. Mutual respect,
103. Create,
104. Operation management,
105. Quality management,
106. Supervise,
107. Understanding external environment,
108. Credibility,
109. Development,
110. Sense of responsibility,
111. Memos,
112. Feedback,
113. Direct communication,
114. Security,
115. Chain of commands,
116. Logo,
117. Productivity,
118. Empathy,
119. Evaluation,
120. Contact,
121. Responsive,
122. Give instructions,
123. Reactive,
124. Transparency,
125. Create good environment,
126. Plan,
127. Participation,
128. Tough,
129. Commitment,
130. Approve,
131. Encourage,
132. Talk,
133. Friendly,
134. Laissez-fair,
135. Ideas,
136. Reward and punishment policy,
137. Take action,
138. Direct supervision,
139. Prevent problems,
140. provide,
141. Continuous education activity,
142. Conferences,
143. Workshops,
144. Quietness,
145. Psychological support
146. Direct behaviour
147. Critical thinking,

148. Teamwork,
149. Assess,
150. Study,
151. Accommodate,
152. Friendly solution,
153. Collective work,
154. Team spirit,
155. Recognition,
156. Updating,
157. Implement,
158. Share,
159. Take opinions,
160. Adjust,
161. Adapt,
162. Advising,
163. Reminding,
164. Warning,
165. Defending staff,
166. Revising,
167. Task oriented,
168. Directing,
169. Forcing,
170. Coaching
171. Counselling

Appendix L Codes definitions

A

1. Accepting: The fact of accepting a difficult or unpleasant situation
2. Accepting ideas: to accept and consider ideas from others
3. Alerting: To give a spoken or written warning to a staff who has broken a policy
4. Approachable: Friendly and easy to talk to
5. Accountability: a situation in which someone is responsible for things that happen and can give a satisfactory reason for them
6. Approve: to accept requests
7. Autocratic behaviour: a leader who has total power, and who does not allow anyone else to make decisions
8. authoritarian behaviour: demanding that staff obey completely and refusing to allow them freedom to act as they wish
9. Awareness of organisational purpose: a leader is fully aware about the organisational vision and purpose.
10. Awareness: knowledge and understanding of a particular activity or subject " organisational policies and procedures"
11. Assurance: a promise that a leader behaves as expected
12. Aggressive: behaving in an angry and violent way towards staff
13. Adjust: to change standard slightly to make it fit, work better, or be more suitable for staff
14. available in workplace: a leader is available in the workplace and be close to staff

B

15. Balance: the leader's ability to balance between practicing flexible, understanding, soft and strict behaviours, depending upon understanding the situation
16. Being responsible: a leader feels the responsibility toward his staff, and tries to solve departmental problems and do not avoid them
17. Breaking barriers: a leader tries to create a cooperative environment in which staff help each other
18. Brain storming: an activity or business method in which people meet in a group to suggest a lot of new ideas to choose from for possible development
19. Break the rule: a leader intervene directly to help staff when having a disaster without following certain rules, but considering safety, critical thinking and overall plan.

C

20. Containment: a leader tries to control some problems arise from staff without harming them legally
21. Communication: the process of sharing information, which increases understanding between people or groups
22. Consultation: the process of discussing something with staff in order to get their advice or opinion about it

23. Coaching: a leader gives advices to staff on what to do in particular situations
24. Cooperation: a leader works together with staff or doing what they ask him/her
25. Coordinator: a leader whose job is to make different groups work together in an organized way to achieve something
26. Clarifying tasks: a leader explain the task details for each staff to make sure they understand it
27. Challenge the situation: a leader tries to overcome hard situations that meet the leader itself or the staff
28. Counselling: a leader provides professonal assistance and guidance in resolving personal or psychological problems for staff
29. Connection: a leader knows several people within the organisation to facilitate communication process
30. Compensation: the combination of money and other benefits (= exchange of rewards) that an employee receives for doing their job
31. Change: the process or result of making something different or becoming different
32. Call: to ask someone to come to a place
33. Caring: kind and gives emotional support to others
34. Consensus: a generally accepted opinion or decision among a group of people, leader and staff
35. Consider others: to care about or respect other people or their feelings and wishes
36. Checking: a leader makes sure that something or someone is correct, safe, or suitable by examining it, him, or her quickly
37. Collective decision: a decision that is taken by a group of people
38. Create: to make something exist
39. Credibility: the fact that a leader can be believed or trusted
40. Commendation: praise, or an official statement that praises a staff
41. Constitution: a written set of rules by which an organisation is governed
42. Counter check: a second check for security or accuracy
43. Corrective action: to take action when discovering something wrong in order to fix it
44. Contact: to communicate with someone in order to give or receive specific information

D

45. Discussion: the activity in which people talk about something and tell each other their ideas or opinions
46. Delegation: the act of delegating a particular job, duty, right, etc. to someone
47. Democratic: staff can give their opinions and participate in decision-making
48. Distribution: the process of giving things out to several people
49. Develop: to invent something or bring something into existence
50. Develop standards: to invent or build new policies and procedures
51. Determined: wanting to do something very much and not allowing anyone or any difficulties to stop you
52. Direct action: a leader intervenes directly to solve a problem
53. Doing rounds: a set of regular visits that a leader makes to a number of places or people, especially in order to examine tasks accomplished by staff

54. Diplomatic behaviour: acting in a way that does not cause offence
55. Disregard: a leader who does not take staff requirement seriously, as he/she thinks it is not that important
56. Direct supervision: different staff are assigned (key person) by the leader to supervise staff in several area
57. Direct behaviour: to point mistakes directly
58. Divide: to use different staff for different purposes or activities
59. Disciplinary action: a punishment method for dealing with a staff who causes problems or does not obey company rules
60. Directing: to manage or guide by advice, helpful information, instruction, etc.

E

61. Education: the process of teaching or learning
62. Explanation: the details or reasons that a leader gives to make something clear or easy to understand
63. Extra off: giving more offs as a reward of hard work performed by staff
64. Engagement: a leader involves everyone in leadership process so that they feel they are leaders
65. Enthusiastic: showing enthusiasm
66. Empowerment: the process of giving an individual or a group of people more authority
67. Eject: to force someone to leave a place because doing a mistake (team leader)
68. Elastic: to be able to focus not only on one thing
69. Empathy: the ability to share staff's feelings or experiences by imagining what it would be like to be in that person's situation
70. Evaluation: to judge the quality of the task performed by staff.

F

71. Fairness: treating people equally or in a way that is right or reasonable when assigning and distributing tasks responsibilities.
72. Flexible-leadership behaviour or flexibility: the quality of being able to change or be changed easily according to the situation (the problem, the staff, and the patient)
73. Flexible leadership behaviour or flexibility: to understand and accept staff mistakes and not punishing them accordingly.
74. Financial rewards: an advantage, more money that a staff receives if they are successful, work hard
75. Feedback: information about something such as a new product or someone's work that provides an idea of whether people like it or whether it is good.
76. Friendly behaviour: behaving in a pleasant, kind way towards someone
77. Friendly environment: A friendly place is pleasant and makes you feel happy and comfortable
78. Friendly solution: to reach agreeable decision that satisfy all parties
79. Feel: to experience something physical or emotional
80. Follow up: a further action connected with something that happened before

81. Facilitate: to help staff deal with a process or reach an agreement or solution without getting directly involved in the process, discussion, etc. yourself

G

82. Grateful: showing or expressing thanks to staff
83. Group: a number of people that are put together or considered as a single thing

H

84. Help: to make it possible or easier for staff to do something, by doing part of the work yourself or by providing advice or support
85. Hierarchy: a system in which the people within an organisation are organised into levels according to the authority they have
86. Humble: a leader is not proud or believing that he/she is important

I

87. Involvement: the act or process of taking part in something
88. Improve: to make something better
89. Investigation: the careful examination of a problem, especially to discover the truth
90. Intervene: to become involved in difficult situations in order to improve it or prevent it from getting worse
91. Individualistic decision: a decision that is taken by one person.
92. Implement: a leader let his/her staff to apply rules and regulations laid down by the organisation

J

93. Job description: a leader give staff a list of the tasks and responsibilities involved in a job

K

L

94. Lectures: a formal talk on a serious subject given to a group of people at workplace
95. Listen: to give attention to staff in order to hear him or her
96. Logo: a symbol displayed on an organisation's signs, etc. that expresses the organisation's character and purpose

M

97. Make sure: to look and/or take action to be certain that something happens, is true
98. Make sure: to ensure that a particular task has been accomplished.
99. Meeting: a planned occasion when people come together to discuss something.
100. Monitoring: a leader observing and checking the progress and quality of tasks performed by staff over a period of time.

101. Moral incentives: leaders increase the amount of confidence felt by their staff especially when they are in a dangerous or difficult situation (under stress).
102. Mission: the result that an organisation is trying to achieve through its plans or actions

N

103. Negligence: not giving enough care or attention to someone or something.

O

104. Organise: a leader arranges something for staff to do
105. Observation: to watch carefully the way something happens or the way someone does something, especially in order to learn more about it
106. Openness to external environment: a leader tries to change and adapt new things as they see them useful in other similar organisation based in his/her experience.
107. Open-minded: a leader who is willing to accept ideas and opinions that are new or different to the leader's own

P

108. Protecting staff: the act of keeping staff safe from injury, damage, or loss physically and psychologically
109. Punishment: the act of punishing someone or bad treatment
110. Passive action: to intervene after occurrence of a problem
111. Patience: when a leader is able to wait, or to continue doing something despite difficulties, or to suffer without complaining or becoming annoyed
112. Preparation: plans or arrangements that leaders make to prepare for disaster events.
113. Praising: to express admiration or approval of the achievements
114. Participation of leadership: the act of taking part in an event or activity
115. Prioritisation: to decide which of a group of things are the most important so that you can deal with them first
116. Productivity: the ability to do as much work as possible in a particular period
117. Prevent conflicts: a leader tries to prevent problems with and between staff to avoid procedural action
118. Promotion: the process or fact of giving someone a higher or more important job
119. Provide security: to provide staff secure job and secure workplace
120. Point out: to tell staff about something, often because a leader thinks that they do not know it or have forgotten it
121. Provide: to give something to staff, or to make it available for them to use in order to do the task.
122. Planning:
123. Problem solving: The process of finding solutions to day-to-day or complex issues

Q

124. Quality management: the activity of managing a department's systems and processes to make sure that every part of the department does things to a high standard
125. Quietness: to be able to maintain temperament in difficult situations

R

126. Respect: to treat something or someone with kindness and care.
127. Recognition: the act of praising or rewarding staff for something they have done
128. Rapid decision-making: the process of taking fast decision especially in clinical situations.
129. Responsive: a leader makes a positive and quick reaction to something or someone
130. Reactive: a direct leadership intervention to events or situations in order to prevent or solve problems
131. Respond: a leader says or does something as a reaction to something that has been done or has happened
132. Rewards: an advantage given by leaders to followers including money, overtime and days off to compensate task achievements and hard work.
133. Role model: a leader who staff admire and whose behaviours they try to copy
134. Replace: to change something that is damaged, lost, etc. for something newer or better
135. Rotation: the process of regularly changing the person who does a particular job, so that it is done at different times by different people
136. Reminding: to make staff think of policy or procedure they have forgotten or might have forgotten
137. Reward and punishment policy: staff are rewarded or punished according to their achievement and commitment.
138. Revise: to look at or consider again an idea in order to correct or improve it
139. Reporting: to communicate with higher authorities in regards to departmental problems.

S

140. Solving problems: a leader take action to address problems
141. Self-giving: to provide help
142. Self-motivated: a staff who are able and willing to work without being motivated and told what to do
143. Semi authoritarian-behaviour: a leader use his formal authority to make certain decisions, but they speak with the people involved only to satisfy them regardless of their agreement
144. Strict leadership: Using authority to impose decisions or applying disciplinary procedures on staff members who commit repeated or harmful mistakes.
145. Staff development: improvement of a skill, ability, quality,

146. Shouting: a leader utters a loud call or cry, typically as an expression of a strong emotion
147. Support: to help someone emotionally, or in practical way
148. Strong leadership: supportive and determined leadership
149. Strong: firm and determined behaviour
150. Share information: the process of exchanging ideas, views, knowledge between leaders and staff
151. Soft behaviour: not severe or forceful enough, especially in criticizing or punishing someone who has done something wrong
152. Supervision: to watch staff and their activities to make sure everything is done correctly and safely
153. Sharp nature: a person who gets angry very quickly.
154. Self-control: the ability to control oneself, in particular one's emotions and desires or the expression of them in one's behaviour, especially in difficult situations
155. Study: to examine problem very carefully in order to solve it
156. Sense of responsibility: to feel the responsibility toward staff, and try to solve departmental problems and do not avoid them
157. Streamline: to simplify regulations and policies for staff so that they can follow them effectively.
158. Suggestion:

T

159. Training: a leader prepares staff for a job or an activity by learning skills
160. Tolerance: a leader is able to deal with something unpleasant or annoying
161. Team work: to work together in order to achieve a shared aim, rather than trying to achieve things just for yourself or working against others
162. Team: a group of people who work together on a particular activity, project, etc
163. Take action: the process of doing something, especially when dealing with a problem or difficulty
164. Thanking: to express to staff that you are pleased about or are grateful for something that they have done
165. Transparency: the quality of being done in an open way without secrets
166. Tough: a leader who is difficult to deal with

U

167. Understanding staff circumstances: a leader responds to staff circumstances whether these are in the workplace or socially, and try to solve them
168. Understanding staff needs: a leader assigns duties to staff according to their skills and competences
169. Understanding department's circumstances: a leader is aware of all the circumstances that may affect the function of the department whether it is internal or external
170. Understanding external environment: a leader is aware of customers 'patients' wants and needs and tries to meet them

171. understanding staff personalities: a leader who is able to knows the strengths and weaknesses of his staff
172. Understanding: a leader who has the ability to know how other people are feeling, and can forgive them if they do something wrong
173. Unfairness: not treating staff in equal way, or not morally right

V

174. Vision: the ability to imagine how something could develop in the future.

W

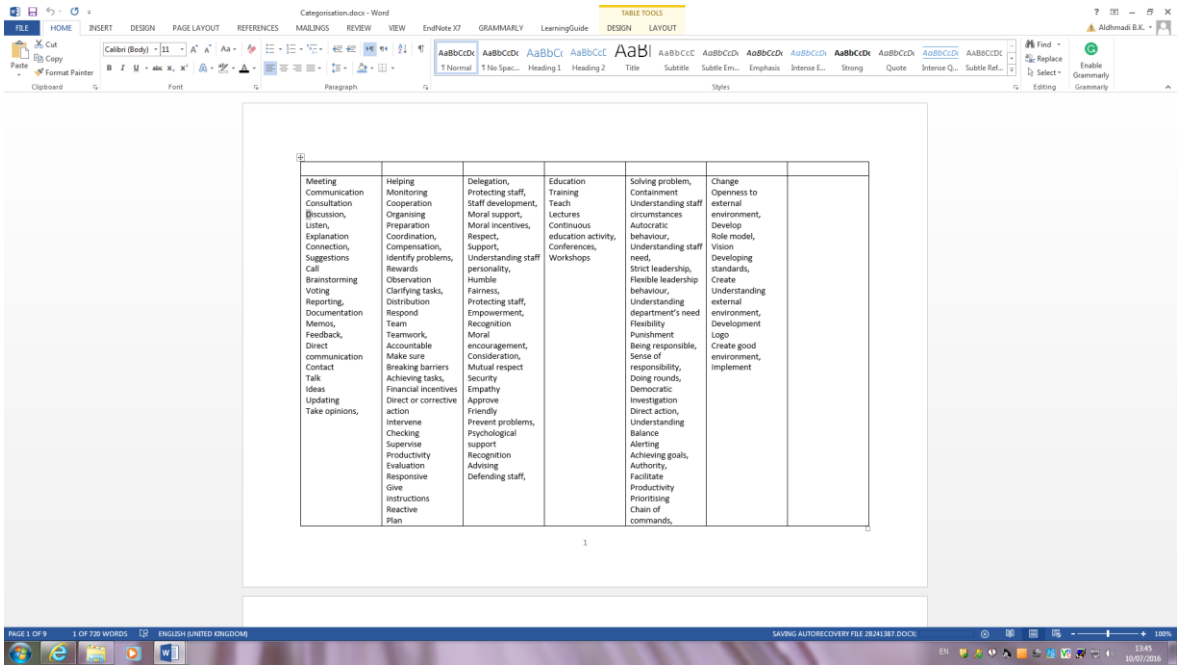
175. Warning: To give a spoken or written warning to a staff who has broken a policy

X

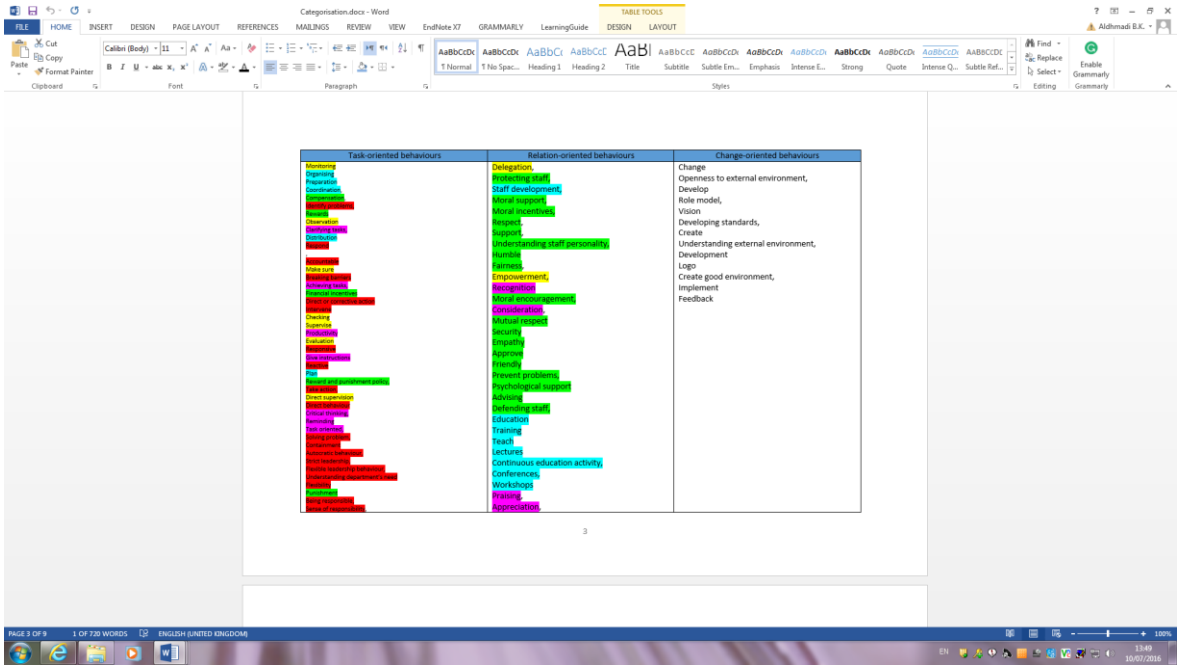
Y

Z

Appendix M Categorisation

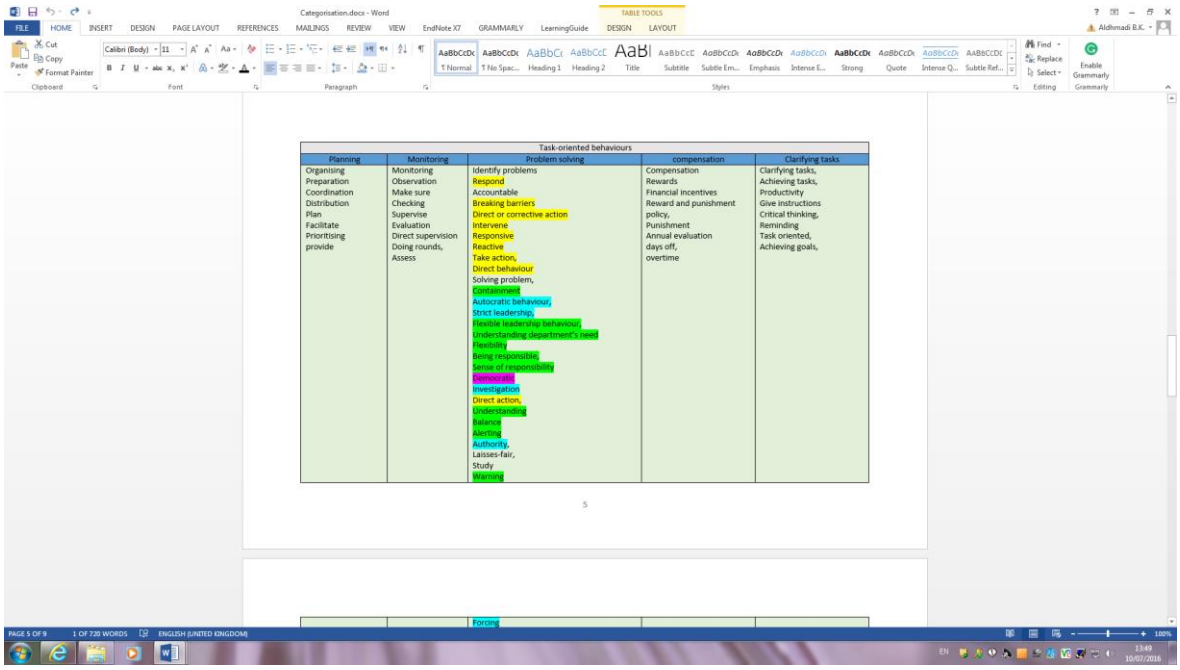


Meeting Communication Consultation Discussion, Listen, Explanation Connection, Suggestions Call Brainstorming Voting Reporting, Documentation Memos, Feedback, Direct communication Contact Talk Ideas Updating Take opinions,	Helping Monitoring Cooperation Organising Preparation Coordination, Compensation, Identify problems, Rewards Observation Clarifying tasks, Distribution Respond Team Teamwork, Accountable Make sure Breaking barriers Achieving tasks, Financial incentives Direct or corrective action Intervene Checking Supervise Productivity Evaluation Responsive Give instructions Reactive Plan	Delegation, Protecting staff, Staff development, Moral support, Moral incentives, Respect, Support, Understanding staff personality, Humble Fairness, Protecting staff, Empowerment, Recognition Moral encouragement, Consideration, Mutual respect Security Empathy Approve Friendly Prevent problems, Psychological support Recognition Advising Defending staff,	Education Training Teach Lectures Continuous education activity, Conferences, Workshops	Solving problem, Containment Understanding staff circumstances Autocratic behaviour, Understanding staff need, Strict leadership, Flexible leadership behaviour, Understanding department's need Flexibility Punishment Being responsible, Sense of responsibility, Doing rounds, Democratic Investigation Direct action, Understanding Balance Alerting Achieving goals, Authority, Facilitate Productivity Prioritising Chain of commands,	Change Openness to external environment, Develop Role model, Vision Developing standards, Create Understanding external environment, Development Logo Create good environment, Implement	



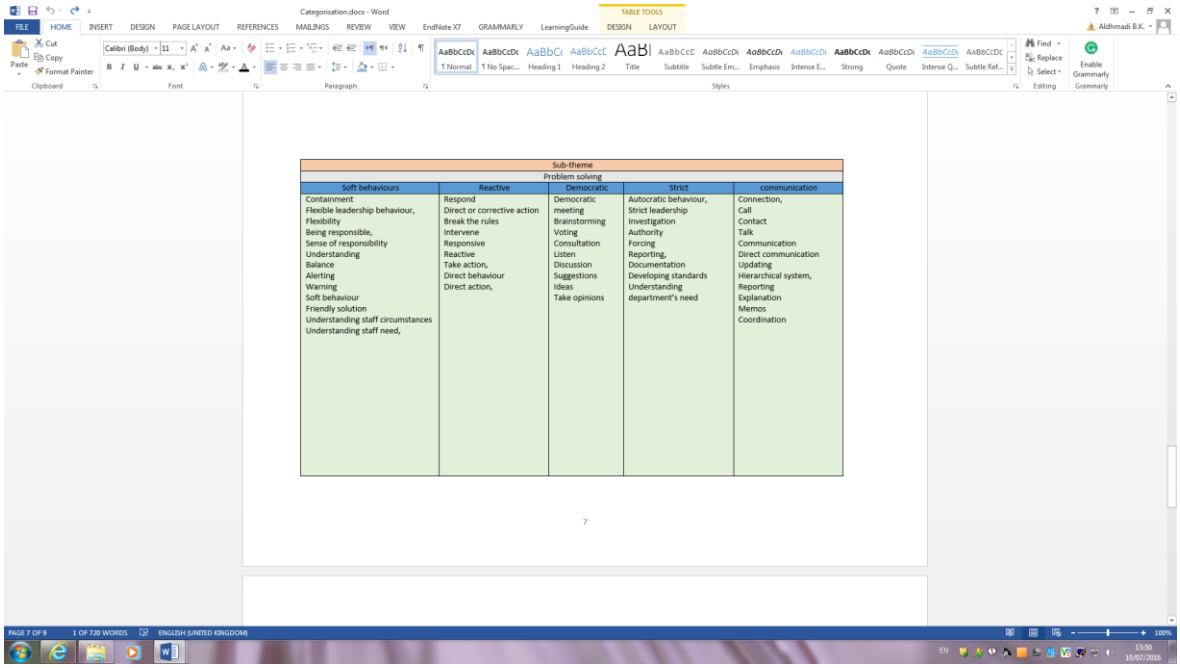
Task-oriented behaviours	Relation-oriented behaviours	Change-oriented behaviours
Monitoring Organising Preparation Coordination, Compensation, Identify problems, Rewards Observation Clarifying tasks, Distribution Respond Team Teamwork, Accountable Make sure Breaking barriers Achieving tasks, Financial incentives Direct or corrective action Intervene Checking Supervise Productivity Evaluation Responsive Give instructions Reactive Plan Reward and punishment policy Delegation, Direct supervision Problem solving Critical thinking Reminding Task-oriented Solving problem, Containment Autocratic behaviour, Strict leadership, Flexible leadership behaviour, Understanding department's need Flexibility Punishment Being responsible, Sense of responsibility,	Delegation, Protecting staff, Staff development, Moral support, Moral incentives, Respect, Support, Understanding staff personality, Humble Fairness, Empowerment, Recognition Moral encouragement, Consideration, Mutual respect Security Empathy Approve Friendly Prevent problems, Psychological support Advising Defending staff, Education Training Teach Lectures Continuous education activity, Conferences, Workshops Praising, Appreciation	Change Openness to external environment, Develop Role model, Vision Developing standards, Create Understanding external environment, Development Logo Create good environment, Implement Feedback

Appendix M

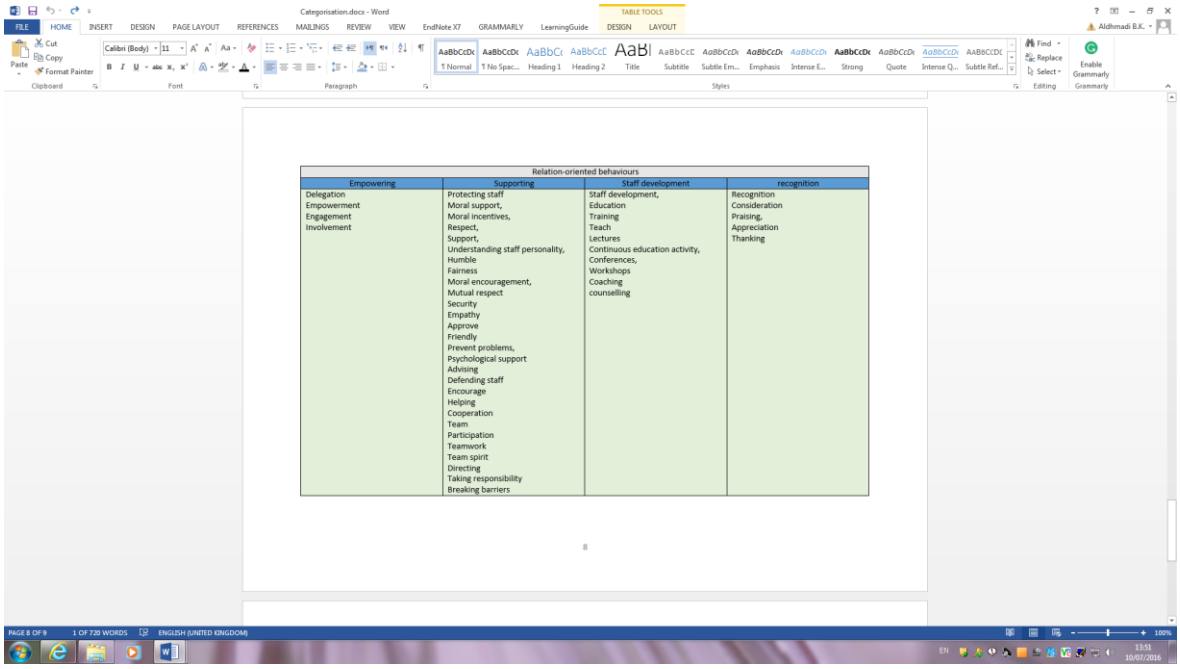


Task-oriented behaviours				
Planning	Monitoring	Problem solving	compensation	Clarifying tasks
Organising Preparation Coordination Distribution Plan Facilitate Prioritising provide	Monitoring Observation Make sure Checking Supervise Evaluation Direct supervision Doing rounds, Assess	Identify problems Respond Accountable Breaking barriers Direct or corrective action Intervene Responsive Reactive Take action, Direct behaviour Solving problem, Containment Autocratic behaviour, Strict leadership, Flexible leadership behaviour, Understanding department's need Flexibility Being responsible, Sense of responsibility Democratic Investigation Direct action, Understanding Balance Alerting Authority, Laisses-fair, Study Warning	Compensation Rewards Financial incentives Reward and punishment policy, Punishment Annual evaluation days off, overtime	Clarifying tasks, Achieving tasks, Productivity Give instructions Critical thinking, Reminding Task oriented, Achieving goals,

		Forcing		

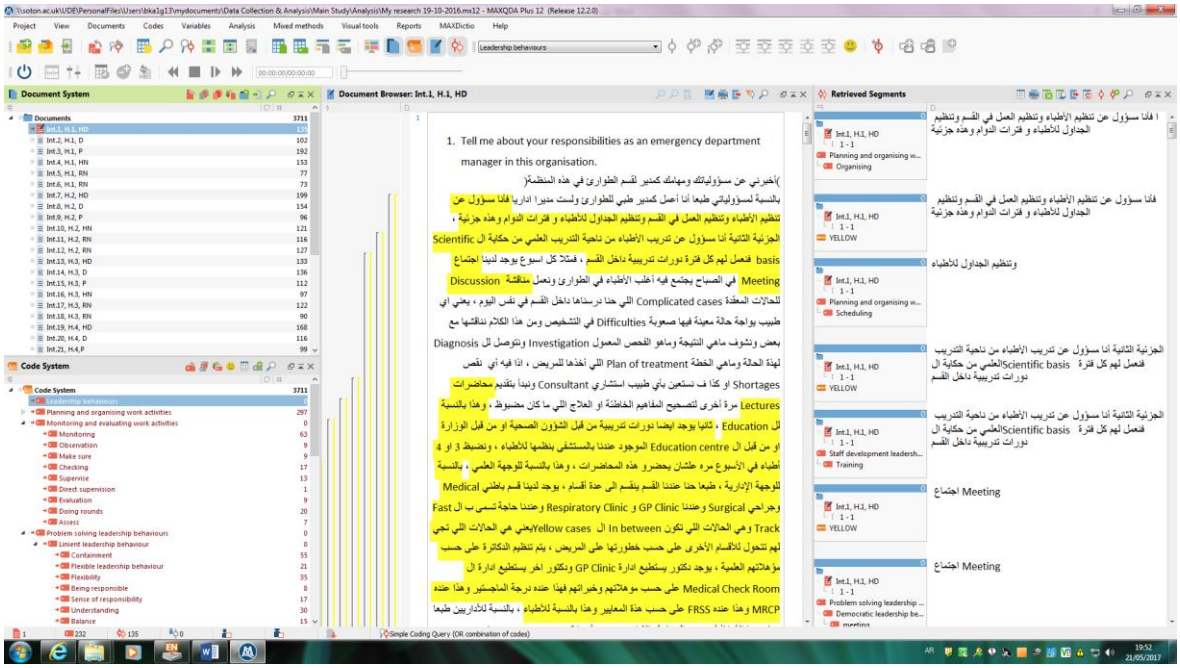


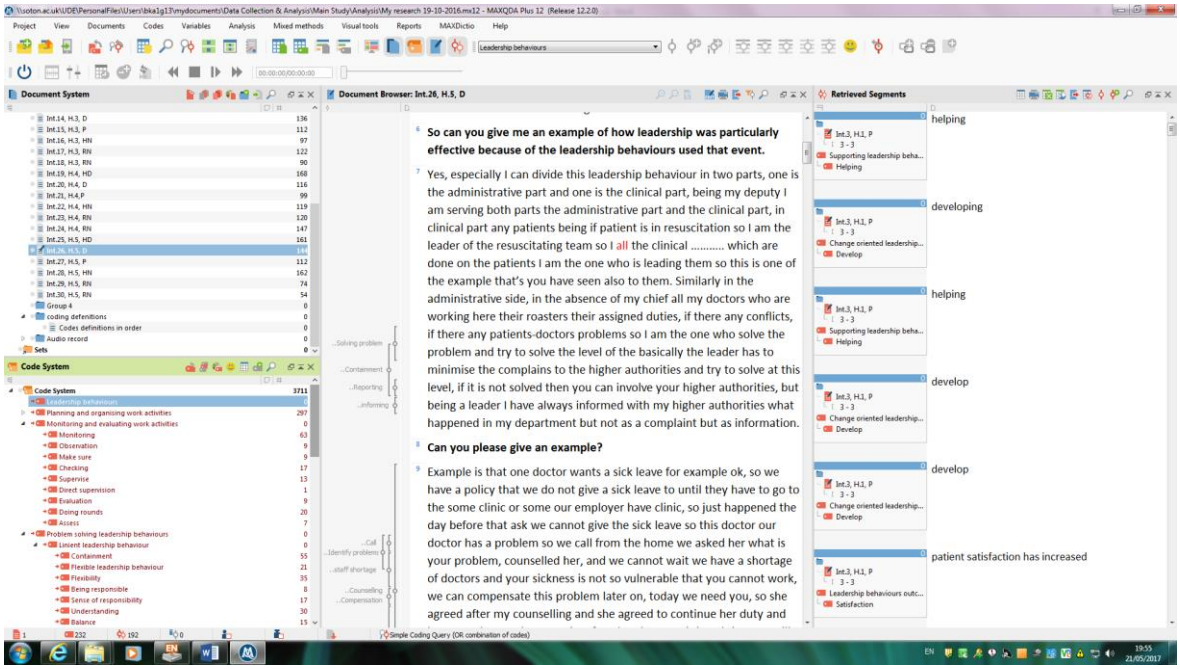
Sub-theme				
Problem solving				
Soft behaviours	Reactive	Democratic	Strict	communication
Containment Flexible leadership behaviour, Flexibility Being responsible, Sense of responsibility Understanding Balance Alerting Warning Soft behaviour Friendly solution Understanding staff circumstances Understanding staff need,	Respond Direct or corrective action Break the rules Intervene Responsive Reactive Take action, Direct behaviour Direct action,	Democratic meeting Brainstorming Voting Consultation Listen Discussion Suggestions Ideas Take opinions	Autocratic behaviour, Strict leadership Investigation Authority Forcing Reporting, Documentation Developing standards Understanding department's need	Connection, Call Contact Talk Communication Direct communication Updating Hierarchical system, Reporting Explanation Memos Coordination



Relation-oriented behaviours			
Empowering	Supporting	Staff development	recognition
Delegation Empowerment Engagement Involvement	Protecting staff Moral support, Moral incentives, Respect, Support, Understanding staff personality, Humble Fairness Moral encouragement, Mutual respect Security Empathy Approve Friendly Prevent problems, Psychological support Advising Defending staff Encourage Helping Cooperation Team Participation Teamwork Team spirit Directing Taking responsibility Breaking barriers	Staff development, Education Training Teach Lectures Continuous education activity, Conferences, Workshops Coaching counselling	Recognition Consideration Praising, Appreciation Thanking

Appendix N Qualitative software MAXQDA





Appendix O Mixed Methods Appraisal Tool (MMAT)

PART I. MMAT criteria & one-page template (to be included in appraisal forms)

Types of mixed methods study components or primary studies	Methodological quality criteria (see tutorial for definitions and examples)	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	• Are there clear qualitative and quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	• Do the collected data allow address the research question (objective)? E.g., consider whether the follow-up period is long enough for the outcome to occur (for longitudinal studies or study components).				
	Further appraisal may be not feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analyzing qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomized controlled (trials)	2.1. Is there a clear description of the randomization (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome data (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomized	3.1. Are participants (organizations) recruited in a way that minimizes selection bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				
	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2. Is the sample representative of the population understudy?				
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4. Is there an acceptable response rate (60% or above)?				
5. Mixed methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				
	Criteria for the qualitative component (1.1 to 1.4), and appropriate criteria for the quantitative component (2.1 to 2.4, or 3.1 to 3.4, or 4.1 to 4.4), must be also applied.				

*These two items are not considered as double-barreled items since in mixed methods research, (1) there may be research questions (quantitative research) or research objectives (qualitative research), and (2) data may be integrated, and/or qualitative findings and quantitative results can be integrated.

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