A critique of transactional leadership in healthcare

Abstract

Leadership theory is common within nursing curricula and the focus of considerable literature, yet it remains a somewhat elusive concept and subject to numerous interpretations. Much of the literature on leadership is contradictory and each model claims to be more effective than another. This article critiques one approach to leadership, transactional leadership and considers its use within nursing practice. It argues that it remains useful as an approach to meeting short-term goals and, within healthcare, a particular emphasis is placed on intrinsic motivation as part of the transactional element of this leadership approach.

Key Words

To be drawn from the Nursing Standard taxonomy by editorial team

Leadership

From 2020, healthcare system's world-wide have faced large scale challenges amidst a pandemic which has threatened the health of nations and healthcare workers themselves. Leadership of organisations, teams and people has a key role to play in ensuring staff can adapt, change roles and responsibilities and create a safe, caring environment for service users. In the UK, within its standards of proficiencies for registered nurses, the NMC (2018a) states that nurses provide leadership by acting as a role model for best practice in the delivery of nursing care. A registered nurse should minimally understand the principles of effective leadership, lead and manage nursing care and exhibit leadership potential (NMC 2018a). This emphasises the view that leadership is not the domain of the top of any hierarchy, but the concern of all nurses. Such a view is reflected in approaches such as collective leadership (Nightingale 2020).

Literature continues to proliferate with leadership models and continued claims that leadership is important to promote good team working and/or safer patient care (Bian et al 2019, Navon et al 2020, Pishgooie et al 2018). Aiming for a consensus on a leadership definition remains a somewhat futile exercise as there are many diverse

points of view. The majority of leadership theories start from a point of the view that there are leaders and followers. The role of a leader is to set the vision or create an environment for followers to accomplish agreed goals. To this end, Northouse (2007) states that leadership is a process whereby an individual influences a group of individuals to achieve the common goal. However, the language of leadership has shifted, moving away from such a standard definition. Drath (2008) set the tone by highlighting dialogue, shared direction and commitment to aligned goals. Hulks et al (2017) argued that there should be a fundamental shift in leadership from a pace setting model to one which fosters participative and facilitative ways of working. Systems leadership widens this debate by considering alignment and dialogue across boundaries, organisations and systems. Authentic leadership considers how leaders can use relationships to enable people to find meaning at work, building trust and optimism, promoting inclusive and healthy work environments and encouraging honest relationships Alilyyani et al (2018). This concept of a more shared-leadership approach can be seen within collective leadership (Nightingale 2020).

As the leadership discussion widens, it is important to consider what works well in terms of the nursing context and fundamentally how this can be incorporated into practice. But again there is no finite answer as to which model works best in healthcare settings (Maxwell 2017, Cameron et al 2012). Much leadership research in nursing has focussed upon organisations in the acute sector and little is written about nursing in settings such as mental health, the community or indeed the independent sector, which further hinders the discussion and comparisons. It is therefore important that consideration is given to the care environment and the context in which care is taking place when discussing and researching leadership.

Transactional leadership

A model which appears to have less current favour, yet is often still used within nursing and healthcare, is transactional leadership. This article argues that it has merit in nursing and healthcare as a means to meet for short-terms goals, and can be productive when used with clear direction and the utilisation of intrinsic motivation. It is primarily based on the work of Burns (1978).

Transactional leadership is based on a number of premises:

1) It is short-term goal or task focused
2) There is contingent reward. This means reward given when a desired circumstance is met. There is a transaction. The leader clarifies expectations and establishes the rewards for meeting these expectations. These could be an extrinsic reward, such as a monetary reward, perhaps time off or some other tangible reward. It could link to intrinsic motivation. Here, there is nothing tangible but the person is thanked and praised, and offered positive feedback as the form of reward. Of course, in reality, reward may be a mixture.
3) Management by exception. The leader intervenes only when necessary but will establishe sanctions for failing to meet the standards of the task set. This can either be active, through a process of monitoring, overseeing and correction before issues arise, or passive, where the leader waits for problems before taking action.

In nursing and healthcare, a criticism of the transactional approach is that this can lead to a non-holistic approach to patient care as a result of a focus on task completion (Giltinane 2013). Yet particularly in nursing, being a transactional leader may bring certainty for staff to an ever changing situation. Acknowledging that uncertainty but still providing clear guidance is a central tenant of the nursing code of conduct in setting standards. In many ways, in the UK, the NMC (2018b) use a transactional model to outline the code of conduct emphasising it is a way of “reinforcing professionalism”. The Code is a statement of required minimum standards which registered nurses agree to when paying their annual fee. Sanctions are implicit in the code, as failure to meet the expected standards may result in disciplinary action and possibly removal from the nursing register. This is a clear example of a transactional model of leadership from the NMC; the reward is registration, the ultimate penalty for failure to meet the standards could be removal from the register.

Clarity in leadership

In the use of transactional leadership, followers should be made aware by the leader of the required task and the standard expected of them. They should also be aware of the reward or sanctions which may occur if their performance is either satisfactory or

fails to meet the required standard. Active leaders are ones who seek out errors and enforce rules in order to stop subsequent issues. Passive leaders are those who intervene after issues occur most often seen in the phrase ‘don’t fix what isn’t broken’. Cope and Murray (2017) argue that passive management by exception is commonly associated with suboptimal performance and thus suboptimal patient care. Yet in a recent study by Navon et al (2020) neither has been shown to be better than the other so long as both exhibit clarity of intention to followers. However, a laissez-faire approach, or taking no action at all, can be associated with confusion from followers and possibly lower performance as found by Bass (1999) in a review of two decades of leadership research.

In a climate where safety is paramount, there is a place for a transactional model of leadership and as a nurse, setting standards, delegation and attention to detail are an intrinsic part of the role. Authors such as Kark et al (2018) argue that transactional leadership can be seen as a preventative model and this is important in healthcare if staff try to avoid negative consequences of actions, comply with expectations and follow policy. If however, the negative outweighs the positive this can become problematic and lead to staff feeling disempowered and discouraged about their work. A member of a team who feels their good work is praised and rewarded by their team leader is much more inclined to go the extra mile than someone who feels they are constantly criticised.

A leader who sets clear standards, gives comprehensive explanations and instructions on what is expected is often valued by their colleagues (Bian et al 2019). Providing staff with the means to achieve their work and ensuring they are supported by policy and processes is another crucial element of any nursing role. Transactional leadership can mean staff focus on their job role, performing their duties with a degree of autonomy whilst supporting and complying with policies (Bian et al 2019). The key is clarity that staff know what is expected of them.

Applied well, transactional leadership might provide a basis for structuring developmental expectations in staff, as well as building trust, because of a consistent honouring of 'contracts' over time (Bass & Alvolio 1993). It also feeds into a culture which recognises and rewards outstanding service such as awards for team of the

year or nurse of the year , which may encourage and motivate excellence in care. Many organisations have implemented their own reward schemes, such as staff member of the month with celebratory events recognising the people who contribute to excellence and outstanding work. These are examples of more extrinsic rewards.

A fundamental issue with regards to transactional leadership is the question of whether or not it is primarily a management framework rather than a leadership model. This stems from a task-focused leadership style involving short-term goals (Cope and Murray 2017). It is process-focused, rather than looking to a bigger vision which is often the general definition of leadership.

Hersey et al (1996) outlined the difference between management and leadership as manager accomplishing organisational goals and the leader influencing followers regardless of rationale. It's clear therefore to see the root of the transactional leadership debate This can appear a little complicated and perhaps the easiest way to consider management and leadership is in the nature of the work and its outcomes. Table 1. highlights the differences between management and leadership.

Table 1. Key differences between management and leadership

Management	**Leadership**
Sets direction	Creates vision
Allocates resources	Creates an environment for success
Monitors results	Focuses on results through problem solving approaches
Manages staff	Develops people
Promotes order and consistency	Strives for improvement and change
Is in a position of authority	May not be in position of authority

In their seminal work on leadership, Heifetz and Linsky (2002) outline two types of challenges which people face, technical and adaptive. The technical challenge is one which already has an answer and has a solution which has often been used before; the adaptive challenge is one where there is ambiguity and unpredictability. They

argue that technical challenges require management solutions and adaptive challenges require leadership solutions. Showing someone how to take a blood sample would be a technical challenge whereas asking someone to deal with a distressed relative might require an adaptive solution.

Transactional leadership can appear as management but in essence it is a leadership model because it supports staff to face adaptive challenges by providing clear standards and expectations. A good transactional leader should create an environment for success, problem solve and develop people which are all attributes of leadership. Working as a lone practitioner in the community for example, means a degree of risk might be taken with patients as there is no one immediately available to ask. Therefore working with policies in place and agreed standards from a team leader means creating a climate of positive risk taking which is helpful to that practitioner.

Care environments can be created which are calm and follow routine if combined with patient-centred care. Routine is often an important element of clinical care and can be valued by patients who know what to expect in circumstances where they are frightened and experiencing a lack of control. For example, a calm environment which appears orderly may enable a person with dementia to experience less fear and confusion than a busy and chaotic area where people come and go without explanation. As a relative or family member walking into a clean, peaceful environment which is welcoming and ordered makes a huge difference to initial impressions.

According to some authors, transactional leaders motivate followers by appealing to their intrinsic motivation through using incentives to motivate them (Harrison 2018). Nurses self-image can be enhanced because they are important to others so intrinsic motivation or altruism may well be an important factor in appealing to them according, to work from Brekke & Nyborg (2010). If improving patient experience is improved by transactional leadership (Wong 2015) then perhaps this is also a motivating factor for healthcare staff.

Criticism of transactional leadership

Cummings et al (2018) argue that a focus on completing tasks does not achieve optimum outcomes for the nursing workforce and transactional leadership can mean poorer levels of empowerment, staff health and wellbeing. In circumstances where a transactional leader was being harsh or unreasonable in applying sanctions this would be a fair criticism. However, many elements of transactional leadership may be required in healthcare in order to simply get the job done.

Regardless of efforts to widen the emphasis of nursing care it is often a focus on task, whilst improving patient care, which is at the forefront of many nurses daily work and indeed that of nurse leaders (Cummings et al 2018). Poor staffing levels and inadequate skill mix may increase a focus on task and leaders under stress may become less aware of the need to develop people and empower them. Many leadership models pit transactional leadership against other models because it has often been attributed to a culture of bullying or command and control. Thus, transactional leadership is often seen as a bad thing but it is still the dominant model of a nurse manager according to more junior nurses (Pishgooie et al 2018).

Critics of transactional leadership discuss its inability to focus on relationship building and concern for staff but this is not necessarily implicit in a transactional model - it is the application which may be poor. It may be that linking it with another model such as authentic leadership ensures the focus on relationships and concern for staff which is needed. However, the 2019 NHS staff survey has shown little decrease in five years in areas such as bullying and harassment from both colleagues and managers. Conversely, there has also been little increase in staff gaining a sense of autonomy or control over changes (West 2020). This would suggest that if transactional models of leadership are being used by some nurse managers it may, in part, be responsible for a continuing culture of bullying, leading to the poor quality care and leadership highlighted by the Francis report (2013).

In a systematic review of leadership styles by Cummings et al (2018), the authors state that whilst transactional leadership was unique in that it linked to improved job satisfaction, it conversely led to poor outcomes for staff well-being and empowerment.

The emphasis on completion of tasks, whilst important in some respects to the nursing workforce, is not in and of itself sufficient when considering other elements of nursing such as retention of staff, the complexity of advocating for people or for ensuring motivation and relationships in teams . Fundamental to nursing care is being an active and useful member of a team and working with others in relationship building, listening, communicating and speaking up for others. In other words, a disempowered nursing workforce will not feel able to speak out when things go wrong or ask for more resources if there are not enough. Furthermore, they will not regard challenging the hierarchy in order to provide more sensitive and personalised care permissible.

Increasing metrics and targets in healthcare organisations are a means of monitoring success, responding to challenges and managing variation and are a visible method of political influence on the system. They are often applied in a transactional way, with sanctions for poor performance and rewards for organisations who perform well. Yet for many staff the demands of this monitoring and target setting can make it hard to focus on care and give priority to people (McCann et al 2015, Philips &Norman 2020).

Such a focus can result in a series of hierarchical checks at all levels of the organisation underpinned by policy and procedure which start to resemble a form of control, rather than a response to the complexity and challenges of human caring (Phillips & Norman 2020). This would appear to highlight another area of concern with using a transactional model of leadership in practice. Bass (1985) has argued that transactional leadership is more suited to what he describes as a ‘well-ordered society’ and that transformational leadership is required for areas where there is constant change or instability. This may be due to the fact that transformational leadership focuses on building vision, the needs of followers, motivation and role modelling.

Mixed models of leadership

Bass et al (2003) in a series of work on transactional and transformational leadership came to the conclusion that both are required in order to have successfully performing teams. A transactional leader will set goals and expectations and clarify responsibilities which is the foundation for a good relationship. A transformational leader will build on this by developing people and encouraging their motivation to continue to improve. Transformational leadership enables leaders to provide and set

a vision and motivate followers to carry it out through a process of inspiration and leading through example (Northouse 2007).

In community settings, it appears that the model of transactional leadership is followed at a more junior level of nursing but that more senior nurses use a transformational model (Cameron et al 2012). However, Cameron et al (2012) found that in community settings what they called a “quasi-family” model emerged where a focus on relationships between team members and close familial-type relationships were emphasised. The authors felt that this might in part be due to lone working and stress where strength of feeling that developing a team as a family unit was important. Transactional models were quickly subsumed into more transformational models after which a quasi-family model emerged. Other models were not regarded by nurses as intrinsic to their role. Yet there was no clear fit in community teams for any one model of leadership and this may again give a clue as to the multi-faceted nature of what is required in leadership in nursing.

In mental health settings, one author did not consider a transactional model of leadership but suggested a model of transformational and ethical leadership worked best (Jambawo 2018). Jambawo (2018) argues that such a combination leads to positive cultures and outcomes along with improved relationships and behaviours from staff. Ethical leadership, where leaders act with respect for values and beliefs and demonstrate honesty, fairness and integrity, ensures that staff will feel able to meet the challenges of national policies directed at improving care and improving services (Jambawo 2018).

In most care settings, models of leadership with a clear focus on ethics, questioning the status quo, motivating others and role modelling will enable staff to feel able to meet complex situations and care for people as individuals and partners. Authentic leadership which was developed by Alvolio et al (2004) appears to follow on naturally from transformational leadership and transactional leadership. This places an emphasis on ethical behaviour and integrity where leaders use their life experience, morality and psychological capacity, building trust, transparency and a climate of openness in teams (Wong & Laschinger 2012). Mondini et al (2020) state that authentic leadership has four dimensions: self-awareness, transparency, morals and ethics and balanced processing or decision-making which takes into account the views

of others. Focussing on effective teamwork and building relationships with teams in a climate of trust and openness may well be central to developing a leadership model in nursing. Combining this with ensuring tasks are completed, providing direction and clear explanations supported by policy such as in transactional leadership is essential.

Conclusion

Transactional leadership has much to recommend it, as its longevity in healthcare amply demonstrates but it needs to be combined with other leadership styles in order to leaven what can sometimes be seen a rigid and punitive approach with a need for individual and team motivation. Creating teams with integrity and compassion and demonstrating the same compassion to each other as we show to the people we care for will mean that our leadership style is congruent with our nursing philosophy.

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