

Emotional Intelligence

Impact on Leadership Capabilities

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The term *emotional intelligence* (EI) has been advanced to describe the set of personal attributes that enhance social and professional relationships. As developed by Goleman¹ and Mayer et al,² the elements of EI encompass the full range of interactions between individuals and society, including self-awareness, social awareness, self-regulation, and relationship management (**Figure**). Of these, the key constituents of EI are self-assessment and empathy. Most psychologists believe that EI is not static but is a set of skills that can be learned with commitment and behavioral modeling.³

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. Boyatzis⁴ studied 2000 supervisors and executives and found that 14 of 16 distinguishing traits for success were emotional rather than cognitive. Spencer and Spencer⁵ defined job competencies in 286 organizations and noted that 18 of 21 competencies associated with high performance were emotionally based. Comparing “star” performers with average performers in diverse industries, Goleman⁶ found that emotional advantages were noted twice as frequently in high performers and were much better predictors of achievement than were cognitive advantages. These attributes were more quantitatively assessed in a study of financial service firms. Profit margins were higher for brokers or managers who demonstrated distinguished abilities in self-management (+390%) and self-awareness (+78%).⁷

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 contends 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 4 geographically separated medical schools noted that 20% of them had significant depressive symptoms.⁸ Depression and anxiety scores were higher for young physicians (aged <35 years) than for 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 (eg, 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 would be well suited to serve as role models for their younger colleagues. Gabbe et al⁹ surveyed 131 chairs of obstetrics and gynecology departments, achieving a 91% response rate. A surprising 88% of the chairs experienced moderate to severe

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burnout as measured by a standard inventory (the Maslach Burnout Inventory–Human Services Survey) that quantitated emotional exhaustion, depersonalization, self-efficacy, and personal achievement. The principle drivers of burnout were global and local financial pressures, Medicare audits, and hospital downsizing, 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 are less well defined are 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 Thomas¹⁰ postulated that the more modern leader would have fundamentally different skills and tactics than the chief executive officer of a more traditional era. 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.

Today's surgical leaders certainly 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 using the information to better understand and address the dissatisfactions of the larger group.

At the University of Chicago, Chicago, Ill, we were fortunate to collaborate on these issues with Harry Davis, MBA, Goetz Professor and Distinguished Service Professor of Creative Management in the Graduate School of Business. Professor Davis interviewed a representative group of faculty with different professorial ranks and areas of interest (H. Davis, unpublished data, May 2002). Based on their detailed comments, he found 2 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



Figure. Elements of emotional intelligence.

in the degree of autonomy that they had. 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 that their value to the enterprise was real but transient, and they often felt that their contributions would soon be forgotten when they left. Finally, many had negative and unsettled feelings best described as “shattered dreams.” Their expectations of a career in surgery were falling short owing 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 could all take to address the issues. Although our progress in these efforts has been tempered by reality at times, 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 the faculty. For the last few years, I have kept a list of their 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 disparaged and turned 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 tactic than recycling yet another young physician into an adverse environment. In addition to exploring the obvious (ie, what the senior physician could do to improve the comfort and performance level of his juniors), on a number of occasions, deeper personal insight was gained. Quite 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 rather than 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, like all chief executive officers, must be aware that their personal conduct and equanimity send a strong signal to the entire group.

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, thus 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.

Accepted for Publication: March 31, 2006.

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Previous Presentation: This paper was presented at the 77th Annual Meeting of the Pacific Coast Surgical Association; February 19, 2006; San Francisco, Calif; and is published after peer review and revision.

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