A leadership education framework addressing relationship management, burnout, and team trust

Bobbie Ann Adair White, EdD, MA^a , Christie Bledsoe, EdD^b , Randy Hendricks, EdD^b, and Alejandro C. Arroliga, MD, MSc^{c,d}

^aDepartment of Humanities in Medicine, Texas A&M University College of Medicine, Temple, Texas; ^bDepartment of Education, University of Mary Hardin–Baylor, Belton, Texas; ^cDepartment of Medicine, Baylor Scott & White, Temple, Texas; ^dDepartment of Medicine, Texas A&M University College of Medicine, Temple, Texas

ABSTRACT

Despite the collaborative nature of medicine, most medical professionals are not taught or trained to lead collaboratively. Even when leadership skills and content are incorporated into the curriculum, rarely is the content focused on relationship management and trust, both of which are imperative to collaborative and team leadership in medicine. Resonant leadership is a leadership framework centered on emotional and social intelligence. Emotional intelligence, a concept involving skills that can be taught and improved, has proven to be important in leadership. Resonant leaders, or leaders with social and emotional intelligence, develop positive relationships and environments, engaging team members to work toward a common goal through mindfulness, hope, and compassion. This article examines the current state of leadership education and development and proposes resonant leadership as a viable framework for education. A leadership framework heavy on emotional and social intelligence is ideal for the team environment of medicine, and there is literature to back up the positive outcomes of leading with this framework in a clinical setting, including reduction of burnout, building team trust, and better relationship management.

KEYWORDS Burnout; education; leadership; resonant leadership; trust

Scholars in physician leadership have asked physicians to answer the call for leadership roles.^{1–3} Additionally, up to 98% of internal medicine residents surveyed stated that they needed more team leadership training,⁴ and chief medical residents indicated that they did not receive any formal leadership training before or during the year they served.⁵ Leadership is an important part of medicine, especially team leadership; nevertheless, a void in leadership education,⁶ including conflict management education,^{4,7,8} remains. Good leadership requires people who are skilled at relationship management, because negative conflict affects clinical care.⁹ In endorsing the importance of leadership education in medicine, this article introduces the concept of resonant leadership to a wider audience, giving direction to physician leadership curriculum development. Resonant leadership is a framework that relies heavily on emotional and social intelligence and thus may be ideal for the team environment of medicine.

LEADERSHIP EDUCATION

Several leading scholars in physician leadership have recommended incorporating leadership development into the curriculum. Stoller recommended a longitudinal curriculum mirroring the student's developmental stage with a large focus on “emotional intelligence, self-awareness, self-management, social awareness, and managing relations with others.”⁸ Stoller was not alone in the view that leadership education is about self-awareness and humility. Schei primarily discussed the role of leadership for physicians in patient-physician relationships but also focused on the important roles of self-awareness and intellectual humility.¹⁰ These thoughts and approaches are different from the lists of management skills in many leadership curricula. Because leadership is derived from initiative and internal motivation, it is important that it be taught in such a way to facilitate drive and growth.

Intentionality is also important for teaching leadership skills. These skills should be explicitly taught early and

Corresponding author: Bobbie Ann Adair White, EdD, MA, Department of Humanities in Medicine, Texas A&M University College of Medicine, 2401 S. 31st St., Temple, TX 76508 (e-mail: bawhite@medicine.tamhsc.edu)

Received September 26, 2018; Revised November 14, 2018; Accepted November 15, 2018.

reinforced throughout professional education and socialization, rather than through modeling alone.^{11,12} Training makes a difference in all aspects of clinical medicine, and leadership skills training is no exception. For example, in a study on team leadership skills during cardiopulmonary resuscitation, the only characteristic positively associated with leadership skills during intervention was previous leadership training.¹³ In order to ensure that health professionals are comfortable with leadership, it is important to provide training. Eliminating the unknown is a good way to ensure positive results. Leadership education will help clinicians when their clinical competence is not the issue but instead the problems relate to team trust, team direction, or individual buy-in.¹⁴

LEADERSHIP DEVELOPMENT CONCEPTUAL FRAMEWORK

Because success in a profession does not automatically translate to success in leadership, it is important to look at what does translate to success in leadership. Emotional intelligence accounted for 85% to 90% of the difference between good and great leaders.¹⁵ The domains of emotional intelligence include self-awareness, self-management, social awareness, and relationship management. Individuals with emotional intelligence are able to manage their own and others' emotions, building strong relationships that positively influence performance.¹⁵ Additionally, leaders with emotional intelligence engage others through emotions and passion, ultimately understanding their motivations. Working through these channels, leaders with strong emotional intelligence are able to move teams, communicate vision, and unite focus.¹⁷

Emotional intelligence is a component of a larger concept called *resonant leadership*. Resonant leadership as a conceptual framework gained popularity in the last 20 years, first through *Primal Leadership: Learning to Lead with Emotional Intelligence* by Goleman et al.¹⁶ and then through *Resonant Leadership* by Boyatzis and McKee,¹⁵ when the authors backed the theoretical framework with data from the fields of management, psychology, organizational behavior, education, medicine, and neurophysiology. At the foundation of this theory is leading people with emotional and social intelligence, focusing on the importance of self and other awareness. Leading with resonance creates harmony and a full understanding of all team members. This style of leading reduces stress and burnout, encouraging collaboration and productivity, which are all important for medical teams. Therefore, leading with resonance (social and emotional intelligence) builds positive relationships that aid in the navigation of difficult conversations and situations.¹⁵ Resonant leaders develop positive relationships and environments, engaging team members to work toward a common goal, which is done through mindfulness, hope, and compassion.¹⁸

Key research findings in the fields of medicine, psychology, and philosophy illustrated how leaders moved from

good to excellent, citing emotional intelligence as a major component of creating resonance. Some scholars in the medical literature, but more specifically the nursing leadership literature, proposed resonant leadership as a mitigating factor for negative effects from restructuring in the hospital; it was assumed that this would work as a result of managing emotions and building relationships in the workplace.¹⁸ Additionally, a lack of resonance had a negative effect on health and quality of patient care.^{17,19} Leaders using emotional intelligence through skills such as empathy and listening built empowerment, trust, and understanding in medical teams.^{17,20} Resonant leadership was also linked with a reduction in burnout and turnover, reducing incivility due to empowerment of team members.^{20,21} A more direct clinical outcome pertaining to resonant leadership applies to mortality rates: "High levels of resonant leadership contributed to lower patient mortality rates at statistically significant levels."²² This relationship-focused leadership style promotes healthy work environments, which retains nurses.²⁰

Often leaders are not aware of the signals that they give to others, which can negatively impact the culture or tone of the organization. Therefore, being aware of self and others can help leaders navigate difficult conversations and situations.¹⁵ Resonant leaders use negative emotions in a cautious manner, managing them and only using them when appropriate. Teamwork is facilitated through empowerment and a strong sense of empathy, which also builds community and a common focus.¹⁸

DISCUSSION

Physicians are expected to acquire leadership skills through observing others.^{1,23} This expectation has led students to seek and request leadership training as early as medical school.^{6,24} Additionally, faculty and resident physicians agreed that there was a need for formal training.^{1,4} Some have argued that dual degrees serve this need, but dual degrees require more time from students, and additional time deters clinicians from taking coursework despite its future necessity. Webb et al conducted a systematic review of current leadership curricula in undergraduate medical education and found that they were not uniform or guided by established leadership frameworks.⁶ Based on the review of previous publications and conversations with clinicians and medical students, it seems that medical professionals are ready for curricular revision that includes guidance on clinical leadership skills. Using the common conceptual framework of resonant leadership for curriculum development will ensure self and other awareness, moving toward better relationship management, less burnout, and more team trust. Overall, this framework would offer more than just skills-based education; it would ensure that physicians had the background and awareness needed for any leadership situation.

ORCID

Bobbie Ann Adair White <http://orcid.org/0000-0002-1408-3383>

Christie Bledsoe <https://orcid.org/0000-0002-9151-8053>

Alejandro C. Arroliga <http://orcid.org/0000-0002-7245-2159>

1. Blumenthal DM, Bernard K, Bohnen J, Bohmer R. Addressing the leadership gap in medicine: residents' need for systematic leadership development training. *Acad Med*. 2012;87(4):513–522. doi:10.1097/ACM.0b013e31824a0c47.
2. Chervenak FA, McCullough LB, Brent RL. The professional responsibility model of physician leadership. *Am J Obstet Gynecol*. 2013; 208(2):97–101. doi:10.1016/j.ajog.2012.03.005.
3. Stoller JK. Developing physician-leaders: a call to action. *J Gen Intern Med*. 2009;24(7):876–878. doi:10.1007/s11606-009-1007-8.
4. Fraser TN, Blumenthal DM, Bernard K, Iyasere C. Assessment of leadership training needs of internal medicine residents at the Massachusetts General Hospital. *Proc (Bayl Univ Med Cent)*. 2015; 28(3):317–320. doi:10.1080/08998280.2015.11929260.
5. Merriam SB, Corbelli JA, Rothenberger SD, Jeong K, Zimmers SM. Managing from the middle: a survey of chief medical resident perceptions of leadership skills. *Acad Intern Med Insight*. 2017;15(3):12–15.
6. Webb AMB, Tsipis NE, McClellan TR, et al. A first step toward understanding best practices in leadership training in undergraduate medical education: a systematic review. *Acad Med*. 2014;89(11): 1563–1570. doi:10.1097/ACM.0000000000000502.
7. Abbas MR, Quince TA, Wood DF, Benson JA. Attitudes of medical students to medical leadership and management: a systematic review to inform curriculum development. *BMC Med Educ*. 2011;11(1):93.
8. Stoller JK. Help wanted: developing clinician leaders. *Perspect Med Educ*. 2014;3(3):233–237. doi:10.1007/s40037-014-0119-y.
9. Azoulay E, Timsit J-F, Sprung CL, et al; Conflicus Study Investigators and for the Ethics Section of the European Society of Intensive Care Medicine. Prevalence and factors of intensive care unit conflicts: the Conflicus study. *Am J Respir Crit Care Med*. 2009; 180(9):853–860. doi:10.1164/rccm.200810-1614OC.
10. Schei E. Doctoring as leadership: the power to heal. *Perspect Biol Med*. 2006;49(3):393–406. doi:10.1353/pbm.2006.0048.
11. Baird DS, Soldanska M, Anderson B, Miller JJ. Current leadership training in dermatology residency programs: a survey. *J Am Acad Dermatol*. 2012;66(4):622–625. doi:10.1016/j.jaad.2009.10.009.
12. Hendel T, Fish M, Galon V. Leadership style and choice of strategy in conflict management among Israeli nurse managers in general hospitals. *J Nurs Manag*. 2005;13(2):137–146.
13. Yeung JHY, Ong GJ, Davies RP, Gao F, Perkins GD. Factors affecting team leadership skills and their relationship with quality of cardio-pulmonary resuscitation. *Crit Care Med*. 2012;40(9):2617–2621. doi: 10.1097/CCM.0b013e3182591fda.
14. Tiffan B. The art of team leadership. *Physician Exec*. 2011;37(2): 78–80.
15. Boyatzis R, McKee A. *Resonant Leadership*. Boston, MA: Harvard Business School Press; 2005.
16. Goleman D, Boyatzis RE, McKee A. *Primal leadership: Learning to Lead with Emotional Intelligence*. Boston, MA: Harvard Business School Press; 2004.
17. Cummings G, Hayduk L, Estabrooks C. Mitigating the impact of hospital restructuring on nurses: the responsibility of emotionally intelligent leadership. *Nurs Res*. 2005;54(1):2–12.
18. Teleos Leadership Institute. Resonant leadership. <http://www.teleosleaders.com/howwedoit/resonant.php>. Accessed November 12, 2018.
19. Cummings G. Investing relational energy: the hallmark of resonant leadership. *Nurs Leadersh (Tor Ont)*. 2004;17(4):76–87.
20. Laschinger HKS, Wong CA, Cummings GG, Grau AL. Resonant leadership and workplace empowerment: the value of positive organizational cultures in reducing workplace incivility. *Nurs Econ*. 2014; 32(1):5–15.
21. Squires M, Tourangeau A, Spence Laschinger HK, Doran D. The link between leadership and safety outcomes in hospitals: leadership and safety outcomes in hospitals. *J Nurs Manag*. 2010;18(8):914–925. doi:10.1111/j.1365-2834.2010.01181.x.
22. Cummings GG, Midodzi WK, Wong CA, Estabrooks CA. The contribution of hospital nursing leadership styles to 30-day patient mortality. *Nurs Res*. 2010;59(5):331–339. doi:10.1097/NNR.0b013e3181ed74d5.
23. Frugé E, Mahoney DH, Poplack DG, Horowitz ME. Leadership: “They never taught me this in medical school.” *J Pediatr Hematol Oncol*. 2010;32(4):304–308. doi:10.1097/MPH.0b013e3181cf4594.
24. Kogan JR, Bellini L, Shea JA. Implementation of the mini-CEX to evaluate medical students' clinical skills. *Acad Med*. 2002;77(11): 1156–1157.