

Emotionally Intelligent Healthcare

White Paper



Business Advisors for the Healthcare Industry

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TABLE OF CONTENTS

Abstract	3
Emotionally Intelligent Healthcare.....	3
Framing the Issue.....	3
The Affordable Care Act	3
Physician Influence is Critical	5
The Role of Emotional Intelligence.....	5
Literature Deconstruction	7
The ACA and Physician Leadership.....	7
Wide-Sweeping Changes to the U.S. Healthcare System.....	7
Why Physician Leadership is Critical.....	7
The Gap Between Medical Training and Effective Leadership.....	8
Emotional Intelligence and Health Care.....	8
EQ in the Context of Healthcare	9
Criticism of EQ	9
Support of EQ in Leadership Training	10
EQ Training for Physicians	11
Methodology	11
Interview Data Analysis.....	12
Personal Leadership Style and Training.....	13
Physician Leadership and the Impact on Others.....	14
Understanding the Impact of the ACA	15
Recommendations	15
Introduce and Initiate Change	16
Establish Leadership Training.....	16
Deliver Ongoing Support and Coaching.....	17
Conclusion.....	17
Ideas for Further Research.....	18
References	19
Exhibit A	21
Physician Interview Questions.....	21
Administrator Interview Questions	21
Exhibit B	23

ABSTRACT

This paper examines the value of emotional intelligence skills in physician leadership development through the lens of the changes implemented by the Affordable Care Act. The Affordable Care Act offers several programs designed to improve patient quality and reduce healthcare costs by offering financial incentives to hospitals and physicians. These programs, designed to change the delivery of patient care, quality outcomes measurement, and reimbursement for services to physicians, also encourage physician involvement to lead the charge for clinical redesign. Discussion of physician medical training and its relationship to effective leadership qualities, together with emotional intelligence skills, form the basis for this research. Through interviews with current physician leaders and review of relevant, current research, we examine how the soft skills associated with emotional intelligence are essential in guiding physicians in the practice of leadership.

EMOTIONALLY INTELLIGENT HEALTHCARE

The purpose of this paper, using action research principles, is to examine the value of teaching emotional intelligence skills to physician leaders and to discuss how those skills better prepare and assist them in the transition to changes brought about by the Affordable Care Act.

Slightly different from traditional research, action research is a collaborative approach to inquiry or examination using the principles of relationships, communication, participation, and inclusiveness. Unlike traditional studies, the action researcher must “actively participate in the research process, not as an expert who *does* research *on* people, but as a resource” (Stringer, 2014, p. 20). Simply put, action research examines an issue using qualitative data gained not only by a literature review of existing research, but also by interacting with those people directly affected by the issue through interviews, focus groups, and/or surveys. The Methodology section of this paper describes how we used action research to examine the issue of physician leadership and the skills they utilize for success.

FRAMING THE ISSUE

THE AFFORDABLE CARE ACT

The Affordable Care Act (ACA) is one of the most hotly debated topics in recent political history. With healthcare spending representing almost 20% of gross domestic product (GDP), the cost of healthcare is an important and relevant topic for our nation (Kocher, Emanuel, & DeParle, 2010). Since the passage of the ACA in 2010, the United States House of Representatives has attempted to repeal this Act nearly 50 times, a position that is split along political party lines (Overland, 2015). Although cost control/reduction in healthcare has overwhelming bipartisan support as evidenced by the repeal of the flawed Sustainable Growth Rate (SGR), historically it is used to determine Medicare reimbursement rates for physicians. The goal of this paper is not to discuss the efficacy or political views of the ACA. Rather, discussion of this legislation provides the rationale for examining physician leadership development and the array of skills needed to navigate successfully the changes brought about by the ACA.

Over a rollout period of five (5) years, beginning in 2010, the ACA included sweeping changes in the way health systems and physicians deliver care to patients, incentivized collaboration between hospitals and physicians, and implemented changes to the way physicians have historically been reimbursed for their services (“Key Features”, 2015). Enacted in part to provide health insurance to more than 45 million uninsureds, the ACA expanded several programs aimed at reforming the way physicians and hospitals are paid and required collaboration between physicians and hospitals to improve the quality of healthcare and reduce spending. These programs include Value Based Purchasing, Accountable Care Organizations, and population health management (“Key Features”, 2015).

Value Based Purchasing offers hospitals financial incentives to improve quality outcomes for patients and reduce hospital-acquired infections and readmissions. Physicians are at the center of this improvement measure; they make the decisions about how patients are treated and have substantial control over utilization of a hospital’s resources. Successful Value-Based Purchasing programs require clinical redesign, which is something non-clinical hospital executives cannot do without physicians leading the way (Lee and Cosgrove, 2014, Norwood, 2013).

Accountable Care Organizations (ACOs) are risk-sharing organizations designed to improve quality, reduce costs, and allow the healthcare provider to share in the cost savings with the insurer. The ACA allows for incentives paid to physicians who collaborate to improve quality, better coordinate patient care, and reduce hospital readmissions. Payment for services remains as fee-for-service (for now) but if patient care is high quality, and costs are reduced, the ACO can share in the savings (Hall & Lord, 2014, “Key Features”, 2015).

Population health management is designed to treat specific, high-cost, chronic diseases such as diabetes. Under this program, payments for care are “bundled” to physicians and hospitals to manage these chronic diseases within a pre-determined population of patients. Much like “managed care” capitation payments in the 1980s, there is one lump-sum payment for each patient regardless of the cost of treating that patient, incentivizing reduced healthcare costs (Dadlez, 2014). Where physicians have been historically paid based upon volume, on the surface these programs discourage volume and reward quality through lower utilization of healthcare services that may not benefit a patient’s health outcome. However, as quality outcomes increase, payers will allocate more patients to a physician’s care. As more people sign-up for health insurance under the ACA, the number of patients will also increase thereby continuing the monetary reward to physicians for volume.

The radical changes in the delivery of patient care and reimbursement brought on by these three programs form the basis of this research and aims to show the critical need for physician leadership. Without physicians at the helm, any such significant changes to our healthcare system are doomed to failure (Lee and Cosgrove, 2014). Physicians who collaborate effectively with other providers and health systems to improve patient quality and outcomes, increase the value of medical services, and enhance patient experiences will thrive and become the leaders of this new healthcare system (Kocher, et al., 2010). However, leadership requires a particular set of skills including teamwork and collaboration, leading change and persuading others to embrace change, inspiring vision for the future, and demonstrating a willingness to challenge fundamental processes and risk trying new ones--skills not generally taught during medical training.

PHYSICIAN INFLUENCE IS CRITICAL

Physicians are the only caregivers that write orders, perform surgery, interpret diagnostic tests, and write prescriptions. They alone “hold the pen” in healthcare, making their place at the table in the new world of collaborative healthcare mandatory (Norwood, 2013). The clinical quality and patient safety metrics directly affecting a health system’s revenue cycle requires further clinical redesign and physician clinical expertise. Only physicians can best serve as the translators between clinical and non-clinical staff. Physicians offer unique clinical insight in developing better ways to serve patients, improving clinical quality, and generating financial margins a health system needs, thus creating a definite need for teamwork between physicians and health system executives and putting physicians in a decidedly “leader” role (Norwood, 2013).

However, medical school and medical training programs give little attention to leadership and teamwork. Physicians are trained to be autonomous and competitive, independence is valued and rewarded, quality is an individual standard, and detachment is necessary to keep emotions from interfering with a physician’s ability to objectively diagnosis and treat a patient (Lewis, Rees, Hudson, & Bleakley, 2005). This clinical training results in good physicians, but not necessarily in good physician leaders (Hess, C., 2013; Stoller, J., 2008).

As a result, physicians may find it difficult to take or follow direction from others, communicate openly and honestly with team members, and collaborate with other physicians or allied health professionals. Clinically, physicians are taught to identify problems and often develop a reflex for deficit-based thinking, no matter the environment or circumstances, and may struggle to develop an appreciative inquiry style of thinking. Appreciative inquiry is relational and grounded in an appreciation for what went well and how an outcome could be improved rather than looking at it as a problem (deficit) (Stoller, 2009; Marquardt, 2005). The appreciative inquiry also keeps the focus on improvement and learning rather than venting and complaining and is embraced by many successful leaders as the more effective leadership style when leading change (Marquardt, 2005). Other leadership challenges such as giving and receiving feedback, taking risks through innovative thinking, and challenging the status quo are all qualities of effective leadership (Prati, Douglas, Ferris, Ammeter, & Buckley, 2003) but may seem like foreign concepts to some physician leaders.

THE ROLE OF EMOTIONAL INTELLIGENCE

Within the healthcare industry, as in many other industries, equating intelligence with leadership ability is common but can be a significant error. Intelligence is an important building block for physicians as well as successful healthcare leaders, but relying strictly upon intelligence to navigate the complexities of healthcare is insufficient (Fernandez, Peterson, Holmstrom, & Connolly, 2012). Traditionally, physicians have been promoted into leadership positions based on clinical skills and accomplishments rather than leadership competencies (Stoller, 2008). However, healthcare comprises a unique combination of patient and family anxiety, challenging diagnosis and treatment, and financial and regulatory complexity. Intellect and clinical expertise are certainly helpful but represent only a small part of the leadership traits needed for successful healthcare leaders (Fernandez, et al., 2012).

Intelligence, as discussed above, refers to cognitive intelligence. American psychologist David Wechsler contributed the most often cited definition of intelligence: “Intelligence is the aggregate or global capacity of the individual to act purposefully, to think rationally, and to deal effectively with his environment” (Salovey, Brackett, & Mayer, 2007, p. 3). However, another aspect of intelligence considered by some to be the “foundational element of leadership effectiveness” is emotional intelligence (EQ) (Prati, et. al., 2003, p. 22).

Research on EQ dates back to Wechsler in 1958, but the first published manuscript on EQ was written by Dr. Peter Salovey and Dr. John Mayer in 1990 (Salovey, et. al., 2007). The first of four models currently dominating the field, Salovey and Mayer defined EQ as “the subset of social intelligence that involves the ability to monitor one’s own and other’s feelings and emotions, to discriminate among them, and to use this information to guide one’s thinking and actions” (Prati, et al., 2003, p. 22). Along with psychologist David Caruso, Mayer and Salovey developed a model known as the “ability model” for EQ based on four components: (1) the ability to perceive emotions, (2) the ability to use emotions to facilitate thought, (3) the ability to understand emotions, and (4) the ability to manage emotions (Cherniss, 2010).

In his early research, American-Israeli psychologist Reuven Bar-On suggested EQ is a combination of inner-related social and emotional competencies that help predict success by how a person expresses oneself, how a person relates to others, and how a person deals with strong emotions and control impulses (Bar-On, 2005). He developed the second model of EQ, referring to EQ as “emotional and social intelligence”, containing five main components: (1) intrapersonal skills, (2) interpersonal skills, (3) adaptability, (4) stress management, and (5) general mood (Cherniss, 2010).

Third and the most recent model is “trait emotional intelligence”, developed by Greek psychologist Constantinos Petrides. It includes all “personality facets specifically related to affect” (Cherniss, 2010, p. 112) and consists of four components: (1) well-being (self-confidence, happiness, and optimism), (2) sociability (social competence, assertiveness, and emotional management of others), (3) self-control (stress management, emotion regulation, and low impulsiveness), and (4) emotionality (emotional perception of self and others, emotion expression, and empathy) (Cherniss, 2010).

Finally, the fourth model developed by professor and organizational theorist Richard Boyatzis and psychologist Daniel Goleman, and inspired by the earlier research of Salovey, Mayer, and Caruso, was designed to encompass the social and emotional competencies linked to outstanding performance in the workplace. Their model, often referred to as a “mixed model”, consists of a number of specific behavioral competencies organized into four groups: (1) self-awareness, (2) self-management, (3) social awareness, and (4) relationship management (Cherniss, 2010).

Still considered a relatively new concept in academia, EQ gained mainstream organizational popularity with Goleman’s 1995 publication of *Emotional Intelligence--Why it can matter more than IQ*. In it, he defined EQ as the ability to know one’s emotions, manage emotions, motivate oneself, recognize emotions in others, and handle relationships (Goleman, 1995). Goleman’s mixed EQ model is widely used in organizational development and is a “key predictor of job performance with stronger support than either cognitive ability or academic achievement in determining job performance” (Bratton, Dodd, & Brown, 2011, p. 129). Developing and working

with teams, conflict management, and setting emotional standards of behavior are just a few of the “soft” skills related to EQ that drive leadership performance.

LITERATURE DECONSTRUCTION

There exist a substantial number of research studies and scholarly journal articles addressing the ACA, physician leadership, and the value of EQ skills for leadership success. The purpose of this research paper is to examine and present evidence that connects those topics together as a path to effective physician leadership development.

THE ACA AND PHYSICIAN LEADERSHIP

Wide-Sweeping Changes to the U.S. Healthcare System

“Physicians have a moral calling to promote the health of their patients and the overall health of all citizens” (Kocher, et al., 2010, p. 536). Before the passage of the ACA, barriers were in place to keep physicians from fully pursuing that ideal. The ACA attempts to remove those obstacles, creating a pathway for physicians to change the way they promote overall health for their patients. By providing access to health insurance for all Americans, strengthening availability of primary care physicians, financially incentivizing physicians and hospitals to improve quality of care and reduce the cost of providing that care, the ACA is the most comprehensive overhaul of the U.S. healthcare industry in its history (“Key Features”, 2015; Kocher, et al., 2010; Norwood, 2013). A change of this magnitude cannot realistically be a success without physicians at the helm together with non-physician healthcare leaders. There must be room at the table for non-clinical hospital executives and physician leaders to work together creating a new, progressive avenue for delivery of patient care that emphasizes quality and reduces spending (Kocher, et al., 2010; Norwood, 2013).

Why Physician Leadership is Critical

The ACA promotes several new programs aimed at improving quality outcomes and reducing healthcare spending. Because of each program’s focus on clinical redesign and integration between physicians and hospitals, this paper focuses on the imperative need for physician leadership in three of these programs: Value Based Purchasing, Accountable Care Organizations, and population health management (Hall & Lord, 2014; Norwood, 2013; Dadlez, 2014). By shifting risk from Medicare to physicians and hospitals, allowing for shared savings when healthcare costs fall below expectations, and focusing on quality outcomes attributed to specific high-cost, chronic diseases, physicians must be central players. While the ACA focuses, in part, on cost reduction, the emphasis on clinical redesign and integration must focus on what is best for the patient rather than on maximizing short-term revenue goals. Non-clinical healthcare executives may be excellent at achieving the latter, but they are not equipped to excel at the former without strong physician leadership (Dadlez, 2014; Hall & Lord, 2014; Kaplan, et al., 2012; Lee & Cosgrove, 2014; Norwood, 2013).

The Gap Between Medical Training and Effective Leadership

Medical schools and training programs give little attention to the skills needed for effective leadership. In fact, skills taught in clinical programs are counter to the necessary skills to assume a leadership role and succeed (Hess, 2013; Lewis, et al., 2005; Stoller, 2008; Stoller, 2009). Medical training values independence, competition, conformity to standards, and creates “deficit-based thinkers” (Stoller, 2009, p. 877), meaning physicians are conditioned to look for problems to solve. Clinical skill is built and reinforced on the ability to identify and successfully solve problems. However, physicians’ reflex for deficit-based thinking often makes it difficult to adopt a more open, appreciative inquiry style of thinking about organizational issues (Stoller, 2009; Marquardt, 2005).

Demanding academic curricula focused on scientific and clinical training offers limited exposure to formal leadership training. However, with the call for more physicians engaged in finding solutions in the changing healthcare system, there must be targeted leadership training for those physicians who choose to move out of clinical roles and into management or leadership positions. Skill sets utilized in the practice of medicine may vary widely in a broader, more strategic leadership position (Dye, 2014). In the broader leadership role, physicians may be called upon to collaborate, build bridges and alliances, mend relationships, and address other physicians who exhibit disruptive behaviors. Without specific training on how to meet these responsibilities, physicians may be challenged to succeed in leader roles.

EMOTIONAL INTELLIGENCE AND HEALTH CARE

The Accreditation Council for Graduate Medical Education (ACGME) is the organization responsible for the accreditation of post medical training programs within the United States. Their mission is to “improve the health care and population health with the assessment and quality of resident physicians’ education through accreditation” (“About ACGME,” 1981). The ACGME has defined six core competencies for graduate medical education that map to clinical indicators of outcome and performance. Those competencies include Patient Care, Professionalism, System-Based Practice, Interpersonal and Communication Skills, Medical Knowledge, and Practice-based Learning and Improvement.

Patient Care, Professionalism, System-Based Practice, and Interpersonal and Communication Skills represent components of the doctor-patient relationship and research has shown a positive correlation between physicians’ EQ, specifically recognizing and managing emotions, and patients’ trust, willingness to follow-up on medical care, and their overall satisfaction with both the physician and the hospital (Arora, et al., 2010). Additionally, communication and teamwork are both necessary components of System-Based Practice and both map to EQ competencies. Research shows “significant positive correlation between the two domains” (Arora, et al., 2010, p. 760).

Research continues to examine how EQ maps to the ACGME competencies and how incorporation of EQ as a tool in medical training can improve both clinical and educational outcomes (Arora, et al., 2010; McKinley et al., 2014).

EQ in the Context of Healthcare

One clear definition of EQ is “the accurate appraisal and expression of emotions and the ability to monitor one’s own and others’ feelings and emotions, to discriminate between them and to use the information to guide one’s thinking and actions” (Mayer & Salovey, 1990).

Medical students typically learn to blunt their emotions to cope with the stress of medical school. They are taught to value detachment in clinical training, reflecting the belief that emotions interfere with a physician’s ability to do his or her job. Detachment is seen as a way to maintain distance from patients to keep objectivity in diagnosis and treatment (Lewis, et al., 2005). One of the physicians interviewed explained it by saying that to practice clinical medicine, the best physicians can draw people near but remain detached so they can objectively treat the patient in a manner consistent with what the patient needs and deserves. He suggested that practicing this type of clinical detachment might make EQ skills, such as empathy, less evident in physicians’ behavior (Interview respondent, personal communication, May 2015).

Physician development of EQ skills such as self-awareness, social awareness, self-management, and relationship management can be applied to improve patient and family communications, appraisal and collaboration with other physicians, nurses, and administrators, and the ability to manage emotions and stress in an environment teaming with stress. With years of medical and scientific training, physicians are often seen as a pillar of logic and rational thinking. As a result, there may be a gap between EQ competencies and those required by the ACGME (Caruso and Salovey, 2004). Studies suggest that EQ training should be offered throughout physicians’ careers to build these competencies and ultimately provide enhanced patient care (Stoller, Taylor, & Farver, 2013).

Criticism of EQ

Some researchers agree that EQ does map to the ACGME concept of Patient Care, Professionalism, System-Based Practice, Interpersonal and Communication Skills, Medical Knowledge, and Practice-based Learning and Improvement. Specifically, research has shown a positive correlation between EQ and professionalism, the doctor-patient relationship, interpersonal and communication skills (Arora, et al., 2010; Lewis, et al., 2005). However, critics argue that individual outcomes obtained from the various tools used to measure EQ should not be used as a predictor of performance (Lewis, et al., 2005). A significant number of researchers call for additional studies in the validity of measuring EQ, given the debate over EQ as a personality trait or an ability. Critics argue that if EQ is an ability, there should be objective measurement of that ability. Conversely, if EQ is a personality trait, then objectivity is not possible. Additionally, several measurement tools are self-reporting. By the very nature of self-reports, critics also argue objective criteria cannot be applied for scoring the report (Arora, et al., 2010; Lewis, et al., 2005).

Many researchers agree there are few other constructs in social science that have had more controversy than EQ and the claims of success in a professional setting. Critics of EQ can agree on the issues of multiple definitions and numerous self-reporting tools; they question the ability to measure a seemingly unmeasurable concept (Atwater & Yammarino, 1992; Lewis, et al., 2005).

Support of EQ in Leadership Training

In light of formidable challenges in the healthcare industry, the need for strong leadership is clear. Many healthcare institutions are cognizant of the need for the development of their leadership pipeline and will call on those strong professionals to be part of the solution in reducing costs, enhancing access to care, and ensuring quality healthcare (Stoller et al., 2013). EQ suggests that our emotions are a valuable source of data and can assist in helping to solve team problems. Emotions and thinking are inextricably linked, and the leaders who have the ability to self-monitor their emotions, understand their impact on others, motivate others, and create a collaborative environment may have a direct influence on the performance of a team (Caruso and Salovey, 2004).

In addition to enhancing team performance, EQ has been organizationally linked to enhanced productivity, increased job satisfaction, and reduced turnover. A leader's ability to create an emotionally intelligent environment or culture may help mitigate burnout and stress of team members. Because of the anxiety associated with illness and injury, medical environments by their very nature are stressful to patients as well as the medical team caring for them. Situations occur when admitting to a mistake, communicating with family members, or dealing with a frustrated colleague may involve competence in EQ-related areas. The ability to control and self-manage one's emotions, and actively listen and provide supportive feedback to others serves the best interests of the patient as well as the medical worker (Arora, et al., 2010).

James Stoller, M.D., Chairman of the Education Institute and Head of Respiratory Therapy at Cleveland Clinic, is a prolific author and researcher in the field of physician leadership development. In his article "Developing Physician Leaders: A Call to Action" (2009), he outlines four specific factors outside the hospital environment that present particular leadership challenges:

- Complex external factors such as insurance and regulation.
- Evolving new technologies.
- Challenging management of a professional workforce.
- Potentially competing care delivery goals, e.g., "the tension between expense reduction, clinical care, and patient quality" (Stoller, 2009, p. 876).

This complexity is compounded by "the characteristics of physicians, who value autonomy and...may be disinclined to collaborate or to follow" (Stoller, 2009, p. 876) but further validates the need for formal leadership training.

In the book *Emotional Intelligence--New Perspectives and Applications*, Fernandez, et al. (2012) argued that EQ skills strongly influence the culture of an organization, and while the skills may not be innate, they can be developed and taught. Development of EQ skills is dependent upon how the material is presented and the willingness of the participant to learn (Fernandez, et al., 2012).

EQ Training for Physicians

There is increased pressure due to limited resources, complex outpatient services, and growing regulatory requirements to develop and empower physician leaders to help improve the value of care, manage chronic diseases more effectively, and understand the transition to patient-led healthcare. To meet this challenge, physicians need additional skills to navigate and lead the change. Caryl Hess, Ph.D, is the Director of the Cleveland Clinic Academy at Cleveland Clinic in Ohio, one of the many health systems working to develop healthcare leaders with an emphasis on physician leadership education. In her 2013 article on leadership development, she suggests that in the field of leadership development, tensions brought on by change can be reduced if leaders are taught to maximize their emotional intelligence (Hess, 2013). “Leadership development is about the relationship between leaders and their followers and the leader as a follower. It is about the intimate connection a leader has with a team of physicians, nurses and administrators in a healthcare setting” (Hess, 2013, p. 75).

The question is how to provide such training to a group of professionals disinclined toward collaboration and teamwork. Several studies have suggested different models including educating the faculty and physicians around the common language of EQ, choosing participants who are willing to invest personal time and reflection in the effort and providing an environment that is open learning and personal reflection in which participants can learn (Taylor, Farver, & Stoller, 2011). Other suggestions include meeting the physicians where they are in their career using a “spiral curriculum” (Stoller et al., 2013, p. 246). This approach allows for training and development of different EQ competencies over the time and experience of the learner. Basic concepts such as self-management including self-control, adaptability and optimism may be considered early on to residents and medical students. More complex competencies such as developing others, inspired leadership, collaboration, and conflict resolution can be taught as the physician progresses in his or her career (Stoller et al., 2013).

METHODOLOGY

While researching EQ training for physician leaders, it was important to interview both physician leaders and non-physician administrators working directly with physicians. Interviewing both groups allowed for more balanced research data. To aid in connecting with physician leaders, we elicited the help of the Texas Hospital Association (“THA”), St. David’s Health System, and Coker Consulting, a healthcare consulting firm based in Atlanta, Georgia.

We met with Ted Shaw, President and CEO, and Mitzi Ressmann, Senior Vice President of Operations, both of THA, explained the purpose of this paper, and asked for physician and non-physician administrator contacts who would agree to participate in this research. Ideally, the participants would include those who had received leadership training and those who had not.

Additionally, we had similar conversations with Max Reiboldt, President and CEO of Coker Consulting, and Ellis “Mac” Knight, MD, Senior Vice President and Chief Medical Officer, also of Coker Consulting. Both provided us with numerous relevant contacts, completing the group of interviewees needed to conclude our qualitative research.

Lastly, we also worked with Eric Norwood, President of CenterPoint Insights, an advisory firm for healthcare leaders, who was instrumental in providing contacts with physicians who completed leadership training with MEDI Leadership, a leadership development firm dedicated to the healthcare industry. Although we met with several St. David's Health System executives, we were unable to gather information relevant to this paper. They were willing to assist us but St. David's organizational structure did not lend itself to examining physician leaders.

Following the conversations above, along with direction and oversight from our Professor, Dr. Tom Sechrest, we developed a series of open-ended questions focusing on each interviewee's experience with leadership and emotional intelligence, using the ACA to frame the purpose of our research. The questions to both administrators and physicians were mostly identical except a few questions posed to administrators meant to identify possible gaps in physician leadership characteristics.

Once our questions received approval from Dr. Sechrest, we scheduled 15 interviews for completion over the course of six weeks. Because of geographic limitations, we conducted all but one of the interviews by telephone. Nine of the interviewees were physicians in executive leadership roles, the majority of whom were Chief Medical Officers within large health systems. Despite holding an executive-level leadership position, only five of the nine physicians had completed formal leadership training; the other four had no formal leadership training. The remaining six interviewees were non-physician administrators (one was a nurse practitioner) who worked directly with physicians in different capacities.

We prioritized the questions for each interview based on a one-hour time limit. The number of questions completed in each interview was dependent upon the interviewee's depth of response to each question. Some physicians and non-physician administrators took more time to answer each question, allowing for fewer questions overall. Our interview process included one researcher asking the questions while the other took detailed notes. We both reviewed these notes after each interview to ensure accuracy. Each interviewee responded forthrightly to the questions, agreeing that our examination of the value of emotional intelligence training for physicians in response to the ACA was extremely relevant. They each offered their availability for further questions and requested a copy of this paper upon completion.

INTERVIEW DATA ANALYSIS

Based on the methodology described previously, "data" in this section refers to the responses received to interview questions posed to physicians and non-physician administrators. Several interview questions were identical regardless of the interviewee (physician or administrator), other queries were asked of administrators only, and still others for physicians only. Most of those interviewed, especially the physicians, were passionate and eager to talk in depth about leadership. Consequently, we asked additional questions to clarify their responses, resulting in the opportunity to delve more deeply with each interviewee on the topic of leadership.

Analysis of the data was performed by dividing the questions into three categories: (1) personal leadership style and training, (2) physicians as leaders (asked of administrators only) and, (3) understanding of the ACA and its impact. The answers were compared and contrasted between the two groups and within each group, i.e., physicians and non-physician administrators. A list of the specific questions asked is included in this paper as Exhibit A.

PERSONAL LEADERSHIP STYLE AND TRAINING

We asked each interviewee to name the top five behaviors exhibited by leaders they respected. Because leadership is a complex process and has multiple dimensions, opinions vary widely about what makes a great leader (Northouse, 2013). Not surprisingly, of the 15 people interviewed, the respondents listed more than 40 different behaviors exhibited by leaders they respected. Both administrators and physicians chose qualities like job competence, effective communication skills, trust, and integrity as essential for good leadership. As a group, administrators focused on qualities such as articulating a vision, respect for others, and the ability to motivate followers. Physicians said leadership qualities like team building, empathy, self-awareness, and remaining calm in challenging situations were most important. Interestingly, administrators were far more likely to model their own leadership style after those they admired than physicians were. As a group, and knowing their reflex toward independence, the physicians were not likely exposed to thinking of leadership as something to model themselves after.

When asked, several physicians believed they were effective leaders, although only about half those interviewed had ever participated in a leadership development program. The other half had not studied leadership, did not challenge assumptions about their leadership style, and only opened themselves to feedback from peers and hospital executives, as opposed to including their followers in the feedback process. Rather than offering this insight as a criticism, we believe it speaks to the ingrained nature of clinical training.

One of the most impactful trends that emerged from the physician interviews was an apparent difference between physicians who had leadership training and those who had not. Physicians with leadership training spoke in terms of “we” when discussing the impact of their leadership position. As Kouzes and Posner (2012) state in *The Leadership Challenge*, “leaders mobilize others to want to struggle for shared aspirations...leadership is a relationship” (p. 30). The physicians who participated in leadership development had a clear understanding that leadership is a relationship between leader and follower and they do not accomplish anything alone. Those who had not actively developed a leadership style or participated in leadership development tended to speak in terms of “I”; at almost no time did they refer to “us” or “we” in the dialogue about their actions as a leader. The language of “I” appears to reflect their working as an individual versus as a member of a team. This trend should not imply anything negative about the physicians who have not received formal training to develop their leadership style. Rather, it may suggest that effective leadership skills can be learned, and physicians, in particular, are fully capable of developing new skills beyond those taught in medical school.

A second theme discovered during the interviews likely offers evidence about the lack of leadership training for more than half the physician leaders interviewed. According to the administrators and physicians we interviewed, there is a definite lack of importance placed upon physician leadership development in the organizations where physicians are put in leadership roles. Funding may be a limiting factor but most of the administrators we interviewed readily admitted that physician leadership development receives only minor consideration by health system executives. Research of the literature revealed two important issues supporting the interview data: the tradition of promoting physicians to leadership positions based on clinical or academic skills and accomplishments rather than on leadership abilities, and general inattention to developing leadership competencies in physicians (Stoller, 2008).

To gauge their level of understanding and knowledge base, we asked each interviewee to describe EQ and the value of EQ skills development for physicians in leadership roles. While no respondent knew the actual definition of EQ, some administrators defined EQ as the ability to understand another's point of view, acknowledging how one feels, attunement to important issues, and having an understanding of how physicians think. Some physicians described it as self-awareness, the ability to influence others, having empathy, rational decision making, and having an awareness of your life and the lives of those around you. Perhaps surprisingly, physicians had the clearest understanding of EQ.

The majority of administrators agreed that EQ was essential for physician leaders, specifically the ability to collaborate with others in the wake of ACA changes to the traditional healthcare delivery model. They also believed with EQ skills, improved communication skills, increased engagement, and better awareness of a physician's impact on others would ultimately improve patient outcomes. Likewise, the physicians interviewed expressed their thoughts on the value of EQ skills and the relationship to effective leadership, believing EQ development would lead to greater empathy, improved social skills, and the ability to control their emotions when appropriate. Several physicians gave a definitive answer to the connection between EQ and leadership, stating, "...leadership and EQ cannot be separated" (Interview respondent, personal communication, May 2015) and; "...a leader cannot be effective without emotional intelligence" (Interview respondent, personal communication, May 2015).

PHYSICIAN LEADERSHIP AND THE IMPACT ON OTHERS

Because leadership is a relationship between leader and follower, we wanted to know the followers' view of physician leaders *in general*. To that end, we asked each administrator to list the three most difficult aspects of working with physician leaders. Listed below, in no particular order, are some of the common themes from their comments (all administrators interviewed had more than ten years' experience working with and for physicians):

- Physicians pride themselves on their individual competency--they are excellent at the individual level. Working in teams, whether with other physicians or non-physicians, is difficult for them.
- Physicians are not trained to manage or be managed, and they typically do not like to scrutinize other physicians or be scrutinized themselves.
- They want things without regard for available resources, and cannot relate to financial or operational barriers/issues within a hospital system.
- Physicians have large egos, are difficult to talk to, and often bypass rules of the organization to get what they want (every administrator said this with varying degrees of detail).
- Physicians are a team of one.
- They are reluctant to change and are often inflexible in the face of change.
- Everything is about the problem in the moment; physicians have difficulty seeing the big picture.

This question was not intended to denigrate physicians, but feedback from all sides is necessary for any leader. It enhances the leader's awareness and enables self-improvement in areas that, without feedback, they may be unaware need improvement. However, most of the physicians interviewed either received no formal feedback on their leadership performance or only received it from the CEO of their hospital system.

UNDERSTANDING THE IMPACT OF THE ACA

Lastly, when asked to explain their understanding of the ACA and discuss their readiness, there were a wide variety of answers from both administrators and physicians. The answers ranged from complete unawareness of ACA changes to complex planning for physicians and administrators in anticipation of these changes. This inconsistency certainly speaks to the uncertain and complex nature of the ACA, and its effect on the day-to-day operations for physicians, administrators, and hospitals. There were equal amounts of criticisms and praises for the issues the ACA tries to address, which is not surprising given the constant reporting of debate on both sides of the aisle in our government. All physicians understood there would be a shift from fee-for-service to pay for performance on patient outcomes, changing the way they are currently reimbursed for patient care. Overall, physicians and administrators alike accepted the reality of the changing healthcare industry, but nearly everyone interviewed lacked a clear understanding of what the ACA will mean for their role and their organization, further reinforcing the overall ambiguity and complexity of this legislation.

Research definitively concludes there is a critical need for physician leadership in our complex healthcare system. The physicians interviewed were motivated to take their place at the table of leadership through what amounts to a revolutionary change in the delivery of care. However, many physician leaders may be unprepared for such responsibility, although not for lack of willingness. Leadership is a study unto itself, and there exists an apparent deficit in leadership development for physicians. Clinical excellence, academic accomplishment, or intelligence is not sufficient to result in effective leadership. One physician interviewed concluded that having organizational literacy and behavior competencies in leadership would greatly enhance the ability of physicians to lead the way through the paradigm shift in how healthcare is delivered (Interview respondent, personal communication, May 2015). Many physicians agreed that if physician engagement is not made a high priority, the radical and meaningful changes will not successfully come to fruition.

RECOMMENDATIONS

Developing leadership competencies and embracing change are widely valued concepts in successful organizations across many industries. The healthcare industry, however, has been slow to adopt these concepts. Major governmental changes are awakening healthcare systems to the critical need for physician leaders and the development necessary to aid in their success.

General leadership competencies are amply discussed in numerous leadership books and journals although the complexities inherent in healthcare suggest the need for specific leadership traits such as leading teams, embracing change, inspiring others toward a vision, and emotional intelligence (self-awareness, self-management, social awareness, and relationship management) (Cherniss, 2010). EQ is an often-debated topic but copious research exists suggesting one's mastery of EQ skills is "a key predictor of job performance with stronger support than either cognitive ability or academic achievement" (Bratton, et al., 2011). Through the lens of EQ, this section discusses several recommendations for health systems to consider in their quest to develop physicians as leaders.

INTRODUCE AND INITIATE CHANGE

Physicians by the very definition of their position can be considered leaders and have a unique opportunity to be at the forefront of the current revolution in healthcare. As Albert Einstein said, "...to raise new questions, new possibilities, to regard old problems from a new angle, requires creative imagination and marks real advance in science" (Getzels, 1979, p. 168). A physician leader's ability to go beyond the existing clinical skills, develop and demonstrate mastery of vision, improve communication and collaboration skills, and learn to solve complex problems through appreciative inquiry would place him or her at the forefront of this healthcare revolution.

Our research clearly showed there are varying degrees of knowledge about the ACA and its implications for physicians and hospitals. To reach their full leadership capacity, physicians now must educate themselves and understand how to be part of the overall solution, rather than wait until something is done to them. Administrators and physicians alike would do well to create a vision, communicate that vision, and set goals to improve patient outcomes, involve other healthcare workers and patients, and hold themselves and each other accountable to those goals.

ESTABLISH LEADERSHIP TRAINING

Start small. The ACGME has defined teamwork and interpersonal communication skills as specific competencies physicians must demonstrate. Initial training should be linked explicitly to these competencies. Evidence has suggested that a higher EQ is positively associated with more compassionate patient care and contributes to teamwork and doctor-patient communication (Arora, et al., 2010). Select a small group of physician leaders who can quickly assimilate these skills, provide them with quality EQ training, and allow CME credits as an incentive. Armed with these new skill sets, these leaders can begin to seed the organization with emotionally intelligent behaviors and competencies and build a culture that will support change. While teaching "technical" skills needed in healthcare management (such as finance, operations, information systems, and strategic planning) is valuable to anyone assuming a leadership role in healthcare, teaching "soft" skills associated with EQ has been "frequently cited as an essential competency for physician-leaders" (Stoller, 2008, p. 310). Any physician-leadership development program should include a strong focus on EQ skills. Programs offering degrees or certificates in healthcare management that do not include an emotional intelligence component are missing a critical element in the competencies needed for effective leadership. Physicians and healthcare administrators who are interested in leadership roles may wish to pay particular attention to courses that will help develop their EQ competencies, which are seen as critical to career development and organizational success (Taylor et al. 2009.).

Career growth and increased responsibilities call for additional training to ensure the competencies needed to be successful as a leader. Discrete competencies such as self-awareness, social awareness, self-management, and relationship management can be taught (Stoller, 2013). Teaching them at the right time in a physician's career would

Recommendations for Developing Physicians as Leaders

- Introduce and Initiate Change
- Establish Leadership Training
- Deliver On-going Support and Coaching

allow iterative teaching to match the skills at the time of the need. The needs of first-year residents are clearly different from that of a more seasoned Chief Medical Officer. Providing a curriculum that meets a resident where they are or where they would like to be would allow them to focus on emotional self-control, adaptability, and optimism skills while providing faculty and fellows the freedom to concentrate on developing others, teamwork, and conflict resolution (Stoller, 2013).

Training for busy professionals presents its challenges. As such, training programs considered more effective suggest high quality, problem-based learning that results in shared success (Arora, et al., 2010; Lewis, 2005). Such didactic learning will allow teams to develop a common language and potentially assist them to apply the knowledge in day-to-day situations.

Multiple self-reporting tools exist for measuring EQ. We do not offer an opinion on the value of one tool over another as it goes beyond the scope of this paper. However, we suggest that an organization or potential leader choose one of the tools to get a baseline understanding of his or her EQ and begin educating themselves utilizing the enormous library of books, articles, and leadership training materials currently available. We have included a short, but relevant list of books on EQ attached as Exhibit B at the end of this paper.

DELIVER ONGOING SUPPORT AND COACHING

“Leaders rarely fail because they don’t know what to do. They fail because of how they do it” (Norwood, 2013, p. 3). Leadership is a study unto itself, and many effective leadership qualities are not innate. The old belief that “leaders are born, not made” has been on the cutting room floor for many years. Leadership competencies, including EQ, can be learned, and effective, inspiring leaders can be made.” As such, we recommend that physicians who choose to pursue an executive leadership role commit to ongoing support as they navigate the leadership waters. Executive coaching from someone with EQ training, mentoring from other successful leaders, and debriefing/feedback opportunities all provide safe venues to discuss particular challenges relating to EQ skills. Lastly, we believe strongly (as do several physicians interviewed) that lifelong learning is the cornerstone of effective leadership. Leadership development is not a “one and done” effort and physicians who embrace a lifetime of learning will lead us all to the next paradigm of healthcare.

CONCLUSION

“Great leaders move us. They ignite our passion and inspire the best in us. When we try to explain why they are so effective, we speak of strategy, vision, or powerful ideas. But the reality is...great leadership works through the emotions.”

Daniel Goleman – *Primal Leadership* (2013)

The United States is on the precipice of major changes in the healthcare industry. Whether one supports the ACA or not, points on which we can all agree are that healthcare has become more complex, costs have skyrocketed, and the current trajectory of the industry cannot be sustained. Physicians and administrators must function differently and develop smarter and more efficient ways to deliver patient care.

This level of change requires not just good leadership, but great leadership: the kind of leaders that can not only solve medical problems, but also motivate people and involve them in solutions, educate patients, and engage the entire healthcare team toward better patient outcomes. There is a need to look at the problems differently and to arm leaders with the tools that have previously not been readily available in the medical curriculum, but that can support them as they take on the challenges that change of this magnitude will require.

Physician leaders may not have all of the answers, but their involvement in the solution is essential. Emotional Intelligence is one of the tools that can allow for enhanced self-awareness and an increased understanding of what motivates others. We need the strength and momentum of an empowered and skilled workforce that can drive the necessary and critical changes in our nation's healthcare industry. Leadership is not for the faint of heart; but for those brave souls who are willing to try, it is its own reward.

IDEAS FOR FURTHER RESEARCH

In this white paper, we have attempted to identify the benefits of EQ competencies for physician leaders as they transition through the complexity of the ACA. While there is substantial research on the topic of EQ, leadership and EQ, and physician leadership development, the field of EQ and the impact on leadership performance is still relatively new and academically in the "early stages of development and hypothesis testing" (Cherniss, et al., 2006, p. 239). Researchers agree that more qualitative and quantitative data is needed to understand the effect emotions have on leadership and organizational success. However, researchers also agree that, in addition to other leadership qualities, successful leaders also possess well-developed EQ skills, demonstrating a positive connection between successful leaders and EQ competency (Fernandez, et al., 2012).

In this section, we identify several topics for further study, specifically in healthcare, that would make a significant contribution to the field of EQ and leadership competencies. Examining the link between EQ training for physician leaders and success in patient outcomes and career success may illuminate specific curriculum needs relative to EQ training in medical schools and residency programs. An examination of quality outcomes and patient satisfaction between EQ trained versus non-EQ trained physicians may lend itself to the development of health system strategies that raise patient satisfaction scores. Research focused on the development of measurable outcomes that align specifically with the healthcare industry may influence efforts in recruitment and evaluation of current and future leaders, and provide a framework to examine performance in specific areas such as organizational performance, productivity, job satisfaction, turnover, and reduction of disruptive behaviors. Further investigation into the cultural dynamics and dysfunctions within hospitals between physician and non-physician leaders would illuminate the many aspects of a cultural divide that cannot be solved by merely improving physician leadership skills. In other words, leadership is everyone's job. Finally, research to evaluate the effectiveness of one-on-one executive coaching designed to improve EQ versus a classroom setting or experiential training courses may influence the overall success of leadership development programs.

Leadership is not as much about *what* the leader does but more about *how* they do it. Because the study of EQ and leadership examines the behavior and outcomes of actual leaders, the research provides realistic rather than theoretical conclusions about the value of EQ competency. The more prolific the research on EQ, the better we can understand how individuals influence organizational dynamics, culture, and success, enabling development of curricula and tools for EQ mastery.

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EXHIBIT A

PHYSICIAN INTERVIEW QUESTIONS

1. Of the best leaders you have learned from or respected, what are the top five behaviors they exhibited?
2. Describe your leadership style. What specific similarities/differences have you noticed between your leadership style and that of the leaders you have respected?
3. In what ways has training influenced your leadership style?
4. Describe your understanding of emotional intelligence.
5. In what ways do you believe that developing emotional intelligence can influence leadership performance?
6. Do you believe you are effective as a leader? If so, why? In what ways do you challenge your assumptions about your leadership style?
7. In what ways do you recognize the strengths of the people in your organization?
8. How do you open yourself to receive feedback from your team?
9. How do you utilize the strengths of people in your organization?
10. Describe a time you held yourself and your team accountable for accomplishing stated goals.
11. In what ways do you create a culture/environment that encourages innovation?
12. Leadership is often a lonely position. Who is the 'go to' resource for you to talk through issues/challenges?
13. Change is difficult for most. As a leader, what have you considered to enable you to drive the benefits of the changes in the health care system?
14. In what ways could emotional intelligence training assist you in your practice or with your patients?

ADMINISTRATOR INTERVIEW QUESTIONS

1. Think of the best leaders you have learned from or respected. What are the top five behaviors they exhibited? Why do you believe they made the best leaders?
2. What specific similarities/differences have you noticed between your leadership style and that of the leaders you have respected?
3. What are the three most difficult aspects of working with physician leaders?
4. How valuable is emotional intelligence (soft skills) for physicians in leadership roles?
5. How is the Affordable Care Act going to affect your hospital? How will it affect your current role?
6. Do you think your physician leaders are prepared for the changes brought about by the ACA?
7. What type of leadership training does your organization provide for physicians? If not, why?
8. Describe the training physicians receive.
9. How do you measure physician competency in leadership (or how does the organization measure it?)
10. In what ways do you create a culture/environment that encourages innovation and delivery to a goal?
11. Describe your understanding of emotional intelligence.

12. In what ways do you believe that developing emotional intelligence influences leadership performance?

EXHIBIT B

In addition to the references used to write this paper, below is a list of other reference books on the subject of emotional intelligence:

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