Role conflict: leaders and managers

David Stanley reviews the literature, and discusses his own research, on the difference between leadership and management.

It should come as no surprise to most nurses that the best and most experienced clinical members of wards or unit teams do not necessarily make the most effective managers.

Yet employers persist in appointing senior clinical staff into ward or unit managerial posts, or worse, encourage clinical staff to take up managerial posts and then burden them further by asking them to retain clinical responsibilities (Stanley 2006a, 2006b).

Some modern matrons and consultant nurses have taken up these positions, as have many ward managers, senior ward leaders and ward sisters (Stanley 2006a, 2006b).

The result can be conflict, confusion, challenges to the clinicians' values and beliefs, or ineffective leadership and management, leading to diminished clinical effectiveness, or even dysfunctional ward or units, and therefore poor quality care (Stanley 2006a, 2006b).

It appears that the drive to place clinicians in key leadership roles (Department of Health 1999, 2000) is hindered by a commonly held misunderstanding about the difference between leadership and management.

This article examines the literature on differences between leadership and management, and discusses the results of a study undertaken by the author that shows that nurses are aware of both these differences and the problems that arise from them (Stanley 2006a, 2006b).

Role conflict: literature search

Where the focus of clinical staff is divided between their clinical role, with its associated professional values, and their managerial role, with its associated organisational values, there is clearly potential for conflict.

In considering nursing's future role, Naughton and Nolan (1998) recognise that the drive to offer more power to nurses can lead to tensions, particularly between the professional aspirations of nurses and the demands placed on them by new managerial cultures.

In his 1993 study, Forbes suggests that traditional managerial tasks such as staffing, staff evaluation and budgeting are best left to administrators because these duties cloud the clinical focus of senior clinical nurses. This is supported by Doyal (1998), who finds that nurses appointed to managerial roles have a 'confusion of identity', which often leads to 'anxiety and isolation for the post holders'.

Firth's (2002) interviews with 12 ward managers identify 'role ambiguity' as a main theme. The participants were unclear about their role, and even became angry about how their role had evolved. Eight of the 12 indicated that their role would be more productive if they could delegate administrative tasks to others.

Firth's findings are similar to the author's own exploration of the role of ward sisters in general ward areas (Stanley 2000).

One participant in this study said: 'I think it is a role that is diminishing slightly. Ward sister, ward leader, ward manager, team leader: there are 101 names for it, and I don't think it is respected very much in the NHS because it is a very difficult role, straddling clinical and managerial responsibilities. You never know quite where your boundaries are.'

My conclusions are that ward sisters struggle with limited support and resources, as well as staff shortages, and are ill prepared for their role, particularly in relation to leadership and quality issues (Stanley 2000).

Participants said they experienced conflict because of their preconceived, traditional ideas of what their role and responsibilities should be, or because of conflict between their professional and clinical values (Stanley 2000).

Blurred boundaries

Reed and Kent (1997) confirm that the role boundaries between nurse managers and senior nurses have 'blurred', and that this has led to a loss of clear nursing leadership.

Murphy et al (1997) also find that nurses are often confused about ward managers' role and function, which are 'characterised by complexity, loss of focus and role overlap'.
Role overlap and complexity also lead to nurse managers describing themselves as disempowered and less satisfied, and contribute to problems of senior nursing staff retention (Contino 2004, Patrick and Laschinger 2006, Swearingen and Liberman 2004).

In Christian and Norman’s 1998 exploration of the role of clinical leadership and managerial role in 28 UK nursing development units (NDUs), it emerged that many clinical leaders and managers who lack strong managerial responsibilities can develop a vision of the future but have no authority to turn this vision into reality, while those with day-to-day managerial responsibilities find it difficult to extract themselves from administrative issues to think in strategic terms.

The solution to the problems in this case was to help the NDU clinical leaders and managers achieve ‘operational effectiveness’ by supporting them to exercise authority and further managerial responsibility.

The authors conclude however that the ‘solution ignored the important point that leadership and management may be very different and even conflicting activities, and may not be easily combined in the same role’ (Christian and Norman 1998).

Malcolm et al (2003) suggest that clinical leaders should remain focused on professional issues, quality and care, and should not cross ‘over to the other side’; that is, to management.

The consultant nurse role was developed in the UK to allow clinical leaders to do just this. Guest et al (2001) find however that consultant nurses still encounter problems such as role ambiguity, overload, conflict, overlap and boundary management.

Training
Rowden (1998) suggests that nursing strategists need to think more critically about the training needs of clinical ward sisters.

Considerable investment in training from the NHS Modernisation Agency and the NHS Leadership Centre has had an impact. Its focus on leadership and managerial skills however may leave unaddressed the core issue affecting front line sisters, ward managers, charge nurses, modern matrons and consultant nurses, all of whom commonly experience conflict when having to balance the managerial and clinical demands on their posts or time (Doyal 1998, Firth 2002, Forbes 1993, Stanley 2000, 2006a, 2006b).

The regularity with which the subjects of role conflict and blurred role boundaries feature in the literature points perhaps to a fault in the structure of ward or unit management, and helps to confirm that clinical leadership and management are two different things.

Leadership and management
Zaleznik (1977) says that ‘managers and leaders are two very different types of people’. He adds that conditions favourable to the growth of one may be even detrimental to the other, and suggests that they have different attitudes towards their goals and careers, and form different relationships with others.

Kotter (1990) also thinks that leadership and management are different, with each having their own function and characteristic activities. He explains that management is about planning, controlling and putting appropriate structures and systems in place, while leadership is about:

- ‘Aligning’ people
- Setting a direction
- Motivating people
- Inspiring people
- ‘Employing credibility’
- Adopting a ‘visionary position’
- Anticipating change
- Coping with change.

Kotter (1990) also acknowledges that both leadership and management are necessary for complex organisations to function properly.

Zaleznik (1977) believes that managers’ goals arise out of necessity rather than desire, and managers excel at diffusing conflict between individuals or departments, placating all sides while ensuring that an organisation’s day-to-day business is done.

Leaders’ goals, on the other hand, arise from a personal and passionate desire to infuse meaning into the world (Zaleznik 1977). Leaders focus on people and meaning but managers, while they like to work with people, tend to maintain low levels of ‘emotional’ involvement and can refrain from assuming that the meaning of events can be understood.

Leaders tend to be solitary, proactive, intuitive, emphatic and attracted to situations of high risk; they ask the ‘why not’ question and ‘do the right thing’, while managers ‘do things right’ (Bennis and Nanus 1985). Leadership is therefore rooted in the maxim that the more change there is, the more leadership is required (Kotter 1990).

Zaleznik (1977) suggests that managers can be seen as passive, while Kotter (1990) describes them as being involved with planning and budgeting, setting goals and targets, organising and staffing, controlling, problem solving, and coping with complexity.
Indeed, management and complexity are co-dependent, and modern management has evolved because, without it, large organisations and complex enterprises tend to become chaotic. Thus, good managers bring order and consistency to the quality and profitability of business.

Leadership, on the other hand, is about coping with change and even, to some extent, creating chaos. Leadership has become an important issue, particularly in relation to current health service needs, because more change always demands more leadership (Kotter 1990).

Warren (2005) suggests that the main difference between leadership and management is ‘vision’. Management, he states, consists primarily of analysis, problem solving and planning, while leadership consists of vision, values and communication.

Leaders, according to this view, can clarify the purpose of activities. They can be described as comprising the ‘heart of an organisation’, and the essence of leadership is to inspire groups to come together for common goals (Warren 2005).

Leaders motivate, console and work with people, to keep them bonded and eager to move forward. This means setting direction, communicating it to everyone and keeping people on track when times are tough.

Transformation and transaction

Transformational leadership (Burns 1978, Downton 1973) is strongly associated with Bass (1985, 1990) and his work on the distinctions between leadership, or ‘transformational leadership’, and management, or ‘transactional leadership’.

Here, transformational leadership is described as a process that changes and transforms individuals. It involves the emotions, motives, ethics and long term goals of those who follow transformational leaders, and requires of leaders an exceptional ability to influence and move such followers to accomplish more than is usually expected of them. Transformational leadership incorporates both charismatic and visionary leadership (Northouse 2004).

Leithwood (1999) suggests that transformational leadership involves setting directions, establishing visions, developing people, and organising and building relationships.

Also known as ‘transactional management’, transactional leadership (Burns 1978), on the other hand, is based on a relationship of exchange between leaders and their followers. Transactional leaders focus on the purposes of the organisations they lead and assist people to recognise what needs to be done in order to reach desired outcomes (Day et al 2000).

Transactional leaders require the skills and abilities to deal with the operational, day-to-day and mundane transactions of organisational life (Kakabadse and Kakabadse 1999).

Thus management is a function that must be exercised in any business or organisation, while leadership is a relationship between leaders and the led that can energise organisations or businesses. Leadership and management can be described therefore as two different concepts (Table 1).

<table>
<thead>
<tr>
<th>Area or factor</th>
<th>Qualities associated with leaders or leadership</th>
<th>Qualities associated with managers or management</th>
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<tbody>
<tr>
<td>Goal</td>
<td>Change</td>
<td>Stability</td>
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<tr>
<td>Seeks</td>
<td>Vision and the expression of values</td>
<td>Achievement of aims or objectives</td>
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<tr>
<td>Theoretical style</td>
<td>Transformational or congruent</td>
<td>Transactional</td>
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<tr>
<td>Conflict</td>
<td>Uses conflict constructively</td>
<td>Avoids or manages conflict</td>
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<tr>
<td>Power</td>
<td>Personal charisma and values</td>
<td>Formal authority and a hierarchical position</td>
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<tr>
<td>Blame and responsibility</td>
<td>Takes the blame</td>
<td>Blames others</td>
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<tr>
<td>Energy</td>
<td>Passion</td>
<td>Control</td>
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<td>Relationship to followers</td>
<td>Follwers</td>
<td>Subordinates</td>
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<tr>
<td>Direction</td>
<td>Explores new roads</td>
<td>Travels on existing paths</td>
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<td>Main focus</td>
<td>Leading people</td>
<td>Managing work or people</td>
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<tr>
<td>Planning</td>
<td>Sets direction</td>
<td>Plans detail</td>
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<td>Driven by and appeals to Heart and spirit</td>
<td>Heart and spirit</td>
<td>Head and mind</td>
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<td>Response</td>
<td>Proactive</td>
<td>Reactive</td>
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<tr>
<td>Persuasion</td>
<td>Sell</td>
<td>Tell</td>
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<tr>
<td>Motivation</td>
<td>Excitement for work. unification of values</td>
<td>Money or other tangible rewards</td>
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<tr>
<td>Relationship to rules</td>
<td>Breaks or explores the boundary of rules</td>
<td>Makes or keeps rules</td>
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<tr>
<td>Risk</td>
<td>Takes risks</td>
<td>Minimises risks</td>
</tr>
<tr>
<td>Approaches to the future</td>
<td>Creates new opportunities</td>
<td>Establish systems and processes</td>
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<td>Who within an organisation</td>
<td>Anyone and everyone</td>
<td>Those with senior hierarchical positions</td>
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<tr>
<td>Relationship to the organisation</td>
<td>Essential</td>
<td>Necessary</td>
</tr>
</tbody>
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Table 1. Differences between leadership and management
The primary aim of the research discussed below was to explore clinical leadership, with one of its key emergent themes being what participants understood as the differences between leadership and management (Stanley 2006a, 2006b, 2006c).

Methods
The study was qualitative, employed grounded theory (Strauss and Corbin 1998) and involved three phases:
- Phase 1: the results from 830 questionnaires that offered general information about clinical leadership, the qualities and characteristics of clinical leaders, and who nurses perceived to be clinical leaders
- Phase 2: 42 focused, in-depth interviews with a random selection of nurses from grades D to H in four different clinical areas or units in one acute NHS trust
- Phase 3: eight further interviews with nurses nominated as clinical leaders during the 42 initial interviews.

Results
While a vast amount of data was produced by the study, this article focuses on the participants' understanding and reactions to questions specifically about leadership and management, and the differences between the two.

Differences between leadership and management
Participants were asked to describe what they saw as the difference between leadership and management.

The consensus was that managers tend to depend on their position, title and hierarchical status, while leaders depend on their knowledge, experience and ability to inspire people.

In general, managers were seen as having 'more authority than a leader' (P28), and leadership was seen as 'not necessarily grade related' and 'a quality that some people have, the ability to inspire colleagues' (P8).

One participant said the difference was that 'the manager has got the title, and therefore they manage because of the title, but there are other people that lead by virtue of their opinion' (P22).

Some participants emphasised the interpersonal aspect of leadership, describing leaders in terms of 'dealing with people, while management was more about dealing with systems and processes' (P22).

In support of this view, the participant said: 'Leadership involves everybody; leadership is more about guiding people. It's about talking to people, being on their wavelength, seeing how they feel, seeing what they are capable of doing. Management to me is more office based, managing the people that are working for you. Managing budgetary constraints and things like that.' (P11)

Others said that 'management was about being controlled' (P14), or that 'managers found it difficult to get properly involved' (P15).

Diminished clinical input of managers
Describing the difference between managing and clinical leadership, many participants offered views about the diminished clinical input of managers.

One, referring to the former Commission for Health Improvement (CHI) and the former National Institute for Clinical Excellence (NICE), said: 'Managers are very good. Unfortunately for them, they are no longer clinical. They do clinical shifts, but they are so boggled down with everything else that's going on with CHI and NICE and all the paperwork that's involved with it. On the shop floor, we used to say it was the sisters and staff nurses - and there are some exceptional ones - that are the leaders.' (P1)

Another participant, describing her ward manager, said: 'Sometimes, perhaps she is not very approachable. You feel that she's obviously busy doing the managerial stuff and actual running the ward, doing the day-to-day things, rather than being able to support the staff clinically. She doesn't carry much of a clinical workload; she is more administrative.' (P30)

Role conflict
When asked about being a leader or manager, one participant said that 'being a manager, it was sometimes hard to either do one or the other' (P11).

Another responded to the same question by saying: 'Management and leadership are totally separate entities. There are barriers, especially the higher up the ladder you get. You get focused on the clerical side, and the patient care can suffer.' (P1)

A number of participants saw 'barriers between the two' (P31), with one indicating that they were so separate that 'they could pick someone off the street and make them into a decent manager, but leadership comes from within; it's different' (P39).

Supporting the notion of a division between the functions of leaders and managers, another participant supposed that leaders 'would be more involved with the actual work, whereas a manager would be more involved with the paperwork and that sort of thing' (P18).

Other participants described managers as 'distant from the ward' (P33), 'more interested in the finance and things' (P32), 'more office based' (P36), 'hidebound' (P12) and having 'more authority than a leader' (P28).
Who is a leader? Who is a manager?
To clarify who participants perceived to be managers or leaders, each was specifically asked if modern matrons, of whom there were three in the clinical areas of the study, or their ward manager or senior sisters were managers or leaders.

One participant said of a modern matron: 'I don’t see her as clinical and she is not somebody I would admire in the same way as a clinical nurse. Although she is obviously clinical, she’s lost a lot of clinical skills purely because she does what she does. I think she is all tied up with administration, management and finances; that just comes out every time.' (P4)

She added: ‘I think, when she was first appointed, I thought “Why can’t we have, say, another two or three D grade nurses instead of another tier of management?” I just saw her as another stick to beat us with. I thought “Why can’t we employ more nurses to come and do the work?”’ (P4)

Another said: ‘We’ve got a matron who is mainly office based, managing staff, beds, finances and things like that, whereas, if you’ve got somebody who’s based within the ward setting, they’re going to be more of a clinical leader.’ (P29)

Other comments about modern matrons included ‘it’s like a supervisory role’ (P13) and ‘I think she is seen as a manager; she’s simply not involved on the ward every day.’ (P5).

These comments show there is some distance between the health department’s ambition that modern matrons should be ‘strong clinical leaders with clear authority at ward level’ (DH 2000) and the opinions of many of the participants in this study.

Relationships between leaders and managers
Participants’ understanding of the relationship between nursing management and clinical leadership is summed up by comments such as: ‘Management could diminish your impact as a leader. The negative side of nursing promotion is the fact that there is a greater tendency to come off the shop floor, which can tend to diminish your impact as a leader.’ (P24)

Recognising that leaders were found at all levels, and in a range of different areas, several participants described a leader as ‘someone who doesn’t have to be in management position’ (P37), ‘someone inspirational’ (P24) and ‘someone who comes with knowledge and experience’ (P26).

Leadership and management were seen as different things, although a relationship existed between them. Managers were seen as being somewhat removed from care and more intent than leaders to climb the managerial career ladder. Thus they lost clinical credibility and effectiveness when compared with leaders.

Clinical leaders however were perceived to be at any level and could advance clinical care because they were approachable, inspirational, visible, clinically skilled, experienced and, most importantly, driven by their core nursing and care values.

Nominated clinical leaders
The researcher interviewed eight nurses who had received the most nominations as clinical leaders (CLs) from staff in the four clinical areas involved in the study.

An analysis of these interview data identified two categories of how the differences between leadership and management were described, namely ‘juggling everything’ and ‘conflict’.

The 42 participants made 130 separate nominations for clinical leaders (Fig. 1). From these, one modern matron, two grade G ward managers, and five grade F ward sisters or junior sisters received the most nominations.

The nominated clinical leaders appeared to have a common preoccupation with balancing their clinical and managerial responsibilities: ‘juggling everything’, as one put it (CL3 grade G). Another said: ‘I see myself as having two priorities. One is the patients, obviously,
applied leadership

and the second is my staff. If there is a conflict between staff requirements and patient requirements, the patients’ requirements come first (CL1 grade F).

Many clinical leaders implied that they would be happier if they did not have to deal with the managerial aspects of their role, and the following views were common:

- ‘I’d rather not be dealing with people’s salaries and annual leave request, or with monitoring sickness, because I would be far more valuable out on the ward working alongside junior colleagues.’ (CL4 modern matron)
- ‘My role is patient care. I am accountable for everything I do for my patients. I would say that this is my major role.’ (CL6 grade F).

Clinical leaders said they were driven by their ‘beliefs about patient care’ (CL1 grade F), and spoke of their desire to apply and display high quality care.

Conflict appeared if clinical leaders’ managerial responsibilities appeared to diminish their effectiveness as clinical leaders. One said that ‘the more management responsibility you’ve got, the less you are visible in the clinical area’ and that, referring to career progression, ‘there is only so much you can do, which is one of the reasons why I don’t want to go any further’ (CL5 grade F).

Not only were leadership and management different from each other, but the eight clinical leaders and most of the 42 other nurses interviewed clearly indicated that taking on managerial responsibilities was likely to be detrimental to their ability to lead.

Summary

There is considerable evidence that the functions of leadership and management in the same post can lead to confusion, conflict and diminished clinical and managerial effectiveness.

This issue must be addressed if ward or unit efficiency, patient and client care, and nursing standards are to be improved.

One solution to this is to divide the roles into two by creating both clinical leadership and management posts. An example of the latter would be that of the ward or unit administrator, who is dedicated to supporting clinical staff by managing the wards or units on a daily basis.

Such administrators could deal with the clerical, storage, safety and staffing issues, as well as risk assessments, complaints and general administrative duties, that are essential for wards or units to function effectively, and that are currently associated with senior ward clinicians.

References


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were such a change to take place, modern matrons, clinical nurses and ward sisters would retain strong influence over the clinical direction and quality issues of wards or units by supporting junior and newly qualified colleagues, offering examples of high quality care and being role models for the best approach to nursing care.

such a change could reduce tension between leaders and managers, and would ease the conflict for senior clinical nurses who face competing demands and solve the current confusion about role boundaries.

Of course the cultural shift to achieve this would be tremendous and, should it take place, there would be implications for continuing professional development. However, the benefits for patient care could be tremendous too.

Conclusion
Each phase of the research discussed in this article has emphasised the differences between leadership and management. The literature review also supports the notion that leadership and management are different things.

The significance of these differences, in relation to clinical care and the management of clinical areas, is that the resulting conflict and confusion, and the inherent division between core clinical values and organisational goals, place nurses with leadership and management responsibilities in positions of diminished clinical effectiveness or in weakened managerial positions (christian and norman 1998, Firth 2002, Stanley 2006a, 2006b).

As a result, ward managers, senior sisters, consultant nurses, modern matrons and other senior clinical nurses with managerial responsibilities may find themselves climbing the managerial ladder but at the cost of effective clinical leadership.

To develop more efficient ward or unit management, as well as clearer and more effective clinical leadership, it may be time to accept that combining leadership and management functions in single posts is inefficient and counterproductive, both to the individuals concerned and the health service's future development.

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