Title: Leadership and emotional intelligence in nursing and midwifery education and

practice: a discussion paper

Running Head: Leadership and Emotional Intelligence.

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ABSTRACT

Aim: A discussion of the concepts of leadership and emotional intelligence in nursing and midwifery education and practice.

Background: The need for emotionally intelligent leadership in the health professions is acknowledged internationally throughout the nursing and midwifery literature. The concepts of emotional intelligence and emotional-social intelligence have emerged as important factors for effective leadership in the health care professions and require further exploration and discussion. This paper will explore these concepts and discuss their importance in the healthcare setting with reference to current practices in the United Kingdom, Ireland and internationally.

Design: Discussion paper.

Data sources: A search of published evidence from 1990 - 2015 using key words (as outlined below) was undertaken from which relevant sources were selected to build an informed discussion.

Implications for Nursing/Midwifery: Fostering emotionally intelligent leadership in nursing and midwifery supports the provision of high quality and compassionate care. Globally, leadership has important implications for all stakeholders in the healthcare professions with responsibility for maintaining high standards of care. This includes all grades of nurses and midwives, students entering the professions, managerial staff, academics and policy makers.

Conclusion: This paper discusses the conceptual models of leadership and emotional intelligence and demonstrates an important link between the two. Further robust studies are required for ongoing evaluation of the different models of emotional intelligence and their

link with effective leadership behaviour in the health care field internationally. This is of particular significance for professional undergraduate education to promote ongoing compassionate, safe and high quality standards of care.

SUMMARY STATEMENT

Why is this review needed?

- The importance of the promotion of caring and compassionate leadership in the health services has been emphasized in national and international literature in recent years.

- Emotional intelligence is viewed as a range of abilities/traits that determine how well we relate with ourselves and others in everyday demands and pressures and has been linked to effective leadership behaviour.

- It is crucial and timely to explore how effective and emotionally intelligent leadership behaviour is fostered in nursing and midwifery education and practice to promote high standards of compassionate care.

What are the key findings?

- There is an important link between effective leadership and emotional intelligence.

- Both the Congruent and Authentic theories of leadership are suited to the clinical disciplines of nursing and midwifery and are closely aligned to the models of emotional intelligence.

- The personal qualities required for emotionally intelligent leadership can be learned and nurtured.

How should the findings be used to influence policy/practice/research/education?

- The integration of emotional intelligence and leadership skills is recommended both for undergraduate and continuing education in the nursing and midwifery professions to promote effective, caring and compassionate leadership.

- Further robust studies are required for ongoing evaluation of the different models of emotional intelligence and their link with effective leadership behaviour in the health care field.

INTRODUCTION

The need for emotionally intelligent and effective leadership in the health professions is acknowledged throughout the nursing and midwifery literature internationally (Akerjordet & Severinsson 2010, Collinson 2006, Marquis and Huston 2006, Scheck McAlearney 2006). Collinson (2006) established a direct link between effective leadership behaviour and the successful performance of an organisation. This demonstrates the importance of leadership in any setting, particularly health care, where performance is linked to the provision of quality standards of care for service users. A recent systematic review emphasises this point in demonstrating how effective leadership enhanced positive outcomes for service users in health care (Wong *et al.* 2013). Globally then leadership has important implications for all stakeholders in health care disciplines with responsibility for maintaining high standards of care. This includes all grades of nurses and midwives, students entering the professions, managerial staff, academics and policy makers (Hartley & Benington 2011, Squires *et al.* 2010, Department of Health 2012).

There are many theories of leadership in the national and international literature but their relevance to nursing and midwifery has been questioned due to a lack of research specific to

the health care setting (Stanley 2006a, 2006b, Halligan 2008). This makes it difficult to determine what exactly makes for effective leadership in the health care professions (Stanley 2008, Halligan 2010). The concepts of emotional intelligence (EI) and emotional-social intelligence (ESI) have emerged as important factors for consideration in relation to leadership in the health-care professions (Bar-On 2002, 2006, Akerjordet and Severinsson 2008). Although these concepts are viewed as discrete it is generally accepted that EI has some co-relation with social intelligence so the term EI will be used throughout this paper to portray both (Ashkanasy and Daus 2005).

EI has been variously described in the literature as an ability, a trait, or a blend of both (Austin *et al.* 2004, Snowden *et al.* 2015). As a concept it has been difficult to define and articulate due to differing perspectives (Foster *et al.* 2014). Based on the trait model Bar-On (2002, p.31) defined EI as 'a multi-factorial array of emotional and social competencies that determine how effectively we relate with ourselves and others and cope with daily demands and pressures'. Sadri (2012) asserted that EI is one of the primary elements of effective leadership. These competencies are acknowledged as being particularly significant for effective leadership in the health care professions and require further exploration (Benson *et al.* 2012). The aim of this paper then is to present a discussion on the concepts of leadership and EI and to make recommendations for their future integration into nursing and midwifery education and practice.

Background

What is leadership?

There are many definitions of leadership in the international literature with several different theories presented across many disciplines (Howieson and Thiagarajah 2011). Armstrong (2009, p.4) defines leadership as: 'the process of getting people to do their best to achieve a

desired result. It involves developing and communicating a vision for the future, motivating people and gaining their engagement.' (Armstrong 2009, p.4).

This definition highlights leadership as a process rather than a 'thing' to be possessed. This emphasis is in keeping with Wood (2005) who rejects leadership theories that focus on either individual traits or transactions, arguing instead for a more ontological view that recognizes the process of leadership. This ontological emphasis intimates that leadership is a fluid, dynamic process. It is not static but emerging and evolving over time and is not dependent on individual characteristics or transactions (Wood 2005). The appeal of this view is that leadership as a social construct can be supported and developed rather than being reliant on the characteristics of an individual. In other words, contrary to the traditional trait theories of leadership, leaders are not just born, they can also be made (Gentry *et al.* 2012). This belief has implications for all health care professionals and is of particular significance for nursing and midwifery education as it indicates that as a process leadership can be learned and nurtured rather than being something innate in an individual (Watson 2005, Foster *et al.* 2015, Snowden *et al.* 2015).

Why is leadership important?

The value of effective leadership in promoting quality standards of nursing/midwifery care is unquestionable but is sometimes only noted when it is absent as recognized in national and international reports into poor standards of care published in recent years. For example; the Francis report in the UK (Francis 2013) highlighted serious incidents of deficient standards of care in separate National Health Service (NHS) Hospital Trusts with poor nursing leadership cited as a major contributing factor. Inquiries into failings in maternity services in both the UK and Ireland have also cited poor leadership as a key factor in both the provision of poor quality care for women and their babies as well as a lack of development in the profession (The King's Fund 2008, CMACE, 2011, NMC LSA reports 2011-12, HIQA 2013, HSE 2013,

2014, Knight *et al.* 2014, Kirkup 2015). In some of these inquiries poor leadership is cited as a primary contributing factor leading to maternal or perinatal death (HSE 2013, 2014, Knight et al. 2014, HIQA 2013, CMACE, 2011, Kirkup 2015). Inadequate standards of care are cited across the international nursing and midwifery literature also and this issue has been linked to staff shortages, poor skill-mix, lack of caring and compassion among staff as well as incompetent leadership (Institute of Medicine (US) 2002, Wakefield 2008, Australian Nursing Federation 2009, Ball *et al*. 2014, Dawson *et al.* 2014, Hanafin and O'Reilly 2016).

Many critics have debated the findings of these reports into unsafe practice, arguing that the reasons for failings in care provision are complex and multi-factorial and the recommendations made are too simplistic to effect change (Paley 2014, Ploug Hansen 2014, Shaw 2014, Traynor 2014). Despite this debate the recommendations made in these reports have implications for all health care providers and stakeholders globally with the aim of maintaining quality standards of care and preventing future harm to service users (Shawn Kennedy 2014). These recommendations have specific interest for educationalists in the professions as fostering of a questioning disposition as well as the development of EI attributes in nursing and midwifery students may help avoid widespread participation in thoughtless and uncaring practices (Roberts & Ion 2015, Benson *et al.* 2012)

It is important then to explore how effective emotionally intelligent leadership behaviour is fostered in undergraduate education for health care professionals. This includes a consideration of the relevant leadership theories and how they fit with the different models of EI as well as their implications for nursing and midwifery education and practice (Curtis *et al.* 2011a, Benson *et al.* 2012).

Data sources

To inform this discussion a general keyword search was undertaken to locate appropriate literature from 1990 - 2015. The keywords used included: 'leader', 'leadership', 'emotional intelligence' 'emotional and social intelligence' and 'nursing' 'midwifery'. The aim of the search was to identify relevant sources to develop a discussion rather than undertake a comprehensive and exhaustive search. Using an iterative process databases were searched including: Academic Search Complete, Business Source Complete, CINAHL, DARE, Embase, Maternity and Infant care, MEDLINE, Google scholar, ProQuest and Teacher Reference Center.

Relevant websites, government papers and conference papers were also searched for 'grey' literature of relevance (Lefebvre *et al.* 2011, Gough *et al.* 2013). Citation searching (snowballing) and searching of management/leadership focused journals was also undertaken to ensure articles of specific interest were included (Borrego *et al.* 2014). A summary of the main sources of evidence used for the following discussion are listed in a supplementary online file as per guidelines from Kable *et al.* (2012).

DISCUSSION

Leadership theories

There is extensive literature on leadership theories across all disciplines. These may be categorized as trait, behavioural, contingency, relational and new leadership theories (Halligan 2010, Bolden *et al*. 2003) (Table 1). The early leadership theories, like trait and behavioural, emphasize the characteristics and/or behaviour of the individual as opposed to the process. These theories conform to the 'leaders are born' philosophy (Spector 2006, Curtis *et al.* 2011a). In contrast, contingency and relational theories focus more on the relationship and/or transaction between leaders and their followers with a stronger suggestion

that leaders can be made (Spector 2006, Curtis *et al.* 2011a). The contingency and relational theories, In particular, transformational theories, appear to have more relevance for nursing and midwifery as they acknowledge the relationships between those involved in the leadership process (Welford 2002, Thyer 2003, Carney 2006, Sullivan and Garland, 2010, Harms and Crede 2010). Despite the popularity of traditional leadership theories few have been fully evaluated in the healthcare field (Yukl 2006, Harms and Crede 2010). In research undertaken by Stanley (2006 a,b,c) findings suggested that these theories did not fully articulate the attributes, characteristics and qualities necessary for effective leadership in clinical disciplines like nursing and midwifery. The emerging congruent and authentic theories however are closely aligned to the attributes of EI and are purported to be appropriate for clinical healthcare disciplines.

The theories of congruent and authentic leadership

The theory of congruent leadership is based on research studies undertaken in the clinical area by Stanley (2008). This theory focuses on leaders who 'respond to challenges and critical problems with actions and activities in accordance with (congruent with) their values and beliefs' (Stanley 2008, p.523). Although the congruent model recognizes the process of leadership it also distinguishes specific attributes said to make for an effective clinical leader. These include the following which fit in with the qualities of EI and are of significance for professional education: being an effective communicator, decision-maker, motivator, being open, approachable, being visible and acting as a good role model. It could be argued that this research is limited specifically to leaders in the clinical environment as this is where the research was undertaken. However the above attributes include those commonly associated with effective leadership across all disciplines and environments (George 2000). Joyce (2009) demonstrated similar results in research using case study methodology comparing effective

leadership in education and healthcare. These findings emphasized the context of the setting, suggesting that one style of leadership does not fit all.

Another emerging theory of interest is that of authentic leadership which incorporates many of the positive attributes of EI as well as promoting the concept of collaboration and a shared vision (Avolio *et al.* 2004, Avolio and Gardner 2005).This theory emphasizes the importance of being true to oneself rather than creating a false persona as a leader (Sparrowe 2005). Authentic leaders through increased self-awareness, self- governance and positive mentoring, foster the development of authenticity in followers (Ilies *et al.* 2005). This in turn contributes to sustainable positive results for the organization as well as enhanced well- being for all involved (Avolio *et al*. 2004).

May *et al.* (2003) emphasize the ethical/moral component of authentic leadership which would be of great significance for the health care disciplines following the Francis report (2013) and other international publications as discussed and also fits well with the image of EI (Sadri 2012). However, following an integrative review Akerjordet and Severinsson (2010) argue that EI does not necessarily make one an ethical person as these attributes can be used for anti-social as well as social reasons. Kristjansson (2006) makes a similar point suggesting that the moral influence in the EI model is vague and tends to promote competency and achievement rather than moral values and compassion. Rankin (2013) found a link between EI, positive moral values and compassionate care in a longitudinal study undertaken with first year undergraduate nursing and midwifery students. These studies recommend further evidence based knowledge and critical reflection around EI and leadership when relating the concepts into professional research, education and practical settings. This is an important consideration for introducing EI and leadership skills into nursing/midwifery education.

Similarly, Cooper *et al.* (2005) stress the importance of defining, measuring and researching the key constructs of authentic leadership to ensure a balanced and empirical evaluation before embarking on authentic leadership development programmes. It is argued that the attributes and constructs under scrutiny in this type of research are difficult to pin down, for example how does one measure self-awareness and authenticity? Cooper *et al.* (2005) suggest various research methodologies and strategies that may be of use but also question whether indeed an authentic leader can be developed or is authenticity an innate attribute? How does one measure these complex concepts and how valid and reliable are the instruments used? This is an area of concern for those researching EI also (Conte 2005, Benson *et al.* 2012, Sadri 2012).

Are leaders born or made?

Leadership theories demonstrate considerable differences of opinion on whether leaders are born or made. In particular the emphasis on traits suggest that these are innate and in the individual from birth. However Conger (2004) argues that leaders are both born as well as made in that our predetermined genes and our life experiences together can promote effective emotionally intelligent leadership behaviour. Conversely even someone who has natural leadership ability may prefer to take a back seat and choose a less demanding role than that of the leader. Conger (2004) proposes three early life forces that may influence the development of leadership capabilities. Firstly, baseline traits necessary for effective leadership, secondly, the drive to become a leader and finally, the influences in the arena (field or profession) where the individual is based. Later life influences were also seen as crucial suggesting that the ongoing development of leadership skills is necessary (Feather 2008). Despite this Conger (2004) argued that most managers felt that formal education or training did not enhance the development of their leadership skills. Contrary to this, research findings across different disciplines including nursing, have demonstrated that strategic leadership training

specific to individuals and situations does work well if integrated effectively into an organisation (Fulmer and Conger 2003, Fulmer and Bleak 2007, MacPhee et al 2012).

Raelin (2004) argues that leadership training as it stands in most organizations is deeply flawed and recommends instead a model of work based learning. This model recognizes that the workplace offers as many opportunities for learning as the classroom, but this must be accompanied with structured reflection on work practices. Raelin (2004, p.135) further suggests that this type of leadership (or 'leaderful') development can 'release the leadership potential in everyone'. This 'leaderful' practice is based on four critical tenets that Raelin refers to as 'the four c's': collective, concurrent, collaborative and compassionate. In this style of leadership any or every member of the team can be the leader, all members are respected and everybody helps out to achieve the work of the team. This reflects the key perceptions around EI also (Momeni 2009, George 2000). These views reinforce the theory that leaders may be born but can also be made and ongoing nurturing of leadership and EI skills is essential even for those naturally inclined to be leaders (Sadri 2012, Foster *et al.* 2014). The important aspect is that leadership (or 'leaderful') development is undertaken in a supportive and compassionate work-based environment to nurture the key attributes necessary for EI. The introduction of the concept of 'self leadership' in the very early stages of undergraduate education is promoted by Rosser (2014, p.952) to empower all practitioners in the development of individual leadership skills rather than focusing on the 'exceptional individual' or 'charismatic extrovert'. This would strongly endorse the introduction of structured and supportive preparation and experience in EI and leadership skills early on in the undergraduate professional curriculum and this should include appropriate feedback for all the students involved (Johnson 2014, Rosser 2014)..

Personal qualities and values are viewed as the pivotal theme in many leadership skills frameworks for educating healthcare staff (NHS Leadership Academy 2011, Casey *et al.* 2011, University College Dublin/HSE 2012). These include self-awareness, the ability to manage oneself, a desire for personal and professional development and personal integrity, which closely reflect the attributes of EI. The emphasis on personal qualities in leadership frameworks emphasizes the 'trait' models of leadership and EI. It is argued however, that this does not mean these qualities are innate. Rather, the focus should be on the support and development of these qualities in the individual through strategic training. This focus leads to a 'patient-centred leadership' style which enhances standards of care and patient safety Hiscock and Shuldham (2008 p.903).

The importance placed on personal integrity in leadership frameworks is crucial in the health care disciplines. The tenets of self-belief, self-awareness and the empowerment of self and others are closely aligned to effective leadership and emotional intelligence (May *et al.* 2003, Avolio *et al.* 2005, Sparrow *et al.* 2005, Stanley 2014).

Models of EI and Leadership

There are three popular models of EI in the literature and they describe EI as being either ability- based (Mayer, Salovey and Caruso 2000), trait- based (Bar-On 2002, 2006) or a combination of both- a mixed model (Goleman 1995, 1998) (see table 2). Although all these models are popular in leadership development programmes there are many debates about their use. Sadri (2005) suggested that the Mayer- Salovey-Caruso model of EI has been accepted by the academic community as it is based on abilities which are measurable. This seminal 'four branch' model outlined four levels of emotional abilities: perception of emotion in self and others; assimilation of emotion to facilitate thought; understanding of emotion and managing and regulating emotion in self and others (Mayer *et al.* 2000, 2004).

The trait and combination models of EI have been adopted by the non-academic community and are used extensively for leadership development programmes (Sadri 2012). The Goleman mixed model (1995, 1998) consists of five skill domains, three of which relate to personal effectiveness and two of which relate to social competence, thus blending traits and abilities. The personal competencies include self-awareness, self-regulation and motivation whilst the social competencies incorporate empathy and social skills. All these competencies have been cited as essential for effective leadership (Health Workforce Australia 2012) but the Goleman model has been criticized for an over-reliance on traits, which it is argued cannot be altered and are difficult to measure with validity (Conte 2005). The Bar-On model (2002, 2006) emphasizes EI as an aspect of personality with a focus on traits thus attracting similar criticism. Daus and Ashkanasy (2003) argue that whilst these models may be useful for the development of an organization they are too general and may be likened to conventional personality models.

The debate in the EI literature focuses on the difficulties in defining the concepts and differentiating between emotional intelligence and personality (Landy 2005, Locke 2005). Ashkanasy & Daus (2005) argue that emotional intelligence is separate to other intelligences, like social intelligence, but accept that there is a positive co-relation between the two. Locke goes further to suggest that there is no such thing as EI although intelligence can be applied to emotions in a reasoned way. In relation to leadership Locke (2005, p.429) dismissed the link altogether stating that rationality and 'actual intelligence' are of more significance than EI for effective leadership. This statement may be more suited to less 'caring' business-focused environments since EI and the presence of caring and compassionate leadership skills are viewed as essential for nurses and midwives (Hornett 2012, Francis 2013, Snowden *et al.* 2015). There is limited data available in relation to how EI may influence traditionally held ideas of academic intelligence. However Codier & Odell (2014) demonstrated a positive link

between academic performance and EI in first year student nurses, calling for further research in this area with a consideration of work place performance also.

The research methods used in EI have been criticized in the literature (Landy 2005, Locke 2005). Conte (2005) argued that because EI has been defined in so many different ways it is too vague to be measured effectively. In addition there seems little difference between the instruments used and typical personality tests which lack scientific validity (Foster *et al.* 2015). The main difficulty with the measurement tools used to assess EI is that they are based on self -reporting which may affect their validity (Conte 2005, Codier *et al.* 2010). The measurement of variables in the concept are also reported to lack validity and reliability with Landy (2005) suggesting that researchers in this field need to pay more attention to their choice of dependent variables. Ashkanasy and Daus (2005), whilst agreeing with some of the criticism levelled at EI models and research, argue that EI is a valid concept and will continue to play an important role in organizational behaviour including leadership. They recommend the ability model of EI as a suitable focus for researchers in the future. Conte (2005) concurs with this view suggesting that the ability model has more potential for valid measurement than the other models used. Roberts *et al.* (2010) urge researchers interested in EI to consider conducting a robust focused study in this area to help resolve the issues identified. This needs careful consideration for those interested in exploring the concept for nursing and midwifery education or practice.

Implications for nursing and midwifery

Despite the debate in the EI literature around its worth the concept has become popular among nursing (Duygulu *et al*. 2011, Foster *et al*. 2015) and midwifery disciplines (Gould 2003, Patterson & Begley 2011) particularly in relation to the development of leadership qualities. There are calls for EI to be incorporated into all undergraduate programmes with

proposals for testing of these concepts prior to entry into the 'caring' professions (Patterson & Begley 2011, Benson *et al.* 2012, Foster *et al.* 2015). Snowden *et al.* (2015) present a convincing argument to support EI in nursing and midwifery disciplines. They argue that the concept of EI should be defined depending on the model used. The measurement of the concept is then undertaken in congruence with the chosen model and this supports validity (Qualter *et al.* 2010, Snowden *et al.* 2015). In a literature review into EI in midwifery practice Patterson & Begley (2011) emphasize the need for midwives to become more emotionally intelligent to manage work related stressors and develop effective relationships with colleagues and women. To this end it is recommended that specific strategies are put in place for pre-registration curricula to strengthen EI learning.

Additional studies in nursing and midwifery also recommend that a specific emphasis on developing EI is required in undergraduate professional curricula to help enhance the leadership skills of student nurses/midwives on graduation (Codier *et al.* 2010, Duygulu *et al.* 2011, Benson *et al.* 2012, Foster *et al.* 2015, Snowden *et al.* 2015). Benson *et al.* (2012) measured levels of EI, leadership skills and caring in student nurses for the duration of their undergraduate education programme. Findings demonstrated little change in EI scores for the students over the course of their professional education. Following on from these results the researchers recommend specific interventions to support EI development especially for those students with low EI scores.

Despite the criticisms of the trait models of EI they are frequently used in nursing/midwifery research. Duygulu *et al.* (2011) used the Bar-On model to assess nursing students' leadership and emotional intelligence. The findings demonstrated that the students were more concerned with task oriented than people oriented leadership behaviours. The authors recommended further research in this area and assert that more needs to be done in undergraduate education

to support students in the development of specific EI and leadership skills. Codier *et al.* (2010) also chose to use the trait model for their mixed methodology narrative study exploring the evidence of EI attributes in nurses. Despite the limitations of the model used the researchers argued that it was the best fit in relation to the methodology of the study. This concurs with Snowden *et al.* (2015) in asserting that the model used should fit with the context of the study. Findings from Codier *et al.* (2010) suggest that EI is an important concept in nursing and again recommended further research to determine which model is most appropriate to use.

Snowden *et al.* (2015) used a mixed model for their longitudinal study assessing EI in student nurses. Their findings demonstrated that, despite assertions to the contrary, prior caring experience did not heighten EI in the participants. Rather, specific initiatives to support the development of EI, for example; mindfulness training, was recommended throughout undergraduate education. Despite some limitations the findings of this study were strengthened through the use of a mixed model so that both abilities and traits were defined and measured. The different interpretations of EI were viewed as positive rather than negative in that the assessment of both traits and abilities was perceived as a more holistic approach. In conclusion Snowden *et al.* (2015) emphasized the importance of EI in developing caring and compassionate nursing leaders prevent further failings in the health services as with the aforementioned Francis report.

 Following a recent integrative review of the literature Foster *et al.* (2015) found that a range of EI constructs were used in nursing disciplines with a reliance on the trait-based models. A range of strategies were used to measure students EI skills but these were not always clearly articulated and often lacked validity due to the reasons already outlined. This review supports the opinion that EI can be developed through ongoing education and support of the student

and this will enhance social, interpersonal and leadership skills. As recommended by Benson *et al.* (2012) strategies for EI education in pre-registration curricula were highlighted in an integrative review by Foster *et al.* (2015). These included EI self-assessment, reflection activities, modelling of EI behaviours and development of empathy. Other studies reviewed demonstrated positive findings through experiential learning strategies, personal development and peer mentoring (Foster *et al.* 2015). It is recommended that a wide range of strategies as above known to support EI should be integrated into undergraduate curricula. It is also argued that as EI and leadership skills can decline over time they should be offered to all qualified nursing and midwifery staff on an on-going basis as part of professional development (Foster *et al*. 2015). to enhance EI in nursing and midwifery education Foster *et al.* (2015) recommend an ability-based model for curricula and learning and teaching approaches.

As previously indicated a positive link between academic performance and EI in first year student nurses has been demonstrated in a research study by Codier & Odell (2014). These researchers argue that how the student performs in nursing school and in the workplace after graduation are both important indicators of student success. Achievement in both practice placements and the academic Institution is essential for the development of competent, caring and knowledgeable practitioners.

Similarly Fernandez *et al*. (2012) explored the relationship between trait emotional intelligence and learning strategies and their impact on academic performance among first-year nursing students. Using a prospective survey design on a sample size of 81 first year nursing students emotional intelligence was measured using the adapted version of the 144-item Trait Emotional Intelligence Questionnaire. In addition the grade point average (GPA) score obtained at the end of six months was used to measure academic achievement. Findings from this study demonstrated that emotional intelligence was a significant predictor of

academic achievement. The researchers suggest that higher levels of EI may have an impact on students motivation to succeed and do well (Fernandez *et al*. 2012). As with recommendations from other studies it is suggested that the skills for EI are an essential component of undergraduate curricula.

The belief that EI leadership skills can be learned is an important point for the quality of nursing and midwifery services and education (Cummings *et al.* 2008, Curtis *et al.* 2011a,b, Duygulu *et al.* 2011). Following a systematic review in this area Cummings *et al.* (2008) identified that leadership can be nurtured through focused education strategies and by modelling and practicing leadership competencies. However it is argued that the research in this area is not particularly robust and there is a need for further high quality evidence to inform practice for the future (Cummings *et al.* 2008).From the perspective of nursing and midwifery education if EI leadership is a process that can be learned it will mean there is potential for all students to develop these skills with appropriate education strategies and support. The overall emphasis on personal qualities and values in both the leadership and EI literature demonstrate the important link between the two concepts which should be further researched and fostered in nursing and midwifery disciplines to promote a caring, compassionate and questioning culture in healthcare.

Conclusion

The professions of nursing and midwifery globally are facing serious challenges with difficulties in recruitment and retention, staff shortages, poor skill mix as well as reports of poor standards of care and lack of compassion. This discussion paper highlights the need for effective and emotionally intelligent leadership in the professions to effectively address these challenges. Strategies for developing EI and leadership skills should be introduced into all

undergraduate curricula and promoted on a regular basis through post-registration updates. Ongoing robust research in this area is recommended to establish the most effective methods for measuring and developing EI and leadership skills particularly in the context of nursing and midwifery. Specific evidence-based strategies for enhancing EI and leadership skills should be implemented and evaluated to make recommendations for future practice.

The need for emotionally intelligent and ethical leadership in the professions is paramount to highlight and confront the challenges for all involved in health service provision. It is up to each nurse and midwife to explore their particular area of practice and reflect on where they may promote EI leadership skills in themselves and their colleagues/students. Promoting these skills in the professions may help empower nurses and midwives to become more pro-active in campaigning for better resources in the health services and professional education as well as caring for each other. This may help achieve the goals of safety and quality as well as compassionate care across the health services.

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* http://www.icmje.org/recommendations/

References

Akerjordet K. & Severinsson E. (2010) The state of the science of emotional intelligence related to nursing leadership: an integrative review. *Journal of Nursing Management* **18,** 363–382.

Akerjordet K. & Severinsson E. (2008) Emotionally intelligent nurse leadership: a literature review study. *Journal of Nursing Management* **16**, 565–577.

Armstrong R. (2009) *Armstrong's Handbook of Management and Leadership. A Guide to Managing for Results*. 2nd Edition, Kogan Page, London.

Ashkanasy N. M. & Daus, C. S. (2005) Rumors of the death of emotional intelligence in organizational behaviour are vastly exaggerated. *Journal of Organizational Behavio*r **26**, 441-452.

Austin E., Saklofske D., Huang S., & Mckenney D. (2004) Measurement of trait emotional intelligence: testing and cross-validating a modified version of Schutte et al'.s (1998) measure. *Personality and Individual Differences* **36**, 555–562.

Australian Nursing Federation (2009*) Ensuring quality, safety and positive patient outcomes. Why investing in nursing makes* $ense. Issues Paper. Australian Nursing Federation , Melbourne.

Avolio B.J., Gardner W.L., Walumbwa F.O., Luthans F. & May D.R. (2004) Unlocking the mask: A look at the process by which authentic leaders impact follower attitudes and behaviors. *The Leadership Quarterly* **15**, 801–823.

Avolio B.J. & Gardner W.L. (2005) Authentic leadership development: Getting to the root of positive forms of leadership. *The Leadership Quarterly* **16**, 315–338.

Ball,J.E., Murrells,T. Rafferty,A.M, Morrow, E. and Griffiths, P. (2013) 'Care left undone'

during nursing shifts: associations with workload and perceived quality of care. *BMJ Quality*

and Safety 0:1–10. doi:10.1136/bmjqs-2012-001767 (accessed May 4th 2016).

Bar-On R. (2002). *Emotional quotient inventory: Short (Bar-On EQ-i:S):*

Technical manual Multi-Health Systems, Canada.

Bar-On R. (2006). The Bar-On model of emotional-social intelligence (ESI). *Psicothema,* **18**,

supl., 13-25.

Benson G., Martin L., Ploeg J. & Wessel J. (2012) Longitudinal Study of Emotional

Intelligence, Leadership and Caring in Undergraduate Nursing Students. *Journal of Nursing*

Education **51** (2), 95-101.

Bolden R., Gosling J., Marturano A. & Dennison P. (2003) *A Review of Leadership Theory*

and Competency Frameworks. Centre for Leadership Studies, University of Exeter.

Borrego M., Foster M.J. & Froyd J. E. (2014) Systematic Literature Reviews in Engineering

Education and Other Developing Interdisciplinary Fields. *Journal of Engineering Education*

103(1), 45–76.

Carney M. (2006) *Health Service Management: Consensus, Culture and the Middle*

Manager Oak Tree Press, Cork.

Casey M., McNamara M., Fealy G. & Geraghty R. (2011) Nurses' and midwives' clinical leadership development needs: A mixed methods study. *Journal of Advanced Nursing* **67**(7), 1502- 1513.

Centre for Maternal and Child Enquiries (CMACE) (2011). *Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006–08. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom*. BJOG: An International Journal of Obstetrics and Gynaecology. **18**(Suppl 1):1-203.

Codier E. & Odell E. (2014) Measured emotional intelligence ability and grade point average in nursing students. *Nurse Education Today* **34**(4), 608–612.

Codier E., Muneno L., Franey K. & Matsuura F. (2010) Is emotional intelligence an important concept for nursing practice? *Journal of Psychiatric and Mental Health Nursing* **17**(10), 940–948.

Collinson G. (2006). What makes an effective healthcare leader? Results of the best leadership practices research in healthcare. *Practice Development in Healthcare*. **5**(2), pp 81-91.

Conger J. A. (2004) Developing leadership capability: What's inside the black box? *Academy of Management Executive*, 18, (3) 136-139.

Conte J. M. (2005) A Review and Critique of Emotional Intelligence Measures. *Journal of Organizational Behavior* **26**(4), 433-440.

Cooper C.D., Scandura T.A. & Schriesheim C.A. (2005) Looking forward but learning from our past: Potential challenges to developing authentic leadership theory and authentic leaders. *The Leadership Quarterly*. **16,** 475–493.

Cummings G. Lee H. MacGregor T. Davey M. Wong C. Paul L. & Stafford E. (2008) Factors contributing to nursing leadership: a systematic review. *Journal of Health Services Research and Po*licy. **13**(4): 240–8

Curtis E.A., de Vries J. & Sheerin F.K. (2011a) Developing leadership in nursing: exploring core factors. *British Journal of Nursing* **20**(5), 306-309.

Curtis E.A. de Vries J. Sheerin F.K. (2011b) Developing leadership in nursing: the impact of education and training. *British Journal of Nursing* **20** (6), 344-352.

Daus C. S. & Ashkanasy N. M. (2003) Will the real emotional intelligence please stand up? On deconstructing the emotional intelligence 'debate'. *Industrial and Organizational Psychologist* **41** (2), 69-72.

Dawson, A.J., Stasa, H., Roche, M.A. Homer, C.S.E. and Christine Duffield (2014) *BMC Nursing*, 13:11, 2-10, http://www.biomedcentral.com/1472-6955/13/11. (accessed 4th May 2016).

Department of Health (2012) Future Health. *A Strategic Framework for Reform of the Health Service 2012 – 2015.* The Stationary Office, Dublin.

Duygulu, S., Hicdurmaz D. and Akyar I. (2011) Nursing Students' Leadership and Emotional Intelligence in Turkey. *Journal of Nursing Education. 50 (5), 281-285.*

Feather R. (2009). Emotional intelligence in relation to nursing leadership: does it matter? *Journal of Nursing Management* **17**(3), 376-382.

Fernandez, R., Salamonson Y. & Griffiths R. Emotional intelligence as a predictor of academic performance in firstyear accelerated graduate entry nursing students. *Journal of Clinical Nursing*, 21, 3485–3492, doi: 10.1111/j.1365-2702.2012.04199.x. Accessed 26th April 2016.

Foster K., McCloughen A., Delgado C., Kefalas C. & Harkness E. (2015) Emotional intelligence education in pre-registration nursing programmes: An integrative review. *Nurse Education Today* **35**(3), 510–517.

Fulmer R.M. & Bleak J.L. (2007) Strategic Leadership, Part 1: Applying Lessons Learned from Research about Strategic Leadership Development. *Graziadio Business Review,* available at: http://gbr.pepperdine.edu/2010/08/strategic-leadership-part-1/ (accessed 5th April 2016).

Fulmer, R. M., & Conger, J. A. (2003). *Growing your company's leaders: How great organizations use succession management to sustain competitive advantage.* American Management Association, New York.

Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. The Stationery office, London.

Gentry W., Deal J.J., Stawiski S. & Ruderman M. (2012) *Are Leaders Born or Made? Perspectives from the Executive Suite.* Center for Creative Leadership, U.S.

George J. (2000). Emotions and leadership: The role of emotional intelligence. *Human Relati*ons **53**(8), 1027-1055.

Gough D, Oliver S. & Thomas J. (2013) *Learning from Research: Systematic Reviews for Informing Policy Decisions: A Quick Guide. A paper for the Alliance for Useful Evidence.* Nesta, London.

Gould D. (2003) Emotional Intelligence. *British Journal of Midwifery* **11**(4), 203.

Goleman D. (1995). *Emotional intelligence: Why it can matter more than IQ.* Bantam Books, New York.

Goleman D. (1998). *Working with Emotional Intelligence.* Bantam Books, New York.

Halligan P. (2010) Leadership and Management Principles In: Brady A-M (ed). *Leadership & Management in the Irish Health Service*. Gill & Macmillan, New York, 49-74.

Hanafin, S. and O'Reilly, E. (2016) *International review of literature on models of care across selected jurisdictions to inform the development of a National Strategy for Maternity Services in Ireland*. Department of Health, Dublin.

Hartley J. & Benington J. (2011) *Recent trends in leadership. Thinking and action in the public and voluntary service sectors.* The King's Fund, London.

Harms P. & Crede M. (2010). Emotional intelligence and transformational and transactional leadership: A Meta-Analysis. *Journal of Leadership and Organizational Studies* **17**(1), 5-17.

Health Information and Quality Authority (HIQA) (2013) *Investigation into the safety, quality and standards of services provided by the Health Service Executive to patients, including pregnant women, at risk of clinical deterioration, including those provided in University Hospital Galway and as reflected in the care and treatment provided to Savita Halappanavar. Executive Summary and Recommendations.* HIQA, Dublin.

Health Service Executive (2013) *Investigation of Incident 50278 from time of patient's self referral to hospital on the 21st of October 2012 to the patient's death on the 28th of October, 2012.* HSE, Dublin.

Health Service Executive (2014) *HSE Midland Regional Hospital, Portlaoise Perinatal Deaths (2006-date).* HSE, Dublin.

Health Workforce Australia (2012) Leadership for the Sustainability of the Health System: Part 1- A Literature Review. Siggins Miller Pty Ltd., Adelaide, Australia.

Hiscock M. & Shuldham C. (2008) Patient centred leadership in practice, *Journal of Nursing Management* **16**(8), 900–904.

Hornett M. (2012) Compassionate leadership. *British Journal of Nursing* **21**(13). 831.

Howieson B. & Thiagarajah T. (2011) What is clinical leadership? A journal-based meta-review. *The International Journal of Clinical Leadership* **17**(1), 7–18.

Ilies, R., Morgeson, F. P. & Nahrgang, J.D. (2005) Authentic leadership and eudaemonic well-being: Understanding leader–follower outcomes. *The Leadership Quarterly* **16**, 373–394.

Institute of Medicine (2002*) Leadership by example: coordinating government roles in improving health care quality.* National Academies Press, Washington, DC. Available at http://www.nap.edu/catalog/10537/leadership-by-example-coordinating-government-roles-in-improving-health-care. (accessed 26th April 2016).

Johnson G. (2012) Leadership-what's that got to do with me? *Midwives.* **3**, 52-53.

Joyce P. (2009). Leadership and organizational effectiveness – lessons to be drawn from education? *Journal of Nursing Management* **17**(4), pp 492-502.

Kable, A.K., Pich, J. & Maslin-Prothero,S.E. (2012) A structured approach to documenting a search strategy for publication: A 12 step guideline for authors. *Nurse Education Today* **32**(8), 878-886.

Kirkup B. (2015) *The Report of the Morecambe Bay Investigation. An independent investigation into the management, delivery and outcomes of care provided by the maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust from January 2004 to June 2013.* The Stationary Office, U.K.

Knight M., Kenyon S., Brocklehurst P., Neilson J., Shakespeare J. & Kurinczuk J.J. (Eds.) on behalf of MBRRACE-UK. (2014) *Saving Lives, Improving Mothers' Care - Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009–12.* National Perinatal Epidemiology Unit, University of Oxford, Oxford.

Kristjansson K. (2006) ''Emotional intelligence'' in the classroom? An Aristotelian critique. *Educational Theory* **56**(1),39–56.

Landy F. (2005) Some historical and scientific issues related to research on emotional intelligence. *Journal of Organizational Behavior* **26**, 411–424.

Lefebvre C., Manheimer E. & Glanville J. (2011) Chapter 6: Searching for studies. In: Higgins, J.P.T. and Green, S. (editors). *Cochrane Handbook for Systematic Reviews of Interventions. Version 5.1.0* [updated March 2011]. The Cochrane Collaboration, available from www.cochrane-handbook.org. Accessed 23rd August 2015.

Locke E.A. (2005) Why Emotional Intelligence Is an Invalid Concept. *Journal of Organizational Behavior* **26**(4), 425-431.

MacPhee M., Skelton-Green J., Bouthillette F. & Suryaprakash, N. (2012) An empowerment framework for nursing leadership development: supporting evidence. *Journal of Advanced Nursing* **68**(1), 159–169.

Marquis B. & Huston C. (2006). *Leadership roles and management functions in nursing.* Lippincott Williams and Wilkins, Philadephia.

May D. R., Chan A. Y. L., Hodges T. D. & Avolio B. J. (2003) Developing the moral component of authentic leadership. *Organizational Dynamics* **32**(3), 247–260.

Mayer J.D., Salovey P. & Caruso D.R. (2004), Emotional intelligence: theory, findings and implications. *Psychological Inquiry* **15**(5), 197-215.

Mayer J.D., Salovey P and Caruso D.R. (2000). Models of emotional intelligence. In Stenberg, R. (Ed.), *Handbook of Intelligence.* Cambridge University Press, Cambridge, 396-420.

Momeni N. (2009) The relation between managers' emotional intelligence and the organizational climate they create. *Public Personnel Management* **38**(2), 35-48.

NHS Leadership Academy (2011) *Leadership Framework: A Summary*. NHS Institute for Innovation and Improvement, Coventry.

Nursing and Midwifery Council (2012) NMC 2011-12 LSAA reports. NHS, London.

Paley J. (2014) Cognition and the compassion deficit: The social psychology of helping behaviour in nursing. *Nursing Philosophy* **15**(4), 274-287.

Patterson D, Begley AM. (2011) An exploration of the importance of emotional intelligence in midwifery. *Evidence Based Midwifery* **9**(3): 128-134.

Ploug Hansen H. (2014) Review: Caring after Francis: Moral failure in nursing reconsidered. *Journal of Research in Nursing.* 19 (7–8), 557-558.

Qualter P., Ireland J. & Gardner K. (2010) Exploratory and confirmatory factor analysis of the Schutte Self-Report Emotional Intelligence Scale (SSREI) in a sample of male offenders. *British Journal of Forensic Practice* **12**(2), 43–52.

Raelin J.A. (2004) Don't bother putting leadership into people. *Academy of Management Executive* **18**(30), 131-135.

Rankin B. (2013) Emotional intelligence: enhancing values-based practice and compassionate care in nursing. *Journal of Advanced Nursing* **69**(12), 2717–2725.

Roberts M. & Ion R. (2015) Thinking critically about the occurrence of widespread participation in poor nursing care. *Journal of Advanced Nursing* **71**(4), 768–776.

Roberts R.D., MacCann C., Matthews, G. & Zeidner M., (2010) Teaching and learning guide for: emotional intelligence: towards a consensus of models and measures. *Social and Personality Psychology Compass* **4**(10), 968–981.

Rosser E. (2014) What role can education play in developing leadership? *British Journal of Nursing* **23**(17), 952.

Sadri G. (2012) Emotional intelligence and leadership development. *Public Personnel Management* **41**(3), 535-548.

Scheck McAlearney A. (2006). Leadership development in healthcare: A qualitative study. *Journal of Organizational Behavior* **27**(7), 967-982.

Shawn Kennedy M. (2014) It All Comes Back to Staffing. Both quality of care and safety are at stake. *American Journal of Nursing* **114**(7) 7.

Shaw T. (2014) Review: Caring after Francis: moral failure in nursing reconsidered. *Journal of Research in Nursing* **19**(7-8), 559-561.

Snowden S., Stenhouse R., Young J., Carver H., Carver F. & Brown N. (2015) The relationship between emotional intelligence, previous caring experience and mindfulness in student nurses and midwives: a cross sectional analysis. *Nurse Education Today* **35**(1), 152–158.

Sparrowe R. (2005). Authentic leadership and the narrative self. *The Leadership Quarterly* **16**(3), 419-439.

Spector P.E. (2006) *Industrial and Organisational Psychology: Research and Practice.* 4th edn. John Wiley and Sons, New Jersey.

Stanley D. (2006a) In command of care: clinical leadership explored. *Journal of Research in Nursing* **2**(1), 20–39.

Stanley D. (2006b) In command of care: toward the theory of congruent leadership. *Journal of Research in Nursing* **2**(2), 132–144.

Stanley D. (2006c) Recognising and defining clinical nurse leaders.*British Journal of Nursing* **15**(2), 108–111.

Stanley D (2008) Congruent Leadership: Values in action. *Journal of Nursing Management* **16**(5), 519–524.

Stanley D. (2014) Clinical leadership characteristics confirmed. *Journal of Research in Nursing* **19**(2), 118–128.

Squires M., Tourangeau, A., Spence Laschinger H.K. & Doran D. (2010) The link between leadership and safety outcomes in hospitals. *Journal of Nursing Management* **18**(8), 914–925.

Sullivan E.J. & Garland G. (2010) *Practical Leadership and Management in Nursing*. Pearson Education Limited, Harlow.

The King's Fund (2008) *Safe births: Everybody's business. Independent inquiry into the safety of maternity services in England*. King's Fund, London.

Thyer G. (2003) Dare to be different: transformational leadership may hold the key to reducing the nursing shortage. *Journal of Nursing Management* **11**(2), 73–79.

Traynor M. (2014) Caring after Francis: moral failure in nursing reconsidered. *Journal of Research in Nursing* **19**(7–8), 546-556.

University College Dublin, School of Nursing, Midwifery & Health Systems/Health Service Executive (2012) *Evaluation of the National Clinical Leadership Development Project Pilot. Final Report.* HSE, Dublin.

Wakefield, M.K. (2008) The Quality Chasm Series: Implications for Nursing. Chapter 4 in: Hughes RG, editor. Patient Safety and Quality: An Evidence-Based Handbook for Nurses. Rockville (MD): Agency for Healthcare Research and Quality (US). Available from: http://www.ncbi.nlm.nih.gov/books/NBK2677/pdf/Bookshelf_NBK2677.pdf. (accessed 26 April 2016).

Watson C. (2008) Assessing leadership in nurse practitioner candidates. *Australian Journal of Advanced Nursing* 26(1), 67-76.

Welford C. (2002) Matching theory to practice. *Nursing Management* **9**(4), 7–11.

Wong C.A., Cummings G.G. & Ducharme L (2013) The relationship between nursing leadership and patient outcomes: a systematic review update. *Journal of Nursing Management* **21**(5), 709–724.

Wood M. (2005) The Fallacy of Misplaced Leadership. *Journal of Management Studies* **42**(60, 1101-1121.

Yukl G. (2006). *Leadership in Organizations* (6th ed.) Pearson-Prentice Hall, Upper Saddle River, NJ.

Table 1 Summary of Traditional Leadership Theories (Bolden *et al.* 2003)

Great Man Theories	Based on the belief that leaders are born with innate qualities and are destined to become leaders
Trait Theories	Leaders possess certain traits that are positive in nature. Fits in well with 'Great Man Theories'
Behaviourist Theories	Focuses on what leaders do rather than on their qualities
Situational Leadership	Leadership is specific to the situation; leaders will adapt their style according to the specific situation they are in.
Contingency Theory	This is a refinement of situational leadership. Focuses on identifying situational variables and match this with a specific leadership style to suit.
Transactional Theory	Emphasises the relationship between leaders and followers, focusing on mutual benefits.
Transformational Theory	Change is the central concept and leadership is about empowering followers to excel in their performance

Table 2: Models of Emotional Intelligence (EI) Codier *et. al.* (2010)

Model	**Ability based Model** (Mayer, Salovey and Caruso 2004)	**Trait- based Model** (Bar-On 2002, 2006)	**Mixed model** (Goleman (1995, 1998).
Description	**Four levels of emotional abilities:** Perception of emotion in self and others; assimilation of emotion to facilitate thought; understanding of emotion and managing and regulating emotion in self and others	Emphasizes EI as an aspect of personality with a focus on traits such as empathy, emotional expression, adaptability, and self – control.	**Five skill domains:** Three relate to personal effectiveness, two of which relate to social competence, thus blending traits and abilities. The personal competencies include self-awareness, self-regulation and motivation whilst the social competencies incorporate empathy and social skills.
Assessment tools	MSCEIT	EQ-i	ECI
Limitations	Good face and discriminant validity	Overlaps with other personality tests affecting face and discriminant validity	Overlaps with other personality tests affecting face and discriminant validity