DISCUSSION PAPER

Leadership and emotional intelligence in nursing and midwifery education and practice: a discussion paper

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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 healthcare 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 UK, 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 healthcare field internationally. This is of particular significance for professional undergraduate education to promote ongoing compassionate, safe and high quality standards of care.

Keywords: emotional and social intelligence, emotional intelligence, leader, leadership, nursing midwifery

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Introduction

The need for emotionally intelligent and effective leadership in the health professions is acknowledged throughout the nursing and midwifery literature internationally (Collinson 2006, Marquis & Huston 2006, Scheck McAlearney 2006, Akerjordet & Severinsson 2010). 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 healthcare 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 (Squires et al. 2010, Hartley & Benington 2011, 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 healthcare setting (Stanley 2006a,b, Halligan 2010). This makes it difficult to determine what exactly makes for effective leadership in the healthcare 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 healthcare professions (Bar-On 2002, 2006, Akerjordet & 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 & 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. 2015). 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 healthcare professions and require further exploration (Benson et al. 2012). The aim of this paper then was 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 & 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. 2015). This belief has implications for all healthcare professionals and is of particular significance for nursing and midwifery education as it indicates that as a process leadership can be learnt and nurtured rather than being something innate in an individual (Watson 2008, 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, Centre for Maternal and Child Enquiries (CMACE) 2011, Nursing and Midwifery Council 2012, Health Information and Quality Authority (HIQA) 2013, Health Service Executive 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 (Centre for Maternal and Child Enquiries (CMACE) 2011, Health Information and Quality Authority (HIQA) 2013, Health Service Executive 2013, 2014, Knight et al. 2014, 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 & 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 healthcare 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 (Benson et al. 2012, Roberts & Ion 2015).

It is important then to explore how effective emotionally intelligent leadership behaviour is fostered in undergraduate education for healthcare 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 (Bolden et al. 2003, Halligan 2010) (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, Harms & Crede 2010, Sullivan & Garland 2010). Despite the popularity of traditional leadership theories few have been fully evaluated in the healthcare field (Yukl 2006, Harms & Crede 2010).

Table 1 Summary of traditional leadership theories (Bolden et al. 2003).

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<tr>
<th>Theory Type</th>
<th>Description</th>
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<tr>
<td>Great man theories</td>
<td>Based on the belief that leaders are born with innate qualities and are destined to become leaders</td>
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<tr>
<td>Trait theories</td>
<td>Leaders possess certain traits that are positive in nature. Fits in well with ‘Great Man Theories’</td>
</tr>
<tr>
<td>Behaviourist theories</td>
<td>Focuses on what leaders do rather than on their qualities</td>
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<tr>
<td>Situational leadership</td>
<td>Leadership is specific to the situation; leaders will adapt their style according to the specific situation they are in.</td>
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<tr>
<td>Contingency theory</td>
<td>This is a refinement of situational leadership. Focuses on identifying situational variables and match this with a specific leadership style to suit.</td>
</tr>
<tr>
<td>Transactional theory</td>
<td>Emphasises the relationship between leaders and followers, focusing on mutual benefits.</td>
</tr>
<tr>
<td>Transformational theory</td>
<td>Change is the central concept and leadership is about empowering followers to excel in their performance</td>
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In research undertaken by Stanley (2006a,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 health care. 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 and promoting the concept of collaboration and a shared vision (Avolio et al. 2004, Avolio & 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 healthcare 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 in 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 pre-determined 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. First, baseline traits necessary for effective leadership, second, 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 2009). 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 & Conger 2003, Fulmer & 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 by structured reflection on work practices. Raelin (2004, p.135) further suggests that this type of leadership (or ‘leadersful’) development can ‘release the leadership potential in everyone’. This ‘leadersful’ 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 (George 2000, Momeni 2009). 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. 2015). The important aspect is that leadership (or ‘leadersful’) 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 2012, Rosser 2014).

Personal qualities and values are viewed as the pivotal theme in many leadership skills frameworks for educating healthcare staff (Casey et al. 2011, NHS Leadership Academy 2011, University College Dublin, School of Nursing, Midwifery & Health Systems/Health Service Executive 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 healthcare 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. 2004, Sparrowe 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 et al. 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 (2012) 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 (1995, 1998) mixed model 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 while 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 while 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 and 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. 2012).

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<tr>
<td>Description</td>
<td>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</td>
<td>Emphasizes EI as an aspect of personality with a focus on traits such as empathy, emotional expression, adaptability, and self-control.</td>
<td>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.</td>
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<tr>
<td>Assessment tools</td>
<td>MSCEIT</td>
<td>EQ-i Overlaps with other personality tests affecting face and discriminant validity</td>
<td>ECI Overlaps with other personality tests affecting face and discriminant validity</td>
</tr>
<tr>
<td>Limitations</td>
<td>Good face and discriminant validity</td>
<td>Overlaps with other personality tests affecting face and discriminant validity</td>
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Leadership and emotional intelligence

2015). There is limited data available in relation to how EI may influence traditionally held ideas of academic intelligence. However, Codier and 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), while 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 and 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 ongoing 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 and 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 6 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 learnt 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 learnt, 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 health care.

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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Conflict of interest

There is no co conflict of interest.

Author contributions

All authors have agreed on the final version and meet at least one of the following criteria [recommended by the ICMJE (http://www.icmje.org/recommendations/)]:

- substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content.

Supporting Information

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