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Leadership styles and theories

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Abstract

It is useful for healthcare professionals to be able to identify the leadership styles and theories relevant to their nursing practice. Being adept in recognising these styles enables nurses to develop their skills to become better leaders, as well as improving relationships with colleagues and other leaders, who have previously been challenging to work with. This article explores different leadership styles and theories, and explains how they relate to nursing practice.

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LEADERSHIP IS COMPLEX, comprising many definitions and qualities (Grimm 2010). One definition of leadership is 'a multifaceted process of identifying a goal, motivating other people to act, and providing support and motivation to achieve mutually negotiated goals' (Porter-O'Grady 2003). Leadership, specifically in clinical practice, has been defined as 'direct involvement in clinical care while constantly influencing others to improve the care they provide' (Cook 1999). The Department

of Health (2007) suggests that 'the essence of clinical leadership is to motivate, to inspire, to promote the values of the National Health Service (NHS), to empower and create a consistent focus on the needs of the patients being served'.

A leader's role is to elicit effective performance from others. This involves leading and influencing the development of shared values, vision and expectations to enhance their organisation's planned goals and overall effectiveness (Feather 2009). Traditionally, leaders were seen as having different personality traits from those of followers (Winkler 2010). Grimm (2010) described these traits as confidence, purpose, courage, ethical fitness and ability to prioritise.

Whitehead *et al* (2009) proposed that although some people are natural leaders, everyone can be a leader, given the necessary knowledge and skills. Mahoney (2001) and Cummings *et al* (2008) suggested that leadership skills can be advanced through education. One way is by using the Leadership Framework (NHS Leadership Academy 2011), which was designed to enable healthcare staff to understand their progression as leaders, and to help and support nurses who are recognised as potential leaders. Consisting of seven domains, the framework is based on the belief that leadership is not restricted to people with designated leadership roles, and that everyone can contribute to the leadership process. Crevani *et al* (2010) supported this by describing leaders as members of a group, with potential to influence that group.

Successful organisations develop their leaders' emotional intelligence by enhancing their self-awareness, self-management, social awareness and social skills (Feather 2009). Emotional intelligence has been defined as the ability to manage the effect of emotions on relationships with others (Walton 2012). Goleman (1998) believed that the most effective leaders possess emotional intelligence. He suggested that even with high-quality training,

good ideas and an analytical mind, a leader will not be 'great' without emotional intelligence.

While research on emotional intelligence has developed, the concept remains controversial and studies to test its effectiveness are rarely done well (Cavazotte *et al* 2012). Few studies have tested whether emotional intelligence is associated with leadership emergence over and above cognitive intelligence, personality traits and gender (Côté *et al* 2010). In studies examining emotional intelligence, it is difficult to control the personality traits that might affect leadership styles. This can make emotional intelligence difficult to measure (Cavazotte *et al* 2012).

For leaders to identify followers' emotions accurately, they need to be aware of their own feelings and emotions. Health care is constantly changing, which some employees may find overwhelming. Emotionally intelligent leaders will not rush to fix, cure or control the responses of staff to change, but are empathetic to their concerns, allowing people to express their feelings without judgement, pressure or guilt (Feather 2009). These leaders recognise that emotions can change from one situation to another. By managing these emotions, leaders can deal with the stress of failure or decisions that have led to poor outcomes (Feather 2009).

Transactional leadership

Offering rewards to others in return for compliance is defined as transactional leadership (Sims *et al* 2009). Burke *et al* (2006) suggested that transactional leadership, based on contingent rewards, can have a positive effect on followers' satisfaction and performance. However, a transactional leader focuses on management tasks, and will not identify shared values of a team. By contrast, transformational leaders inspire others with their vision and work together with their team to identify common values (Marquis and Huston 2009). The transactional approach is task-orientated and can be effective when meeting deadlines, or in emergencies such as when dealing with a cardiac arrest. This approach can lead to non-holistic patient care, because nurses focus on the task they need to complete, rather than the patient as a whole (Bach and Ellis 2011).

Autocratic leadership is an example of transactional leadership. Autocratic leaders have been described as controlling, power-orientated and closed-minded (Bass 2008). They stress obedience, loyalty and strict adherence to the rules (Bass 2008). Autocratic leaders may be disliked by their team, but this may evolve into appreciation and fondness once the positive results of their leadership become evident (Bass 2008).

Although staff may dislike autocratic leaders, they often work well under them (Bass 2008). Schoel *et al* (2011) found that well-liked leaders might be perceived as ineffective while disliked leaders might be perceived as effective.

Autocratic leaders can be effective because they create good structure, and determine what needs to be done (Bass 2008). They provide rewards for compliance, but punish disobedience (Bass 2008). However, autocratic leaders can be abusive, create fear among staff and often make decisions without consulting the team (Bass 2008). Followers of an autocratic leader can rely heavily on their team leader and may underperform in the leader's absence. Although the Nursing and Midwifery Council (2008) advises that all nurses are accountable for their actions, an autocratic leader will take full accountability. In this situation, leaders experience significant pressure while followers remain relatively stress-free.

Transactional leaders can be categorised into three types: contingent reward, where rewards are offered if certain criteria are met; management by exception-active, where leaders aim to intervene in followers' behaviours before they become problematic; and management by exception-passive, where leaders do not intervene until followers' behaviour becomes problematic (Horwitz *et al* 2008).

When leadership is weak, poor performance is not addressed, resulting in poor-quality patient care and unacceptable behaviour being allowed to flourish (Bassett and Westmore 2012). The 'management by exception-passive' style is similar to the laissez-faire style of leadership, in which leaders have little control and provide minimal direction (Marquis and Huston 2009). Unlike transactional leaders, the laissez-faire leader does not plan or co-ordinate and there is little co-operation from followers. Laissez-faire leaders are likely to be inefficient and unproductive (Marriner Tomey 2009). Whitehead *et al* (2009) suggested that mature followers can thrive under laissez-faire leadership as they need little guidance; however, others may struggle. Box 1 provides a reflective description of working for an autocratic leader.

Transformational leadership

Transformational leaders recognise followers' potential, but in terms of Maslow's (1987) hierarchy of needs, will go further to satisfy their higher needs – such as self-esteem and achieving their full potential – to engage followers fully. Vinkenburgh *et al* (2011) suggested that transformational leaders inspire their followers to go beyond the call of duty and act as mentors. Rolfe (2011) stated that leaders

should be visible role models and empower followers to become leaders. Empowered followers possess increased organisational loyalty, motivation and job satisfaction, reducing sickness levels and promoting a positive work environment (Rolfe 2011). This may be because leaders display the skills required to develop successful relationships with followers, in an environment where both leaders and followers aim to meet the organisational goals necessary to fulfil the team's vision.

Transformational leaders express a clear, compelling vision of the future, intellectually inspire followers, identify individual differences and assist followers to develop their strengths (Bass 2008). Sims *et al* (2009) suggested that transformational leaders provide inspiration and motivation to invigorate others to pursue the team's vision. If followers have input into the team's vision they feel valued, and the relationship between leader and follower is enhanced. This encourages followers to develop ownership of the team's vision and move towards achieving this, thereby increasing morale. Followers become motivated to develop their own leadership skills (Rolfe 2011).

Horwitz *et al* (2008) identified different types of transformational leadership. Inspirational motivation is where leaders influence followers through charismatic communication of a set of goals and motivate the team to achieve them. Individualised consideration occurs when leaders help followers achieve their desired essential needs. Idealised influence is divided into 'idealised influence attributed', in which the leader's charisma is used to form strong positive emotional bonds with followers, and 'idealised influence behaviour', in which idealised behaviour of the leader becomes apparent in collective values and actions throughout the organisation. Finally, intellectual stimulation pushes followers to think creatively, and pursue new and creative ideas.

Transformational leaders tend to adopt a democratic approach to leadership. Democratic leaders believe workers are motivated to do well; they seek autonomy and opportunities to prove themselves (Bass 2008). Democratic leaders are considerate and share responsibility with their followers. This allows followers to develop their own leadership skills and become independent, while reducing the leader's stress and risk of burnout (Bass 2008). However, Whitehead *et al* (2009) suggested that democratic leaders have less control than autocratic leaders, because they provide guidance to their followers rather than controlling them. They ask questions and make suggestions, rather than issuing orders. This can work well if followers have adequate knowledge and skills, and

they work well with each other. (Marriner Tomey 2009). Democratic leaders consult followers before making decisions, but consulting many people can be time consuming and the democratic style may be frustrating for those wanting rapid decisions (Marquis and Huston 2009). Whitehead *et al* (2009) suggested that although democratic leadership can be less effective than other forms of leadership, it can be more flexible, and usually increases motivation and creativity. Box 2 provides a reflective description of working for a democratic leader.

When leading an individual, transformational leaders aim to develop their full potential by enhancing their abilities and skills, and improving self-esteem. They achieve this by taking an interest in staff as individuals, and providing tailored support. When dealing with groups, these leaders aim to express the significance of group goals, develop shared values and beliefs, and motivate a united effort to achieve group goals (Wang and Howell 2010).

Effective transformational leadership requires trust between the leader and followers. If followers trust the leader they will do whatever the leader envisions (Bach and Ellis 2011). Rolfe (2011) recommended that to develop trust, leaders should treat everyone in the way they

BOX 1

Reflective description of working for an autocratic leader

I have worked with a transactional clinical leader who was considered by some team members to be harsh and abrupt. However, she would reward tasks completed to a high standard by being pleasant and complimentary for the rest of the shift. This style of leadership appeared effective at the time as shifts ran smoothly when she was in charge. However, she was not a popular leader. New team members could be fearful of her because she would shout orders. This leader was authoritative and commanded obedience from all staff.

While she was good at issuing orders and getting work done, she would not recognise staff members' personalities and traits, allocating people to work together who did not get along, causing arguments and friction in the team. She was oblivious to this disharmony, and would not intervene until situations created problems.

(Bass 2008)

BOX 2

Reflective description of working for a democratic leader

I have worked with a transformational leader who encouraged me to learn more about and subsequently take on parts of a new role. This leader recognised my strengths in organisation and time management, and enhanced these skills by encouraging me to take on the role of shift co-ordinator, and by asking me to complete clinical audits. The enthusiasm and belief in my skills motivated me to complete these tasks. This leader was also a democratic leader; considerate, maintaining good working relationships, and consulting followers before making decisions.

(Bass 2008)

would wish to be treated. Rolfe (2011) and Grimm (2010) suggested that leaders should be honest, acknowledge individual achievements, show interest in their working day, include followers in decision making and listen actively to what they are saying. Trust between leaders and followers is important, because transformational leadership is an approach based on change. Leaders who use this approach are able to use their own qualities to motivate their followers to change (Grimm 2010). A leader who has trust and support from his or her followers can lead a team through change more successfully than a leader who does not (Bach and Ellis 2011, Rolfe 2011).

Transformational leadership is important for improving patient outcomes (Wong and Cummings 2007). Malloy and Penprase (2010) suggested that it can improve clinical environments so clinical leaders can deliver quality agendas and ensure staff are engaged in the process. Research has shown that where there are well-developed transformational leaders, nursing teams take on more responsibility, and have greater empowerment and job clarity (Dierckx de Casterlé *et al* 2008).

The transformational leadership approach is popular, but Bass (2008) and many other management theorists have warned that transformational qualities need to be combined with traditional transactional management skills. This may require leaders to adopt an autocratic style to manage staff sickness or conflict within the team. This is reflected by Whitehead *et al* (2009), who suggested that effective leaders need to have vision as well as a plan and structure if goals are to be accomplished.

Although an effective approach, transformational leadership does not address all relationship situations. Some management requirements of the leader's job can have a negative effect on the relationship with followers. For example, addressing issues such as sick leave and team conflict can have a negative effect on relationships, yet they are essential to being an effective leader (Rolfe 2011).

Situational leadership

Since healthcare organisations face constant change, it is important for top-tier leaders to encourage subordinate leaders to develop different leadership styles to manage different situations (Grimm 2010). This requires adoption of the situational leadership approach, where effective leaders adapt their leadership style to manage particular situations. For example, simple or complicated situations would be best handled through a task-orientated approach such as transactional leadership (Crevani *et al* 2010).

The core competencies of situational leaders are the ability to identify the performance, competence and commitment of others, and to be flexible (Lynch *et al* 2011).

Situational leadership has been defined as being 'based on a relationship between the leader's supportive and directive behaviour, and between the follower's level of development' (Grimm 2010). Supportive behaviour involves the personal involvement leaders have with their followers, achievable by maintaining communication and providing emotional support. Directive behaviour is the amount of direction the leader provides to the group, in terms of defining group roles. This can be achieved by the leader explaining the activities each role should complete and how these tasks are to be completed. The development level of the followers is a result of their own experiences, willingness and ability to take on responsibility (Grimm 2010). This has also been referred to as the 'readiness level' a follower displays. For example, an enthusiastic beginner would respond most effectively to directive leadership (Papworth *et al* 2009).

Clinical nurse leaders can apply the situational approach when supervising newly qualified nurses or nursing students, as the leader's approach depends on the follower's level of experience and confidence. A newly qualified nurse will have a base level of clinical knowledge, but will lack experience and confidence. In this case, the leader would adopt a more directive role until the nurse gains confidence and experience (Grimm 2010).

Situational leadership, also known as having a contingency approach, has become popular, as different situations require different leadership styles (Grimm 2010). Despite this, it has been criticised for focusing too much on leaders and not enough on group interaction (Parry and Bryman 2006), whereas transactional and transformational theories are based on interactions between leaders and followers. People and leadership situations are complex, and therefore adaptability is paramount to the situational leadership approach. This approach encourages leaders to recognise the complexity of work situations and consider many factors when deciding which action to take (Whitehead *et al* 2009). Box 3 provides a reflective description of working for a situational leader.

Conclusion

Various leadership styles and theories are relevant to nursing practice. Despite studies examining and explaining leadership, no definitive theory has emerged to guide leaders, and there is no definitive evidence on which theory is most effective (Rolfe 2011). Although many nurses prefer

the transformational leadership approach, the author believes a situational leadership approach would be more suitable to cope with the ever-changing NHS. Given the flexibility of situational leadership, leaders can adopt as many different leadership styles and theories as necessary. Nurses are faced with many different situations every day, and no particular leadership style is suitable for all situations. Nurses should, therefore, be flexible in their leadership styles, and adapt these to fit different circumstances **NS**

BOX 3

Reflective description of working for a situational leader

In my role as mentor, I adapt my leadership approach to the student's knowledge and confidence. If I am mentoring a less confident or knowledgeable student, I provide more information and direction than if I were teaching a more advanced and confident student. I also perceive my clinical supervisor to be a situational leader. As well as a great support to junior staff, she is approachable. However, she can be autocratic in her role as a district nursing sister, which is essential when making important decisions about caseload and staff management.

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