Abstract:

A theory of behavioral competencies associated with emotional intelligence that influence job performances are tested in physicians who hold leadership positions in their organization. An emotional intelligence competency (EIC), survey that measured eighteen competencies distributed among four cluster groups was administered to physician leaders and their supervisors, peers and direct reports. The resulting 360 degree assessment permitted a comparison of the physician leaders self assessment scores with one another and those working closely with them. In addition, independent objective and subjective measures of physician leadership effectiveness were available for comparative evaluation. Eleven of thirty-four physician leaders who volunteered to participate had complete profiles and five others had several surveys submitted. One hundred and two self and other surveys form the basis of this exploratory study. Descriptive statistical analysis revealed results restricted to the upper half of the five point Likert scale. Participating physician leader scores often exceeded mean scores from peers, direct reports and supervisors. Specific EICs clustered at the upper and lower ends of the distribution. However, the results range was sufficiently restricted only relative differences were observed. The results of the analysis are discussed and refinements applicable to future studies considered. The association of particular EICs and leadership styles are also addressed in the context of the participating physician leader results.

Key Words: Physician leaders, Behavioral Competence, Emotional Intelligence, 360 degree assessment, Outstanding & Typical Performance, Leadership Styles

1. Introduction:

Emotional intelligence, i.e., the ability to monitor one’s own and other’s emotions, to discriminate among them, and to use this information to guide one’s thinking and actions (Salovey & Mayer, 1990 ) has emerged as an important leadership attribute (Boyatzis, 1982; Goleman, 2000; Goleman, 2001b; Goleman, 2002 ). Emotional intelligence is made manifest through the use of emotional intelligence competencies, which are underlying characteristics of an individual causally related to effective or superior performance in a job (Boyatzis, 1982; Spencer & Spencer, 1993). Emotional intelligence is essential for leaders attempting to cope with an increasingly complex and fast-paced world. Some of the greatest challenges facing organizations and the people who work in them are learning to cope with discontinuous change, managing massive amounts of data, and working together more effectively (Cherniss, 2001 ). Emotional intelligence and its manifestation as specific behavioral competencies influence and enhance individual and organizational effectiveness in dealing with these issues.

2. Literature Review:

There is complementary literature that affirms the importance of emotional intelligence in clinical practice. These studies emerge from the relationship-centered care movement (Tresolini, 1994), the selection and education of new physicians (Carrothers, 2000), a growing interest in the retention of competence throughout a physician’s entire career (Ramsey, 1993; Novack, 1997; Violato, 1997; Irvine, 1999), and a decline in medical professionalism (Swick, 2000). Unfortunately, this literature also suffers from a lack of consensus regarding terms, definitions, methods, and instruments of analysis, making it difficult to directly compare the results of different studies (including the present one). Despite these limitations there is a recognition and re-discovery that humanistic and socio-behavioral attributes are important aspects of physician effectiveness (Ramsey, 1993; Violato, 1997). Furthermore, these qualities can be selected (Carrothers, 2000), measured (Carrothers, 2000; Ramsey, 1993; Violato, 1997), and strengthened through awareness and practice (Novack, 1997; Epstein, 1999). Much of this work was recently summarized by Epstein & Hundert (2002). In their review they identify seven dimensions of professional competence shared by physicians including cognitive, technical, integrative, contextual, relationship, affective / moral, and habits of mind. Sub elements included under several of these headings are dimensions of the emotional intelligence framework utilized in this study.

3. Importance of EI for Physicians:

Another initiative affirming the importance of emotional intelligence competencies in clinical practice is the Outcomes Project sponsored by the Accreditation Council for Graduate Medical Education (ACGME). The latter group is responsible for general policy and oversight of postgraduate medical education in the U.S. Two years ago it initiated a major transformation of its residency review and accreditation process (ACGME), re-directing emphasis toward accountability for demonstrable competence development appropriate to each primary care, medical or surgical specialty. A set of six general competencies applicable to all programs (patient care, medical knowledge,
practice-based learning and improvement, interpersonal and communication skills, professionalism and systems-based practice) assign significant importance to the development and measurement of emotional intelligence competencies (ACGME). A challenge facing the ACGME and residency program directors across the country is the creation of reliable, robust, comparable methods for developing, teaching, and measuring the cognitive and non-cognitive competencies required by this initiative. An important aspect of this preliminary study is the relationship between the competencies identified by the survey and alternative leadership styles. Recent publications by Goleman and Goleman, Boyatzis & McKee provide a framework linking key emotional intelligence competencies to six leadership styles: visionary, affiliative, democratic, coaching, pacesetting and commanding. These styles are complementary not mutually exclusive. The authors encourage flexibility and the use of different styles for different purposes. Proficient leaders will recognize the benefits associated with different approaches and will master the key emotional intelligence competencies so they can utilize each style in an authentic and effective manner.

4. Emotional Intelligence Competencies:

There is a body of evidence suggesting leaders and managers with a well developed complement of emotional intelligence competencies are more effective than peers (with similar education and experience) who lack a highly refined set of these qualities (McClelland, 1998; Boyatzis, 2000; Goleman, 2001b). Goleman (2001b) cites studies by a consulting firm (the Hay Group) that measured financial performance among comparably sized insurance companies. Firms led by chief executive officers who exhibited outstanding emotional intelligence competency levels had better financial performance as measured by both profitability and growth. In another study (Goleman 2001b) senior health care executives were more adept at integrating key emotional intelligence competencies such as organizational awareness, and relationship skills such as influence, into their professional activities. McClelland (1998) demonstrated a link between superior behavioral competency levels and success in earning performance bonuses among senior executives in an international consumer products company and Boyatzis et al. (2000), while studying partners in a large consulting firm, observed that senior partners with emotional intelligence competency profiles reflecting high levels of self regulatory, self management and social skills consistently contributed higher levels of profitability when compared with their “typical” colleagues. The contribution of emotional intelligence to effective job performance increases as an individual assumes greater responsibility. In circumstances where all incumbents have the requisite cognitive and technical knowledge and relevant experience, the outstanding leaders complement these abilities with maturity, self awareness, empathy, active listening skills and other characteristics that make a meaningful difference in their performance and contribution to the success of the organizations where they work. Much of the literature on emotional intelligence and its accompanying behavioral manifestations has been drawn from studies in business and related industries.

5. EI for Physicians:

There is a paucity of information regarding emotional intelligence competencies and how they influence practitioners and leaders in medicine and related health care professions. The available literature focuses on the physician – patient relationship rather than the provider’s colleagues and co-workers or the organization where care is delivered. The contribution of emotional intelligence to more effective physician leadership remains unexplored. While one might hypothesize physician leaders will demonstrate a repertoire of emotional intelligence competencies similar to managers and professionalism other fields there are good reasons to explore and validate this hypothesis. Guthrie summarizes several of the differences frequently observed when physicians and managerially trained health care executives are compared. These differences are summarized in the following chart.

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<th>Differences between Physicians &amp; Executives</th>
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<tr>
<td><strong>PHYSICIANS</strong></td>
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<tr>
<td>• Expert mindset</td>
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<td>• “Do-er”</td>
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<td>• Works one-on-one, in sequence</td>
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<td>• Values autonomy</td>
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<td>• Success = intrinsic</td>
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<td>results such as patient-</td>
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<td>physician relationships, problem</td>
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<td>solving, income generation</td>
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<td>• Little or no business</td>
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Guthrie describes a number of implications that may emerge from these distinctive profiles including: (1) barriers to effective communication between physicians and executives; (2) differing views of the importance of organizational vs. individual objectives; (3) different views regarding the relative importance of patients and the care they receive; (4) a delayed, often conservative response to the need for organizational change among physicians; and (5) direct economic conflict between reasonable objectives of a hospital or health system and the individual success of physicians. Physicians and health care executives often view the same issue through distinctly different lenses and, as a result, arrive at different causal explanations and select alternative corrective actions. The intent of this project was to conduct a preliminary, exploratory study examining the influence of emotional intelligence competencies on the effectiveness of physicians in formal leadership roles. A key objective was to gain an understanding of how important these attributes were to physicians in leadership roles and whether these competencies discriminate outstanding from typical leadership performance. This knowledge could be instrumental in the development of contemporary physician
leaders and the selection, education and mentoring of future physicians and their leaders. Effective planning, implementation, and delivery of health care services in the United States is dependent upon current and future physician leaders’ ability to work effectively with others and see societal as well as an individual perspective regarding their profession and its import.

6. Health Care Industry of US:

At present health care delivery in the U.S. is in turmoil. During the past twenty-five years dramatic changes in the financing and delivery of health care have combined with remarkable scientific progress to create a paradoxical situation. On the one hand a majority of Americans enjoy access to the most advanced, technologically sophisticated health care in the world, while at the same time more than forty million Americans lack basic, systematic care because they do not have health care insurance and, therefore, cannot gain access to the delivery system except in emergent or life-threatening situations. Throughout this period American physicians have been under duress. Changes in the methods of reimbursement for services rendered, challenges to their clinical autonomy from managed care insurers, the legitimization of alternative medicine, and the emergence of better informed, more inquisitive patients seeking more influence on care decisions, have each contributed to a sense of alienation and loss among American physicians. Physician morale in the U.S. is at its lowest level in decades. Increasing numbers of middle-aged and older physicians are retiring prematurely. Applications to U.S. medical schools have declined for the fourth consecutive year. The hegemony physicians held over the American health care delivery system is broken. The model that dominated the delivery of medical and surgical services for more than fifty years has been shattered without an attractive alternative to replace it.

Despite this dilemma, physicians continue to provide medical and surgical services in increasingly complex care settings and delivery models. Many have accepted salaried positions and work as highly compensated professional employees in large health care delivery systems. Contemporary care is often planned, organized and delivered by a team rather than an individual physician. These changes require new competencies in collaboration and teamwork. Increasingly diverse patient populations and co-workers require enhanced sensitivity to cultural differences. Decisions regarding the most effective use of limited resources benefit from the ability to listen to alternatives with an open mind, to constructively negotiate creative solutions that optimize resources and outcomes. All of these practices require the exercise of emotional intelligence and the demonstration of related competencies. To be effective in this setting, physicians and their leaders must work to improve their understanding and use of emotional intelligence competencies in a manner similar to the way they embraced the explosion of scientific knowledge during the twentieth century. Unfortunately, too little attention has been devoted to this subject by the medical profession when selecting leaders. The latter are virtually always chosen from within the discipline; whether it is family medicine, cardiology, neurosurgery or any of the other twenty to thirty recognized medical and surgical specialties.

Depending on the nature of the organization, these nascent leaders are usually accomplished, recognized practitioners in their professional community. They may be highly regarded by peers for their professional or technical achievements or they may have the largest patient referral base or extraordinary success in obtaining resources from foundations and grant-making agencies. For the last five decades the keys to securing a physician leadership position were evidence of success in the practice field and integration and demonstration of the normative values and beliefs most important to physician colleagues. Emotional intelligence, when considered, was a secondary factor in the selection of most physician leaders. Nowhere is the need to build awareness of emotional intelligence and its related competencies more important than with contemporary physician leaders who need these skills if they are to be effective role models and representatives for the physician community. Unfortunately, there has been little systematic study of physician leaders and the characteristics that discriminate highly effective performers from those who are excellent practitioners or clinical investigators but falter when thrust into a complex leadership role where their clinical skills are not sufficient for the task. This study was intended to begin to uncover some of the traits that distinguish outstanding from average or typical physician leaders.

The study was designed to acquire preliminary information on the emotional intelligence profiles of practicing physicians who also hold formal leadership roles in their organization. There is a dearth of reliable published information on this topic. Furthermore, the selection, education, and socialization of physicians is sufficiently distinct it may be imprudent to assume those selected for managerial and leadership roles will be more similar than different from professional managers. For example, many physicians adopt a “pace-setting” leadership style; one that emerges from the individual contributor/practitioner model prevalent in American society and professional practice throughout the twentieth century. This style has been shown to be one of the least effective styles for leading in most contemporary settings. Key emotional intelligence competencies that underlie this style include initiative, conscientiousness and a drive for achievement; all features characteristic of many physicians in the U.S. Absent or under-represented are empathy, relationship building, communication, collaboration and team leadership – each a key competency demonstrated by leaders who adopt the more effective affiliative, democratic or visionary styles. The key question this study addressed is whether emotional intelligence competencies were correlated with outstanding leadership performance by physicians in managerial roles. Variations in the emotional intelligence competencies of participating physician leaders were the independent variables, while leadership effectiveness, as determined by a set of independent, objective measures regularly utilized by the sponsoring organization, was the dependent variable. Additional research questions included: Are there differences in the patterns and / or levels of competencies
demonstrated by outstanding and typical physician leaders? Do particular competencies or clusters of competencies correlate with specific outstanding performance as determined by independent measures of leadership effectiveness? This exploratory study revealed high levels of emotional intelligence competencies among the participating physician leaders. Strong performance was evident in all of the emotional intelligence competency clusters. Social awareness skills, notably empathy and service orientation, were prominently represented and complemented by high levels of trustworthiness, teamwork and self confidence. The midranges of results were populated by competencies associated with the relationship management and, to a lesser extent, the self management clusters. Among the former, developing others, was consistently displayed at high levels. Achievement orientation was also prevalent in self and other survey results. Relatively lower but sound scores were associated with a number of the self awareness (emotional self awareness, accurate self assessment) and self management (adaptability, optimism, initiative) competencies. It was this group where differences in the relative rankings of specific competencies by the physician leaders and their peers, supervisors and direct reports were apparent. The other subgroups consistently ranked emotional self awareness; accurate self assessment and conflict management lower than physician leaders scored them. In general, there was more congruence among the self, peer and supervisor results than with direct report ratings. The largest numbers of relative disparities were observed when the results from physician leader self surveys were compared with direct report scores and rankings.

7. EIC Surveys:

Emotional Intelligence competencies survey results did not reveal meaningful differences between outstanding and typical physician leader emotional intelligence competency profiles when these groups were separated by the introduction of independent, objective measures of leadership effectiveness. Nor were there notable differences in the patterns of emotional intelligence competencies displayed by the typical and outstanding leaders who participated in the study. There are several factors that may have contributed to this outcome. The number of physician leaders who participated was modest; making discrimination difficult. The range of results displayed is relatively narrow, which is a feature that demands a larger sample in order to detect modest differences. The physicians who chose to voluntarily participate in the study may represent a unique or select population relative to all potential participants. Finally, there is a possibility others (peers, direct reports, supervisors) selected by the participating leaders to contribute to the three hundred and sixty degree assessment might represent a group of respondents especially supportive of their physician leaders. These reservations must be placed in the context of broader generic threats to the validity of studies on emotional intelligence. Cherniss, in a chapter entitled “Emotional Intelligence and Organizational Effectiveness”, included a section on “Unresolved Issues & Dilemmas” regarding the subject of emotional intelligence and related competencies. Three of the topics he considered are germane to this study. The first relates to the definition of the concept as well as the distinction between emotional intelligence and emotional intelligence competencies. Cherniss’ discussion is paralleled and complemented by Goleman, writing in the same text. He suggests that Bar-On, who introduced the term Emotional Quotient, places emotional intelligence within a theory of personal well-being; while Salovey & Mayer’s concepts are best located within the sphere of intelligence theory, and his own model fits well with a theory of. Goleman also acknowledges the similarities between emotional intelligence and the concepts of intra- and interpersonal intelligence introduced by Gardner in his theory of multiple intelligences. In essence Cherniss acknowledges a need for further clarity and greater consensus with regard to the definition of emotional intelligence.

A second area where further development is warranted concerns the tests used to measure emotional intelligence and related competencies. There are five well described instruments in the literature. Only one, the Multifactor Emotional Intelligence Scale or MEIS concerns itself with the measurement of emotional intelligence, while the others EQI of Bar-On, the ECI 360, and the EQ map of Cooper & Arioli measure variations of behavioral evidences related to emotional intelligence. Gowing provides a thoughtful description of each test, its strengths and limitations while Davies offers a more critical assessment of the tests and their validity. A third challenge is the need to reconcile the predictive power of emotional intelligence relative to IQ. This is a complex, long-standing set of concerns where proponents of different persuasions have devoted significant efforts to debating the merits of each. This is interesting in the context of the current study where all the participants are intelligent and well educated. It is unlikely differences in the respective IQ scores could explain variations in physician leadership effectiveness. If this assumption is correct then other attributes (emotional intelligence competencies?) may account for any differential and more extensive testing may provide a basis for validating this assumption. A search for related studies in the literature met with limited success. No other studies addressing the relationship between behavioral characteristics and independent measures of physician leadership effectiveness were identified. There is one report comparing standard measures of primary care physician effectiveness (in a managed care setting) with behavioral competencies identified using behavioral event interview methods. It demonstrated modest correlation between clinical effectiveness and certain behavioral competencies, e.g., empathic care-giving. However, the subject population was practitioners not physicians in leadership roles and the study sample was small.

Leading professionals, especially physicians, is a challenging task exacerbated by the changes confronting health care today. Core attributes of most physicians include expertise, autonomous behavior, collegiality, and service to others. As a consequence of the way American physicians have been selected, educated, and socialized during their training many are highly competitive, relatively independent practitioners. They often eschew teamwork and collaboration and other affiliative behaviors. Their
education and socialization fosters pacesetting or commanding leadership styles that may be appropriate in certain clinical circumstances, e.g., a busy emergency department or a critical care unit, but could be counterproductive when used in other care settings. Democratic, affiliative or coaching styles are likely to be effective when working with physicians. Like most professionals, physicians are very democratic and resist hierarchical, command and control leaders (unless they are leading!). The physician leaders surveyed in this study may not be typical. They demonstrated high levels of empathy, as well as teamwork and collaboration competencies. These fit well with democratic, affiliative and coaching leadership styles. Study physicians also scored well in developing others, an important attribute for effective coaching. Trustworthiness or transparency and service orientation are two other competencies among the top five manifests by this group. Both are important when building trust and reliability with followers and encouraging a customer focus when serving patients. Relative weaknesses revealed by the survey include conflict management and influence skills; both valuable when adopting a democratic leadership approach and a potential developmental opportunity.

8. Conclusion:

As suggested above this “profile” may not be characteristic of physician leaders in general. Factors that may be influencing it include the employed group practice status of the participants, their primary care orientation, and the medical group’s investment and commitment to managed care principles and practices. While a combination of democratic, coaching and affiliative leadership styles may serve physicians well in relating to colleagues and other members of the health care team, incorporating visionary leadership competencies is essential as a physician executive assumes broader leadership responsibilities. If a pacesetting and / or commanding style have been an important part of a physician leader’s portfolio it would be prudent to reduce reliance on these options as confidence in other styles is practiced and refined. Beginning with the early design phase of this project there was a concern that endogeneity , i.e., the potential for the dependent variable (physician leadership performance relative to independent criteria) to unduly influence the independent variables (emotional intelligence competencies), could be operative. It was determined the most effective way to reduce or eliminate this possibility was to select performance indicators that were unlikely to be influenced in this way. The performance measures chosen to distinguish outstanding and typical performers are not likely to be influenced in this manner and it is unlikely defensible claims could be advanced that outstanding performers received special considerations and were able to reciprocate by demonstrating higher levels of the behaviors relevant to the measured emotional intelligence competencies.

References:


