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Emotional Intelligence: Can It Enhance Your Personal and Professional Life?

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Irrespective of our life paths, the ability to initiate and sustain effective interactions with others is a key determinant of personal and professional success. This is particularly true for physicians who often find themselves in a wide variety of informal and formal leadership roles—in medical systems, clinics, and operating theatres. Furthermore, the stress and long hours involved in medical practice frequently put an additional burden on our personal relationships with family and friends. Successfully navigating these challenges requires a level of insight into our behaviors and the behaviors of others.

THE SCOPE OF EMOTIONAL INTELLIGENCE

The term "emotional intelligence" (EI) has been advanced to describe the set of personal attributes that enhance social and professional relationships. As developed by Goleman and others, the elements of EI encompass the full range of interactions between individuals and society including self-awareness, social awareness, self-regulation, and relationship management.[1,2]

Of these, the key constituents of EI are self-assessment and empathy. Most workers in the field believe that EI is not static but a set of skills that can be learned with commitment and behavioral modeling.[3]

Some practical aspects of each category are listed in the following text.

Self-awareness
- accurate self-assessment
- self-confidence

Social awareness
- empathy
- service orientation
- organizational insight

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Self-regulation
- emotional control
- trustworthiness
- adaptability
- initiative

Relationship management
- communication
- conflict management
- teamwork

The increased interest in EI is supported by a growing compilation of data that demonstrate that enhanced social interactions improve personal performance in a wide range of settings. Boyatzis studied 2000 supervisors and executives and found that 14 of 16 distinguishing traits for success were emotional not cognitive.[4] Spencer and Spencer defined job competencies in 286 organizations and noted that 18 of 21 competencies associated with high performance were emotionally based.[5] Comparing "star" performers to average performers in diverse industries, Goleman found that emotional advantages were noted twice as frequently in high performers and were a much better predictor of achievement than cognitive superiority.[6]

EMOTIONAL INTELLIGENCE IN MEDICAL PRACTICE AND LEADERSHIP ROLES

Although having greater insight into one's feelings could be expected to correlate with success in leading others, supportive data in the medical field are not robust. That said, one could easily argue that the need for such informed and consistent leadership has never been greater. There is recent information that would argue that physicians are experiencing considerable emotional stress due to a host of financial and other pressures that are dramatically changing both the practice of medicine and how doctors perceive their role in society. A survey of 1951 full-time physicians and scientists from four geographically separated medical schools noted that 20% had significant depressive symptoms.[7] Depression and anxiety scores were higher in young physicians (<35 years of age) than in their more senior colleagues. Relevant to this discussion, the very highest depression and anxiety levels were noted in surgeons; the lowest scores were recorded in emergency medicine physicians who had high acuity challenges but "controllable lifestyles." This suggests that the context in which the stress occurs (e.g., the degree of personalization, total work hours) has more to do with adverse emotional effects than the level of stress itself.

It would be comforting to think that physician leaders, who are generally selected for both academic achievement and positive personal characteristics, might have better coping mechanisms and thus be well acquitted to serve as role models for their younger colleagues. Gabbe et al. surveyed 131 chairs of obstetrics and gynecology, achieving a 91% response rate.[8] A surprising 88% of chairs experienced moderate to severe "burnout" as measured by a standard inventory (MBI-HSS), which quantitated emotional exhaustion, depersonalization, self-efficacy, and personal achievement. The principle drivers of burnout were global and local financial pressures, Medicare audits, and hospital down-sizing not the traditional intramural academic conflicts of past times. The incidence of burnout did not correlate with experience or length of tenure as a leader.

As a rule, these most troubling problems had a single unifying theme—they were not directly controllable by the chairs. Dealing with them without undue personal strain would require a level of detachment coupled with strategic planning. For whatever reason, many of these experienced leaders were unable to maintain personal equanimity under these circumstances. One could reasonably conclude that the chairs' efficacy as role models for their junior faculty likely suffered in parallel.

It is clear that in such times of transition and challenge, optimal leadership is needed. What is less well defined is the specific actions that can improve the skill sets of modern surgical leaders and enhance their abilities to counsel and motivate their colleagues.

Although it is obvious that developing an improved understanding of one's emotions is the ideal first step in this process, achieving personal insight is often difficult. In designing a recent study of 43 highly successful business leaders, Bennis and Thomas postulated that the "more modern" leader would have fundamentally different skills and tactics than CEOs of a more traditional era.[9] In fact, their subsequent research demonstrated that the views of both sets of leaders were remarkably similar. One common experience was particularly revealing. A majority of those interviewed described an unplanned and usually traumatic incident in mid-life that caused them to reformat their personal views of achievement and develop a higher level of empathy for others. In nearly every instance, they credited this specific response for their improved leadership performance.

Certainly today's surgical leaders do not lack for such "learning opportunities." The challenge is using the experiences to grow rather than becoming frustrated. Since it is difficult to dispassionately analyze personal reactions during trying times, useful information can often be gained from the reactions of others experiencing the same environment. The further benefit is utilizing the information to better understand and address the dissatisfactions of the larger group.

At the University of Chicago, we were fortunate to collaborate on these issues with Harry Davis, professor in the Graduate School of Business. Professor Davis interviewed a representative group of faculty with different professorial ranks and areas of interest. On the basis of their detailed comments, he detected two distinctly different views of their professional situations that were, paradoxically, often expressed concurrently.

The first viewpoint could be characterized as the "half-full" glass. Physicians expressed pride in the mission of the department and university and general satisfaction in the degree of autonomy they enjoyed. They took pleasure in their achievements in the full range of academic activities including teaching, clinical care, and research. That said, the same individuals expressed considerable frustration in other elements of their job (the "half-empty" glass). They spoke of unity gained only through identification of "common enemies" such as hospital and university administrative restrictions. They bemoaned what they perceived as a "culture of expendability." They felt their value to the enterprise was real but transient and often felt that their contributions would soon be forgotten when they left. Finally, many described negative and unsettled feelings best described as "shattered dreams." Their expectations of a career in surgery were falling short due to the changes in reimbursement rates, malpractice expenses, and the unrelenting demand for clinical productivity. It was repeatedly stated that this emphasis on clinical volume made academic work only a secondary product. It was particularly revealing that despite their candor in all areas, dissatisfaction with compensation *per se* was not a prevalent complaint.

Our department leadership was impressed with the dichotomy of views. Most importantly, for perhaps the first time, we acknowledged the same feelings within ourselves. We discussed the findings with the entire faculty (and later the house staff) and focused on what specific steps we all could take to address the issues. Although our progress in these efforts has been, at times, tempered by reality, there has been considerable value to the open communication and frankness.

The information gained from the process continues to be relevant to my work with physicians. For the first few years, I kept a list of their underlying concerns on my desk. I am continually reminded of the legitimacy of the observations by how frequently specific complaints and behaviors by individual faculty can be directly traced back to the underlying "emotional" issues that were identified by Professor Davis. Addressing these deeper and highly personal concerns, not just the operational manifestations of those issues, often leads to more lasting solutions.

As just one example, these insights have been useful in assisting the "difficult" physician who disparages and turns over associates repeatedly. These poor working relationships were rarely the result of the skill level of the new colleague. Far more often they reflected some other issue entirely, such as the senior surgeon's discontent over perceived status in the organization. Although it was rarely easy to initiate, a frank discussion that identified the key driver and addressed it has been a far more efficient tact than recycling yet another young physician into an adverse environment. In addition to exploring the obvious (i.e., what the senior physicians could do to improve the comfort and performance level of their juniors), on a number of occasions deeper personal insight was gained. Quiet often, this self-knowledge translated to more collegial behavior in other areas.

Such successful "teaching" of EI requires an immediate and real-life context to both stimulate and reward skill acquisition. Personal insight is an important element, but it is useful to remember that efforts are most effective when directed toward modification of *behavior* not *personality*. The goal is a practical one—minimization of poor personal interactions by recognition and self-correction of nonproductive behavior. Although motivated learners can occasionally gain these skills by self-study, the presence of role models and mentors can greatly facilitate the process. As a consequence, surgical leaders must always be aware that their personal conduct and equanimity sends a strong signal to the entire group.

OPTIMISM

One of the key messages successful physician leaders must embody is optimism. For most surgeons in a clinical role, this should come easily. We all have had experience with patients who "feed off" our confidence, often demonstrating accelerated recoveries when they believe an operation has been successful. As well, a surgeon who does not demonstrate confidence is unlikely to garner much of a referral base and for good reason. Analogous to the aviation industry, no one wants to hear their airline pilot saying "I really hope I will be able to land this plane in Chicago."

There is some evidence that optimism has measurable physiologic consequences. In a now famous study of 941 people aged 65–85 years, Giltay and colleagues assessed cardiovascular and other risk factors and used a detailed questionnaire to separate the subjects into quartiles based on their disposition (optimistic vs pessimistic).[10]

Even after appropriate stratification for health measures, mortality over 9 years of observation was highly correlated with the degree of optimism. For example, 70% of the most optimistic men lived 9 years, whereas only 40% of the least optimistic survived the same interval.

Further support for this effect is provided by data from the so-called Nun study, most recently analyzed by Dunner et al.[11] Investigators had access to handwritten autobiographies of 180 nuns prepared when they entered their convents beginning in 1930. Entries were blindly coded for emotional content (i.e., positive, neutral, or negative in tone). All cause mortality was tracked late in their lives over a 10-year period. A positive attitude, expressed early in life, was a clear marker for greater longevity. Taken together, these studies strongly suggest that optimism and positivity have measurable physiologic benefits and likely reflect "hard wired" personal characteristics evident early in life.

THE CONCEPT OF "FLOW"

In addition to maintaining an optimistic attitude, enhanced EI necessarily includes the self-regulation of constructing a work and life environment that allows us to focus on the things that we consider important and fulfilling while limiting, as much as feasible, those tasks that are less rewarding. One of the most obvious issues to address might be the hectic pace of life in general and especially that associated with the delivery of health care.

In most surveys of full-time workers in the western world, those in the United Kingdom and United States work the longest hours by far. In 2002, one study documented that the US workers exceeded the hours worked by those in Europe by 25% with mean hours of 2000 per year (about 40 hours per week) in comparison with 1700 per year (about 30 hours per week).[12] I think we might agree that we know few surgeons—residents or attendings—who wouldn't exceed those numbers substantially. The Pew studies show conclusively that a hectic pace, associated with long hours and overlapping activities, clearly and adversely impacts personal satisfaction. In their most recent survey, only 27% of people who felt they were always rushed in daily life described themselves as "very happy" as compared to 42% who almost never felt rushed.[13]

In one sense, this feeling of "rushing around," which could be defined as urgency without importance, is unfortunately the single defining characteristic of many of our lives. Whether we are frantically thumbing our digital devices or mesmerized by CNN, I would argue that we too often spend our time on details and urgencies that lack much meaning.

To address this trap, my former University of Chicago colleague and prominent psychologist, Mihaly Csikszentmihalyi described a more purposeful ideal for our lifestyle, which he calls "flow."[14] Flow is characterized by complete immersion in a complex activity that is intrinsically motivated by our own talents and interests. The initial observations of this phenomenon were made in surgeons, athletes, and musicians who train for years to reach the high level of skill necessary for superior performance. In detailed interviews, all described a similar sense of clarity, serenity, and even ecstasy when purposefully engaged in the most challenging and difficult activities. Although flow shares some surface characteristics with other urgent tasks, it is elevated by the matching of hard-won skills and innate talents with a meaningful and noble purpose.

Csikszentmihalyi argues that true happiness is found in those who can find a way to maximize the time they are "in flow" in their personal and professional lives.

CONCLUSION

In the highly demanding environment of modern medical practice, positive interpersonal interactions are necessary to optimize clinical and academic productivity. Searching for a better understanding of others has the additional value of enhancing insights into our own actions and reactions, improving personal satisfaction. As the value of EI becomes even more evident, it is quite likely that more formal assessments of these skills will be used in selecting and training the surgical leaders of tomorrow.

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