

**NURSING LEADERSHIP:  
A CASE OF INDONESIA**

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## **ABSTRACT**

Nursing leadership is one of the key areas which can have an impact on workforce outcomes and health systems. Although leadership is recognised as a pivotal part of nursing, knowledge of leadership evolution amongst nurses in Indonesia is limited and requires investigation. This thesis sets out to explore nurses' leadership in this country. A mixed-method study is employed to address this purpose. The quantitative phase of the research identifies nurses' leadership as measured by the Multi-factor Leadership Questionnaire (MLQ-5X). To complement the findings of the quantitative stage, a qualitative study, using an in-depth interview approach, explores further nurse perspectives of leadership. Data were collected from a random sample of 250 nurses and head nurses from a hospital in the city of Banda Aceh, Indonesia. The survey results revealed that both head nurses and their staff perceived transformational and transactional leadership as existing within the hospital environment. Interview data analysis revealed three main themes in regard to leadership: the meaning of leadership, the expected leadership characteristics, and factors that influence nurse leadership. Several important factors, such as context and culture, were noted as important within the interview data and are not recognisable in the MLQ survey. Reflecting on these findings, therefore, the measure's applicability in nursing is reconsidered. Implications for the future of nurse leadership in Indonesia are highlighted.

## **DEDICATION**

First and foremost, to my mother and father, Mama Nuraini Yusuf and Papa Muhammad Nur; to my late mother-in-law and father-in-law, Umi and Bapak, how I wish you were here with us; to my greatest supporter in life, my best friend, my love, my husband, Dr Eddy Gunawan; and my lovely children, Sahira, Daniel, Shareef, and Arfa. Your continuous love has sustained me throughout my whole life

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## LIST OF ABBREVIATIONS

AHA	American Hospital Association
ANCC	American Nurses Credentialing Center
BPJS	Badan Penyelenggara Jaminan Sosial
BPS	Badan Pusat Statistik ( <i>Statistics Indonesia</i> )
CR	Contingent Reward
CEO	Chief Executive Officer
DEPKES	Departemen Kesehatan ( <i>Health Department</i> )
DIKTI	Pendidikan Tinggi
FRL	Full Range of Leadership
FOM	Force of Magnet
GTL	Global Transformational Leadership scale
GAM	Gerakan Aceh Merdeka ( <i>Aceh Armed Independent Movement</i> )
HPEQ	Health Professional Education Quality
HN	Head Nurse
INNA	Indonesian National Nurses Association
IT	Information Technology
IC	Intensive Care
ICN	International Council of Nurses
LPI	Leadership Practices Inventory
LAI	Leadership Assessment Inventory
MLQ	Multifactor Leadership Questionnaire
MBE-A	Management-by-Exception-Active
MBE-P	Management-by-Exception-Passive
MRP	Magnet Recognition Programme
MOH	Ministry of Health
MDG	Millennium Development Goals
MS	Medical Surgical
MoU	Memorandum of Understanding
NMC	Nursing and Midwifery Council
PPNI	Persatuan Perawat Nasional Indonesia
PUSKESMAS	Pusat Kesehatan Masyarakat ( <i>Sub District Health Center</i> )
PUSTU	Puskesmas Pembantu ( <i>Village Health Post</i> )
Posyandu	Pos Pelayanan Terpadu ( <i>Integrated Health Post</i> )
PNPM	Professional Nursing Practice Model
SN	Staff Nurse
TLQ	Transformational Leadership Questionnaire
TLI	Transformational Leadership Inventory
UNDP	United Nation Development Project

UREC      University Research Ethics Committees  
WHO      World Health Organisation  
ZAGH      Zainoel Abidin General Hospital

# CHAPTER 1 INTRODUCTION

## 1.1. Introduction

This research aims to explore nurse leadership in the country of Indonesia. A mixed-methods design is used to address questions relating to the nature and meaning of nurse leadership. The quantitative phase of the research identifies nurses' leadership as measured by a survey method questionnaire, the Multifactor Leadership Questionnaire (MLQ-5X). The subsequent qualitative study will explore further nurses' views on the concept of leadership.

The thesis is structured over seven chapters. In this introductory chapter, background ideas for the study will be introduced, followed by an overview of the health system and nurse profession in Indonesia as well as a description of the research setting. In the following chapter I will present the literature review. In this second chapter, an appraisal of the literature pertaining to leadership and its significance in the nursing field will be provided. A critique of those cultural factors impacting on leadership will also be included as an important aspect of leadership effectiveness. This chapter will also allow a detailed consideration of research aims and objectives. After the literature in the field has been recognised, the plan for the research will then be described in Chapter three. This is where the methodology and justification for the process will be presented. Details of each the research steps will be described in this chapter. Analysis of results from both phases of the study (quantitative and qualitative) will be presented separately in chapters four and five. Chapter six will address a broad consideration and discussion of the survey and interview results in an integrated fashion. The discussion will be presented concurrently to allow me to further analyse any supporting or contradictory results from both survey and interviews. Potential implications in the area of nursing education,

leadership practice, and policy as well as recommendations for further research will also be suggested in the chapter. Lastly, Chapter seven will also conclude the entire journey of the study. In this conclusion, highlights of the study will be restated.

## **1.2. Background**

Nurses represent the largest professional group in the healthcare team (Huber, 2006) and play a significant front-line role, meaning that the profession is in an ideal position as an initiator of change. The International Council of Nurses (ICN) had released an action plan to address a global nursing crisis and made attempts to bring together global partners in order to engage in developing, implementing and financing several critical areas to address these challenges (Tyer-Viola et al., 2009). Amongst these, nursing leadership is one of the key areas recommended for global attention (Tyer-Viola et al., 2009). From this point, leadership was recognised as a vital element in nursing which can have an impact on workforce outcomes and the health system.

The origin of nurse leadership remains a key question within the field (Williams & Irvine, 2009). Despite this it is recognized that the identification of nurses' perceptions and views on leadership helps to conceptualise better work conditions to make the most of nurses' performances and services (Eneh, Vehviläinen-Julkunen, & Kvist, 2012) and Indonesia is no different in this respect. There is limited information on how the nurses see leadership in the country and a lack of research has been undertaken on the experiences of nurses. Alongside this, however, there is also a strong personal desire to explore this field, this motivation relates to my past and my own experiences as a student. At that time I noticed the nurses had a limited role in the hospital. Nurses at this time acted only act as "workers" who delivered tasks and acted on orders. Arguments or discussion between nurses and other health professionals, such as



physicians, in regards to patients' treatment, interventions, or even on policies were rarely observed.

My personal thoughts about this relay on my own student experiences, but extend to more recent observations made working within a nursing faculty. I have found that nurses are often discouraged from voicing their opinions and this discouragement results in a lack of confidence to voice one's own views. There was, and still is I believe, an assumption that it would be useless to talk because it will be never heard. In fact, the more I get closer with these nurses, I see that the nurses are highly capable both on their work and leadership. However, these capabilities are often set aside or disregarded. Thus, looking at this problem encouraged me to further explore leadership amongst the nurses. As such I see my work, and the work of others in the field, as a "wake-up call" both for the nurses and community in the country. The nurses, on one side, need to be self-assured that they have capability to lead and to be a leader. They have ability to initiate change, be innovative, and be trustworthy. It was hoped that this study would be an opportunity to disseminate knowledge to community/policy makers that will inform them that nurses are leaders and yet credible leader for change; for better care for Indonesian. Thus, investment in the capacity for nurses and allowing opportunity for their leadership to grow would be a meaningful step to pursue.

This thesis intends to explore nurses' leadership in the country of Indonesia. This study offers a significant contribution to the body of knowledge in nursing, in particular on the topic of leadership within the Indonesian nursing profession. This current study recognises that it is the nature and characteristics of one's job that determines how people see leadership. This study was conducted in a hospital setting. A hospital is a complex environment which contains a large number of stakeholders such as doctors, nurses, administrative staff, auxiliary services providers,

interns, and students. These professionals work side by side, but each of them has their own work dimensions or job pressures that can only be understood by individuals involved in that particular role. By exploring further how each profession comprehends leadership, it may be possible to reach a more informative conclusion about each group's definition of leadership, the expected or ideal attributes of leaders, or factors that may flourish or inhibit leadership growth amongst them.

This research has helped to show how these nurses perceive leadership and has also provided an extensive perspective that broadens our understanding of the leadership concept. Nurses, as the focus of this study, have their own perspective of leadership which may differ from that of other professionals. This introduces an important message: if we attempt to explore nurses' leadership, we must assess a group of nurses. In other words, mirroring leadership exploration gained from other elements of jobs/contexts may be less substantive when applied to a different work environment. Leadership is a highly specific aspect for a specific group of individuals. Finally, the entire process of this study, ranging from research planning to a discussion of the findings, suggested several key messages that would add novel and valuable principles in viewing leadership and its evolution within the nursing profession.

To help provide the reader with information about the context of healthcare in Indonesia, the following section will provide an overview of its health system and the nursing profession in the country.

### **1.3. Healthcare in Indonesia**

It will be useful at this point for the reader to begin to understand the context of this research and the environment within which the research was undertaken. This section provides

information on Indonesia's health system, the organisational structure of the country's health system, and its nursing profession.

### 1.3.1 Overview of Indonesian Health System

Indonesia is an archipelagic country within the Southeast Asia region. The country consists of five main islands: Sumatra, Java, Celebes, Borneo, and Papua; these areas are sub-divided into 33 provinces. The World Health Organisation (WHO) reported that the population had recently exceeded 200 million; Indonesia is now the fourth most populated country in the world after China, India and the United States of America (WHO, 2010)

In 2000, Indonesia and another 188 nations agreed upon a pledge to free people from extreme poverty and multiple deprivations under the United Nations Development Programmes (UNDP). This declaration was then framed as the eight Millennium Development Goals (MDG) to be achieved by 2015 (UNDP, 2000). Alongside the poverty reduction plan, the health status of the population remains high on the agenda (UNDP, 2000). Data from 2009 show a high mortality rate (307 deaths found for every 100,000 live births, which in turn remains high). MDG plans to reduce this to 105 deaths by 2015. According to recent statistical data from BPS (Badan Pusat Statistik) or Statistics Indonesia, life expectancy in the country is 69 years and remains the lowest in comparison to several neighbouring countries. For example, in Malaysia, Thailand and Vietnam life expectancy is 74 years, while in Singapore it is 80 (BPS, 2012).

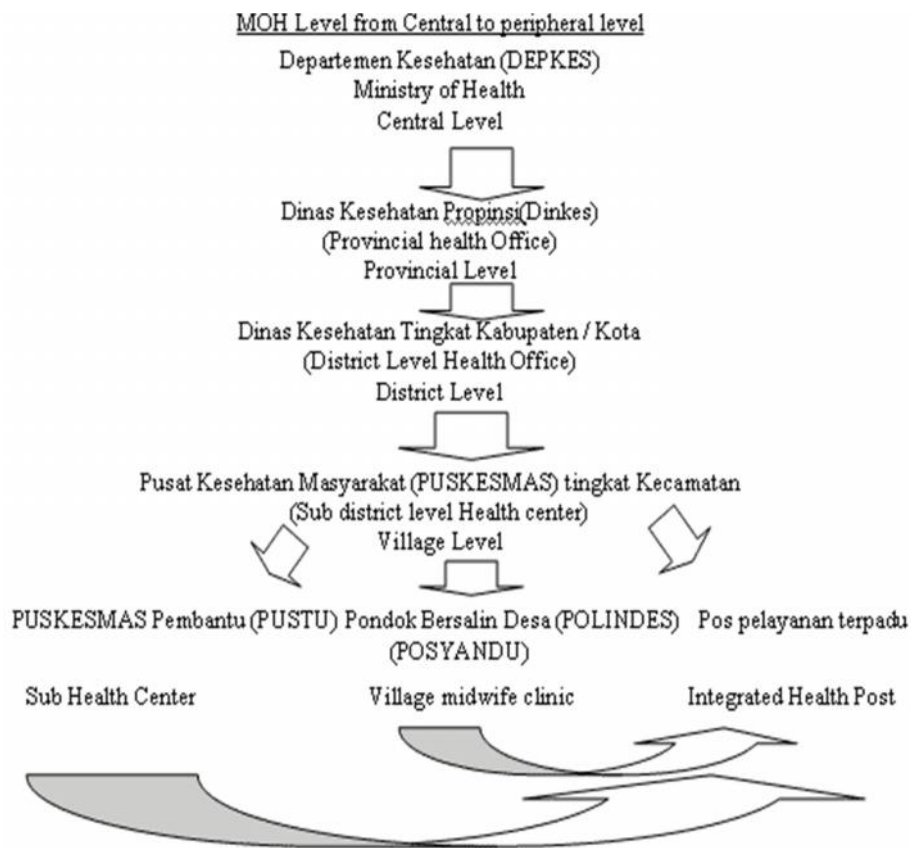
Although Indonesia, a developing country, is making slow progress in its development plans, the government is striving to increase the quality of life of its citizens. The health sector remains a top priority for the nation's development. The health paradigm of a curative approach has shifted to preventive actions. According to the Indonesia Department of Health (Departemen

Kesehatan or DEPKES), the Government is attempting to engage in health promotion and an improvement strategy for maternal and child health by increasing the number of health centres and health practitioners in remote areas (DEPKES, 2011).

### 1.3.2. Organisational Structure of the Health System in Indonesia

The following figure describes the flow of health system in Indonesia.

Figure 1.1. Structure of Indonesia’s health system



Source: WHO, 2012

In spite of regional autonomy, the main health policy formulation and standards are the responsibility of the Ministry of Health (MOH). The MOH then provides guidance and supervision for the policy conduct at the provincial health office level (WHO, 2010). Indonesian

hospitals are established at the provincial and district/city level and are commonly located in each region's capital city. Most PUSKESMAS are now equipped with in-patient services; therefore, any issues or health problems beyond the capability of PUSTU or POLINDES will be referred to PUSKESMAS at the sub-district level and, if necessary, to the hospitals in the district/city or provincial capital. The provincial or district/city hospitals are maintained as secondary referral centres. Even so, these hospitals' facilities may vary slightly. Most hospitals at the provincial level have been equipped with advanced health support including technology utilisation or ancillary services that may not be provided or available in the district/city ones (WHO, 2010).

The Health Department of Indonesia (DEPKES) reported that there are public and private hospitals in the country. These hospitals are available as both general and special care centres. Public hospitals are all centres covered by the ministry of health and provincial or district/city governments; military and private non-profit health centres are also included in this category. Meanwhile, private centres include hospitals run by private companies, individuals or state-owned enterprises. The number of publicly-owned hospitals exceeds those in the private sector. Recent data on registered hospitals show a total of 1,963, 1,485 of which are in public ownership; these public hospitals have 1,175 general care centres, and 310 specialise in particular areas such as cancer or mother and child units. Furthermore, there are 478 privately managed hospitals available in 325 general care centres and 153 special care hospitals (DEPKES, 2011).

In regard to the health financial system, Indonesia recently implemented national insurance for its citizens. The program aimed to provide low premium cost with wide coverage insurance for nearly 250 million people (Rachman, 2015). This includes regular check-ups,

maternity services and expensive treatments (e.g., cancer) in both private and public hospitals. To date, more than 150 million Indonesians have enrolled in the program. The BPJS (Badan Penyelenggara Jaminan Sosial), the official government entity created to run the program, continues to promote it and is attempting to simplify the bureaucracy to attract more enrollees who have taken out private, self-paid insurance. Therefore, despite the challenges of the deficit faced by the government due to low nominal premiums policy so far, enrollment in this national program will become mandatory from January, 2019 (Rachman, 2015).

A brief introduction to the Indonesian health system has been presented. Since the main attention of the research is on nurses in the country, an overview of nursing in Indonesia is required to give readers a better insight prior to exploring the topic further.

### 1.3.3 Nursing in Indonesia

The educational entry level for nurses in Indonesia ranged from Diploma III to the Bachelor's stage (Hennessy, Hicks, Hilan, & Kawonal, 2006b). The development of nursing education since 1999 has shown that about 1% of nurses are educated at university level to the degree of Bachelor's, Master's and Doctorates (Shields & Hartati, 2003). The applied concepts in nursing education are influenced by the American nursing curriculum (Strength & Cagle, 1999). Textbooks or other nursing reading materials are mostly American-based resources providing a challenge for users in understanding them, since the majority of teachers and students have difficulty reading in English (Gillund, Rystedt, Wilde-Larsson, Abubakar, & Kvigne). Moreover, Gillund et al. found that, due to limited resources, most of the qualified nursing students receive an offer of a teaching position following graduation from school,

creating nursing instructors who have an inadequate amount of clinical experience (Gillund, Rystedt, Wilde-Larsson, Abubakar, & Kvigne, 2012; Lock, 2011; Shields & Hartati, 2003).

In terms of nursing availability, Shields et al. found that there were about 50 nurses per 100,000 people in Indonesia (Shields & Hartati, 2003). Most of these nurses were educated at diploma level, known as Akademi Keperawatan, in both private and public institutions. More recently, the nursing profession in Indonesia has been striving to develop competency assessments and accreditation procedures. Each level of nursing education has been standardised and accredited for decades by referring to Presidential Act No. 8, 2012, regarding the Indonesian National Qualification Framework (Indonesian National Nurses Association (PPNI), 2012). The aforementioned Act is a general rule for all Indonesian professionals. After a significantly long process, the Nursing Law (Undang-Undang Keperawatan) was passed by the country's legislature under Bill No. 38/2014 (Indonesian National Nurses Association (INNA), 2014). The law addresses several critical areas such as legal protection for nursing professionals, the organisation, and professional education for nurses. In addition to this, nurses in Indonesia are expected to adhere to a code of conduct standardised by INNA. These professional standards involve nurses' responsibility for clients, nurses and their best practice, community, colleagues, and their own profession (PPNI, 2012). In general, the code of conduct set for Indonesian nurses are in line with standards or expectations of professional nurses in other countries, such as the Nursing and Midwifery Council (NMC) code for nurses and midwives across the UK. The NMC code prioritises nurses' professional standards with regard to clients, effective practice, the preservation of safety, and the promotion of professionalism and trust. Standards established by both entities, the INNA and NMC, emphasised professional values which must be upheld by nurses. Interpretation of the code may vary amongst nurses due to geographic or social

challenges; however, nurses must comply with these regulations and standards without compromise.

Aside from the law, Shields and Hartati's (2003) review on Indonesian nursing revealed that many nurses still encounter the perception that they are the "doctor's helper". Shields added that, compared to the United Kingdom or other developed countries, where nursing has its own autonomy and power, the hospital structure in Indonesia is mostly dominated by doctors; the structure leaves nurses with minimum power with little incentive to make changes or pursue higher education. This general overview of the conditions faced by nurses in Indonesia is similar to that pertaining to Bangladesh. Zaman's description of nurses as the 'ladies without lamps' is indicative of the values and norms of Bangladeshi nurses, who suffer from negative social images (Zaman, 2009). In both Indonesia and Bangladesh, Zaman (2009) observed that nurses spend a large proportion of their time undertaking 'paper-work' due to limited resources available in their workplaces for the completion of administrative tasks.

Having noted the limitations within the country's health system and how the nursing profession is regarded in Indonesia, the following section will begin to draw attention to emerging problems to be addressed in this research. There are several issues that might be raised in regard to nursing in Indonesia. The following brief review, therefore, explains why it is pertinent to explore nursing leadership in the country.

#### **1.4. Problem Statement**

Nursing represents a pivotal element in the Indonesian healthcare system. However, in regard to the profession's development, Lock (2011) has underlined two factors limiting the



growth of nursing in Indonesia. These significant factors are the absence of a national register or registering body and wide variations in the abilities of nurses completing their pre-service education (Lock, 2011). Registration is required to ensure that nurses are able to reach minimum standards before commencing their practice (Wellard, Bethune, & Heggen, 2007). Since such regulations are not in place, this leaves Indonesian nurses far behind their counterparts in other Asian countries such as Thailand, Malaysia and Singapore (Lock, 2011). Moreover, whilst a number of different grades of nurses are available in the country (e.g., diploma, degree level), the roles and responsibilities attached to nursing are inconsistently defined (Hennessy, Hicks, Hilan, & Kawonal, 2006a; Hennessy, et al., 2006b; Lock, 2011). A research survey conducted by Hennessy and colleagues in 2006 revealed that there is little difference in how different grades of nurses perceive their nursing roles. Despite the lack of central regulation to provide practice guidance, the nature of the nursing role is more dependent on the geographical location of practice.

The most notable consequence in regard to the aforementioned problems is a difficulty in assessing and monitoring nursing practice (Hennessy, et al., 2006a, 2006b). The dearth of national laws specifically addressing nursing responsibilities, job descriptions and competence boundaries imposes significant barriers on these nurses embarking on their journey toward professionalism (PPNI, 2012). Although criticisms of nursing practice in the country are ongoing, Hennessy and colleagues argued that attempts to tackle fundamental issues in defining nurses' professional roles and development are not being systematically addressed. While recognising that Indonesian nurses are striving for professional standards, research has emphasised that leadership is the focal point for these nurses to achieve professional

acknowledgement. However, developing nursing leaders in Indonesia is one of the greatest challenges faced by the profession. (Efendi, Kurniati, & Yeh, 2012).

There are a number of factors that interfere in the development of future nurse leaders. Miller and Cummings' recent investigation indicates the reluctance of high school students to pursue nursing as their future career (Miller & Cummings, 2009). The students perceive that nursing is not a profession in which they might practise their leadership capabilities (Miller & Cummings, 2012). Although the generalisability of the study is limited by, for example, sample and settings constraints, the study demonstrates the urgent need to improve nursing leadership at all levels.

In the case of Indonesia, nurses face a substantial dilemma. A lack of clarity in the role, job description and regulations in their own profession makes it difficult for these nurses to perceive themselves as potential leaders (Shields & Hartati, 2003). In addition, most of the available research and measurements on leadership were originally designated and developed in the Western world; the compatibility of its application in the Indonesian context requires further exploration. Recognising this gap in nursing leadership, I am drawn to undertaking an in-depth exploration of nursing leadership within the Indonesian context. This is expected to be an important step for developing the leadership and professionalism of nurses in the country. For this purpose, I chose hospital-based nurses in one province of Indonesia as the research setting. A description and overview of the context chosen will be presented in the following section.

## **1.5. The Research Setting**

The province of Aceh is located in the western part of Indonesia and has an area of 58,375,63 km<sup>2</sup> with 119 islands (Aceh, 2011). At just 125 metres above sea level, the temperature is rather high at around 25 degrees Celsius and there is 85% humidity. This region borders the Malacca Strait to the North, North-Sumatera province to the East, and the Indian Ocean to the west and south (Aceh, 2011). The population stands at 4,597,308 with a density of 79 residents per km<sup>2</sup>.

I chose the Zainoel Abidin General Hospital (ZAGH) as the site for this research principally because it is the main referral centre for health services and is also the education/teaching hospital for the province (Rumah Sakit Umum Daerah Zainoel Abidin (RSUDZA), 2012). In terms of facilities and nurse numbers, the hospital surpasses any health centres in Aceh region. In addition to this, the province of Aceh has been struggling with serious tragedies. A conflict between Aceh's armed independence movement (the GAM) and the central Indonesian administration sparked violence and insecurity for the Acehnese. The clash made the province conditions very fragile until the total meltdown caused by 2004's Boxing Day Tsunami (Cornish, 2014); The Tsunami triggered serious efforts at peace through the conduct of the 2005 Helsinki Memorandum of Understanding (MoU) signed between the armed independence movement and the Indonesian government. The peace agreement granted Aceh significant autonomy and powers in political, cultural and economic spheres (Cornich, 2014). The Syaria law is another particular aspect of Aceh. The law, which was established in 2003, acts as a code to which all Muslims in Aceh must adhere in the form of Islamic rules governing prayers, fasting, and behaviour (Newton, 2015).

The earthquake and tsunami tragedy which occurred in December 2004 in Indonesia damaged the hospital. The ZAGH suffered widespread destruction and lost a number of its operational staff (RSUDZA, 2012). During the tsunami relief efforts, mobile field units were built by German armed forces to temporarily replace the hospital buildings in order to maintain its position as the provincial healthcare service centre (RSUDZA, 2012).

In 2006, the government of Aceh together with KfW Entwicklungsbank-Germany agreed upon the total reconstruction of the ZAGH through the provision of a grant of 31 million Euros for the construction provided by the German Federal Ministry for Economic Cooperation and Development (RSUDZA, 2012). After four years, the project reached its completion in 2010. With the comprehensive improvement of the hospital design and equipment, it is expected that this hospital will provide excellent health services for the people of Aceh and beyond.

The new ZAGH has 450 beds and the current available facilities include in-patient units, an A&E (Accident and Emergency) unit, and an ambulatory care unit (RSUDZA, 2012). Notwithstanding all the physical improvements, the investment in staff competency is undeniably imperative in order to achieve quality in health services. A number of nurses, physicians and auxiliary staff have been given numerous opportunities to develop and sharpen their skills through training, field trips or staff exchange programs, both domestic and overseas; these capacity-building opportunities were also part of the disaster relief contribution program provided by donors (RSUDZA, 2012). All of the above has rendered the ZAGH distinct from other healthcare institutions in Aceh. Therefore, I consider the nurses in the hospital as the focus of this study.

The preceding sections in this introduction chapter have provided a brief overview of the nursing profession in Indonesia's health system and explained why the problems surrounding

nursing leadership in this country must be addressed in research. The following stage, therefore, is to introduce the conceptual framework used in this study. A brief explanation of the framework concept chosen for this study will be presented below. The details, however, will be addressed further in Chapter 2, the literature review.

## **1.6. Conceptual Framework**

The conceptual framework used in the study was based on the Full Range of Leadership (FRL) model initiated by Bass (Bass and Riggio, 2006). The principle of the model emphasises a range of leadership behaviours which all leaders demonstrate, incorporating elements of transformational, transactional, and laissez-faire leadership in a continuum; the measure for this range of leadership is the Multifactor Leadership Questionnaire (MLQ).

The FRL constructs four dimensions of transformational leadership encompassing idealised influence, inspirational motivation, intellectual stimulation and individual consideration (B. Bass & R. Riggio, 2006). Idealised influence typifies leaders who evoke an ideal model for followers; inspirational motivation typifies leaders who inspire followers to embrace the vision of the organisation; intellectual stimulation typifies leaders who arouse innovation and awareness and support problem-solving capabilities among the followers; individual consideration typifies leaders who enhance followers' self-esteem and act as counsellors for them.

The FRL also incorporates transactional leadership and laissez-faire leadership in addition to transformational style. This leadership behaviour involves exchange or transaction between leaders and followers as compensation for performance; this includes contingent rewards, whereby leaders provide adequate rewards for followers once the objectives are met,

and management by exception, whereby leaders leave followers to do the job and will not intervene as long as goals are achieved. Finally laissez-faire leadership regarded as the most ineffective form of leadership. Authority and decision-making are absent; the leaders avoid involvement in any process of leadership (Bass & Riggio, 2006).

The theory framework is recognised as most widely used leadership construct (Kirkbride, 2006). Its applicability across settings, particularly within healthcare and nursing fields, has been well documented. For instance, Kanste et al. (2009) aimed to examine the structure of the FRL. Their test showed that the concept can be applied among nurses, thus emphasising the universality of this construct.

By introducing the framework used in this study, together with an overview of the Indonesian context and the problems raised in this study, it is expected that this research will make a convincing contribution to the body of knowledge and amongst nurses in the country.

## **1.7. Chapter Summary**

The challenges encountered by nurses in Indonesia (e.g., resources and regulation enforcement) may influence the way they see leadership. Unfortunately, there is an extreme paucity of exploration on how these nurses perceive the leadership concept. For the purpose of introducing the research, this chapter has given a brief description of the study background and the problems noted as the knowledge gap that this research will address. The conceptual framework and the setting have also been described. The following stage is the literature review. The next chapter in this thesis provides an appraisal of the relevant literature on leadership and how the concept has evolved in the nursing field as the investigated element in the study; it will also form the basis for developing objectives for this research.

## **CHAPTER 2 LITERATURE REVIEW**

### **2.1. Introduction**

The existing literature on leadership and its nature and function within the nursing field is reviewed in this chapter. The discussion begins with an outline of our broad understanding of the notion of leadership, including an exploration of definitions, differentiating leadership and management, the theory approach to leadership, leadership from a cultural perspective and, lastly, the leadership measure. These will then lead specifically to research questions addressed in this study. In addition, an assessment of the concept of leadership in the nursing context, an analysis of nursing leadership, and a range of outcomes, perceptions of leadership and the application of leadership measures to examine nursing leadership studies will be presented.

### **2.2. Search Strategy**

The search strategy aimed to locate recently published studies in leadership. Peer-reviewed databases of CINAHL via EBSCO, MEDLINE via OvidSP, and PsycINFO were searched. Governmental databases such as NIHR and NHS publications were also explored. The review of generic leadership understanding was supplemented by literature and publications from the management and organisational leadership studies field. Meanwhile, the key search terms used to locate nursing leadership literature included the following:

- Nursing AND leadership AND perceptions
- Leadership AND nurses AND management
- Nurse leaders AND leadership
- Leadership AND Nurses AND organisation

- Nurses AND leadership AND leadership styles OR leadership behaviours
- Staff nurse AND leadership AND perceptions

In order to understand the relationship between nursing and leadership, a manual search was conducted as an additional effort to locate relevant articles. This mainly involved an examination of the *Journal of Nursing Management*, the *Journal of Nursing Administration*, the *Journal of Advanced Nursing*, and the *Leadership Quarterly* publication references.

### **2.3. Inclusion and Exclusion Criteria**

Papers included in this literature review were selected provided their abstracts and titles met the following criteria: peer-reviewed research, English language publications, discussions of nurse leaders' and/or nurse managers' leadership practices, measuring staff nurse or head nurse leadership perceptions, and identifying nurse leadership styles or behaviours and outcomes.

The setting and target participants for this current study are the hospital nurses at the ZAGH; for this reason, therefore, I had a preference for nurses' clinical leadership within hospitals as their organisations so that I would be able to identify any similarity or distinctiveness in those published studies with findings I obtained in the field. However, research from other nurses' settings, such as amongst community or public health nurses, will also be integrated as additional insight and to enrich the topic of discussion. Furthermore, in this research only quantitative, qualitative, and mixed-methods nursing leadership studies published during the past ten years were included. Nevertheless, to provide supportive literature, some earlier publications were also incorporated into this review. Grey literature was generally omitted from the search list except for governmental reports. To avoid this, reviews from major databases were prioritised to ensure the quality of the research included in this thesis. For government



reports, my main focus was on credible entities which are relevant and have a positive impact on this research. These, for example, include published reports/data from the Ministry of Health, nurses' national organisations, or the United Nations (UN).

The criteria for the chosen literatures were outlined. All of these are required in order to ensure the accuracy and significance of reviews integrated in the thesis. In the following sections, a review and evidence gathered from the literature will be presented. Definitions of leadership and how it evolved within the nursing profession will be explored further.

## **2.4. Leadership**

### **2.4.1. Leadership defined**

Although one might intuitively understand the word leadership, it can be perceived in different ways (Northouse, 2010). The concept has been investigated using a range of research methods in various contexts of groups and/or organisations; however, there is no single justification yet for a specific definition of the leadership concept on which all scholars are agreed (Bennis, 2007). There are thought to be several reasons for the ambiguity in the meaning of 'leadership' (Bass & Stogdill, 1990; Yukl, 2002). First, the way in which the term "leadership" was introduced to the scientific arena was not properly redefined. Second, leadership was used interchangeably with other terms such as authority, administration or power. Third, there are overlapping meanings of the leadership concept. Finally, each individual has his/her own perspective on the meaning of leadership; therefore, one's own definition may be disputed by someone else (Stogdill, 1974). This was confirmed by Stogdill (1974, p. 259), who stated that there were "...almost as many definitions of leadership as there are persons who have attempted to define the concept". There is common sense in these explicit reasons since the leadership

research has grown over time (Daft, 2005); this evolution continues to expand and will continue to change the meaning of leadership (Price, 2006).

A number of definitions have been introduced by scholars. A prominent leadership scholar, Bass (1990), suggests that leadership focuses on a group process; it is a matter of personality and its effects, the inducement of compliance, the exercise of influence, the involvement of particular behaviours, a form of persuasion, a power relationship, a tool to obtain goals, an effect of interaction, the initiation of structure, and a differentiated role. The suggested meaning is helpful for initiating a general understanding of leadership. However, this seems too broad to be selected as the main definition of the concept (Smith et al., 2012); a relative connection between the themes of compliance, influence, and persuasion describes a restrictive form of leadership exercise. It appears as if leadership is applied in a formal sector; meanwhile, there are many people who possess leadership characteristics as proposed above but they do not occupy a formal leadership role.

To address this deficiency, Yulk (2002, p. 3) has assessed nine definitions considered to be among the “best definitions” in the context of leadership over the past 50 years. These include the following:

- Leadership is “the behaviour of an individual...directing the activities of a group toward a shared goal” (Hemphil & Coons, 1957, p.7)
- “Leadership is exercised when persons...mobilize...institutional, political, psychological, and other resources so as to arouse, engage, and satisfy, the motives of followers (Burns, 1978, p. 18)

- Leadership is “the ability of an individual to influence, motivate, and enable, others to contribute toward the effectiveness and success of the organisation... (House et al., 1999, p. 184).

A closer look at these definitions revealed a dynamic view of the concept as time progressed. Despite the differences, communal components of leadership were described. Leadership elements encompass a person as the leader, mobilisation of a group of followers, the involvement of influence to engage others, and a shared goal.

The importance of influence, coordination, followers, and group goals components are mentioned in Vugt et al.’s definition of leadership. They define the context of leadership as an attempt to influence and persuade individuals to contribute to group goals and coordinate the effort to achieve those goals (Van Vugt & Spisak, 2008). Daft has conceptualised an almost similar construct for leadership definition. Here, it is said that leadership is an influence relationship among leaders and followers who intend real changes and outcomes that reflect their shared purposes (Daft, 2005). The exercise of influence and direction to achieve goals has also been construed by Borkowski (2005) as the meaning of leadership. Precisely, she mentioned that leadership is “a complex process by which a person sets direction and influences others to accomplish a mission, task, or objective, and directs the organization in a way that makes it more cohesive and coherent” (p. 173). These definitions emphasise that leadership is a continuous process of engaging other people in a certain direction. A person who takes the role of the leader needs to occupy people’s attention by influencing them. In other words, influence is the basis of the leader-and-follower relationship with the aim of pursuing their common objectives.

Cognisant of these multiple definitions of leadership, Bass (1990) suggests that locating a proper definition of leadership is not necessarily required, since the choice of definition is dependent on the methodological and substantive aspects of leadership in which one is interested, as well as how meaningful it is in assisting us to understand effective leadership (Yulk, 2002). Most importantly, there are several main components in defining the concept of leadership: It is a process; there is influence in leadership; it occurs in groups; and leadership involves common goals (Northouse, 2010).

#### 2.4.2. Theory Approaches to Leadership

Perspectives on the concept of leadership have changed over time. This section will draw attention to the ways in which it has been considered, focusing upon the disciplinary perspectives which have been used to inform our understanding. In early leadership development, the theories focus on leaders' behaviours and characteristics (e.g., trait theory or behaviour theory). Later on, the followers' role and the context in which leadership occurs became the main leadership theory approaches (Bolden, Gosling, Marturano, & Dennison, 2003); this is known as the new leadership model, e.g., authentic leadership, Complexity Leadership Theory (CLT) (DeChurch, Hiller, Murase, Doty, & Salas, 2010; Kao & Kao, 2007; Yukl, 2002)

Cognisant of these theories, Bass developed the Full Range of Leadership (FRL) (Bass & Avolio, 1997). The FRL encompasses three leadership styles: laissez-faire, transactional, and transformational leadership. FRL covers the whole range of views on leadership, which is its major achievement. The theory successfully provides a clear conceptualisation of the behavioural aspects of management and leadership (Bass & Avolio, 1997). In particular, it encompasses the non-leadership style, as in laissez-faire, early views on leadership where leaders offered rewards

for compliance and punishment for deviations from standards, as explained in transactional leadership, and, finally, transformational leadership which encourages employee/staff commitment through vision and personal involvement. Considering the additional value offered by this theory, I therefore chose the FRL approach as the main framework of this study. It is not only a new model of leadership but is also helpful for mapping a comprehensive picture of leadership behaviours that I believe will be appropriate for my research purposes and setting.

Prior to explaining the theory that I focus upon in the thesis, I will present an overview of some major traditional approaches to provide an in-depth understanding of leadership theories' development.

#### 2.4.2.1. Early leadership theories

Three major early leadership theories are reviewed in this thesis. They are (1) trait theory, (2) behaviour theory, and situational/contingency theory. An overview of each approach will be provided below.

##### ***Trait Theory***

Trait theory was the first prominent approach in leadership studies. There was a scholarly interest at that time in seeking determinants or factors that make certain people great leaders. The theories were later known as “great man” theories because the focus of this approach was to pinpoint the inherited quality characteristics possessed by great social, political and military leaders who were for the most part male. It was believed that great leaders were born with quality traits and, therefore, only certain people possessed them (Daft, 2005; Kao & Kao, 2007)

The strengths of the theory include its consistency with the premise that a leader is a great person who possesses quality characteristics (e.g., intelligence, integrity, determination), i.e. special attributes that cannot be seen in a non-leader. This approach is capable of highlighting how leaders and their personalities are related to the leadership process; it illuminates the characteristics required for someone who wants to be a leader (Northouse, 2012).

Despite the theory's strengths, scholars have noted some weaknesses in this approach. Among these are the following: trait theory fails to prioritise which attributes are important and which ones are not; there are no clear distinctions between the traits that might be cultivated to help someone become a leader and those that may not help with this objective (i.e., highly subjective determinations of the most important leadership traits); the theory fails to conclude exactly which attributes are required for someone to become a leader; and, since the focus of this approach is on leaders and their attributes that cannot be learned, these characteristics are therefore difficult or almost impossible to measure (e.g., leaders' loyalty, integrity, honesty) (Bolden, et al., 2003; Horner, 1997; Northouse, 2012).

### ***Behaviour Theory***

Behavior theory was developed in response to the shortfalls identified within the trait approach. This theory focuses on examining certain behaviours that can be learned in fostering a leader (Kao & Kao, 2007). Several major strengths of the theory have been cited, as follows: it has the ability to focus on leadership behaviours within studies; the approach has sound validity and credibility; the theory clearly explains leaders' behaviour focuses, which are task and relationship; this theory provides a meaningful conceptual map that has helped to broaden the understanding of leadership itself (Horner, 1997).

Although the theory has framed a better construct to understand the complexities of leadership, some weaknesses of the model have been noted. These include the following: it has failed to sufficiently address how leaders' styles are related to performance outcomes (Yukl, 1999); the approach has not been applied universally in various circumstances (Yukl, 2002); and certain leaders vary their behaviour depending on the situation because not all contexts call for a high-task and high-relationship leadership style (Yukl, 1999).

### *Situational/Contingency Theory*

As research into leadership emerged, scholarly thoughts on the concept expanded to the point that leadership style was mediated by situational factors such as culture, leader-staff relationship, or motivation. Both situational factors and contingency were developed by various scholars, but they were later combined because, conceptually, they are closely related.

The point to highlight in this theory is that leaders' leadership enactment depends upon situations (Sims, Faraj, & Yun, 2009). Several theories addressing the models include Harsey and Blanchard's situational theory (Harsey & Blanchard, 1982), Fiedler's contingency theory (Fiedler, 1964), and House's path-goal theory (House, 1971).

Harsey and Blanchard's situational theory was initiated around 1969. The theory implies that a particular leadership style will be effective in a specific external circumstance (Harsey & Blanchard, 1988). One leadership style will be effective in one situation, but when the context is different another type of leadership approach may be preferred (Sims, et al., 2009). This is similar to Northouse's assertion that different circumstances call for different leadership styles; an effective leader is the one who recognises the followers' demands and therefore strives to

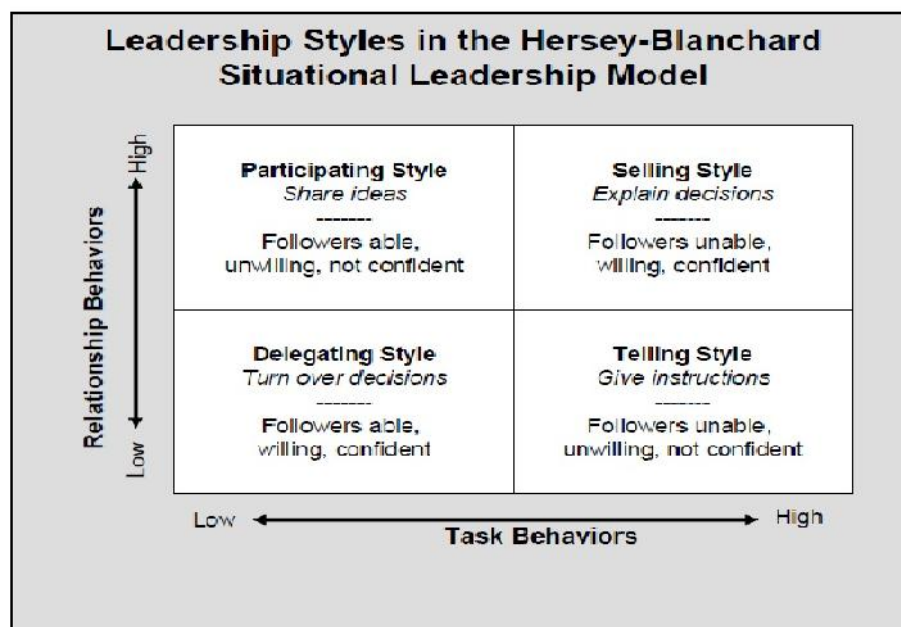
cope with the changes and adapt his/her leadership style to their needs (Northouse, 2012). In Harsey and Blanchard's theory, there are four degrees of situational leadership styles which involve task and relationship behaviours:

- Telling style (S1), high task-low relationship behaviour;
- Selling style (S2), high task-high relationship behaviour;
- Participating style (S3), low task-high relationship behaviour;
- Delegating style (S4), low task-low relationship behaviour.

In addition, theorists have defined the four follower developmental stages:

- Level 1 (unwilling and unable)
- Level 2 (willing and unable)
- Level 3 (unwilling and able)
- Level 4 (willing and able)

Figure 2.4-1 Hersey-Blanchard situational leadership model



Source: Northouse (2010)



The above description indicates that the four degrees of situational leadership styles largely rely on followers' developmental levels. For example, the telling style implies that a leader acts by giving guidance because followers at this level have low ability and low willingness (S1-Level 1); meanwhile, the degree of delegating style is exhibited when followers have strong willingness and high ability to handle the responsibility given to them (S4-Level 4). Each degree of situational leadership style enactment (S1 to S4) depends on the followers' ability and willingness or motivation (Level 1 to Level 4) (Kao & Kao, 2007).

In line with Harsey and Blanchard's proposed approach to leadership, House's path-goal theory is based on the idea that the leader's job is to help followers develop paths and ways that will lead them to achieve their objectives. The theory emphasises that a major function of a leader is to enhance subordinate expectancies and instrumentalities. These psychological states play roles in affecting subordinate satisfaction and motivation (Wofford & Liska, 1993). Leaders make their best effort to motivate followers to attain goals; House's approach to leadership therefore emphasises the provision of guidance in order to enhance follower performance and satisfaction (Northouse, 2012).

The leader's performance impacts on the group's achievement, and this common fact is largely forecast by the leader's motivational pattern. It can be said that a certain motivational pattern is the best for any group to achieve success. Fiedler's contingency theory therefore explains that leaders' effectiveness relies on the relationship between the leader and the group, the structure of the task, and the power of the leader (Fiedler, 1964). Different circumstances require different leadership behaviours, suggesting that even highly valued leadership behaviour may not be appropriate or effective under certain conditions.

In summary, leadership studies have progressed over time. Schools of thought have expanded, shifting our understanding of leadership from one based upon individual and trait characteristics to one that recognises context and leader-staff relationships. Personality dimensions as traced in traits theory rely heavily on traits and motives of leaders but fail to address environmental factors which may also contribute to their success. Regardless of whether a leader has a task-motivated or relational-motivated style of leadership, it will be of no value unless the situation matches his/her leadership style. Leaders' behaviour is largely dependent on their personalities, the situation in which they find themselves, and the type of followers (Fiedler & Chemers, 1974; Northouse, 2012)

There is no ideal leader described in the theories; however, in today's world of dynamic changes, leaders must utilise additional skills to meet complex needs. There is a growing interest in leadership approaches capable of tackling turbulent situations in organisations. Scholarly efforts to address this became fruitful by the end of the 1970s. A new model of leadership was introduced that not only explored leaders' effective performance but also extended to how leaders were capable of developing extraordinary performance, providing visionary leadership, and boosting teams' commitment to achievements with outstanding outcomes.

This novel approach to leadership was later categorised as the contemporary theory of leadership; among the proposed models is transformational leadership. This was first introduced by Burns (1978) and further developed by Bass (1985). A later achievement from the model was the development of the Full Range of Leadership (FRL) theory, which will provide the framework for this research. The following discussion will explore transformational leadership and how it evolved in the FRL. A separate discussion on the difference between transformational and transactional leadership from the perspective of the FRL will also be provided.

#### 2.4.2.2. Contemporary theory approach

Since the early 1980s, attention has shifted to the introduction of the notion of transformational leadership (Northouse, 2010), which was further developed as the Full Range of Leadership (FRL). James McGregor-Burns first introduced the term ‘transformational leadership’ (Borkowski, 2005). The popularity of transformational leadership as a new paradigm (Bryman, 1992, as cited in Northouse, 2010) attracted a great deal of research at the time. The focus on transformational leadership has continued to the present day. In particular, research has explored the extent of transformational leadership from the perspective of leaders themselves or their staff, those factors that contribute to it, and its implications for staff and organisational outcomes (G Cummings et al., 2008; Huber, 2006; Laurent, 2000).

The following discussion will provide an explanation of the FRL and transformational and transactional leadership as they are the construct elements of the model. It should also be emphasised that the thesis focuses on the FRL model because this approach is one that is available in the present day and is able to represent and assess the whole range of leadership practices, ranging from the least valued style to the most preferred one. Further exploration of the model and a justification of its suitability for this study will be provided concurrently.

#### ***Full Range of Leadership (FLR) Theory***

Burns argues that the leadership concept is based on a continuum model of behaviour (Tannenbaum & Schmidt, 1973). This means that the leadership pattern exhibited by leaders is context-specific. The leader’s personality and subordinates’ diversity or individual uniqueness are described as factors that influence how the manager and subordinates behave, while the situation is related to general organisational conditions which include internal and external

aspects of the organisation. The interdependency between all of these forces drives leaders' ways of behaviour toward their followers.

Bass expanded Burns' initial ideas on transformational leadership by emphasising the follower's needs rather than the leaders'. The aim of paying more attention to the followers can be achieved, first, by applying transformational leadership to situations where the outcomes are less desired and, second, by viewing transactional and transformational leadership as a single set of leadership approaches (Northouse, 2010); the basis is that transformational and transactional leadership are quite dependent on each other to some extent (Yammarino, 1993). Previous investigations (Bass & Avolio, 1994; Bycio, Hackett, & Allen, 1995; Hater & Bass, 1988; Howell & Avolio, 1993) added to the body of evidence on the effectiveness of single transformational leadership and its relationship to followers' satisfaction and motivation to achieve goals; however, in certain circumstances, leaders were called upon to exhibit a transactional style of leadership.

The elaboration of both the transformational and transactional leadership was pictured as a Full Range of Leadership (FLR) model. The essence of this model is that leaders behave with certain leadership styles to some extent (Bass & Riggio, 2006). FLR incorporates all four components of transformational leadership (i.e., idealised influence, inspirational motivation, intellectual stimulation and individualised consideration), two transactional leadership factors (i.e., contingent reward (CR) and management by exception active and passive (MBE-A, MBE-P)), and leaders described as Laissez-faire (LF). As this French phrase means "hands-off", it portrays leaders who ignore responsibility, have little contact with staff, and make less effort to satisfy followers' needs. This is the most ineffective form of leadership as nothing occurs within; no transaction takes place and authority remains unused. When all these factors are combined,

they comprise seven different factors from the aforementioned leadership styles (Bass & Riggio, 2006).

The FLR model illuminates individuals who represent optimal profiles of leadership and less favoured ones. Leaders who possess optimal profiles infrequently exhibit the Laissez-faire (LF) style; such people show a higher tendency to transactional leadership and largely display the transformational style. Meanwhile, a poor-profile leader most frequently behaves in ways of LF and exhibits the fewest components of transformational leadership (Bass & Riggio, 2006).

Finally, while most available research has prioritised transformational leadership over the leader-follower relationship, in some circumstances other forms of leadership such as transactional leadership can be quite effective. Walumbwa and Ojode underlined that investigations into leadership had failed to provide evidence of the superiority of either transformational or transactional leadership (Walumbwa, Wu, & Ojode, 2004). The FLR model reveals the equal importance of transactional and transformational leadership. Bass (1995) suggested that, depending on conditions, transformational leadership augments the transactional style in forecasting followers' satisfaction and performance. Transactional leadership, particularly through contingent rewards, serves as a foundation for effective leadership. In addition, the value added to transactional effectiveness and satisfaction would be greater if it were combined with transformational leadership. Below, each element of the FRL model is explained.

## **1). Laissez-Faire Leadership Style**

The term 'laissez-faire' means a "hands-off" approach which represents the absence of transactional leadership. It is the most passive form of leadership, and there is nothing going on in this style of leadership (Antonakis, Avolio, & Sivasubramaniam, 2003). Further, Antonakis et al. explained that authority is not in use; the leader provides no feedback and has no responsibility to help his/her followers.

Northouse (2010) asserted that laissez-faire is literally not a form of leadership. A hands-off leader has no concern for the followers' performance. The achievement of results is not something that he/she cares about. This leader allows the work to flow in whatever way the followers prefer, since guidance is absent.

## **2). Transactional Leadership**

Transactional leadership is based on the primary concepts of social exchange theory. The principle of social exchange is that individuals engage in interaction that involves the giving and receiving of social, political and psychological rewards; the exchange basis is to provide economic benefits to both leaders and followers. Bass and Riggio (2006) illustrate transactional leadership with reference to the politician who promises not to raise taxes should he/she be elected as a member of a house of representatives. In engaging in transaction, leaders and followers maintain the performance and reward until both parties view the exchange as no longer of value. Before the initiation of this transaction, it is necessary to assess the parties' best interests. Leaders are successful when they meet the needs of followers and utilise the rewards to motivate staff loyalty and performance; hence, this exchange creates a balanced system within an organisation (Sullivan & Decker, 2009).

Table 2.4-1 Comparison of Transactional and Transformational Leadership

Transactional Leadership	Transformational Leadership
<ul style="list-style-type: none"> <li>• Builds on man’s need to get a job done and make a living</li> <li>• Is preoccupied with power and position, politics and perks</li> <li>• Is mired in daily affairs</li> <li>• Is short-term and hard data-orientated</li> <li>• Focuses on tactical issues</li> <li>• Relies on human relations to lubricate human interactions</li> <li>• Follows and fulfils role expectations by striving to work effectively within current systems</li> <li>• Supports structures and systems that reinforce the bottom line, maximise efficiency and guarantee short-term profits</li> </ul>	<ul style="list-style-type: none"> <li>• Builds on man’s need for meaning</li> <li>• Is preoccupied with purposes and values, morals, and ethics</li> <li>• Transcends daily affairs</li> <li>• Is orientated toward long-term goals without compromising human values and principles</li> <li>• Focuses more on missions and strategies</li> <li>• Releases human potential-identifying and developing new talent</li> <li>• Designs and redesigns jobs to make them meaningful and challenging</li> <li>• Aligns internal structures and systems to reinforce overarching values and goals</li> </ul>

Source: Comparison of transactional and transformational leadership (Covey, 1992)

Table 2.4-1 presents a comparison of transactional and transformational leadership. Transformational leadership is viewed as the expansion of transactional leadership. A transformative leader attempts to focus on individual needs of followers and also pays attention to their personal development; thus, in transactional leadership, leaders and followers exchange things of value for personal advancement. Meanwhile, followers find transactional leaders influential. This is because the exchange itself is for the sake of the benefit that followers might gain by doing what the leaders want them to do (Kuhnert & Lewis, 1987).

Transactional leadership relies on the existence of contingent rewards (B. Bass & R. Riggio, 2006). These rewards might be positive or more negative active or passive forms termed Management by Exception (B. Bass & R. E. Riggio, 2006). The first constructive transaction is contingent rewards (CR). With this form of leadership, leaders attempt to obtain agreement from followers on things that need to be accomplished and what the rewards will be if they

satisfactorily complete the assignments. The agreement should be clear in terms of what “must be done” and the benefits to the followers. However, Burns highlighted research by (Antonakis, et al., 2003) whereby the act of reward exchange can be transformational if the reward form is psychological, such as praise. The next type is management by exception (MBE). This form of leadership entails corrective criticism, negative feedback, or negative reinforcement. It has been found to be less effective than contingent rewards and transformational leadership. In conducting it, leaders who actively exhibit management by exception (MBE-A) are those who directly monitor followers for any errors or rule violations and then take corrective action. The MBE-A is highly applicable and effective if it is within the conduct of safety procedures. Meanwhile, the passive side of management by exception (MBP-P) involves leaders who intervene after problems have been found and then follow up with a disciplinary process. This kind of leadership is considered helpful for supervising huge numbers of subordinates who directly report to the leaders.

### **3). Transformational Leadership Style**

In examining leadership models, Burns conceptualised two types: transactional and transformational (B. Bass & R. E. Riggio, 2006). Transactional leadership emphasises the social exchange that benefits the relationship between leader and follower. The range of theories that have applied the concept of transactional relationship include Fiedler’s contingency model, path-goal theory, dyad-linkage theory, and the Vroom-Yetton theory (Wofford & Goodwin, 1994). While there is a ‘give and take’ opportunity in the transactional model, the transformational leadership model emphasises intrinsic motivation (Bass & Riggio, 2006) and the charismatic and affective aspects of leadership (Bryman, 1992). Transformational theory underlines interpersonal



relationships rather than social exchange to transform and achieve change in organisations and human services. Within this approach to understanding leadership, leaders and followers merge their interests and values to attain common goals. The principle of being a transformative leader is to encourage the staff's commitment rather than focusing on individual self-interests. A transformative leader engages with others and through this connection raises motivation and morality for leader and followers; this leader is highly attentive to followers' needs and attempts to enable followers to reach their fullest potential (Northouse, 2010). Transformational leaders are defined as "value-driven change agents who make followers more conscious of the importance and value of task outcomes. They provide followers with a vision and motivate them to go beyond self-interest for the good of the organization" (Borkowski, 2005, p. 211).

According to Bass and Avolio (Bass & Avolio, 1994), there are five critical strategies in transformational leadership performance: first, idealised influence that incorporates employees' pride in vision and mission; second, leaders' behavioural influence on employees in exhibiting vision and mission; third, inspirational motivation; fourth, intellectual stimulation; and, fifth, the leaders' individualised consideration expressing appreciation when goals are achieved.

These significant strategies allow leaders to promote a constructive atmosphere by valuing staff involvement in the organisation (DeGees, Claessens, Longrich, & Schubert, 2003; Upenieks, 2003). Idealised influence describes leaders as role models for followers (DeGees, et al., 2003). DeGees and colleagues (2003) emphasise that this approach provides vision and generates trust and strong emotional attachment between leaders and followers; these leaders are highly respected by followers because of their capabilities and determination and can be counted on to do the right things. Furthermore, through inspirational motivation, transformative leaders

attempt to clearly communicate high expectations to followers (DeGees, et al., 2003). By motivating and inspiring followers, leaders raise team enthusiasm and commitment to meet organisational goals; inspirational motivation also plays a key part in lifting team spirit in the organisation (Bass & Avolio, 1994). Together with intellectual stimulation, it is also argued that transformational leadership promotes innovation and creativity, discourages a blame culture and raises consensus in responses to problems (Bass & Avolio, 1994). More recently, Bass and Riggio (2006) have argued that transformational leaders recognise the uniqueness of team members (B. Bass & R. Riggio, 2006). The significance of coaching and mentoring as a feature of transformational leadership has also been noted (B. Bass & R. Riggio, 2006; Northouse, 2010).

Regardless of the strengths of transformational leadership, this model has attracted several criticisms. The main criticism is that it has conceptual ambiguity. The characteristics of 'change agent', 'nurturing vision' and 'motivation' cause difficulties in defining the parameters of transformational leadership. The four major concepts demonstrate substantial overlaps and lack clarity and scope within each dimension (Yukl, 1999). Other weaknesses are related to the elitism that may be displayed by transformational leadership. The roles of change agent and advocator of new directions give the impression of a "one-man show" within a leader-and-followers relationship; apparently, it shows a leader who is acting independently of followers or putting him/herself above followers' needs (Northouse, 2010). In addition, transformational leadership may exhibit a heroism bias (Yukl, 1999). The emphasis on the leader's role as one who elevates followers to move beyond expectations provides the basis for an explanation of the failure of transformational leadership to explain the reciprocal influence between leaders and followers. In leadership, leader and follower are like the two sides of a coin, with mutual

influence occurring between them. Finally, the new vision and values that emerge under transformational leadership may not be superior to previous ones, leaving leaders and followers unable to decide which direction is better (Northouse, 2010).

The above explanation presented critiques of several leadership theories starting from the early time to a new comprehensive approach such as Full Range Leadership (FRL) theory. Considering strengths and limitations on each theory, the FRL approach is much highlighted in here. The theory considered as an approach that compatible with current world condition. Bass (1999) has asserted that with turbulence in market place and workforce resulted the urge for more transformational leaders and less transactional leaders if they are to remain effective. Within academic discussion, scholarly attention on the theory has also made the FRL becoming the focus of research in the last two decades. As a theory model, this approach offers a universal leadership model which claimed to be fit with various settings. In addition to this, the FRL theory has a specific instrument, the MLQ survey. The survey tool frequently assessed and studied on leadership research. In cognisant of these reasons, it suggests the FRL approach and its measure is appropriate to be applied in this study to explore nursing leadership in Indonesia. Studying the nursing leadership in an Indonesian context will extend the body of knowledge and contribute to an increased understanding of nursing leadership amongst Indonesian nurses.

Most related leadership theories have been discussed in this section. Thus, justifications on the chosen framework for this study are also stated. However, discussion on differentiating between leadership and management is needed since both terms are debatable in most cases. The following section will explore this in detail.

### 2.4.3. Distinguishing between leadership and management

Identifying the difference between leadership and management remains an on-going debate (Yukl, 2006). This confusion is mainly associated with the overlapping functions of leadership and management; both roles are often executed at the same time or even defined interchangeably. In spite of the controversy, Sullivan and Decker (2009) have suggested the line between the two terms. Leadership involves a leader who influences others to achieve specific aims. Leaders have the capacity to empower, motivate, and boost others' energy to commit and put forward their best efforts to attain organisational goals. A manager, on the other hand, is one who carries responsibilities related to the position assigned to him/her. A manager is employed by an organisation to ensure that the organisation accomplishes its goals efficiently (Sullivan & Decker, 2009).

Kotter (2001) has underlined that the leadership function is about preparing organisations for change and coping with it. In leading change, the leader establishes a direction, empowers people, and motivates and inspires them to pursue the vision. Interestingly, he emphasises that these leadership characteristics have nothing to do with exotic personal traits; they are merely a system of action that is necessary for success. However, in order to achieve this success, good management is pertinent to help the organisation cope with complexity. Coping with complexity involves interrelated roles of planning, organising, motivating, controlling and problem-solving (Kotter, 2001). These core functions of management are coherent (Harsey & Blanchard, 1988). Planning is the initial task in setting goals and objectives for the organisation and in developing ways to achieve them. The next step is to gather all potential resources and organise them in the most effective way to achieve the goals. Planning and organising must be combined with motivational efforts, which will largely determine the level of employees' performance in order

that the organisation might accomplish its goals. Motivation usually involves directing, communicating and leading. Finally, controlling involves the evaluation of results and follow-ups to compare outcomes with set plans in order that appropriate adjustments of actions might be made (Harsey & Blanchard 1998).

The opinions set out above reveal that the role of leadership is to develop mutual purposes with followers to create change, while management is more about coordinating people and actions to accomplish a task (Rost, 1993). It is clear that leadership and management have their own functions and distinctive roles but they are complementary as variables for success; strong leadership with weak management will not succeed. These two systems must be used in a balanced way (Kotter, 2001).

The review of FRL and its leadership elements as the theory in this research has been presented. The next step is to investigate leadership involvement within nursing, why it is important in this profession and what research had revealed on nurses' perceptions of leadership.

## **2.5. Nursing Leadership**

The constantly changing healthcare environment and turmoil in the hospital setting regarding technology, safety, costs, and labour issues have had a major impact on the current nurse workforce concerns; in this complex system, there is a demand for well-qualified nurse leaders (Porter-O'Grady, 2011). The emerging role of leadership in healthcare has been discussed in the nursing field as a succession factor for organisations (Sullivan & Decker, 2005). Here, it is suggested that nursing leaders have the capacity to empower, motivate, and boost others' energy to commit to and put their best efforts into achieving organisational goals. A nurse leader

embraces a huge determinant function to achieve group consensus and structure to accomplish organisational aims, alongside the provision of guidance for the group, maintenance of group satisfaction, and the development of cooperation and performance (E. J. Sullivan & Decker, 2005)

Leadership is a process; it involves influence, it occurs in groups, and there are common goals (Northouse, 2010). These concepts are all applicable to nursing leadership in that nurses hold the key to enhancing patients' and organisational outcomes and exert an influence in driving the organisation towards the desired objectives (Jones & Gosling, 2005). However, in order to gain leadership capabilities, Jones argues that it is imperative that nurses first view themselves as leaders and have the competency to lead. These competencies exist in a continuous process of learning which can be obtained through personal education, experience, and working closely with expert mentors (Jones & Gosling, 2005).

#### 2.5.1. Nursing leadership and the range of outcomes

Nurses work closely with patients. This opportunity puts the nurses in a position where their perspective must be voiced to help shape policy and ensure the highest quality of care (Hancock, 2014b). The notion of leadership style in nursing and the ranges of outcomes are well documented (AbuAlRub & Alghamdi, 2012; Cowden, Cummings, & Profetto-McGrath, 2011; Suliman, 2009). The scope of leadership influence was found to be a positive determinant of patient outcomes and quality of care (G Cummings et al., 2010; Spence Laschinger, Wong, & Grau, 2012).

In supporting the above statement, Sammer and colleague's investigation highlights that nursing leadership is one of the major variables in facilitating a safety culture at the unit level.

They underlined that the achievement of safety itself cannot be completed without recognising the involvement of nurse leaders at all levels (Sammer & James, 2011). Although future testing of leadership models that examine the mechanisms of influence on outcomes is warranted, scholars documented a positive relationship between relational leadership and a variety of patient outcomes. This current evidence suggests relationships between positive relational leadership styles and higher patient satisfaction and lower patient mortality, medication errors, restraint use and hospital-acquired infections (Wong & Cummings, 2007).

Recognition of these significant roles of leadership in nursing demonstrates that it is important to develop such skills within the profession. The investigations and studies I have presented help to assert that nursing leadership is one of the leading facets for organisational change and improvement of outcomes. The following discussion will explain further upon the role of leadership within nursing profession.

### 2.5.2. Why Leadership in Nursing?

It has become apparent that nurses' working conditions remain a challenge faced by current healthcare systems. The shortage issue, the difficulty of retaining and attracting nurses, and staff burn-out are examples of the problems surrounding the nursing profession, which have nearly always been mentioned as the problems to be resolved (Wong et al., 2013). Identification of fundamental factors related to these principal dilemmas has shown that management behaviours and leadership styles are strongly connected to staff members' intentions to leave or stay in the organisation (Force, 2005). Evidence of nursing leadership practices and their impacts on the profession are well reviewed (Chiok Foong Loke, 2001; Fallis & Altimier, 2006). For instance, studies have shown that leadership has a direct influence on staff satisfaction,

performance, and intentions to leave (Medley & Larochelle, 1995; Robbins & Davidhizar, 2007; Spence Laschinger, et al., 2012).

Among the noted studies on nursing leadership, Cummings and her colleagues (G Cummings, et al., 2010) have provided some of the strongest evidence available to date that emphasises the influence of leadership on the nursing workforce. The purpose of this meta-analysis by Cummings et al. (2010) was to systematically review and synthesise findings about the relationship between leadership styles and outcomes for the nursing workforce and the environment. This research was also intended to analyse claims that relational or people-focused leadership behaviour resulted in more positive personnel outcomes than task-focused leadership. The independent variable stated was various styles of leadership. The nursing workforce (e.g., staff job satisfaction, wellbeing) and the working environment were the outcome variables. The researchers presented adequate discussions of previous studies to support the phenomena of leadership approaches and nursing workforce outcomes. The conceptualisations of leadership definitions and their elements were also described.

Inclusion criteria for this review were published studies in English, peer-reviewed, measurement of manager leadership practices, and research that examined leadership behaviours and outcomes for nurses and organisational work environments. Quality assessment, data extraction and analysis were completed on all research included in the review. The keywords used to locate studies published between 1985 and May 2009 were as follows: leadership, research, evaluation, and measurement.

The investigators utilised a quality assessment and validity tool for correlational studies. This indicator was applied in several previous systematic review research papers. The adapted tool was used to examine four areas of each study: (1) study design, (2) sampling, (3)



measurement, and (4) statistical analysis. Via content analysis, leadership outcomes were categorised into five premises: (1) staff satisfaction with work, role and pay, (2) staff relationships with work, (3) staff health and wellbeing, (4) work environment factors, and (5) productivity and effectiveness.

After final selection, 53 studies were identified that examined relationships between nursing leadership and outcomes for the nursing workforce and work environment. The majority of the studies were conducted in the United States. Nursing job satisfaction was the most frequently examined leadership outcome. In particular, 22 studies found that the highest job satisfaction was correlated with relational-focused styles, i.e., transformational leadership. The rest of the studies reported leadership outcomes such as staff relationships with work, staff health and wellbeing, and work environments.

Although this study comprehensively reviewed leadership behaviour and the nursing workforce, certain factors may have distorted the validity of the findings. There may have been reporting bias because the study included published and quantitative studies only. Published research may tend to over-report positive findings. All of the 53 studies mainly used correlational or survey study designs; quantitative design is the most frequently used methodology in the field of nursing leadership. In addition, almost all the studies utilised different variable measurements. The MLQ is among the most used leadership tools, but other measures were also applied. Thus, the various leadership and outcome measurements may limit the validity and generalisability of the findings. Overall, a discussion of the implications of the findings for the nursing workforce and environment, leadership theory, future research, and translation of evidence into practice was also provided. The review resulted in a firm recommendation on the need to encourage and develop leadership competency to improve

nurses' outcomes.

In the light of this review, Germain et al. (2010) conducted a comprehensive analysis of leadership factors that influenced nurses' performance. Eight studies were screened by a robust tool for quality assurance. The analysis output reported 25 factors that have an impact on performance. These factors were compiled into five categories: (1) leadership practices, (2) individual nurse characteristics, (3) access to resources, (4) relationship building, and (5) autonomy. Among these, effective leadership was highlighted as the crucial factor in nursing performance and organisational objectives. Person-centred leadership is greatly preferred as a booster for a positive workplace environment. The researchers finally debated the reciprocal benefits of developing effective leadership; here, it was concluded that organisations that pay rigorous attention to exploring effective leadership styles tend to have committed and high-performing employees (Brady & Cummings, 2010).

The identification of leadership in nursing was further noted as a key factor that offers possible solutions to workforce issues at the Magnet-certified institutions. The Magnet Recognition Program (MRP)<sup>®</sup> is the highest level of certification for healthcare organisations in recognising their excellence in nursing practice (Morgan, Lahman, & Hagstrom, 2006). The underlying assumption of the Magnet designation is to offer a potential solution to the nursing shortage by attracting and retaining nurses in all healthcare settings (Brady-Schwartz, 2005). In 2005, the 14 forces of magnetism were identified: (1) quality of nursing leadership, (2) organisational structure, (3) management style, (4) personnel policies and programs, (5) professional models of care, (6) quality of care, (7) quality improvement, (8) consultation and resources, (9) autonomy, (10) community and the healthcare organisation, (11) nurses as teachers, (12) the image of nursing, (13) interdisciplinary relationships, and (14) professional

development. These forces are considered the primary elements that promote professional and exemplary nursing practice. By 2007, the 14 forces of magnetism (FOM) were condensed into a new model perspective. Each aspect of the FOM was categorised within the appropriate empirical domains of evidence, resulting in five magnet model components. The model components are as follows: (1) transformational leadership (derived from quality of nursing leadership and management style forces); (2) structural empowerment (derived from organisational structure, personnel policies and programs, community and the healthcare organisation, image of nursing, and professional development forces); (3) exemplary professional practice (derived from professional models of care, consultation and resources, autonomy, nurses as teachers, interdisciplinary relations, quality of care, and quality improvement forces); (4) new knowledge, innovations, and improvements (derived from quality of care, and quality improvements); and (5) empirical quality outcomes (derived from the quality of care force) (ANCC, 2008).

Together with influential leadership, the magnet environment structures flexible and decentralised governance. The environment develops nurses' involvement in decision-making in order to expand their contributions to professional growth and partnership with all community groups. The process and structure used to achieve structural empowerment by the organisation should demonstrate professional engagement, development and recognition of nursing (ANCC, 2008).

In recent years, the model has been applied broadly worldwide (Kelly, McHugh, & Aiken, 2011). More health institutions are now obtaining their certification or are on their way to making the magnet journey. The role of nursing leadership and outcomes are the main focus of its approach; this has been concluded in several comparative studies. In an earlier study by

Upenieks (2002), for example, the author determined that differences in nursing outcomes in magnet and non-magnet hospitals were linked to nursing leaders' leadership behaviour, which was related to how visible and responsive the leaders were to their staff.

A convenience sample of two magnet and two non-magnet hospitals was used in the study. After obtaining a list of magnet facilities from ANCC, two magnet hospitals were approached and found willing to participate. The non-magnet hospitals were obtained from the American Hospital Association (AHA) Annual Survey of Hospitals. These hospitals were also selected based on their willingness to participate. Both magnet and non-magnet facilities were selected from the same geographic area and had similar characteristics, e.g., bed numbers, and non-profit status. Of the seven non-magnet hospitals that were approached, five declined and two agreed to participate.

All medical-surgical registered nurses from the four hospitals were invited to participate. Of the 700 questionnaires that were distributed, 305 nurses returned usable questionnaires. The return rate was 44%. The number of participants from the magnet hospitals was 144, and from the non-magnet hospitals the sample was 161. The participants were aged 40 to 49 years. In addition, among the nurses in the magnet hospitals, 52% had graduated from baccalaureate nursing programs compared with 31% from non-magnet hospitals. The nurses in magnet facilities had 0-5 years' more experience than those in non-magnet hospitals. In the data analysis, the total mean for nurses at magnet hospitals was 143.75, while for non-magnet hospital nurses the mean was 125.33. The mean difference was significant at  $p < .001$  ( $t = 6.02$ ). The mean score of the magnet hospitals was higher on all six subscales compared to the score of the non-magnet hospitals. The data showed that nurses in magnet facilities had higher job satisfaction because they had better relations with physicians, more autonomy, and more control

over their practice environments. In addition, the greatest mean difference between nurses in magnet and non-magnet hospitals was in organisational structure. Clinical nurses in magnet facilities perceived that they were receiving greater support from their administration, had an enhanced self-governance structure, and received more educational opportunities. This finding indicates that magnet hospital leaders exhibited greater visibility and responsiveness to staff concerns and patient care delivery issues (Upenieks, 2002).

In a subsequent study, Upenieks conducted a triangulation analysis to examine whether magnet hospitals were still able to provide a higher level of nursing outcomes compared to non-magnet hospitals (Upenieks, 2003). Moreover, the relationship between leadership effectiveness demonstrated by nurse administrators, directors and managers and the level of nurses' job satisfaction in both magnet and non-magnet facilities was also assessed. Triangulation analysis was used to enhance the quality of the study. Upenieks combined quantitative and qualitative research methods to reveal a more comprehensive understanding of the measured association between variables. A total of 700 self-administered questionnaires were distributed. The return rate was 44%, with 305 nurses returning usable questionnaires. For qualitative analysis, the sample population consisted of 16 nurse leaders from the same four hospitals. Seven leaders were from magnet institutions, and nine were from non-magnet hospitals. The analysis demonstrated that nurses in magnet hospitals received greater support from administration than non-magnet hospital nurses. The leaders in magnet institutions were more visible compared to those in non-magnet hospitals. Nurses' opportunity for advancement was also higher in magnet hospitals. The investigator concluded that differences in outcomes (e.g., satisfaction) in the two types of hospital were due to differences in leaders' actual visibility, support and responsiveness.

A decade later, the claims about nurses' outcome differences between magnet and non-magnet designated institutions were revisited by Kelly et al. (2012). This time, the researchers mailed a survey to a population of nurses in different work regions. The sample included 567 hospitals, 46 of which were magnet-certified. In these participating hospitals, 4,562 nurses working at magnet hospitals and 21,714 nurses working at non-magnet hospitals were surveyed. The response rate was very good, at 86%. The variables measured were nurse characteristics, staffing, work environment, education, hospital characteristics, and outcomes (e.g., burn-out, job dissatisfaction and intention to leave). Analysis of variables was consistent with other substantial evidence showing that magnet hospitals have better work environments and much better nurse outcomes.

As Kelly et al. had emphasised, the application and value is retained in the Magnet certification program spread across countries. In Indonesia, for example, the MRP was integrated in nursing but in the implementation form of the Professional Nursing Practice Model (PNPM). PNPM is in line with MRP; it is a system (structure, process, and professional values) that enables professional nurses to manage delivery of nursing care and a supportive work environment (Storey et al., 2008). Although PNPM is not yet widely employed across nursing centres in the country, its implementation has been recognised as a strategy for enabling hospitals to improve the quality of nursing care in Indonesia (Sitorus, Hamid, Azwar, & Achadi, 2012).

### 2.5.3. Perceptions of nurse leadership

The evidence reviewed above is part of a number of studies that confirm the importance of the leadership role in nursing and that the work of nurses is influenced by their leadership.

This emphasises that staff nurses' and leaders' leadership are assets to health organisations; to maximise their potential, it is essential for healthcare institutions to address their points of view in any organisational aspects. These views must be recognised, appreciated, and aligned with organisational objectives (Sullivan & Decker, 2009).

To emphasise how leadership aspects affect nursing performance and outcomes, recent studies have identified the importance of examining the views of leadership from the nurses' perspective (Cummings et al., 2010; Eneh et al., 2012). In Eneh et al.'s study, a sample of 1,497 Finnish nurses was surveyed to identify their perceptions of leadership. It was found that 70% of the nurses expressed positive views on leadership; in particular, managers who had closer interactions with staff were rated more positively than those who were less supportive. Although the measure used lacks a validation report and the response rate for the survey was extremely low (26.4%), the study emphasises that exploring leadership from the nurses' perspective lays the foundation for the organisation to further understand how their nurses see leadership. Thus, this is the essential information that will help to design the development plan required for leadership enrichment for nurses. Attempting to identify nurses' perceptions of leadership using a survey design may not have fully captured nurses' views and the findings may lack generalisability (Eneh et al., 2012). However, the study provides a generic conclusion as an evaluation road map as well as for institutional reflective action. With more rigorous research in this area, it is expected that nursing leadership at every management level will flourish and the nurse leaders, in particular, will pay more attention to regularly assessing their leadership capability to improve outcomes.

Another interesting point to note in the nursing leadership literature is that there are certain factors that contribute to the way nurses perceive leadership. Nurses from different age cohorts,

for instance, may differ in how they perceive leadership (McNeese-Smith & Crook, 2003). The nursing workforce is composed of four generational groups: the veterans (i.e., those born between 1925 and 1945), the Baby Boomers (born between 1946 and 1964), the Gen-Xers (1965-1980) and, lastly, the millennial generation who were born after 1980 (Hu, Herrick, & Hodgins, 2004). These nurses were born and raised in different eras. These age cohorts vary in terms of economic, social, and political conditions, which may have shaped nurses' patterns of thinking and behaving and their views on work and authority (Hu, et al., 2004; Kupperschmidt, 2000). Apart from the era in which the nurses grew up, the hierarchy effect on leadership perception was also noted. Research showed that staff nurses and managers have different conceptions of leadership. Sellgren (2006) highlighted that there were differences in opinions on preferred leadership styles; for example, staff prefer leaders who are more expressive in their leadership behaviour than the leaders themselves prefer and demonstrate (Sellgren, Ekvall, & Tomson, 2006).

In the light of the nursing leadership perspective, it was highlighted that all nurses have the potential to be leaders, but waiting for a leader to appear from the crowd is fruitless. It takes effort from the organisation to develop the potential in nurses and prepare them to be future leaders (Hancock, 2014a), and attempts to locate and nurture potential leaders are meaningless if nurses themselves are not challenged to become involved in leadership roles. Hancock (2014) and Wong et al. (2012) state that nurses may have certain concerns that will hinder attempts to encourage them to embark on leadership. Wong et al. (2012) conducted an analysis of 18 focus groups with 125 staff nurses and managers in four regions across Canada. The analysis revealed that the factors that influence nurses' perspectives on pursuing leadership roles (e.g., management positions) were personal demographics and disposition, and situational attributes.



Demographic characteristics included age, years of experience and life circumstances; personal disposition involved skills, intrinsic rewards, and professional commitment. Meanwhile, situational factors encompassed leadership development opportunities, manager role perceptions, and the presence of mentors. Age was the most commonly perceived factor in the personal demographic theme that influenced nurses' decisions to pursue leadership roles. The younger nurses expressed a greater willingness to take on leadership challenges compared to the more experienced ones because the older nurses believed that it was too late for them to apply for the positions. However, all the nurses agreed that interpersonal skills are pertinent to effective leadership. Intrinsic rewards (e.g., autonomy), skills and commitment were all seen as positive factors in embarking on a management role. In the meantime, organisational factors are no less important. This is categorised as a situational theme. Situational factors represent vital strategies that will facilitate nurses' aspirations to leadership commitment.

Apart from the factors described above and in recognition of the importance of exploring leadership from the nurses' perspective, cultural differences are among the ultimate factors that should be considered in producing effective nursing leadership (Lu et al., 2002). It has been argued that leadership might be seen as an imported concept for Asian organisations from a Western point of view (Su, Jenkins, & Liu, 2012). For example, studies have shown that Western types of leadership are not suitable for application to Chinese hospitals. However, there is limited evidence from either Western or Eastern research on leadership in hospitals from the nurses' perspective (Su et al., 2011). Similarly, evidence on how leadership evolves amongst nurses in Indonesia is also rather limited, thus indicating the need to explore this concept further.

I have attempted to explore leadership evolution within the nursing field. In the meantime, I recognise that there is a need to expand my knowledge and critiques on leadership from

contextual and cultural perspectives. This will provide a deeper understanding of the influence of contextual and cultural matters on leadership as well as exploring the comprehensive elements that may influence nursing leadership perceptions and behaviours in the country. The following discussion will explore this culture and context view in more detail. However, prior to that, I will present a brief discussion on how to differentiate between leadership and management behaviour. This is significant for an understanding of the distinct roles they might have, some of which overlap; this will be followed by a review of the cultural aspects.

#### 2.5.4. Leadership: Context and culture

While there is a tendency for Western-based research on organisations and leadership to dominate the literature, Hofstede (1980) raised the notion that values gained from those studies may not fit within other cultures and environments. Hofstede defined culture as the collective mental programming of the people in an environment. People share common values with members of their own group (Hofstede, 1980). According to his analysis, there are four domains that differentiate cultures across societies; these are power distance, uncertainty avoidance, individualism-collectivism, and masculinity-femininity. These cultural domains were determined through a combination of theoretical reasoning and statistical analysis. A large survey was administered over six years in a single, large, American-based multinational corporation in 40 countries.

Despite scholarly criticism of this opinion (Day & Antonakis, 2011), Hofstede's investigation of culture is highly regarded within the field of leadership and culture studies (Northouse, 2010). Culture adds complexity to the study of leadership but it is imperative for understanding the field (Dickson, Den Hartog, & Mitchelson, 2003). The majority of leadership

scholars have noted that the diversity of cultural values underlies differences in the perception of leadership (Wendt, Euwema, & van Emmerik, 2009). Different settings, ethnic composition, demographic, social, political and economic characteristics, and organisational functions may contribute to the perception of leadership competency. (Moe, Pappas, & Murray, 2007; Takahashi, Ishikawa, & Kanai, 2012; Wang, Chontawan, & Nantsupawat, 2012).

It has been asserted that differences in context may influence leaders' behaviour (Antonakis, et al., 2003). Evidence has supported this argument by showing that there is no single prototype of leadership that fits all situations (Lord, Brown, Harvey, & Hall, 2001). A certain leadership style can be interpreted differently in other contexts due to cultural influences within the observed society; for instance, leaders' sensitivity is perceived as weak leadership behaviour in a culture that strongly prefers an authoritarian style. However, this same sensitivity is likely to be an essential leadership attribute in a culture that places high value on a nurturing style of leadership (Bass & Stogdill, 1990; Hofstede, 1993).

Following the arguments on cultural effects on leadership, Yukl (2002) argued that most leadership studies were conducted in the United States or Europe (Yukl, 2002). This, therefore, tends to show a bias towards theories or research on leadership that have a North American character (House, 1995), such as a tendency towards individualistic rather than collectivistic behaviour, or prioritising rationality over religion or superstition (Sternberg, Antonakis, & Cianciolo, 2004).

Amongst the strongest evidence to date on the importance of researching culture in relation to leadership in a larger context is that presented in the GLOBE (Global Leadership and Organizational Behavior Effectiveness) study (Northouse, 2010). The primary aims of this study are to identify universal and culturally-derived leadership attributes and behaviour in multiple

countries. This global research was initiated around 1991 by Robert House. Since then, it has expanded into a multi-phase program, in which more than 170 principal investigators from more than 60 countries were selected as the best representatives of all nationalities to collaborate in investigating relationships between societal culture, organisational culture and practices, and organisational leadership (Den Hartog, House, Hanges, Ruiz-Quintanilla, & Dorfman, 1999). Data were collected via surveys, unobtrusive measures, interviews, media analysis, and archival material, mostly from the United Nations (Dickson, et al., 2003).

Project GLOBE described 64 nations' cultures, based on nine domains, several of which derived from Hofstede's cultural analysis (Dickson, Castaño, Magomaeva, & Den Hartog, 2012). These are as follows: performance orientation, future orientation, assertiveness, power distance, humane orientation, institutional collectivism, uncertainty avoidance, and gender egalitarianism. An additional strategy applied to examine cultural differences in the GLOBE project is culture clusters. This approach assesses differences between cultures in general and the uniqueness of each culture, and it can be used to examine similarities between some societies and certain values that are acceptable across a group of nations. Project GLOBE categorised ten clusters based on an analysis of more than 60 countries and none of them has an independent cluster or classification; among these are sub-Saharan Africa, Confucian Asia, Southern Asia, Latin America, Anglo, Eastern Europe and Latin Europe (Dickson, et al., 2012).

The findings of the GLOBE project emphasised that the value of leadership varies across the culture of regions. The status and influence of leaders depends heavily on the cultural forces to which they belong (House, Hanges, Javidan, Dorfman, & Gupta, 2004). For example, a combination of family and tribal norms produces an authoritarian style of leadership in Arab countries. In another example found in the study, participative leadership had positive effects in

the United States and South Korean cultures; however, in societies such as Mexico and Taiwan, directive leadership is much preferred.

Beyond countries and continents, the complexity of culture is inseparable with professionals leadership practice. In nursing context, for instance, scholars have acknowledged that practice settings influence leadership of the nurses. The diversity within nursing setting may encompass relationship between leader and staff, educational opportunity, or autonomy (G Cummings, et al., 2008). It has been reported that nurses self efficacy in leadership behaviours would elevate when nurses in the practice given more opportunities to observe, model, and practice leadership behaviours (Jenkins & Ladewig, 1996). However, in the setting where social emotional leadership is lacking, leaders' leadership effectiveness is likely to get lower because staff nurse had less contact with the leader.

Scholarly critiques on the contextual and cultural phenomena of leadership have been presented. It is clear that the factor of the environment where the leadership is being practised and the norms being upheld influence leadership behaviours. Certain leadership values that are highly regarded in some cultures may not receive similar appreciation if applied in other contexts. There is certainly nothing wrong in labelling behaviours for a specific type of leadership; however, there is a likelihood that, in other contexts, that particular leadership style will be exhibited in different behaviours. For example, although the universal concept of transformational leadership may be valid, Bass states that the enactment of this leadership style may vary among societies; this means that this shared preference for transformational leadership attributes will not be expressed in the same way (House, et al., 2004).

Leadership definitions, relevant theories and leadership's evolution in nursing as well as in cultural aspects have been reviewed. The next section will introduce the theoretical framework for this research.

#### 2.5.5. Theoretical framework for this research

Evidence has revealed the existence of transformational leadership and its positive outcomes in many countries. Universal leadership characteristics can be viewed as common principles of leadership and values among diverse people (Day & Antonakis, 2011). I have gained the understanding that since transformational leadership was introduced it has shifted existing contexts of leadership which primarily focused on leaders' personal characteristics or leaders' rewards and punishments to a focus on how leaders elevate followers' motivation to produce better performances for the sake of organisations. Thus, although transformational leadership is strongly preferred, the presence of earlier leadership values is undeniably important in certain circumstances. In cognisance of this, the FRL elaborates transformational leadership and existing leadership approaches (i.e., labelling as transactional leadership) on the same plate. They are different from but complementary to each other. The leadership scope in the FRL covered comprehensive leadership elements ranging from the highly inactive and ineffective laissez-faire leadership to highly effective and influential transformational leadership.

Reflecting on this perspective, I found that the application of the Full Range of Leadership (FRL), which encompasses the whole range of leadership (i.e., laissez-faire, transformational and transactional leadership), suits the main purpose of the study, which aims to explore nursing leadership in Indonesia. FRL is the approach that in the present day is able to integrate, with a clear conception, management behaviours (labelled Transactional Leadership)

and Transformational Leadership which incorporates charismatic and visionary leadership.

In order to identify the preferred leadership style within the FRL framework approach, a measure had been designed specifically for this purpose. It is the Multifactor Leadership Questionnaire (MLQ). The measure was developed by Bass (1995). The instrument is widely applied to measure the leadership range and is applicable to organisations (Tejeda, Scandura, & Pillai, 2001) including those in the nursing field (Kleinman, 2004). The MLQ has been used extensively in multinational contexts such as in Western countries (e.g., the United States, Great Britain, Canada), European regions (e.g., Belgium, Germany, Switzerland), Australia, and Asia (Middle East, China, Malaysia and Korea) (B. Bass & R. E. Riggio, 2006). On the basis of this review, the MLQ is the measure applied in this research setting. Its application in examining nursing leadership perspectives in Indonesia is extremely limited. The use of the FRL together with its specific measure, the MLQ, will therefore help to explore leadership in an Indonesian nursing context, embodying leadership perspectives among Indonesian nurses.

The following discussion will provide a review of the MLQ as the measuring instrument in this study. To gather a comprehensive knowledge of this specific field, several critiques of its applicability across cultures will also be explored.

#### 2.5.6. Multifactor Leadership Questionnaire (MLQ)

Whilst recognition is given to the equal importance of both transactional and transformational leadership, a number of instruments have been developed to measure leadership. These include the Multifactor Leadership Questionnaire (MLQ), Transformational Leadership Inventory (TLI), Leadership Assessment Inventory (LAI), Global Transformational Leadership scale (GTL), Rafferty and Griffin's transformational leadership scale, Transformational Leadership Questionnaire (TLQ), and the Leadership Practices Inventory (B.

Bass & R. Riggio, 2006). Among these instruments, the MLQ is the most frequently applied measure of transformational leadership (Bryman, Collinson, Grint, Jackson, & Uhl-Bien, 2011).

The Multifactor Leadership Questionnaire (MLQ) is the foremost tool used to measure transformational leadership. Use of the MLQ is widespread (Northouse, 2010). The instrument was initially developed by Bass in 1985 through interviews with 70 senior executives. From the descriptions of leaders who inspired them and how those leaders behaved, Bass constructed a set of questions that laid the foundation for the MLQ (B. Bass & R. Riggio, 2006).

The psychometric properties of the MLQ have been tested by multiple studies. For instance, Antonakis and colleagues' assessment of the tool revealed strong support for its validity. They found that the MLQ clearly articulated and set boundaries for the nine factors of the Full Range of Leadership. Hinkin and Schriesheim (2008) also examined the properties of the MLQ and found a number of ways in which the tool might be applied to obtain valid and reliable results (Hinkin & Schriesheim, 2008).

In its development, the instrument has undergone several revisions (B. Bass & R. Riggio, 2006). Bass noted that the original version contained 73 items, measuring five factors. Revisions were made to exclude items not focusing on leadership style. This first attempt to re-examine the original version resulted in 67 items measuring the concept of Full Range of Leadership (FLR), 37 of which examined transformational leadership. Within the revised scale, the nine items for measuring outcomes such as leaders' effectiveness and satisfaction with the leaders are also included. Moreover, following scholarly efforts to improve its credibility, the current version of the tool is available in the refined form of the MLQ (5X). It consists of 36 standardised items in which four items examine each of the nine leadership domains within the



FRL. In this form, nine items measuring additional outcomes, as in the previous version, are presented.

In performing the assessment, there are two forms of the MLQ that need to be completed (B. Bass & R. Riggio, 2006). The first one is the Leader Form; this form requires the leaders to self-rate their behaviour. However, self-rating is at risk of being a research bias factor. To complement the leaders' leadership assessment, therefore, the MLQ provides the Rater Form, which consults leaders' supervisees or direct reports to rate the frequency of leaders' behaviour. The Rater Form is considered the most important part of the MLQ assessment because it rates leaders' transactional and transformational behaviour. Using 5-point rating scales, the form measures the transactional and transformational range of behaviour from 0 (Not at all) to 4 (Frequently, if not always).

#### 2.5.6.1. Critical appraisal of the MLQ as a leadership measure across cultures

As noted previously, it has been argued that there is a strong tendency to North American bias in leadership theories, models and measurements (Day & Antonakis, 2011). In applying leadership models or measures derived from a different cultural context, it is pertinent to bear in mind the roles that cultural differences may play, and how these may influence the meaning, enactment and effectiveness of leader behaviours (Sternberg, et al., 2004). Den Hartog and Dickson added that values from the original context where the model was developed are not necessarily found in other cultures (Dickson, et al., 2003).

Although transformational leadership is found to have a positive effect, it has been asserted that the questions' structure in the measure is somewhat abstract. Additionally, this

leadership style does not necessarily look the same in each culture and is possibly enacted in different ways depending on the context observed (Dickson, et al., 2012). Alimo-Metcalfe and Alban-Metcalfe also suggested that most leadership instruments are predominantly based on US research findings (Alimo-Metcalfe & Alban-Metcalfe, 2005). From their perspective, the generalisability of a US-based leadership approach is arguable. They assert that the initial development of the US model of transformational leadership is too narrow, the main focus of observations being primarily on top managers in organisations rather than middle- or lower-level managers. They also found that the model failed to address gender concerns where the numbers of male and female research subjects were unequal.

Despite several concerns that have been addressed by some scholars' analyses, the MLQ remains a dominant measure for examining the nursing leadership context. Its applicability has been sound and reliable although it has been used in non-English speaking countries and outside of Western culture. The subsequent discussion will review the measure's application in nursing leadership studies.

#### 2.5.6.2. The MLQ in nursing research

In addressing nursing leadership fields, a number of nursing leadership studies have applied the MLQ to assess leadership range. In a systematic review conducted by Cummings et al., it was revealed that most of the published nursing leadership literature has examined transformational behaviour through the MLQ (G Cummings, et al., 2008). In addition, Cummings's review showed that research was conducted predominantly in the United States setting but found that the MLQ is also applied in non-English-speaking countries. Nursing leadership research has confirmed the validity and reliability of the MLQ 5X, such as that by

Failla and Stichler (2008). Their study applied the MLQ to measure the leadership behaviour of nurse managers. The MLQ was used to identify which leadership behaviour was effectively related to individual and organisational success. In this research, two versions of the MLQ were used. One was the self-assessment Leader Form (5x-Short) for nurse managers. The other was the Rater Form (5X-Short) completed by staff nurses to reveal their perceptions of their managers' leadership behaviour. In multiple studies, the Cronbach's alpha for the Leader Form ranged from 0.60 to 0.78. For the Rater Form, the Cronbach's alpha for the domains varied from 0.70 to 0.84. The MLQ's internal reliability coefficients for this study were lower. Cronbach's alpha for the Leader Form ranged from 0.39 to 0.84. The Rater Form coefficient ranged from 0.61 to 0.84. The lower coefficient in this study was probably due to the small sample size of nurse managers. Furthermore, more recent studies conducted to investigate nursing leadership styles have also ascertained the validity and reliability of the MLQ 5X. For example, Broome has reported the applicability of the MLQ 5X in her study. The internal consistency of the leadership styles and outcomes measure range from 0.84 to 0.73 (Broome, 2013).

The application of the MLQ instrument in languages other than the English version is well documented. This measure has been translated and tested in multiple languages ranging from German and French to Japanese, Arabic and Hebrew (B. Bass & R. Riggio, 2006). In its application for investigating nursing leadership in non-Western countries, assessments of the instrument's validity and reliability are found to be relevant to the contexts (AbuAlRub & Alghamdi, 2012). Results from several countries revealed that the MLQ is applicable within these settings. For example, an assessment of transformational leadership among nurses in Australia and Saudi Arabia demonstrates valid properties of the instrument (AbuAlRub & Alghamdi, 2012; Linton & Farrell, 2009; Sellgren, et al., 2006).

Although research has documented the universality of transformational leadership and the MLQ (Antonakis, et al., 2003; B. Bass & R. Riggio, 2006), concerns about the measure's factor structures have raised doubts about the instrument's construct validity (Yukl, 1999). Therefore, due to the stated reason, further reassessment of the factorial structure to strengthen the MLQ's psychometric properties in its application to nursing is required (Vandenberghe, Stordeur, & D'Hoore, 2002).

Cognisant of the paucity of assessments addressing the MLQ's psychometric properties in nursing studies, Kanste and colleagues presented an interesting review to evaluate the instrument's psychometric properties within the profession (Kanste, Miettunen, & Kyngäs, 2007). The review emphasised that the MLQ, when applied in nursing studies, was a fairly reliable instrument, especially for its internal consistency within a sample of nurses. Analysis of the measure's internal consistency provided satisfactory results. The criterion of a Cronbach's Alpha of 0.70 was successfully obtained for the leadership subscales. Furthermore, the researchers found that the instrument revealed stability in its test-retest assessment at two times measurement since the reliability coefficient reached the criterion of 0.50. It should be underlined that, in the full nine-factor model, none of the subscales received empirical support. However, after the researchers had modified the model the six- and three-factor structures were then shown to be adequate and supported.

However, although Kanste et al.'s report is relatively current in assessing the properties of MLQ for the nursing context, the generalisability of the research may be limited. Some have noted limitations in the minimum number of samples used in the study and the setting, which focuses only on nurses in Finland. In addition, the most notable inadequacy of this study is that the researchers recognised the lack of cross-validation for the modified version of the MLQ.

Even though the reduced set of items appeared to be representative in measuring transformational leadership among Finnish nurses, this proposed model will require further assessment for its application in other contexts (Kanste, et al., 2007).

Regardless of the above criticisms of the MLQ, the use of this measure remains predominant in examining nursing leadership behaviours (Kleinman, 2004). The FRL model and the MLQ in particular have been highlighted as a compatible approach that suits the present situation (Vera & Crossan, 2004); environmental challenges are becoming ever more volatile in the present day, thus rendering the organisation prone to turbulence on the way to achieving its goals. With this factor in mind, one way to tackle the challenges is through the leadership of those leaders who express a more transformational and less transactional leadership style. Furthermore, compared to others types of leadership measure, the MLQ instrument has thus far been considered a well-used one across cultures, and it is a well-validated tool that helps to assess leadership comprehensively through the framework of the FRL (Walumbwa, Orwa, Wang, & Lawler, 2005).

These reviews suggest that the FRL approach with the MLQ as its measure is appropriate for application in this study to identify nursing leadership among hospital-based nurses in the Indonesian context. Exploring leadership from the nurses' general perspective in the country will expand the body of knowledge and increase understanding of the Indonesian nurses' leadership field since little is known about how these nurses see leadership through the lens of the MLQ.

## **2.6. Aims and Research Objectives**

This research aims to explore nurse leadership in the country of Indonesia. The current health system and development of nursing in Indonesia has been outlined in the first chapter of the thesis. In addition, critiques of nursing leadership showing how the concept is evolving among nurses are addressed.

In cognisance of the noted limitations in the country's health system and the treatment of the nursing profession in Indonesia, as noted in Chapters 1 and 2, several issues might be raised in regard to nursing in Indonesia; an exploration of nursing leadership in the country is perhaps the most pertinent step.

I understand that all these leadership prototypes, such as transformational, transactional and laissez-faire, as in the FRL, were mainly built and developed in Western countries. However, transformational leadership possesses universal characteristics (B. Bass & R. Riggio, 2006). Scholars have suggested that transformational leadership, as reflected within the FRL, has already emerged in culturally collectivistic societies such as Asia (Jung, Bass, & Sosik, 1995). Unfortunately, there is an extreme paucity of literature on the applicability of the FRL in the nursing context in Indonesia.

For the case of Indonesia, most of the available research on and measurement of leadership was initially designed and developed in the Western world; the compatibility of its application to the Indonesian context requires further exploration. Recognising this gap in nursing leadership literature, I am drawn to undertaking an in-depth exploration of nursing leadership in the Indonesian context. This is expected to be an important step for developing the leadership and professionalism of nurses in the country.

Reflecting on this noted gap, the following section lists several objectives for this research:

1. To identify the presence of transformational leadership amongst nurses in Indonesia, as measured by the MLQ
2. To explore Indonesian nurses perceptions on leadership
3. To explore whether nurses in different hierarchical positions construe leadership in the same way or differently
4. To investigate factors which may influence nurses' perceptions on leadership
5. To compare findings in this study to nursing leadership research that has been conducted in other countries

## **2.7. Chapter Summary**

The literature on nursing leadership has suggested multiple positive outcomes; however, a search of the databases only displayed four sources focusing primarily on health and nursing development in Indonesia. There is a very limited number of published studies investigating nursing development in Indonesia (Shields & Hartati, 2003); in particular, there is an extreme paucity of work on how nurses in the country perceive leadership. Substantial dilemmas surrounding a lack of clarity in the role, job description, regulations enforcement, and contextual culture, as described in the previous chapter, make it difficult for these nurses to perceive themselves as potential leaders.

In addition, most of the available research into and measurement of leadership was initially designed and developed in the Western world; the compatibility of its application to the Indonesian context requires further exploration. Recognising this gap in the nursing leadership

literature, I am eager to undertake an in-depth exploration of nursing leadership in the Indonesian context. This is expected to be an important step in developing the professionalism of nurses in the country.

Finally, this chapter has reviewed the leadership and nursing literature to explore the importance of leadership and nurses' perceptions of the context. The findings of the research reviewed support the notion of a positive influence of leadership on nursing outcomes and performance. However, although the exploration of the nursing perspective on leadership is pivotal for the organisation, there is a dearth of literature examining nursing leadership from the perspective of Indonesian nurses. As the next stage after the literature review, the following chapter will discuss the methodology of this study.



## **CHAPTER 3 METHODOLOGY**

### **3.1. Introduction**

This chapter presents the design and methods used in the study to address the research questions outlined in the previous chapter of the thesis. The chapter begins with an overview of the research methodology in leadership studies which involved quantitative, qualitative, and mixed methods. Prior to introducing the details of each research phase, I will present a brief discussion on research design, components involved in a design, and types of research design. All of these are required in order to decide which procedure is appropriate for a study.

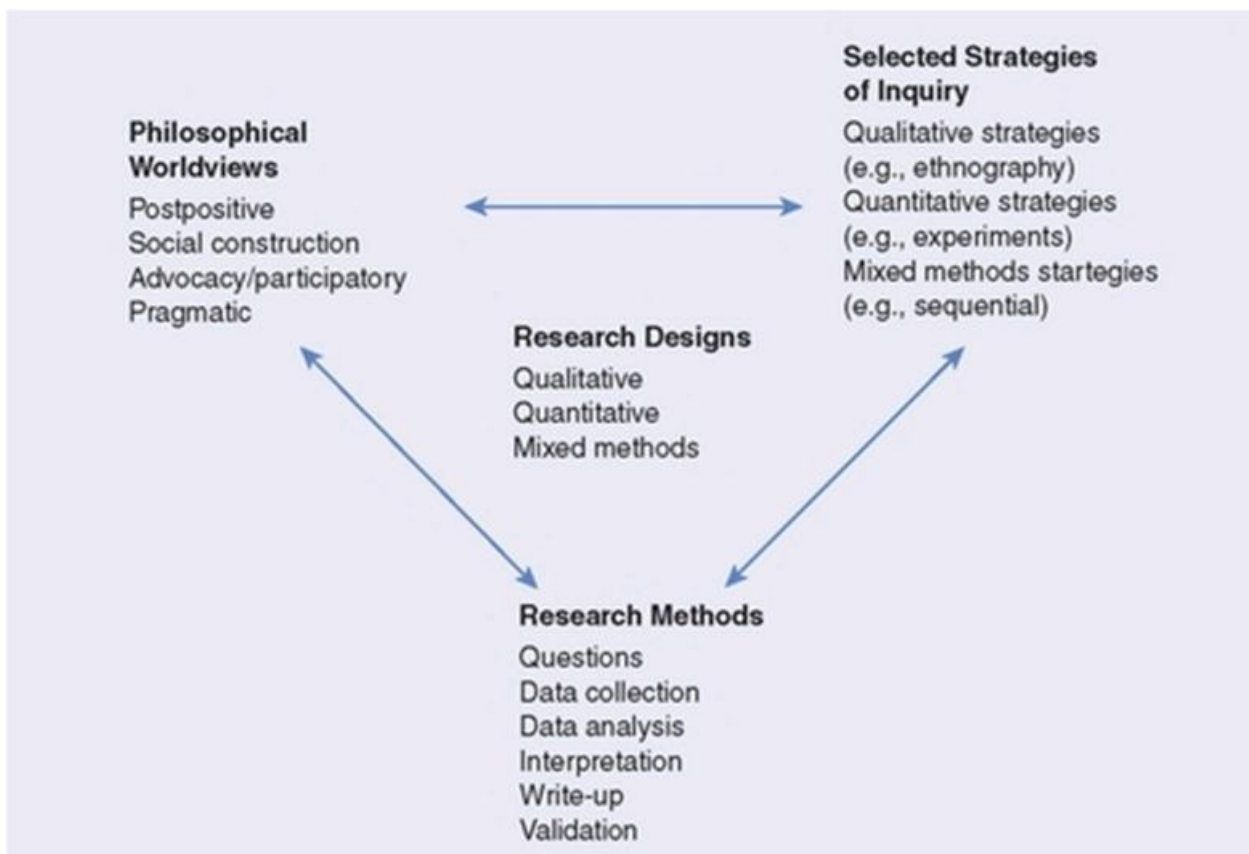
This particular study utilises a mixed methodology. A justification for this decision will be presented. Each phase of the method is described and explored in detail. The study applied quantitative methods at the initial stage; these methods' design, the research instrument, the characteristics of the sample participants, and the procedure for delivering the survey are discussed. The strategy applied for the survey analysis is also described. In the next part of the chapter, the methodology for conducting the qualitative study will be presented. This includes the research sample's characteristics and selection criteria, the study procedure, and the interview data analysis. The study interviews were conducted in Indonesia; therefore, the approach to handling translation and transcription issues and strategy will be addressed. Finally, the summary of the methodology is presented at the end of the chapter.

#### **3.1.1. Research design**

According to Creswell (2009), research designs are defined as plans and procedures for research that span the decisions from broad assumptions to detailed methods of data collection

and data analysis. Scholars have also labelled research design as the “research method” (Walter, 2006), or research paradigm. In selecting a suitable design, there are three components that we need to consider which will be described as follows. These are (1) philosophical worldviews, (2) strategies of inquiry, and (3) specific research methods.

Figure 3.1-1 A framework for choosing a design and interconnectedness between the components



Source: Creswell (2009, p. 5)

The post-positivist worldview can be interpreted as “a basic set of beliefs that guide actions” (Creswell, 2009); in other words, this represents the researcher’s general orientation to the nature of the research. It takes the form of traditional research and tends to be more suited to

quantitative research than to qualitative research. This view is sometimes known as positivist/post-positivist research or empirical science. As presented in figure 3.1-1 above, the worldviews encompass the following: first, post-positivism, which is generally related to the quantitative approach; second, constructivism, which is mostly associated with qualitative methods; third, advocacy/participatory, which is generally more suitable for qualitative rather than quantitative approaches; and, lastly, pragmatism, which is typically related to mixed-methods research (Creswell & Clark, 2007). Furthermore, each worldview has different views on the elements of ontology (concerning the nature of reality), epistemology (the relationship between the researcher and that being researched), axiology (the role of values), methodology (the process of the research), and rhetoric (the language of research).

The second component of a research design is the strategies of inquiry. These are types of qualitative, quantitative, and mixed-methods designs that provide a specific direction for procedures in a research design (Creswell, 2009). The table below presents strategies of inquiry for each design.

Table 3.1-1 Alternative Strategies of Inquiry

Quantitative	Qualitative	Mixed Methods
<ul style="list-style-type: none"> <li>• Experimental designs</li> <li>• Non-experimental designs, such as surveys</li> </ul>	<ul style="list-style-type: none"> <li>• Narrative research</li> <li>• Phenomenology</li> <li>• Ethnographies</li> <li>• Grounded theory studies</li> <li>• Case study</li> </ul>	<ul style="list-style-type: none"> <li>• Sequential</li> <li>• Concurrent</li> <li>• Transformative</li> </ul>

Source: Creswell (2007, 2009)

Table 3.1-1 presents types of strategies of inquiry elaborated in each research approach. Quantitative strategies involve experimental designs, which are used to seek information on

whether a specific treatment influences an outcome, and non-experimental designs, such as surveys, which are applied for studying trends or attitudes of a population, which are represented by numeric description.

Qualitative strategies comprise five approaches. The first is narrative research; in this method, the researcher studies the lives of individuals by asking them to provide stories about their lives. The second is phenomenology; this is a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by the participants. The third is ethnographies; this method involves the researcher studying an intact cultural group through observation or interviews in a natural setting over a prolonged period of time. The fourth is grounded theory; in this strategy, the researcher distills a general, abstract theory of a process, action, or interaction grounded in the views of the participants. The fifth is a case-study; this approach involves the researcher exploring in depth an event, program, or activity through multiple data collection procedures for a specified length of time.

The mixed-methods strategies hold three generic strategies of inquiry. The first is sequential mixed methods; here, the researcher seeks to elaborate or expand on the findings of one method with another method. The second is transformative mixed methods, in which the researcher applies a theoretical lens as an overarching perspective within a design containing both qualitative and quantitative data. Lastly, there is the concurrent technique; in this strategy the researcher merges qualitative and quantitative data in order to obtain a comprehensive analysis of the research problem.

The last major element in a research design is specific research methods that involve the forms of data collection, analysis, and interpretation that researchers propose for their studies (Creswell, 2009). The choice of methods is dependent upon the researcher's intention in

specifying the type of information to be collected in advance of the study or allowing it to emerge from the participants. For example, the analysis may also be in the form of numeric or textual information recorded from the voices of participants. In the meantime, interpretation also varies; it could be done on the basis of statistical results, or the researcher may interpret the themes emerging from the data.

The three components of research designs (worldviews, strategies of inquiry, and research methods) have been described. Each element needs to be carefully examined depending on the research problem to be addressed in a study.

### 3.1.2. Types of research design

The interconnectedness of the three major components in a research design lead to three types of research design: the quantitative, qualitative, and mixed methods. These will be briefly discussed below.

The quantitative approach comprises a post-positivist worldview, an experimental strategy of inquiry, and pre-and post-test measures of attitudes. Quantitative research, however, depends on the collection of quantitative data (Johnson & Christensen, 2004). This type of method can be conducted in the form of: (1) experimental research and (2) non-experimental research. Experimental research is classified as the strongest research method for obtaining evidence of a causal relationship between two variables. The setting in which to conduct such research also varies, such as a field or laboratory (Johnson & Christensen, 2008). In cases where experimental research cannot be employed, researchers use non-experimental research. There are two types of non-experimental research: causal-comparative research and correlational research. In causal-comparative research, the primary independent variable of interest is categorical, while

the correlational research variable of interest is quantitative. However, both experimental and non-experimental research share similar systematic procedures: (1) determining the research problem and hypotheses, (2) selecting the variables for the study, (3) collecting the data, (4) analysing the data, and (5) interpreting the results (Johnson & Christensen, 2008).

The qualitative approach refers to the constructivist worldview, ethnographic design, and observation of behaviour. In this approach, the researcher seeks to establish the meaning of a phenomenon from the views of participants; one key element of the data collection is to observe participants' behaviours by engaging in their activities (Creswell, 2009).

Meanwhile, mixed-methods research is a type of research that combines quantitative and qualitative research techniques, methods, approaches, concepts, or language into a single study set (Johnson & Christensen, 2004). Mixed-method research takes a pragmatic worldview and collects both quantitative and qualitative data sequentially. The study begins with a broad survey in order to generalise results to a population and then focuses, in the second phase, on a qualitative strategy (Creswell, 2009).

A brief discussion of research design along with components that must be considered prior to selecting a suitable research approach has been provided. Since the focus of the research in this thesis is on leadership, it is worth taking an overview of the research design that has been proposed to examine this concept.

### **3.2. Overview of Research Design on Leadership Studies**

This section reviews approaches that have been designed to examine leadership. It will help the reader to understand methods addressed in the leadership literature and how the trend

towards mixed methodology has evolved in the field, subsequently influencing the decision to apply this strategy as the chosen method for this study.

### 3.2.1. Approach to leadership studies

Current research reviews of leadership have revealed that the quantitative approach has dominated the literature over the past hundred years (Avolio, Walumbwa, & Weber, 2009). Quantitative research in this field has been largely facilitated by a single method of data collection, specifically the self-administered questionnaire (Bryman, et al., 2011). The supportive and dominant position of quantitative designs in examining leadership is well documented by Gardner and colleagues (Gardner, Lowe, Moss, Mahoney, & Cogliser, 2010). An extensive evaluation of published articles in the *Leadership Quarterly Journal* in the first and second decades of publication revealed that the quantitative-based approach was used in 71% of studies during the first ten years, increasing to 87.4% in the second decade (Gardner, et al., 2010).

Despite strong support for the quantitative approach, scholars have noted some limitations in regard to the application of the questionnaire as a focus for data collection. The main disadvantages include the risk of low response rate, researcher bias in constructing the concept, data from scales being affected by response sets, or a tendency for same-source bias in leadership studies when respondents are asked to supply data relating to both the leadership variables and the outcome measure (Bryman, et al., 2011).

Cognisant of these limitations and intending to provide a different methodological approach to leadership research, scholars have conducted a qualitative approach to leadership research. Bryman found that a third of published articles in the most refereed journal on

leadership employed a qualitative research framework (Bryman, 2004). Although purely qualitative designs seem to be less favoured by leadership scholars, this approach is attracting increasing attention. Lowe and Gardner noted that the research distribution for this type of design reached 39% (Lowe & Gardner, 2001). Unfortunately, however, a later evaluation of the proportion of leadership research employing a qualitative approach declined to 24.1% in the following decade (Gardner, et al., 2010). Bryman has noted some arguments around researchers' reluctance to employ qualitative designs in leadership studies. One possible explanation is that it may be related to the social psychological bias of earlier pioneers in leadership research, who were resistant to qualitative designs. In appraising quantitative and qualitative research, a quantitative design for leadership research shows a tendency to an input-output model in which the main focus of the researcher is to investigate the impacts of leadership, factors that influence leadership behaviour, or what kinds of people become leaders (Bryman, 2004). Meanwhile, qualitative studies emphasise the importance of context and the setting in which the research takes place. Furthermore, qualitative research is found to be more sensitive to the implications of particular conditions for leaders and their styles of leadership.

### 3.2.2. Mixed methodology for leadership research

Whilst recognition is given to scholars' reviews of both quantitative and qualitative approaches to assessing leadership, the importance of both designs in leadership research is acknowledged. Understanding that leadership is a complex field to study provides support for the idea of extending research beyond a single quantitative or qualitative design (Stentz, Plano Clark, & Matkin, 2012). One way of integrating multiple approaches in leadership research is to combine quantitative and qualitative research methods. Mixed methods have been advocated in



leadership research and are recognised as an important approach in this field (Avolio, et al., 2009; Bryman, et al., 2011).

It has been argued that the main reason for proposing mixed methods is to fulfil and comprehend the need to expand the research findings/discussion (Creswell & Plano Clark, 2010). In defining this methodology, Johnson and colleagues incorporated major scholars' perspectives (Johnson, Onwuegbuzie, & Turner, 2007) and then articulated a definition of the method as "the type of research in which a researcher or a team of researchers combines elements of qualitative and quantitative approaches (e.g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the purposes of breadth and depth of understanding and corroboration" (p. 123). Furthermore, Stentz et al. also emphasised that, by combining quantitative and qualitative designs, researchers can maximise their studies' strengths, provide more complete results and explanations, improve validity of the results and/or contextualised understandings, achieve multi-level perspectives, and take account of cultural influences (Stentz, et al., 2012).

According to Bryman (2004, p. 759-760), there are a number of ways of combining quantitative and qualitative methods:

- Triangulation: Some studies explicitly employ quantitative and qualitative research to determine how far the ensuing data are mutually reinforcing.
- Preparation: Qualitative research is sometimes conducted in order to prepare for quantitative research in terms of generating hypotheses or developing research instruments, but for only one of the studies.
- Expansion and complementarity: Quantitative and qualitative research is frequently combined so that one set of data is employed to expand upon the other set.

- Different issues: Quantitative and qualitative data are collected in relation to different research questions or topics.
- General patterns plus meaning: This is a form of combining quantitative and qualitative research whereby quantitative data are employed to provide general patterns, such as leaders' effectiveness levels, while the qualitative data provide insights into the meanings of leaders' behaviours for followers

### 3.2.3. Selection of research methods

Selecting a suitable research design requires a good understanding of available research designs and their elements (Walter, 2006). In this regard, Creswell (2009) also added three criteria that influence a researcher's choice of a research design. These are (1) research problem, (2) personal experiences, and (3) audiences. A research problem refers to the issue that needs to be addressed in a study. Certain issues/problems need specific approaches. For example, quantitative research is the best approach to use in testing a theory; qualitative research is very useful if a concept/phenomenon has previously attracted only limited research; a mixed-methods design is beneficial when the quantitative or qualitative approaches cannot adequately solve a research problem and the strengths of both quantitative and qualitative research can provide the best understanding of the investigated concept/phenomenon. The next criterion is personal experiences. The chosen method is likely to be influenced by the researcher's own personal training and experience. When a researcher is familiar with a certain approach (e.g., quantitative, qualitative, or mixed methods), he/she is most likely to use types of design with which he/she is comfortable. Finally, there is the audience factor. Researchers conduct research for audiences who will accept their work. Depending on the audience to whom the researchers present their

work (e.g., journal editors, grant dispensers, etc), the experiences of these audiences are likely to shape researchers' decisions on the choice of research approaches.

No one research design is superior to the others. Scholars have suggested multiple ways of selecting appropriate research strategies. However, these should be seen as complementary. Skills, time and budget are other factors that researchers need to consider in addition to the aforementioned criteria.

#### 3.2.4. Methods Selected for this Study

A mixed-methods approach has been employed in various fields and disciplines (Stentz, et al., 2012). The application of mixed methods in nursing leadership studies has been employed by a number of researchers (Brady & Cummings, 2010; Dierckx de Casterlé, Willemse, Verschueren, & Milisen, 2008; W. Gifford, Davies, Edwards, Griffin, & Lybanon, 2007; W. A. Gifford et al., 2008; Lee & Cummings, 2008). Acknowledging the pertinence of mixed methods in leadership research, the proposed research will employ the combined approach to examine nursing leadership among nurses in Indonesia. The rationale for mixing the two types of data is that neither quantitative nor qualitative methods alone are adequate for capturing a detailed explanation of nurses' leadership in the country. The study will be the first of its kind to explore Indonesian nurses' leadership. When combined, these methodologies complement each other and generate a more complete picture of the proposed research questions (Tashakkori & Teddlie, 1998).

Before pursuing a mixed-methods design, it is necessary to clarify several key areas to build a persuasive and strong study (Creswell & Plano-Clark, 2011; Plano Clark & Creswell, 2011). The four main decisions concern:

- The level of interaction between the quantitative and qualitative strands
- The relative priority of each strand
- The timing
- The procedure for mixing the studies

To complement the proposed research questions, I decided to use the methods interactively rather than independently. This means there is a direct interaction before the final conclusions of the study are drawn, whilst using the methods independently would call for distinct implementation of the two designs, as the researcher is only mixing them at the final stage of study (Creswell & Plano-Clark, 2011). Regarding the priority of the research methods, the quantitative and qualitative phases will be given equal status in this study. Although the quantitative data will be collected first, this will not indicate the priority of this phase over the qualitative one.

The next decision concerns the timing. This is merely related to the order in which the researcher applies the results from the two sets of data (Creswell & Plano-Clark, 2011). In this study, I chose sequential timing, where the implementation of the two methodologies is pursued distinctively. The collection and analysis of the quantitative data will occur at the initial phase of the study as the baseline for developing the next stage of the methodology (i.e., qualitative). The final decision I have to consider is to determine where and how to mix the quantitative and qualitative strands. Creswell and Plano-Clark explicitly classified several stages of a study at which a researcher might combine the data sets. After analysing each strategy, I decided to combine both methods during data collection. This will be achieved by *connecting* the results of one study strand with another during data collection (Creswell & Plano-Clark, 2011).

From these decision points, it is concluded that the major framework of the mixed-methods approach for this study is the explanatory sequential research design. Creswell and Plano-Clark defined it as “methods implemented sequentially, starting with quantitative data collection and analysis in phase 1 followed by qualitative data collection and analysis in phase 2, which builds on phase 1” (p. 73). With this design, the interaction between the methods occurs separately in two distinct stages (Creswell & Plano-Clark, 2011). After statistical analysis of the quantitative data, collection and analysis of qualitative data will be undertaken. The design for the qualitative data collection will depend on the results of the quantitative stage; thus, this intermediate stage is where the connection occurs.

The description above has explained the strategy and roadmap addressed to answer the research questions in this study. However, I had to modify this plan in the middle phase of the study. This was done after I had conducted the initial analysis of the quantitative phase. At that point, it was found that the results from the survey data did not substantially contribute to the inquiries; in particular, no significant statistical findings were obtained for most of the analysed variables (e.g., perception differences among nurse groups). Instead of using the qualitative phase as the expansion of the quantitative findings, therefore, I resolved to use the interview analysis (i.e., qualitative) to expand the methodology of quantitative analysis (Bryman, 2004). The strategy of combining quantitative and qualitative methods in this study was intended for the purposes of complementarity (Bryman, 2004), whereby quantitative and qualitative research are combined so that one set of data is employed to expand upon the other set.

Equal priority can be given to the quantitative and qualitative phases (Ivankova, Creswell, & Stick, 2006). Thus, with this change, priority was given to the qualitative stage as the centrepiece of the study. The first part of this study employs a quantitative method, using a

self-administered survey (i.e., MLQ) to assess nurses' leadership. However, previous authors have warned about the impact on the MLQ; nurse leaders tend to have an inflated score on transformational leadership characteristics. This is more likely to occur in studies that addressed same-source ratings. Such studies are considerable but the concluded findings pose problems in their interpretation since they may be prone to method bias (Hutchinson & Jackson, 2013). In relation to the current study, Hutchinson and colleagues' review raised questions about its findings. To minimise this possible bias, researchers suggested collecting non-same-source data from staff nurses or others in the organisation to examine leaders' leadership performance. At the outset of the study, I am aware of this potential distortion. Therefore, to gain a better perspective on how head nurses in Aceh-Indonesia perceive leadership, the qualitative approach might complement the survey, which is helpful for suggesting another point of view. The qualitative stage will explore the initial findings and provide a broader explanation of values or norms that may, or may not, affect the enactment and perceptions of leadership. In the final stage, the results of the quantitative and qualitative stages will be integrated (Ivankova, et al., 2006).

In the following overview, I will further explain each stage of the study in detail.

### **3.3. Phase I**

This section will address the details of the quantitative methods in the study. It will discuss the design purposes, the instrument, data collection, and the analysis of the data.

#### **3.3.1. The design purpose**

The purpose of the quantitative study in the research is to examine the overview of nursing leadership in Indonesia. To meet this aim, the Multifactor Leadership Questionnaire

(MLQ) is applied as the study instrument. The MLQ is a self-administered questionnaire which is widely accepted and used in many countries and work settings. It is the most widely used measure of transformational leadership. Since no measure of transformational leadership for Indonesian nurses is available at present, the application of the MLQ in this research will fill this gap. The role of the MLQ is to identify the existence of transformational leadership amongst nurses. It is also intended to explore their perceptions of nursing leadership in the country.

### 3.3.2. Translations of the MLQ-5X instrument into Indonesian

The current version of the MLQ 5X-Short was used in the study. The questionnaire is available in an Indonesian version from a private company which is the license holder for the instrument (TheMindGarden, 2010). The MLQ has a five-point Likert response, ranging from 0 (not at all) to 4 (frequently, if not always). The indicators were reported to be valid and reliable. Construct validity was established in previous studies by multiple factor analysis. Permission to use the questionnaire was obtained from the publisher.

The applicability of the Indonesian version of the MLQ to nurses had been initially pilot-tested on 25 staff nurses and ten head nurses in another hospital in the same area, which will be described later in this chapter. These nurses were asked to complete the measure voluntarily. The results gathered from the pilot study were useful for establishing the clarity and conformity of the measure before it was administered to the targeted study participants (i.e., staff nurses and head nurses at the ZainoelAbidin General Hospital, Banda Aceh).

### 3.3.3. Data collection method

This subsection describes the data collection procedure and survey method.

#### *Data Collection*

The data collection method can be defined as the researcher's attempt to obtain data to be analysed for the purpose of a study. It is pertinent at this stage for a researcher to apply suitable instruments capable of providing precise and truthful measures of the variables of interest (Gray, 2009). This study examines nursing leadership in Indonesia. Therefore, the psychometric properties of a chosen measure must be considered. It has been suggested that a standardised instrument be employed to investigate a subject of interest because the constructed measures usually already have an established reliability and validity (Gray, 2009). A researcher needs to ensure the availability of the instrument beforehand. If it does not exist, a new standard measure has to be constructed. However, establishing a new measure is a time-consuming process. For this study, therefore, the application of an established measure was considered the best mode of data collection (i.e., MLQ 5X-Short). The measure applied in this study has been discussed in the previous chapter; however, the suitability of the measure will be addressed in detail in a later section of this chapter.

A quantitative survey has been selected as the initial stage of this research. The following section discusses the decision to use the survey method in this study.

#### *Survey Method*

Surveys are characterised as a systematic set of data. The aim is to collect information about the same variables or characteristics from at least two or more cases, thus enabling the traits of these cases (i.e., people/participants) to be described (DeVaus, 2002). When applying a



survey method, the use of a questionnaire is the most common technique. It is capable of reaching a wide range of groups of people, generating a large amount of data in a fairly short timeframe (De Vaus, 2002); it also address concepts previously established as important in the field.

In designing a survey method, there are several pertinent elements that researchers need to address, as described in the Table below.

Table 3.3-1 Creswell’s (2009) checklist for survey design

	Is the purpose of a survey design stated?
	Are the reasons for choosing the design mentioned?
	Is the nature of the survey identified (cross-sectional/longitudinal)?
	Are the population and its size mentioned?
	Will the population be stratified? If so, how?
	How many people will be in the sample? On what basis was the size chosen?
	What will be the procedure for sampling?
	What instrument will be used in the survey? Who developed the instrument?
	What are the content areas addressed in the survey? The scales?
	What procedure will be used to pilot-test the survey?
	What are the variables in the survey?
	How are these variables cross-referenced with the research questions and items in the survey?
	What specific steps will be taken in the data analysis to:
(a)	Analyse returns?
(b)	Check for response bias?
(c)	Conduct a descriptive analysis?

(d)	Collapse items into scales?
(e)	Check for reliability of scales?
(f)	Run inferential statistics to answer the research questions?
	How will the results be interpreted?

Source: Creswell (2009)

The Table identifies the major considerations researchers will face when planning a survey. This Table was central to my decision-making at the outset and was used to guide my data collection activities. I adhered to this suggested checklist to ensure that I had chosen the correct procedure and process for administering the survey, which is the most appropriate method for this study.

The purpose of the survey is to generalise from the sample to the population of nurses in Banda Aceh, Indonesia, in order to yield inferences mainly about nursing leadership in the country. The study employs a special-purpose survey in order to obtain data that are not available elsewhere for the purpose of the study analysis (Fowler, 2013).

The practicality of questionnaires in helping researchers to gather primary data has been noted. They are particularly useful when they match the proposed research objectives and when the study requires a set of standardised questions; questionnaires are also appropriate when researchers need to reach a large number of study participants when investigating relationships between variables (Gray, 2009).

Some notable weaknesses, however, may be found when applying a survey questionnaire method. These include the possibility of a low response rate, especially for a lengthy

questionnaire (e.g., more than six pages of questions) (Gray, 2009), and their inability to provide further details on the investigated phenomena (De Vaus, 2002).

Despite the weaknesses, this method is convenient because participants are able to fill in the questionnaires at their own pace, the data analysis procedure is relatively simple, anonymity is guaranteed, and interviewer bias, which frequently occurs in an interview process, can be minimised (Gray, 2009). These factors, therefore, further indicate that survey questionnaires were suitable for the first stage of the study, particularly because of their ability to capture general phenomena of interest and because they are inexpensive to apply. As for the method, this study employed a cross-sectional approach. The data were collected at a single point of time from a sample selected to represent the population of nurses in Indonesia. Thus, the survey was expected to gather information about the nurses' leadership in the country.

#### *The Survey Questionnaire: Validity and Reliability*

This subsection discusses the validity and reliability of the survey questionnaire applied in the research. Validity and reliability are quality measures for research instruments. Validity describes the degree to which an instrument measures what it is intended to measure; reliability refers to the degree of consistency or dependability with which an instrument measures an attribute (Polit & Beck, 2008).

In this study, two survey questionnaires were used. The first one was the demographic questionnaire, and the second was the leadership questionnaire, the Multifactor Leadership Questionnaire (MLQ-5X Form Short).

a. Demographic Questionnaire

The first questionnaire was designed to describe participants' demographics. It was developed specifically for this study. The description included gender, marital status, age, highest degree gained, work experience, and certification (if any). These characteristics were used to assess how these demographic variables were involved in or influenced nurses' leadership.

b. Leadership Questionnaire

The Multifactor Leadership Questionnaire (MLQ) 5X Form Short is the instrument most widely used to describe leadership styles. Leadership styles assessed by the measure were identified as transactional leadership, transformational leadership, and laissez-faire leadership styles (B. Bass & R. Riggio, 2006). The initiator of the instrument was Bass (1995); since its development, the instrument has been applied in various types of organisation (Northouse, 2010). Although it has been widely recognised, several studies have asserted that the earlier version of the MLQ may not always have been consistent. Therefore, revisions have been suggested to strengthen its psychometric properties (Antonakis, et al., 2003; Northouse, 2010; Tejada, et al., 2001).

The initial version of the MLQ consisted of seven leadership factors, namely charismatic behaviour, inspirational leadership, intellectual stimulation, individualised consideration, contingent reward, management-by-exception, and laissez-faire leadership (Bass, 1985). These factors were then collapsed into six. This was done by merging charismatic behaviour and inspirational leadership into a single charisma construct. Although these two factors have distinctive constructs, their differentiation was found to be empirically indiscernible. The six

leadership factors, however, received a number of criticisms from researchers because they were unable to replicate the proposed model. It was then suggested that revisions be made by collapsing several of the initial leadership factors into higher-order factors such as transformational leadership (Avolio, Bass, & Jung, 1999).

Addressing researchers' concerns with the previous MLQ survey, the MLQ Form 5X was developed (Avolio, et al., 1999). The new version has 45 items, 36 of which encompass nine leadership factors, with the other nine items measuring three leadership outcomes. Details of the nine leadership factors are described below (B. Bass & R. Riggio, 2006):

- Five transformational leadership factors: (1) idealised influence (attribute), (2) idealised influence (behaviour), (3) inspirational motivation, (4) intellectual stimulation, and (5) individualised consideration
- Three transactional leadership factors: (1) contingent reward, (2) management by exception active, (3) management by exception passive
- One laissez-faire leadership factor
- The three leadership outcomes are extra effort, effectiveness, and satisfaction

The scoring is derived from the sum of the items divided by the number of items that make up the scale. If an item is unanswered, the total for that scale is divided by the number of items answered. All the leadership style scales have four items, extra effort has three items, effectiveness has four items, and satisfaction has two items. The scores lie between 0 and 4.

The consistency of the MLQ 5X has been tested in multiple studies. The scales demonstrate good-to-excellent internal consistency with Cronbach's alphas above 0.80 for all the scales (B. Bass & R. Riggio, 2006). This is supported by Antonakis et al. (2003), who have revealed evidence that the nine factors sufficiently comprise the construct for the MLQ 5X

instrument. In addition, through the application of Confirmatory Factor Analysis (CFA), the nine-factor model has indicated a clear pattern of consistency across contexts.

Reliability scores for all the scales were high, ranging from 0.74 to 0.94. The scores surpassed the common standard rules suggested in the literature (Avolio, Bass, & Zhu, 2004). The reliability of the MLQ 5X was also reported by a number of studies including Muenjohn et al. who confirmed the acceptability of the original MLQ 5X, with a Cronbach's alpha coefficient of 0.86. The application of the MLQ 5X in their research proved its ability to capture the nine leadership factors representing transformational, transactional and laissez-faire leadership styles.

The internal consistency of the MLQ 5X in this study was explored by using Cronbach's alpha and item-total correlations. The test showed that the instrument reached the acceptable scores for the alpha, thus suggesting that the measure is applicable in the study. Further details of the test are provided in the following discussion.

#### *Internal consistency of the MLQ-5X Indonesian version*

The internal consistency of the MLQ-Indonesian version, which was provided by the MindGarden, Inc., was explored using Cronbach's coefficient and item-total correlation. Cronbach's reliability coefficient normally lies between 0 and 1. Although there is no lower limit to the coefficient, the internal consistency of the scale is greater the closer it approaches 1 (Gliem & Gliem, 2003). Nunnally had suggested that a coefficient of 0.70 for Cronbach's is sufficient for measures (Nunnally, 1978), while Gliem and Gliem (2003) mentioned that reaching an alpha value of 0.8 is a reasonable goal. Further guidance on the Cronbach's score has been provided in the literature where “ $\alpha > .9$  – Excellent,  $\alpha > .8$  – Good,  $\alpha > .7$  – Acceptable,  $\alpha > .6$  – Questionable,  $\alpha > .5$  – Poor, and,  $\alpha < .5$  – Unacceptable” (George & Mallery, 2003).

Meanwhile, the item-total correlation check is required to ensure that the responses to a particular item reflect the responses to other items on the scale (De Vaus, 2002). Kanste and colleagues reported that there is no exact guidance on the acceptable item-total correlation values (Kanste, et al., 2007). An item-correlation value of 0.20 is considered adequate (Streiner & Norman, 1995), while De Vaus argued that, with a value of less than 0.3, the item should be deleted from the scale (De Vaus, 2002). This value estimate is supported by Nunnally, who suggested that item-total correlation values above 0.30 should be considered good (Nunnally, 1978).

For this study, I have examined the internal consistency of this measure. The assessment results showed support for the MLQ-Indonesian version instrument. Cronbach's coefficient values for the leadership scales are all above 0.90, which is excellent in terms of scale reliability. Most of the Indonesian MLQ values for the item-total correlation were good. Item-total correlations were as follows: 42 items were good ( $\geq 0.30$ ), two items were adequate ( $\geq 0.20$ ), and one item was inadequate ( $< 0.20$ ). As suggested by the literature, the inadequate item might have been dropped from the scale; however, the deletion of the particular item did not influence the alpha value. Even had it been deleted, the Cronbach's score would have remained high (0.96). For that reason, the item was retained.

#### 3.3.4. Pilot study

It has been suggested that, prior to its commencement, a study needs to be piloted in order that any issues might be encountered in advance (Gerrish & Lacey, 2010). To assess the feasibility of this study, the Indonesian version of the MLQ questionnaire was pilot-tested on selected participants. The main purpose of conducting the pilot test was to confirm the

applicability of the measure among the nurses. The MLQ 5X-Form has established its feasibility in multiple validity and reliability checks. The pilot study for the main research was conducted in the same fashion and with a representative sample of the target population. This strategy was in line with the suggestion (Babbie, 1990).

The pilot study was conducted in Aceh province between 1 and 22 August 2013. Prior to conducting the pilot study, research permits were obtained from the research and development office. The permits were gathered from one piloted hospital in Banda Aceh. This was a public hospital with approximately 450 hired nurses. The total number of participants involved in the pilot study was 40 (ten head nurses and 30 staff nurses). Only 35 questionnaires were returned from ten head nurses and 25 staff nurses. The other five staff members did not return them.

The method of delivering the instruments to the piloted participants was mainly hand/physical delivery. This method was chosen because it was the only reasonable way to ensure that the questionnaire reached the nurses. Other methods of handling it, such as email or postal delivery, were impossible to perform due to the limited resources available. I personally assumed that the postal system within the hospital was not working; I had been told that all letters are manually circulated within the hospital. In addition, the technology for email access was inadequate.

When I handed the survey instrument to each of the nurses, they stated that they did not want to complete it immediately. They preferred to complete it at their own pace. Therefore, the questionnaires were collected at a later appointed time. This was understandable since each staff nurse and head nurse has different workloads to accomplish in their unit.

After completing the questionnaires, two head nurses and five staff nurses were interviewed to provide some information on their experience of filling in the survey. Overall,



they understood the statements and had no difficulty with the survey. However, they did suggest that a minor change of wording from “organisation” to “hospital” would help them to better understand the questions. This change, however, did not alter the measure’s reliability and validity.

The time taken to answer the questionnaire varied among staff nurses and head nurses. They required an average of 15 minutes to complete the demographic data and the MLQ-5X form questionnaire. However, some head nurses mentioned that they were unable to complete the survey immediately. Duty calls or sudden meetings occurred frequently which they felt would interrupt their concentration on the survey. However, an interesting point I noticed when conducting the pilot study was the support given to the research. The head nurses, in particular, thought that this type of study is important to assess the leadership effectiveness of nursing leaders. They hoped that the follow-up to the study would help to improve nursing leadership.

A discussion of the pilot study has been provided. The analysis of the pilot stage indicated that it was feasible to continue with the main study. The results of the pilot suggested minor changes to the survey instrument to help the nurses understand it much better; thus, the revisions were applied in the main study. This pilot stage also confirmed that hand/physical delivery was preferred to other modes of delivery in order to obtain a high response rate.

### 3.3.5. Population and sampling

It is important for a researcher to understand the population and its characteristics in order to decide on a sample design and procedure for selecting participants. The definitions of population and sampling are provided in the following discussion.

### *Population*

A research population is the entire set of individuals or objects having some common characteristics. In identifying a study population, researchers have to know what characteristics the participants should possess and must also be clear about the population to whom the study might be generalised. The process of research population identification is important in order to select the sample that best represents the population (Polit & Beck, 2008).

### *Sampling*

The processes involved in selecting a study sample are as follows: defining the population, choosing an appropriate sampling frame, selecting a method for sample recruitment, and deciding on an adequate sample size and sample selection (Walter, 2006). A sample is a subset of a population. However, the use of a sample may inadequately reflect the population's characteristics. Researchers therefore need to assess the representativeness of a sample. This involves assessing a sample's quality by matching it with the typicality of the population traits from which the sample is drawn (Polit & Beck, 2008).

Sampling methods apply probability and non-probability procedures. The more sophisticated the method used to select samples, the higher the likelihood that the samples will provide a true representation of the population (Polit & Beck, 2008). The probability method is the only feasible technique that enables researchers to obtain representative samples. It is a complex method that gives an equal chance of selection to all members of the population. Probability sampling includes random, systematic, stratified, and cluster sampling (Creswell, 2009; Polit & Beck, 2008). On the other hand, representativeness is an issue in non-probability sampling (i.e., convenience, purposive, and quota). This method does not provide an equal

chance of every element in the population being included in a study. The main advantages of applying this method are its convenience and the fact that it is economical/practical to perform. Sometimes, the non-probability approach is the only option. However, caution must be exercised in generalising inferences and conclusions obtained from the data (Polit & Beck, 2008).

### 3.3.6. Population and sampling for this study

In this research, the total population in the study was entirely composed of staff nurses and head nurses at one hospital in Indonesia. The sampling frame used to guide the sampling procedure is the complete list of staff nurses and nurse managers employed at this hospital. In the quantitative stage, the probability sampling technique (i.e., random sampling) was pursued to obtain study participants.

The Human Resources (HR) department within the hospital agreed to provide the complete set of information from the nurses' database for research purposes. The information provided was as follows: full names; unit of work/ward area; position in the unit; highest education achieved; and length of employment. This information was kept secure at all times by the researcher in a locked cabinet in a secure place, and only the researcher had access to it.

#### *Sample Characteristics and Selection Criteria*

All head nurses were invited to participate in the study. Staff nurses had to be qualified nurses, willing to take part in the study and also to have worked in the observed hospital for a minimum of one year. The 'length of employment' and 'qualifications' data were available from the database. This confirmation was necessary to enable the researcher to select study participants based on the determined inclusion criteria.

Some researchers have considered six months' working experience for nurses to be sufficient for leadership research (e.g., Failla & Stichler, 2008). In this study, however, I thought that six months was a fairly short period of time in which to experience various challenges at the workplace. Therefore, I preferred to use one year's working experience as the minimum criterion. The main reason for using this criterion was to ensure that staff nurses have had sufficient time to practise their leadership skills as well as experience challenges to their leadership. This period of time is also consistent with previous selection criteria in other nursing leadership studies (Perkins, 2010).

### *Sample size*

Sampling in quantitative research is characterised as either probability or non-probability (Polit & Beck, 2008). Probability sampling appears to be strongly preferable to non-probability sampling because it generates greater confidence in the representativeness of samples (Polit & Beck, 2008). The application of probability sampling in the research is intended to increase the validity and generalisability of the study. In particular, this addresses common weaknesses in the quantitative design of most nursing leadership studies in which convenience sampling is frequently chosen (G Cummings, et al., 2010).

All head nurses were invited to take part in the research. Meanwhile, according to the database 550 staff nurses were employed in the hospital. To obtain results with a 95% level of certainty, the calculated sample size for staff nurses was 224 (Saunders, Lewis, & Thornhill, 2009; SurveySystem, 2012). The estimation of the level of certainty in this research is largely influenced by traditions in social research regarding appropriate sample sizes (Collis & Hussey,

2009; Saunders, et al., 2009) and it adheres to the same principles as previous nursing leadership research (Perkins, 2010).

To obtain study participants, the entire head nurses' pool was invited to participate in the research. Twenty-six head nurses were invited to take part in the study. For the sample of staff nurses, it was decided that recruitment should be based on a systematic random technique. Systematic random sampling was chosen for its accuracy and suitability for the setting and sample sizes. Simple random, stratified random, or cluster random sampling are better applied with much larger population sizes (Saunders et al., 2009). Systematic sampling involves selecting the sample at regular intervals from the sampling frame. The cases are selected systematically using the sampling fraction to determine the frequency of selection (Saunders et al, 2009). In this case, the sampling fraction was obtained by dividing the population size by the required sample size.

$$f = n \div N$$

Given the sample size of 224 (n) and the total population of 550 (N), the obtained fraction was estimated at 2.4. The fraction of 2.4 showed the starting point for choosing the sample, which was somewhere between the first two people on the database list which was in alphabetical order. I decided to fix the starting point at person number two and then continue to select at every second interval after this until the desired sample size had been achieved.

The next screening step for the obtained random sample or participants was to ensure that all the persons selected fulfilled the inclusion criteria. According to the database information, these selected staff nurses were eligible to take part in the study. The recruited staff nurses covered all the wards and ambulatory care in the hospital except for the lactation and family planning unit, which was staffed entirely by midwives.

Participants for the study were obtained. Prior to administrating the survey, the study had undertaken research ethics approval from the University of Sheffield. Ethics approval procedure along with the ethical challenges faced along the way and how they were addressed will be presented in the following section.

### 3.3.7. Ethics

This research aims to explore Indonesian nurses' perspective on leadership through a mixed methodologies approach. Prior to administering the survey at the targeted hospital, the Zainoel Abidin General Hospital (ZAGH) in Banda Aceh, Indonesia, I had an opportunity to informally arrange *meet and greet* sessions with the nursing director and all the wards' and ambulatory care's head nurses. I introduced myself and explained what I intended to do in the hospital. During these meetings, they demonstrated their hospitality and welcomed my intention to conduct research in their workplace. They were kindly supportive and showed their interest in the study, expressing the hope that it would improve nursing leadership capacity in the country. This approach was in line with the suggestion by Bryman (2008). The procedure towards data collection is summarised in the following figure.

Figure 3.3-1 Data collection procedure



The study ethical procedure has been approved by the University Research Ethics Committee (UREC) at the University of Sheffield. My correspondents with the ethics committees have highlighted potential discomforts that may occur to the nurses and how to resolve it. In this research, there is a potential distress caused as a result of participants discussing the leadership behaviour of their line managers. In an effort to avoid such discomfort therefore the nurses can talk about issues in general and need not discuss their own line managers' behaviours and actions. The findings of research will be fed back to participants, although this will be done using anonymous data. This is outlined in the participant information sheet and will be reiterated at the beginning of each interview. Every effort will also be made to avoid interviews at times which may expose staff to additional fatigue and tiredness (e.g. at the end of a shift). Further to this, safety is the priority. The fieldwork was undertaken during office hours in a busy suburban hospital. There is limited risk to the personal safety of the researcher. Interviews and survey activities were undertaken in areas of the hospital which place the researcher at very low risk.

Finally, ethics approval from the UREC and permission from the director of ZAGH through its research and development department, and written agreement for data to be collected from each care unit's head nurse, were obtained. After collecting all of these, I was ready to administer the survey to the participants. The following section will present the data collection process for the study.

### 3.3.8. Data collection for this study

Confidentiality and anonymity are imperative in research. To ensure that no information collected will allow the identification of participants, no personal names or addresses should be

collected (Collis & Hussey, 2009). Since this research is a mixed-methods study, it was, however, necessary to identify participants of the survey phase as potential qualitative interviewees. With this in mind I collected relevant identifiable data at the outset which were separated from the survey responses and subsequently used to assist in the recruitment of interviewees.

A number of units were involved in the survey stage; these are listed below.

Table 3.3-2 List of units involved in the study

<u>No</u>	<u>Unit of Care</u>
1	Emergency Department
2	Neurological ward
3	Medical surgical wards
4	Internal medicine wards
5	Paediatrics ward
6	VIP wards
7	Intensive care unit
8	Neonatal intensive care unit
9	High care unit
10	Operation theatre
11	Thalasemia unit
12	Dialysis unit
13	Surgical ambulatory care
14	Orthopaedic ambulatory care clinic
15	Eyes ambulatory care
16	Endocrine ambulatory care
17	Internal medicine ambulatory
18	Skin and genital ambulatory clinic
19	Ear, nose and throat (ENT) ambulatory clinic
20	Paediatrics ambulatory clinic
21	Heart ambulatory care clinic
22	Lungs ambulatory care clinic

As the survey was administered, each selected participant received a study pack containing the following:



- 1) A covering letter informing them of the nature of the study (i.e., survey and interview)
- 2) A participant information sheet relating to the survey part of the study (i.e., survey)
- 3) A copy of the MLQ-Indonesian version questionnaire with return envelope (i.e., survey)
- 4) A consent form for the interview part of the study (i.e., phase-2 qualitative study) along with a separate return envelope
- 5) A participant information sheet relating to the interview part of the study (i.e., phase-2 qualitative study).

The ethics panel agreed that consent to take part in the survey would be deemed implicit by the return of the MLQ questionnaire. In the event of a survey participant also wishing to take part in the qualitative study, they were required to read the information sheet and complete a qualitative interview consent form along with their contact details and basic demographic information, returning it in the separate envelope provided in the pack. By recruiting for the qualitative interview study in this way, the anonymity of the data collected in the survey will not be compromised.

In order to use the MLQ-5X Short Version in this survey, the researcher had to abide by the copyright requirements as stipulated in the MindGarden, Inc., the license holder of the instrument, and indicate that the researcher had used the translation by Avolio and Bass (1995), translated into Bahasa Indonesia in 2006. Furthermore, all information leaflets were written in the Indonesian language. The translation of the covering letters, participant information sheets,

and consent forms was conducted prior to administering the study pack to the participants (See appendix).

There were two versions of the MLQ for the two respondent groups. The Rater – MLQ 5X-short was given to the nurse managers, and the MLQ-Later form was given to the staff nurses. In the process of conducting the research, interaction between nurse managers and staff nurses was avoided (Mack, Woodson, MacQueen, Guest, & Namey, 2005). They were also informed that participation was voluntary and that they could withdraw from the study at any time. Prior to filling in the questionnaire, participants were asked to answer a series of short demographic questions, including age, gender, ethnicity, highest nursing degree achieved, years of experience, nursing skills certificate attained (if any), and shift assignment.

The study pack for the survey was hand-dispatched on Monday 18 November 2013. This method of delivery was chosen not merely for its ease of use, but because no other option was available in the system. The internal mail system and the IT (Information Technology) for internal emails were not in place. Therefore, hand delivery was the only option for administering the survey pack to the participants.

It was expected that the questionnaires would be returned by mid-December 2013 at the latest. To ensure that the survey was completed in a timely fashion, I made phone calls and site follow-up visits to each unit to ensure that the participants did not encounter any problems with the survey. It was anticipated that the survey would achieve an excellent response rate. Apart from the follow-up attempts, additional efforts were needed to provide clear and attractive instructions at the point of recruitment and to make myself available to answer any questions about the study (Bryman, 2008).

Each ward and unit returned the survey packs in different phases. The shortest time taken was two weeks while others were completed and returned after four weeks. I found that the busier the care units, the more time needed to deal with the survey. However, the head nurse told me that they were being very proactive and attentive to ensure that each selected staff nurse in their units received the survey pack, and they were asked to take the opportunity to read the information provided carefully prior to deciding to participate in or withdraw from the research.

By the end of the third week of December, 2013, all the survey packs from the involved wards and units had been returned. Each questionnaire in the returned packs was then examined to check its applicability for further data analysis. After checking all the returned surveys, I found that the overall response from both head nurses and staff nurses was excellent. Gaining the collective support of the head nurses and staff nurses prior to conducting the study was a crucial factor in achieving this excellent response rate.

#### 3.3.9. Data analysis

Several points will be addressed in this subsection. The first concerns the preparation of the data for analysis; the second is the analysis part which involved descriptive and statistical analysis techniques to answer the research questions.

##### *Data Preparation*

Data preparation for analysis involves data classification and data entry. Since the study applies SPSS software, correct data classification and data entry provide initial and important guidance for the use of software in the analysis.

The next step after the data classification is the data entry. Data entry requires great care because it is prone to error. Thus, it is important for the researcher to verify and correct mistakes at this stage (Polit & Beck, 2008). Data entry starts with data cleaning which involves checking for outliers and wild codes. After the data have been cleaned, the next stage is data coding, by allocating numbers to data, and data layout, usually in the form of tables. The next step is to deal with missing data. The missing values may be caused by refusals, errors, or skip patterns at the data entry stage. Therefore, researchers need to minimise non-response subjects to avoid potential bias at the later stage of the analysis (Gray, 2009; Polit & Beck, 2008). Finally, after finishing the data preparation, the analysis can be performed.

In this study, the initial step prior to analysis was the data preparation, in particular the data coding process. The coding steps consisted of allocating codes to the answers to each question, allocating computer columns to each question, producing a codebook (available in the thesis appendices), and checking codes (Bryman & Cramer, 2004; De Vaus, 2002). The next stage was to enter the data into SPSS, having checked and cleaned for errors and missing data. After finalising this step, the proposed statistical tests were ready to be performed (Bryman & Cramer, 2004). Discussion of the statistical analysis will be provided in the following sections.

### *Statistical Analysis*

The application of Likert responses is common in research. However, it has been apparent that misuses or mistakes in Likert data analysis often occur (Boone & Boone, 2012). In this thesis, the variables are measured on a Likert scale (i.e., a five-point scale ranging from 0 = not at all to 5 = frequently, if not always, for leadership styles). Prior to deciding the correct

procedure for data analysis, a clear understanding of Likert-type items and Likert scales is pertinent in order that an appropriate measure of statistical analysis might be addressed.

The difference between Likert-type items and Likert scales depends on how the researcher treats the responses. Likert-type items are types of questions that use some elements of the various Likert responses but the researcher does not attempt to combine the responses from the items into a composite scale; meanwhile, a Likert scale consists of a series of four or more Likert-type items that are pooled together into a single score at the data analysis stage (Clason & Dormody, 1994). In this case, the researcher is interested in the combined score that depicts the character/personality of the study subjects (Boone & Boone, 2012). In an interesting argument raised by Polit & Beck (2008), it was initially suggested that the Likert scale instrument generates data that are actually ordinal; however, they asserted that many analysts believe that treating them as interval measures results in too few errors to warrant concern.

Prior to analysing Likert data, the measurement scale represented by each item needs careful attention. Likert-type items categorised as ordinal measurement scales because of the numbers assigned to this type of item indicate a stronger relationship without necessarily describing how much stronger. Recommended descriptive analyses for ordinal measures include the mode or median for central tendency and frequencies for variability. Chi-square or Kendall Tau tests are also appropriate for further investigation of the measure (Boone & Boone, 2012). The description of Likert data analysis is presented in the following Table.

Table 3.3-3 Suggested data analysis procedures for Likert-Type and Likert Scale Data

Suggested data analysis procedures for Likert-Type and Likert Scale Data		
	Likert-Type Data	Likert Scale Data
Central Tendency	Median or mode	Mean
Variability	Frequencies	Standard deviation
Associations	Kendall tau B or C	Pearson's <i>r</i>
Other Statistics	Chi-square	ANOVA, t-test, regression

Source: Boone & Boone, 2012

As suggested in the above table, the treatment for Likert scale data is apparently different. An interval measurement scale is applied. Since Likert scale items are formed by combining the scores from four or more Likert-type items, the merged score for Likert scales should be analysed at the interval scale. Suggested descriptive statistics are the mean for central tendency and standard deviations for variability. Appropriate extended data analyses for this interval scale measurement include Pearson's *r*, t-test, ANOVA, and regression techniques (Boone & Boone, 2012).

The differences between Likert-type data and Likert scales have been discussed. The discussion has helped to confirm the compatibility of the chosen statistical analysis in this study, which tends towards a parametric test. The following subsection discusses some general assumptions as the foundation for the determination of a suitable statistical test (Field, 2009).

#### Parametric Test for this Study

This study applied parametric analysis. The basis for this decision is related to a set of particular assumptions; there are several generic suppositions that call for researchers' attention, as follows:

- Continuous measures
- Random sampling
- Normal distribution
- Independence of observations
- Homogeneity of variance

(Pallant, 2010).

In this thesis, assumptions of continuous measures, random sampling, and independence of observations are dealt with prior to data collection.

Continuous measures for these data were met. Since the study applied a standardised questionnaire, the manual for handling the data obtained has been provided by the instrument developer, including a technique to rescale the collected data into continuous variables (Avolio, et al., 2004).

For random sampling, it is stated that the method has to be ideally met for parametric testing; however, this assumption is not regularly applied in the field (Pallant, 2010). Yet, to enhance the data, I have attempted to address the random method in the sampling strategy.

Normal distribution plays a key role in inferential statistics (Polit & Beck, 2008). Field (2009) has asserted that the hypothesis-testing is expected to have a normal distribution, but when this assumption is not found, the logic behind the hypothesis is flawed (p. 132). However, a large sample size of more than 30 should not cause a problem if this assumption is violated (Pallant, 2010). Mindful of this assumption, I have therefore examined and included the values of skewness and kurtosis of the data to assess their normal distribution.

The following assumption is the independence of observations. This suggests that each observation must not be affected by any other observation (Pallant, 2010). The two or more

groups comprise distinct individuals, not the same individuals measured twice (StatGuide, 2013). The assumption, however, depends upon the parametric tests used (Field, 2009), which are frequently related to certain statistical analyses such as t-test or ANOVA.

A further parametric test assumption is the homogeneity of variances. This is used to check whether the variances of two groups (or more) differ (Bryman & Cramer, 2004). The Levene test for equality of variances can be applied to check this assumption (Bryman & Cramer, 2004; Field, 2009). The Levene test is used to examine homogeneity of variances. The Levene test is significant at  $p < 0.05$ . If the value of the test is  $> 0.05$ , the variances are significantly different. Meanwhile, if the Levene test shows a score of  $< 0.05$ , this means that the variances are averagely equal; i.e. the assumption of homogeneity of variances is confirmed (Garson, 2012).

To assess the normality assumption, there are two ranges of tests; it can be presented as graphs or as a numerical feature. Visual presentation includes the use of histograms, Q-Q plots or boxplots, while numeric presentation includes skewness, kurtosis, Kolmogorov-Smirnov (K-S) or Shapiro-Wilk tests (Bryman & Cramer, 2004; Field, 2009). The K-S test is generally less powerful than other tests of normality (StatGuide, 2013); the K-S is the preferred choice in non-parametrical tests in which assumptions about the distribution of the variables are not involved (Bryman & Cramer, 2004). The Shapiro-Wilk test, meanwhile, is indeed a powerful tool for checking normal distribution; however “the test for kurtosis may be more powerful than the Shapiro-Wilk test, especially if the heavy-tailedness is not extreme. If a distribution has normal kurtosis but is skewed, the test for skewness may be more powerful than the Shapiro-Wilk test, especially if the skewness is not extreme” (StatGuide, 2013).



The use of skewness and kurtosis is preferred in this study. A common rule-of-thumb test for normality is to run descriptive statistics to obtain skewness and kurtosis and then divide these values by the standard errors (Garson, 2012). The skewness helps to reveal the symmetry of the distribution, while kurtosis informs the distribution peakedness (Polit & Beck, 2008). When the longer tail points to the right, the distribution is rather positively skewed, and vice versa. Positive kurtosis values show too few cases in the tails, while negative kurtosis indicates too many cases in the tails of distribution (Garson, 2012). The skewness and kurtosis values should be within the +2 to -2 range when data are normally distributed; some authors prefer the +1 to -1 criterion when normality is critical (Field, 2009; Garson, 2012). In this thesis, the analysis criterion used was within the range of +2 to -2.

The MLQ-5X Short is the survey instrument applied in this research. It is a Likert scale measure and is continuous. Therefore, as suggested by Boone et al. (2012), the use of mean, standard deviation, t-test, Pearson correlation, and regression are suitable for analysing the survey questionnaires returned by the study participants. Although the normality of data in this research was confirmed due to the large sample size, the test to prove this assumption was conducted by assessing skewness and kurtosis values. Overall, common assumptions for the parametric test have been generally met. The data are now ready for further analysis, starting with an assessment of the descriptive statistics.

### *Descriptive Statistics*

Descriptive statistics describe and summarise data (Polit & Beck, 2008). According to DeVaus (2002), descriptive statistics are applied to reveal patterns in the responses of people in a

sample and to examine variables that may or may not support the statistical test assumptions applied in answering the research questions (Pallant, 2010).

The information collected from the descriptive statistics includes frequency, mean, standard deviation, range of scores, and skewness, all of which are helpful for a brief description of the study participants (Pallant, 2010). The mean is found to be the most widely used descriptive statistic for clarifying patterns in a set of data; it is also the most stable index of central tendency because mean values fluctuate less than modes or medians. This assumption applies when scores' distribution is symmetrical. On the other hand, in skewed distribution the values of mean, mode, and median will differ, with mean values leaning in the direction of the long tail (Polit & Beck, 2008). In this research, means and standard deviations are helpful for interpreting certain research questions assuming that the data express normal distribution; therefore, the technique was considered appropriate for this study.

The presentation of graphical analysis is frequently applied in descriptive statistics. Not all types of graphs, however, are compatible with all types of data (Pallant, 2001). The type of graph used depends on the type of data available. To gather demographic information in the study, categorical variable patterns were applied. Therefore, frequencies were used to find out how many people provided each response. Continuous variables, meanwhile, are accompanied by descriptive statistics that supply the mean, standard deviation, median, kurtosis, and skewness. In addition, some information in the sample and variables are better communicated by graphs such as pie chart, histogram, or scatter plot. For example, correlations between two continuous variables can be shown on a scatter plot (Polit & Beck, 2008). The scatter plot helps the reader to visualise the magnitude and direction of the relationship (Bryman & Cramer, 2004; De Vaus, 2002).

### *Statistical Analysis:*

In addressing the research questions, there are two stream tests that largely suit the inquiries; these are related to identification of differences between groups and their relationships. Each of the steps is discussed below.

#### a. Differences Between Groups

Statistical analysis tests to examine differences between groups include the t-test, one-way analysis of variance (Salanova, Lorente, Chambel, & Martínez), two-way ANOVA, multivariate analysis of variance (MANOVA), or analysis of covariance (ANCOVA). The number of groups determines the appropriate test of differences. The following discussion provides an overview of the different statistical analysis tests.

The t-test is applied to investigate the differences in means between two sets of groups. It is used to find significant differences between two mean scores of two variables: one categorical, independent variable and one continuous, dependent variable (Saunders, et al., 2009). There are three types of t-test: one-sample t-test, independent samples t-test, and paired t-test. A one-sample t-test is used when comparing a single sample of participants with the mean value of the population from which the sample is drawn. An independent t-test is conducted to determine statistically significant differences in mean values between two groups. Meanwhile, when a researcher needs to compare mean scores of two groups at two different times, the paired t-test is used (Saunders, et al., 2009). Before proceeding to conduct the t-test, there are several codes of conduct that should be noted: first, the level of measurement should be at the ratio or interval type of measure; second, the scores should be randomly drawn from the population; and, lastly, the scores should have normal distribution (Coakes & Steed, 2009).

One-way ANOVA is used to examine significant differences in the mean scores of continuous dependent variables within three or more groups (Saunders, et al., 2009). Statistical analyses known as multiple comparison procedures or *post hoc* tests are required to determine where these differences exist (Polit & Beck, 2008). If a researcher aims to investigate the impact of two categorical independent variables on one continuous dependent variable, the two-way ANOVA test takes place for statistical analysis purposes (Saunders, et al., 2009).

The extension of the ANOVA test is in the form of one-way MANOVA or ANCOVA. The one-way MANOVA is required when a researcher wishes to compare mean values of two or more groups of continuous dependent variables; specifically, this requires one categorical, independent variable and two or more continuous, dependent variables. In the meantime, ANCOVA is applied to find differences between groups of a dependent variable; at the same time, the researcher controls for one or more covariates (i.e., typically an extraneous influence on the dependent variable) (Polit & Beck, 2008). The variables occupied in ANCOVA consist of one categorical independent with two or more levels, one continuous dependent variable, and one or more continuous covariates (Saunders, et al., 2009).

Multiple approaches to identifying differences among groups under study have been provided. The application of the analysis techniques for investigating significant differences reveals that the discussed statistical analysis of t-test and ANOVA are appropriate for application in the study. The t-test helps to identify the differences between the staff's and head nurses' perceptions of leadership; meanwhile, since several demographic characteristics are available in the data, ANOVA is most suitable for finding the difference in more than two groups in their perceptions of leadership and outcomes (i.e., continuous dependant variables).

b. Relationships between Variables

Several approaches are used to examine the relationships between variables. These include Pearson correlation, multiple regression, factor analysis, Chi-square test, discriminant factor analysis, logistic regression, canonical correlation, and structural equation modelling. The tests of Pearson correlation, multiple regression, and factor analysis are commonly applied in survey research (Pallant, 2010). I intended to use relationships analysis in this study to further explain the survey results and to assist me in providing an in-depth discussion of the MLQ application in the research.

Recognising that a number of tests are available to identify the relationships as well as the assumptions underlying each of them, I realised that the Pearson correlation and regression analysis are the most appropriate tests for my purposes. Pearson correlation is an analysis used to identify the strength and direction of two continuous variables. There are several assumptions to fulfil prior to conducting the analysis: (1) the level of measurement should include interval or ratio variables, or one type of continuous variable with one dichotomous independent variable; (2) each subject must be related pairs in both variables of interest; (Law) each measurement should be free from other measurement influence; (4) each variable has to show a normality type of distribution (i.e., confirmed by histogram check) ; (5) the scatter plot should establish a roughly straight line; and (6) the variables should have homoscedasticity (i.e., the pattern or scatter of the points should be similar to all values) (Pallant, 2010).

The Pearson relationships coefficient lies between -1.00 and +1.00. The coefficient indicates the type of relationship found between variables. This, however, does not imply the strength of the relationship. The sign of the coefficient merely indicates a positive or negative relationship between variables of interest (Pallant, 2010). Furthermore, the Pearson test can be

extended in the form of a technique known as multiple regression. It is also commonly applied by researchers to explore the predictive ability of independent variables over one continuous variable. The idea of regression is to summarise the relationship between two variables by generating a line that fits the data closely (i.e., the line of best fit) (Bryman & Cramer, 2004; Pallant, 2010).

The description of relationship statistical analysis has been presented. The Pearson product moment analysis and regression are the best tools to obtain information on the extent of the relationship between the perceived leadership and outcomes among these nurses. The basic assumptions for such tests have confirmed the suitability of this chosen analysis for use in this study.

The following is a summary of each statistical test technique used to answer some of the research questions in this study that can be assessed using these quantitative analyses:

**Descriptive analysis** was applied to gather information on participants; it included frequency, percentage, mean, standard deviation, skewness, and kurtosis. The purpose of this analysis was to answer the following research questions: (1) To what extent is leadership present in Indonesia, as measured by the MLQ? (2) How do nurses in Indonesia perceive leadership?

**Independent samples t-test and ANOVA** were used to answer research question no. 3: “Do nurses in different hierarchical positions construe leadership in the same way?” The t-test analysis was applied to identify differences between head nurses, staff nurses, and data demographic variables in their interpretation of leadership.

**Pearson correlation and multiple regression** were used to look for the relationships between the variables. The aim was to conduct further analysis on the above statistical tests. In addition, the analysis was applied to find possible relationships between variables and, thus, does not

ascertain a cause-effect relationship (De Vaus, 2002). Pearson correlation was applied to provide a further explanation of the statistical findings in the MLQ survey. It was applied to identify relationships between leadership styles and the outcomes, which was intended to assist and sharpen the discussion of the research findings.

A detailed exploration of the quantitative methods used in this study has been presented. As an expansion, and to complement this initial analysis, qualitative methods were pursued. The following discussion will present the process and procedure of conducting the qualitative methods in the field.

### **3.4. Phase II**

This section will address the details of the qualitative phase of this study. The discussion includes a review of the purposes, the data collection process, and the analysis procedure.

#### **3.4.1. The purpose**

The purpose of the qualitative method was to provide further exploration of the research questions in this study. The qualitative study was intended to broaden the discussion context of nursing leadership by obtaining an in-depth understanding of the nature of nurses' leadership dynamics in the country. This approach was intended to enable me, as the researcher, to gain valuable insights, allowing adequate conceptualisation of nurse leadership in Indonesia which, in turn, may be useful for identifying additional features that might be incorporated into the MLQ in the future.

### 3.4.2. Data collection

The following subsection presents a discussion of the data collection method for the qualitative phase of the study. The range of approaches for collecting qualitative data is discussed generally in order to provide a justification for the chosen method.

#### *Methods for Collecting Qualitative Data*

According to Ritchie et al., the application of qualitative methods is largely dependent on the research aims and specific questions that need to be addressed. There are two broad groups of approaches to collecting qualitative data: obtaining naturally occurring data and using generated data methods (Ritchie, Lewis, Nicholls, & Ormston, 2013).

The use of naturally occurring data is an approach developed to investigate phenomena in their natural settings. The method is useful for exploring and gaining an understanding of social behaviours and interactions in their real contexts. The approach is commonly relevant for studies that seek understandings of culture or community lives. Particular methods of gathering data in naturally occurring settings include the following:

- Participant observation: the researcher combines the constituent study population or its organisational or community settings to record actions, interactions, or events. This method is useful for anthropological and ethnographic research as it gives the researcher direct access to experience and observe the phenomena.
- Observation: this method gives the researcher the opportunity to record and analyse behaviours, events, or actions through his/her own eyes. It is particularly useful for investigating processes in which several players are involved, where unspoken communications are likely to be important.



- Documentary analysis: this is conducted when events do not allow direct investigations or access. The data collection involves the study of any existing publications or reports to gather understandings of substantive elements of unobservable situations.
- Discourse analysis: this involves the construction of texts and verbal accounts to explore systems of social meaning (Tonkiss, 2000, as cited in Ritchie et al.). A set of sources including written materials or interviews are used to analyse peoples' interpretations of social action.
- Conversation analysis: the method examines the details of how conversations are constructed and enacted. The main aim of this method is to explore social intercourse in natural settings.

The second broad approach to qualitative settings is the generated data method. The approach involves a process of recalling attitudes, thoughts, or events from peoples' own perspectives as well as allowing them to contemplate the meaning of those beliefs to them. There are several ways of generating data, including the following:

- Biographical methods: these use life stories or experience to understand the phenomena of interest. The source may be either verbal or non-verbal types of data.
- Individual interviews: these are considered the most frequently applied method in qualitative studies. Interviews provide an undiluted or straight-focus perspective from the individuals in whom the phenomena under study are present. The subject can be covered in great detail in order that further understanding might be obtained from participants' personal contexts.
- Paired (or triad) interviews: these are in-depth interviews with two or three individuals at the same time. Paired interviews allow participants to reflect on what

they hear from each other. This is useful when investigating subjects in which others may hold important roles or when the subject is complex and it is advantageous to explore it in a joint reflection.

- Focus groups: this method involves four-to-ten participants discussing the research topic together. Focus groups have a particular value when it is felt that the group process will illuminate the research issue. As the participants are all able to pour out their ideas or thoughts throughout the discussion, focus groups provide an opportunity for reflection and refinement which can sharpen respondents' insights into their own circumstances.

(Ritchie, et al., 2013)

Cognisant of the broad range of options available for qualitative data collection, I had to decide which one would best suit the research. Lewis (2003) had suggested that the researcher's choice of method is largely influenced by which type of data will best illuminate the phenomena under research and by practicality. The researcher also needs to consider the importance of context, whether a recounting of the research phenomenon is likely to be sufficiently detailed, the paramouncy of interpretation, and accessibility.

Generated data collection methods allow respondents to describe the personal or organisational contexts in which research phenomena are located and how they relate to them. However, if the issue under investigation requires observation in a natural setting in order to yield sufficient understanding, the naturally occurring data method is preferred. Naturally occurring data also bring value when the research subject is a complex process or interaction in which the respondents sometimes cannot be expected to give a detailed or full account of the research topic. Naturally occurring data depend on what is observed or read by the researcher.

The researcher undertakes the role of interpreting the data and making them explicit. Meanwhile, the meanings of generated data rely on respondents' interpretation as they are allowed to explain their answers on the research topic in their own words. Additional explanations of the investigated phenomena may, however, be provided by the researcher, although the critical parts are the participants' point of view. The final factor to be considered by the researcher when choosing data collection methods is accessibility. Assuming that events of interest exist, the researcher has to consider how to gain access to that environment. Should generated data be the choice, the researcher will need to judge which approach is most feasible to shed more light on the research issue (Ritchie et al., 2013)

The key methods in generated data approaches are in-depth interviews and focus groups. Lewis has asserted that in-depth interviews and focus groups play different roles; therefore, the selection is based on three factors: the type of data sought; the subject area; and the nature of the study group.

- The nature of the data sought indicates how detailed the exploration will be. In-depth interviews provide an opportunity for full-account investigations of each individual perspective within which the phenomenon is located. The approach is even more useful for exploring complex or sensitive issues at a very detailed stage. Meanwhile, subjects are covered in fewer details in focus groups. This method is appropriate when interaction between participants will help to illuminate the research focus.
- The subject area: in-depth interviews are generally best applied to sensitive subjects or experiences as they allow in-depth focus, clarification, and detailed understanding of phenomena. Focus groups, however, are best suited to more abstract or intangible topics that can be tackled when the group members work together.

- The study groups: in-depth interviews allow better access to participants than focus groups, particularly when very busy respondents or those with mobility constraints are involved. Research participants in in-depth interviews have nothing in common. However, commonality is useful in focus groups as the relationships formed by the members may help them to shape ideas or engage in creative thinking.

Table 3.4-1 Applications of In-depth Interviews and Focus Groups

	In-depth Interviews	Focus Groups
Nature of data	<p>For generating in-depth personal accounts</p> <p>To understand the personal context</p> <p>For exploring issues in depth and in detail</p>	<p>For generating data that are shaped by group members' interaction - refined and reflected</p> <p>To display a social context - exploring how people talk about an issue</p> <p>For creative thinking and solutions</p> <p>To display and discuss differences between the group members</p>
Subject matter	<p>To understand complex processes and issues (e.g., motivations, decisions)</p> <p>To explore private subjects or those involving social norms</p> <p>For sensitive issues</p>	<p>To tackle abstract and conceptual subjects where enabling or projective techniques are to be used; or in difficult or technical subjects where information is provided</p> <p>For issues that would be illuminated by the display of social norms</p> <p>For some sensitive issues, with careful group composition and handling</p>

Study population	For participants who are likely to be less willing or able to travel	Where participants are likely to be willing and able to travel to attend group discussion
	Where the study population is geographically dispersed	Where the population is geographically clustered
	Where the population is highly diverse	Where there is some common background or relationship to the research topic
	Where there are issues of power or status	For participants who are unlikely to be inhibited by a group setting
	Where people have communication difficulties	

Source: Ritchie et al., 2013

*Method for Collecting Qualitative Data in this Study*

Reflecting on the presented discussions, I decided to pursue generated data methods. Since the focus of this study is nursing leadership, I considered it wise to apply these methods because they allow participants to describe the context from their own perspective and how they relate to it. Providing respondents with the opportunity to explore their own thoughts and to be explicit as well as spontaneous in presenting their ideas has helped me to gain a greater understanding of leadership phenomena directly through the nurses' eyes.

After considering generated data methods as the approach best suited to this study, I then had to make a further decision about which method to use to gather the points of view of the participants, i.e. whether in-depth interviews or focus groups would help me to answer the research questions in this study. Initially I considered focus groups for qualitative data collection; however, cognisant of several factors such as the difficulty of bringing all the nurses together due

to their various daily duties and the need for the research to explore individual perspectives, I realised that personal in-depth interviews would best assist me to obtain an understanding of nursing leadership. The obvious strength of this face-to-face approach which guided me to select it is the fact that it would help me to explore the leadership concept in more depth and detail compared to other techniques. Moreover, the status barrier among nurses in the hospital in which the research was located also led me to prefer in-depth interviews to focus groups. I was concerned that the hierarchical power may inhibit those nurses from being brave enough to “speak out” in group discussions (Cook, 2001; Su, et al., 2012).

### 3.4.3. Sampling characteristics and selection criteria

This subsection presents an overview of sampling methods in qualitative studies. The discussion initially focuses on scholars’ reviews of sampling approaches before explaining the sample size applied in this study.

#### *Sampling in Qualitative Studies*

Guest et al. have mentioned that sampling design frameworks for qualitative studies are virtually non-existent. The concept of sampling relies on the saturation stage: the point at which no new theme or information is obtained. Guest et al.’s study intended to operationalise saturation. They found that saturation can be obtained within the first 12 interviews, while metathemes were present in six interviews (Guest, Bunce, & Johnson, 2006). Charmaz (2011) has suggested that the study objectives are the main determinant of research design as well as sample size. A small qualitative study with modest claims would generate saturation faster than a complex one (Charmaz, 2011).

In addition to a mixed-methods approach, Creswell and Plano-Clark (2011) recommend that the individuals who participate in the qualitative study should be those who have participated in the quantitative phase, thus helping to provide a stronger connection between the two phases. Qualitative participants will be selected on the basis of the quantitative statistical results, especially those likely to be most helpful in explaining the phenomena of interest (Creswell & Plano-Clark, 2011). The qualitative follow-up phase might reasonably have a smaller number of participants than the quantitative phase (Creswell & Plano-Clark, 2011; Teddlie & Yu, 2007).

It is understood that saturation point is the level that qualitative data need to achieve; however, the concept offers little guidance for estimating the qualitative sample size (Guest, et al., 2006). Guest et al. mentioned that limited guidelines are available for determining the actual sample size. For example, they found only seven publications that specifically address actual sample size. Among them are Morse's (1994) suggestion for an ethnographic and ethnoscience study based on a sample of 30-50 interviews, Creswell's (1998) suggested sample of 20-30 for grounded theory, or Creswell's (1998) notion of a sample of five to 25 for investigating phenomenology. However, these authors did not provide their empirical arguments for the use of these numbers. Furthermore, there are no explanations of why a certain approach requires more participants than others (Flick, 2009).

#### *Sampling Approach in this Qualitative Study*

The purpose and aims of the study are the ultimate determinants when drawing qualitative samples (Mason, 2010). Regardless of the number of participants, it is the skills of

the researcher that determine the quality of data collected (Morse, Barrett, Mayan, Olson, & Spiers, 2008).

In keeping with mixed-methods guidelines, therefore, the recruitment process was initiated when the initial survey was delivered; an additional page containing a voluntary agreement to be contacted for the qualitative study was attached. This information was kept securely and was not divulged to any third parties.

In addition to this guideline, a theoretical sampling strategy was applied. This process is mainly used in grounded theory and is a kind of purposeful sampling method (Coyne, 1997). In this process of selecting samples, the researcher jointly collects, codes and analyses the data and decides what data to collect next (Glaser & Strauss, 1967). I opted for this strategy because the sampling is a data-driven type of process (Coyne, 1997). The approach was considered in this study in order to anticipate the richness of data in cases where information obtained from the respondents (i.e., those who consented earlier) was less sufficient. This strategy was also employed for clarification purposes, especially for topics that are important in the context; further investigation may be needed for certain issues.

There are three types of theoretical sampling strategy: Open sampling, relational or variational sampling, and discriminate sampling (Corbin & Strauss, 1990). In open sampling, researchers are open to all possibilities of participants, places, or situations. Relational or variational sampling relates to purposefully chosen persons, sites, or documents that maximise possibilities of generating data regarding variations among dimensions of categories. Discriminate sampling involves the sites or persons who will maximise the chances of verifying the story lines and relationships between categories, or filling in poorly developed categories (Corbin & Strauss, 1990). With this guidance, I decided that relational or variational sampling



would greatly suit my purposes as I would be able to invite persons for interviews who would potentially be able to deliver sharper information to provide a better understanding of the nursing leadership context among the nurses in the research site. They would be persons who are highly experienced in terms of the leadership roles they hold in the setting. However, since the strategy is a data-governed type of method, modification was liable to occur as the analysis evolved.

#### *Sample Size in this Qualitative Study*

With the aim of reaching saturation, I decided that, in this study, 20 nurses would be recruited: ten nurse leaders and ten staff nurses. This sample size was based on my attempt to be consistent with previous mixed-design nursing leadership research (Upenieks, 2003), and this sample was deemed sufficient for the purpose of gathering qualitative data (Guest et al., 2006).

#### 3.4.4. Interviews procedure in this Study

A semi-structured interview approach was applied to obtain qualitative data. Semi-structured interviews allow a flexible interview process, enabling the researcher to gain the interviewee's perspective and understanding on issues and events, and forms of behaviour (Bryman, 2008). The interview questions were developed based on the literature review and the quantitative findings as well as other issues of interest, in particular the cultural aspects of leadership. For example, there was a question about "what do the nurse understand by the term leadership?" Such question is pertinent to ask because it draws the mainstream for the research. Main reason in choosing this question was related to published literatures and related research that mostly explore the definition of leadership at the first stage prior to investigate other associated factors such as work setting, years of employment, etc. In addition to that, personal

interest also involved. Previous experience as nursing student in the hospital introduced the image that these nurses have less opportunity to sharpen their leadership skills. Thus, I wanted to explore in-detail about the nurses perspective on the term of leadership as crucial segment of the research.

I used an interview guide containing a list of questions to be covered (see appendix for interview questions). The whole interview process was conducted in Indonesian. Prior to conducting the interviews in the observed hospital, the interview guidelines were pilot-tested with two staff nurses and two head nurses in another hospital to ensure that the questions were clear and the answers addressed the intended inquiries.

#### 3.4.5. Translation and transcription issues and strategy

Presenting the findings from qualitative data collected in one language and translating them into another is argued to have an impact on the trustworthiness and credibility of the research (Birbili, 2000). Given that the qualitative data for this study will be collected through interviews conducted in Indonesian, translation is required to present the findings in English. Difficulties may be created by the narrative being presented with a different interpretation in translation, as well as issues around the translation of words for which there is no true equivalent in the source language (Twinn, 1997).

Although it has been asserted that translation may challenge the validity of research, scholars have underlined that this risk is manageable when the translation process is conducted by a person who is well-versed in both languages and their cultural backgrounds. The researcher's language proficiency, along with an intimate cultural understanding, will greatly

facilitate the process of finding equivalent and comparable meanings between the source and target languages (Chen & Boore, 2010).

Several alternative strategies have been proposed to improve the rigour of qualitative data. Interviews conducted in an original language should be transcribed verbatim; then each transcript should be translated into the target language (English). Multiple checks against the translated transcript during analysis and synthesis are recommended to enhance data credibility. In the second strategy, the transcribing process should only be conducted for key themes or issues that emerge in the translation process. However, although this approach saves time and money, it may produce a greater risk of losing key information and result in incomplete interpretation of the context because of possible distortion in drawing key messages from the participants (Regmi, Naidoo, & Pilkington, 2010).

In response to the aforementioned strategies, Chen and Boore (2010) developed an intermediate procedure based on a review of literature and their own previous study. They did not propose translating all data from the source language into English for analysis because they found that similar concepts and categories were developed during analysis of the qualitative data, regardless of whether Chinese or English was used as the medium for analysis (Chen & Boore, 2010). In their strategy, the content of interviews is transcribed verbatim in the original language, and key themes that emerge are then translated into English (Chen & Boore, 2010).

Despite the absence of standardised procedures for evaluating the impact of translation on the credibility of qualitative data (Chen & Boore, 2010), researchers who have to translate data from one language into another are required to be explicit in describing their decisions, as well as the translation procedures and the resources used (Birbili, 2000). Therefore, to check and validate the accuracy of the transcription and translation, the following strategies are employed

in this research: First, I transcribed all interviews in Indonesian and analysed them; second, after collecting key messages, I translated the themes into English. In order to check the accuracy, I sought some advice and worked closely with the University of Syiah Kuala language centre, part of my host institution. Back-translation may be conducted at this point to ensure that the translated key information has comparable meanings in both languages (i.e., English and Indonesian).

At the beginning of each interview, I have explained how the data were collected and treated confidentially. The interview notes, the survey responses and the analysis were kept in a locked cabinet in a secure place. I managed to ensure that at no time during the interview process did staff nurses and nurse managers meet or interact. All audio recordings were also kept securely until they had been transcribed. The transcriptions contained no information that would allow individuals to be identified and they were kept in an electronic format on a secured and password-protected computer. After the final analysis has been completed, all electronic data will be permanently deleted, and all hard-copy documents will be destroyed.

#### 3.4.6. Data analysis

This subsection presents data analysis approaches in qualitative data. The discussion provides an overview of the methods and then explains the approach applied in this study.

##### *Data Analysis in Qualitative Research*

The qualitative approach generates a vast amount of data. Namey et al. have asserted that typical analysis of qualitative data involves content and thematic analysis. Content analysis is valued for its efficiency and reliability. A large numbers of text files can be quickly scanned and

keywords tallied. Meanwhile, thematic analysis emphasises the identification of explicit and implicit ideas from the obtained data; this approach allows a deeper interpretation of the analysis than the content method by developing codes for themes or ideas which are then linked to initial data (Namey, Guest, Thairu, & Johnson, 2007).

Scholars have described templates or models of analysis for qualitative data, such as template analysis (King, Cassell, & Symon, 2004) or framework analysis (Pope et al., 2000). Regardless of the chosen method or researcher preference for certain analyses, there is no main or ultimate approach to analysing qualitative data (Namey, et al., 2007). The models, in fact, simplify reality as a tool to provide a powerful perceptual grid for further understanding of the phenomena of interest (T. Cummings & Worley, 2001)

Regardless of the methods applied for analysis, they all share common general approaches. Qualitative analysis involves the transcription of data verbatim, the organising of data into easy-to-retrieve sections, familiarisation with data by reading and re-reading them, preliminary coding after familiarisation with the data, identification of themes or emergent concepts, and interpretations (Lacey & Luff, 2007).

Software packages have been available to assist researchers during data analysis. However, even if computer-assisted software is at hand, the software package will not be able to perceive links between theory and data or define an appropriate structure for analysis (Pope, Ziebland, & Mays, 2000); it is the role of researcher determination and his/her analytical skills to move the research toward propositions about the data.

### *Data Analysis for Qualitative Data in this Study*

The aim of the analysis was to further explore nurses' leadership phenomena as well as to complement quantitative method findings in the first phase of this study. In this study, after I had transcribed the interview recordings verbatim and checked them for accuracy by comparing them with the original recordings, I imported these anonymised transcripts into the NVivo Version 10, which is a computer-assisted qualitative data analysis software package. To protect the interviewees' anonymity, any identifiable information provided by the respondents, such as people's names or work units, was removed.

In analysing qualitative data, I prefer a form of analysis that tends to be inductive, thereby allowing the inclusion of a presumption or *a priori* as well as emergent concepts. The inclusion of *a priori* concepts was considered appropriate since previous ideas or concepts gained from the literature and previous quantitative studies could be included as identified categories in developing themes. However, during the analysis I was mindful of remaining open to new information and concepts that may emerge from the data (King et al., 2004) to ensure that the data were generated inductively (Namey, et al., 2007).

Amongst the methods that met my criteria was Framework Analysis (Lacey & Luff, 2007). I applied the Framework procedure to conduct a thematic analysis of the qualitative data. This procedure has been developed at the National Centre for Social Research in the UK (Bryman, 2008). The Framework approach is commonly applied in health research (Pope, et al., 2000). The most notable strength of the technique is that the analytical process tends to be more explicit and strongly informed by *a priori* reasoning or preset aims/research objectives. According to Bryman (2008) and Pope et al. (2000, p. 116), there are five stages in the Framework technique: (1) familiarisation, (2) identifying a thematic framework, (3) indexing,

(4) charting, and (5) mapping and interpretation. Details of how these steps were addressed are outlined below:

- Familiarisation

The purpose of this step is to achieve immersion in the raw data (or typically a pragmatic selection from the data) (Pope et al., 2000). I attempted to achieve familiarisation in this study by listening to tapes, reading transcripts, studying notes, etc, in order to list key ideas and recurrent themes. In doing so, I achieved an initial familiarisation at the mid-point of the data collection process. I selected five transcripts and reviewed them. This approach was in line with the suggestion by Ritchie et al. (2003), as it enabled me to see the patterns and diversity of respondents interviewed within that period. During the process, some key topics and potential themes emerged. From this stage, I was able to note the general atmosphere of the interviews, which was later used to develop the second step of the analysis.

- Identifying a thematic framework

The second stage of analysis involves identifying all the key issues, concepts and themes by which the data might be examined and referenced (Pope et al., 2000). In this study, I found that developing a thematic framework was a dynamic process and I attempted to refine the emerging themes over the course of data analysis. This was carried out by drawing on *a priori* issues and questions derived from the aims and objectives of the study as well as issues raised by the respondents, as identified in the familiarisation stage,

and views or experiences that recur in the data. The end product of this stage was a hierarchical index of themes, topics and subtopics that labelled the data into manageable chunks for subsequent retrieval and exploration.

- Indexing

The aim of indexing is to apply the thematic framework or index systematically to all the data in textual form (Pope et al., 2000). This process entailed annotating the transcripts with numerical codes from the index, usually supported by short text descriptors to elaborate index headings for relevant topics and subtopics from the thematic framework. Single passages of text can often encompass a large number of different themes, each of which has to be recorded, usually in the margin of the transcript; therefore, when new topics emerged, new categories were created and needed to be added to the framework. The process for indexing in this analysis was performed through NVivo. The software allowed me to create a system called “nodes” to represent individual topics or subtopics. The data indexed at the created nodes can be retrieved at a single click, thus facilitating data management for this qualitative study.

- Charting

Charting entails rearranging the data according to the appropriate part of the thematic framework to which they relate, and forming charts (Pope et al., 2000). Unlike simple cut-and-paste methods that group together verbatim text, the charts contain distilled summaries of views and experiences. The charts enable the analyst to find patterns and details of similarities or differences in a theme or concept (Ritchie et al., 2003).



Therefore, I constructed the charts by creating columns to identify the respondents and their demographic details, and for notes and synthesis of observations.

- Mapping and interpretation

The purpose of this stage is to use the thematic charts to define concepts, map the range and nature of phenomena, create typologies and find associations between themes with a view to providing explanations for the findings (Pope et al., 2000). The process of mapping and interpretation is influenced by the original research objectives as well as by the themes that have emerged from the data themselves. To explicitly explain the phenomena perceived by the nurse respondents, the thematic charts were transformed into a visual presentation. This model will be elaborated in the qualitative findings chapter to help explain the relationship between themes and subthemes. The use of direct quotations under the themes facilitated the authenticity of the explanatory and contextual factors identified, and it also assisted the exploration of similar or distinct views expressed by the nurses. Clarification of subjects under discussion, if needed, was done by inserting additional words inside square brackets. Each nurse respondent was represented by a number to protect her identity; however, the age, position and work unit were included in the text in order that comparisons within the demographic groups might be visible to the reader.

### 3.4.7. Methodological quality of qualitative study

The assessment of a qualitative study is based on the rigour of the methods employed. Therefore, as the researcher I need to demonstrate that the methods used are reproducible and consistent. In this quality assessment, I adhered to certain criteria suggested by Lacey et al. (2001). Among the factors that I have attempted to address in order to ensure the quality of analysis are the following:

- a. Describing the approach to and procedures for data analysis
- b. Justifying why these are appropriate within the context of the study
- c. Clearly documenting the process of generating themes or concepts from the data
- d. Referring to external evidence, including previous qualitative *and* quantitative studies, to test the conclusions from the analysis as appropriate.

(Lacey & Luff, 2007)

The majority of the points stated have been explored in the above explanation of this qualitative section. The explanation and justification of framework analysis as the chosen approach for the study have been presented, including an explicit description of attempts to document each stage of the analysis procedure. External evidence to support the conclusion, however, will be addressed further in the discussion chapter of the thesis.

The rigour of the study results depends on the researcher's ability to represent an analysis that is accurate and truthful according to the data collected (Lacey & Luff, 2007). To enhance the trustworthiness of the study, credibility, transferability, dependability, and confirmability are the key factors to which I must attend (Guba & Lincoln, 1994).

I attempted to maximise the credibility of the analysis by conducting constant comparisons, as described in point (b) of the framework analysis stages above, whereby the

process of refining the thematic framework was sustained as the research analysis progressed; thus, all topics that emerged from the transcript data were incorporated into the framework. I also checked for the deviant cases. This involves the examination of contradictory data (Mays & Pope, 2000). Identification of such data was useful for refining factors that further explain the context of the study.

Transferability in qualitative findings alludes to the generalisability of the findings beyond the research setting (Ritchie, et al., 2013). To make this assessment, I have therefore attempted to provide the most representative description of the research setting and methods used in the study. In the meantime, the dependability of the analysis findings needs to be emphasised. To achieve this, regular discussions with the research supervisors during the analysis stage were very helpful for sharpening the findings. In other words, this was done to achieve agreement on the themes I have developed and on the interpretation of the data. Briefings and supervisory advice help to underline any potential biases that may occur during interpretations of the data (Teddlie & Tashakkori, 2009).

The last point I have to carefully take into account is the confirmability. This relates to adequate and systematic use of the original data in that readers might be convinced that the interpretations of the analysis relate to the data gathered (Lacey & Luff, 2007). I dealt with this criterion through reflexive notes or field diaries during the qualitative phase of this study. In this way, the researcher will be aware of the ways in which the findings may be influenced by the researcher's prior assumptions and/or experience (Mays & Pope, 2000).

### **3.5. Chapter Summary**

The research methodology for both the quantitative and qualitative phases of the study has been discussed. The methodology has been presented to justify the most appropriate design, method, and analysis for each study phase.

The choice for the quantitative research was the survey questionnaire. This method was chosen because it was appropriate for addressing the research questions, it provided the basis for an overview of nursing leadership styles among nurses, and it was practical to apply within the available study period.

The qualitative study was conducted via personal in-depth interviews. Its strengths as well as my own aim of gaining a greater understanding of nursing leadership have been the main reasons for preferring this method over others. In the analysis stage, although the applicability of the Framework Analysis has been noted for the research needs, I remained flexible with the analysis approaches. This was merely because no ultimate methods were available for qualitative analysis; besides, they all share common procedures but may use different terms or labels. The attempt to achieve reliability and validity in the research is also presented to ensure the accuracy and truthfulness of the analysis.

## **CHAPTER 4**

### **PHASE I**

### **QUANTITATIVE STUDY**

#### **4.1. Introduction**

The aim of this study was to explore nursing leadership in Indonesia. How these nurses perceive leadership was measured by the MLQ-5X survey questionnaire. This chapter presents the findings from the analysis of the research survey, in particular how nurses rate themselves and their leaders' leadership styles. The main analysis techniques used to analyse the survey data are descriptive and parametric statistical tests such as t-test, ANOVA, Pearson Correlation, and regression. The rationale for the selection of these approaches to the analysis of the survey data has been outlined in Chapter 3. All the statistical analyses were performed using SPSS version 21.

This chapter begins with a brief overview of the survey procedure and descriptive statistics of the participants. Following this, the nurses' perceptions of leadership styles are presented. Differences between the head nurses' self-perceptions and their staff nurses' perceptions of their leadership styles are examined. Here, nurses' demographic profiles were also explored to determine whether they made any difference to how they perceived leadership. In addition, correlation analyses between the leadership style of the head nurses as perceived by staff nurses and the staff nurses' satisfaction, effectiveness, and willingness to exert extra effort were undertaken. These outcomes are among the variables explored in the MLQ survey instrument. Finally, as stated in the purpose of the quantitative study, findings obtained in this initial phase of the research were expected to help frame general perspectives on nursing leadership among nurses in the country.

## **4.2. Procedure**

### **4.2.1. Review of Survey Procedure**

After obtaining ethical approval from the University of Sheffield and the Zainoel Abidin General Hospital (ZAGH), the study setting, the researcher approached 250 nurses to complete the MLQ 5X survey for the study. Of these, 224 participants were staff nurses and 26 were head nurses. The MLQ questionnaire was administered in person. Participation was on a voluntary basis and both head nurses and their staff were encouraged to fill in the survey as honestly as possible. Participants were informed that all their answers would remain confidential and only the researcher would have access to the responses. The survey consisted of nine questions of a demographic nature and 45 questions in the MLQ Form 5X Short; it was carried out between 18 November and 15 December 2013. In the demographic questionnaire, all participants were asked to choose one option for each question which best described their natural setting. Meanwhile, the MLQ Form 5X questions were answered by circling or crossing the one number in each statement that coincided with their views or was at least close to their opinions. Responses in the MLQ took the form of a five-point Likert scale ranging from “not at all” to “frequently, if not always.” The head nurses completed the Rater form and the staff nurses filled in the Later Form. The total amount of time spent answering the survey ranged from 15 to 20 minutes (see Appendix for a copy).

### **4.3. Description of Participants**

The participants' demographics surveyed included age, gender, ethnic group, religion, educational level, position, length of employment, training received, and shift assignment. The

Tables below show the descriptive statistics of head nurses and staff nurses in the form of frequency and percentage.

Table 4.3-1 Descriptive statistics of head nurses (n=26)

Age Group	Frequency	Percent
31-40	2	7.7
41-50	21	80.8
51-60	3	11.5

Sex	Frequency	Percent
Female	26	100.0

Ethnic Groups	Frequency	Percent
Acehnese	24	92.3
Javanese	2	7.7

Religion	Frequency	Percent
Islam	26	100.0

Education	Frequency	Percent
Diploma III-Nursing	1	3.8
Diploma IV-Nursing	11	42.3
Bachelor-Nursing	11	42.3
Diploma IV-Midwifery	2	7.7
Bachelor-Public Health	1	3.8

Training	Frequency	Percent
BTCLS/ACLS <sup>1</sup>	23	62.5
Chemotherapy	1	12.5
E&D	1	12.5
Dialysis	1	12.5

Work Shift	Frequency	Percent
Morning	26	100.0

<sup>1</sup> BTCLS: Basic Trauma and Cardiac Life Support  
 ACLS: Advance Cardiac Life Support

Length of Employment (Years)	Frequency	Percent
11-15	4	15.3
16-20	6	23.1
21-25	3	11.5
>26	13	50.0

Type of Unit Care	Frequency	Percent
Critical care	6	23.1
Medical surgical	6	23.1
Ambulatory care	14	53.8

Source: Analysis of survey data

Table 4.3-1 highlights the descriptive statistics (frequency) of demographic descriptions of the head nurses who participated in the study. The largest group of head nurses by age was the 41-50 group (80.8%), followed by the 51-60 group (11.5%). The smallest group by age was the 31-40 group (7.7%). All the participating head nurses were female (100%) and most of them were native Acehnese (92.3%); only a few were of Javanese origin (7.7%). Nearly half of the head nurses had completed undergraduate degrees in nursing (42.3%) and Diploma IV in nursing (42.3%). The rest of them graduated with Diploma IV-Midwifery (7.7%), Diploma III in nursing (3.8%) and Bachelor's degrees in public health (3.8%). They had attained basic and advanced trauma life support certificates (62.5%). Meanwhile, several of them had the same percentage trainings in chemotherapy, advanced accident and emergency, and dialysis (12.5%). As for the work shifts, all the head nurses worked only in office hours (100%). Half of the head nurses had been employed in the hospital for more than 26 years (50%); they are very experienced nurses in the hospital. Some of them had 16-20 years of employment (23.1%) while slightly fewer had 11-15 years (15.3%) and 21-25 years of tenure (11.5%). In addition, the participating head nurses were predominantly ambulatory care leaders (53.8%) followed by critical care and medical surgical unit head nurses.



The following Table shows the descriptive statistics of staff nurses participating in the study.

Table 4.3-2 Staff nurses' demographic description (n=224)

Age Group	Frequency	Percent
21-30	97	43.3
31-40	95	42.4
41-50	28	12.5
51-60	4	1.8
Sex	Frequency	Percent
Male	39	17.4
Female	185	82.6
Race	Frequency	Percent
Acehnese	221	98.7
Gayonese	1	.4
Bataknese	2	.9
Religion	Frequency	Percent
Islam	224	100.0
Education	Frequency	Percent
Diploma III-Nursing	121	54.0
Diploma IV-Nursing	21	9.4
Bachelor-Nursing	73	32.6
School of Health Nurse/Senior High Level	3	1.3
Diploma III-Midwifery	5	2.2
Diploma IV-Midwifery	1	.4
Training	Frequency	Percent
No Training	188	83.9
BTCLS/ACLS	26	11.6
Wound care	9	4.0
HIV/AIDS	1	.4
Work Shift	Frequency	Percent
Morning	124	55.4
Noon	61	27.2
Night	39	17.4
Length of Employment	Frequency	Percent
<5 years	87	38.8
6-10 years	78	34.8
11-15 years	20	8.9
16-20 years	16	7.1
21-25 years	10	4.5
>26 years	13	5.8

Unit of Work	Frequency	Percent
Critical care	75	33.5
Medical surgical	84	37.5
Ambulatory care	65	29

Source: Analysis of survey data

According to the table above (Table 4.3-2), the largest group of staff nurses by age was the 21-30 group (43.3%) followed by the 31-40 group (42.4%) and the 41-50 group (12.5%). The smallest group by age was the 51-60-year-olds (1.8%); therefore, from these data we can see that the staff nurses at the hospital are relatively young. More than half of the staff nurses were female (82.6%), while the male staff accounted for 17.4%. The majority of nurses were Acehnese (98.7%). The remainder were Bataknese (0.9%) and Gayo (0.4%). Among these nurses, only 0.4% had completed Diploma IV-Midwifery, while school health nurses (Senior high school level) accounted for 1.3%; the majority of them were Diploma III-Nursing graduates (54%). However, a significant number of them possessed a Bachelor's in nursing (32.6%). Just over a third of the staff nurses in the survey had been working in the hospital for less than five years (38.8%), while others had been employed for 6-10 years (34.8%). Only a small number had worked for 21-25 years (4.5%). The data presented in Table 4.3-2 on the staff nurses' years of work showed that the staff predominantly have less experience. In addition, a small percentage of the staff nurses reported that they had received nursing care training. Several of them hold basic and trauma life support certificates (11.6%), while some have received wound care (4%) and HIV/AIDS care training (0.4%). In the study, half of the staff nurses involved in the survey were on the morning shift (55.4%), followed by those on the noon shift (27.2%) and the night shift (17.4%). The nurses participating in this research mostly work in the medical

surgical unit (37.5%) and critical care (33.5%); meanwhile, a smaller number of surveys were received from ambulatory care unit staff (29%).

#### **4.4. Measures**

The head nurses' and staff nurses' demographics descriptions have been outlined. In the meantime, the MLQ 5X, the measure for the study, comprised three leadership dimensions:

- a. Transformational leadership (20 items)
  - 1) Idealised attributes (4 items)
  - 2) Idealised behaviours (4 items)
  - 3) Inspirational motivation (4 items)
  - 4) Intellectual stimulation (4 items)
  - 5) Individualised consideration (4 items)
- b. Transactional leadership (8 items)
  - 1) Contingent reward (4 items)
  - 2) Management-by-exception (active) (4 items)
  - 3) Management-by-exception (passive) (4 items)
- c. Laissez-faire (8 items)

In addition, three leadership outcome variables measured by the instrument were as follows:

- a. Satisfaction
- b. Effectiveness
- c. Extra effort

The ratings scale for the MLQ was as follows: (0) Not at all, (1) Once in a while, (2) Sometimes, (3) Fairly often, and (4) Frequently, if not always. Through the survey, assessment of nurses' leadership in the thesis entails exploration of the following:

- Head nurses' self-perceived leadership styles
- Staff nurses' perceptions of head nurses' leadership styles
- Difference between the head nurses' self-perceptions and their staff nurses' perceptions of their leadership style
- Difference between demographic profiles and the perceived leadership factors of the head nurses
- Identification of relationships between the leadership style of head nurses as perceived by staff nurses and the staff nurses' willingness to exert extra effort, leaders' effectiveness, and job satisfaction

## **4.5. Results**

### **4.5.1. The perception of leadership style**

This section provides a review of the analysis of head nurses' and their current nursing staff's perceptions of leadership behaviours. The transformational, transactional, and laissez-faire leadership perceptions were identified by the use of the MLQ-5X questionnaire.

#### **a. Head nurses' perceptions of their transformational leadership style**

Head nurses' perceptions of the transformational leadership style are presented in the following Table.

Table 4.5-1 Head nurses' perceptions of transformational leadership (n = 26)

Variables	Mean	SD	Skewness	Kurtosis
Transformational Leadership	2.5423	.58236	-.220	-.582
Idealised attributes	2.1538	1.04661	.814	1.524
Intellectual stimulation	2.3558	.60487	.194	2.455
Individualised consideration	2.6346	.64896	-.129	-.433
Inspirational motivation	2.6635	.91089	-1.365	2.409
Idealised behaviours	2.9038	.60447	-.208	-.487

Source: Analysis of survey data

The means and standard deviations of head nurses' responses on MLQ items that measure transformational leadership were obtained to analyse the existence of transformational leadership among them. The five factors of transformational leadership style showed mean scores as follows: *idealised attributes*, 2.1; *intellectual stimulation*, 2.3; *individualised consideration*, 2.6; *inspirational motivation*, 2.6; *idealised behaviours*, 2.9. In the meantime, the composite mean score of transformational leadership was 2.5. The standard deviations were rather small, except for the idealised attributes factor, at 1.04. The MLQ survey has a response range of *not at all* (0) to *frequently, if not always* (4). The results as shown in these data signified that head nurses perceived themselves as transformational leaders. All head nurses' responses indicated that, *sometimes to fairly often*, they express the transformational leadership style. Among the five factors, *idealised behaviours* had the highest mean score, which highlighted that the head nurses utilise this more than the other transformational leadership variables.

b. Head nurses' perceptions of transactional leadership

The analysis of the transactional leadership variables among the head nurses is presented in the Table below.

Table 4.5-2 Head nurses' perceptions of transactional leadership (n = 26)

<b>Variables</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Skewness</b>	<b>Kurtosis</b>
Transactional Leadership	2.1635	.33206	-.105	-.356
Management-by-exception Passive	.9712	.62581	.473	-.247
Management-by-exception Active	2.5673	.63858	-.060	.287
Contingent reward	2.9519	.74168	-1.082	2.005

Source: Analysis of survey data

The means and standard deviations of head nurses' responses on transactional leadership are as follows: *Management-by-exception (Passive)*, 0.97; *management-by-exception (Active)*, 2.5; and *contingent reward*, 2.9. The data revealed that the head nurses possess transactional behaviours, 2.1, which *fairly often* appeared through the use of *contingent reward* followed by the *management-by-exception (Active)* factor. The *management-by-exception (Passive)* factor was also utilised by the head nurses but only *once in a while*.

c. Head nurses' perceptions of laissez-faire leadership style

Assessment of head nurses' perception of laissez-faire is presented in the Table below.

Table 4.5-3 Head nurses' perceptions of laissez-faire leadership (N = 26)

<b>Variables</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Skewness</b>	<b>Kurtosis</b>
Laissez-faire	.6154	.55331	.391	-1.477

Source: Analysis of survey data

From the data above, it was determined that the mean of the head nurses' responses was 0.61 with an SD of 0.55. This score indicated that the head nurses perceive themselves as expressing laissez-faire leadership factors *not at all to once in a while*.

d. Staff nurses' perceptions of head nurses' transformational leadership

The following Table presents staff nurses' perceptions of their head nurses' transformational leadership style.

Table 4.5-4 Staff nurses' perceptions of transformational leadership (n = 224)

<b>Variables</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Skewness</b>	<b>Kurtosis</b>
Transformational Leadership	2.5147	.53300	.056	.140
Individualised consideration	2.2913	.66648	-.145	.037
Idealised attributes	2.3125	.67382	.265	-.262
Intellectual stimulation	2.3471	.69898	-.272	-.080
Inspirational motivation	2.7455	.65010	-.689	1.885
Idealised behaviours	2.8772	.69632	-.265	-.460

Source: Analysis of survey data

The mean scores obtained from the nursing staff for the five factors of transformational leadership were as follows: *individualised consideration*, 2.2; *idealised attributes and intellectual stimulation*, 2.3; *inspirational motivation*, 2.7; and *idealised behaviours*, 2.8. Staff nurses perceived that their line head nurses exhibit transformational leadership (2.5) through all the five factors. According to the staff, the head nurses' usage of these factors ranged from

*sometimes* to *fairly often*. Among these, *idealised behaviours* rated the highest, followed by the *inspirational motivation factor*. In other words, this shows that staff nurses perceive that their leaders' behaviour inspires them and their head nurses are convincing role models.

e. Staff nurses' perceptions of head nurses' transactional leadership

The nursing staff's perceptions of their head nurses' transactional leadership style are described in the following Table.

Table 4.5-5 Staff nurses perceptions of head nurses' transactional leadership (n = 224)

<b>Variables</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Skewness</b>	<b>Kurtosis</b>
Transactional Leadership	2.1429	.47822	.143	-.216
Management-by-exception Passive	1.1663	.75797	.699	.409
Contingent reward	2.4810	.65904	-.627	.599
Management-by-exception Active	2.7813	.72017	-.722	1.008

Source: Analysis of survey data

The mean score in the data showed that staff nurses perceived that their head nurses *sometimes* express transactional leadership (2.1; SD = 0.47). The most common factor was *management-by-exception active*, 2.7, followed by *contingent reward*, 2.4 and *management-by-exception passive*, 1.1. This means that staff nurses perceived that their head nurses' utilisation of these three factors ranged from *once in a while* to *fairly often*.



f. Staff nurses' perceptions of head nurses' laissez-faire leadership style

Nursing staff at the ZAGH perceived that their head nurses' were utilising the laissez-faire factor *not at all to once in a while*. The mean score for this style was 0.88 and SD = 0.71. The Table below depicts this result.

Table 4.5-6 Staff nurses' perceptions of head nurses' laissez-faire leadership

<b>Variables</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Skewness</b>	<b>Kurtosis</b>
Laissez faire	.8895	.71953	.734	.003

Source: Analysis of survey data

The findings on nurses' perceptions of leadership style as measured by the MLQ indicated that staff nurses perceived their head nurses as expressing both transformational and transactional leadership factors *sometimes to fairly often*. The head nurses also perceived this in a similar way. The difference in mean scores in these leadership factors was found in the *contingent reward* of the transactional leadership variable, in that head nurses were likely to practise it *fairly often*, but the staff nurses perceived it *sometimes*. In regard to laissez-faire factors, both the nursing staff's and head nurses' perception responses were *not at all to once in a while*.

4.5.2 Differences between the head nurses' self-perceptions and their current staff nurses' perceptions of their leadership style

After obtaining the initial information on head nurses' self-perceived leadership styles and staff-perceived leadership styles, the next step was to examine whether any significant differences exist among these groups of nurses by comparing the effect of the means of these two

groups. Therefore, an independent t-test analysis was conducted with the null hypothesis that there was no difference between the head nurses' perceptions and their current staff nurses' perceptions of their leadership style. General assumptions for the parametric tests have been discussed in the methods chapter. The following Table presents the t-test results

Table 4.5-7 Means differences between head nurses' perceptions and staff nurses' perceptions of the leadership style ( $P < 0.05$ )

<b>Variables</b>	<b>Position</b>	<b>N</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Std. Error Mean</b>	<b>P value</b>
Transformational Leadership	Staff Nurse	224	2.5147	.53300	.03561	0.805
	Head Nurse	26	2.5423	.58236	.11421	
Idealised attributes	Staff Nurse	224	2.3125	.67382	.04502	0.457
	Head Nurse	26	2.1538	1.04661	.20526	
Idealised behaviours	Staff Nurse	224	2.8772	.69632	.04652	0.852
	Head Nurse	26	2.9038	.60447	.11855	
Inspirational motivation	Staff Nurse	224	2.7455	.65010	.04344	0.561
	Head Nurse	26	2.6635	.91089	.17864	
Intellectual stimulation	Staff Nurse	224	2.3471	.69898	.04670	0.952
	Head Nurse	26	2.3558	.60487	.11862	
Individualised consideration	Staff Nurse	224	2.2913	.66648	.04453	0.013*
	Head Nurse	26	2.6346	.64896	.12727	
Transactional Leadership	Staff Nurse	224	2.1429	.47822	.03195	0.778
	Head Nurse	26	2.1635	.33206	.06512	

Transactional Leadership	Staff Nurse	224	2.1429	.47822	.03195
	Head Nurse	26	2.1635	.33206	.06512
Contingent reward	Staff Nurse	224	2.4810	.65904	.04403
	Head Nurse	26	2.9519	.74168	.14546
Management-by-exception Active	Staff Nurse	224	2.7813	.72017	.04812
	Head Nurse	26	2.5673	.63858	.12524
Management-by-exception Passive	Staff Nurse	224	1.1663	.75797	.05064
	Head Nurse	26	.9712	.62581	.12273
Laissez-faire	Staff Nurse	224	.8895	.71953	.04808
	Head Nurse	26	.6154	.55331	.10851

Source: Analysis of survey data

The analysis of means differences indicated that head nurses' perceptions of the five transformational factors (idealised attributes, idealised behaviours, inspirational motivation, intellectual stimulation, and individualised consideration) ranged between 2.15 and 2.90. The staff nurses, in rating their leaders, perceived the transformational leadership factors between the mean scores of 2.29 and 2.87. The mean difference values between head nurses' self-rating of transformational leadership and staff perceptions of their head nurses' leadership were not statistically significant, with the exception of *individualised consideration* ( $P < 0.05$ ). These results indicate that the head nurses' perceptions of themselves as expressing transformational leadership behaviours are similar to those of their staff; however, the factor of *individualised consideration* was seen differently. The head nurses see themselves as utilising this particular factor to a much greater degree than their staff nurses' perceptions of this usage. In brief, this means that the head nurses perceive themselves as having the ability to coach their staff to fulfil their development needs.

Head nurses perceived themselves as using transactional leadership. Their mean self-rating perceptions of this leadership style ranged from 0.97 to 2.95. The staff nurses also indicated that their head nurses utilise transactional leadership, with mean scores ranging from 1.16 to 2.48. There was no statistically significant difference between the head nurses' perceptions and their staff's perception of transactional style. However, in the *contingent reward* factor, a statistically significant difference was obtained ( $P < 0.05$ ). This result showed that the head nurses rate themselves as using *contingent reward* ( $M=2.95$ ;  $P < 0.05$ ) to a greater extent than was perceived by their nursing staff. Lastly, analysis of the means of the laissez-faire leadership factor also showed that there was no statistically significant difference between head nurses' and their staff's perceptions. Head nurses' and staff's perceptions of this factor ranged from 0.61 to 0.88.

The results on all nine factors (i.e., five transformational factors, three transactional factors, and one laissez-faire factor) highlighted that staff nurses confirmed their head nurses' self-assessments of leadership style. The analysis of means differences generally showed no significant difference in head nurses' and their nursing staff's perceptions of leadership, except for the *individualised consideration* and *contingent reward* factors. However, this data set indicated that transformational leadership was perceived as preferable to transactional and laissez-faire leadership styles.

#### 4.5.3 Analysis of differences between demographic characteristics and the perceived

transformational, transactional, and laissez-faire leadership factors of the head nurses at the ZAGH

Results of the MLQ survey analysis showed the existence of transformational leadership among the nurses. Transactional leadership, however, was rated as the second most predominant style. In the meantime, laissez-faire was perceived as the least. However, it had yet to be determined whether the demographic characteristics of the nurses contributed to the differences in their perceptions of leadership. To discover whether the demographic profiles of the nurses might explain any differences in how they perceived the entire leadership range, the perceptions of the total sample (n = 250) of both head nurses and their staff were tested.

In order to obtain the data for this enquiry, one-way ANOVA was conducted. The test was particularly aimed at seeking significant differences between the selected demographic characteristics of age, gender, education, experience, type of care unit where the nurses currently work and transformational, transactional, and laissez-faire leadership factors. The findings of this analysis are presented below.

##### a. Perceptions of leadership factors and nurses' age groups

The ANOVA analysis of nurses' perceptions of transformational leadership factors with the participants' age groups is set out in Table 4.5-8.

Table 4.5-8 ANOVA perceptions of leadership factors and nurses' age

Variables	F	Sig.
Transformational Leadership	.986	.400
Idealised attributes	2.628	.051
Idealised behaviours	1.061	.366
Inspirational motivation	1.349	.259
Intellectual stimulation	1.009	.389
Individualised consideration	.315	.814
Transactional Leadership	.109	.955
Contingent reward	.190	.903
Management-by-exception Active	2.226	.086
Management-by-exception Passive	.495	.686
Laissez-faire	.812	.488

Source: Analysis of survey data

Four age groups were examined with a view to identifying perceptions of leadership styles. The one-way ANOVA results on transformational leadership yielded the information that there was no significant difference in overall perceptions ( $P > 0.05$ ) of transformational behaviour and the five factors; however, the *idealised attributes* factor indicated a strong tendency to significant differences among them ( $P = 0.051$ ).

The ANOVA test on nurses' age and transactional leadership and laissez-faire styles also indicated that there were no significant differences. All the factors of transactional and laissez-faire leadership exceeded the alpha value ( $P > 0.05$ ). These results highlighted that the nurses, regardless of their age, showed no significant differences in their perceptions of transformational, transactional and laissez-faire leadership.

b. Perceptions of leadership and nurses' gender

The analysis to identify the differences in nurses' leadership perceptions and gender factors is described in the following Table.

Table 4.5-9 ANOVA of nurses' perceptions on leadership and gender

Variables	F	Sig.
Transformational Leadership	5.192	.024*
Idealised attributes	2.854	.092
Idealised behaviours	1.909	.168
Inspirational motivation	2.802	.095
Intellectual stimulation	5.803	.017*
Individualised consideration	2.864	.092
Transactional Leadership	6.577	.011*
Contingent reward	.619	.432
Management-by-exception Active	1.584	.209
Management-by-exception Passive	8.149	.005*
Laissez-faire	4.622	.033*

Source: Analysis of survey data

As shown in Table 4.5-9, male and female nurses were compared to determine whether there were any differences in their perceptions of leadership. The results showed statistically significant differences between the groups in all three leadership ranges (i.e., transformational, transactional, and laissez-faire leadership). With respect to transformational leadership ( $F=5.19$ ;  $P < 0.05$ ), the subscale of *intellectual stimulation* indicated a significant difference between male and female nurses ( $F=5.80$ ;  $P < 0.05$ ). Aside from transformational leadership, the data revealed that gender accounted for significant differences among these nurses in their perceptions of

transactional leadership ( $F=6.58$ ;  $P < 0.05$ ) and the laissez-faire factor ( $F=4.62$ ;  $P < 0.05$ ). In transactional behaviour, the significant difference scored highly in *management-by-exception passive* ( $F=8.15$ ;  $P < 0.05$ ). In other words, these data have indicated higher mean scores among male nurses with regard to transformational, transactional, and laissez-faire leadership perceptions compared to the female nurses.

c. Perceptions of leadership and nurses' level of education

The ANOVA results examining nurses' perception of leadership and their level of education are presented in the table below.

Table 4.5-10 ANOVA nurses' leadership perceptions and education

<b>Variables</b>	<b>F</b>	<b>Sig.</b>
Transformational Leadership	1.002	.417
Idealised attributes	.804	.548
Idealised behaviours	.685	.635
Inspirational motivation	.904	.479
Intellectual stimulation	.679	.639
Individualised consideration	.958	.444
Transactional Leadership	.799	.551
Contingent reward	.521	.760
Management-by-exception Active	.766	.575
Management-by-exception Passive	.962	.442
Laissez-faire	1.308	.261

Source: Analysis of survey data

The participants' level of education was examined to identify its influence on perceptions of leadership style. As depicted in Table 4.5-10, it appears that there was no significant difference between educational level and all leadership subscales ( $P > 0.05$ ).



d. Perceptions of leadership and years of work experience

The one-way ANOVA test results on nurses' leadership perceptions and their length of experience are presented in the following table.

Table 4.5-11 ANOVA nurses' leadership perceptions and length of experience

<b>Variables</b>	<b>F</b>	<b>Sig.</b>
Transformational Leadership	1.336	.250
Idealised attributes	1.792	.115
Idealised behaviours	1.026	.403
Inspirational motivation	1.359	.241
Intellectual stimulation	1.091	.366
Individualised consideration	1.187	.316
Transactional Leadership	1.535	.180
Contingent reward	1.652	.147
Management-by-exception Active	.718	.611
Management-by-exception Passive	1.484	.196
Laissez-faire	.925	.465

Source: Analysis of survey data

Table 4.5-11 presents the assessment of nurses' leadership style in relation to participants' years of employment. In general, there was no significant difference in the means of transformational, transactional, and laissez-faire leadership styles and their subscales in respect of the nurses' experience ( $P > 0.05$ ).

e. Perceptions of leadership and nurses' type of care unit

The following ANOVA results depict nurses' perceptions of leadership and their current place of work.

Table 4.5-12 ANOVA nurses' perceptions of leadership and type of care unit

Variables	F	Sig.
Transformational Leadership	7.705	.001*
Idealised attributes	10.746	.000*
Idealised behaviours	5.580	.004*
Inspirational motivation	1.595	.205
Intellectual stimulation	3.811	.023*
Individualised consideration	6.657	.002*
Transactional Leadership	2.917	.056
Contingent reward	2.161	.117
Management-by-exception Active	4.521	.012*
Management-by-exception Passive	.630	.533
Laissez-faire	.598	.551

Source: Analysis of survey data

As shown in Table 4.5-12, there were a number of leadership factors that indicated significant differences in regard to nurses' leadership perceptions and the type of care unit in which they worked. The assessment of leadership range among nurses who worked in critical care, medical surgical, and ambulatory care units showed that the most significant difference occurred in transformational leadership perception ( $F = 7.71$ ;  $P < 0.05$ ). Nearly all the transformational leadership subscales produced significant results except for *inspirational motivation* ( $P > 0.05$ ). The factor of *idealised attributes* had the highest difference score ( $F = 10.75$ ;  $P < 0.05$ ), followed by *individualised consideration* ( $F = 6.66$ ;  $P < 0.05$ ), *idealised*

*behaviours* ( $F = 5.58$ ;  $P < 0.05$ ) and *intellectual stimulation* ( $F = 3.81$ ;  $P < 0.05$ ). Furthermore, the transactional leadership barely reached the significance level ( $P = 0.056$ ). The factor of *management-by-exception active*, however, showed a significant difference between these comparison groups ( $F = 4.52$ ;  $P < 0.05$ ). As for the laissez-faire style, the result of the test for this leadership factor was not statistically significant.

One-way analysis of ANOVA has been conducted. Information and data on the demographic characteristics of participating nurses and their leadership perspectives were obtained. The next step aimed to assess the relationships between nurses' leadership perceptions and the three organisational outcomes as outlined in the MLQ survey. The process and findings gathered from the analysis of the enquiry will be explored in the following section.

#### 4.5.4 Relationships between leadership style of head nurses as perceived by staff nurses and staff nurses' willingness to exert extra effort, leaders' effectiveness, and staff nurses' job satisfaction

To obtain data in this enquiry, two steps had to be taken. The initial stage was to attend to the means and standard deviations of the head nurses' perceptions and their staff's perceptions; the second was to assess the relationship analysis and regression in order to identify the effect of the staff nurses' perceptions of the leadership style of the head nurses on the willingness of the nursing staff to exert extra effort, their effectiveness, and their job satisfaction.

Data on mean score analysis of head nurses' and their staff's perceptions of the three outcomes are summarised in Table 4-5-13.

Table 4.5-13 Head nurses' perceptions of the outcomes of extra effort, effectiveness, and job satisfaction

<b>Leadership Outcomes</b>	<b>N</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Skewness</b>	<b>Kurtosis</b>
Extra Effort	26	2.5256	.65437	-.451	-.001
Effectiveness	26	2.8077	.75269	-.326	-.382
Satisfaction	26	3.0962	.67852	-.897	2.252

Source: Analysis of survey data

The data revealed that head nurses perceived that they encouraged their staff nurses to exert extra effort *sometimes to fairly often* (M = 2.52); they also perceived that their nurses were effective *sometimes to fairly often* (M = 2.80) and that they were satisfied with their work *fairly often to frequently, if not always* (M = 3.09).

The information on how staff nurses perceived these outcomes is described in the next Table.

Table 4.5-14 Staff nurses' perceptions of the outcomes of extra effort, effectiveness, and job satisfaction

<b>Leadership Outcomes</b>	<b>N</b>	<b>Mean</b>	<b>Std. Deviation</b>	<b>Skewness</b>	<b>Kurtosis</b>
Effort	224	2.7917	.79250	-.471	.217
Effectiveness	224	2.6295	.77480	-.221	.290
Satisfaction	224	2.7701	.83883	-.358	.105

Source: Analysis of survey data

The mean scores of nursing staff's perceptions of the leadership outcomes were generally similar. The staff's willingness to exert extra effort was 2.79; this shows that they were willing to exert extra effort *sometimes to fairly often*. As for the effectiveness of their head nurses, the staff perceived their head nurses as effective *sometimes to fairly often* (2.62). Job satisfaction was also

perceived in the same range (2.77). This indicates that nursing staff were satisfied with their jobs *sometimes to fairly often*.

After the analysis of head nurses' and their staff's perceptions of the three outcomes, correlation analysis was used to obtain further information to determine the relationships between staff nurses' perceptions of the leadership style of their nurse managers and extra effort, effectiveness, and job satisfaction. The correlation test was conducted to assess relationships between the variables. The relationship results are presented in Table 4.5-14.

Table 4.5-15 Analysis of relationships between nurses' perceived leadership and the outcomes of extra effort, effectiveness, and job satisfaction

<b>Leadership Factors</b>	<b>Extra Effort</b>	<b>Effectiveness</b>	<b>Satisfaction</b>
Transformational Leadership	.494 <sup>**</sup>	.670 <sup>**</sup>	.622 <sup>**</sup>
Idealised attributes	.197 <sup>**</sup>	.411 <sup>**</sup>	.368 <sup>**</sup>
Idealised behaviours	.465 <sup>**</sup>	.458 <sup>**</sup>	.530 <sup>**</sup>
Inspirational motivation	.404 <sup>**</sup>	.511 <sup>**</sup>	.550 <sup>**</sup>
Intellectual stimulation	.539 <sup>**</sup>	.689 <sup>**</sup>	.622 <sup>**</sup>
Individualised consideration	.331 <sup>**</sup>	.562 <sup>**</sup>	.373 <sup>**</sup>
Transactional Leadership	.305 <sup>**</sup>	.484 <sup>**</sup>	.376 <sup>**</sup>
Contingent reward	.477 <sup>**</sup>	.561 <sup>**</sup>	.540 <sup>**</sup>
Management-by-exception Active	.434 <sup>**</sup>	.503 <sup>**</sup>	.430 <sup>**</sup>
Management-by-exception Passive	-.249 <sup>**</sup>	-.049	-.166 <sup>*</sup>
Laissez-faire	-.410 <sup>**</sup>	-.195 <sup>**</sup>	-.299 <sup>**</sup>

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

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

Source: Analysis of survey data

Correlation analysis results showed that staff willingness to exert extra effort has positive relationships with all five transformational leadership factors (*r* ranging between 0.19 and 0.54). Extra effort was also positively related to two transactional leadership factors: *contingent reward*

( $r = 0.48$ ) and *management-by-exception active* ( $r = 0.43$ ). In the meantime, negative relationships were found between extra effort of staff nurses and *management-by-exception passive* ( $r = -0.24$ ) and the laissez-faire factor ( $r = -0.41$ ).

As for the effectiveness of leaders, positive correlations were found with all five factors of transformational factors ( $r$  ranged between 0.41 and 0.69) and two factors of transactional leadership: *contingent reward* ( $r = 0.56$ ) and *management-by-exception active* ( $r = 0.50$ ). A negative relationship with the laissez-faire factor was noted ( $r = -0.19$ ).

Nursing staff job satisfaction had positive relationships with the whole range of transformational leadership factors ( $r = 0.36$  to  $0.62$ ). The two factors of transactional leadership were also positively correlated with staff satisfaction: *contingent reward* ( $r = 0.54$ ) and *management-by-exception active* ( $r = 0.43$ ). Furthermore, a negative relationship was found between *management-by-exception passive* ( $r = -0.05$ ) and the laissez-faire factor ( $r = -0.29$ ).

Analysis of correlations between leadership factors and the three outcomes outlined above showed a tendency roughly towards a positive relationship. However, it was not clear which leadership style in particular signified the outcomes. Therefore, regression analysis was performed in order to obtain information about the leadership style that best predicts outcomes. Data on regression tests of leadership factors and nurses' extra effort, effectiveness, and job satisfaction are shown in the table below.

Table 4.5-16 Regression model for leadership style factors and extra effort

<b>Leadership Styles</b>	<b>Beta</b>	<b>t</b>	<b>P value</b>
<b><u>Transformational Leadership</u></b>			
Idealised behaviours	.202	2.422	.016
Intellectual stimulation	.366	4.832	.000
<b><u>Laissez-faire</u></b>	-.278	-3.665	.000

Source: Analysis of survey data

The regression results showed that extra effort was significantly predicted by two transformational factors: idealised behaviours (Beta = 0.20, Sig. = 0.016) and intellectual stimulation (Beta = 0.37, Sig. = 0.000). The nursing staff outcome of extra effort was also significantly predicted by the laissez-faire style (Beta = -0.28, Sig. = 0.000). The model summary of the findings is as follows:

Table 4.5-17 Model summary

<b>Model</b>	<b>R</b>	<b>R Square</b>	<b>Adjusted R Square</b>	<b>Std. Error of the Estimate</b>
1	.666 <sup>a</sup>	.443	.420	.60367

Source: Analysis of survey data

Table 4.5-17 presents the model summary, which identifies that R = 0.666 and R<sup>2</sup> = 0.443. This model indicates that 44% of the variability of staff nurses' extra effort was explained by the model in which the significant variables lay in idealised behaviours, intellectual stimulation, and the laissez-faire.

Following the test on the staff's extra efforts, the next regression analysis was conducted to examine the prediction of leadership effectiveness of the leaders. The results can be seen in the table below.

Table 4.5-18 Regression of leadership factors and effectiveness

<b>Leadership Styles</b>	<b>Beta</b>	<b>T</b>	<b>P value</b>
<b><u>Transformational leadership</u></b>			
Intellectual stimulation	.474	7.002	.000
Individualised consideration	.243	3.794	.000
<b><u>Laissez-faire</u></b>	-.166	-2.456	.015

Source: Analysis of survey data

The regression test revealed that the staff's perceptions of leaders' effectiveness were significantly predicted by two transformational leadership factors: intellectual stimulation (Beta = 0.474, Sig. = 0.000) and individualised consideration (Beta = 0.243, Sig. = 0.000). The laissez-faire style was also noted as a significant predictor of leaders' effectiveness (Beta = -0.166, Sig. = 0.015). The model summary of the regression outcome is as follows:

Table 4.5-19 Model summary

<b>Model</b>	<b>R</b>	<b>R Square</b>	<b>Adjusted R Square</b>	<b>Std. Error of the Estimate</b>
1	.745 <sup>a</sup>	.555	.537	.52749

Source: Analysis of survey data

The model summary in Table 4.5-19 indicates that  $R = 0.745$  and  $R^2 = 0.555$ . Thus, the model reveals that 55% of the variability of nursing staff's perceptions of leaders' leadership effectiveness is explained by the model in which the significant variables existed in intellectual stimulation, individualised consideration, and laissez-faire style.



Finally, the regression test was performed to examine which leadership style best predicts the nurses' job satisfaction. The results are shown in Table 4.5-20 below.

Table 4.5-20 Regression of leadership styles and job satisfaction

<b>Leadership styles</b>	<b>Beta</b>	<b>t</b>	<b>P value</b>
<b><u>Transformational leadership</u></b>			
Idealised attributes	.184	2.526	.012
Idealised behaviours	.175	2.272	.024
Inspirational motivation	.166	2.428	.016
Intellectual stimulation	.416	5.958	.000
<b><u>Transactional leadership</u></b>			
Management-by-exception Active	-.303	-3.771	.000
<b><u>Laissez-faire</u></b>			
	-.213	-3.050	.003

Source: Analysis of survey data

The regression coefficient on staff job satisfaction and leaders' leadership showed that perceived work satisfaction was significantly predicted by four transformational factors: idealised attributes (Beta = 0.184, Sig. = 0.012), idealised behaviours (Beta = 0.175, Sig. = 0.24), inspirational motivation (Beta = 0.166, Sig. = 0.016), and intellectual stimulation (Beta = 0.416, Sig. = 0.000). In the meantime, staff nurses' job satisfaction was also significantly predicted by one transactional leadership factor, management-by-exception active (Beta = -0.303, Sig. = 0.000), and by laissez-faire (Beta = -0.213, Sig. = 0.003). The model summary of the regression results is as follows:

Table 4.5-21 Model summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.725 <sup>a</sup>	.526	.506	.58937

Source: Primary data analysis

Table 4.5-21 presents the model summary which reveals that  $R = 0.725$  and  $R^2 = 0.526$ . This result indicates that 52.6% of the variability of staff job satisfaction was explained by the model in which the significant variables existed within the idealised attributes, idealised behaviours, inspirational motivation, intellectual stimulation, management-by-exception active, and laissez-faire factors.

The results of the regression analysis indicated that transformational leadership and laissez-faire were the predictors for the staff nurses' outcomes of their willingness to exert extra efforts, effectiveness, and job satisfaction. In the meantime, transactional leadership was found to be the best predictor for nurses' job satisfaction, but it was not significant for staff nurses' extra effort and effectiveness outcomes.

#### 4.6. Chapter Summary

In this quantitative analysis of the MLQ survey, the results demonstrated that transformational and transactional leadership are the dominant leadership behaviours as perceived by head nurses and their current staff at the hospital under study. Both groups indicated higher scores respectively in transformational leadership, transactional leadership, and laissez-faire styles. However, the overall findings highlighted that there were no significant differences in how the head nurses and their staff perceived the entire leadership range as, in most of the assessed variables, they generally showed no statistically significant results.

Analysis of the differences in perceptions of transformational and transactional leadership styles and nurses' demographic profiles of age, education, and length of experience showed that they were not statistically significant. Meanwhile, the findings indicated a statistical difference between nurses' gender and type of care unit where they work and the perceptions of leadership factors in the MLQ.

The survey also provided data on nursing staff perceptions of the outcomes of their willingness to exert extra effort, leaders' effectiveness, and job satisfaction in respect of the perceived leaders' leadership. The findings showed positive relationships between nurses' outcomes and transformational and transactional leadership styles. Extra effort, leaders' effectiveness, and nurses' work satisfaction all showed positive relationships with all five transformational leadership factors and two of the transactional factors (i.e., contingent reward and management-by-exception active). Meanwhile, the passive-avoidant style, such as management-by-exception passive and laissez-faire, had a negative correlation with the three outcomes. Finally, an extension of the analysis of this relationship was conducted using regression tests. Regression data have helped to affirm that roughly fifty per cent of nursing staff outcomes was explained by transformational leadership and laissez-faire style.

The data and findings analysis of the MLQ survey have been gathered. To complement the leadership assessment among the nurses, findings on the qualitative analysis of this mixed-methods study will be presented in the next chapter of the thesis as the second phase of the research.

## **CHAPTER 5 PHASE II QUALITATIVE STUDY**

### **5.1. Introduction**

The mixed methodology used in this nursing leadership study is my initial involvement with qualitative research. My quantitative research background brought challenges for me during my attempts to analyse qualitative interviews. Regardless of the difficulties, persistence and determination in dealing with this hardship proved fruitful; this helped me gain the ability to be reflexive and critical in the interpretation of the Indonesian nurses' view of leadership, which will be presented in this chapter.

The chapter presents the findings of the qualitative study as the subsequent phase of this mixed-methods research. Qualitative interviews acted as a complementary methodology for exploring nursing leadership in Indonesia. Semi-structured interviews with head nurses and staff were conducted to seek, from the nurses' perspectives, their interpretations and understanding of leadership, how hierarchical differences among these nurses impact the way they perceive leadership, and how factors such as culture or political conditions contribute to nurses' perceptions of nursing leadership.

The chapter is structured in two main sections. The initial part provides a brief description and overview of the interviewed nurses, followed by the findings section. Themes and subcategories distilled from the analysis of the interviews will be presented and thoroughly explained in this second segment as the centrepiece of this chapter.

## **5.2. Description of the Interviewed Nurses**

In this qualitative research, twenty nurses (N = 20) at the Zainoel Abidin General Hospital (ZAGH) took part in semi-structured interviews to explore their perceptions of leadership in nursing. To capture leadership perspectives among these nurses, 12 staff nurses and eight nurse leaders, two of whom were leaders in the nursing department and six of whom were head nurses at unit/ward level, were individually interviewed. The nurses who participated in the interviews were those who consented earlier in the initial stage of this research.

More than forty nurses showed an interest in participating in the interviews. From this list, I recruited nurses according to various criteria such as nurses' work units (e.g. medical-surgical, intensive care, or polyclinic/ambulatory care), years of experience, or most recent educational attainment. This approach is consistent with a purposive sampling strategy, as outlined earlier.

The roles of nurses who took part in the interviews are summarised in Table 5.2-1 below.

Table 5.2-1 The classification of the interviewed nurses

Person	Age Group	Education	Length of employment	Occupation	Sex	Unit of work
Nurse 1	41-50	Bachelor	>26 years	Nurse leader	Female	Intensive Care
Nurse 2	51-60	Bachelor	>26 years	Nurse leader	Female	Medical Surgical
Nurse 3	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 4	51-60	Bachelor	21-25 years	Nurse leader	Female	Ambulatory/Polyclinic
Nurse 5	41-50	Bachelor	21-25 years	Nurse leader	Female	Intensive Care
Nurse 6	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Medical Surgical
Nurse 7	31-40	Bachelor	6-10 years	Staff nurse	Female	Intensive Care
Nurse 8	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 9	41-50	Diploma III-Nursing	6-10 years	Staff nurse	Female	Medical Surgical
Nurse 10	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Intensive Care
Nurse 11	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 12	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 13	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Medical Surgical
Nurse 14	41-50	Bachelor	16-20 years	Nurse leader	Female	Medical Surgical
Nurse 15	41-50	Bachelor	16-20 years	Nurse leader	Female	Medical Surgical
Nurse 16	51-60	Bachelor	>26	Nurse leader	Female	Nursing Unit
Nurse 17	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Medical Surgical
Nurse 18	51-60	Master (Postgraduate)	>26 years	Nurse leader	Female	Former Nursing Leader
Nurse 19	21-30	Diploma III-Nursing	<5 years	Staff nurse	Female	Medical Surgical
Nurse 20	31-40	Diploma III-Nursing	6-10 years	Staff nurse	Female	Intensive Care

Source: Analysis of survey results

Table 5.2-1 provides brief information about the interviewed nurses for the qualitative phase of this research. I interviewed nurses from a wide age range and this is evident from the Table, although a larger proportion was within the 31-40 age category. The educational level varied among these nurses. All of the head nurses hold a Bachelor's in Nursing and the most

recently attained educational level was Diploma III-Nursing for the staff. Only one leader holds a Master's qualification (postgraduate), but she was the former head of the nursing department.

In Indonesia the majority of hospital nursing staff hold Diploma III-Nursing (Health Department, 2011). At the ZAGH, according to the current nursing director almost all head nurses initially held Diploma III, as did the staff. However, since the hospital board members signed an agreement with the nursing department of the local university a few years ago, the opportunity to pursue higher education has been made available for them through curricula designated for senior head nurses and staff at this hospital.

At the ZAGH, the majority of employees are female nurses (according to the data set of nurses provided by the Human Resource department). During my time in the field, male nurses were rarely seen on the wards. There are two types of employment system for nursing staff; the PNS (Pegawai Negeri Sipil) and contract nurses. The PNS nurses are civil servants; they are permanent employees and were recruited by the government. The contract nurses, meanwhile, were recruited by the hospital. The contracts are non-permanent and renewable every three months depending on performance. This local recruitment policy was initiated to cover staff shortages. It has been implemented in the hospital for the last few years. Almost all the interviewed staff nurses, including head nurses, are civil servants (PNS). Five of the participating staff nurses are employed on a contract basis. While the PNS nurses have been working in the hospital for nearly ten years, the contract nurses are relatively new, with an average length of employment of nearly five years.

The head nurses who participated in the interviews were all female. They have been working in the hospital for 20 years or more. All ward leaders in the hospital are female head nurses with the exception of wound ambulatory care. This unit has a male nurse leader. I made

several visits to this particular unit but, unfortunately, I did not have an opportunity to meet him personally to arrange an interview.

The contexts of the nurses' work were also diverse. This was to ensure that I gained and captured the full views of these nurses. Therefore, 11 interviews were conducted in the medical-surgical wards, five interviews took place in intensive care units, and one interview was conducted with a polyclinic/ambulatory care nurse.

The following discussion will provide further details of the results of interviews with the country's nurses.

### **5.3. The Interview Findings**

The analysis of the data identified three major themes regarding nursing leadership. To present the findings in detail, I included demographic characteristics in order; these are data of the person (e.g., nurse 1), position (i.e., HN: Head Nurse; SN: Staff Nurse), age group (e.g., 41-50), and unit of work and years of experience (e.g., Medical Surgical (MS) = 21-25). The reason for including these data is to provide the reader with the demographic information for each respondent. The explanation for this has been addressed in the methodology chapter under the qualitative study section.

The core themes and sub-themes of interview findings are summarised in Table 5.3-1 below. There are three core themes, each with a number of subordinate themes, as follows:

1. The meaning of leadership
2. The expected leadership characteristics
3. Factors that influence nurses' leadership

Each theme is subsequently addressed in sections 5.3.1 to 5.3.3.



Table 5.3-1 Identified themes and sub-themes of the interviews

Themes	Sub-themes
1. The meaning of leadership	<ul style="list-style-type: none"> <li>• Leadership defined as:                             <ol style="list-style-type: none"> <li>1. Person in charge</li> <li>2. Structural job</li> <li>3. As attempt to manage staff</li> </ol> </li> <li>• Leadership and managerial roles</li> <li>• Marginal leader(s)</li> </ul>
2. The expected leadership characteristics	<ul style="list-style-type: none"> <li>• Relational-based characteristics</li> <li>• Task-focused attributes</li> </ul>
3. Factors that influence nurses' leadership	<ul style="list-style-type: none"> <li>• Personal values</li> <li>• Culture</li> <li>• Welfare</li> <li>• Political conditions</li> </ul>

### 5.3.1. The meaning of leadership

The initial stage of exploring nurses' perspectives on leadership began by understanding the meaning of leadership. During my interviews, I found that a range of perspectives were apparent in demonstrating the way leadership was understood. This preliminary theme covers nurses' definitions of leadership and the types of leadership evident within the setting, how respondents understand leaders' and managers' roles, and how hierarchical factors and the current employment status of these nurses influence their leadership understanding.

#### 5.3.1.1. Leadership defined

This sub-theme was concerned with the articulated definition of leadership among the nurses. There are a number of common definitions voiced by the nurses. The descriptions within this sub-theme provide an overview of nurses' thoughts about leadership in the research setting.

Details of the definitions I have obtained will be presented and explored in the following discussions.

a. Person-in-charge (PIC)

Nurse respondents have articulated that leadership is exercised by a person who is in charge and holds responsibility. In this case, it refers to someone who is entrusted by the hospital board members to take responsibility for a certain unit.

*“Well, leadership is about person in charge; who leads a few people to manage an organisation or services in the unit so that care or our service delivery indeed follows the guidelines...” (Nurse 14, Head Nurse (HN); 41-50; Medical Surgical (MS) = 16-20)*

Here, leadership is interpreted as directing and facilitating a group of nurses to ensure that their performance meets the standards and operational system of the institution. The head nurse’s responsibility is seen as embodying the control and power to require her staff to obey instructions in order to meet goals. This gives the impression that staff performance is strictly guided and must not deviate from guidelines.

The head nurse is therefore accountable to the unit’s or ward’s routines, activities and problems as part of her leadership responsibilities. A staff nurse confirmed this perspective in the following quote:

*“...[being]responsible for any problems or complaints from nurses and patients in this unit. That is leadership...” (Nurse 3, Staff Nurse (SN); 21-30; MS = <5)*

It seemed that the role of leadership could only be exercised in the individual units of the hospital. This idea suggests nurses’ strictly limited conception of leadership, indirectly illustrating the restrictive role and spatial limits to their legitimacy as leaders. With this limited scope of leadership, apparently the head nurse’s main focus is the unit assigned to her; she may not recognise the impact of her leadership roles on the hospital as an organisation. The nurses’ sense of belonging seemed to be concentrated on their own units, where they may overlook their position and the contributions they have made to the organisation as a whole. Furthermore, it appeared that the extent of the discussion of leadership as responsibility led to structural context and hierarchy definitions. This is discussed in more detail below.

b. Structural Job

The interviewed nurses, in particular the head nurses, used the word “subordinate” to refer to their staff when we discussed the notion of leadership. This spoken word reflected a sense of hierarchy and boundary lines between leaders and staff. Head nurses’ conception of leadership as a means of providing guidance for staff confirms this hierarchical view:

*“...it is a way for the organisation to lead subordinates, guide them in daily tasks, and provide advice for daily outcomes”  
(Nurse 1; Head nurse; 41-50; Intensive Care (IC) = 21-25)*

In addition, this perceptive definition suggests attachment and dependency relationships between them, in that a leader needs subordinates to legitimately become a leader, and subordinates seem incompetent at work without facilitation from a leader.

*“Leadership means...ability to lead subordinates, guide, giving input to them...guide daily activities” (Nurse 4; Head nurse; 51-60; Ambulatory Clinic (AC) = 21-25)*

Leaders guide and oversee subordinates; this interpretation of leadership may suggest that the unit leader is the one who holds an important position and is the centre of power on the ward. This appeared to fit the conditions within the hospital, not only because it is the busiest health centre in the province but also because it is a teaching hospital that accommodates nursing clinical students, medical interns, and other auxiliary support pupils. I observed that almost all the wards were crowded with people, including patients with family members who stayed beside them all day and night, trainees, and staff. The environment inside the head nurse’s office is even more intense; the head nurse constantly receives calls from consultants asking about patients’ progress, students from various disciplines who need some advice, and staff with all kinds of reports, not to mention patients’ complaints. These sorts of scenarios can all occur at the same time, which indirectly required her to demonstrate the authority of the leading position she holds.

Depending on the type of care unit, the chaotic environment as described above mostly exists on intensive care wards. The conditions may place the head nurse in a critical position, where she needs to respond rapidly to any given matter; thus, this may show that nurse leaders are more likely to regard leadership as being less democratic since the opportunity for discussion with others prior to decision-making is rare.

*“...oversee and guide the staff; that is what I meant by leadership; and also educate and accommodate them. We are working in a teaching hospital, students including from nursing are here as well; therefore, we are the ones who guide and lead them as unit leaders...” (Nurse 5, HN; 41-50; IC=21-25)*

These comments rather emphasise the distance between leaders and staff. It seems that staff nurses see the leader as the one who does nearly everything for the team. The leader spoon-feeds the staff with tasks or daily duties, ultimately leaving them limited room for self-innovated action. Everything that is settled by the leader appears fixed and definite for the staff, leaving them no space for questioning or reasoning on what they have been told.

Nurturing staff independence and autonomy at work appeared to be less of a priority. In the following argument, for instance, the staff nurses were happy with this situation, reflecting that they let the leader drive them anywhere or do *the thinking* for them in the workplace. Losing work autonomy did not feel problematic or worrying as they could count on someone else to do the job and make the big decisions for them.

*“Leadership for me is about someone who sets or gives the rules; or someone who makes a work structure for his/her subordinates...” (Nurse 11, SN; 21-30; MS=<5)*

*“Leadership means someone who gives decisions, solves any problems, and the one who manages the ward” (Nurse 9, SN; 41-50; MS = 6-10)*

Nurses' view of leadership as a structural definition also implies competency as an important element within their understanding. It seemed that these nurses are not concerned about their ability to offer constructive thoughts at work. The expression of excessive hopes and expectations of the leader suggested that staff have little courage to embrace risks. Risk avoidance was reflected by these nurses since the leader is there to guide, facilitate, and carry the burden for them in the ups and downs of their work; there is no need to worry about problems at work because someone else will handle them.

*“...we are working as a team here and indeed we need someone who can guide us. She/he sets clear rules. So, when we are in problems, we have someone who can facilitate us to go through it and help to figure out the best solutions. She/he is indeed someone who we can lean on...” (Nurse 3, SN; 21-30; MS=<5)*

Clearly, from the above discussion, leadership is seen as a context related to hierarchy, tasks, facilitation, or decisions; almost all nurses interpreted leadership in this way. Despite these findings, I felt that something was missing from the way in which they communicated the meaning of leadership. As an interviewer, I expected someone to offer a stronger opinion on their understanding of the meaning of leadership. This enquiry received no response until I met a former nursing leader at this hospital, Mrs. H.

As presented in the methodology chapter, the nurses participating in the qualitative study were the ones who had consented earlier at the outset of the survey's administration. However, certain questions, such as how a highly experienced nurse leader might understand leadership and whether senior leaders would provide the same explanations, prompted me to expand the

analysis. To address these purposes, an additional sampling strategy, the theoretical sampling approach, was employed. The main intention was to acknowledge leadership interpretation from the perspective of someone who had been the highest-ranking leader in the nursing department but now no longer served as a leader therein. Therefore, I was sure that Mrs. H would be the best person to interview. I was able to contact her later and explained my aim in interviewing her. As expected, her positive expression and warm-hearted welcome was a good start.

Her interview was the longest of all. Her opinions and views on leadership were very attractive and yet illustrated her broad experience and maturity as a leader. When asked, as an initial enquiry, for her definition of leadership, she responded:

*“Leadership is how a leader attempts to manage  
his/her staff to attain organisational goals” (Nurse  
18; Former leader; 51-60)*

The important point here seemed to be the leader’s attempt to achieve the organisational goals. In regard to leadership and organisational objectives, among the twenty respondents only one staff nurse and Mrs. H articulated this. It was surprising to find that none of the head nurses mentioned it. The head nurse respondents (i.e. those whom I had interviewed earlier) stated that leadership meant the leader’s role as a provider to guide or facilitate subordinates’ activities, but they did not stress their own work performance and contribution to the organisation.

The emphasis on goals in the above opinion reflected the purpose of an organisation. According to this view, an organisation is not created simply to gather people together; certain outputs should also be expected. It seems that an organisation is a channel that embarks upon guiding people towards something specific.

The basis for this, as argued by Mrs. H, was the fact that nurses represent the largest group of health employees within the team. As they comprise the majority of the healthcare team, this may give the nurses more opportunity to engage in leadership. Thus, visionary leadership and missions clearly stated by leaders to staff would be the main driver sending the nursing workforce in positive directions; she explained:

*“Leadership is very important for this hospital. This is because nursing profession holds nearly 2/3 portion from the whole healthcare teams. Nurses have the longest direct contact time with patients. In a ward, a nurse is not alone, there are many of them; you can imagine if no one leads them with clear vision and mission; of course, each nurse will work in different ways; and care that is being given is different from ward to ward because [there is] no leadership within” (Nurse 18; Former leader; 51-60)*

Apparently, primacy was given to involving others in the endeavour to achieve organisational goals. It looked as though she wanted to describe a leader as a mission carrier; i.e. a leader is someone who sets the vision and clear direction for the supervised people or groups. This expressed the idea that specified and descriptive goals are required to ensure that the supervisees know what to expect from their performance and that the organisation is on the right track in seeking to achieve its objectives.

A young staff nurse also emphasised leadership as a means of achieving organisational goals. The staff nurse perceived it as follows:



*“An organisation is established to achieve clear objectives; therefore, leadership is needed to get it in there...” (Nurse 10, SN; 31-40; IC=6-10)*

The nurse asserted in the interview that the aim of creating an organisation is to achieve objectives. Meanwhile, leadership is an effort made to guide people within an organisation to attain the expected goals. The guidance may involve persistence, encouragement and support for staff.

Therefore, in efforts to reach organisational goals, bringing all the people together is a critical factor for the organisation; this view appeared in the following opinion:

*“Leadership in nursing is indeed important. If no one guides them, they will work according to their own rules. To unite staff differences, therefore we need leader, command; ...everybody is different, so we need one person to lead...” (Nurse 2, HN; 51-60; MS=>26)*

The nurses realised that diversity among staff is inevitable. In this sense, leadership in these data is viewed as providing a central role in attempting to unite all kinds of differences that might include personalities, cultures or characters. Leadership was seen as a medium through which to embrace staff diversity; I felt that ensuring they all had the same vision is pertinent and, yet, this is a prerequisite for their successful journey

I believed that ensuring organisational success by reaching the expected outcomes is not an easy task. Multiple efforts by the people in the organisation emerged as a pertinent factor in organisational success. Further explanation of this is provided in the subsequent sub-theme.

c. Leader's Attempt to Manage Staff

The leader's attempt to manage staff was argued earlier by Mrs. H. The attempt that she emphasised may suggest pressure on staff. Leadership was meant to be an opportunity to push a group of staff to reach the set goals of the organisation. It seems that a leader must do whatever she/he can as long as staff performance guarantees success and organisational achievement.

This argument, furthermore, may allude to the likelihood of leaders in the hospital being authoritarian, as appeared in the comments below:

*“...when we offer a new policy or introduce something new to make things much better, they are all very welcoming at the beginning. But when it turns to execution on field, everybody runs...they're afraid that it will be new burden for them...” (Nurse 18, former leader)*

This nurse felt that her staff seem open to change but in reality they do not really want to embrace it even though it is for their own sake. This reluctant atmosphere was apparently the biggest constraint she experienced during her leadership period. This subsequently influenced the way she defined leadership. It may be true to some extent that force, reflected through the “leader's attempt to manage”, may break down the barrier or resistance among staff; or it could be that forcing them to do something good is the only way to solve problems in their workplace.

Furthermore, the *attempt* could actually be regarded as the leader's influence. There was an occasion that helps to clarify this assumption, and this appeared in the quote below:

*“...leadership is everywhere...we are the real leader, not an administrative one. We can be a leader in any places; it just the matter of how to influence others!...” (Nurse 18, former leader; 51-60)*

The presented opinion illustrates that leadership is not simply related to assigned position or leading hierarchy. Leadership according to her seems broader than that; in particular, the ability to grab people’s attention and influence them to do something means that a nurse is taking a leadership role. This also suggests that leadership has no spatial element.

The emphasis on influence may reflect the idea that leaders must instil a strong and clear vision and mission in their staff and, most importantly, attempt to turn the stated vision and mission into reality. I felt that the core meaning of ‘attempt’ as defined earlier refers to action; it is the action of how to influence a group of people to do the work and inspire them to give their best performance to make organisational objectives attainable.

Overall, in describing these leadership definitions, the nurses at the same time underlined leaders’ roles and functions with regard to supervisees and the organisation. For instance, some interviewees perceived the nature of head nurses’ position as an extension of the hospital’s CEO or believed that leaders are those who manage tasks. There appeared to be mixed perceptions in defining leadership and managerial roles. To understand this topic in more detail, the following discussion will address it further.

#### 5.3.1.2 Leadership and managerial roles

Nurses acknowledged that the presence of a leader is an absolute necessity within an organisation. This was commonly stated by each nurse during the interview sessions. Nearly all

of the staff and head nurses viewed the leader as someone who leads as well as manages the work.

*“Leadership is someone’s management in leading an organisation...” (Nurse 16, nurse leader; 51-60)*

Leadership was manifested as management. In this view, nurses felt that leading and managing constituted a single job for a leader.

A similar argument was expressed by a head nurse:

*“...absolutely needed, if we don’t have the leader, then everything is ruined, no one managing the unit. If no one handles the leading, how could we have the works done properly...?” (Nurse 5, HN; 41-50; IC=21-25)*

The nurses, although they are in different leadership positions, tend to articulate the similarity of leaders’ and managers’ roles. The leaders have several subordinates and should therefore put their best efforts into assisting staff to complete their tasks. The nurses felt that it is the leader’s job to do the leading and manage tasks to ensure that everything flows as expected. The *leading* and *managing* are perceived as an opportunity to ensure that jobs are performed effectively. This, however, may reflect nurses’ dependency on leaders. The achievement of objectives is merely determined by the one who holds the leading position.

I gained the impression that the nurses have a limited perspective on leadership and managerial roles. For them, these two contexts are the same. I believe this is simply because the leadership patterns they have observed in their leaders, as the primary model (i.e., the head nurses), are exhibited by the type of leaders who focus more on performing regular management in the workplace rather than leadership actions. A staff nurse put forward this view:

*“Leaders! He/she is the one who assigns jobs to us, and builds an organised management system. The leader guides us through and is responsive...” (Nurse 11, SN; 21-30; MS=<5)*

For the staff, leaders are those who assign tasks to staff and establish systematic procedures in order to manage the workflow. It seemed that leaders’ ultimate job is only to manage things at work. I felt that, in their perception, the scope of the leaders’ role is concerned with the fulfilment of tasks; this may therefore describe a very superficial and less sincere relationship between leader and staff.

On another occasion, a nurse appeared to confuse leadership and managerial roles:

*“Manager and leader...I don’t see that we have a manager here. I think manager is only within company like that. But, sometimes a manager holds control too. The difference is that there is leader above manager in a company (smile and laugh)...I don’t know exactly about this.” (Nurse 12, SN; 21-30; MS=<5)*

The head nurses are the closest models for staff nurses. The leaders’ actions and daily performances are their learning curve. Reflecting on the above premise, this shows that there is limited opportunity for nurses to observe leadership in practice. The lack of a leadership model and a figure to show the ‘real’ act of leading and/or managing makes it difficult for the nurses to articulate the topic. To some extent, this might mean that the head nurses’ fail to model and perform leadership roles. They see the leader only as person who is in command and gives orders. Nurses thought of leadership primarily as an opportunity to exercise control over a group

of people, thus making the leading position a main source of power. The manager, meanwhile, has a limited measure of control. Head nurses exclaimed:

*“...the leader is the manager. Although I am the leader in this unit, I am also the one who manages it. It is very important, because if there is no leader here, the staff might not know what to do. So, we are the CEO at the unit level”*  
(Nurse 1, HN; 41-50; IC=21-25)

*“On daily tasks in the unit, I am the nurse leader and am the one who manages this unit...”* (Nurse 15, HN; 41-50; MS=16-20)

These opinions assert that the leader’s and manager’s roles are inseparable; however, the underlying point is that the ground-level leaders (i.e., head nurses) do everything they can to ensure that everything works smoothly and as expected. Seemingly, the head nurses see themselves as the hospital’s executive representatives.

Responsibility, as emphasised by the head nurses above, may describe two important elements. First, it illustrates her territorial line of authority and space to execute her leading and managing skills. Second, it alludes to the reduced likelihood of the CEO (Chief Executive Officer) being present and supervising staff nurses in the ground units. In other words, the CEO’s leadership at unit level is devolved to the head nurses. These comments further confirmed the perceptual hierarchy found in earlier data. The hierarchy aspect features strongly in many nurses’ opinions and interview scenarios, which may suggest a power struggle between leaders. Most of the interviewed head nurses expressed a spatial element in their interpretation of

leadership. This gives the impression that their leadership is meaningful only in certain territories.

While some nurses felt that leading and managing roles are performed alongside each other, different opinions about leaders' roles were captured during the interviews. A staff nurse believed that leaders and managers hold distinct positions.

*"...actually, leading and managing are different. You do not have to be a leader in order to manage. However, what we see in our place is that leader is the manager (laughed). I think there is no need for me to explain it further" (Nurse 10, SN; 31-40; IC=6-10)*

The nurse recognised the leader's position in the unit and admitted that the manager is not the leader. The manager is the extended hand of the leader in the organisation. The manager holds control and power but with limited scope, often defined spatially or in relation to a set of resources.

The nurse thought that, ideally, the leader's and manager's roles should be separate. She appeared to be trying to say that being a manager or holding any management position is merely about fulfilling a task or job that is given or entrusted to someone. Meanwhile, being a leader takes on a broader context. It seemed that the nurse was trying to articulate that becoming a leader is not an overnight process; there are many processes involved in preparing a leader as well as building the characteristics pertaining to leadership. I felt that these may relate to experience, education, and other personal factors that give a person the right to be called a leader.

Unfortunately, it appeared that the leader in this hospital is far from ideal. I gained this impression during my discussion with the nurse. The nurse expressed her disappointment at the leader. She might have expected her leader to be a model from whom she could learn; however, the leading figure in her environment acts more like a manager. She seemed pessimistic about recent leaders' competency and had little hope that the hospital's leadership would improve.

Motivation and support from the institution, therefore, is considered by these nurses to be a crucial element that might boost their performance.

*“No, the hospital never offers something that can build us to be better in our leadership; in fact, we asked for it. Training is so rare in here. At least, we already asked for management training, so that we know how to lead and make a work atmosphere...” (Nurse 5, HN; 41-50; IC=21-25)*

The nurses felt that leadership capacity is attainable in many ways as long as the opportunity is provided to them. However, not all nurses seemed confident of their own ability to undertake leadership; this condition places them at the edge of the organisation. They clearly stated that leadership is pertinent to nursing. The following discussion will examine this further since I felt that this particular expression conveyed a sense of the existence of marginal leaders in this organisation, which becomes an important perspective from which to explore nursing leadership among these nurses.



### 5.3.1.3 Marginal leader

The ZAGH is a government-run service institution. The employment system in the hospital includes the civil servant and contract-based staff nurses. Apparently, there is a perceived gap between the employment status of a PNS nurse and that of a contract nurse.

*“As a contract-based nurse, I do not have capacity as future leader or see support from the hospital that can develop me to be in the frontline. Maybe, I am on contract basis here. It would be different for the PNS nurses, I believe!” (Nurse 13, SN; 31-40; MS=6-10)*

I have observed in more than one interview the contract-based nurses demonstrating a lack of confidence in recognising themselves as future leaders. They felt that they were unable to lead because they are not permanent members of staff. The entitlement to develop leadership capability was considered an opportunity open to PNS nurses, but not to them.

I found that the statement by a nurse who holds non-permanent status implied the hopelessness of her current position. The nurse seemed less optimistic about her future in the organisation. In other words, there is a crisis of confidence among the nurses. The nurse's comment indicated her dissatisfaction with the way in which the hospital treats the contract staff. However, her opinion implied there is nothing she can do to improve the situation; it is just the way things are.

I found that surrendering to the situation was a common phenomenon when the nurses expressed their thoughts on leadership. The nurses felt unenthusiastic and seemed to lack the capability to be change agents. This may be because their positions are not secure and there is no guarantee that they will one day be entitled to permanent employee status in the organisation.

Surprisingly, the feeling of inability or lack of confidence in their own leadership competency was not expressed only by contract nurses whose status is insecure: even a PNS and permanent staff nurse mentioned that becoming a top leader is a mission impossible for nurses.

*“Nurses have potential to lead...well, maybe for change.*

*Whatever or whoever the leader in the hospital, we are still below here. To lead a hospital like this I think it is impossible. Maybe we can lead in community health centre (Puskesmas)...” (Nurse 7, SN; 31-40; IC=6-10)*

The argument above may illustrate the average mentality of nurses regarding their own competency. Their role is simply to get things done. This condition calls for leadership empowerment for all staff nurses at any level. The nurses acknowledged that they have been offered some educational opportunities for performance improvement regardless of employment status, as found in this statement;

*“We have trainings here. The hospital offers that stuff for all contract nurses and the PNSs...” (Nurse 13, SN; 31-40; MS=6-10),*

However, it seemed that the nurse did not feel the impact of those efforts. I believe they would have felt a lot more content in their argument had the offers had a positive influence on them. It was clear to me during the interviews that there was something missing and unfulfilled about these nurses, particularly when a permanent staff nurse mentioned the following:

*“There is barrier for leadership position in here. This hospital treats the PNS and contract nurses differently...” (Nurse 6, SN; 31-40; MS=6-10)*

This permanent staff nurse expressed her concern about the difference in the way the nurses felt they were treated in the organisation. This discrepancy, according to her, will do no good. In fact, this helps to explain why contract staff feel marginalised; the contract nurses were in a precarious position and look like disadvantaged employees.

I observed that the feeling of being “second-class workers” seemed to have been created by the environment within the hospital. The treatment received by the contract nurses, in terms of payment or performance evaluation system, is different to that afforded the PNS staff. Meanwhile, the act of evaluating the PNS nurses was perceived as looser. Disciplinary action such as dismissal is almost impossible since PNS is related to the national government system, and the bureaucracy pertaining to it is very complex. The contract nurses thus need to take care over their performance if they wish to keep their jobs; in contrast, the permanent staff do not seem to apply themselves as rigorously at work because they know they will never be fired unless they fail to meet minimum standards, such as being late for work. In general, salaries are considered sufficient and to have improved in recent years for PNS nurses; however, although the contract nurses’ incentives are good, there is a wide gap. All nurses’ job responsibilities are the same on the ward regardless of their employment status. Unfortunately, this is not taken into account. The discrepancies have remained in place.

The nurses believed that they should ideally be provided with leadership opportunities. Unfortunately, it seems that obtaining this meaningful chance is still challenging. The window of opportunity remains locked to nurses, in their perception; nurses are merely the doctors’ followers. A head nurse said:

*“I see staff potential to be leaders. They have the potential but just sometimes nothing facilitates them to be one. They are smart; when responsibilities are given to them I am sure they can manage it. I think maybe it just because no opportunity is available...nurses are still perceived as servants although we hold high education.” (Nurse 1, HN; 41-50; IC=21-25)*

This opinion emphasised the lack of opportunity as the barrier to nurses’ ambitions. She felt that potential leaders are available, but apparently the organisation seems to neglect the talents and competences of these nurses.

Discussions about opportunity in leadership with these nurses led to additional issues which seemed to be strongly related to one another; these are about power and autonomy. A head nurse noted:

*“All nurses have potential. They are smart...but, sometimes, other professionals do not want to be rivalled by nurses, like competing. Sometimes trust is given but it still cannot be to the fullest; [they] feel like [they are] tied up; they do not dare enough. Actually, they shouldn’t be like that, other places are not like here” (Nurse 5, HN; 41-50; IC=21-25)*

The importance of leadership within the wider organisation was recognised as a critical factor in facilitating nurses to become leaders in their own right. In this sense it was felt that Executive Board members should provide an environment where nurse leadership might flourish.

The head nurse believed that nurses had leadership competences but on that occasion she expressed her feelings and was outspoken about the reality in the field. Her criticisms implied that nurses were being empowered half-heartedly. The hospital seemed to impose a barrier preventing nurses from reaching the top. I felt that the paradigm of the nurses' position in the ground service areas was still the main inhibitor. The prospect of nurses holding power or exercising leadership as board members is apparently worrying for certain parties. Therefore, in order to prevent such a situation, the power is locked up for use by certain professionals only.

The power scheme in this hospital seemed more dedicated to the medical doctors' profession. Since its establishment, the hospital's leadership system has been dominated by doctors. I observed that the hospital concentrates more on improving the quality of services through facilities and equipment. Meanwhile, attention to staff nurses' development seemed insufficient.

The feeling of being marginalised, as perceived earlier by the nurses, may derive from the strong perspective that other professionals in this hospital are smarter or contribute more with the skills they possess compared to the nurses. Doctors, in particular, seemed to be people who *know more* and their opinions or instructions are apparently mandatory.

This doctor-led scheme is mainly what they experience every day, especially those working on the wards. This scenario has existed for decades. The doctors hold important positions in nearly all hospitals' leading aspects. Meanwhile, the highest position for a nurse is as the head of the nursing department (Kepala Bidang), and this position is under the vice-director of medical services. I strongly believe that this long-standing bureaucratic scenario may have instilled in nurses the notion that they have limited chances of reaching the top; this implies that nurses have too little power compared to their closest colleagues, the doctors.

This disproportionate power-sharing by nurses also seemed to be related to the lack of trust afforded them in bearing responsibility. The work environment did not seem to encourage nurses to exercise their autonomy. The nurses were determined to do their best but their efforts were often hindered by *half-granted* authorisation for the profession.

In addition to power, it appeared that trust is seen as a means of boosting the nurses' authority and acknowledging their competency.

*“I tell them and they execute what I’ve told. They have to learn everything I’ve asked them to. When I am not in place they will know what to do and how to react accordingly. My principle with staff is that when I am not with you in the ward, you hold the unit, you play the power. But if you encounter any problems, then let me know.” (Nurse 5, HN; 41-50; IC=21-25)*

A supportive environment was identified as a condition conducive to improving the staff's self-confidence and independency at work. Thus, the organisation's concern to promote nursing leadership might be channelled through educational improvement plans or action to encourage nurses to move forward and realise their leadership potentials. But these efforts often fail due to nurses' reluctant attitude.

*“I think the hospital top leadership really helps nursing leadership improvement. However, it now depends on nurses themselves; do they want improvement or to stay the same? For example, knowledge improvement...not all nurses or staff want to implement case reflection discussion, no one wants to be the champion as the initiator for this programme...” (Nurse 18, former leader; 51-60)*

This view would suggest that the organisation is not primarily to blame for the conditions in which potential leaders cannot flourish or prospective leaders are marginalised. It is much more pertinent to consider individual introspection rather than looking for a party to blame or hold responsible for this misfortune. Self-involvement for change and, in particular, leadership challenges seemed to be related to personal choice. Some nurses may take the opportunity for self-development, while others take their job responsibilities as part of the regular cycle of life; work life simply means finishing the job and then getting ready to go home. There is no need to become even busier at work by taking on extra challenges as someone else will undoubtedly take the opportunity.

A perceptive analysis of the definition of leadership has revealed an insight into how these nurses understand leadership. Self-motivation and the nurses’ perception of the general context and circumstances surrounding them may have shaped their thoughts on the concept. If, for instance, these nurses were to give further consideration to the benefits and positive changes they might deliver through leadership challenges and competences gained, I believe they would articulate leadership differently.

I believe that each perspective was expressed for a reason. Nurses' thoughts on the meaning of leadership cannot be separated from their expectations and hopes for ideal leadership attitudes. To explore these further, the following core theme will explore the expected leadership characteristics.

### 5.3.2. The expected leadership characteristics

The data on leadership capabilities and attributes revealed nurses' expectations of a leader. Several ideal attributes perceived by these nurses can be categorised as relational- and task-based characteristics. These specific attributes will be explained in the following discussions.

#### 5.3.2.1. Relational-based characteristics

Relational-focused leadership skills are identified as leadership behaviours that facilitate attitudes, behaviour and interactions, determining how the leader and staff structure their work and relationship experience. A wide range of relational-focused attributes have been identified by the nurses.

##### a. Democratic leaders

From the interviews, I noted that the nurses commonly expected a democratic type of leadership behaviour. A democratic style of leadership appeared to be the one most prevalent within the data. The nurses preferred this form of leadership over an authoritarian style.

*“She is democratic leader...I mean, there is openness between me and the leader. For example, if I am facing a problem, then we will find solutions together...” (Nurse 8, SN; 21-30; MS=<5)*



Staff nurses acknowledged that their leader demonstrated democratic behaviour. The democratic values that they expressed were rather regarded as the type of relationship they expect to have with the leader.

A later interview with a head nurse confirmed this perspective:

*“Yes for democratic and I am for it. This means there is openness between me and staff. However, there will be time when I cannot expose certain things to them. We tackle all problems together” (Nurse 14, HN; 41-50; MS=16-20)*

Although the nurses acknowledged openness in their relationship, this collaborative spirit may not apply in all aspects of their relationship. The head nurse still seemed to have some closed zones, indicating that there are certain contexts she cannot share with her staff. However, this protectiveness was not as strong as her emphasis on the importance of proximity relationships between staff and head nurses. It was felt that the nurses wanted to break down any barriers around them.

The nuances in the nurses’ work environment, it seems, cultivate a collaborative culture in which interdependence, mutual connection and help are the priorities encompassing anything else. Solidarity perceived in their relationship may suggest the nurses’ sense of communality, at least among nurses in the same workplace.

b. Appreciative

Appreciative skills are seen as the ability to acknowledge and praise people’s achievements and meaningful contributions to the workplace. Nurses expected recognition for

their positive contributions so that they feel appreciated for their efforts in fulfilling their allotted responsibilities.

*“For positive achievement, we should at least thank her/him for what they have done. I think we are lacking at appreciating people around, especially the staff. We need to practise it as our positive culture...” (Nurse 18, former leader; 51-60)*

*“yaa...at least give something to appreciate staff achievement (paused)...it does not have to be a present; if we have opportunity for training, so we facilitate her to join it as appreciation.” (Nurse 1, HN; 41-50; IC=21-25)*

Leaders and staff nurses believed that appraisal and leaders' acknowledgement is important. For the staff, in particular, recognition of their work made them feel motivated towards greater achievement and work performance.

*“They need to show their recognition for staff. They could announce it or simply as certificate of appreciation from hospital's leadership for the best staff performance; we used to have it, but not any more at this time. Actually, appreciation would motivate us and the award-winning staff can be the role models for others.” (Nurse 10, SN; 31-40; IC=6-10)*

*“I think the best way to appreciate staff is by showing acknowledgement for what we have done. Compliments are good, but no need to do that all the time (paused)...just acknowledge us; and this will motivate us to work better.” (Nurse 8, SN; 21-30; MS=<5)*

The meaning of appreciation was also perceived by nurses as extra financial rewards and bonuses. In general they felt that the hospital’s leadership did not express recognition of staff achievements, but financially nurses felt happy with their jobs’ compensation.

*“In the hospital we have a work appraisal scoring nowadays. For example, if the staff fulfils her duty by being punctual at work time, then she will get financial reward.” (Nurse 15, HN; 41-50; MS=16-20)*

*“We do not have that sort of appreciation for work in this hospital; however, they compensate us well, it is OK!” (Nurse 5, HN; 41-50; IC=21-25)*

c. Objectivity

The nurses felt that objectivity in leadership behaviour is interpreted as caring and fairness. These leadership constructs were viewed as key factors that may determine harmonious leader-staff relationships. In such a scenario, the leader treats his/her staff in the same manner

without discrimination, being sensitive to any problems the staff may have and attentively helping to manage them in order to overcome difficulties. One staff nurse put it like this:

*“...I expect her to show that she cares; treat their staff equally. When we are in problems, the leader offers his/her hand to find the best available solutions...” (Nurse 11, SN; 21-30; MS=<5)*

Objective relationships between the leader and the staff seemed to be a leadership attitude that nurses expected from their leaders; their relationship is built upon professional attachment.

The head nurse emphasised the importance of being objective in nursing leadership:

*“The leaders should see objectively what staff have done. I see sometimes people elbowing each other to get to the top. I do not like it. She (i.e., the leader) should judge us based on personal and fair approach, not through what others have said; for example, one may say, oohhh, X is not good; however, the leader takes that into account unfortunately. She listens too much to all those bad judgements without clarifying it...” (Nurse 4, HN; 51-60; AC=21-25)*

This nurse's view seems to illustrate a rather less secure environment. The work environment apparently discourages attitudes of fairness and objectivity. Unfortunately, I feel that this unhealthy work culture will be difficult to change if the mentality of leaders is resistant to improvement. The nurses seemed to realise the ideal leadership behaviours. However, this is meaningless if the leaders are not consistent in expressing their positive attributes, as explained below.

*“Leaders should have intellectual capacity and physical endurance. She needs to stay focused in her work and not carried away by family problems or any personal issues...”*

*(Nurse 18; Former leader; 51-60)*

Apparently, consistency in nursing leadership is seen as a pattern of behaviour related to leaders' adherence to the principles that have been upheld in the organisation. Leaders who espouse firmness and solid attitudes are objective and fair with staff regardless of the conditions or circumstances around them.

d. Role model

Amongst several relational-focused leadership characteristics which have been distilled from the interview data, the nurses place a strong emphasis on role model as the ultimate leadership principle.

*“In my opinion, I have a principle that if we lead people, we have to be the role models first; for example, if we asked people to be disciplined (read: never late for work, being on time), then we, the leaders, need to be disciplined at the first line. If we want change, the leader has to change first then ask others. But if there is no willingness within us, the leaders, no willingness to be disciplined, no willingness to be a change agent...then it is impossible for us to change people” (Nurse 16, nurse leader; 51-60)*

The nurse felt that leadership is demonstrated successfully when the leader's positive behaviours are emulated by the staff. Positive changes, however, need initiation by leaders because staff members learn best from real actions. Hands-on involvement through leading by example is believed to be an effective leadership principle; therefore, a leaders' self-awareness of her critical position for the staff seems key.

*I think changes have to start from leader first, and then we can correct others after. But it does not necessarily mean when we trust someone to lead then she is the role model...sometimes not all leaders can be role models. However, we, the leaders, must be role models...Let other people judge, we can't judge ourselves. Above all, I do think that we have to be role models first, then correct others." (Nurse 18; Former leader; 51-60)*

A staff nurse confirmed this perspective:

*"Come on...show good examples so automatically staff will follow the leader. Mistakes do happen, therefore we need leader to guide us...leading by example is totally important!"*  
*(Nurse 8, SN; 21-30; MS=<5)*

Being a role model was seen as inspiring for both staff and head nurses. This is because staff members feel that their leaders are not only important for what they do but are also competent at creating a positive work culture and positive norms, fostering a good understanding with staff members. According to the nurse, nurturing a feeling of empathy and understanding is

the key approach to expressing a holistic connection with the staff, not just in relation to fulfilling their roles and work tasks.

*“I expect that between us, the unit leaders, and the top hospital leadership, we are like-minded. Unit leaders like us know more about anything happening in our field; so, I hope they understand the real conditions that we are dealing with. If they care, I think, there won’t be any obstacles at work; but if they don’t, then it will be hard for us.” (Nurse 5, HN; 41-50; IC=21-25)*

Inspiring leadership and the role model principle are complementary. There seems to be a mutual relationship between the two whereby inspirational leadership is achieved if the leader is truly a role model for her staff. According to these nurses, the leader inspires them as a result of several characteristics including communication skills, the ability to stay calm in any conditions, and demonstrating sincerity and diligence with regard to his/her responsibilities. This interesting opinion was expressed in the following quotes:

*“Inspiring leader for me is a leader who shows sincerity; for example Mr X, he inspires me, he is smart and can communicate well with others; but if I try to be like him, I just can’t do it because I get so tense sometimes. Our previous leader Mr Y, I also learned from him...the point is that an inspirational leader means a leader who can be the role model for the staff.” (Nurse 18; Former leader; 51-60)*

*“An inspirational leader for me is someone who has adequate knowledge and experience in leading...he/she can be the role model; behaviours that I see from her are the model for me. It could be about being loyal, [having] sincere and close relationship with staff, or smart. I understand that nobody is perfect, but we can hold on her.”(Nurse 9, SN; 41-50; MS=6-10)*

Leading by example seemed to be the main, ideal attribute expected from a leader. It was felt to be one of the most effective approaches for leadership and good staff relationships. However, relational-centred types of behaviours alone may not be sufficient to describe ideal nursing leaders. There are several other attributes that leaders need to consider, and these are identified as task-focused characteristics.

#### 5.3.2.2.Task-focused attributes

Task-based attributes are related to the relationship approach in which leader and staff focus on accomplishing tasks. The structure of task responsibility often refers to organisational mechanisms in the institution. The head nurses, however, are accountable overall and exert their authority when complex issues occur.

Goal attainment was viewed as the focal point of job and task management; yet, participation and negotiation facilitate their daily activities. The following sections will explore the identified task-based attributes as described by nurses in detail.



a. Attentive

Nurses acknowledged that leaders who pay attention to their staff's work and offer instruction where appropriate make them feel secure at work. They believed that nursing leaders have a responsibility to monitor the staff. This was seen as a chance to evaluate the staff's work performance. The feeling of being monitored reassures the staff as it shows the leader's attentiveness to the tasks entrusted to them.

*“It would be better that our work is monitored by leader; being active. I believe it is the leader's responsibility to see her staff performance and do daily evaluation.” (Nurse 12, SN; 21-30; MS=<5)*

This is confirmed by the head nurse:

*“I always monitor my staff even if I am on leave. They will report anything that happens in this unit. If I can't manage to pick up the phone, they will text me or even jot down some notes on our board. I want to let them know that I care for them” (Nurse 1, HN; 41-50; IC=21-25)*

Active monitoring felt like supervision to the staff. Direct observation facilitates work confidence and learning opportunities. This is what staff expect from their leader: being available and showing willingness to allocate their time to monitor and teach them.

*“...leader and staff can talk together. If I make any mistakes, leader can discuss with me, as staff, how to deal with it...but what I expect is that direct monitoring. Head nurse and her deputy are willing to teach us so that we are steady at work.” (Nurse 17, SN; MS=6-10)*

b. Delegating

Delegating was perceived as an opportunity for the leader to provide leadership exercises for the staff by assigning responsibilities. According to the respondents, opportunities to take on a given responsibility will facilitate confidence and enrich the staff's work experience. This was felt to be a manifestation of trust between the leader and the staff. From the leader's perspective, the intention is seemingly to express her care, democratic behaviour, and unselfishness:

*“I establish supervision team, one ward one supervisor. All of the supervisors will have a meeting with me and I'll make a report to the CEO. It is impossible for me to look after all the wards. Therefore, I made a request to the CEO so that one supervisor supervises two wards, but then he gave me a supervisor for each ward. I am a supervisor too. We have a weekly meeting or every two weeks to discuss any incidents or problems within the ward/s” (Nurse 16, current leader; 51-60)*

c. Corrective action

The nurses believed that standards and work procedures are established to assist employees' performance. They understand that divergence from the expected performance may call for corrective action. In performing this, however, leaders are expected to mediate discussions and take a wise approach to control the situation and avoid further mistakes.

*“...in my opinion, for corrective action the leader needs to privately talk with staff first. So we can clarify the condition and know why mistakes occur. Head nurse is just like parents, a mother...she is the one who mediates us if we do mistake, and later on we can find solutions together, a nice way out.” (Nurse 10, SN; 31-40; IC=6-10)*

This perspective may suggest nurses' preference for a collaborative approach within their relationship. It seems that they need a leader whom they can really trust, as this will make the nurses feel much more comfortable, rather than being left alone and castigated for making errors. This particular opinion indicates that nurses on intensive care duty put more emphasis on collaborative relationships compared to those in other work units. Intensive care work, as the above nurse perceived, is greatly prone to errors. Thus, the nurses realised that they required a monitoring but communicative leader to give them more confidence in their performance.

In addition, nurses believed that corrective action works alongside the role model principle. Both seemed pertinent for enhancing performance, and leaders need to apply them in a balanced way. A head nurse recounted her experience of offering corrective action and being a role model:

*“Well, I think corrective action and role model are associated. Both are needed in balance. We are the role model and at the same time correct our staff’s mistakes by showing them the proper one.” (Nurse 2, HN; 51-60; MS=>26)*

A senior leader has a similar perspective:

*“We need to work them both at the same time...I think changes happen step by step. I still find someone who admires me because what I’ve told her made her better. I am happy my correction on her leaves positive mark on her behaviours. Telling people about what is good means I have to be good myself. I need to be careful in my actions.” (Nurse 18, former leader; 51-60)*

Rather than criticising, a more communicative way of finding solutions when errors occur is believed to be much more favourable. This perspective emphasised that correcting behaviours is not an instant process; however, the leaders believed that the staff learn from the leaders’ actions and values they that uphold in their attitude. Therefore, realising their position, these nursing leaders felt that they need to ‘walk their talk’ in the first place.

In summary, the exploration of the leadership characteristics theme, as presented above, sheds light on nurses’ expectations of their leaders’ attitudes. Both relational- and task-oriented leadership behaviours have been identified; however, it has become apparent that the two aspects complement each other. Although it was felt that the nurses preferred relational-centred leadership, the presence of task-based components of leadership cannot be ignored. These

attributes have to be expressed in a balanced way in order to create more favourable working conditions.

Thus, reflections on the interview data and results from the preceding themes (i.e., exploration of leadership definition and ideal attributes expected from leaders) have delineated several factors that may challenge nurses' leadership capabilities. To further understand these, therefore, the theme of factors that influence nurses' leadership is the highlight of the following discussion

### 5.3.3. Factors that Influence Nurses' Perceptions of Leadership

During the process of analysing the leadership context among these nurses, it became clear that the personal values and the surrounding circumstances of the nurses influence their behaviour and the way they see leadership. Diverse qualities of experience and education, as well as environmental aspects of culture and political conditions, are among the variables that were felt to be initiating nurses' perspective on leadership; this may encompass the nurses' views on and attitudes to leadership. A detailed exploration of these factors is presented in the subsequent discussion.

#### 5.3.3.1. Personal values

This sub-theme addresses several personal factors that had an influence on nurses' perspectives on leadership and their behaviours. Among them are individual context, education, and work experience elements.

a. Context

Context refers to the circumstances surrounding nurses on a daily basis. An individual approach and field observation of the nurses revealed that nurses' leadership attitudes towards a particular event depend upon the conditions they are currently experiencing. A head nurse explained:

*“We have to see what kind of conditions there are first, then we can determine type of leadership styles that are appropriate for that moment. In here, we are dealing with humans; you know, some of the staff may have family problems before they go to work, so we as leaders have to adjust ourselves.” (Nurse 2, HN; 51-60; MS=>26)*

The conditions apparently play a role in the leader's attitudes. The head nurse realised the complexities surrounding each staff member. Aside from personal issues, I have observed a condition that may confirm the complexities of nurses' circumstances. The nurses were expected to provide patient care as well as performing other duties, including writing paper reports, during their short working shifts, which are six hours in the morning (8 am to 2 pm), six hours in the afternoon (2 pm to 8 pm), and a 12-hour night shift (8 pm to 8 am). Obviously, the morning shift is the busiest time. The shift looks odd and has not been changed for years mainly due to the old safety policy for night shift nurses. In addition to that, the number of patients on each ward is out of balance with the required nursing staff. There were times when I saw some wards caring for nearly 40 patients, but the total number of nurses on duty was only 14, including a head nurse and a vice-head nurse. This small number of staff is allocated for three shifts, with the morning

shift having six staff members including a head nurse, and the afternoon and night shifts having three staff members. In such circumstances, it was felt that the leaders' flexibility towards the staff was important. On the other hand, there was a sense that the leaders felt pressurised by this expectation; they had no choice but to accept the conditions and meet the staffing needs.

Despite the leaders' flexibility, the nurses acknowledged that they possessed certain leadership styles. Democratic and authoritarian leadership styles were among the common behaviours that they reported. Although these nurses preferred democratic leadership to the authoritarian style, they acknowledged that leadership behaviours were strictly dependent on the conditions; it is the conditions that do the talking. These nurse leaders emphasised that a certain leadership style is not suitable for all contexts. The leaders explicitly stated their reluctance to be authoritarian but sometimes they felt that they were required to behave in that way:

*“I follow the flow; there is condition where I have to be authoritarian, well, it really depends on situations. I would say, most of the times I am being democratic, but sometimes I have to be authoritarian with my staff.” (Nurse 4, HN; 51-60; AC=21-25)*

Another head nurse said:

*“I cannot always be democratic; however, I have to admit that there are times when I need to discuss something with one or two staff members... at other times, I have to decide things on my own. The conditions talk by the way; from there, I can determine which matters that I need to act on my own or maybe I need prior discussions with staff before proceeding further.” (Nurse 14, HN; 41-50; MS=16-20)*

The willingness to show flexibility, as evidenced by these opinions, may serve as an important competency. It is difficult to switch attitudes from one situation to another. The nurses’ perspective on context and leadership seemed to address the leaders’ adaptability to different conditions and showed their efforts to avoid rigidity in their leadership characteristics.

Another interesting opinion was noted from my discussion with a nurse leader with more than ten years’ experience in critical care. She clarified that the context of work is not necessarily a factor in leadership behaviours. Although a highly demanding environment, such as the critical care unit, required fast and agile attitudes, this is not taken into account when leaders deal with their staff. The leaders’ actions with regard to patient services and to staff nurses were seen as two different compartments, where each context needs particular attention. Patients’ care was directed by fixed and secure guidelines, while the leaders’ handling of the staff needed persistence and on-going efforts to point them in a positive direction. In other words, this nurse



may be indicating that it is not the environment that directs the leaders' leadership style but, rather, the type of issues and timing of the decisions.

*“...fast, like that type (smile). But I’m not really like that. I mean, my leadership and decision making for patient services and where I am right now is completely different; for nursing services, we have the guidelines of how to deal with patients, but, in dealing with my nursing colleagues...mmmhhh...I am trying to be firm, but...how to say this...it cannot be just like “turning over your palm”. It is not easy...but it does not mean I cannot be firm to them.” (Nurse 16, Nurse leader; 51-60)*

I have the impression that the nurse leader was trying to say that dealing with nursing colleagues is more challenging than patient care. Both tasks require constant attention, but it seems that commitment with staff needs extra perseverance and patience. The patient care system is described as a clear path of work with guidelines and a secure procedure. However, leadership of staff is a different kind of journey. The way she articulates this particular challenge implies a tough yet resistant mentality among the people under her leadership flag. It seems to me as though she is accentuating her efforts to tackle the difficulties she encounters although a successful outcome may still be far away.

With regard to pressure within the work environment, apparently a demanding job atmosphere does not necessarily contribute to leader behaviours. A staff nurse authenticated this opinion:

*“Although we are in high care unit in which everything has to be according to guidance, well, the leader, she is not an authoritarian leader. The most important thing is that you know what you are doing.” (Nurse 10, SN; 31-40; IC=6-10)*

The staff nurse recognised that, although their work requires precision and agility, her leader still takes a flexible approach according to the situation. Their more comfortable relationship suggests trust between the leader and the staff. The leader appeared to be providing room for the staff to exercise autonomy as well as to improve their competency.

The presented views confirmed nurses’ perspective on the significance of context in the way they exhibit leadership. Flexibility in their leadership behaviours seemed to be the key component in leadership and leaders’ competency. Apart from circumstances, education and experience are seen as other elements that cannot be separated from personal context in leadership, as discussed below.

b. Education and experience

The interviewed nurses’ educational backgrounds varied. The majority of the staff hold Diplomas in Nursing and head nurses had recently obtained their nursing degrees. In several interviews nurses mentioned their concerns about education and leadership. They believed that education contributes to leadership behaviours and gives them the required skills to lead.

*“When I was in Diploma-III nursing there was no such things called management or leadership. I did not get it there. I gained my knowledge on management and leadership when I pursued my nursing degree in nursing; otherwise, I would not know more about it!” (Nurse 5, HN;41-50; AC)*

The attention to education seemed to have a great impact on leadership, in particular for the head nurses, who are currently trusted by the organisation to lead the ward. There is a feeling of gratitude for the improvement in their leadership skills and knowledge after they had gone back to school or attended relevant training.

I have noted that many of the nurses had been working in the hospital for more than 20 years. Within that time, they had started to work as qualified nurses immediately after finishing their Sekolah Perawat Kesehatan (SPK) or Health Nurse School. This school is equivalent to senior higher education. There was a significant gap before they went back to school to obtain Diplomas in nursing. The Nursing Diploma is a three-year college course. These experienced nurses were then later appointed as head nurses or to other relevant leading positions mostly while holding their Diploma-level qualifications. In line with what one nurse said earlier and from what I have observed in the field, Diploma education places a limited emphasis on the subject of leadership and management. The main focus remains on practical learning or vocational skills. Nurses are more likely to advance their leadership and management skills with bachelor-level education.

Although education was a factor, leadership was recognised as a critical point for these nurses; apparently the organisation is more likely to appoint nurses to leading positions on the

basis of their length of employment rather than on the basis of them being the right people for the appropriate leadership roles.

*“...in this hospital, a nurse leader should obtain a degree or master level; the hospital top leadership should place her in appropriate position according to education and experience she has...” (Nurse 8, SN; 21-30; MS=<5)*

Discussions on seniority-based leadership took place on several occasions during my attempt to understand nurses' leadership. Seniority in this case refers to someone who is older and has been working in the hospital for a significant length of time. According to field observations, it is quite common to see leadership positions in the nursing profession held by senior people. Apparently, senior nurses were trusted more as leaders than the youngsters. The responsibility to lead is likely to be given to those with longer working experience, as a staff nurse respondent confirmed:

*“I actually feel motivated to bring changes sometimes, but, I do not think that all people will accept...they will say, “you are just too young, you were born yesterday, you do not know anything yet”; you know, that kind of sayings...” (Nurse 3, SN; 21-30; MS=<5)*

It was felt that senior nurses apparently receive more respect from the organisational leadership. Meanwhile, young nurses are considered to have less experience and are therefore likely to be second choice in terms of career development. Seniority is therefore perceived by these nurses as a more pertinent factor in the choice of a leader. A head nurse put it like this:

*“...after management trainings in the city of Surabaya, at least, I know more about nursing and how to lead nurses. If I were not there, I am only be a unit leader because of seniority; they will pick me as leader although I have minimum skills and knowledge of leadership, that is it!...” (Nurse 5, HN; 41-50; IC=21-25)*

This point of view gives a sense that education and experience are complementary. Education is considered the key to excellence because it is felt that knowledge improves attitudes and leaders' critical thinking; meanwhile, through experience, leaders gain the opportunity to tackle challenges or obstacles within the organisation. Ideally, leaders should have strengths in both aspects. However, the stated perspective is that the reality is contrary to what she expected; leadership roles are assigned to persons regardless of their competences, which may or may not justify their claim to the position.

Aside from seniority and experience variables, it seemed that leaders' preceding exposure to various work environments also influenced their leadership, especially when dealing with staff:

*“I don't think I'm being an authoritarian who must be heard and who asks people to do what I want; I'm not like that. I never force people. Maybe, it could be influenced by my previous experience when working abroad. I am trying to be disciplined without forcing others to do as I do...” (Nurse 16; Nurse Leader; 51-60)*

Any challenges, and bad or good moments, were viewed as an effective means of sharpening leadership capability. The leadership behaviours she was currently enacting were mainly learned and gained from earlier experience. Here, she seems to emphasise the leadership styles or behaviours that sound effective in one context or a certain work culture that she initially thought of as ideal; however, this may not be suitable in her current environment.

From the above analytical description, I have concluded that, for these nurses, pursuing education and persistence in learning brings added value to leadership competency. Experience is of course pivotal. But the nurses seemed to feel stronger in their positions as leaders when their valuable experience was accompanied by adequate yet supportive on-going education.

Nurses have acknowledged how personal conditions contribute to the way they express and see leadership. However, there are some external events surrounding the nurses which indirectly play roles in shaping nurses' leadership behaviours as well as influencing their thoughts on this context. Among these are culture, politics, and financial status. The next sub-theme will consider these elements.

#### 5.3.3.2. Culture

Almost all nurse respondents recognised that norms and social values around them contribute to their behaviours. The manners and attitudes of the people in the region were perceived by these nurses as the regional values of the Acehnese.

*“The culture of Aceh influences us; you know in here people have hard core personality and easily get angry. We are dealing with these types of characters so it influences our daily life; day by day, we get used to it. Sometimes I wonder why other people outside of Aceh have gentler character?...” (Nurse 1; HN; 41-50; IC=21-25)*

The nurse participants stated that the community and perhaps the way they were raised were the main reasons for their attitudes. However, it was felt that there was cultural negativity surrounding the nurses’ behaviours. The sense of negativity towards their regional culture and the characteristics of the local people was reflected in the hospital atmosphere. This can be seen in particular aspects. First, since the hospital is the main health referral system in the province, this condition puts the organisation under the public spotlight. Common problems reported concerned a nurse who was being harsh to patients or neglecting them when they were in need of care:

*“...this is the disease of Acehnese, if we make rules, they won’t listen. Especially with the patients’ families here, they’ve been told to limit and manage their visiting times, but what happens now is opposite. It is so disturbing. You know sometimes there are sayings such as nurses are so harsh and loud. The culture condition makes us like that.” (Nurse 9, Staff Nurse)*

It was apparent that the nuances of the local culture as mentioned above make it more difficult to support the nurses to achieve the expected performance. The Acehnese are typically perceived as

stubborn yet tough characters. The stated opinion may reveal the sense that the nurses had dealt with a very demanding context of norms. Thus, unfair community judgements of nurses may occur. The above-mentioned nurse perceived that the public show less consideration for or may even be unaware of the real circumstances facing the nurses in their daily work. The local people may have blamed nurses when they experienced shortcomings in the service. It seemed that the nurses had no option but to adapt themselves to what the surrounding culture demanded of them.

*“Yes, I do see a lot of culture influence for us here in Aceh. In Aceh, women cannot be leaders. Maybe because we are not used to leading; for example, the wife at home can only take function as manager, not the leader. I mean, all decisions are on husband’s side. I think this kind of scenario makes us think that leaders are men...” (Nurse 6, SN; 31-40; MS=6-10)*

It seems that leadership is held primarily by men. The nurse believed that Acehnese people are accustomed to norms according to which the father is the main decision-maker. Fathers and husbands in families receive great respect and must be listened to. Reflecting on this context, the patriarchal culture appeared to be strongly ingrained among the people. I felt that had a certain influence on how nurses see leadership. They may perceive that leadership is not something they deserve, and they therefore feel less motivated to take the initiative in introducing and innovating change.

The nurses understood that the profession is a female-dominated type of job. In the meantime, this may influence the nurses’ view of leadership; they may feel that women cannot move to higher positions or they may consider it something they do not need to think about. It seemed that family business is more than enough to occupy their lives.



*“...my leadership is around this little unit. All my staff are women so I think family business brings the greatest influence for them. The family conditions do influence my work...” (Nurse 14, HN; 41-50; MS=16-20)*

The common cultural perspective of “women’s place is at home” or the idea that women should be dedicated housewives illustrates the barrier to female nurse leadership roles at their workplace. It seems that nurses’ contributions occur more at home than in their work environment since the values and norms around them encourage them to behave in that way.

Almost all of the interviewed nurses are Acehnese. They have certainly been dealing with tough norms and characters, but I also feel sure that the nurses, by and large, also possess this hard-core personality and hold the values of Aceh. Culture and norms within the nursing environment may not serve as barriers to leadership. They might actually serve as their strength and indirectly train people not to surrender easily to the conditions. The appalling tsunami disaster that hit the region a decade ago greatly challenged the Acehnese strength. Despite those difficulties, the people proved their spirit and summoned up patriotism against the despair caused by their loss. The hospital had been severely damaged and was barely able to function to help the victims. According to information I have obtained from a nurse leader, Mrs. H, those who were safe took the initiative themselves to restart the hospital functions by organising help and doing everything possible to help their colleagues and other people affected by the disaster. At that critical moment, nurses were able to show their dedication to their professions and community, thus proving their leadership competency. The nurses, apparently, have acknowledged their ability to remain strong regardless of their limitations or the difficult environment.

Explanations of the elements surrounding nurses that affect their perspective on leadership are not limited to the cultural context. Another noted issue is the financial or welfare state of the nurses, as explored in the following discussion.

#### 5.3.3.3. Welfare

Regarding financial conditions, it was felt that financial assurance boosts the spirits and commitment of the nurses. When they are satisfied and their welfare is maintained, nurses feel motivated to do their best. A head nurse explained:

*“About encouraging staff’s work commitment and job satisfaction...mmm, I think I did it but there is nothing obvious yet. Financially maybe! But that is the CEO’s business. It could be part of job satisfaction for nurses. Sometimes we also have training and offer it to those who have great performances. Maybe, we only can manage to stimulate and develop their leadership that way for the time being.” (Nurse 5; HN; 41-50; IC=21-25)*

The nurses expressed a strong belief in the relationship between financial motivation and performance.

*“I think hospital management appreciates us well. Our performance gets balanced reward. They indeed put more attention to our welfare. The leadership at this time is much better than previous one.” (Nurse 12, SN; 21-30; MS=<5)*

*“Yes, welfare and facilities at work have impact on leadership. But it is not the main thing. The staff in this ward are all OK with positive change; they are not resistant to it...(Nurse 15, HN; 16-20; MS=16-20)*

Adequate financial remuneration is expected to improve behaviours, particularly performance, which nurses consider important in leadership in nursing; leadership is not only about holding a leading position but is also about having positive morals and the ability to do one’s best. Thus, a leader can be entrusted with any given responsibilities. Leaders admitted, however, that financial and welfare contributions are not the ultimate guarantee of nurses’ achievement:

*“Financial and behaviours relationship is relative. It really depends on the person. If a nurse is someone who naturally has good morals, she will stay good regardless [of the] amount of money you give to her; but, for someone who does not possess positive morals or values, even if you give the whole money for that person it may not change anything, she will stay the same.” (Nurse 14, HN; 41-50; MS=16-20)*

Apparently, personal motivation was acknowledged as the root of change. However, the organisation may have expected to leverage nurses’ motivation through remuneration. This seemed to be the key to performance; it was felt that when nurses’ performances are boosted, attitudes towards workload and responsibility are certainly positive. Thus, welfare and financial

compensation for leadership initiatives are highlighted but they are not the ultimate focus for improving nurses' leadership and behaviours.

*“Workload and rewards nurses received in recent days are fair. It does bring positive influence for them. I believe welfare will improve attitudes, but it is not the main factor. Some other supportive factors are not less important; such as family or politics...economic condition and also communication.” (Nurse 18; Former leader; 51-60)*

Money cannot always do the talking; multiple events within or surrounding the nurses' environment seemed to be trusted as contributors to nursing leadership behaviours. The maintaining of welfare was believed to be a factor that might promote positive attitudes, but if this is not coupled with or supported by an environment conducive to cultivating leadership, the effort may be pointless. Additional events, such as political conditions among the nurses, were highlighted and are probably inextricably linked to leadership; they therefore require further exploration in the following sub-theme.

#### 5.3.3.4. Political conditions

As presented in the background chapter, the province of Aceh has been struggling with serious tragedies including a prolonged regional conflict and the 2004 tsunami. This civil unrest and disaster have together brought many changes to Acehese life. In the political sector, according to what I have observed, the extent of political autonomy held in the province has created space for the liberal movement, the GAM, on the governmental stage. Political power

steered by this new seat of power influences various sectors. Most of the district leaders including the current provincial governor and his executives were involved in the independence movement, the majority of whom were originally the elite members of the GAM (Cornich, 2014).

Unfortunately, not every sector of the Aceh community is benefiting from this power shift. The nurses, in particular, felt that this new governmental power circle was a challenge for nursing leadership. Government intervention often crossed nurses' authority lines. For example,

*“We got the command from one of the political leaders to let someone stay in VIP, whatever is the reason, he has to be in there. So as nurses, we have no choice except to fulfil their wish. This is what I meant by feeling useless in front of the patient.” (Nurse 15, HN; 41-50; MS=16-20)*

Provincial political conditions were highlighted as an external context that interferes frequently with nurses' leadership. Nurses believe that they are entitled to power and authority in the hospital, but when orders arrive from the top man they have no option but to obey them.

The nurses seemed to perceive their political conditions as less supportive for the profession, especially for their leadership performance. One exclaimed:

*“I feel I am being disturbed by this political condition at the moment!” (Nurse 15, HN; 41-50; MS=16-20)*

The political dynamic was felt to be restraining nurses' expression of leadership. This nurse assumed that political interests have a higher priority and that it is much more important to attend to them than to the nursing profession. They found this very disappointing:

*“Politics do influence us; politics actually shackle nursing leaders. With Aceh’s political condition at the moment, we cannot be free in our own zone...” (Nurse 16, Nurse leader; 51-60)*

*“Political interests are higher than this profession, I mean, nurses do hold potential as leaders, but...(sighed)!” (Nurse 4, HN; 51-60; AC=21-25)*

The nurses expressed their concern over the political intervention in the unit’s leadership. They experienced the intervention as pressure within their working environment. Due to this external demand, nurses felt restricted to a limited zone, which left them feeling unable to maximise their leadership functions.

*“As a staff member here, I see a lot of political influence in this hospital; for example in our management system. There are so many interventions from out there which impact the hospital’s policy, I believe. Even in the unit level, I feel head nurse cannot reach her fullest roles because of political pressure.” (Nurse 10, SN; 31-40; IC=6-10)*

*“I think there is political influence but for the big management only; indeed they have been influenced by political interests. However, for unit level, I do not think that politics influence us.” (Nurse 7, SN; 31-40; MS=6-10)*

The above opinions stressed the political intervention as perceived by staff nurses in two different work units. The staff nurse at the medical surgical site seemed to place less emphasis on the impact of politics on her work compared to the intensive care nurse. The nurses realised that since the former combatants were engaged in a political contest in local governance, they seemed to be playing a role in determining the hospital's policy system. In particular, the nurses believed that this was occurring in the upper management, which would certainly affect the grass-roots level.

There was initially a lack of detail on the mechanism by which this pressure is felt by these nurses. When questioned further, the nurse at the intensive care unit expressed an interesting view:

*“There are barriers for nurses to move forward...I think politics is one of those. If we don't have someone who knows us here, or if we don't have someone who can get our name to the top part; well, we'll stay the same; if no one knows us, then no self-development for sure; like a dead end...” (Nurse 10, SN; 31-40; IC=6-10)*

There was a feeling that the practice of political patronage was going on in their workplace. In the light of this noted opinion, the nurses believed that support for leadership was limited to certain people, in that the government, either in the hospital or at the provincial level, might provide opportunities on the basis of networking or relationships. It seemed that acknowledgement of competency is not the priority. Thus, the condition may describe a context in which the closer one's relationship with the rulers or top leaders, the better one's chances of

advancement.

Finally, all the main findings obtained from the interviews have been presented. As the researcher, I see that there is space in this institution for cultivating the potential in these nurses and turning it into real energy and the spirit of leadership, a genuine spirit that comes from within. The opportunity may be available to them as long as the nurses are willing to search and strive for it; change will not come by itself - nurses must demonstrate persistence and effort to prove their competence to handle any challenges. Prior to proceeding to the next chapter, the following section will summarise the findings that emerged from this interview approach.

#### **5.4. Chapter Summary**

Reflecting on the discussion of the themes and sub-themes emerging from the qualitative interviews, it is clear that the nurses have varying perceptions of leadership. Initial exploration of the meaning of leadership revealed several definitions. The nurses see leadership as the person in charge, a structural job, and an attempt to manage staff. Under this theme, leadership and managerial roles were also clarified. A definition of a marginal leader was included to represent a distinct view of leadership; here, nurses attempted to describe some potential leaders but they are mostly unrecognisable in the organisation. Following the noted definitions, the expected leadership characteristics were presented. The description of these attributes highlighted several favourable or less preferred behaviours of the leaders. These behaviours entail relational and person-related attributes. Moreover, the investigation of nurses' views on leadership may not be complete without acknowledging factors that influence their leadership perspectives. Analysis of the interviews generated three main categories for the theme: personal, culture, and political conditions. Through the lens of these data, it has been possible to provide explanations of



variables that may support or even hinder the attempts of nursing leadership to flourish among the nurses in Indonesia.

The findings from the qualitative stage of the study have been presented. Since this study has employed a mixed methodology, the next step is to incorporate the findings gathered from both quantitative and qualitative results. This integration, therefore, will be explored in a chapter discussing the survey and interview results.

## **CHAPTER 6 DISCUSSION**

### **6.1.Introduction**

Investigations into the nursing profession crisis have highlighted that leadership is of central importance to the problem's resolution. Consequently, numerous efforts have been made to search for possible links between leadership and a range of outcomes related either to workforce issues (e.g., job satisfaction, burnout, or retention) or to patient care. Unfortunately, despite findings confirming the positive impact that leadership may have on the most pertinent outputs of nursing, nurses' understanding of leadership has not been widely researched.

This perspective leaves important gaps in our understanding of what nurses truly think of leadership. Studies examining the leadership perspective shared by nursing professionals are steadily emerging in the international literature. However, the findings from the research critical appraisal presented in Chapter 2 indicate a considerable shortage of such studies in the context of Indonesian nurses. In an attempt to address these issues, this thesis has therefore set out to explore leadership among nurses in the country.

This final chapter seeks to evaluate all the information from the literature review and the quantitative and qualitative studies. The chapter discusses and explores the results' contribution to the objectives of the research and to the existing literature. The strengths and limitations of the study from the mixed-methods perspective will be presented afterwards. Recommendations relevant to future research, policies, and practice will also be integrated here before this discussion chapter is summarised.

The initial section below is the summary of the research. In addition to that, it will also present brief reflection on the challenges of utilising mixed methods and critique of the theoretical framework applied in the study.

## **6.2. Summary of the Research**

The literature review addressed evidence on leadership studies and theories pertaining to the concept and the emergence of leadership in the nursing field. A critical review of studies addressing the general context of leadership and, in particular, its evolution in the nursing profession identified that leadership is the key element for improving nursing outcomes. However, what also became clear in the review was the paucity of research assessing perspectives on leadership among Indonesian nurses.

The main objectives of the study were, firstly, to assess nurses' leadership perspectives by employing a well-used leadership survey instrument, the Multifactor Leadership Questionnaire (MLQ), and, secondly, to explore nurses' thoughts on this concept using one-on-one interviews. The study utilised a complementary mixed-methods design whereby results obtained from both methods would add to and complement each other. The preceding three chapters have outlined the findings of this mixed-methodology study and integrated the results from both designs.

The study is the first of its kind to explore nursing leadership in Indonesia. The use of a survey and in-depth interviews was able to bridge the gap in knowledge of the nursing profession, particularly its leadership aspect. The survey was used to gather general views of the nurses' thoughts on leadership, and the interviews were able to further examine the nurses' views on this concept. The quantitative survey revealed that the nurses expressed transformational and

transactional leadership behaviours. In the meantime, qualitative findings added another layer of interpretation aimed at determining how we understand nurses' leadership. Analysis of the interviews introduced several topics related to nurses' definition of leadership, their expectations towards nursing leadership, and factors that influence nurses' leadership behaviours. The results from both designs were then integrated in a separate chapter (Chapter 6). The findings identified the role played by personal aspects of education and experience, as well as external factors related to culture, social context, or political conditions, and how this affected the way nurses in Aceh-Indonesia defined, expected, and perceived leadership.

This research has emphasised that the context factor in leadership has been considered previously in the literature. The analysis of how nurses see leadership in this current study further explains this assumption by recognising that it is the nature and characteristics of an individual job that determine how the person doing that job perceives leadership.

By integrating the two data sets, I have recognised important elements around the nurses in Aceh-Indonesia that are likely to impact the way they see leadership in its entirety, including how they define and perceive it and what they expect from it. Indonesia is known for its richness in ethnicities, languages, cultures and resources. The province of Aceh, one of the regions in the country and the main field of the research, has its own local characteristics that distinguish it from others. In this study analysis, the survey results confirmed that nurses exhibited transformational and transactional leadership behaviours. On one side, such outcomes are prevalent across leadership research that applies the MLQ instrument. Furthermore, this study has introduced the finding that approaches to leadership are actually mediated by several circumstances that are strongly tied to personal conditions (i.e., experience and education) and external situations (i.e., context, culture, gender perspective and politics).

Utilising a mixed methodology has been beneficial for me as the researcher to gain a deeper investigation on nurses' leadership perspective. It was a difficult and yet challenging process combining two different study methodologies. Although it is "do-able" to run, I felt the research results would enjoy more meaningful presentation under a single set of study. For example, If I had opportunity to conduct similar research in the future, I would pursue with pure qualitative approach. The more I engaged with results obtained in this study, the more I understood that leadership is a personal and individual entity which can be imparted by circumstances around the people. Those circumstances-such as culture or experience elements-cannot be obtained through the use of survey or quantitative investigation, therefore, I would do pure qualitative study because it would allow further opportunity for me in extending discussion and analysis about nurses perspective on leadership. On the other hand, applying the instrument, such as survey, may introduce leadership phenomena of certain group; but, it would be at-a-glance only. It can be less advantageous, with quantitative analysis, if we want to explore in-detail about individuals' views on leadership because there is the lack of chance for the researcher to investigate personal/group views further.

In regards to the framework chosen for the study, I found that the FRL model was applicable to inform the existence of transformational or transactional behaviours; however, it failed to capture other important factors around leadership. For example, the role of culture on leadership. Literatures have suggested that this element is one of crucial factor that influence leadership. Upon its application within this mixed methods study, unfortunately, the MLQ as the measure for the FRL is less likely acknowledged the segment of culture. The measure, would have been a lot more meaningful if such factor were included as part of leadership survey.

Brief segment of the study contribution to knowledge was presented. In addition to that, my personal reflection on the pursuance of mixed methodologies was highlighted. Further to this step, the following section gives me an opportunity to discuss in depth the findings and phenomena I have noted during the conduct of the study. I will also show that the objectives of the study are well presented.

### **6.3. Discussion**

This part of the thesis aims to discuss the extent to which leadership was present among nurses in Indonesia (as measured by the MLQ), to explore how nurses perceive leadership, to examine whether nurses in different hierarchical positions construe leadership in the same way and, finally, to identify how the findings of this study compare to nursing leadership research in other countries. In exploring these aspects, I will start each topic of discussion with a brief description of the findings gathered from the use of both quantitative and qualitative methodologies, while at the same time elaborating relevant research/literature in the field.

#### **6.3.1. Leaders and staff leadership perceptions**

##### *Leaders' self-perceived leadership behaviour*

The study began by identifying how the nursing staff leaders (i.e., head nurses) self-rate their leadership. The MLQ quantitative results indicated that 26 head nurses who participated in the survey perceived themselves as transformational leaders and transactional leaders at the same time. The laissez-faire leadership factor, however, was rated as the least preferred leaders' style.

In the quantitative findings, the head nurses rated themselves as using all five transformational factors of idealised behaviours, inspirational motivation, individualised

consideration, intellectual stimulation, and idealised attributes; the two transactional variables of contingent reward and management-by-exception (active) were also used. The average score for transformational leadership revealed that the head nurses viewed themselves as utilising that style of leadership “\_sometimes\_” to “\_fairly often\_”; nevertheless, the score for transactional leadership indicated that they perceived themselves as showing this style *sometimes*.

These findings confirmed Bass’s earlier argument that leaders display both transformational and transactional leadership styles (Bass, 2008). In fact, these are essential counterparts. Bass et al. further explained that when leaders paired these leadership traits at the same time, significant and positive performances can be obtained (Bass, Avolio, Jung, & Berson, 2003). It is important to note that it is the individuals in leadership positions who are reporting these behaviours; importantly, followers may not share their viewpoint.

As outlined in the literature, transformational leadership encompasses leaders who behave in certain ways to achieve superior results by employing one or more of the five factors of transformational behaviours (B. Bass & R. Riggio, 2006). Transformational leadership characteristics inspire followers with challenges, but at the same time the leaders make them fully understand the meaning of their actions. This allows leaders to enrich followers’ capabilities as well as to provide individual consideration through coaching or mentoring. On the other hand, transactional leadership offers rewards or disciplines for the followers. The exchange of rewards or punishments between leaders and followers depends on the adequacy and fulfilment of duty or performance (Bass, 2008).

The results indicated that the head nurses demonstrated both transformational and transactional leadership; in particular, the leaders’ preference for transformational traits was evident in the quantitative data in this study. The manifestation of higher scores in and

preference for transformational leadership over transactional and laissez-faire leadership has been documented among nursing leaders (Dunham-Taylor, 2000; Malloy & Penprase, 2010; Merrill, 2015), in that the nurse leaders use this style fairly often compared to transactional leadership.

In relation to transformational leadership subscales, the head nurses considered “idealised behaviours” to be the commonly employed trait. This factor suggested that transformational leaders behave in ways that allow them to demonstrate themselves as role models for their followers (Bass & Riggio, 2006). The notion of being a *role model* was supported by qualitative interview analysis. The theme of “the expected leadership characteristics” highlighted head nurses’ emphasis on this particular characteristic. They strongly articulated their commitment to leading by example as a critical factor in leaders’ leadership. This finding supported Bobbio and colleagues’ earlier research on Italian nurses’ perceptions of leadership. In their study, they noted that the leader’s role model behaviour was the key to sustained relationships between nurse leaders and staff, as well as the foundation for trust amongst them (Bobbio, Bellan, & Manganelli, 2012). In addition, a study of Middle Eastern nurses noted that leadership was about being a role model. Role modelling is the nature of the leadership process and it was perceived as the essence of developing transformational behaviour (Omer, 2005).

Overestimating scores on self-reported transformational characteristics among nurse leaders is a prevalent finding in the literature. In a review, it is known as attributional distortions (Hutchinson & Jackson, 2013). It occurs because the MLQ instrument typically invited nurse executives/managers to exercise self-rating. Due to this factor, the impact on the MLQ is the inclination for nurse leaders to have an inflated score on transformational leadership characteristics; it is more likely to occur in studies that addressed same-source ratings. Although



such studies are considerable, the concluded findings pose problems in their interpretation since they may be prone to method bias (Hutchinson & Jackson, 2013). In relation to this current study, Hutchinson and colleagues' review raised questions about its findings. To minimise this possible bias, previous authors have suggested collecting non-same-source data from staff nurses or others in the organisation to examine leaders' leadership performance. At the outset of study, I was aware of this potential distortion; therefore, to gain a better perspective on how head nurses in Aceh-Indonesia perceive leadership, I decided that a qualitative approach might complement the survey as it would be helpful in suggesting another point of view.

Reflecting on the complementary study, the qualitative strategy, the survey finding on head nurses' self-perceived leadership seems to contradict the views of followers based on the interviews' analysis. Under the theme of "the meaning of leadership", the head nurses were more likely to interpret leadership as direction and facilitation. The leaders help their staff to maintain standards and procedures. This domain of thoughts reinforced the view that transactional traits were more prominent amongst the head nurses than transformational and laissez-faire behaviour. The survey data on the presence of transactional style confirmed that head nurses perceived themselves "*fairly often*" as utilising contingent reward (CR), followed by the management-by-exception (Active) (MBE-A) factor of this leadership. Contingent reward involves the leader assigning followers to tasks that need to be done and, as a result, rewards are offered when the followers successfully carry out their duties (Bass, et al., 2003; B. Bass & R. Riggio, 2006). Further, the MBE-A trait, which was rated after the CR, shows that the head nurses actively monitor the staff's mistakes or errors and take disciplinary action when their tasks are not carried out in accordance with the guidelines.

Transformational leadership is frequently studied in nursing leadership research. However, head nurses in Aceh-Indonesia held the opposite view, instead demonstrating a tendency to transactional approaches. Predominant use of this transactional style in a nursing context has been recognised (Shirazi et al., 2015). As Shirazi et al. argued, the transactional type of leadership is traditionally applied in nursing education, resulting in the nurses becoming familiar with such characteristics and bringing this into their practice.

In relation to this study, the head nurses' inclination to transactional leadership may be reflected in the survey return rate. The study received 100% returned surveys and all were usable. This seems near impossible to achieve, recognising that not all nurses may have been happy to respond to the survey. The head nurses were convinced that they had directed the staff to fill them in and ensured that all questionnaires administered in their unit were returned.

Finally, in regard to the avoidant type of leadership, the head nurses did not perceive themselves as using a passive-avoidant leadership style. Subjects reported “*\_not at all\_*” to “*\_once in a while\_*” when asked about this approach. This result is similar to the findings of (Bormann & Abrahamson, 2014), Suliman (2009) and Janssen (2004). Laissez-faire is the leadership factor with the lowest ratings. This explains that head nurses did not prefer this style; therefore, they paid more attention to transformational or transactional leadership behaviours. Laissez-faire behaviours are least popular mainly because this style is considered to represent the absence of leadership. The leaders avoid decision-making and hesitate to take leadership actions (Northouse, 2010).

The qualitative data findings emphasise that the head nurses are involved in all the ups and downs in the workplace. This was distilled under the sub-theme of “person-focused attributes”. According to what they have explained, the leader's characteristics should set aside

laissez-faire behaviour. The head nurses revealed their strong preference for a communicative approach with staff and a willingness to build a supportive work environment. Therefore, this passive-avoidant type of leadership is unlikely to appear amongst them.

### *Staff's perceptions of leadership*

An exploration of nursing leaders' leadership would not be complete without acknowledging the followers' perceptions of leadership styles. The MLQ assessment results on what the staff nurses think of their leaders indicate that nursing staff perceive their head nurses' leadership style to be both transformational and transactional, in that transformational leadership was used “\_sometimes\_” to “\_fairly often\_”. Of all the transformational factors, idealised behaviours obtained the highest mean score. Interestingly, this subscale was also noted as the predominant transformational leadership factor among head nurses. This mirrors an indication that staff admired, respected and trusted the leaders; the staff believed their leaders possessed extraordinary capabilities and determination (Bass & Riggio, 2006). In other words, nursing staff in this hospital perceived their head nurses as role models for them. They wanted, to some extent, to emulate their leaders' performance. This expectation was reflected in the interview findings in “the expected leadership characteristics” theme. The point here is that leaders need to be role models for the staff; hence, it is a leadership success when the positive attitudes of the leaders are followed by the staff (Ilies, Cui, Dimotakis, & Spitzmuller, 2013).

Similar to transformational leadership, staff nurses perceived their leaders as utilising transactional leadership “\_sometimes\_” to “\_fairly often\_”. Amongst the staff nurses, the “management-by-exception (Active)” factor (MBE-A) received the highest score, followed by the “contingent reward” (CR) factor. This finding probably shows the tendency of these staff

nurses to prefer a direct-monitoring type of leader who is always with them to check for errors. The staff's preference for close mentorship was found to be in line with the interviews' analysis. Under the sub-theme of "task-focused attributes", active monitoring is highly expected from the head nurses. The staff nurses clearly expressed the need for monitoring and teaching by their leaders.

As noted in both the survey and interview findings, the nursing staff's inclination to accept the head nurses' direct observation may sound rather like safeguarding. The basis of "feeling safe" is the fact that the staff know that the leaders are on their side, and they can therefore have more confidence in their performance. In line with this study, mentoring and coaching on action-oriented work was recognised as leaders' essential contribution to building nurses' competence. Leaders' hands-on involvement in such interventions (i.e., mentoring, always being there for staff nurses) is actually seen as a positive experience for staff nurses in developing their clinical leadership (McNamara et al., 2014).

Research on transactional leadership in nursing has pointed out certain arguments that this leadership trait can be more beneficial than other types of leadership behaviours. Transactional leadership characteristics are considered necessary in order to strengthen best practice, ensure safe performance with clients, and comply with legal responsibilities (Stordeur, Vandenberghe, & D'hoore, 2000; Verschueren, Kips, & Euwema, 2013). This idea has, however, been contested. For example, Hoffmeister et al. hypothesised that all leadership facets as measured by the MLQ predicted safety outcomes for staff such as safety climate, injury, or safety compliance. Management-by-exception (MBE) factors of transactional leadership behaviours did not, however, contribute to any safety-related outcomes (Hoffmeister et al., 2014). An earlier study has also pointed that the MBE segment of transactional characteristics

has the least possible connection with safety (Judge & Piccolo, 2004). Such studies, however, raise caution with regard to their generalisability. Limitations such as data collection at one point of time, the presentation of associations between leadership and safety variables but not causal relationships, or a lack of interpretation of research results are of concern. Although they may not be applicable across disciplines, these studies have helped draw attention to the idea that leadership does have a significant role to play in safety assurance; the leadership approach may be different but the ultimate goal is the same.

Depending on the context, in workplaces where safety precautions are upheld most stringently (e.g., hospitals), performance needs to be strictly guided by the approved standards and procedures. However, close monitoring or corrective action by leaders may not necessarily restrict the staff's attempts to build their self-confidence or stifle innovation. In certain environments, for example, leaders' prominent transactional style may produce an opposite reaction if it is utilised in circumstances that demand extensive creativity and innovation (e.g., technology businesses). This is because the staff in that place may not feel free to express their capabilities when they know they are being observed for mistakes (Bryant, 2003). Eventually, people in creative jobs may sometimes learn from mistakes. Their involvement in multiple trial-and-error procedures could be the path to finding the best, yet premium, output. Creative business workers need opportunities to experiment with their ideas and to be innovative. Certainly, this is almost impossible to apply when dealing with patient care since everyone's performance needs to be precise and correct in terms of procedure.

Lastly, in regard to the avoidant type of leadership factor, staff nurses perceived that their head nurses use the laissez-faire approach “*\_not at all\_*” to “*\_once in a while\_*”. This result was similar to what the head nurses had expressed in earlier discussions. The staff nurses find that

their leaders show leadership character and are not seen to be passive or clueless in leading. A possible explanation for the low response given to the laissez-faire style can be linked to Vinkenburg et al.'s study on descriptive gender stereotypes in leadership styles. The study showed that women display more transformational and contingent reward traits, while men much prefer management-by-exception and laissez-faire behaviours (Vinkenburg, van Engen, Eagly, & Johannesen-Schmidt, 2011). In this research, female nurses predominated among the survey participants; therefore, preference for passive leaders is least likely.

From the above discussion, the head nurses and their staff perceived that transformational and transactional leadership existed amongst them. This shows that the nurses appreciate behaviours that encourage interaction and a constructive atmosphere between leader and staff. In the meantime, laissez-faire was the least preferred style and was avoided by the nurses. This is mainly because this style depicted leader unresponsiveness and an absence of leadership actions. In some places, I discovered that there are times when head nurses and the staff have different opinions on leadership. To explore this further, the following section will discuss this topic to provide a better insight into nurses' leadership in Aceh-Indonesia.

### 6.3.2. Discrepancies in leadership perceptions among the nurses

A range of research into nursing leadership has shown a tendency for nurse leaders to assume that they exhibit transformational behaviour more than any other leadership styles (Casida & Parker, 2011; Clavelle, Drenkard, Tullai-McGuinness, & Fitzpatrick, 2012). However, the results amongst the nurses in Indonesia in this study indicated that there was no significant difference in mean scores found in most factors between head nurses' self-perceived leadership and staff-perceived leadership styles.

The survey data revealed that the head nurses' self-rating scores were generally similar to their current nursing staff's rating values in all nine leadership factors of the MLQ measure, with the exception of two subscales. Significant differences were found in the *individualised consideration* of transformational leadership factor and the *contingent reward* item of transactional behaviour. This indication was in line with some previous studies, such as Failla and Stichler's research, in which they found no significant difference between nurse managers' perceptions of their leadership style compared to staff nurses' perceptions of their leaders' behaviours for most factors; however, in the two most critical indicators of transformational leadership, *individual stimulation* and *individual consideration*, significant differences were found (Failla & Stichler, 2008).

This finding somewhat contradicts common phenomena seen across nursing leadership studies. In most cases, the MLQ showed that nurse leaders perceived themselves as expressing transformational characteristics more than their staff perceived them as doing; yet, the differences in perceptions of leadership among the groups are significant in most factors (McGuire & Kennerly, 2006; Suliman, 2009). Although the discrepancies between nurses' leadership perceptions were not highly apparent in this research, the tendency for leaders to overrate themselves has been noted earlier (Alimo-Metcalfe, 1998). Several rationales may explain why such differences appeared regularly in the leadership literature; for instance, they may due to the well-known phenomenon of defensiveness in self-perception and the inclination to maintain a positive self-image and thus maintain self-esteem (Steel & Ovalle, 1984; Gioia & Sims, 1985, as cited in Alimo-Metcalfe, 1998).

The lack of attention given to transformational leadership factors in this study may indicate that the head nurses and staff do not take into account the distance between them.

Distinguishing between distant leadership and close leadership is becoming important when considering the transformational leadership paradigm (Alimo-Metcalfe & Alban-Metcalfe, 2005). It is predicted that, the more distant the leader, the greater the likelihood of the followers perceiving transformational characteristics in them (Sosik, Juzbasich, & Chun, 2011). However, the power distance between head nurses and staff in this study does not appear sufficiently significant to allow the head nurses to overrate themselves in transformational traits, except in the *individualised consideration* subscale.

In relation to *individualised consideration*, why does this factor show such a significant difference? There is a possible reason for its appearance among these nurses. *Individualised consideration* is a transformational factor, in that leaders pay special attention to each individual follower's needs for achievement and growth. The leaders are acting as coaches and mentors to develop followers in order to help them reach higher levels of potential (Bass & Avolio, 2006). Here, it is expected that leaders will show their acknowledgement of individual uniqueness in that, regardless of the followers' characteristics, the leaders recognise them and demonstrate acceptance of those differences. Prior to examining the difference in leadership perceptions between the head nurses and their staff, the head nurses rated it much higher than do their staff. There is a possibility that these head nurses *categorise* themselves as highly responsive to staff needs and yet strive to create supportive working conditions, which may be true to some extent. In the interview theme "factors that influence nurses' leadership", the head nurses confirmed their efforts to embrace diversity among their staff. The head nurses expressed a flexible approach when dealing with staff. In contrast, the staff did not support their head nurses' claim on this attribute. The score on *individualised consideration* revealed by the staff was much lower than that of the head nurses. Nursing staff perceived their head nurses to be inadequate at



addressing differences among staff. This was further evidenced under the interview theme of “the expected leadership characteristics”. There was a sort of complaint expressed by staff particularly regarding head nurses’ objectivity and fairness in the way they treat their staff. Although the head nurses said that they uphold equality among staff and acknowledge that each person is unique, these staff felt that they did not really see this. This phenomenon has been clarified by McDaniel et al. (1992). They argued that nursing employees are highly prone to being exposed to middle managers and form a more truthful interpretation of their behaviour; because of this, staff nurses tend to rate them less favourably in terms of possessing transformational characteristics (McDaniel & Wolf, 1992).

The distance factor may actually contribute to the accuracy level for staff or followers in perceiving their leaders’ characters. Of course, this is not to emphasise that social distance is the prerequisite condition for leaders to possess phenomenal leadership traits such as charisma, as identified in transformational leadership. However, Shamir (1995) has argued that there are fundamental differences between distant charismatic leadership and close charismatic leadership. Since the staff nurses in this hospital may have limited opportunities to interact with higher-echelon leaders, their direct leadership observation will mainly focus on the head nurses as the leaders who are proximal to them; therefore, the nursing staff may underrate them. The nursing staff’s sensitivity in examining the head nurses’ leadership capability is probably a lot more apparent than, for instance, their chief nurse executive. Although executive leaders are not the focus of the study, such circumstances have been recognised in the organisational behaviour literature. These high-ranking leaders have fewer face-to-face interactions with staff and are therefore more likely to be rated by them on the basis of impressions of their leadership style rather than their actual performance (Shamir, 1995).

The next factor that revealed a significant difference as mirrored in the MLQ is *contingent reward* of the transactional leadership behaviours. The mean score on this subscale is higher among the head nurses than among the staff, which indicated that the head nurses' transactional behaviours appeared through the use of *contingent reward*. Their nursing staff, on the other hand, rate it much lower than do the head nurses. This constructive transaction of contingent reward has been shown to be effective when used to motivate others to achieve better levels of development and exemplary performance (Bass & Riggio, 2006). This involved the clear assignment of jobs that needed to be done and the types of rewards offered once staff had finished them satisfactorily.

The head nurses confirmed that they pay great attention to task fulfilment and always make sure that the staff accomplish the tasks well. The head nurses articulated this argument as "the meaning of leadership". Under the qualitative sub-theme of "leadership defined", leadership has been described as directing and facilitating attempts by the leader to ensure the staff's performances meet the standard. Head nurses' prominent roles are highly focused on fulfilling tasks or ensuring their completion and not much more than that. Their understanding of leadership may thus help to clarify the reasons why nursing staff's ratings of contingent reward are lower than those of their proximal leaders. Since their head nurses put more emphasis on the importance of finishing jobs, it therefore appears evident that the staff preferred *management-by-exception Active* (MBE-A) as the highest perceived score on leaders' transactional behaviours. MBE-A called for continuity of leaders' observations to prevent errors at work. The head nurses' focus on standard level of performance therefore makes MBE-A a lot more desirable when staff nurses perceive their leaders' leadership. With regard to this view, previous authors have discussed two types of leadership that can be problematic; transactional leadership, which

involved rewards, compliance and the disciplining of staff members for deviation from rules/expectations, and passive leadership (Cowden, Cummings, & Profetto-McGrath, 2011b; Raup, 2008a). Since the head nurses in this hospital demonstrate transactional leadership, as perceived by their staff, this probably means that the head nurses failed to provide the motivating role they ought to have demonstrated to the staff. The staff motivation element was rarely mentioned by head nurses during my interviews with them. If their relationship remains as it is, this may be a problem since *bonding* between the staff and their head nurses will be disrupted. Therefore, it is expected that the head nurses will pursue strategies to resolve these conditions, mainly because the ability to build and restore personal connections with staff is pivotal for the institution and it has been identified as part of exemplary nurse leaders' characteristics (Anonson et al., 2014).

Interestingly, there is one factor that does not show a statistically significant difference but both head nurses and their staff seem to favour this trait. This is the *idealised behaviour* of transformational leadership characteristics. The nurses' ratings on this factor may indicate that this is their highest priority since it introduces the importance of the role model in their relationships. However, the interview findings and analysis contradict this survey result. An immense gap was found between head nurses and nursing staff, particularly in their way of perceiving leadership traits that relate to role models (i.e., this is mainly characterised in *idealised behaviour*). This discrepancy was evident in the theme of "the meaning of leadership" and the sub-theme of "leadership and managerial roles". On one side, the head nurses confidently claimed that they have been good role models and always try their best to show positive attitudes to staff, with the expectation that their subordinates will emulate them in their own performances. But this, unfortunately, does not concur with the opinions of the nursing staff.

These leaders were perceived as far from ideal by their staff. The staff expect leaders from whom they might learn; however, the leading figures around them are merely those who possess managerial skills but are inadequate at expressing leadership competencies. In regard to this condition, the literature has indicate that it cannot be assumed that a person who plays a formal managerial role will have the ability to enact adequate leadership skills and qualities (Jackson, 2008; Schwartz & Tumblin, 2002). Although scholars have underlined that management and leadership are seen as two sides of a coin, this is not necessarily mentioned (Watson & Thompson, 2008). There are cases when companies fail as a result of leaders who initially demonstrate excellent management skills but have poor leadership capacity. The failure of British Petroleum (BP) and Nokia, for example, brought valuable lessons. Both are large companies providing different services; nonetheless, the causes of their crises were apparently driven by similar scenarios: senior leaders' shortcomings in leadership skills. These leaders failed to engage their employees to become active participants in organisational strategy (Groysberg & Slind, 2012). It is common to expect that some people who hold senior/respected positions will have leadership skills; however, the sorts of skills required are often less coherently articulated (Watson & Thompson, 2008). Depending on the context, specific leadership elements for particular roles have been identified. For instance, Watson et al. (2008) outlined several criteria relating to professorship such as professional standing, authority in the field, accountability, and highly developed communication skills. However, in real situations, professors are often assigned on the basis of success in research and scholarship. It would not be wrong to assume that respected researchers who have risen to the level of professors will possess leadership qualities considering their experience and academic virtues. Also, learning from the fall of BP and Nokia, at a glance, probably no one would have expected these companies to fail

because they have certainly built a sound screening standard for their leadership posts. These examples have taught us that those who become senior leaders or successful researchers will not necessarily possess leadership ability (e.g., Watson and Thompson, 2008). The condition depicted amongst nurses in Banda Aceh-Indonesia is similar to the cases above. The head nurses involved in this study are highly experienced nurses. However, an exploration of their leadership qualities from the perspective of the staff nurses has further emphasised that seniority does not always co-exist alongside leadership capability.

In addition to the above discussion, we might also suggest that nurses in Banda Aceh-Indonesia will expect the type of leaders who are capable of combining multiple leadership characteristics. To a certain degree, it is quite reasonable for these staff nurses to anticipate a flexible leadership approach from their leaders, recognising their workloads or pressure within a hospital setting. In relation to this, scholarly discussions on leadership in nursing has reached a kind of consensus on the need for nurse leaders to show their flexibility and be able to adapt to situations in order to engage with and spread their influence among staff (Démeh & Rosengren, 2015; Wilkes, Cross, Jackson, & Daly, 2015). From the perspective of a researcher and the phenomena I observed in the field, the demand for leaders' flexibility in dealing with staff was explicitly expressed by the staff nurses. This introduces the notion that a single type of leadership would not be an effective tool for nurse leaders to bond with the staff. Therefore, leaders may find it worthwhile to comprehend and connect relationship-focused (e.g., transformational leadership) leadership behaviour and task-oriented leadership characteristics (e.g., transactional leadership).

The transformational style has been predominantly emphasised in nursing leadership studies (G Cummings, et al., 2010; Mannix, Wilkes, & Daly, 2015); in this current research,

however, the theme of “the meaning of leadership” distilled from the interviews’ analysis introduces the prevalent use and articulation of task-oriented leadership characteristics much more than transformational traits. Meanwhile, the survey results showed that transformational factor ratings apparently lean towards standard values or average scores.

For some time, the leadership literature has noted transformational characteristics as the true meaning of leadership, and transactional behaviours are the structure built for managerial roles. However, the qualitative findings emerging in the sub-theme of “leadership and managerial roles” show the confounding perspectives of leadership and manager. Almost all the head nurses articulate leadership as leaders’ efforts to complete tasks or responsibilities designated by the hospital board members; meanwhile, a very small number of them see it as an attempt and process to achieve organisational goals. Looking at this limited perspective, it may not be wrong for the staff nurses to point out leaders’ limitations in leadership competencies. The staff nurses confidently expressed this assumption when they were asked for their opinions on the meaning of leadership and being a manager.

Despite these sorts of pessimistic values attributed to the head nurses, these leaders were convinced that their leader-staff relationships go beyond jobs or nursing duties. The theme of “the expected leadership characteristics” revealed that these head nurses acknowledged several person-focused attributes such as appreciation and objectivity, and they stressed the importance of ‘walking the talk’. Although the types of leadership qualities distilled from the interviews with the nurses partially cover transformational characteristics as described by Bass, the initiator of transformational leadership, those attributes may provide an insight into the presence of transformational leadership among the head nurses; this also means that the head nurses have the competency to balance and share their focus due to task-centred relationships with staff.

The literature has suggested that transformational and transactional styles are a single set of leadership (Northouse, 2010); thus, they are each dependent on the other (Yammarino, 1993). Findings obtained from the survey and the interviews in this study support this notion. It may not be possible to expect a certain leadership behaviour to be superior to others. In practice, each style complements the other and each may be less effective if it stands on its own. The following section will discuss this assumption further.

### 6.3.3. Which leadership style should be prioritised?

The existence of transformational leadership is emphasised in most leadership research. This poses the question of whether all leaders should behave in that way. Organisations, on the other hand, also seem to push their leaders in order that they might be called and recognised as *transformative leaders*. This tendency may be the result of recent organisational leadership trends and work demands, or of pressure to obtain certain exemplary designations (e.g., Magnet hospitals). In the case of Indonesia, the widespread reputation of transformational leadership encouraged local researchers to explore how this leadership behaviour impacts on various nursing outcomes such as nurse satisfaction, preferred nurse leaders' characteristics, or nurse work engagement. Most of these are presented in the form of undergraduate and Master's level theses which are kept in university repositories and are unpublished. Like other similar research, the conclusions of those studies promoted the application of transformational leadership as effective leader behaviour (e.g. Krissudiro & Virgosita, 2013)

Transactional leadership characteristics apparently dominated nurses' perspectives on leadership in this study. It is possible that such traits are the most effective and useful for them. Arguably, leaders' willingness to motivate and empower is desirable, but not all nursing

workforces may need this at the first stage. The transactional style, which involves leaders' intervention and monitoring, may be what the nurses require at the initial stage. The nursing workforce participating in this research are predominantly young (i.e., 38.8%) and have less than five years' work experience. In these circumstances, it should be clarified that these nurses still expect a lot more direction and a stronger mentorship role by leaders.

Stordeur et al. (2000) explained that transactional leadership in nursing relates considerably to the experience and capabilities of the individual because there may be occasions when the leader's intervention is required to prevent errors and establish best practice. Of course, it is in the process of establishing a desired level of expertise that the leaders address their motivation, encouragement, attentiveness, and appreciation of all the staff's hard work. The output of the action is that type of leader who acts in a transactional way, but in the meantime she/he also maintains and continues to incorporate transformational behaviours in his/her interactions with staff.

Bass (1995) had argued that it is the transformational leadership that augments the transactional style; however, the findings of this study suggest the opposite. The fact that the study setting was a hospital may be the main reason. Nurses' inclination to behave in transactional ways may be strongly due to the fact that nursing work is conducted firmly on the basis of standardised procedure. This nature of the work prioritises safety assurance (Stordeur et al., 2000), thus causing the nurses to concentrate more on meeting the best standardised performance of tasks entrusted to them rather than encouraging an emotional approach to leadership.

The aforementioned discussion has helped to clarify that the nature of work determines which leadership behaviour should be exercised. Reflections from this study provide further



explanation that leadership in the nursing profession is prone to the type of leadership that ensures top performance. This is possibly related to the main duty of nurses as professionals who uphold safety assurance as their top priority. However, we have to acknowledge other elements surrounding the nurses in this study which, to a greater or lesser extent, have an impact on how they comprehend leadership in nursing. The following section will further explore the factors that influence Indonesian nurses' leadership.

#### 6.3.4. Factors that influence nurses' leadership

Several important factors that influence nursing leadership in Banda Aceh, Indonesia, were related to context, culture, gender, hierarchy, experience and education. Each of these will be discussed in turn below.

##### 6.3.4.1. Context and leadership

The distinctive view on leadership amongst nurses in this study emphasises the importance of the context in which leadership takes place. The exposure of context on nurses' leadership is mainly explained by the findings gathered from the interviews. The theme of "factors that influence nurses' leadership" supports the aforementioned premises. Head nurses, in particular, claimed that their leadership attitudes depend upon the conditions they are currently experiencing, which means that these head nurses acknowledged the interplay between situational condition and their leadership (Osborn, Uhl-Bien, & Milosevic, 2014). That is to say, the head nurses may be able to determine which leadership acts are appropriate at certain moments.

It has been argued that the ability to understand and manage situations is the key area of accountability for leaders (Kerns, 2015). This initial study's findings on nurses' leadership in Indonesia supports nurse leaders' (i.e., head nurses) capability to adopt a leadership behaviour that matches the given conditions. The head nurses, in general, are critical in the way they perceive leadership, especially in relation to internal work situations/wards. Although there is limited literature available to confirm the relationships between nurses' ward specialisation and leadership style (Zydzianaite, Lepaite, & Suominen, 2013), Lord et al. have argued that individuals' definitions of leadership depend upon innumerable situational and contextual factors (Lord, et al., 2001). Identification of leadership perspectives amongst nurses in Indonesia, for example, elucidated that flexibility in leadership attitude is apparently very well articulated among leaders in critical care wards. This is probably influenced by the type of work environment that tends to require them to be fast and highly responsive. In the meantime, in medical-surgical or ambulatory care units, the head nurses made similar acknowledgments on the role of conditions in leadership; however, the way these nurses explain leadership and their behaviours to staff is often found to be less explicit compared to leaders in critical units.

This current study is the first of its kind to explore nursing leadership in Indonesia. The perspective of these nurses identified the importance of the role of context in the way they express leadership views. Contextual factors, such as environmental risk, explain that environmental crises may generate different expectations of leaders compared to stable environments. This can be seen in a situation of high safety concerns, where active management by exceptional leadership has a more prominent role than in low-risk conditions. The high-risk conditions require the leaders to be "quick and fast" in their decision-making due to the critical situations in which they find themselves (Avolio, et al., 2009). Avolio et al.'s (2009) argument

is in line with the situation observed in the current research field. Demanding work conditions, such as in critical care units of hospitals, will potentially shape the nurses' perspective on their leadership understanding and behaviours.

In this regard, investigations have confirmed that conditions around a group of people are responsible for response variability beyond the influence of individual differences (Vroom & Jago, 2007). A high level of responsiveness amongst critical nurses and the need to be alert at most times have trained them to be a lot more skilful in their judgement of the leaders-staff relationship and their valuation of leadership among them. As well as the head nurses, the nursing staff who work in critical care tend to have a more critical perception of leadership compared to those in medical-surgical or ambulatory units. Although some have relatively less experience, critical care nurses show their confidence in their leadership capability, have clear expectations of leader-staff relationships, and yet are self-assured in that they have autonomy as an opportunity for development. However, these matters are seen slightly differently among staff nurses in medical-surgical units. For example, when they were asked about their perspective on leadership, these nurses were unlikely to be able to define it unless the matter was explored further. Again, this assumption further recognises that leadership is a context-specific rather than a generic concept (Watson & Jackson, 2009). The conditions amongst the nurses are likely to demand particular types of leaders and particular sorts of leadership. Therefore, nurses in certain wards are likely to see leadership differently from how other nurses see it.

Another important message I gathered from this research concerns nurses' confounding view of leadership and management as the effect of the conditions in which they are involved. The sub-theme of "leadership and managerial roles" showed that the nurses see hardly any difference between the two. The almost indistinguishable perspectives on leadership and

management roles may emphasise several elements; first, the lack of leadership figures in their settings; second, the inability of the organisation to expose them to leadership opportunities; third, the possibility that the nurses have always been driven into task-oriented work schemes which have therefore overshadowed the evolvement of leadership amongst them. These may have been true considering that, in all probability, attention to Indonesian nursing development is more focused on practice than on leadership. A similar concern was reflected in a study conducted amongst Lithuanian nurses in which the researchers concluded that leadership in nursing is typically assumed to be a less important aspect than skills/practice improvement (Zydzionaite, et al., 2013).

The reality I observed in the field seemed to support the above discussion. The hospital system is undergoing some reforms; these include the increasing use of technology in many departments, including in nursing. However, during this transition process, manual work or paper-based reports are more than enough to constitute an extra burden for them. I met many nurses, including the head nurses, who complained that they are still juggling with administrative work and paperwork. Moreover, shift ratios at work may be another challenge for nurses. Staff allocations in each set of duty hours are unbalanced compared to the workloads that they have to accomplish. It may not be surprising that, due to these burdens, attention to leadership is set aside; therefore, we tend to find nurse leaders who demonstrate leadership styles that are mainly aimed at maintenance and doing the job rather than focused on the real aspect of leadership itself, such as managing the decision-making in ethical dilemmas (Zydzionaite & Suominen, 2014).

The actual situation seen in this Indonesian setting may suggest this question: “Do we have to create conditions that pressurise nurses to enable them to exercise their leadership?”

Certainly, the discussion as presented above may lead to this assumption. Context has led head nurses and staff in shaping their perceptions, behaviours and expectations of leader-staff leaderships. An interesting argument, however, was noted during the interview analysis. Present conditions may not always influence leadership; rather, it is determined more by timing and the type of issues they encounter. To some extent, this supports Lord et al.'s assumptions about numerous contextual factors that may affect leadership enactment, which could involve the moment when the leadership is exercised. Timing and type of problems are therefore acknowledged by nurses in this setting as being among the variables that leaders have to be aware of in determining their leadership action. It is important to note that these factors may only apply to nurses in this context and may not be relevant to others. Each individual condition is unique and distinct from the others; therefore, contextual factors that influence leadership may be perceived differently in different places.

#### 6.3.6.2. Culture perspective

The interviews' analysis brought many insights into how work and regional cultural values influence nurses' leadership perspectives and behaviours. The sub-theme on "culture" highlighted that the social norms upheld in the nurse's workplaces, including how they were raised, influences the way respondents view leadership. This is somewhat in line with House et al.'s suggestion that preference on leadership depends greatly on the cultural background to which the people belong (House, et al., 2004). Hardcore or stubborn personalities, for instance, are among the reflected characteristics they were trying to describe, which may support claims regarding the near-authoritarian style of leadership among the leaders. On the other side, the qualitative findings highlighted some leaders' arguments about the possibility of authoritarian

behaviours appearing. In its development, nursing has been prone to autocratic leadership values. The type of leadership characterised as primitive leadership style is strongly based on hierarchy as well as the dominancy of the leader over the staff (Kelly, 2010). In general, the authoritarian concept may always have had a negative reception and been avoided in many organisational leadership settings; in nursing, however, this type of leadership is viewed rather differently. Being cognisant of the culture of nursing work, the existence of authoritative leadership may have been applicable or even sometimes required in hospital settings. Authoritative leadership implies that head nurses need confidence to articulate nursing values in decision making (S Sellgren, Ekvall, & Tomson, 2008); this also emphasised nurse leaders' ability in their leadership qualities. This can be related to the fact that, in any hospital, emergency conditions may occur at any time; therefore, precision at work is prioritised for safety assurance. Awareness of safety and the need to always be precise thus creates a system or culture that demands a leader who provides clear instructions for staff to follow and who is endowed with such legitimacy that no one will dispute the given orders. Here, it is clear that culture in the workplace is likely to contribute to nurses' leadership viewpoints.

Aside from the hospital's work culture, head nurses and their staff strongly emphasise the sense of solidarity among them. The head nurses, in particular, pointed out that nurses are united; they acknowledged a family-like relationship between leader and staff. There is a collectivistic tendency amongst them, which means that the nurses demand responsibility and care from one another. In most Asian cultures, House and colleagues asserted that collectivism is more fundamental than individualism (House, et al., 2004); collective values are much more appreciated because the people in this culture have been taught to always prioritise communal needs above personal interests. This assumption seems to have been applied in this context since

the study was set amongst Indonesian nurses. The culture prevailing in these nurses' communities, therefore, may be highly influential for them in terms of prioritising togetherness over individual needs.

In addition, preference for a family-oriented leadership approach was highly prominent among staff nurses. In "the meaning of leadership" theme, nursing staff expected and desired leaders who are accommodative, facilitating, always there to direct them, and communicative. Since nearly all head nurses are female, the staff wanted a mother-type leader who exudes care and protection at all times; however, they admitted that they did not receive very much of this from their current leaders. These sorts of characteristics described by the nurses in an Indonesian setting are pervasive across nursing leadership literature. Over time, the literature noted communication skills, coach and mentor orientation, or ability to empower others as frequently expected leadership qualities (Anonson, et al., 2014; Feltner, Mitchell, Norris, & Wolfle, 2008; Rouse, 2009). Moreover, the presence of family- or parent-like leadership expectations may indicate the pivotal role of parent figures amongst the nurses in Indonesia. These findings are in line with Gani's finding that Indonesians depicted leaders as possessing the roles of father (wise), mother (aspirational), friend (tolerant, social, open), educator (patient), priest (moral), and pioneer (creative and intelligent) (Gani, 2004).

The combination of a work culture that tends to support an authoritarian style and nurses' preference for nurturing leader characters as in family life may also suggest an expectation of paternalistic leadership characters. The existence of paternalistic leadership in nursing values has been identified. It is characterised by a supervisory and charismatic style of leaders who demonstrate strong personalities and confidence in their ability to boost group self-assurance and reduce anxiety (P. Kelly, 2010); it can also be expressed as a combination of strong discipline

and authority with fatherly benevolence and morality (Farh & Cheng, 2000). Authoritarianism refers to authority and control, and it demands obedience from followers; benevolence describes holistic concerns for each individual's needs and wellbeing to obtain followers' gratitude and obligation; finally, morality signifies a role model or exemplar attitudes that gain the respect and admiration of followers.

In Southeast Asian countries, the regional culture preserves collectivistic values and appreciates paternalistic leadership. This is because collectivistic culture places greater emphasis on interconnectedness between individuals, compliance and loyalty (Chhokar, Brodbeck, & House, 2013). This study is the first attempt to explore nursing leadership in Indonesia. The preceding discussion has emphasised how cultural values held by the nurses influence their leadership expectations. These nurses, from what they described, have the identified leadership capabilities a nurse leader should possess, which correspond strongly with the values surrounding them. A deep understanding of the culture and beliefs of a group of people among whom leadership will be exercised is therefore critical for leaders. In other words, leaders who enact leadership that corresponds with the cultural expectations of certain settings are perceived as effective leaders (Dorfman, Javidan, Hanges, Dastmalchian, & House, 2012). The culture that values romantic relationships, desires leadership characteristics that are nurturing and prioritises group needs over individualism is not flawless. The drawback of this culture is the low value attached to equality and assertiveness (House, et al., 2004); this means that this system nurtures men's leadership and the hierarchical norms amongst them. This is somewhat in line with the findings of this study. The theme of "culture" confirmed that nurses see the strong presence of patriarchy and low egalitarian value within their culture. This, therefore, will be explored further in the following discussion on gender and hierarchy dimensions in leadership.



#### 6.3.6.3. Gender in leadership

The majority of staff nurses who participated in the study and all the head nurses are women. The survey showed that transformational leadership obtained a slightly higher rating compared to other types of leadership behaviours as measured by the MLQ tool. Such results may have been due to the discrepancy between the number of male and female nurses participating in the study.

The disproportionate number of male and female participants is likely to influence the preference of leadership behaviour in the MLQ. In female-dominated settings, such as in this study, it has been argued that women exert more transformational leadership behaviour than male leaders (Bass, 1999) and men's and women's normative roles have been described as affecting their leadership behaviour and outcomes (Ayman & Korabik, 2010; Eagly, Johannesen-Schmidt, & Van Engen, 2003). It is asserted that female gender roles demand typical norms of caring, supportive and considerate behaviour. These may be an effective means of approaching transformational leadership and those described norms allow women to overshadow the masculine-impression type of leadership (Eagly, et al., 2003; Yoder, 2001). Women's attentiveness to relational aspects of work may find transformational leadership congenial to them. The tendency towards transformational leadership by women rather than by men can be explained by the possibility and trend that leaders' gender identities may influence their behaviour in a way that is consistent with their own gender role (Eagly, et al., 2003). Eagly and colleagues thus argued that transformational, transactional, and laissez-faire styles of leadership vary somewhat between women and men. Although some evidence casts doubt on this (Alimo-Metcalfe & Alban-Metcalfe, 2005), the most important leadership factor that emerged from this study is the ability of leaders to show concern for others' wellbeing.

Interestingly, laissez-faire and management-by-exception (passive) aspects were described as “men’s” preferred characteristics. It has been argued that men are more likely to engage in these leadership styles than women (Eagly & Carli, 2007; Ibarra, Carter, & Silva, 2010; Martin, 2015). This study is the first study in Indonesia that attempted to explore nursing leadership in the country. Despite the existence of transformational leadership polarised more in women, this current study illuminated the possibility that male nurses may prefer transformational leadership; for instance, statistical significant differences were found only in the *intellectual stimulation* factor of transformational leadership, in the *management-by-exception (Passive)* subscale of transactional leadership, and in laissez-faire subscales. These factors were perceived as higher among male nurses than among their female counterparts; this is in line with most studies that explain gender and leadership preference, with the exception of the *intellectual stimulation* of transformational leadership. Indeed the *intellectual stimulation* factor received high priority among male staff nurses. This may indicate that male nurses perceived that their female head nurses utilise this particular factor to a greater degree than other types of transformational factors. This is the opposite of what is generally seen in leadership research where it is underlined that men perceived other types of transformational factors of *idealised influence, inspirational motivation, and individualised consideration*. It is interesting that the male nurses who participated in this study paid more attention to *intellectual improvement*. In general, this shows that the male nurses may expect the female nurses to pay more attention to knowledge development and the stimulation of skills improvement at work. Their preference for the intellectual factor over others may relate to their own context, the hospital. Conditions in the workplace have potentially shaped their view that skills require more consideration than other aspects of their role. Research has shown that leadership performance of female-led management

systems tends to be different with male leaders (Khan & Vieito, 2013; Melero, 2011). The female side predominantly used and preferred interpersonal interaction (Melero, 2011). This argument is probably in line with what we see from the male nurses in this research. They may have perceived that their female head nurses' leadership ability should go beyond typical female leader characteristics such as nurturing, caring, or high personal connectedness. Although this study conducted amongst nurses in Indonesia did not seek to compare female and male nurse leaders, the findings on male nurses' preferences regarding their leaders' leadership styles have further emphasised that gender difference is an important aspect of leadership research.

Bass had highlighted the gender differences in the perception of transformational style in his research. Women leaders were rated by both female and male staff as showing several key components of transformational leadership, such as charisma and individualised consideration, more frequently than male leaders. This is, however, slightly different from the findings obtained in this research. The *intellectual stimulation* factor was the one they preferred.

The male staff nurses' preference for *intellectual stimulation* may be linked to data on transactional leadership and laissez-faire. In transactional leadership, the male staff rated the *management-by-exception Passive* (MBE-P) factor and laissez-faire style higher than the female nurses rated them and the difference was significant. As explained previously, MBE-P leaders pay attention to their staff's performance but only take action when mistakes occur, while laissez-faire describes the absence of a leader's leadership. Perhaps the male staff have thus far perceived their leaders as being passive with them. Attention was only attracted when performance deviated from the standard and caused substantial errors. In addition, the data may also suggest that the male nurses perceived their leaders as failing to express leadership actions, especially when dealing with their performance. Therefore, *intellectual stimulation* may have

been a leadership behaviour that the male staff expected from their leaders. This could be in the form of mentoring, coaching, or education imparted from leader to staff in order that nurses might be able to achieve their best work performance because the leaders are actively assisting and improving them (Bleich, 2014).

The findings suggest that transformational leadership was exhibited by male and female leaders regardless of the sex of the raters; however, female leaders displayed it more (Bass, Avolio, & Atwater, 1996). Several arguments have shed light on the finding that women were more likely to engage in transformational leadership than men. This may be in line with findings obtained in this study. The majority of nurses participating in this research are female. Therefore, we might anticipate transformational leadership ratings slightly higher than other types of leadership styles. This was later confirmed by the statistical results.

However, the interviews' analysis may counter this assumption. The nurses, to some extent, cannot fully engage in transformational leadership, mostly for context-related reasons. Bass's review had questioned the appearance of transformational leadership in female-dominated fields such as nursing (Bass, 1999). As stated earlier, the safety factor is the priority in their work. In the interview findings, under the theme of "the meaning of leadership", nurses stated that there are times when leaders should be somewhat authoritarian, but on other occasions a personal approach and discussions are preferred and even encouraged. Some gender-related analysis may not be applicable in nursing-related contexts since most of the research used in the investigation involved corporate leadership segments. Although caution should be exercised in applying their analysis to the nursing field, their findings were useful in an attempt to clarify gender context roles whereas male leaders are much more likely than female leaders.

#### 6.3.6.4. Hierarchy and leadership

According to Hofstede (2001), Indonesia is a country whose culture has a high score on power distance and a low score on individualism. Power distance represents a position of superiority of a leader whereby a leader is respected because of his knowledge, skills and moral standards (Aycan, 2006); in addition to this, the country upholds the norm that prioritises the collective interest rather than personal goals (Dorfman, et al., 2012; Muenjohn, 2015). Individualism, therefore, is frequently seen as a negative aspect of one's life.

Power, in this culture, is almost certainly dominated by a father or husband in family life. The sub-theme of "gender" in the qualitative findings has noted nurses' perspective that leadership is seen specifically as a man's job. In other words, patriarchal authority and hierarchy are more prominent here. This may be in line with Westwood's argument about headship characteristics (Westwood, 1997). It is generally found more among Eastern people than in Westerners. Headship is characterised as the formation of patriarchy and hierarchical norms with harmony building and moral leadership.

This might lead us to assume that leadership is stronger among men than among women. Powell has asserted that although nursing by its nature requires female characteristics, the leadership and managerial side of the profession favours men and behaviours related to a masculine stereotype (Powell, 2012). Like other Indonesians, most Acehnese have been raised to respect and obey the authority of the father as the family decision-maker. Under the theme "the meaning of leadership", the obligation to obey and the preference for men in leading roles were part of the nurses' perspective.

It was not surprising to find that female-dominated professions such as nursing still favour male leaders. Widyahartono's finding that, in Indonesia, staff frequently hope that their

leaders will be not only managers but also protectors, mentors and fathers, who must be responsible for them, underlines this notion (Widyahartono, 2007). The nurses who participated in the interviews in this study identified that men somehow deserve to take on the leadership role and they have greater expectations of a leader. Unfortunately, research has reported that the “think leadership, think male” (S. P. Robbins & Coulter, 2013) perspective has carved out a barrier for women seeking to undertake a leadership role in nursing. To some degree, this argument may describe women’s apparent inferior capacity to take on leadership roles or leading positions. As a result, men’s leadership status seems more prominent than women’s in a female-dominated profession

On the other hand, it has been argued that the current role of women in Indonesia may have changed. This has been influenced by several elements including traditional custom, Moslem law, and social and political developments (Irawanto, 2011). Due to these factors, there is a tendency for women to participate more in society (e.g., in the labour force) and to have more authority, influence and responsibility in family life (Irawanto, 2011).

In this argument, Irawanto asserted that the Indonesian community nowadays gives women many more opportunities in many social aspects. The nursing field in the country, for instance, may have implemented this trend. Most of the nursing leaders participating in this study are female. However, to a certain degree, hierarchy and gaps still exist in their work. The interview findings under the sub-theme of “the marginal leader” raised some issues related to these aspects. Nurses’ lack of autonomy, doctor-led schemes that dominate work, political interests that pay minimum attention to the profession, or the employment of contract nurses who see themselves in a precarious position are examples of problems expressed by the nurses. Such problems are examples of the dilemmas experienced by nurses in this hospital, which, as noted in

the literature, may make it difficult for them to internalise leadership qualities and develop the potential to expand their capabilities (Speedy & Jackson, 2015). The nurses are aware of their leadership potential, but the issues surrounding their work environment may have prevented their leadership from flourishing.

From my perspective as the researcher in this context, I believe that nurturing the nurses' potential by focusing on leadership development may actually serve as a reciprocal benefit between the nurses and this hospital, in the sense that these nurses would see this as a confidence booster to their work performance, which would be advantageous to the organisation. Were the hospital board members to take this opportunity to invest in their staff, I feel that this organisation would reap the benefits in the near future. Prospective nurse leaders would no longer be at the edge of the institution because everyone would feel that they belonged and would be provided with an equal chance to grow.

Hierarchy and gender roles in leadership have been discussed. In addition to these, there are some other relevant factors of considerable importance from the viewpoint of the nurses; these are experience and education. The following section will explore these in more detail.

#### 6.3.6.5. Experience and education

Research has revealed that experience and education are related to nurses' leadership qualities (Pulcini, Jelic, Gul, & Loke, 2010). Interestingly, the results of this quantitative study amongst nurses in a hospital in Indonesia showed that the length of work experience and educational level appeared to have no significant effect on the way nurses perceive leadership. Initially I was expecting to see differences in leadership perspectives amongst the nurses since their work experience and educational levels are quite diverse. However, the survey results may

have given a true representation of these nurses. Most of the nurses participating in the study had obtained Diploma-III (i.e., vocational nurses) as their highest educational level, and they have less than six years' experience. This may cause these nurses to perceive leadership no differently to others; this may also indicate that the nurses do not take education or job experience into account as factors that influence leadership.

Such findings in this study may explain why the nurses were less critical in valuing leadership. This may be in line with Rassin's study in that there is a tendency for vocational nurses to place a higher value on obedience but a lower value on independence and critical thinking (Rassin, 2008). In the same study, academic nurses were found to be more self-reliant and visionary than those with lower levels of education. This may suggest that those who have pursued higher education will be better prepared for future challenges or difficulties. Scholars have raised the issue of the need to prepare nurse leaders through education. It is expected that the provision of opportunities for nurses to engage in formal education will improve their leadership practice (L. A. Kelly, Wicker, & Gerkin, 2014; Waite & McKinney, 2015).

Education and experience are inseparable in the nursing profession, particularly with regard to leadership. Leadership in nursing can be optimised by integrating and optimising the two elements (Démeh & Rosengren, 2015; Scott & Yoder-Wise, 2013). Regardless of the type of complexity nurses face, we can assume that better-educated individuals will rely on their ability to do their best to meet their responsibilities and tackle challenges that require initiative and independent thinking. On the other hand, individuals with lower levels of education have limited autonomy or independence, possibly due to their limited knowledge. Thus, these nurses are expected to show an obedient and conformist attitude (Rassin, 2008).



This interpretation may be further supported by the interview findings. The theme of “the definition of leadership” highlighted leadership as a concept related to a ruler, person-in-charge, or facilitator. In this sense, leadership is merely about the boss and their staff. This was expressed by most of the interviewed nursing staff, who were quite young and had little work experience. Interestingly, some experienced nurses, such as head nurses, had almost identical viewpoints to their staff. However, among those nurse leaders who had attained a higher level of education, leadership was viewed as a broader concept. It is not only about leader and staff but also involves vision, the need for courage to take risks at work, mission, goals, and willingness to be an agent of change.

From these viewpoints, we can see a diverse perspective but an expectation of what leadership should be. Vocationally-educated nurses’ views on leadership are rather limited compared to nurses who possessed higher educational qualifications. Most of the interviewed nurses shared the same educational background when they started work at this hospital (i.e., the Diploma-III programme). In these circumstances, it can be assumed that education runs parallel with leadership capability (Middleton, 2013); The nurses in this context, for example, pay less attention to leadership, possibly because in their previous education the main focus was on training and how to perform nursing tasks correctly. Their education did not provide substantial information or knowledge on leadership and its importance in their work environment; In contrast, insights into nursing leadership increased as education and experience improved (Brooten, Youngblut, Deosires, Singhala, & Guido-Sanz, 2012).

Upon further reflection on the interview data analysis, I noted that the nurses admitted that education and experience matter in leadership. These were perceived as contributing agents in improving leadership skills and behaviours; these are “must have” factors and are attached to

each other. The theme of “factors that influence nurses’ leadership” highlighted this finding. Vesterinen et al.’s investigation of factors that influence leadership amongst nurses in Finland supported this current research discussion on the importance of education and experience for the nurses and their leadership competency. Through interviews with several nurses, Vesterinen et al. found that these nurses believed that their earlier work history influenced their leadership style. The nurses were inspired by the positive attitudes of their previous leaders and wanted to emulate the positive sides they had seen in them and avoid the negative ones (Vesterinen, Isola, & Paasivaara, 2009). Furthermore, education influences one’s development as a leader. Education improves one’s thoughts and leadership proficiency (Vesterinen, et al., 2009). Therefore, the provision of educational opportunities in developing nursing leadership is pertinent as this will, in turn, enhance nurses’ professional skills (Vesterinen, Suhonen, Isola, Paasivaara, & Laukkala, 2013).

In summary, the factors that influence Indonesian nurses’ leadership have been explored. The discussion in this section has helped to explain how the variables of context, culture, education and experience shape the nurses’ perceptions and behaviours regarding leadership. With this recognition, it is expected that efforts to improve nursing leadership will continue to grow and the importance of those factors amongst the nurses will be appreciated. Finally, the nurses’ perspectives on leadership have been presented, however, this study has introduced strengths, limitations, and several potential implications across nursing sectors. These will be explored in the next section.

#### **6.4. Strengths and Limitations of the Study**

The use of the MLQ is widespread in nursing. Its application for investigating nursing leadership in non-Western countries has been found to be relevant (AbuAlRub & Alghamdi, 2012). In an earlier argument, the universality of the measure has been documented (Antonakis, et al., 2003). Results obtained from the quantitative research showed that transformational and transactional leadership existed amongst the nurses in the hospital. This was similar to an array of nursing leadership studies conducted in other countries, such as the Middle Eastern region, Finland and Australia (AbuAlRub & Alghamdi, 2012; Linton & Farrell, 2009; S Sellgren, et al., 2006). In addition, these researchers indicated that the measure had valid properties and was applicable in their studies.

A critical appraisal of the nursing leadership literature made clear the preference for transformational leadership as measured by the MLQ. However, the polarisation of certain leadership styles as measured by the MLQ (i.e., transformational behaviour as the most favoured style, and transactional leadership as the lowest level) may actually have resulted in a premature judgement on the nurses' leadership. Certainly, this study does not intend to claim that the MLQ is of *no use* at all; rather, the analysis of this current research may point out the measure's claim of universality. The MLQ may actually be more useful in certain fields, but it may be less appropriate for assessing nursing leadership among hospital nurses in Indonesia. The nature of nurses' work is loaded with unpredictable circumstances sourced either from their internal work or from external elements that require the nurses to be dynamic and capable of demonstrating appropriate leadership styles for particular events. For example, leaders in the intensive care units were aware that they were sometimes required to behave in an authoritarian style, especially when emergencies occurred; however, there are times when the nurses are able to

have open discussions and be proactive in encouraging their staff leadership growth. This shows that there are opportunities for them to elaborate different kinds of leadership styles depending on conditions.

An array of nursing leadership research has underlined the positive impact of transformational leadership (e.g., Cummings, 2010). This may therefore imply that all nursing leaders should strive to achieve transformational exemplary attitudes. Undoubtedly, there is nothing wrong in pointing out that this leadership has the best characteristics for application in nursing; however, it is possible that not all nurses are ready to pursue this leadership. For instance, during my research, I observed that the hospital is undergoing a massive transformation as part of its reconstruction and rehabilitation programmes. In view of this, there is an urgent need for highly task-focused leaders capable of providing clear instructions and directions for the staff. Clearly, this gives limited chances for transformational leadership to grow since there is a lack of opportunity for individual encouragement or educative stimulation. Learning from this condition, therefore, one can see that an initial assessment of the nurses' group condition, which may be related to their general characters, job responsibilities and support they need the most, local culture, or norms and values upheld in their environment, needs to be considered and taken fully into account in order to determine a leadership style that suits them best. Acknowledgement of the context to which the nurses belong and the system around them may be more reasonable at the first stage, prior to suggesting the type of leadership behaviours most suitable for them. Although several studies have confirmed that a leadership type can be effective in a certain setting, we must be selective and critical about this; this is merely because we do not know how suitable the style is for the environment. Therefore, in-depth exploration and context assessment may be preferable as the priority.

Furthermore, this study has improved the understanding of the definition of the leadership concept amongst nurses in Indonesia represented by hospital nurses in one region of the country. Although this study was among the initial efforts in such a context, it has limited generalisability. Since this study was conducted in Aceh, a province in the west of Indonesia, findings and analysis gathered from the nurses of this region may not be representative of all Indonesian nurses. For instance, the leadership views of Acehnese nurses may be different from nurses in Jakarta, the capital city. Indonesia is a country with multiple regions, tribes and ethnicities. With this richness, it seems very obvious that people from different regions will have distinct values, job and life environments, and norms. Perspectives on leadership obtained from the nurses in Aceh may introduce a general impression of Indonesian nurses, but it cannot be inferred that all nurses in the country will see the leadership concept similarly.

In one respect, the use of the MLQ may be one of the strengths of the study since the measure has been revised and refined to its best by prominent leadership scholars. It has also been translated into many languages and reported to be effective in various settings. An Indonesian version is available and it has been utilised in many disciplines such as business or other organisational studies. However, the measure was not greatly appreciated by the nurses in this research. Although the pilot study results confirmed the reliability of the tool and showed no major issues with it, in the main research field, some nurses expressed their concerns and complaints about the instrument. It took a while for some nurses to comprehend each of the questions. They found the questions rather difficult to understand and felt that they overlapped one another. This may have been caused by the background of the measure. It was originally developed in English and in a non-nursing-related context (i.e., as outlined in the literature review). Even though it has been used in a number of nursing leadership studies and was

carefully translated into Indonesian by trusted experts, it may be less applicable amongst nurses in Aceh.

Another noted limitation of this survey is the sampling strategy for the survey. I attempted to gather 224 nurses randomly from a pool of 550 nurses then selecting every second name from an alphabet list of names. Unfortunately, such effort would mean that the last 100 names in the list are ignored, therefore this could impart significant bias for the study since names are frequently related to ethnicity or any kind of diversities those respondents might possess. In addition, the return rate for the survey was perfect. It reached 100% usable returned questionnaires from staff nurses ( $n = 224$ ). The head nurses had confirmed and checked earlier that all staff nurses assigned to fill in the questionnaire had been able to complete it in a timely fashion. However, there may be a downside to this. Despite my satisfaction, as the researcher, at achieving this absolute rate, it is possible that the head nurses' staff had filled in the survey merely to comply with their bosses' orders. There is a possibility that the staff found it difficult to decline to participate since their leaders had asked them to do so. This may have produced a response bias in the survey in that, in this case, completion of the survey was undertaken on the basis of pressure by leaders on staff and there is possibility that the completion and response to the survey are based on what was felt to be the right answer. The respondents were assured confidentiality and anonymity arrangements precluded any responses being traced back to specific individuals that made them.

Nearly all participated head nurse and staff were former students at the Syiah Kuala University's-school of nursing. As such many respondents will have known me in my capacity as a Nurse Lecturer. Most of participated nurses were my students who pursuing bachelor degree in nursing. There is possibility of such factor introduces another bias for the survey and interview

stage. This power, however, might influence them to participate in the research and I have minimum difficulties at obtaining participants since the nurses and I already have an established relationship. The existence of this relationship should be noted and considered a potential bias within the study.

Aside from the limitations of the survey, I recognised that the interviews' analysis needed some attention. They may have lacked representativeness. The interviewees were all female nurses. An attempt was made to select male nurses for the interviews. However, a male head nurse was not available at that time and all the returned consent forms for interviews came from females. The views and perspectives of male nurses might have expanded the analysis of this study had they been included.

In addition to the stated limitations, the translation process must also be considered. The interviews were transcribed and translated into English from the interviewees' native language, Bahasa Indonesian. Although great attention and efforts to address translation issues were made (as outlined in Chapter 3), difficulty in finding similar values to express the interviews' contents across languages was unavoidable. With the assistance of a language expert at the English Language Centre at my host institution, the University of Syiah Kuala, this language barrier was minimised. While maintaining data confidentiality, the English translation of the interviews' analysis was carefully examined to meet the best standards and closest meanings to the native interviews' language as presented in this study analysis.

## **6.5. Study Implication**

This current research has implications for nursing education, nursing leadership and management practice, as well as for future research in nursing leadership.

### 6.5.1. Implications for nursing education

Findings obtained from the survey in this study indicated no significant correlation between level of education and leadership style. In the meantime, interviews with the nurses produced a contrary result. The nurses believed that the quality of one's education is related to one's leadership competency.

Regardless of these conflicting results, earlier research has noted the role of education in leadership and the profession (Al-Hazmi & Windsor, 2014; Janssen, 2004; Mathena, 2002). The positive link between leadership style and hours of training, for example, was perceived as a factor that improves leadership capacity (Janssen, 2004). Further to that, a higher educational degree is found to contribute to building leadership effectiveness (Furze & Pearcey, 1999). This evidence indicates that leadership can be learnt (Saccomano & Pinto-Zipp, 2011). Integrating leadership concepts and related training in the curriculum of in-service education for nurse managers, for instance, might benefit these nurses within or outside academic settings (Casida & Parker, 2011).

Most of the head nurses and staff in this hospital have obtained Diplomas in nursing. The nurses stated that they did not receive much information on leadership and management at the Diploma level. However, I learned from the interviews that some nurses decided to pursue Bachelor's degrees. In the qualitative analysis, nurses clearly stated that they noticed their own improvement in terms of knowledge and attitudes after participating in training and educational opportunities in leadership.

Research demonstrates that effective integration and teaching of leadership have a positive impact on nurses' leadership skills and practice (Curtis, Sheerin, & Vries, 2011). Although the emphasis on education and leadership was not shown in the quantitative data,



analysis of the interviews with the nurses reflected that knowledge of leadership needs to be elaborated in the curriculum of nursing education in Indonesia. Nursing leadership education is urgently required and can be provided by formal nursing institutions (Curtis, et al., 2011). Consequently, leadership education for nurses could possibly be introduced at an early stage. For example, since the Diploma-III is recognised by Law No. 38/2014 as the initial port of entry to nursing, material on leadership can be elaborated from the first year of school and gradually improved until the final stage of education. Education and training have been identified across disciplines as crucial elements that can improve performance, including in leadership. Findings and evidence presented in this current study, therefore, strongly suggest the need for Indonesian nursing institutions to maximise their efforts to elevate education on nursing leadership and make it accessible from an early stage in order to nurture future nurse leaders.

#### 6.5.2. Implications for nursing leadership and management practice

The findings of this study may strengthen nursing leadership and management practice in hospital and beyond as they have helped to elucidate the nurses' viewpoints on leadership. The use of the MLQ in the study showed that the nurses are likely to combine transactional and transformational leadership characteristics. To some extent, such findings support the Full Range of Leadership (FRL) model which incorporates transformational leadership and transactional styles. Certainly, introducing the whole range of leadership as described in FRL may benefit health institutions in the country. For example, raising awareness of the meaning of transformational and transactional styles and their effectiveness in organisations may enable health leaders to elaborate them in their existing norms.

Training or orientation programmes in leadership may help the leaders to recognise this. However, the study's analysis helps us to understand that transformational leadership may not be the only key to successful outcomes in nursing. Rather than persuading the leaders to embark on a new leadership track, such as transformational leadership, Indonesian health organisations might be better advised to encourage their leaders to reflect on their own cultural norms and contexts as there is a possibility that positive values found in other types of leadership (e.g., transformational leadership) already exist inside their culture. By recognising this, existing or even future nurse leaders might take up new values they have learned from other types of leadership and integrate them in their leadership and behaviours.

### 6.5.3 Implications for health policy

Health policy in Indonesia continues to evolve in order to address health challenges in the country. Despite improving health access and facilities in the country, Indonesian health organisations pay great attention to developing healthcare manpower resources. Among these is the nursing profession. An assessment presented in the Health professional Education Quality (HPEQ) project under the Directorate General of Higher Education (DIKTI) identified that developing nursing professionals is one of the priorities for improving the Indonesian health profile, as nurses constitute the largest portion of Indonesian health workers (DIKTI, 2011). Therefore, the report may have implied that nurses are the key to improving the country's health outcomes.

Indonesian government support for and advancement of the nursing profession have been realised through the enactment of the Nursing Law No. 38, for the year 2014 (PPNI, 2014). This legislation has finally been passed after decades of continuous negotiations and hearings in

parliament. It provides legal protection as well as assurance for regulations related to nursing education, registration and nursing practice; this will also provide more opportunities and place a greater emphasis on nursing development and growth ("Law No.38," 2014).

The findings of this study may therefore further strengthen efforts to improve the nursing profession. Developing nursing leadership, nevertheless, is inevitably one of the critical aspects of nurturing nurses' professionalism. Nurses, regardless of their position and place of work, now have stronger voices and rights to create pathways for professional development. Current nurse leaders and staff can participate in mobilising collegial power to propose that their institutions provide adequate constructive action plans in the areas of nurse education, training, research, and practice.

Further, eliminating the barriers between nurses may help to increase nurses' leadership competency. In the context of Aceh, for instance, I observed a dichotomy between nurses in clinical practice (e.g. hospitals) and academic sites. The campus and clinic failed to support each other, as if they were separate entities. Although the hospital is recognised as a teaching institution, I noticed that there is limited mutual work on-going between these two sectors. Lectures, evidence/research updates, or in-service training are rarely provided by local nursing lecturers. The nursing campus lecturers from the Diploma schools or university only make hospital visits to conduct assessments or counsel their students on their training progress. In contrast, I observed a strong connection between the campus and clinic sites amongst the doctors' profession; each supports the other. Therefore, it can be inferred from this study that nurses should encourage decision-makers to bridge the gaps amongst nursing entities by, for example, encouraging regular nursing lectures for practice improvement, conducting research together/establishing research teams, or arranging interchange teaching between experienced

nurses from the hospital and campus. Of course, nurses should propose such policies according to the evidence available. With evidence-based initiation, such policy will have a strong chance of being established.

As previously mentioned, education has offered nurses opportunities for leadership improvement. Therefore, this may suggest some potential policies. Firstly, in regard to entry to the nursing profession, a Bachelor's degree should be considered the professional standard. The World Health Organisation (WHO) has released a recommendation pertaining to this, stating that minimum entry level to the nursing profession should be the Bachelor's degree (Almalki, FitzGerald, & Clark, 2011). This is because leadership competency is found to be in line with educational growth (Dunham-Taylor, 2000); hence, it might be assumed that nurses who have started their nursing careers with Bachelor's degrees will be much more accountable in terms of leadership characteristics and professionalism. Secondly, the promotion of scholarships for nurses' education and advancement programmes should be integrated into the professional developmental plans. These programmes would not only contribute to enhancing nursing skills and performance but would also greatly support the preparation of future nurse leaders. Thirdly, nursing leadership might benefit from the improvement of the public image of nurses. This would include, for example, promoting and organising nursing activities such as arranging school visits, public education/seminars, and international symposia. All of these would make a positive contribution to nurses' pride and attitudes because such efforts would help build a sense of professionalism and give the nurses opportunities to share knowledge with other colleagues and the community.

Aside from the aforementioned policies, nurses' welfare may also need to be revisited. Although "money" is not always perceived as a concept related to the motivation factor at work

(Kudo et al., 2010), the healthcare system should pay attention to benefit schemes and the work-life balance for nurses. Raising salaries and providing family-oriented work systems might be considered. Rewards and appreciation, plus organisational support in helping the nurses to have a balanced work-life, if organised in a fair and equitable way, would serve as positive reinforcements for nurses, boosting their performance and professionalism.

Lastly, Indonesia may not be suffering from an extreme shortage in the supply of nurses. Data from the Ministry of Health and the Higher Education Directorate General revealed that nurses still dominate in the healthcare job market. However, we cannot take this for granted by assuming that there will never be a shortage of nurses in the country. If attempts to attract potential individuals or students into nursing are not properly executed, the nursing shortage may threaten Indonesia soon enough. To prevent this, therefore, actions to improve the nursing profession are unquestionably required and must be initiated. Developing nurses and their leadership capability through supportive attention, such as continuing education, regulations and legislation, and welfare assurance, should be prioritised and must not be ignored.

The implications of this current study suggested that work needs to be done to support the growth of the nursing profession. It might be expected that the introduction of these potential actions in education, leadership practice, and supportive policy in nursing will elevate nurses' professionalism and their leadership competency. To provide further evidence of the need for such efforts, there are several possibilities for future research and these will be presented in the following section.

## **6.6. Recommended Future Research**

There is little available research addressing nursing leadership in Indonesia. This current study will contribute to the development of the body of knowledge on nursing in the country. However, various future studies might help to develop effective leadership in nursing. Future expansion might relate but would not be limited to conducting case-studies to compare nursing leadership across sectors such as public hospitals, military hospitals and private hospitals, comparing nursing leadership across regions in Indonesia (e.g., urban nurses versus rural nurses, or by provinces) or in Southeast Asia for a larger-scale study, or investigating nursing leadership perceptions, including discrepancies, among academic and hospital-based nurses. In addition to this, potential future research might want to elaborate the religious factor and how this element contributes to nursing leadership. Indonesia is one of the most populous Muslim countries. Therefore, it would be interesting to investigate this aspect.

A very significant potential future study, however, might explore the creation of leadership measures that are particularly suitable for Indonesian nurses. A possible strategy for this attempt would be to start by conducting a more representative number of leadership interviews with Indonesian nurses; these would then be used as the foundation for constructing a leadership instrument for nurses. The expectation is that, since the leadership scale would specifically address particular nurses, it would have a greater applicability to nurses in the country. Certainly, this future measure, in its use amongst nurses in Indonesia, would greatly assist healthcare institutions in many ways. For example, it would be useful for nurses' leadership education and training modules, for hiring or promoting new nursing leaders, and, prominently, as part of the basis for supporting Indonesian nurses' professionalism.

## 6.7. Chapter Summary

This chapter has discussed the principal findings of the study in the light of the literature and analysis of the results obtained from the quantitative and qualitative methods. It began by discussing the leaders' self-perceived leadership and the staff's perception of their leaders' leadership and clarifying any discrepancies between them. Further, factors affecting nursing leadership are also discussed; by understanding these, we may gain many more insights into the actual viewpoints on the nurses' leadership.

Although the survey helped to present general impressions of leadership perceptions across groups of nurses, it was interesting to note that it did not make any significant contribution to our knowledge of how the nurses view leadership, compared to what was revealed by the interviews' analysis. Analysis of the interviews has enriched the discussion on understanding the nurses and their leadership. The survey may have overlooked contextual issues, culture, or other specific aspects of the nurses' environment that might have been useful for gathering in-depth views on nursing leadership.

Despite the strengths and limitations of the study, this current research may have drawn an important conclusion on nursing leadership. I have learned that leadership is a distinct and special element in each individual's life. It is the context that strongly influences the way people define, behave towards, and value leadership itself. The nursing field is unique and cannot be compared to other professions. Therefore, this has led us to understand that views on leadership distilled from the nurses' perspectives may be a specific leadership phenomenon for them; therefore, this may not be replicated or obtained in other types of settings.

## **CHAPTER 7 CONCLUSION**

### **7.1. Introduction**

The aim of the study was to explore Indonesian nurses' leadership. With the application of the mixed methodology of quantitative and qualitative strategies, the study is expected to further explain the evolvement of nurses' leadership in the country, thus making a significant contribution to the evolvement of the body of knowledge in the nursing field.

### **7.2. Highlights of the study**

In order to address the paucity of exploration of Indonesian nurses' leadership, this study has employed a mixed-methods approach. The use of quantitative and qualitative research designs was intended as a complementary strategy to tackle the problems addressed in this current study. This study applied a widely recognised leadership measure, the Multifactor Leadership Questionnaire (MLQ), and an in-depth-interviews approach.

Issues around the MLQ, such as its factor structure (Yukl, 1999) and its application across culture and context have been debated (Dickson, et al., 2012). For example, Kanste et al. (2007) have identified that the full nine-factor model and all the subscales did not receive empirical support for use in the nursing field. To a certain degree, it is true that an examination of construct validity and other psychometric properties of the measure is not the purpose of the study; however, the use of the MLQ in this study could potentially draw attention to the generalisability of the measure in the nursing context.

The nurses who participated in the survey found the measure rather difficult to understand. Although further investigation is required to confirm this assumption, the



abstractness of the structure of the questions in the measure has been highlighted (Dickson, et al., 2012). Therefore, it may not be surprising that the analysis of the interviews with Indonesian nurses provides much more insight and essential information and knowledge on nurses' leadership than the survey results. Furthermore, it might also be assumed that the measure's claim to generalisability is therefore debatable. This is in line with Alimo-Metcalfe et al.'s opinion. They recognised that most leadership instruments are dominated by United States-based research findings. Among the shortcomings they noted in the US-based transformational leadership was the tool's failure to address a wider scope of leadership levels (i.e., focusing only on top leaders) or the disproportionate numbers of male and female subjects. Therefore, reflecting on the findings of my study, I agree with their suggestion that the measure's applicability across settings be reconsidered.

Certainly, research utilisation in nursing practice should be initiated with strong evidence prior to its application. This applies to almost all nursing care elements, including leadership. Leadership in nursing, however, may need a slightly different treatment. Scholars have argued that a particular leadership style reported to be effective in certain settings will not necessarily yield similar results when applied in other places. That is to say, although certain leadership styles have shown positive evidence in research, nurses should not automatically claim that, were these to be applied in their organisation, they might expect good results, as concluded in the literature.

Transformational leadership and the use of the MLQ are among the most popular topics in nursing leadership. The MLQ was originally developed in Western countries but its application is borderless. According to the literature review, it can be expected that American-based nursing leadership research will almost always conclude a positive effect of

transformational leadership on the investigated outcomes. For instances, Failla and Stichler (2008) found a positive correlation between transformational leadership and job satisfaction, and Broome's findings confirmed the enactment of transformational leadership among nursing leaders (Broome, 2013). Such findings were made available through reliable journals such as the *Journal of Nursing Administration* (Bolden, et al.) or *Nursing Management*. The fact that transformational leadership positively generates the desired outcomes is strongly emphasised and publicised in the literature. Therefore, this may have carved a general impression among nurses that this leadership style is something they should achieve. With this factor in mind, therefore, nurses across nations have been driven to willingly emulate such behaviours in the hope of reaching similar outputs.

In current literature, what is mostly reflected in nursing leadership reports is the possibility that researchers may have overvalued particular leadership styles, such as transformational leadership. Often, researchers have finalised their findings with a conclusion that this kind of leadership is essential for nurses and that their potential leaders need to be equipped with and trained in this style (e.g., AbuAlrub, 2012; AlYami, 2013). The nurses may therefore concentrate too much on ensuring that they express this particular style in their leadership behaviours for organisational success due to such recommendations.

Studies pertaining to nursing leadership may have overestimated transformational behaviour since most research in the field has noted that it is the optimal leadership and a problem-solver for nursing issues. Reflecting on the literature review of nursing leadership research as well as on the overall results of this current study, I assumed that nurses may have been far less critical in viewing leadership. This is mainly because nurses may have failed to grasp the notion that leadership is a dynamic concept and that it might be comprehended

differently between contexts. In the light of this study, I presume that, initially, all leadership styles, even the authoritarian style, have their positive sides and are effective to some extent provided that they are applied wisely to match the situational context and personal circumstances of the people involved in the setting.

In summary, leadership is essential for effectively managing people and processes (Adams & O'Neil, 2008). Nursing leaders are required to combine relational and emotional capabilities in order to support, stimulate, and invest in the abilities of their staff (Cummings et al., 2009). With more educational opportunities that teach the core practices of leadership, nursing leaders can be trained and their skills sharpened through continuous leadership training and experience (Raup, 2008b)

Finally, the strengths and limitations of the current research have been noted. Due to the diverse conditions across Indonesia, the findings of this study may only apply amongst nurses in Aceh. However, the study has potential implications for the nursing profession. In the quest to overcome future challenges in this rapidly changing environment, it is expected that this research contribution will benefit nursing educators, leaders, policy-makers, healthcare institutions and, on a larger scale, the Indonesian health system in developing future nurse leaders at all levels.

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Appendix 1 Permission to use the Multifactor Leadership Questionnaire (MLQ)

For use by Elly Wardani only. Received from Mind Garden, Inc. on July 30, 2013

**www.mindgarden.com**

To whom it may concern,

This letter is to grant permission for the above named person to use the following copyright material;

Instrument: *Multifactor Leadership Questionnaire*

Authors: *Bruce Avolio and Bernard Bass*

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for his/her thesis research.

Five sample items from this instrument may be reproduced for inclusion in a proposal, thesis, or dissertation.

The entire instrument may not be included or reproduced at any time in any other published material.

Sincerely,

Robert Most  
Mind Garden, Inc.  
www.mindgarden.com

Appendix 2 Ethical approval from the Ethical Committee of the University of Sheffield

Dear Elly

**PROJECT TITLE:** Nursing leadership in Indonesia; A mixed-methods approach

On behalf of the University ethics reviewers who reviewed your project, I am pleased to inform you that on 15th November 2013 the above-named project was **unconditionally approved on ethics grounds**, on the basis that you will adhere to the following document that you submitted for ethics review:

- University research ethics application form (*dated 20/10/2013*)
- Participant information sheet (*dated 20/10/2013*)
- Participant consent form (*dated 20/10/2013*)

If during the course of the project you need to deviate significantly from the above-approved document please inform me since written approval will be required. Please also inform me should you decide to terminate the project prematurely.

Yours sincerely

Jennifer Gray  
Ethics Administrator

--

Jennifer Gray  
Support Officer  
School of Nursing and Midwifery  
The University of Sheffield  
0114 222 2055

**A Study of Nursing Leadership in Indonesia  
Survey-Participant Consent Form**

Please tick each box below

1. I confirm that I have read and understood the information sheet for the above project and have had the opportunity to ask questions.
  
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
  
3. I understand that my participation will be anonymously coded.
  
4. I give permission for members of the research team (researcher and supervisors) to have access to my anonymised survey.
  
5. I agree to take part in the survey.

Please write your name, the date, and your signature below:

Name of participant

Date

Signature

## **A Study of Nursing Leadership in Indonesia Interview-Participant Consent Form**

Please tick each box below

1. I confirm that I have read and understood the information sheet for the above project and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
3. I understand that my interview will be recorded.
4. I understand that only Ms Wardani will listen to the recording to transcribe the responses, after which point the recording will be destroyed.
5. I understand that my participation will be anonymous to protect my identity
6. I give permission for members of the research team (researcher and supervisors to have access to my anonymised responses.
7. I agree to take part in the interview.

Please write your name, the date, and your signature below:

Name of participant

Date

Signature



For use by Elly Wardani only. Received from Mind Garden, Inc. on July 30, 2013

# MLQ                      Multifactor Leadership Questionnaire Leader Form (5x-Short)

My Name: \_\_\_\_\_ Date: \_\_\_\_\_

Organization ID #: \_\_\_\_\_ Leader ID #: \_\_\_\_\_

This questionnaire is to describe your leadership style as you perceive it. Please answer all items on this answer sheet. **If an item is irrelevant, or if you are unsure or do not know the answer, leave the answer blank.**

Forty-five descriptive statements are listed on the following pages. Judge how frequently each statement fits you. The word “others” may mean your peers, clients, direct reports, supervisors, and/or all of these individuals

Use the following rating scale:

- 1. I provide others with assistance in exchange for their efforts..... 0 1 2 3 4
- 2. I re-examine critical assumptions to question whether they are appropriate..... 0 1 2 3 4
- 3. I fail to interfere until problems become serious..... 0 1 2 3 4
- 4. I focus attention on irregularities, mistakes, exceptions, and deviations from standards..... 0 1 2 3 4
- 5. I avoid getting involved when important issues arise..... 0 1 2 3 4

## Appendix 5 The demographic sheet

### Demographic survey

Code #

Nurse demographic data

Directions: Please indicate the appropriate response with a check mark (x).

1. Gender

- Male
- Female

2. Age

- 21-30
- 31-40
- 41-50
- 51-60

3. Ethnicity

- Acehnese
- Gayonese
- Bataknese

4. Religion

- Islam

5. Education

- Diploma III-Nursing
- Diploma IV-Nursing
- Bachelor-Nursing
- School of Health Nurse/Senior High level
- Diploma –III Midwifery
- Diploma IV-Midwifery

6. Training

- BTLS/ACLS
- Wound care
- HIV/AIDS
- Others:.....

7. Work shift

- Morning
- Noon
- Night

8. Length of employment

- <5
- 6-10
- 11-15
- 16-20
- 21-25
- >26

9. Unit of work

- Critical care
- Medical surgical
- Ambulatory care

## Appendix 6 Interview Questions

### Questions for in-depth interview:

1. What do you understand by the term leadership?
2. Do you think leadership is important in nursing?
3. Can you give an example of good leadership style?
4. Do you think this hospital can help develop and assist you to be a leader (ward; clinical directorate; hospital levels)?
5. What is an ideal behaviour that you would expect from your leader? (as role model? Or do you think the leader has to be a risk taker?)
6. What do you think is an ideal leader action in disciplining/corrective action for his/her staff (Should the leader give corrective action after errors occur or actively monitor their staff to prevent errors?)
7. What is an inspirational leader?
8. What do you think is the best way for a leader to appreciate staff work/achievement?
9. Do you think that corrective actions are more important in giving influence than leaders' idealised behaviour?
10. What do you think about your leader's influence in your work unit?
11. Are you happy with your leader's leadership? If yes, what makes you feel happy about it, if not, why?)
12. How effective is your leader's leadership in bringing any positive changes to your work unit?
13. What do you think about your leader's leadership in general?
14. Do you see that the local culture influences your leadership style?
15. Having worked here for some time, do you think that a nurse is a potential leader?