The role of emotion in effective clinical leadership and compassionate care

This article explores the role of emotion in clinical leadership and medical practice and suggests that the Francis report and subsequent debate provides the opportunity for a reframing of how doctors and leaders might engage in 'emotion work'.

The circumstances and consequences of the Mid Staffordshire scandal and the Francis report that came out of it are well documented (Thorlby et al, 2014). It is striking that the report acknowledges that the words suffering, dignity, respect, compassion and sensitivity are highly emotive, yet they are used liberally throughout. This contrasts with Shapiro's (2011) suggestion that not only do official reports sanitize emotions but the processes of professional medical socialization systematically blunt learners' emotional reactions. The commentaries and debates that followed the Francis report focus not only on seeking to understand why health workers, leaders and managers behaved as they did, but in preventing this in future across the NHS and related public services. In a health-care environment in which resources (people, time, funding) are increasingly constrained, a key challenge for clinical and other health-care leaders is to enable health professionals to provide compassion and care while meeting organizational demands, all of which take time. If we are to avoid doctors' stress and burnout, then meeting this challenge is essential.

Howe (2008) suggests that in the people-oriented professions, staff 'inevitably find themselves working daily with people whose needs are pressing and whose emotions are disturbingly aroused … It is critical that … workers understand the part that emotions play in the lives and behaviour of those who use their services…Practitioners need to understand how emotions affect them as they work with users and engage with colleagues'.

This article explores how doctors have traditionally been trained to set aside the emotions they may feel with a view that, by so doing, the 'clinical care' they provide will be better. However, the Francis report and subsequent debates raise questions as to whether this 'scientific' and 'objective' approach, the medicalization of health and disease and the compartmentalizing of tasks to different health professionals contributed to some doctors failing to take responsibility for addressing the poor care at Mid Staffordshire. While all health- and social-care professionals need to protect themselves psychologically from others' suffering and pain, doctors need to be trained to balance scientific objectivity with the risk of objectifying patients by taking a narrow, disease-focussed interpretation of what medical care means.

Emotions and empathy

Until relatively recently, although 'empathy' has long been viewed as a core professional attribute, doctors have not traditionally been taught to use their emotions actively in clinical practice. Thus doctors tend to intellectualize emotions, which helps them remain objective about what they do. Doctors (unlike other health- and social-care professionals) are not traditionally taught or formally equipped to work with their emotions as part of clinical decision-making and care. Medical schools have included constructs such as 'empathy' in selection and assessment processes for many years, but related emotional constructs including 'suffering', 'compassion', 'care' and 'sensitivity' have not been routinely and overtly addressed and, when they are, are framed as a set of cognitive and behavioural skills that can be taught and assessed objectively (Shapiro, 2011).

The words 'emotion' and 'empathy' are closely linked. The Oxford English Dictionary defines 'emotion' as a 'strong feeling deriving from one's circumstances, mood, or relationships with others' and an 'instinctive or intuitive feeling as distinguished from reasoning or knowledge' (www.oxforddictionaries.com). It states that the word is derived from Latin and French meaning excite or move. The word 'empathy' means 'the ability to understand and share the feelings of another', derived from German philosophy, translated from the Greek 'empatheia' – 'passion, state of emotion'.

When looking at the concepts from this perspective, it seems difficult to understand how a doctor could be truly empathic without engaging in emotional connection and an internal discourse about the emotions being felt. The notion that emotions are not an integral part of the clinical reasoning process therefore appears fundamen-

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tally flawed, yet (unlike professions such as psychotherapy) students and doctors in training are not taught to actively surface and work with these emotions. Indeed, a number of studies have demonstrated that measurable levels of empathy decline over the time that students spend in medical training (Hegazi and Wilson, 2013).

McNaughton (2013) makes the point that emotion has been 'either elided as part of a larger construct of values, attitudes and beliefs, or falsely dichotomised with "reason", making it largely invisible as a valuable form and source of knowledge'. She identifies 'emotional intelligence' as particularly relevant to a discourse of emotion as skills. Emotional intelligence, discussed below, is an emotion theory, and is 'a dependable method for measuring and judging capacities seen as not otherwise amenable to reliable capture' (McNaughton, 2013).

If doctors' compassion is to be taught, learned and assessed, it must be measurable and from a skills approach, currently only two things can be measured: the quality of communications and emotional intelligence. McNaughton (2013) criticized the skills approach to emotion for emphasizing performance rather than 'reaching inside the boundaries of the individual', citing a review by Lewis et al (2005) which criticized emotional intelligence for trying to measure the immeasurable and perpetuating an individualized rather than collective model of emotion. Given these comments, perhaps we should be exploring how to teach and assess the unpacking of emotional processes in clinical reasoning as well as focussing on 'measurable' performance.

Emotional intelligence

What is emotional intelligence?

The concept of emotional intelligence gained prominence with the publication of Daniel Goleman's book *Emotional Intelligence: Why It Can Matter More Than IQ* (Goleman, 1996). With this book, Goleman succeeded in bringing to the general population the idea that having a high emotional intelligence was 'a good thing'. Mayer and Salovey (1997) first sought to explain why some individuals are more capable than others of processing emotional information and use it to guide their behaviour by proposing a social interaction model of emotional intelligence. In this model, emotional intelligence was defined as:

> **'...a type of social intelligence that involves the ability to monitor one's own and others' emotions, to discriminate among them and to use this information to guide one's own thinking and actions' (Mayer and Salovey, 1997).**

Mayer et al (2003) later criticized the representation of emotional intelligence as a set of interrelated mental competencies because it could lead researchers to consider it a blanket term for interpersonal skills. They refined the construct to encompass the abilities to:

1. Perceive emotions – to detect and read emotions in self, in faces, pictures and voices
2. Use emotions – to harness emotions in thinking and problem solving
3. Understand emotions – to comprehend emotion in language, perceive nuance and track emotions over time
4. Manage emotions – the ability to regulate emotions in self and in others.

Emotional intelligence thus became a skill set including empathy, the ability to solve problems, optimism, and self-awareness.

Since their initial conceptualization, a number of alternative definitions of emotional intelligence have been proposed (Goldenberg et al, 2006). Davies and Stankov (1998) and Law et al (2004) define emotional intelligence as an abstract construct with four components:

1. Appraisal and expression of emotion in self
2. Appraisal and recognition of emotion in others
3. Regulation of emotion in self
4. Use of emotion to facilitate performance.

Bar-On (1997) defines emotional intelligence as a set of non-cognitive skills, abilities, competencies and capabilities that allows individuals to cope with environmental pressures whereas Kasman et al (2003) describe it as 'the means to perceive and express emotions and regulate emotions in self and others'. These multiple conceptualizations may seem to 'blur' emotional intelligence as a construct, but models of emotional intelligence can be split into two broad types: ability models, and trait and mixed (dispositional) models. Ability models (such as Salovey and Mayer's model) are extensions of information-processing theories of intelligence and conceptualize emotional intelligence as an 'intelligence'. Emotional intelligence comprises a set of cognitive abilities relating to perceiving, understanding, using and managing emotional information and as a further dimension of intellectual competence not considered by traditional conceptualizations of intelligence. Trait models (such as Petrides' model (Petrides and Furnham, 2003)) and mixed (dispositional) models (such as Goleman's (1996) model and Bar-On's (1997) model) view emotional intelligence as a set of interrelated competencies, skills, abilities, personal qualities and personality traits. There is some overlap between the main components of the two types:

- Emotional intelligence is seen as a multidimensional construct with both cognitive and affective elements, consisting of the ability to recognize, deal with and apply emotional information to everyday decision-making and behaviour
- A person with higher levels of emotional intelligence is seen as being able to join together emotions and reasoning, use emotions to facilitate such reasoning, and reason intelligently about emotion
- Standardized, self-report questionnaires are used to measure emotional intelligence.

The reliability, validity and cross-cultural applicability of the tools differ, however, as does the degree of overlap between individual questionnaire items. It is important to stress that an individual's emotional intelligence is

distinct from his/her predisposition to experience certain types of emotions, which is related to the personality traits of positive and negative affectivity (George, 2000). Also, an individual's emotional intelligence does not relate to how intensely he/she experiences emotions. Instead, emotional intelligence represents the extent to which an individual's cognitive capabilities are informed by his/her emotions, and the extent to which emotions are cognitively managed (George, 2000).

Benefits of emotional intelligence

The benefits to lay people of having high levels of emotional intelligence have been demonstrated. For example, emotional intelligence positively influences the ability to identify others' emotional expressions and makes people more satisfied with their interpersonal relationships, more flexible in social interactions, better able to manage their moods and more adaptable when under stress. (Ciarrochi et al, 2000, 2002). Emotional intelligence has also been demonstrated to be a desirable attribute of good leaders and team-workers in a non-clinical setting (Goleman, 2000). The popularisation of emotional intelligence as 'mattering more than IQ' has promoted it as a crucial attribute for successful psychological and social functioning.

It could be argued that the importance of emotional intelligence may be stronger for professionals and leaders in professions whose everyday work is highly emotionally charged and particularly in contexts where there are higher levels of emotional labour (Held and McKimm, 2012). It is therefore logical to conclude that emotional intelligence may have face validity for use in medical education and development of medical leadership and practice, particularly given that an awareness, and understanding, of the role and influence of the multiple emotional experiences faced on a daily basis is integral to becoming and being a good doctor (Weng et al, 2011).

A note of caution

One of the main concerns about applying general theories about emotional intelligence to medical education and developing medical leadership is whether tools designed to measure emotional intelligence can be reliably applied to medical populations. Medical students differ from the general population because their age range is narrow and they are a highly selected population of high academic achievers, with a socioeconomic background narrower than for the general population. The reliability and validity of some, but not all tools, have been confirmed in medical student samples (Brannick et al, 2011) so anyone deciding to use a particular tool to measure emotional intelligence as part of a development tool for medical leadership would need to carefully check the validity of such a tool in that population.

Another concern about using emotional intelligence in this way is whether there is a 'minimum' level, after which emotional intelligence stops having an influence on medical leaders' practices. Given that emotional intelligence research is still in its infancy, there are limited data available to answer this question, which makes it particularly difficult to know how to use it as a selection criterion for other medical education or leadership development.

Finally, what are the potential negative or unintended outcomes of applying emotional intelligence to medical education and leadership? Two obvious concerns are that labelling a student or doctor as emotionally 'unintelligent' could become a self-fulfilling prophecy while labelling one as highly intelligent could set up tensions in the competitive setting of a medical school or trainee leaders. Measuring emotional intelligence will inescapably focus people's attention in a way that could, ultimately, trivialise the very quality that it was intended to strengthen and distract attention from other qualities that are not measured or fed back to people, which might be every bit as important to patients and colleagues.

Emotions and clinical leadership

The Francis report has not only given tacit permission for leaders and health professionals to use emotive language but moves towards mandating health service providers at every level to consider and use emotions as a routine part of their work. For example, while it may seem somewhat contrived to tell 'patient stories' at every NHS trust board meeting, this does ensure that the patient voice is heard, including the emotions and feelings that individual narratives involve and 'stir up' in others. Throughout history, hearing of the plight and suffering of others moves people to action, and in the case of UK health care, the Francis report and other reviews are currently stimulating what will hopefully be meaningful, long-lasting and truly patient-focussed changes. Clinical leaders are vital in sustaining momentum and improving care.

The leadership and other literature offers some insight into how leaders can create a culture of compassion and caring through the appropriate use of emotion. Early work on leadership focused on personality traits, and psychologists identified leadership traits such as emotional stability, conscientiousness, intuitiveness and empathy as key to leadership effectiveness (Cattell and Stice, 1954). In 1973, Mintzberg identified that leadership success was based on ability to establish social networks, work effectively with subordinates and the facility to empathize, all key skills for the collaborative leaders needed by contemporary health services.

Regulating and containing emotions

Stevenson (2007) questions whether the current health service orthodoxy addresses the impact of emotions on professionals. She asks: 'how can organizations … run on principles of order and rationality take into account the underlying emotional dynamics which profoundly affect the behaviour of their staff?'. Effective collaboration must create space to understand the emotions vested in the work. Stevenson (2007) suggests that 'these emotions

should not be viewed in solely negative terms; they are the drivers of positive and negative behaviours and they underpin purposeful behaviour'.

The concepts of emotional competence and self-awareness need to be defined carefully in medicine which has a high emotional 'load' with routine emotion displays from patients, relatives and colleagues. When defining and promoting what is meant by emotional competence, leaders and practitioners need opportunities to address their own emotional vulnerabilities and fallibilities (Heron, 1992; MacCulloch, 2001). This where medicine can learn much from other professions around professional supervision and support.

The emotional intelligence literature identifies the need for leaders to control, regulate or manage disruptive emotions and Goleman implies a causal relationship between disruptive emotions and negative behaviours (Salovey and Mayer, 1990; Goleman, 2000). All emotions are disruptive by their very nature, however, and authentic and congruent leaders (highly valued in complex professional fields) need to establish an atmosphere which both contains emotion yet enables people to express emotions safely. Iszatt-White (2009) suggests that leaders need to be able to allow 'emotional displays' which are part of 'the proactive use of emotion-based work in the accomplishment of leadership work'.

Morrison (2007) suggests that emotional intelligence competence is 'pivotal to gaining the co-operation of other colleagues and services ... to achieve their outcomes'. He argues that competence is not based on control but on awareness of the emotional dimension and the ability to use emotions positively. Yukl (2002) notes that most contemporary leadership theories involve a process of social influence. Avolio et al (2004) suggest that authentic transformational leaders are able to instil hope, trust and positive affectivity in their followers via personal and social identification, and George (2000) concludes that:

'...emotional intelligence contributes to effective leadership as leaders must be able to anticipate how followers will react to different circumstances and effectively manage these reactions'.

This reflects a shift in the way that leadership is being conceptualized around emergent change and shared leadership (Morrison, 2010). This shift acknowledges that individual personality traits (including emotion, integrity and empathy) are important but need to be contextualized within complex systems, networks and interdisciplinary collaboration (Bolden et al, 2003).

Emotional labour and emotion work

The emotions that drive positive and negative behaviours are both drivers and constrainers within dynamic systems. Emotions may be positive or negative, depending on how they are handled. Clinical leaders need to be comfortable with emotional labour and affective leadership, and able to tolerate ambiguity.

Waddington (2005) defines emotional labour as 'paid work which requires a person to express and manipulate emotions as a part of their job'. Crawford (2009) describes emotional labour as 'a requirement to produce emotional states in others or exercise a degree of control over the emotional activities of others', going on to note that good leaders create the conditions for the safe expression of emotion. Expanding the concept of 'patient safety' to include the need for leaders and individual health professionals to 'hold' or contain emotions rather than control them will acknowledge this. This subtle shift highlights the key role of leaders in reading the emotional 'temperature' of patients and carers, within their team, department or organization and outside it. Leaders who fail to do this rapidly fall out of step with their members or followers and lose credibility.

Doctors and other health workers routinely perform emotional labour. Hochschild (2012) proposes that emotion regulation is achieved in two ways. When employees change their outward emotional expressions without feeling emotions they are displaying, they are surface acting. In contrast, when they actually feel the emotions they display, they are deep acting. Emotion work is also performed through spontaneous and genuine emotion. Ashforth and Humphrey (1993) suggest that both surface acting and deep acting may have harmful psychological effects, depending on the degree to which the actor identifies with the role and occupation. 'If emotional labor is consistent with a central, salient, and valued social and/or personal identity … it will lead to enhanced psychological wellbeing' (Ashforth and Humphrey, 1993). Generally, the more congruent and authentic leaders' emotional displays are, the more at ease they are with their actions.

Humphrey et al (2008) distinguish emotional labour performed by transformational leaders from other forms of emotional labour. They suggest that 'leaders who perform emotional labor will be more likely to be perceived as transformational leaders … deep acting will be more effective than surface acting at increasing perceptions of transformational leadership'. 'Leaders high on empathy will prefer to use genuine emotional expressions and deep acting instead of surface acting.' (Humphrey et al, 2008).

Leaders working in emotionally-charged contexts, who can draw on deep acting or spontaneous and genuine emotion, may therefore be considered most effective and gain the respect of followers. Such leaders need to draw on emotional intelligence competencies, demonstrate understanding of their context and networks, and be willing to perform emotional labour. This requires congruence between the leader's personality, behaviours and understanding that appears consistently authentic in a range of situations. Followers typically rate consistency, integrity, courage, enabling and role modelling as key leadership characteristics (Kouzes and Posner, 2007). Most leadership development activities acknowledge that a balance is needed between theory, building on innate personality

traits, and developing practical and interpersonal skills and competencies associated with effective leadership (Bolden et al, 2003; Kouzes and Posner, 2007). Multi-source feedback can be very helpful in developing high level interpersonal leadership competencies.

Affective leadership

Fineman (2004) refers to the recorded emotional narrative as a 'key subjective, biographical production, combining interpretation, embodiment and lived experience'. Doctors are highly familiar with listening to patients' narratives as part of history taking and increasingly urged to engage in reflective writing and practice, but are less familiar in terms of the art of leadership. Denhardt and Denhardt (2006) used the dance of leadership as metaphor for the artful use of affect (expressed emotion) that shows situational awareness, contextual sensitivity and recognition of an individual's needs. 'Recognizing the artistic dimension of leadership … compels us to acknowledge and give further thought to the inner resources required by the leader' (Denhardt and Denhardt, 2006). The affective leader can rapidly assess the affective state of the other, analyse his/her own affective state, and from this select the appropriate affect to display in order to achieve the desired (or best achievable) outcome (Newman et al, 2009). 'It is a transactional process in that the followers agree to play their "role" as long as the "dance" steps are followed. For the skilled leader the process is one of rapid cognition. It happens intuitively, often outside conscious awareness, since the speed at which the various observations and decisions are made is greater than that of conscious thought. Leaders and followers constantly balance the tensions between rational thought, emotion and intuition' (Held and McKimm, 2012).

As services become more integrated, leaders must adopt an emotionally appropriate approach to managing different professional attitudes, expectations and stereotypes. The approach must match the affective expectations of the (often unequal) professional workforce, moderate their own and others' stereotypes and calm fears about professional identity and lack of control. This requires leaders to artfully use affect to enable professionals to work in an atmosphere of connectedness, tolerate uncertainty, and learn from positive and negative emotional experiences.

Conclusions

This article has explored some of the contemporary views relating to emotions, emotional intelligence, emotion work and emotional labour in clinical settings. An overriding message emerging from the literature is that how emotions are expressed and used is highly dependent on constantly changing social norms and expectations. Clinical leaders therefore need to be highly competent in acknowledging and containing their own and others' emotions safely and in reading the organizational and social 'mood' and 'temperature' accurately.

Post-Francis, we are in the midst of a shifting landscape which provides huge opportunities to reconceptualize how doctors and health providers work with and acknowledge not only the emotions of those for whom they care, but those of health professionals themselves. For doctors, this also means rethinking the self-imposed boundaries between doctors and other health providers and in learning how to incorporate emotion work into education, training and everyday practice. For clinical leaders, supporting students and doctors in balancing organizational demands with caring, compassionate, safe patient care is essential but is one of the biggest challenges in today's resource-constrained environments. **BJHM**

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KEY POINTS

- The Francis report and subsequent publications and debates have set the scene for a rethinking of how emotions are used as part of leadership, medical education and practice.
- Emotion work and emotional labour have to be acknowledged as a routine part of doctors' work and doctors need to be trained and supported to use emotions effectively.
- Clinical leaders need a high level of emotional intelligence, but emotional intelligence is only one component of 'emotion work'.
- A key challenge for clinical leaders is to enable doctors to meet organizational demands while providing compassionate and safe clinical care in resource-constrained environments.
- A key leadership skill is being able to accurately judge the emotional and social 'temperature' and 'mood' of situations, teams and organizations.

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