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Congruent Leadership and Empowerment

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Stanley, D. Edith Cowan University, Australia. Congruent Leadership and Empowerment

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ABSTRACT

Who are the clinical nurse leaders? What are the qualities and characteristics of clinical nurse leaders? Why they are seen as clinical leaders and what might their experiences of clinical leadership be? This paper outlines a research project that sought to explore these questions. The research discussed involved surveying registered/qualified nurses (n = 830) who staffed 36 clinical areas in one acute NHS Trust in the English Midlands. The data proved a rich source of information about clinical leadership, the attributes of clinical leaders and who might be recognised as a clinical leader. The questionnaire was followed by interviews with 42 qualified nurses on four clinical areas in the same NHS Trust and these were followed by 8 further interviews with nurses identified from the interviews as clinical nurse leaders. The results demonstrate 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 values and beliefs or view of nursing and care. This resulted in the proposition of a new leadership theory: Congruent Leadership. The attributes of clinical leaders appeared to be clinical competence, clinical knowledge, approachability, motivation, decision making, effective communication, being a role model, visibility and empowerment.

INTRODUCTION - NURSING AND LEADERSHIP

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 appears in what Antobus and Kitson (1999) call the, 'academic, political and management domains' (p.751). Numerous studies or articles (Rafferey, 1993; McKeown and Thompson, 1999; Antrobus and Kitson, 1999; Kitson, 2001; Beech, 2002; Firth, 2002; Jasper, 2002; Faugier and Woolnough, 2003) have focused on nursing leaders who hold senior levels either within organisations, Trusts, nursing divisions, wards and/or departments and 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 the term nursing leadership (Lett, 2002) or even nursing management. 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.

In addition, the slow development of different kinds of leadership models within nursing has been influenced by a dependence on leadership theory that supported change and understood leadership from the perspective of facilitating and developing change. With constant change as a theme in the NHS, and other health services, nursing leadership programmes and the nursing profession's view of leadership has focused on an understanding of leadership based on the dominance of the 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 evidenced based technique' (1999, p. 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 literature review and research study outlined below explore leadership from a clinical perspective and challenge the nursing professions reliance on change focused leadership theory.

LITERATURE REVIEW

The literature review began with the consultation of a wide range of journals, books, previous research papers and Government documents that focused on leadership theories, nursing leadership, clinical leadership, ward leadership and associated topics, such as empowerment, oppression, authority, power, management, the NHS political agenda, organisational structure, organisational culture and boundaries between health professionals and their relationship to leadership roles within health care.

The core of the literature review focused on the application of leadership to a clinical setting and although there appeared to be a wealth of literature that dealt with the role, nature and purpose of nursing leadership (Salvage, 1999; Footit, 1999; McKinnon, 1999; Shepherd, 2000; Wedderburn-Tate, 2001; O'Neill, 2001; Nohre, 2001), the value of developing and nurturing nurse leaders (Scott, 1987; Wright, 1996; McKeown and Thompson, 1999; Read, 1999; Antrobus and Kitson, 1999; Cunningham and Kitson, 2000; Faugier and Woolnough, 2001; Firth, 2001) and the characteristics of nurse leaders (McShery and Brown, 1997; Bower, 2000; Wedderburn-Tate, 2001; Cook, 2001b; Crouch, 2002; Chambers, 2002; McCormack and Garbett, 2003). There was less literature and scant research that related to who the clinical leaders are and what clinical leadership might mean, although Christian and Norman, 1998; Cosens et al, 2000; Cook, 2001a 2001b and Lett 2002 had all initiated work in this area. The discussion of leadership is evident in a wide range of nursing literature (Antrobus and Kitson, 1999), although much is focused on leadership and management or leadership of a general nature. The literature review also considered leadership perspectives from the military, teaching and business fields to ensure that a spectrum of leadership literature was employed in developing the direction of the research.

Defining Leadership

Understanding the concept of leadership was pivotal to understanding the experiences of clinical nurse leaders and like Stodgil (1974, p7) who found that, 'there are almost as many different definitions of leadership as there are people who have attempted to define the concept'. This research began with a plethora of literature proposing, often contradictory views on the meaning of leadership. Following a considerable review of the literature, an eclectic view of leadership is proposed (supported by the writing of Stodgil, 1950; Pondy, 1978; Greenfield, 1986; Bennis, Parikh and Lessem, 1995; Kotter, 1998 and Kakabadse and Kakabadse, 1999) where leadership is seen in terms of unifying people around values and then constructing the social world for others around those values and helping people get through change.

Leadership Theories

Prior to exploring literature related to clinical leadership, clarification of the many leadership theories was also sought. Many were considered, including The Great Man Theory (Galton, 1896, cited in Morrison 1993), the Big Bang Theory (Grossman and Valiga, 2000), Trait Theory (Yoder-Wise, 1999; Grossman and Valiga, 2000), Style theories (that explore how leaders behave, with leaders being described as either democratic, laissez faire, authoritarian or dictatorial (Northouse, 2004) and the Situational or Contingency Theory (Fielder, 1967; Vroom-Yetton, 1973; House and Mitchell, 1974). Were leadership is viewed as the ability to adapt the leadership approach to complement the issue being faced or to determine the appropriate action based on the people involved and the prevailing situation (Adair, 1998).

Downton (1973), Burns (1978), and Bass (1985; 1990) described the Transformational theory of leadership, which appears to be strongly associated with nursing leadership approaches (Finlay, 1998; Bowles and Bowles, 2000; Welford, 2002 and Thyer 2003). Transformational leadership grew from an attempt to tease out the distinctions between management (associated with

Transactional leadership) and leadership (associated with Transformational leadership) (Bass, 1985; 1990). Transformational leaders are described as being connected to a process of attending to the needs of the followers, so that the interaction of each raises the motivation and energy of the other. It is about challenging the status quo, creating a vision and sharing that vision, so that the leader establishes a powerful vision, gains support for their vision and are consistently and persistently driven to maintaining momentum and empowering others (Kakabadse and Kakabadse, 1999).

Bhindi and Duignan (1997) and George (2003) describe an emerging theory, 'Authentic Leadership', where leaders are guided by 'qualities of the heart, by passion, compassion' and lead 'with purpose, meaning and values' (George, 2003, p. 12). All these theories where considered in relation to the literature about leadership and nursing, before embarking upon the research outlined below.

AIM OF THE RESEARCH - RESEARCH QUESTIONS

After considerable preparatory work and the literature review, the research questions that emerged were:

- Who are the clinical leaders?
- Why are they seen as clinical leaders?
- What are their experiences of clinical leadership?

In order to address these questions, an aim and a number of objectives were developed.

Aim:
To identify who the clinical leaders are in a large NHS Trust in the English Midlands and to explore and critically analyse the experience of being a clinical nurse leader.

Objectives:
The research had five significant objectives. These were:

- To identify who the clinical leaders are.
- To examine the qualities and characteristics of clinical nurse leaders.
- To investigate the rationale behind the nomination of clinical nurse leaders.
- To enquire into and critically analyse the experience of being a clinical nurse leader.
- To explore and critically analyse the concepts of leadership and clinical nurse leadership

RESEARCH DESIGN

The methodology employed in this study was fundamentally qualitative in nature, although an eclectic approach towards data collection and analysis was maintained. The two principle methods employed to generate data were a questionnaire and interviews, although casual observations were also made of the four clinical areas involved in the second and third phases of the study. Grounded theory (Glaser and Strauss, 1967; Chenitz and Swanson, 1986; Glaser, 1992; Strauss and Corbin, 1998) was considered the most appropriate approach and became the methodological foundation of the study.

Following the literature review and the selection of an appropriate NHS Trust the study was divided into three phases. The first involved sending a questionnaire to qualified nurses in all the principle patient care areas of the NHS Trust (n = 36 wards/units) although some qualified nursing staff were excluded, including those in midwifery, operating theatres, professional development or senior management/administration.

In total 830 questionnaires were distributed, with 188 being returned (22.6%). The questionnaire distribution was preceded by a pilot study (Stanley, 2004) and staff in the pilot study area (paediatrics) were also excluded from the main study.

The second phase of the study involved interviews with a random selection of qualified nurses in each of four identified clinical areas within the same acute NHS Trust thus far used in the study. The in-depth, semi-structured and focused interviews explored issues related to perceptions of clinical leadership and sought to explore which staff where seen as clinical leaders in these specific clinical areas. The four clinical areas selected included a specialist area (ITU), a general medical ward, a specialist acute medical unit, and a trauma and orthopaedics ward. These areas represented in-patient wards with a range of qualified and unqualified staff and with and without modern matrons. The 42 participants interviewed where randomly selected and included 14 D grade, 17 E grade and 11 F, G, or H grades, including some modern matrons.

The third phase of the research involved identifying two of the clinical leaders nominated by a majority of the participants interviewed in phase two, from each of the four clinical areas, and interviewing them for data about their experience of being a clinical nurse leader.

Ethical Approval

Approval was provided by the Local Research Ethics Committee (LREC) and permission to use the Trust was secured from the senior nursing manager, the head of research and development within the Trust and individual ward managers when interviews with specific clinical nurses took place. All interviews were confidential and participants were assured of their anonymity. Consent forms were used with all interviews and all the data collected was coded and stored in accordance with the UK Data Protection Act (1998).

Limitations and Bias

The limitations and bias of the study were considered to be that:

- It only focused on the views of qualified nurses and nurses in direct patient care areas.
- The study took place in only one NHS Trust (although the Trust was made up of three geographically separate hospitals, each with their own unique sub-cultures).
- The researcher originally worked in the Trust when designing and planning the research (although the researcher resigned and took a post outside the Trust as soon as the research had been approved). The poor questionnaire return rate was a disappointment and could be a limiting factor, but was salvaged by the wider study approach.

RESULTS AND DISCUSSION: THE QUESTIONNAIRE

The questionnaire had a number of specific questions. The first sought to explore the characteristics and qualities that qualified nurses associated with clinical leadership. Respondents were presented with a list of 42 qualities or characteristics drawn from the leadership literature and asked to select the qualities and characteristics they ‘most’ or ‘least’ associated with clinical leadership.

In general, fewer respondents identified the available attributes as being related ‘least’ to clinical leadership. The main qualities and characteristics identified as being ‘most’ or ‘least’ associated with clinical leadership are presented below.

Most:

Approachable (97.3%)	Clinically Competent (95.2%)	Motivator (94.1%)
Supportive (94.1%)	Inspires Confidence (93.0%)	Copes well with Change (90.9%)
Flexibility (90.4%)	Sets direction (89.3%)	Directing and Helping (88.8%)
Integrity (82.2%)		

Least:

Controlling (78.1%)	Artistic (65.9%)	Conservative (62.2%)
Routine (57.4%)	Calculator (47.3%)	Reward/punishment (39.3%)
Administrator (33.5%)	Regulator (32.4%)	Aligns people (27.1%),
Maintenance (25.0%).		

A number (n = 85) of other qualities or characteristics associated with clinical leadership were added by respondents. These included suggestions that clinical leaders have current clinical practice skills e.g. 'do the same thing as the staff they lead' and 'mucks in and works on all levels'. Many related to interpersonal and communication skills or attitudes appropriate for a clinical leader, e.g. 'good listener', 'hard working', 'understanding', 'honest' and 'reliable'. Some related to the clinical leader's relationship to their team or other health care workers e.g. 'ability to unite a team/group' and 'looks out for the best interests of the team', and some related to the caring aspects of the clinical leaders role e.g. 'puts patient care first', 'compassion' and 'caring'.

The questionnaire also explored the issue of who the clinical leader(s) were in each clinical area. This produced 326 nominations for clinical leaders with some nominations for doctors or medical consultants and one for a pharmacist, with the total non-nurse related nominations being 9.2%. The remaining 90.8% of the nominations were for either, F grade junior sisters (21.7%), nurse managers (15%), E grade staff nurses (14.1%), G grade sisters (13.8%), modern matrons (12.5%), and specialist nurses, at either F, G, or H grade (8.8%). There were also a small number of nominations for D grade staff nurses, health care assistants or nursing auxiliaries, a lecturer practitioner and the head of a specific nursing department. Results indicated that in keeping with the pilot study results (Stanley, 2004) F grade junior sisters received the most nominations in both general and specialist clinical areas.

Respondents were also questioned about why they nominated specific individuals, with most either repeating key words from the list of 42 words presented or made statements such as, 'because she is enthusiastic, motivated, very knowledgeable, supportive, encouraging and very kind'. 'Puts patient care first', is 'a senior member of staff who is very involved in the clinical side of nursing' or 'they are all knowledgeable, caring people prepared to stand up for their beliefs even if this is not the popular option'.

RESULTS: THE PHASE TWO AND THREE INTERVIEWS - CLINICAL LEADERSHIP EXPLORED

Data analysis began with the transcription of each interview. Initially each interview transcript was re-read and notes made about the broad categories and key elements. A journal was used to record any significant comments or themes from each interview. These were explored and developed further with subsequent interviews. Data analysis continued when all 42 interviews were reviewed and copied into a Computer-Assisted Qualitative Data Analysis Software (CAQDAS) programme, in this case NVivo 2.0. The principle categories that emerged from the phase two data were leadership issues and clinical leadership characteristics. While in the phase three data the main themes focused on the centrality of care to clinical leader's role, the clinical leadership role and qualities, leadership insight, and challenges faced.

Leadership Issues

One of the central aims of the interviews was to explore the participant's understanding of the attributes and qualities that make good or, indeed, poor leaders. Many participants considered it a leader's responsibility to empower people to perform better. One participant said, 'it's about getting the best out of people'. Most participants described leaders as guides and teachers, indicating that they should be open, approachable and get people to feel part of a team. Many suggested that leaders should provide support, motivate and be individuals they could look up to or admire. Leaders held a central role in the clinical area and were described as having drive or being assertive. Effective leaders were also described as taking responsibility, communicating well, having sound knowledge, being inspirational and were considered to be, 'really approachable…really looked out for you'.

Many participants (n = 34 / 80.9%) made reference to what they saw as poor leadership qualities and characteristics, with poor leaders being identified as gossiping or moody, not listening, lazy, having a dictatorial attitude, no sense of humour, bullying, being unapproachable, showing favouritism towards particular colleagues. In an effort to further understand leadership, participants were asked to describe what they saw as the difference between leadership and management. Every participant provided a perspective on this, with the consensus being that managers tended to

depend on their position, title and hierarchical status, while leaders depended upon their ability to inspire and motivate people while relying on their knowledge and experience.

Clinical Leadership Attributes

The characteristics and qualities associated with clinical leadership were identified in the course of the interviews. The attributes strongly associated with clinical leadership were:

Clinical Competence: Related to remaining credible and competent, linked to clinical experience and the confidence others saw in the clinical leaders' ability. It meant being able to show, or to do, as well as know or teach others about clinical issues.

Clinical Knowledge: Identified by 40 participants (95.2%) who indicated that knowledge of nursing and in particular knowledge that related to a specific area of practice was vital. This was extended into knowing not just about clinical issues, but knowing about teamwork, how individuals worked and of interpersonal relationships. 'You've got to be knowledgeable, but you've also got to have knowledge that's applicable to the area that you work in'

Effective Communication: All the participants indicated that this was a central attribute of clinical leadership. Clinical leaders were respected if they listened and effective communication was seen as elemental if clinical leaders who were not managers or titled leaders were to influence their colleagues.

Decision Maker: Many participants (69%) suggested that decision-making, not just in relation to patient care or clinical issues, but in regard to a whole host of issues was central to clinical leadership. Allied to effective decision-making was the ability to delegate and problem-solve.

Openness/Approachable: In keeping with the questionnaire findings, all of the participants indicated that approachability and openness were seen as desirable characteristics and qualities of clinical leaders. Many participants looked for clinical leaders who, 'valued them', were 'approachable, friendly and understanding', or who were 'open, caring, 'knowledgeable, fair, tranquil, calm, kept secrets', or who 'you could talk to about anything'.

Role Model: Clinical leaders were identifiable because, unlike mangers, they were viewed by participants as role models. Clinical leaders had their standards of care on show and other nurses indicated that it was the ability of a nurse to care effectively for their patients that made them stand out as clinical leaders.

Visible: Thirty two (76.2%) participants indicated that clinical leaders needed to be visible, available and present. Visibility meant that clinical leaders were present in the clinical area, and that they were engaged and involved in the clinical activity. Not being visible, or being unable to be involved in patient care activity was seen by some participants to place them in a difficult position, or one that weakened their clinical leadership potential. One participant said: 'she is an ideal clinical leader because she is very visible'

Empowerment/Motivator: Many (95.2%) participants identified effective clinical leadership with being enthusiastic, able to make colleagues feel confident, supported and encourage. It was also seen to be about empowering people to perform better, sowing a seed somewhere and letting others take the lead. One participant said: 'Belief in what you're doing…because I know people who are higher, at a higher level than me are not necessarily good leaders…there not…they don't necessarily have any belief in what they're doing.

Clinical leaders were identifiable because a significant part of their role involved engaging directly in patient care. Any post or role that limited contact with or relationships with patients or clients would limit their ability to act out, or live out their values or beliefs and limit others ability to recognise them as clinical leaders. It was apparent that the values and principles a clinical leader displayed were a prominent aspect in their identification and the values and beliefs a clinical leader had on show were a key factor in their being recognised as a clinical leader. Describing clinical

leaders, one participant said, 'they've really got this passion and belief about what they do and why they are here'.

Significantly, clinical nurse leaders 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. Leaders who control and manage from within offices or who fail to display their values and beliefs in congruence with their actions were rarely seen as clinical leaders.

Clinical Leaders Role / Focus on care

Clinical leaders described the majority of their role as being related to the delivery of 'hands on' patient care. With two G grade ward managers indicated that their focus was clearly a balance between their management and clinical responsibilities. One commented that she was, 'desperately, trying to keep as hands on as possible' by taking management work home or delegating part of it to other staff. They described themselves as being driven by their, 'beliefs about patient care' and they all spoke of their desire to apply and display high quality care.

Clinical Leadership Qualities

Participants were asked why they thought they had been nominated as clinical leaders and without exception and in keeping with the questionnaire and phase 2 interview results, participants indicated that it was because they had sound clinical knowledge or a degree of clinical expertise, because they acted as role models for the provision of nursing care, were good communicators, approachable and visible in the clinical area and empowered.

Leadership insight

In an effort to understand the clinical leader's experience, a number of questions were asked that sought to discover the participant's insight and understanding of leadership. Only three participants had engaged in formal or structured education about leadership and all the participants (including the three participants who had an opportunity to 'study' leadership) felt that although the courses had been 'valuable' much of what they had learnt about clinical leadership was unrelated to their 'training' and had come from experience.

Challenges

Another avenue for understanding clinical leadership related to the challenges clinical leaders faced. Two sub-categories emerged that were common to the clinical leaders interviewed. These were juggling everything / conflict and maintaining morale.

Clinical leaders appeared to be preoccupied with balancing their clinical and managerial responsibilities. 'Juggling everything' appeared to be a common and constant issue. 'I see myself as having two priorities. One is the patients' obviously, that's what we're here for and my second is my staff…if there is a conflict between staff requirements and patient requirements, the patient requirements come first. Conflict existed because management responsibilities were also seen to diminish their effectiveness as clinical leaders, 'the more management responsibility you've got the less you are visible in the clinical area…there is only so much you can do.'

The second sub-category related to difficulties with, 'keeping the morale of everybody high' and keeping staff motivated so that the patients continued to receive the best care. Clinical leaders commonly found themselves caught in the middle, between their managerial and their staff and patient responsibilities.

Clinical leaders spoke passionately about their high standards of care, their affinity for patient care and their recognition that keeping morale high and their colleagues motivated was one way that they could positively influence the provision of nursing care. All those interviewed discussed the centrality of care to their role and their passion for 'hands on' nursing. Their practice and function

as clinical leaders appeared to be built on a foundation of values and beliefs, structured around their relationship with patients and the care they received.

CONGRUENT LEADERSHIP

A result of the study was the development of the new theory of Congruent 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 clinical leaders function.

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.

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

Followers are attracted to Congruent Leaders because of the metaphorical 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 its like,' or I'm on your side'.

Clinical leaders who display Congruent Leadership match their values and beliefs to their actions. If nursing is to develop effective nursing leaders, it needs to do so without loosing 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. Transformational leaders, in an effort to achieve their vision or goals, can at times, move from positions of influence and power to positions of control. Unwittingly, in doing so, they run the risk of loosing 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 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, p.38) 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.'

CONCLUSION

This research has added greater depth to the nursing professions understanding of clinical leadership and indicators have been found that point toward 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 ads 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 and their ability to recognise empowerment within them selves contributes to the implementation of Congruent Leadership. Therefore, if recognised, demonstrated and established, Congruent Leadership can become a firm foundation on which to bolster leadership and develop empowerment within individual nurses and the nursing profession.

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