Emotional Intelligence
Patient Centered Care
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"By teaching people to tune into their emotions with intelligence and expand their circles of caring, we can transform organizations from the inside out and make a positive difference in our world." — Daniel Goleman

Emotional Intelligence for Physician Leaders
Ted A. James, MD, MHCM June 13, 2019
Harvard Medical School

The first published manuscript on EI was written by Dr. Peter Salovey and Dr. John Mayer in 1990. The concept gained further mainstream popularity with Daniel Goleman's 1995 publication of Emotional Intelligence – Why it can matter more than IQ. Goleman described how individuals with a high EI consistently outperformed those with only a high IQ.

- Self-Awareness: the ability to know your emotions, strengths, weaknesses, drives and goals
- Self-Management: the ability to stay calm when emotions are running high; adaptability
- Empathy: identifying with and understanding the desires, needs and perspectives of others
- Social Skills: managing relationships and resolving conflict to move people in a desired direction

Conversely, the lack of EI is a common source of failure as a leader. Low EI often results in being overly defensive, resolving conflict poorly and not connecting well with your team.
Unfortunately, medical schools and residency programs traditionally give little attention to the soft skills needed for effective leadership. As a consequence, physicians may be challenged to succeed in leadership roles. Whether you are leading a team in the operating room, managing staff in a clinic or running an executive board meeting, these soft skills are essential.
Benefits of High Emotional Intelligence in Health Care:

- Improved communication & teamwork
- Ability to respond well under pressure
- Increased empathy
- Better quality of care
- Greater career satisfaction
- Building Blocks of Emotional Intelligence
- By improving relationships and interactions between patients, health care professionals and administration, organizations that leverage EI can create meaningful and lasting improvements.

--Harvard Medical School

The other key is to be able to recognize the emotion within those we are caring for. To take an emotional time out when needed!

We need to be reminded that over half of all our communication is nonverbal.

Patient satisfaction ratings are strongly correlated with patient perceptions of physician friendliness and caring.

In fact, we know that it no longer is enough to be a skilled physician. One must also be able to create a positive patient experience.

Patients identified the most important nursing actions as "being there," and "taking time to sit down and listen." Nurses identified an ability to establish and maintain appropriate levels of involvement in nurse-patient relationships as important for effective nursing care. Implications for nursing administration, education, and practice are to foster empathic awareness in nurses and facilitate appropriate relationship development between nurses and patients.

- Karen Ann Brown Dissertation "The Nurse, Empathy and Patient Satisfaction"
- http://content.lib.utah.edu/utils/getfile/collection/etd1/id/548/filename/914.pdf

A study with physicians at the University of Kansas:
Seated visits lasted 1 minute and 4 seconds
Standing visits lasted 1 minute and 28 seconds, (no statistical difference)

What was the patient perception?
Sitting encounters lasted 5 minutes and 14 seconds
Standing visits were 3 minutes and 44 seconds. (a big statistical difference)

People want to feel that they have been heard!

How do you know when you have been heard?

Practical ways we can use our emotional intelligence to impact others

Many of these occur due to our own personal discomfort with pain, sadness, grief, lament.

- Reflect back emotions—look for an emotional time out in the conversation
    - This doesn't have to take a long time to be impactful!
    - Surgeon, "I understand you are anxious. Don't be anxious this is the easy part!"
- Refrain from using words like expire or passing. Use the word death or dying.
- Weep with those who weep and mourn with those who mourn Romans 12:15
- Don't try to make others better with platitudes
    - Many Christian platitudes that may be true but not appropriate at the time
- In the midst of active grief don't try to get them to "think positive"
- Don't rush others to Easter morning….can you wait patiently with them in the garden of gethsemane?
- Don't share your grief story in the midst of their grief and pain (not the time)
- Do—be with them in quietness or the loudness of their grief
- Do realize your presence is the very presence of Jesus in their midst
    - Some of our most profound/spiritual visits may have few words
- Do encourage people to get professional help at some point…especially if grief is complex and lingers
- Use Kleenex if needed (be observant not reactionary)
- Consider removing "how are you doing?" from your vocabulary
- Be very careful about placing the weight of medical decisions on family in end-of-life care. The weight of these "decisions" can cause much moral and emotional distress.
    - Examples: coding the 13 year old coming in asking the parents, "what do you want us to do?"
    - Chaplain's sister in law still not talking to her siblings 30 years later because the children "killed their mother" by making the decision to remove a ventilator when the patient was not going to survive.
    - Asking the patient/family if they desire to be coded when you know this will cause more harm
        - At this point the disease process is making these decisions for us
        - I have taken an oath to do no harm and at this point this will harm your loved one
- Compassionately end a conversation when needed

Patient preference for physician discussion and practice of spirituality

Charles D MacLean [1], Beth Susi, Nancy Phifer, Linda Schultz, Deborah Bynum, Mark Franco, Andria Klioze, Michael Monroe, Joanne Garrett

Objective: To determine patient preferences for addressing religion and spirituality in the medical encounter.
Setting: Primary care clinics of 6 academic medical centers in 3 states (NC, Fla, Vt).
Patients/participants: Patients 18 years of age +
Four hundred fifty-six patients participated in the study.

- One third of patients wanted to be asked about their religious beliefs during a routine office visit.
- Two thirds felt that physicians should be aware of their religious or spiritual beliefs.
- Patient agreement with physician spiritual interaction increased strongly with the severity of the illness setting,
- 19% patient agreement with physician prayer in a routine office visit,
- 29% agreement in a hospitalized setting,
- 50% agreement in a near-death scenario

Conclusion: Physicians should be aware that a substantial minority of patients desire spiritual interaction in routine office visits. When asked about specific prayer behaviors across a range of clinical scenarios, patient desire for spiritual interaction increased with increasing severity of illness setting and decreased when referring to more-intense spiritual interactions. For most patients, the routine office visit may not be the optimal setting for a physician-patient spiritual dialog.

Discussion Questions:

What most often blocks you from engaging your emotional intelligence?

What might an emotional “time out” look like in your setting?

How might you prepare yourself to recognize an emotional “time out”?

What platitude (possibly spiritual) do you most often use when someone might be engaged in grief?