In command of care: Toward the theory of congruent leadership

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Abstract This is the second of two papers that discuss clinical leadership in the light of a research study which explored who the clinical nurse leaders are, what the characteristics and qualities of clinical leaders might be, why some nurses are seen as clinical leaders and what their experiences might be (Part 1 (Stanley, 2006)). Outlined are contemporary views about leadership and nursing, with emphasis on transformational leadership. Also explored is the new theory of congruent leadership. It is proposed that congruent leadership is a theory best suited for understanding clinical leadership because it defines leadership in terms of a match (congruence) between the activities, actions and deeds of the leader and the leader’s values, principles and beliefs.

Keywords clinical leadership, nursing leadership, transformational leadership, qualitative research, congruent leadership

Introduction: leadership and nursing
Nursing leadership has grown in significance over the past 20 years (Jasper, 2002; Moiden, 2002); however, the theory and practice of nursing leadership has been poorly developed (Hurst, 1997), and apart from anecdotal accounts, little was written about nursing leadership in the United Kingdom (UK) until Rafferty (1993) published a discussion paper addressing nursing leadership issues. Rafferty concluded, in relation to developing nursing’s leadership potential, that:

Getting it ‘right’ was less important than being prepared to take risks and make a start. It was felt important that different kinds of leadership were needed at different levels and times and therefore it was vital to have a pool of leaders upon which to draw. For this to happen, a number of different models of leadership needed to be fostered.

(1993: 26)

Rafferty also recommended that more attention should be paid to leadership training, management development, research into nursing leadership and clinical leadership. The nursing profession, she declared, required nurse leaders who were ‘visionaries’ (1993: 27) who could support the development and creation of a healthcare system that allowed nurses to express their values and the value of nursing. Rafferty recognised that the development of nursing leadership was in ‘crisis’. She also saw the complexity, contradiction and confusion associated with leadership issues and
recognised that immediate and vital action was needed if the nursing profession was to ‘claim legitimacy in the leadership stakes’ (1993: 26).

Malby (1997) felt that the ‘crisis’ persists because there was a belief that nursing was incapable of promoting a leadership culture or consciousness. However, the Royal College of Nursing (RCN) and the King’s Fund Centre were quick to respond, and soon set up a series of educational programmes facilitating ‘managerial’ support for ward sisters and charge nurses. Other programmes soon followed, and a plethora of opportunities opened for nurses looking to develop their leadership potential. Prominent among these was the RCN Clinical Leadership Development Programme (Cunningham and Kitson, 2000) and, more recently, the NHS Leadership Centre has developed a range of courses.

The Government’s change agenda also supported a resurgent focus on leadership development within nursing. A First Class Service: Quality in the NHS (DoH, 1998) described part of its aims as the development of ‘organisations to support a change in culture and to deliver change’ (1998: 75). Making a Difference (DoH, 1999) and The NHS Plan (DoH, 2000) also set out their support for effective nursing leadership in promoting change. Further research and literature has appeared and a considerable amount has been achieved with still greater developments likely as the NHS Leadership Centre exerts further influence.

Much has been achieved and different levels of leadership have developed, although all appear in what Antrobus and Kitson call the ‘academic, political and management domains’ (1999: 751). Numerous studies or articles (Rafferty, 1993; Antrobus and Kitson, 1999; McKown and Thompson, 1999; Kitson, 2001; Beech, 2002; Firth, 2002; Jasper, 2002; Faugier and Woolnough, 2003) have focused on nursing leaders who hold senior levels within organisations, Trusts, nursing divisions, wards and/or departments. Although clinical leadership is often mentioned, it is rarely the subject of research because of its low status (Antrobus and Kitson, 1999) when compared with other leadership domains. For this reason, the uniqueness of clinical leadership has remained largely unrecognised and under-valued (Lett, 2002). Indeed, research specifically focusing on clinical leadership is sparse, and the term ‘clinical leadership’ is often used interchangeably and inappropriately, alongside or in conjunction with ‘nursing leadership’ (Lett, 2002) or even ‘nursing management’.

This problem is compounded because much of the literature related to nursing leadership was developed to support nurses in management positions or with management responsibilities. This has meant that literature and research to support one concept (e.g. nursing management) has been accepted as transferable when seeking insights or understanding of the related areas.

Another reason for the lack of different leadership models and the slow development of different kinds of leadership within nursing is that leaders were needed in the NHS who could support an organisation that was trying to adapt and be successful in an environment of constant change. This led to a dependence on leadership theory that supported change and understood leadership from the perspective of facilitating and developing change. This required a theory where the followers could be inspired and influenced by pulling them towards a vision of some future state. With constant change as a theme in the NHS, nursing leadership programmes and the profession’s view of leadership has focused on an understanding of leadership based on the dominance of transformational leadership theory and on the assumption that leaders must have ‘vision’ and influence or power to see the vision through.

The NHS Confederation supported this perspective when they indicated that ‘as the NHS seeks a new model for a new century, transformational leadership presents itself...’
as an evidence based technique’ (1999: 4). In many respects this perspective is
sound, and for some levels and types of nursing leader this is the case, although,
when addressing other types of leadership at different levels, this assumption may be
counter-productive and inaccurate.

The net effect is that Rafferty’s (1993) suggestion that nursing needed to develop
different leadership models for leaders at different levels has not been followed up and
the transformational leadership model dominates.

**Transformational leadership**

Transformational leadership (Downton, 1973; Burns, 1978) is strongly associated
with Bass (1985, 1990) and his work to try to tease out the distinctions between
management (associated with transactional leadership) and leadership. Transformational leadership is seen as a process that changes and transforms individuals (Northouse, 2004). It involves emotions, motives, ethics, long-term goals and an
exceptional form of influence that moves the followers to accomplish more than is
usually expected of them, incorporating both charismatic and visionary leadership
(Northouse, 2004). Leithwood (1999) considered transformational leadership from
an educational perspective and identified that it involved setting directions, establishing
a vision, developing people, organizing and building relationships.

Transformational leaders are seen as being connected to a process of attending to the
needs of the followers, so that the interaction of each raised the motivation and energy
of the other. This results in a challenge to the status quo, a new vision and the sharing of
that vision, so that the successful transformational leader gains support for the vision and
is consistently and persistently driven to maintaining momentum and empowering
others (Kakabadse and Kakabadse, 1999). Day et al. (2000: 15) add to this perspective,
saying that ‘transformational leaders not only manage structure, but they purposefully
impact upon the culture in order to change it’. The transformational leader is not associ-
ated with status or power and is seen as being appropriate at all levels of an organisation.

The interdependence of followers and leaders within this theory has meant that
transformational leadership has found favour in care-related and teaching fields and,
according to Welford (2002: 9) ‘transformational leadership is arguably the most
favourable leadership theory for clinical nursing in the general medical or surgical ward
setting’. Thyre (2003: 73) also feels it is ‘ideologically suited to nurses’, while Sofarelli
and Brown (1998) indicate that it is a suitable leadership approach for empowering
nurses and, as mentioned, the NHS Confederation (1999) indicate that transforma-
tional leadership is, in their view, best suited to modern leadership of the NHS.

Transformational leadership has gained favour because it is related to the estab-
lishment of a vision and adaptation to change. Rafferty (1993) sought the develop-
ment of ‘visionary’ nursing leaders, who could take nursing forward and, to some
extent, Rafferty set a precedent whereby the development or possession of a ‘vision’
is seen as central to nursing leadership. However, where ‘doing’ dominates over ‘crea-
ting’, transformational leadership may, in fact, fail to fulfil its promise as a suitable
leadership theory.

Therefore when vision or creativity are not regarded as attributes associated with a
role or post and partly in response to Rafferty’s (1993) call for different models of
leadership to be fostered. A new leadership theory (Congruent Leadership) is
proposed. Congruent Leadership offers a framework that accommodates and demonstra-
utes all the qualities and characteristics of clinical leaders and the vital contribu-
tion they make.
Recognising clinical leaders

Research undertaken as part of the author's doctoral thesis proved a rich source of information about clinical leadership, who the clinical leaders are and the attributes of clinical nurse leaders (Part 1).

The results demonstrated that clinical leaders appeared to be present at all nursing levels and in considerable numbers, but they were often not the most senior nurses and their approach to clinical leadership was based upon a foundation of care that was fundamental to their view of nursing and care. The study also indicated that the type of clinical area had an influence on who might be seen as a clinical leader, and although F-grade sisters were most commonly recognised in all areas as clinical leaders, in specialist areas of practice, F and higher grades were nominated. However, in more general clinical areas, F and lower grades were more commonly identified as clinical leaders.

Cook's (2001) study of clinical leadership attempted to identify the attributes of effective clinical leaders by focusing not on nurses at the 'hierarchical apex of the organisation... but on those nurses that directly deliver nursing care' (Cook, 2001: 33) and, as such, his enquiries were directed toward nurses not deemed to be in conventional nursing leadership positions, but who displayed many of the attributes of highly effective leaders. Cook (2001) indicated that clinical leaders were recognised because they were 'discoverers', 'enablers', 'shapers' (with 'creativity' to generate new ways of working) and 'modifiers' who supported and helped others with the process of change. This author's study, in keeping with many of Cook's (2001) findings, recognised clinical leaders because they knew and could do the work central to their clinical area and practice (Figure 1).

In this author's study, clinical nurse leaders were seen as role models for nursing practice with high-level clinical skills and sound clinical knowledge. They were described as effective communicators, both in terms of listening to and talking to others. They remained open and approachable, were decision-makers and, significantly, they were visible and accessible in the clinical area. Being viewed as 'controlling' was consistently seen as least associated with the qualities of a clinical leader and, as with Cook's (2001) study, having a vision or articulating a vision appeared unrelated and unrecognisable as a dominant feature of the qualities and characteristics for which clinical leaders were recognised. This could be because nurses were drawn to or identified clinical leaders who could lead them through the 'here and

- Approachable and open.
- Empowered/decision-makers.
- Visible.
- Clinically competent and clinically knowledgeable (usually within the specific area in which they work).
- Seen to be displaying their values and beliefs (they lived out what they believed to be important to them. They knew were they stood and hold fast to their guiding principles).
- Effective communicators.
- Positive clinical role models.

Figure 1  The characteristics and attributes identified with clinical Leadership.
now' issues of busy and chaotic clinical work, and who could cope with the demands of each day as it came.

A significant difference between these more recent results and Cook's (2001) study was that Cook saw clinical leaders as 'creative', identifying the typology of 'shapers' to describe them. However, creativity was rarely identified as a defining characteristic in this author's study, with the questionnaire's results demonstrating that 'creative/innovative' was ranked twenty-fifth out of a list of 42 qualities and characteristics 'most' associated with clinical leadership, and 'artistic' was ranked forty-first (second only to 'controlling' as a characteristic least associated with clinical leadership).

Antrobus and Kison (1999: 750) identified 'understanding self and having a clear understanding of values, purpose and personal meaning' as part of the skills repertoire they identified for effective nurse leaders. Cook (2001) also saw clinical nurse leaders as 'valuers' who empathised with others and who tried to gauge their own feelings as well as those of other nurses, while McCormack and Garbett (2003) indicated that 'practice developers' valued and strove for an emotional engagement with their work. In this author's questionnaire and interview results, clinical leaders described themselves as being driven by their values and 'passion' for high-quality patient care. Ultimately the holding and demonstration of values and beliefs emerged as strongly related attributes of clinical nurse leaders. They were followed, therefore, not for their vision and creativity (although they may have had these attributes), but because their values and beliefs were on show and evident in their actions.

Because they display their principles about the quality of care, they dealt with patients in a 'hands-on' fashion. And, because they lived out their values and beliefs, they stood apart from novice clinicians, poor decision-makers, staff who were 'hide-bound' and managers who were tied up with other functions and those who were less visible in the clinical environment.

There is a view that values are inextricable to vision, although Pendleton and King (2003) declare that it may be even more important to know where you stand (a values-centred position) rather than where you are going (pertaining to vision). This implies that values are rooted in understanding an individual's or organisation's principles, while vision is about being able to drive through or respond to changes in the future. From a leadership perspective, Pondy (1978) supports this by suggesting that leadership is the ability to make actions meaningful and allow others to gain a sense of understanding, not necessarily change one's behaviour. But values and vision do appear to be linked and, although they may not be dependent upon each other, they may point to motivations that drive individuals and organisations from different perspectives.

The Department of Health (1999: 52) recognised that 'strong nursing, midwifery and health visiting leadership is needed at every level' and although many studies exploring nursing leadership exist, few focus on clinical leadership, with most studies focusing on senior nurses, the development of 'visionary' leaders (Rafferty, 1993), the development of 'strategic-level leaders' (Mabey, 1997: 27) and nurses with leadership responsibilities implied by their title or who hold senior hierarchical positions within a ward or Trust. This author's study allowed nurses from across a large NHS Trust to nominate or identify who, for them, were clinical leaders and indicate why.

Results indicated that 326 nominations were made for clinical leaders as a result of the questionnaire responses, and in the four clinical areas of the focused interviews, 130 clinical leader nominations were made by the 42 individuals interviewed, with over 60% being for nurses at F-grade level or lower.
Clinical leaders were found to be present in large numbers and at all levels. Managers and modern matrons were nominated, but their nominations were vastly overshadowed by nominations for nurses with predominantly clinical roles, often at staff-nurse level, particularly in general wards. Cook (2001) also suggested that leadership qualities exist at all levels and Ogawa and Bossert (1995) argue that leadership could be associated with roles throughout an organisation. These views are supported by Burns (2001) who also believes that, in a chaotic healthcare environment, 'frontline leaders' are not only 'required at all levels', but they may 'understand the environment's complexities even more than executive leaders' (2001: 478).

It could be that, in the nursing literature or prior studies, nurses have been unrecognisable as clinical leaders because most function at the bedside, doing 'nursing work'. Doing the invisible (Robinson, 1991; Davies, 1995) and 'dirty work' (Roberts, 1983; Wilkinson and Miers, 1999) of nursing implies that they become invisible too, and as doing 'dirty work' makes one 'dirty' by association (Wolf, 1996), clinical nurse leaders may be overlooked or go unrecognised by themselves, their professional colleagues or by the healthcare community in general. This was confirmed when half of the clinical leaders interviewed were 'surprised' at their nomination and didn't recognise themselves as clinical leaders. This invisibility is compounded because clinical leaders are often measured against a set of criteria, characteristics and qualities more in keeping with general leadership or management ideologies and attributes, such as those from the NHSE (2000). As such, clinical leaders who do not demonstrate attributes of being creative, visionary or fit the management profile, may be overlooked, and their contribution to leading at the bedside, doing nursing's 'dirty work' goes unrecognised.

Clinical leaders can therefore be recognised and are almost certainly found working in a predominately clinical capacity and in all types of clinical areas. The F-grade junior sister is a candidate likely to be viewed as a clinical leader by her colleagues and although modern matrons and nurse managers are acknowledged to be in clinical leadership positions, there is considerable dispute about their effectiveness and validity in a clinical capacity.

This point at least is not new, and it highlights discussions within nursing that draw attention to the tension between some nurses' clinical leadership responsibilities and their management function (Rafferty, 1993; Christian and Norman, 1998; Antrobus and Kitson, 1999; Firth, 2002; McCormack and Garbett, 2003; Thyer, 2003). For the senior nurses interviewed as part of this study, the conflict commonly felt was one that pulled them between their desire to remain clinically focused and demands from the NHS or their Trust managers to maintain the management and resources capabilities of their clinical area. Most nurses become nurses to care for patients, and their values are based on maintaining or promoting high standards of care. Increasingly, nurses describe being pulled or pushed to work in ways that interfere or contradict the core values they hold with a target-driven NHS complicating and compromising their professional values system. This is an issue not restricted to senior nurses: as Government targets and tight budgets strike, all levels and types of healthcare staff are caught in what Pendleton and King (2002: 1354) call the 'ethos gap'. The challenges identified by clinical leaders in the author's study related to maintaining staff morale and the increasing gulf between management and clinical expectations and responsibilities is evidence of the effect of this 'ethos gap', where managers and senior nurses are increasingly perceived to be further and further removed from clinical care and nursing's core values.

Being creative and having a vision remains central to the successful application of
transformational leadership, although they do not appear to be features for which clinical leaders are recognised. Their omission brings into question the suitability of the transformational leadership theory to explain or support the role and function of clinical leaders. It also questions the suitability of transformational leadership as the most appropriate leadership theory for understanding and developing future clinical nurse leaders.

The research outlined in Part 1 indicates that clinical leaders are selected because they have their values on show and act in concert with them. Being controlling (associated with a management function) was overwhelmingly regarded as being least connected with clinical leadership. Therefore nurses with management as a discernible feature of their job or role were much less likely to be seen as clinical leaders. As such, when nurses are promoted away from the clinical area or lose direct client contact, many encounter conflict as they are drawn into areas of management and administration, often either removed from or in conflict with their values and beliefs about patient care. Even if this is not the case and a crisis of conscience is avoided, others may recognise the controlling elements and this diminishes the likelihood of their being identified as an effective clinical leader.

Discovering who the clinical leaders are and recognising their qualities and characteristics has resulted in the proposal of a new theory of leadership, 'congruent leadership'. This explains and captures the nuances of clinical nurse leadership.

**Congruent leadership**

Bhindi and Duigman (1997) described what they called 'authentic leadership' where, in order to lead, leaders were required to be true to themselves and leadership was based on the leader's personal credibility and integrity. This view ran parallel to Pondy's (1978) description of leadership, where leaders are encouraged to explore their values and lead from a recognition of what was identified as important to them, rather than on a vision or set of goals. George (2003), writing about leadership from a business perspective, also describes what he calls 'authentic leadership', where leaders are guided by 'qualities of the heart, by passion, and compassion, as they are by qualities of the mind' (2003: 12). They lead, George suggests, 'with purpose, meaning and values' (2003: 12). Likewise, 'breakthrough leadership' (Sarro and Butchatsky, 1996) requires the leader to be a role model and, again, lead from the perspective of having clarified their own values, while respecting and listening to others. These theories, in part, explain why a nurse who is being 'true to herself' might wish to stay at the bedside rather than become a ward manager (Lett, 2002) and runs closely in line with the themes identified in this author's research.

These alternative theories of leadership and the results from this author's study prompted a view of clinical leadership from a new perspective, with congruent leadership proposed as an alternative theory to explain clinical leadership.

Congruent leadership can be defined as where the activities, actions and deeds of the leader are matched by and driven by their values and beliefs about (in this case) care and nursing. Congruent leaders may have a vision and idea about where they want to go, but this is not why they are followed. Congruent leadership is based on the leader's values, beliefs and principles, and is about where the leader stands, not where they are going. Congruent leaders are motivational, inspirational, organised, effective communicators and build relationships. Many have no formal, recognised or hierarchical leadership position and, as such, congruent leadership may offer a better theoretical framework to explain how and why they function (Table 1 compares the features of congruent and transformational leadership).
Table 1  A comparison of the features of Transformational and Congruent leadership

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<thead>
<tr>
<th>Transformational leadership features</th>
<th>Congruent leadership features</th>
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<tr>
<td>• Establishing direction.</td>
<td>• Motivating and inspiring.</td>
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<tr>
<td>• Aligning people.</td>
<td>• Approachable/open.</td>
</tr>
<tr>
<td>• Motivating and inspiring.</td>
<td>• Actions based on values and beliefs.</td>
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<tr>
<td>• Produces change—often dramatic.</td>
<td>• About where you stand (principles).</td>
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<tr>
<td>• About where you are going (vision).</td>
<td>• Effective communicators.</td>
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<tr>
<td>• Effective communicators.</td>
<td>• Visible.</td>
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<tr>
<td>• Creative/initiative.</td>
<td>• Empowered.</td>
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Note: Although there are some similarities, the key differences relate to what motivates the leader: vision or values and principles.

Congruent leaders are guided by their passion for care. They build enduring relationships with others, stand the test of their principles and they are more concerned with empowering others than with power or their own prestige. Congruent leadership explains why and how nurses and other non-titled leaders at all levels can function and be effective without formal influence in the clinical area. One clinical leader in the study summed this up by saying:

Honesty, loyalty, passion, integrity; those sort of things are probably more important . . . years ago when I was less experienced I would have said knowledge would have been oh, right up there, but because of the way I have changed, I don’t think that this is necessarily so any more . . . these other qualities out-weight them.

The interviews with clinical leaders and with nurses talking about what they look for in a clinical leader indicate that not all leadership is about changing people’s vision of the future. Some leaders lead because they demonstrate where their values lie and are followed because others identify with them and stand with them. This is reinforced by the following comments from the interviews:

I am not only able to empathise with patients and their relatives, but with staff as well . . . trying to think ‘what would they be going through?’ . . . it makes my ability to communicate with them much better.

I think people know that I am quite passionate about what I do and I also like to support others to be . . . err . . . to achieve the best they can achieve and very strongly centred on patient care and good standards of care.

Congruent leadership in action can be seen by describing the following example offered during one of the interviews. It relates to an account of a D-grade nurse who was faced with an anxious husband whose wife had undergone emergency surgery. The husband wanted to visit her and be at her side, but he needed to work when the ward had visiting times. The ward enforced strict visiting times for all relatives and other visitors and, although the ward was ‘open’ for a number of hours, this particular man was unable to attend at these times. The D-grade nurse, knowing she was acting against the specific instructions of the ward manager and senior sister, allowed the man onto the ward at 10.30 a.m. to visit his wife. The D-grade nurse undertook to allow this husband on to the ward because she believed that, had this been her husband, this was the action she would have wanted the nurse to follow. The nurse knew that she could have incurred the disapproval and, indeed, on this ward, a reprimand from the ward manager and senior sister, but she undertook to support the husband and defend
her stance against the more senior nursing staff. The incident caused some discomfort for the more junior nurse, and the fallout from her action was that she was reprimanded. This initiated debate at the regular ward meeting that ultimately resulted in many of this nurse’s colleagues agreeing that they would have liked to have done the same and this, in time, led to a revision in the ward’s visiting processes and procedures.

The D-grade nurse employed no long-term strategy in admitting the husband outside of the permitted visiting times, and had not set out to disrupt the ward’s visiting procedures. However, by following her beliefs about respecting the needs of patients and their relatives, the nurse initiated what developed into a slow revolution that resulted in significant change and an improvement in the access relatives enjoyed to their ill, worried and isolated friends and family.

Followers are attracted to congruent leaders because of the banner or standard they carry. They may not even intentionally show it, or they may not be conscious that others see it, but it is this that followers recognise and rally to. Their metaphorical banner or standard is usually a statement of what the clinical leader believes is important to them. It might say: ’I care for patients like they were my family’; ’I teach these children as if they were my own’; ’I’ll be here at the bedside with you’; ’I know what it’s like’; or ’I’m on your side’.

Clinical leaders who display congruent leadership match their values and beliefs to their actions and, in the example above, the D-grade nurse took a risk in following her beliefs. However, her colleagues recognised this action as part of the qualities and characteristics associated with clinical leadership and, as the D-grade nurse was visible and present in the clinical area, and because of her commitment and passion for the core values of nursing, she was (even unintentionally) able to motivate and inspire others to follow. The more senior nurses who had developed the visiting policy were not as present on the ward, did not deal as regularly with dissatisfied or upset relatives and friends, and were not as commonly in positions of having their nursing and caring values and beliefs challenged.

This example is in accord with the examples from Manley’s (2000a, b) study where it is evident that she led with values first and was successful as a clinical leader because others saw her values on show. Her values supported and matched her actions and this congruence formed the basis for her success as a clinical leader. Manley (2000b) recognised that her leadership brought about ‘cultural change’ because her values were used to highlight the contradiction between espoused culture and culture in practice (2000b: 34). Manley (2000b) identified her leadership style as transformational because it was her aim to affect and change the culture of the unit. But when reading the examples given by respondents in Manley’s (2000b) research, they were influenced more by her actions than by her vision. One said, ’the enthusiasm of the consultant nurse incited enthusiasm in myself’ (2000b: 37) another said, ’her influence has definitely influenced me’ (2000b: 37); Manley supported practitioners to become aware of their own values and beliefs, and helped in this process by allowing others to see and recognise her own values and beliefs and how they supported a change in the culture of the ward.

Roberts (1983), when considering oppressed group behaviour, indicated that it may be necessary to view current nursing leadership with scepticism because nursing leaders, in order to break free from oppression, adopt the leadership attributes of the oppressors. In so doing they become unwitting or even complicit co-oppressors, who through their approach to leadership and educational structures support the status quo, maintaining or relegating nurses and nursing to a second-class or subservient status. This approach to leadership leads to divisiveness and competition
among nurses and, to avoid this, Roberts suggests that elite leadership should be shunned and nursing should aim to develop leadership from the ‘grass roots’ (1983: 29) perspective. In many respects this is what Manley was able to achieve, as her colleagues became more empowered and emancipated as ‘practitioners become aware of their values, beliefs and assumptions and helping them to act on them’ (Manley, 2000b: 38). In effect, Manley’s research and the example offered are centred on ‘grass roots’ leadership that is in keeping with the principles of congruent leadership.

If nursing is to develop effective nursing leaders, it needs to do so without losing the core values and principles that guide nursing. Congruent leadership establishes a foundation from which all good or effective nursing leaders can start, because it grounds the leader’s principles within the core values of the nursing profession and ensures that the dominant cultural narrative of nursing is one of patient-centred care, with nursing values and care-centred attributes placed ahead of those associated with the dominant (potentially) oppressor groups of managers and physicians. Transformational leaders, in an effort to achieve their vision or goals, could at times move from positions of influence and power to positions of control. Unwittingly, in doing so, they run the risk of losing their connection to their core values and guiding principles, or at best become embroiled in a state of conflict as their managerial (controlling) demands conflict with their professional and often personal desire to remain focused on patient care.

Congruent leadership is not power-neutral and the power of congruent leadership comes from unifying groups and individuals around common values and beliefs. This is not a strategy as such, but results from this author’s research appear to demonstrate that nurses seek out or follow clinical leaders who are more inclined to display or hold values and beliefs that they themselves hold. Manley (2000b) also found that as she displayed her values and beliefs others began to share them, and the clinical area united as colleagues began to identify with the common purpose of ‘providing patient centred care’ (2000b: 38).

Nurses seeking to lead in a clinical environment will find greater success if their values and beliefs are consistent with the dominant values and beliefs of their colleagues, or if they are able to bring their colleagues to a point where their values and beliefs about care coincide. Conflict can result if the principles and values of one group or individual are at odds with others, and power and influence in terms of leading often falls to the dominant group or leader.

In relation to transformational leadership, power and influence arise from being able to articulate a vision that is accepted and acted upon by the majority of the followers. The leader is held in high regard because they are trusted and because their own self-belief is evident. Change is the goal and as the new vision is worked towards, the leader is able to take the followers forward.

In relation to congruent leadership, the leader’s power and influence is derived from being able to articulate and display their values, beliefs and principles. Followers and others recognise or align themselves with these same values or beliefs, thus supporting and promoting these values and beliefs, increasing the leader’s credibility and worth and promoting the significance of ‘this’ leader’s values and beliefs over any others. Change, although often not the intention (although it was for Manley), results when new values and beliefs are displayed, promoted and then adopted.

Successful clinical leadership is therefore proposed to rest on a model of congruent leadership that is based on leaders who respond to challenges and critical problems with actions and activities in accordance with (congruent with) their values and beliefs.

The strengths of congruent leadership are that:
• It supports the promotion of ‘grass roots’ (Roberts, 1983) leaders.
• It offers a foundation for other theories of leadership to be built upon. From this foundation, clinical leaders, nurses and ‘grass roots’ leaders can develop an understanding and connection with the core values and beliefs about nursing. No longer invisible, nursing work is recognised and clinical leaders can have a positive impact on nursing care and lead nursing forward by standing by the principles central to the profession.
• It may offer nursing an opportunity to develop greater influence in the leadership stakes (Rafferty, 1993). However, until nurses themselves can influence and initiate this and recognise themselves as congruent leaders, others will continue to see clinical nursing as ‘dirty’, ‘invisible’ (Roberts, 1983; Robinson, 1991; Davies, 1995; Wilkinson and Miers, 1999) work and clinical nurse leaders will remain of low status (Antrobus and Kitson, 1999), invisible and dirty by association.
• There may be a greater realisation that values need to become the focus of development in the NHS.
• It builds a strong link between values/beliefs and action. In this regard it is not static, but dynamic. Congruent leadership is not just about being, but about acting, displaying, demonstrating, living the leader’s values and beliefs.
• The result of congruent leadership is a change or identification with the culture of a group or organisation rather than simply addressing group structure.
• It represents a new perspective on clinical nursing leadership and is helpful for advancing our understanding of clinical leadership.

The limitations of congruent leadership are that:

• It is a new theory. It is untried, unsubstantiated and untested by further research. The research undertaken in this study, although substantial, stands alone in its scope and findings and until further research is undertaken, congruent leadership has to be acknowledged as resting on a narrow platform.
• It is similar in some respects to ‘authentic leadership’.
• Congruent leadership is not as obviously in keeping with the dominant NHS drive to seek out and promote leaders who can ‘change’ practice and lead change. There is a tension between striving to practice within a set of professional values related to care and compassion and having to achieve this within a target-driven and resource-poor NHS.
• It is of limited use to leaders who are required to exercise control over others (managers) or who are not visible or engaged in the process of doing the ‘work’ of the people or groups they lead.

Conclusion

Significantly, the nurses in command of care were recognised not because of their position or seniority, creativity or vision (although some displayed these characteristics), but because their values and beliefs about care were on show and were matched by their actions. They built their approach to clinical leadership on a foundation of care that was fundamental to their view of nursing and how patients should be cared for. Clinical leadership is commonly demonstrated in the ward or unit, by a clinical leader who is directly involved in providing nursing care. Clinical leaders are visible to their colleagues and considered to be knowledgeable, competent clinicians, who motivate and inspire others because their values, beliefs and guiding principles
are on show and are recognised as such. Leaders who control and manage from within offices or who fail to display their values and beliefs in congruence with their actions are rarely seen as clinical leaders.

Greater depth has been added to the nursing profession’s understanding of clinical leadership and indicators have been found that point towards the significant contribution clinical leaders can make if they are recognised as such and encouraged to see that leadership does indeed exist at many levels. Clinical leaders commonly display congruent leadership, and their passion for participation in hands-on patient care and in striving to contribute to high quality nursing adds to the pool from which nursing leaders can be drawn. However, they need to be recognised as such, by themselves and the profession in general, because the nurse leader who stands by what they believe is as valuable, and as effective, as the leader with the grand plan. Congruent leadership, if recognised, demonstrated and established can also become a firm foundation on which to bolster leadership within the nursing profession.

**Key points**

- Congruent leadership is proposed as a more suitable leadership theory to explain and understand clinical leadership.
- Congruent leaders demonstrate a match between their values and beliefs and actions or deeds.
- Transformational leadership based on the development and communication of a vision and creativity may not be appropriate as a theory to explain clinical leadership.
- Clinical leaders are approachable, empowered, visible, clinically competent, positive clinical role models, effective communicators and have their values and beliefs on show.

**References**


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In command of care: Toward the theory of congruent leadership

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I concluded my review of the sister-paper to this one (Stanley, 2006) with the observation that it raised more questions than it answered, and left me wanting more. This discussion paper, based on the findings of the empirical study reported previously, goes at least some way towards satisfying this desire. In particular, it challenges the current trend towards the transformational leadership model with a new theory of ‘congruent leadership’. Thus, the unfulfilled promise of the previous grounded theory study to actually deliver a theory is realised in this paper, since the theoretical model of congruent leadership is grounded firmly in data from practitioners themselves.

It might be worth briefly reiterating some of the main qualities of the congruent clinical leader, since they challenge some of our basic assumptions about nurse leaders and nursing leadership. Most significantly, congruent leaders are grounded in the present rather than in the future. As the author so memorably puts it, the issue is about where the leader stands, not where they are going, about stance rather than vision. Although congruent leaders might well have a vision, this is not what makes them attractive to others. Rather, it is their ability and desire to stand by their values and beliefs, even when these fly in the face of managerial policy and accepted practice. This moral stance by congruent leaders lies at the heart of many of their other traits, in particular their strong belief in leading by their actions, their ability to empathise both with colleagues and patients, and their willingness to engage in and to promote the ‘dirty work’ of nursing. From my own experience, none of these findings came as a surprise. The only note of discord for me was the finding that creativity was not considered a valued trait in congruent leaders, although the author suggested that this could perhaps be explained as a failure of the research tool to explain fully what was meant by the terms ‘creative’ and ‘artistic’.

Inevitably in a paper of this length, some issues could not be fully developed, and I was left feeling curious and a little frustrated by some of the unexplored issues. First, the author’s mention of the ‘dirty work’ of nursing immediately triggered in me thoughts of Schön’s ‘swampy lowlands’ of practice. There are, perhaps, links between congruent leadership and reflection-in-action that could be usefully explored in further studies. Second, the very term ‘congruence’, along with the trait of empathy identified by many respondents, led me to think about Carl Rogers’s work on person-centredness. Congruence and empathy, along with non-judgementalism, were the three qualities that Rogers identified as being necessary and sufficient in a
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wide range of activities, including counselling, teaching and leading. For Rogers, these qualities were not skills to be learnt, but a 'way of being' to be developed. Since few of the clinical leaders in this study were actively trying to lead, we should perhaps ask ourselves whether congruent leadership is a natural way of being, rather than a skill to be taught. This question clearly has implications for how the profession prepares the next generation of clinical leaders, and would make a very useful follow-up study.

By the time they reach the end of their PhD theses, many researchers are so exhausted by or fed up with the process that they simply publish their findings and move on to the next topic. I believe that this particular issue has far more to yield and far more to tell us about clinical leadership, and my hope is that it will form the foundation for a continuing and sustained programme of research.

Reference