ORIGINAL ARTICLE

Perceptions of leadership style between nurse managers and their staff in Eastern Saudi Arabia: A cross sectional survey

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ABSTRACT

Background: Understanding nurses' perceptions about their nurse managers is a crucial element to consider as it helps in the performance of the nurse managers and retention of nurses and reflects the nature of a competent workforce in achieving the organisational goals.
Objective: To explore if there is a difference in perceptions of leadership style between nurse managers and their staff and discuss why this occurs.
Methods: A cross-sectional descriptive comparative research design was used.
Results: Nurse managers rated themselves as using transformational and transactional factors more than the nurses perceived them utilising these various leadership styles. Nurse managers, however, rated themselves lower than nurses in both laissez-faire and management-by-exception-passive.
Discussion: The leadership style preferred by the followers is consistently rated higher than the leadership style that their leaders are utilising. Formation of accurate self-perception is a delicate process, especially for people in management positions. Bias in higher self-ratings may occur for several reasons, including gender, which forms the basis of this discussion.
Conclusions: The results highlight the need for nurse managers to reflect on their practices and find new ways to enhance their leadership styles.

Key Words: Nurse managers, Perceptions, Leadership styles, Saudi Arabia, Gender

1. INTRODUCTION

Globally, the importance of nursing workforce issues is being identified, including the need to address the vital role of nurse managers.[1–3] A nurse manager is a professional registered nurse responsible for planning and organising nursing services, supervising nurses, and the quality of work undertaken by nurses in a ward.[2,4] The Saudi Arabian 2030 vision acknowledges the importance of nurse managers as one of the strategies for building the nursing profession and workforce to improve the quality of healthcare in Saudi.[5–7] This study aimed to examine the difference in perceptions of the nurse managers working at Saudi Arabian hospitals in the Eastern Province of Saudi Arabia regarding their leadership styles compared to nurses' perception of their manager leadership styles. In addition, this article sought to explore the reasons for these differences in perceptions.

There are several challenges for the nursing profession and leaders of the nursing and healthcare workforce in Saudi

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Arabia. First, Saudi Arabian hospitals are staffed by only 36.5% of local nurses, while the remaining 63.5% are expatriates, mainly from India and the Philippines.[6,8] Managing nurses from various countries where cultural values, norms, and beliefs are vastly different from Saudi culture creates a challenge.[6,9,10] These differences are an issue regarding information exchange undertaken in healthcare facilities because expatriate nurses need to be more competent in English or become familiar with Arabic.[10] English as a second language is the common language between national and expatriate nurses, creating challenges. Varying language proficiency creates a significant issue regarding interaction with fellow nurses and the patients they are caring for.[11] Another challenge for nursing in Saudi Arabia is the high turnover of expatriate nurses, and high attrition, attributed to many factors.[5,6,10] One of these factors is that expatriate nurses arriving in Saudi Arabia gain experience to leverage moving to work in a Western country, such as Canada or Australia.[10] The consequence of these challenges is high workloads which contribute to dissatisfaction and high attrition rates. It is crucial under these circumstances to have strong nurse manager leadership, as a management style is one of the determinants of staff turnover.[12]

Understanding the perceptions of nurses about their nurse managers is an essential element to be considered as it helps in assessing the leadership styles, the performance of the nurse managers, and retention of nurses, and reflects the nature of a competent workforce (leaders/nurse managers) in achieving the organisational development/goals.[13,14] Differences in how nurses and nurse managers perceive the nurse manager's leadership style is related to satisfaction with the leadership. Satisfaction with leadership is essential in the retention of nurses.[12,14] Retention of expatriate and Saudi nurses is crucial to maintain the workforce supporting the Saudi Arabian 2030 vision to improve healthcare quality. It is easier to achieve this goal with an adequate and stable workforce of nurses.

There are three main leadership styles.[15] First, transformational leadership can be defined as cooperation between leaders and followers to create a vision that guides the required change through motivation.[3,4] This style positively correlates with organizational outcomes, including effectiveness, extra effort, and job satisfaction.[15] The second leadership style is transactional, which values order and structure and focuses on supervision, organization, and performance. Followers under this leadership style receive certain rewards when they act according to the leader's wishes.[15] Finally, laissez-faire leadership avoids making decisions, hesitates to take action, and is absent when needed. Laissez-faire leaders relinquish total control and responsibility to their followers.[15]

Several studies have evaluated nurses' and nurse managers' perceptions of leadership style, finding a difference in perceptions between these two groups. Nurse managers rated their leadership behaviours as being more influential and effective than was perceived by their staff.[13] Similarly, nurse managers were found to consider themselves highly transformational compared to their staff, who rated them as more transactional.[14,16] McGuire and Kennerly[17] confirm this discrepancy between perceptions by others. Likewise, in another study, Andrews et al.[13] found differences in perceptions and believed these differences were related to the nurses' satisfaction with the leadership. In contrast, some studies do not support this difference in perceptions between nurse managers and their staff.[18]

Even though several studies have indicated that there is a difference in perceptions of leadership style between nurse managers and their staff and some indicating no difference, there have been no studies undertaken in the Eastern Province of Saudi Arabia to assess if there is a difference in perceptions in leadership style between nurses' managers and their staff. There still needs to be a discussion of this difference to explore why this is the case. This paper addresses these gaps and is the aim of this study. The research aimed to determine if there is a difference in perceptions of leadership styles between nurse managers and nurses. This paper only presents descriptive statistics of the difference in leadership styles in line with the aim.

2. MATERIALS AND METHODS

A cross-sectional descriptive comparative research design was chosen for this study, utilising characteristics of the quantitative method collected from six hospitals within the Eastern Province of Saudi Arabia. Bass' full-range leadership theory[15] is the conceptual framework used to assess the variables in this study. This framework uses definitions provided earlier of leadership styles with transformational leadership style factors, including idealized influence attributed and behavioural, inspirational motivation, intellectual stimulation, and individualized consideration. Transactional leadership style factors include contingent reward and management by exception.[15]

2.1 Instruments

The MLQ 5X-Short is used[15] to assess nurse managers' leadership styles. This questionnaire contains 45 items representing leadership style factors, including 20 questions covering the five factors of transformational leadership (idealised influence attributed, idealised influence behavioural, inspirational motivation, intellectual stimulation, and individ-

ualised consideration), 12 questions covering the three transactional leadership factors (contingent reward, management-by-exception active and management-by-exception passive), four questions covering laissez-faire leadership and nine questions covering three organisational outcomes. The three organisational outcomes include effectiveness, job satisfaction, and extra effort (four items assess willingness to exert extra effort, two assess satisfaction, and four evaluate effectiveness). The 45-item questionnaire asks managers and nurses to rate the leader's frequency of behaviours and actions on a 5-point Likert scale from 0 (not at all) to 4 (frequently, if not always). The researcher gained permission to utilise the MLQ instrument from the original authors.

The MLQ 5X-Short[15] collected data on this study's independent variables: leadership styles of nurse managers as transformational, transactional, or laissez-faire leaders. This instrument also measured the dependent variables of staff willingness to exert extra effort, leader effectiveness, and staff job satisfaction, all organizational outcomes, and components of the conceptual framework used for this research.[15] As the MLQ 5 X-Short evaluates the full-range leadership model, it also measures the degree to which followers are satisfied with their leader and the effectiveness of the leadership styles.[15]

2.2 Sample and setting

This study included six hospitals within the Eastern Province of Saudi Arabia. Inclusion criteria included: nurses and nurse managers in any of the six hospitals being registered nurses or nurse managers with at least one year of work experience and the ability to speak and read English.

Using a clustered technique for the sampling strategy avoided bias and ensured the representativeness of each study setting. The size and number of total nurses and nurse managers in each hospital determined the sample size obtained from each selected hospital.

2.3 Data collection

All Participants were asked to complete a short demographic survey before beginning the MLQ 5X-Short. Demographic questions included queries for age, gender, nationality, highest nursing degree, and years of experience.

2.4 Recruitment process

In undertaking this study, the researcher maintained ethical standards throughout the study. Ethics approval was obtained from King Abdullah Medical City, Holy Capital, Saudi Arabia (Institutional Review Board), and the University of Technology, Sydney. Following ethics approval, the researcher met the assistant nursing directors in the selected hospitals, who then informed the nurses and nurse managers in the different wards about the study. Participants received a letter from the assistant nursing directors inviting them to contribute to the study. The letter outlined the purpose of the study, the data collection process, and an assurance of anonymity and confidentiality about their identity and the information they provided. Questionnaires were enclosed in sealed envelopes, thereby maintaining the anonymity of the participants. The return of the survey implied consent. Participants were asked to return the questionnaire in a sealed, stamped, self-addressed envelope that was provided or to submit the completed questionnaires in a locked return box located at the nursing management office of the hospitals included in the study. Two weeks were provided for nurses and nurse managers to complete and submit the questionnaire, with a reminder posted on the staff notice board following this time. Once collected, all electronic data were stored on the university password-protected server, with only the researcher having access.

2.5 Data analysis

The participants' responses from the questionnaires were screened, cleaned, and coded using the IBM SPSS version 22 software package. Any missing data were deemed a random occurrence, and mean values for each variable replaced these missing scores.

3. Results

3.1 Demographics

In total, 600 questionnaires were distributed to the nurses, with 283 responses (response rate 47%). Two hundred twenty-five questionnaires were distributed to the nurse managers, and 121 were returned (response rate 54%). Most of these respondents were female (nurse managers, 76%, n = 93; nurses, 84%, n = 238). Nurses were in the 20-29 age bracket (59%, n = 168), while most nurse managers were older in the 30-39 age bracket (48%, n = 59). Regarding nationality, most respondents were expatriates (nurse managers, 65%, n = 67; nurses, 58%, n = 149), with the sample being relatively diverse. The largest expatriate nurse group was from India (nurse managers, 31%, n = 38; nurses, 36%, n = 101). Saudi Arabia was the next largest group for both groups (nurse managers, 31%, n = 38; nurses, 36%, n = 101). Regarding years of work experience, most respondents had 1 to 5 years (nurses, 88%, n = 248; nurse managers, 30%, n = 37). Most nurse managers had a diploma as the highest qualification (42%, n = 51), followed by a bachelor's degree (40%, n = 49). Similarly, nearly half of the nurses had a diploma as the highest qualification (46%, n = 130), followed by a bachelor's (44%, n = 124).

3.2 Perceived leadership styles

To provide an overall description of the scores obtained from the MLQ subscales, means (*M*) and standard deviations (*SD*) were obtained (see Table 1). The highest mean reported subscale was the inspirational motivation for both nurses (*M* = 2.64) and nurse managers (*M* = 3.15). For organisational outcomes, effectiveness (*M* = 2.68) and satisfaction (*M* = 2.68) were equally the highest mean subscale reported for nurses, while for nurse managers, satisfaction (*M* = 3.28) had the greatest mean subscale value.

Table 1. Descriptive statistics of the subscales

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

Exploring differences between the sub-scale responses from the nurse managers compared to the nurses revealed the following. As can be seen from Table 1, the means (*M*) and standard deviations (*SD*) of the nurse managers' responses on MLQ items that measure the five factors related to transformational leadership (idealized influence attributed and behavioural, inspirational motivation, intellectual stimulation, and individualized consideration) were rated higher by the nurse managers compared to the nurses. These results indicated that the nurse managers perceived themselves as utilising the transformational factors often. Compared to the nurses who perceived, on average, that their nurse managers used the transformational leadership factors only sometimes to fairly often.

In addition, the means and standard deviations of the nurse managers' responses on MLQ items which measure the three factors related to transactional leadership (contingent reward, management by exception active and passive), were examined. This indicated that nurse managers had high mean scores for contingent reward and management-by-exception active. This result indicated that nurse managers utilised contingent reward fairly often and management-by-exception active sometimes to fairly often. However, the management-by-exception passive had the lowest mean score, indicating that nurse managers used this less than the other two factors. In other words, nurses perceived that nurse managers needed to provide more information, articulate goals, or create effective solutions and timely responses, whereas nurse managers believed they did.

Then exploring the means and standard deviations of the nurses' responses on MLQ items that measure the three factors for transactional leadership revealed the following. High mean scores for nurses were obtained for contingent reward and management-by-exception active. These results indicated that nurses perceived their nurse managers as utilising contingent reward and management-by-exception active sometimes to fairly often. Furthermore, nurses rated their nurse managers for management-by-exception passive; however, nurse managers rated themselves lower in utilising this sub-factor. Similarly, nurse managers rated themselves as using contingent rewards more than their staff rated them as utilising this transactional leadership factor. Likewise, nurse managers rated management-by-exception active more than nurses rated their use of this leadership behaviour. In other words, nurse managers perceived that they provided an explicit agreement with their staff to accomplish organisational goals, whereas nurses did not believe their managers did.

Lastly, the means and standard deviations of the nurse managers' and nurses' responses on MLQ items that measure laissez-faire leadership were examined. The mean of nurse managers' responses indicated that nurse managers perceived themselves as utilising laissez-faire leadership, not at all. In contrast, nurses perceived their nurse managers as utilising this leadership style not at all too occasionally. These results indicate nurse managers perceived themselves as using laissez-faire leadership lower than their staff nurses. Furthermore, the results suggest that laissez-faire leadership is the least preferred style for both nurse managers and nurses.

The findings demonstrated that nurses perceived their nurse managers as utilising laissez-faire leadership and management-by-exception passive not at all too occasionally and both transformational leadership and two transactional leadership factors sometimes too often. In contrast, nurse managers rated themselves as using transformational and transactional factors greater than the nurses perceived them utilising these various leadership styles. Nurse managers, however, rated themselves lower than nurses in both laissez-faire and management-by-exception-passive.

4. DISCUSSION

The results revealed that nurse managers' and nurses' perceptions of the leadership styles differed. Nurse managers rated

their leadership behaviours (all nine factors) higher than their nurses rated them. Others confirm this discrepancy between the perceptions of nursing staff and nurse managers.[14,17,19] From the followers' perspective, the leadership style preferred by the followers is consistently rated higher than the leadership style their leaders utilize.[14,17,19] When nurse managers preferred a specific leadership style, they scored it higher than the actual one, as they reflected their interest in adopting the leadership styles they wanted but could not.[20]

Several studies do not confirm or support these previous findings.[18,21] Differences were instead believed to relate to the type of nursing department, such as critical care units where nurses viewed their nurse managers as less transformational than other units. In addition, Andrew et al.[13] linked the different perceptions of the leadership style to low satisfaction with supervision and cultural orientation. For instance, Jogulu[22] found that Malaysians preferred transformational leadership, while Australians preferred transactional leadership. In addition to satisfaction, other attributes could affect nurses' perceptions of their managers. For instance, the ability of nurses to understand their managers is an important area to consider. The results from another study revealed that the portrayal of transformational leadership behaviours by nurse managers was paramount in shaping the cultural traits linked to high performance by nurses.[18]

It is clear, therefore, that for some reason, nurse managers tended to overrate themselves, and nurses tended to underrate their managers. There is little recent literature that has explored the reasons for this. People generally have a high opinion of themselves and expect others to view them similarly. Most people, after all, have unrealistically positive views of themselves.[23] These high opinions have been termed "self-enhancement" defined as "taking a tendentiously favourable view of oneself".[23] It follows from this then that people tend to rate themselves higher than others rate them. In other words, self-enhancement.

On the other hand, according to London and Wohlers,[24] the formation of accurate self-perception is a delicate process, especially for people in management positions. Bias in self-ratings may occur for several reasons.[25] Self-rating bias may occur because managers may not seek or inadequately receive feedback from their staff. In other words, they need to seek confirmation of their ability to be an adequate or inadequate manager. Furthermore, managers may judge the feedback they receive as insignificant, especially if their performance evaluation is independent of this feedback. Managers may not actively seek feedback about their management competence in the first place because they fear this could communicate inadequacy. In addition, managers may only seek feedback from staff they know will provide favourable comments, so the sample is biased.[26] Even though managers may gain adequate feedback about their performance, they may need to integrate this information and adjust their behaviour accordingly.[25] It is interesting to note that a study undertaken by Ashford and Tsui[26] found that managers that actively sought negative feedback increased the accuracy of their understanding of how their staff evaluated their work and enhanced their effectiveness. It follows that managers who are aware of how their self-perceptions compare to how others perceive them can promote greater self-insight, leading to personal development and improved management.[27]

There needs to be more research undertaken focused on the factors contributing to this discrepancy and bias in self-ratings. There has been some early research that has explored the effect of gender, finding that female managers were more likely to agree with the perceptions of their staff than male managers were.[24,27] This equates to the actor-observer bias, which relates to the different information that actors (managers) and observers (staff) use to form their perceptions.[27] Actors have more direct, precise information about their emotional status and intentions.[28] In contrast, the observer is focused on the actor and does not have this information about the intentions, which can be subject to error. These differences in perceptions apply to the leadership/management context.[27]

Another influence of gender could help explain this discrepancy.[27] This influence relates to people having a different opinion regarding what constitutes being a leader compared to the schema they hold of women. Part of the reason for this is that management tends to be dominated by males in some organisations. Evidence suggests that the prevailing image of a manager is more like a man than a woman.[27] In other words, being a manager/leader is equated to certain male behaviours, suggesting that women cannot be leaders as they do not have these behaviours.[28] It therefore follows, as leaders, women must aspire to be masculine to be effective managers/leaders but are still women. The actor's gender is, therefore, more noticeable to the observer, which helps explain the difference in perceptions as the leader/manager sees themselves as more masculine, and the staff views the manager/leader as feminine, hence the discrepancy.[27]

Similarly, this research indicated that female nurse managers were more likely to use leadership strategies that resulted in staff satisfaction and trying to work with others satisfactorily. Their leadership strategies could be because females are more caring and sensitive to the needs of their staff. Overall, most managers and nurses (84%) were female in this

research. Interestingly, male nurse managers' percentages were higher than that of male nurses, which may be because males usually prefer to work in administrative roles, especially in a conservative country like Saudi Arabia.[29] There are also more male nurses than female in Saudi compared to other countries.[6] However, much of the literature in this area is dated; therefore, there is a need for more research into this area.

Some unique circumstances in Saudi Arabia add further complexity to the management situation. There is a need to recruit more Saudi nurses. Consequently, there is a reliance on expatriate nurses, the predominant nursing workforce presenting a range of cultural complexities in the management arena. Saudi nurse managers tend to have limited bedside experience and minimal management education.[6,10] One of these cultural complexities is that Saudi Arabian women do not have the same freedom and social benefits as men, which may affect the underlying assumptions about gender.[30] Social beliefs and traditions in Saudi Arabia forbid the idea of gender mixing in the workplace or even a woman directing a man. The fact that 52% of the nurses and managers were expatriates, mainly from India, adds further complexity to this issue. It was outside the scope of this paper to discuss the correlations between the demographics and the MLQ scale.

Lastly, numerous studies published in recent years have used a survey-based approach to ascertain staff perceptions of nurse managers' leadership styles.[2,3,13,14,17,18,21] However, the results revealed by these studies may have limitations as surveys are only sometimes objective or efficient in evaluating the perceptions from various dimensions and correlating the perceptions with other factors. For instance, according to Andrews et al.,[13] the difference between nurse managers' perceptions of their leadership styles and nurses' perceptions of their managers' leadership styles presents a problem in evaluating the survey findings. The language barrier may have been a limitation of this study; the questionnaire was in English; for most nurse and nurse managers respondents, English is their second language which may have minimized their ability to understand the questions. It may have also been possible that nurses may have experienced difficulty and fear in completing the questionnaire, especially considering the cultural complexities of this population.

5. Conclusions

The findings of this study support earlier studies confirming that there is a difference in perception of how nurse managers rated their leadership styles compared to how their nursing staff rated them. These findings indicate that information about a nurse manager's perception of their leadership style and the perception of the staff nurses on nurse managers' leadership behaviour will provide directions for the continuing education and professional development of future leaders. The unanimity of the respondents' perception of the leadership style of the nurse managers gave a clear picture of the nurse manager's skills and knowledge in using different leadership styles because both the nurse managers and nurses did evaluations. These evaluations highlight the need for nurse managers to reflect on their practices and find new ways to enhance their leadership styles further. Providing education on management and leadership styles in Saudi Arabia and the effective use of evaluations to improve self-ratings may support nurse managers' effectiveness. In addition, the role of gender and people's perception of gender roles needs to be factored into professional development of future leaders. Further research may increase an understanding of why nurse managers rate themselves higher on leadership styles than their nursing staff rated them.

Institutional review board statement

Ethics approval was obtained from King Abdullah Medical City (Institutional Review Board RS-MoH 018-35). In addition, received a facilitation letter from Ministry of Health (Research and Studies Affairs Unit). Plus, ethics approval was obtained from Human Research Ethics Committee of University of Technology, Sydney Ref. No. 2013000623.

Informed consent statement

Informed consent was obtained from all participants involved in the study.

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Conflicts of Interest Disclosure

The authors declare that there is no conflict of interest, financial or otherwise with the preparation of this article.

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