Evolution of leadership in nursing

Nadeem Moiden looks at leadership style and theory and relates developments through history to leadership in today's profession

IT IS A HALLMARK of an advanced civilisation that leaders receive their authority from the group they guide and maintain their lead. However since ancient times, the practice and theory of leadership have engaged the interest of humankind.

Before 1980, there was a lack of nursing leadership research in the UK; even until the late 1980s the literature is scarce. The debate surrounding nursing leadership is closely linked to the political and organisational changes that have influenced nurse management in the UK over the past 20 years and while leadership and management are recognised as two separate issues, changes to one are likely to affect the other. It is therefore difficult to discuss leadership in nursing without placing it in its political, managerial and historical context. As the body of research evidence increases leadership is being viewed as a complex relationship between leaders and followers and all the variables that have an impact on them (Yura et al 1981).

The available literature relates to two periods: the late 19th and the late 20th centuries. The former period saw the embryonic development of the modern nursing profession, while the latter saw an intense academic evolution of nursing, with the transfer of most nursing education to universities.

Structural professionalisation has contributed to the change of style in nurse leadership, reducing its traditionally autocratic characteristics while simultaneously increasing the rational and bureaucratic elements in the repertoire of current nurse leaders.

The development of leadership

A selective exploration of references to nursing in the 19th century, which chiefly concern voluntary hospitals, reveals specific characteristics of leadership. These include an emphasis on the practical and domestic aspects of management, on religious ideals and social conscience and on an autocratic and feminised style of leadership in which it was understood that the matron would have been from a higher social class than the sisters (Klakovich 1994).

In its early years, nursing had first a religious and then a military provenance (Abel-Smith 1960). Florence Nightingale, who organised nursing for the first time by founding a school of nursing in the late 19th century, perceived there were two groups of nurses: special nurses, and head nurses and superintendents (Simms 1991). Special nurses were usually better educated, while head nurses and superintendents were usually selected from their ranks (Manthey 1988).

These administrative positions offered an advancing scale of remuneration, an assured position and considerable social and professional prestige (Klakovich 1994). Female respectability was linked to the religious ideal and extended to the uniforms worn by nurses as well as to their general conduct (Lorentzon and Bryant 1997). The involvement of nurses in cleaning duties was clearly stated. For example, it was laid down that nurses, with the assistance of the night nurses, should clean their wards by eight o’clock each day (Merrington 1976).
Nursing carried this history, with its undercurrents of both altruistic service and formal hierarchy, into the NHS in 1948. Florence Nightingale, an early embodiment of the leader figure in nursing, certainly wielded personal power and could influence policy. But she did little to discourage subservience to medicine (Henry et al. 1990). Modern nursing, hospital administration and formalised nurse education were all to emerge from her work (Simms 1991). These changes were to have far-reaching effects for the subsequent progress and development of the nursing profession (Kitching 1993).

In the 1930s, US hospitals recognised the advantages of employing graduate nurses (Hegyvary 1983), while such recognition only came to the UK in the 1960s and 1970s (Allan and Jolley 1982). In depression-era America, graduate nurses constituted a cheap labour supply while private-duty work was dwindling and technology was advancing. However after functioning independently, nurses often experienced difficulty returning to the bureaucratic hospital setting.

At this time matrons were responsible for the organisation and administration of the nursing service as a whole and of the schools of nursing (Allan and Jolley 1982). They supervised all the nursing care provided on their wards and were responsible for clinical teaching and supervision of nursing students assigned to their area. Although some responsibilities were delegated to assistants and nurses, matrons typically used a top-down management style with centralised control. The military and religious origins of healthcare institutions had resulted in rigid hierarchical structures and a rigid leadership style (Reverby 1987).

Team nursing
Team nursing, which is the allocation of small groups of, or teams, nurses to groups of patients for whose care they are responsible (Waters 1985), was introduced into the US in the 1940s and 1950s (Rotkovitch 1983) as a mechanism for nurses to share supervision responsibilities. It was introduced into the UK in the 1980s (Waters 1985).

In team nursing, the patients on a unit were divided among two or three groups of
nursing staff. The most senior or most competent registered nurses are designated team leaders. They give treatments, distribute medicine and supervise the nursing care provided by support staff (Waters 1985). It could be argued that the team nursing model resulted in the further alienation of nursing administration from increasingly dissatisfied caregiving staff, as the managers provided less and less care. When team nursing was introduced nursing care was becoming ever more complex, requiring a continual updating of skills and knowledge. This led to the introduction of primary nursing.

**Primary nursing**

In 1966, primary nursing was introduced into the USA as a system of managing care workload (Hegyvary 1983) It was established in the UK in the late 1980s (Wright 1990). In primary nursing, decision making is delegated to bedside nurses (Wright 1990). Before this system, sisters were heavily involved in decision-making, care planning and teaching, as well as making rounds and contracts with physicians. With the advent of primary nursing, many of the sister’s functions were assumed by primary nurses, which allowed managers to provide structure and support for professional nursing practice.

Primary nursing was an attempt to align nursing practice with professional nursing values. However, the centralised and hierarchical decision-making structures conflicted philosophically and operationally with the primary nursing model. Rigid hierarchical structures reduced the opportunity for creative nursing practice.

**Decentralisation**

A striking characteristic of excellence in organisations is the apparent absence of chains of command (Peters and Waterman 1982). Hence, decentralisation was introduced in the US in the 1970s and established in the UK in the mid-1990s (Cawthorne 1993). In decentralisation, as in work design, authority and responsibility are removed from a few leaders and distributed among the many employees at the frontline of the organisation (Cawthorne 1993). Decentralisation became the means to move away from vertical organisation, in which authority and decision making is vested at the top. It was also a response to financial pressures, which required fewer overheads.

When decentralisation occurred, middle management layers were reduced or eliminated and the scope of nurse manager roles extended. The flattening of the hierarchical structure effectively reduced costs, as fewer administrative layers were required.

**Patient-centred care**

Patient-centred care was introduced in the US in early 1990 and established in the UK around 2000. It is a philosophy that recognises the interdependence of every department in achieving a quality product. Since patient care is a multi-faceted and multidisciplinary activity, decision-making is delegated to those involved in patient care processes. In true patient-centred care, the lines between management and direct caregivers are blurred (Klakovich 1994). Therefore, patient-centred care requires visible management. Intense communication is required to foster the involvement of staff nurses. Sisters are always present to encourage nurses to be comfortable with change, innovation, and risk taking. Hence, it is crucial that staff nurses feel appreciated and valued as integral members of the health teams (Klakovich 1994). After the era of patient-centred care, clinical governance was introduced.

**Clinical governance**

Clinical governance is a new way of working that affects all nurses working in any healthcare setting. The government has defined clinical governance as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding standards of care, by creating an environment in which excellence in clinical care will flourish (Department of Health 1998, Harvey 1998). The activities that highlight it are clinical audit, risk management, evidence-based practice, user involvement, clinical supervision, clinical leadership, continuing professional education, management of inadequate performance, reflective practice, team building and peer review (Harvey 1998, Valentine and Smith 2000).
In order to have increased effectiveness, preparation in leadership is an essential part of the healthcare professional’s preparation for practice. The proper use of leadership concepts and skills allows greater understanding and control of events in work situations (Tappen 1995). However, the call for leadership in the NHS has reintroduced the matron figure. These leaders will be given authority to resolve clinical issues, such as discharge delays, and environmental problems, such as poor cleanliness. They will be in control of the necessary resources to sort out the fundamentals of care, backed up by appropriate administrative support.

By 2004 there will also be around 1,000 consultant nurses employed by the NHS to work with senior hospital doctors, nurses and midwives and draw up local clinical and referral protocols alongside primary care colleagues. In order to strengthen leadership in the NHS the Leading an Empowered Organisation (LEO) project is being implemented throughout the UK. The framework of LEO has been drawn from Fiedler (1967), Hersey and Blanchard (1977), Burns (1978), Stevens (1978), Sashkin (1986), Kouzes and Posner (1987), Drucker (1989) and Kotter (1990), and is influenced by transformational leadership. LEO enables professionals to develop empowerment in themselves and others by addressing responsibility, authority and accountability. It also helps them articulate expectations, develop autonomy, resolve conflicts, take risks and solve problems (NHS Executive 2000a).

Over the next two years 32,050 places are to be provided on this programme (DoH 2000, NHSE 2000b). It is, however, noted that there is no scholarly literature available so that the content can be reviewed.

Theories of leadership
In considering leadership the terms ‘theory’ and ‘style’ are often used synonymously, or it is argued that the styles of leadership comprise another theory of leadership. It is important that these distinctions are made explicit. Most significantly, theory represents reality while style refers to how a practice is performed. Style offers leaders alternative ways of implementing theories of leadership.

There is a wide range of leadership theories. In the view of Rafferty (1993), theories of leadership vary according to the emphasis placed upon personal characteristics of the leader, the effect of the leader on organizational functioning and culture, as well as the leader and group behaviour.

Styles of leadership
A style is the way in which something is said or done. It is a particular form of behaviour directly associated with an individual. Individual behaviour is influenced by experiences in the formative years and by all the input in a person’s life thereafter. Thus the style or approach taken by nurses toward clients, nursing staff members and other associates strongly reflects prior experiences. A single style of leadership is rarely practised (Fiedler 1967). The right leadership behaviour for one situation is not necessarily appropriate in another (Blankenship et al 1989, Tannenbaum et al 1961).

One goal of an organisation is for its leaders to adopt a style of leadership that promotes high levels of work performance in a wide variety of circumstances, as efficiently as possible and with the least disruption. Since working together is essential for group effectiveness, positive past experience with the group encourages further challenge to the group (Tannenbaum et al 1961). Also, confidence depends upon how much trust has been developed over time with group members.

The task, or problem, confronting leaders determines whether they will be able to share decision-making with the group. Leaders with confidence in group members will consider members’ knowledge and competence to be adequate for the task at hand and will be more inclined to share decision-making responsibility with the group. The leader who is comfortable in the group and in the leadership role can take control when necessary and share decision-making responsibility whenever possible (Tannenbaum et al 1961).

Authoritarian style of leadership
Authoritarian styles of leadership range from very rigid to benevolent practices (Likert 1967). In the extreme use of authoritarian leadership, communications and activities
occur in a closed system. Autocratic leaders make all decisions and allow subordinates no influence in decision-making processes (Grohar-Murray and Dicroce 1997). They frequently exercise power, sometimes with coercion, and are often indifferent to subordinates' personal needs. Failure to meet the leaders' goals may result in threats or punishment.

Autocratic personalities are firm, insistent, self-assured and dominating with or without intent, and remain at the centre of attention. This kind of leader feels little trust or confidence in workers and in turn, workers fear such leaders, with whom they feel they have little in common.

McGregor (1960) has produced perhaps the most famous description of attitudes assumed by autocratic leaders. He maintains that autocratic leaders view individuals as naturally lazy, lacking in ambition, disliking responsibility, preferring to be led, self-centred, indifferent to organisational needs, resistant to change, not very bright and lacking in creative potential. Such leaders would not accept that authoritarian leadership is degrading to those individuals being led.

Democratic style of leadership
In the democratic, or participative or consultative, approach leaders are 'people orientated', focusing attention on the human aspects and building effective work groups. Interaction between leader and staff is open, friendly and trusting (Cribben 1972).

In the open system, communication prevails with democratic leaders consulting with group members and solving problems with them, assuming that others want to be considered in the process (Tannenbaum et al 1961). There is a mutual responsiveness to meeting group goals with work-related decisions made by the group. Democratic leaders attempt to develop the group sense of responsibility for the benefit of the whole and for individual accomplishments (Cribben 1972).

Likert (1961) found that a democratic or participative style of leadership leads to high productivity and is the most desirable form of leadership in a wide variety of work situations. Thus, democratic leaders depend on the followers' individual needs, interests and capabilities.

Laissez-faire style of leadership
The laissez-faire style of leadership is at the opposite end of the continuum from the authoritarian style. These leaders give members complete freedom. Under the laissez-faire style of leadership the general climate is one of permissiveness or ultra-liberalism in which there is a lack of central direction or control. Laissez-faire leaders want everyone to feel magnificent. Resources for the work are provided, but the leader participation is limited to answering questions when asked (Stevens 1978).

This type of leader does not give any feedback unless asked (Lewin et al 1939). The free-reign leader avoids responsibility by relinquishing power to followers (Grohar-Murray and Dicroce 1997), allowing them to engage in managerial activities such as decision making, planning, structuring the organisation, setting goals and controlling the organisation. Often, the implication is that laissez-faire leaders hand over all responsibility and are either absent or unidentifiable in the group. The laissez-faire style emphasises individuals rather than the group, leader or task, and allows open communication among members. The obvious danger in laissez-faire groups is the loss of the sense of group unity, which sometimes results in low productivity and little satisfaction among the workforce (Stogdill 1974).

It might be argued that this style can be effective with highly motivated professional group such as those involved in research projects where independent thinking is rewarded, but not in highly structured organisations where control forms the baseline of most operations.

Conclusion
Nursing has emerged as a modern, professionalising occupation with a strong stake in future health policy. In open competition the less powerful position of nursing compared to, say, medicine is more obvious than in the past. Yet, paradoxically, it can be argued that nursing is professionalising at an increasing rate with a strengthening base in universities,
in specialist clinical practice and executive leadership positions. However, looking at various theories that have been developed, the literature shows that the developments in theory building have been gradual and that whenever a new theory has emerged previous theories have been consulted and the most positive aspects have been adopted. There is therefore hope for the future of a more achieved style of nursing leadership.

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