The Call for Leadership to Influence Patient Outcomes

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Leadership is the obvious focus of this journal. Leadership consists of the ability to, first, see today as it really is – all the warts, the issues, the successes and the abysmal failures despite the investment of considerable resources; second, see a preferred future, one that others can engage in and contribute to building; and then third, take action to close the gap between the reality of today and that preferred future. Leadership exists throughout the healthcare system, from the front line through senior executive and regional levels. Opportunities to achieve a preferred future arise each day, in each setting and in each healthcare role.

Leadership in itself is neither good nor evil, despite that it can result in good and bad consequences. It is a process to achieve a preferred future, whether that future is the vision of a single individual or one shared among a community or team. However, the way in which leaders achieve the preferred future – the personal leadership style they use to get there – has considerable consequences (good or bad) for those working with them.

Research into nursing leadership and leadership styles currently focuses primarily on the development of leadership or the relationships among nursing leaders, nurses and other healthcare providers in order to improve healthcare work environments and outcomes for the nursing workforce. The results of several literature reviews of these studies are pretty consistent.

In the leadership development studies (n=9), most interventions were reported to be effective for at least three to six months (Cummings et al. 2008). In studies that examined the outcomes of various leadership styles (n=53), leadership styles that were transformational or relational in nature, when compared to task-focused leadership styles, achieved positive outcomes for the nursing workforce (greater job satisfaction, organizational commitment, less turnover and absenteeism, less job tension, less emotional exhaustion) and for nursing work environments (greater empowerment, better organizational and work team climates, and better nurse–physician teamwork, research utilization and innovation (Cummings et al. 2010a). Studies also reported that relational leadership led to greater productivity, effectiveness and extra effort (Cummings et al. 2010a; Brady-Germain and Cummings 2010) when compared to task-focused leadership styles. Studies published since these reviews were done have shown similar results. These findings are very important, because the nursing workforce is essential to achieving better outcomes for patients, and better patient outcomes is the ultimate goal of our work as nurses and leaders.

The combined effects of leadership by a wide variety of people can lead to transformational change within an organization, but only if strategic efforts to align the visions of the preferred future are undertaken. Otherwise, there is chaos as everyone strives to achieve their own vision without synergy with the rest of the team and with little progress towards quality. The Canadian Institutes of Health Research has recently refocused its goals to the SPOR initiative – Strategy on Patient-Oriented Research, in order to fund and support research that will actually improve health outcomes for Canadians.

> The overarching goal of the Strategy on Patient-Oriented Research (SPOR) is to translate research results into improved health outcomes for Canadians. For patients, this means receiving better diagnoses, treatments and outcomes in a timely manner. For health care practitioners, this means obtaining the latest evidence-based medical information that will enable them to deliver the recommended care to the right patient at the right time. For scientists, this means enhanced resources to test new therapies and produce better research output. For hospitals and other health care institutions, this gives them the ability to attract the best and the brightest minds in health care. For governments, this aims to create a more cost-effective delivery of health care in fields such as primary care and chronic disease management as well as an overall improved health system. (CIHR 2010)

So how do nursing leadership and leadership styles fit with patient outcomes? In another review of the literature to examine the relationship between leadership

styles and patient outcomes, we found that transformational or relational leadership styles were associated with better patient outcomes in terms of reduced adverse events, complications and mortality and increased patient satisfaction (Wong and Cummings 2007). However, the number of studies was quite small (n=7), suggesting that we need more research to examine the mechanisms by which leadership can influence the outcomes for patients.

In our most recent study, we examined the contribution of nursing leadership styles in hospitals to 30-day mortality of medical patients (Cummings et al. 2010b). We categorized hospitals based on the leadership styles of nursing leaders. We used the theory of emotional intelligence and its four domains – awareness of one's own emotions and the ability to manage them, and the awareness of and ability to develop and manage relationships with others – as the basis for leadership styles. Resonant styles reflect high emotional intelligence and are thereby relational in nature, whereas dissonant styles reflect an absence of emotional intelligence, resulting in a more task-focused orientation. Resonant leadership, founded on emotional intelligence as the basis for influencing outcomes, is based on leaders' skills in management, organization and analytical intelligence (Goleman et al. 2002). After controlling for the majority of factors that influence patient mortality – patient demographics, co-morbidities and institutional and hospital nursing factors – the relative contribution of nursing leadership styles to 30-day mortality was 5.15%. High-resonant leadership styles were significantly associated with 26% lower odds of mortality when compared with the mixed leadership group as reference (Cummings et al. 2010b). These results point to the possible contribution, both positive and negative, of hospital nursing leadership styles to patient mortality. After controlling for patient demographics, co-morbidities and institutional and hospital nursing characteristics, high-resonant nursing leadership contributed to lower patient mortality rates at statistically significant levels.

Leadership science is often seen as the softer side of the health sciences, yet our beginning research suggests that it contributes significantly to our understanding of the factors that influence outcomes for patients in the health system. There is sufficient evidence to support inclusion of nursing leadership styles in theoretical and analytical models of determinants of patient mortality. The relationship between leadership styles and patient outcomes, such as length of stay, patient complications and satisfaction with care, should be explored in future research.

The essence of CIHR's SPOR initiative, and other preferred futures that reflect better patient outcomes, can and should be the unifying vision for nursing leadership in healthcare – to ultimately improve outcomes for patients.

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