

Section 1

Leadership principles

Chapter

1

Leadership in emergency medicine

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Key learning points

- Understand the difference between leadership and management, and recognize competencies that make a good emergency department leader.
- Studies of leadership have produced little evidence to explain what works, but more recent studies of emotional intelligence can be used to develop or improve leadership skills.
- Good leaders are risk takers who use occasional failures to learn to become better leaders.

Introduction

Healthcare organizations (HCOs) and emergency departments (EDs) will usually have many managers but few true leaders, even though in today’s ED leadership is more important than ever. The ED leader of today deals with constant change, rising expectations of payers and patients, fewer resources with which to treat more patients, tough competition for talented clinicians and managers, mountains of information and data to sort out, and increasing acuity of patients. Some ED leaders also face chronic staff or equipment shortages, pandemics and disasters, and a variety of other challenges every day. These challenges force us to be creative, to build teams and harness their collective power, and often to change the way patient care is provided in radical ways.

Many of the studies written about leadership have focused on for-profit organizations. *Stodgill’s Handbook of Leadership* makes references to thousands of scholarly studies of leadership.¹ Unfortunately, few academic works address leadership in health care, and almost none deals with emergency medicine. This lack of science is complicated by the fact that much of the

world’s health care is provided by public agencies, which adds a political component to the ED leader’s job. While it can be argued that leadership is different within public and private entities, modern healthcare systems are starting to operate more like private businesses, with a focus on providing cost-conscious, efficient, and high-quality services. Public healthcare leaders need to be just as innovative, entrepreneurial, and motivated as their private-sector counterparts.

Nevertheless, leaders in a public healthcare system must use power in a somewhat unique way. First, these leaders must understand the politicians who often set policy, allocate resources, and determine time frames for action. Second, they must take into account citizens, patients, and patients’ rights groups. Finally, they must translate all of this into meaningful action understood by clinical staff members who often resist change wrought by the “political good.”

Leadership versus management

There is much debate about the differences between managers and leaders. It is usually said that the four key activities of managers are budgeting, controlling, planning, and organizing. Thus, the line between leader and manager can be blurred by the activities of the individual.² Some who think they are leaders are in fact managers because of the way they approach work; some managers are leaders by virtue of how they get the job done. Title alone does not separate the manager from the leader.

The goal of managers is to provide stability, deal with organizational complexity, and implement decisions. Managers put out fires and typically work in a top-down fashion. Managerial roles often arise out of necessity rather than desire. Managers deal with the many details of the staff. In the ED, among

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Table 1.1 Differences between leadership and management

Leadership	Management
Changes status quo	Is part of status quo
Proactive	Reactive
Provides vision to believe in	Establishes structure
Changes rules	Enforces rules
Looks to the future	Deals with “here and now”
Takes risks	Manages risks
Energizes followers	Directs subordinates
Is empathetic	Is sympathetic
Shares authority	Shares responsibility
Thrives on chaos	Thrives on order

many other tasks, managers make the work schedule, hire a nurse for the night shift, handle the daily disagreements between nurses and physicians, develop and enforce rules or policies, and ask for more funds from the hospital leadership. In stable times strong management may be enough to keep the ED running smoothly, but in turbulent times leadership is a necessity.

Leadership is different than management: it is a mindset, an approach to the job. It is often said that managers do things right, whereas leaders do the right things. There can be many leaders in the ED, not just the person who holds the top position. Dawson states that “leadership exists when someone exercises influence over others in their group . . . and emphasises values that are espoused, directions in which future developments are guided, and the manner in which everyday tasks are accomplished.”³ In the ED, leaders might decide that the current work schedule does not take into account the work–life balance of the doctors and nurses, allowing for critical gaps in coverage that impact patient care. They therefore assemble a team to design a new, more flexible work schedule; or decide after analysis of patient flow that two nurses are needed at night but with different starting times; or develop a team-building program to minimize interdepartmental conflict. An ED leader might go to the hospital to ask for more funds based on innovative new strategies that make it possible to see more patients or provide new services that improve

patient care. Whereas managers put out fires, leaders ignite fires with new ideas and innovations, creative thinking for problem solving, and building teams to harness the power of the staff (Table 1.1).

Leaders promote change and question the status quo by promoting new ideas and challenging old ideas, whereas managers are more interested in keeping the status quo. Managers like stability in an organization. They like work to be orderly and uncomplicated, and they make rules and policies to keep things running smoothly. Leaders argue that emergency physicians (EPs) can intubate, that an EP can manage an ED without other specialty services, or that a well-trained nurse can order an x-ray without a physician seeing the patient first – all in order to provide faster, more efficient patient care. Leaders understand there is a sense of urgency to change. Participants from all over the world in the International Emergency Department Leadership Institute (IEDLI) say that they feel an urgency to do things, whether it be to create a new model of emergency medicine in their countries, or to solve a horrible overcrowding situation in their departments. But urgency should not be confused with activity. Rushing around from meeting to meeting is not urgency but frenetic activity. Urgent behavior does not need to be driven by the belief that everything is in a terrible condition, but more by a sense of what is important and “*the determination to move, and win, now.*”⁴ This sense of urgency leads to positive behaviors in which people are proactive and alert, constantly scanning the internal and external environment for opportunities and threats that help determine ultimate success and survival.

Leaders understand the importance of *context*, how a particular event fits into the larger environment and how it is shaped by current or past events. There is a widespread tendency to portray leaders as people who shape events rather than are shaped by them. The multiple challenges facing the ED every day do not lend themselves to being shaped – one cannot shape the arrival of 50 trauma patients from a train crash. Instead, the ED leader is shaped by the reality of patients streaming through the door, and he or she determines a plan of action in response. Think back to our earlier example of the ED schedule. The leader who comes up with a new, innovative work schedule that makes the staff happier and provides better care to patients was shaped by the need reflected from patients and staff, not the other way around. Good leaders sense

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the context of situations. They want to know what is going on and why, what happened before in previous similar challenges, and then use adaptive capacity to achieve success. Adaptive capacity includes such skills as the ability to make sense of a given situation, see how it fits into a bigger picture, and then adapt a plan to deal with it. It also means being able to recognize and seize opportunities. Further, adaptive capacity is the ability to see all of the alternatives to a given situation before weighing the most apparent solution to a problem. Constantly thinking through problems in the same way every time means that new, creative options will often be overlooked for the tried and true path. The issues confronting the ED of today are not simple to resolve; they will take creative thinking. Einstein is often quoted as saying, “We cannot solve problems by the same kind of thinking that created them.”⁵ When all you have is a hammer, everything starts to look like a nail.

Case study 1.1

Dr. Karen Kornet has been the ED chief at her hospital for over two years. Overall the doctors and nurses are very happy. She has instituted some evidence-based protocols, has improved their chronically overcrowded waiting room with changes in triage, and has built a great working relationship between the doctors, nurses, and other ED staff members by using team training. But as more of the doctors are getting older, they are starting to talk about a desire for a better quality of life. They don't want to work nights and weekends forever. Unfortunately she just doesn't have the budget to add additional staff, even though she has asked hospital leadership for additional positions. She has already made changes in the schedule that were well received: by making the evening shift one hour shorter and having the night doctor start two hours earlier, she now has an extra doctor on duty from 21: 00 to 23: 00. By making the night shift a bit longer, she has lessened the load on the evening-shift doctor, decreasing door-to-doctor time during those busy hours but also allowing the evening-shift doctor to feel less fatigued and stressed at the end of the shift. The impact on the night-shift doctor was minimal, because usually things started to slow down after 01: 30, and the night doctor could sleep for a couple of hours.

One thing Dr. Kornet has learned is that it is important to know not only what is going on in her hospital, but also what is going on in neighboring hospitals. This allows her to get great ideas from other ED leaders, some more experienced than she.

She was talking with a colleague from another hospital whose ED was overstaffed. The hospital leadership had been talking about firing some doctors, even though they were very competent. Knowing there were no funds from her own hospital to hire additional doctors, but still wanting to help her staff have a better work-life balance, Dr. Kornet developed a proposal to get coverage for night shifts by using the doctors from the other hospital on a part-time basis. In fact, one of the other doctors who was to be fired, Dr. Hassan, preferred to work only nights because she had young children at home. Dr. Kornet's hospital was receptive to the idea of paying the other hospital for the night-shift physicians, because it allowed Kornet's hospital to add additional staff without the expense of insurance, retirement, or other benefit costs. Because both were regional hospitals, the employer for both was the same, and the exchange was easy. Dr. Hassan's hospital was able to save her job by reducing its overall expense. All the staff doctors were happy with Dr. Kornet because there were two fewer night shifts per week to work. By demonstrating adaptive capacity to the situation of staffing and coming up with a novel approach, Dr. Kornet again showed her ability to come up with a win-win solution for all.

Overcrowding is a problem that is often at the top of an ED leader's list of dilemmas. Many studies describe overcrowding's effect on patient care, and it takes real leadership to solve this worldwide problem.⁶⁻⁸ Some hospital senior staff now recognize that it is not just an ED problem; overcrowding has to do with hospital capacity. As more hospitals shut inpatient beds, many try to manage inpatients with fewer staff, or run shortages of ancillary hospital services like laboratory or x-ray. One study in Ireland describes ED overcrowding as due to discharged ED patients waiting to find services in the community to receive further care.⁹

What does this have to do with leadership? A necessary component of leadership involves building networks and being connected in multidisciplinary, intradisciplinary, and even extradisciplinary groups. For example, trying to solve overcrowding by convening all your ED staff to get ideas will usually not solve the problem by itself. You also may need to reach out to primary care doctors to increase their hours of coverage; to inpatient physicians, senior leaders, and nursing leaders to discharge inpatients faster; and to the community to understand how

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community health is impacting the ED. You may need to network with ED leaders locally, regionally, and worldwide to find out how they are solving the problem. The leader of the ED must be connected to professional medical groups both inside and outside of his or her own hospital, civic groups on the local and regional level, and – if the hospital is government-operated – local politicians so they may advocate for the ED's causes. If there is not an organized group of emergency physicians or nurses in your area, consider starting one.

Leaders use these networks to build collaborations and find new ways to solve old problems. The founder of the Mayo Clinic in Rochester, Minnesota, Dr. William W. Mayo, was first approached with the idea of building a hospital after the local Franciscan Sisters were called on to help during a deadly tornado in 1883.¹⁰ When the emergency was over, the head of the convent, Mother Alfred, asked Dr. Mayo if he and his two sons, Dr. William J. Mayo and Dr. Charles Mayo, would staff a hospital the nuns were considering building. Dr. Mayo originally declined. Hospitals during the nineteenth century were viewed as places people went to die, not to be healed. Also, he thought Rochester was too small to support a hospital. Despite Dr. Mayo's objections, Mother Alfred persisted, and the hospital opened as a 28-bed facility in 1888. Today, St. Mary's Hospital has 1265 beds and is one of the flagship hospitals of the Mayo Clinic. And it all started with a collaboration over 130 years ago.

Leaders are proactive, whereas managers are reactive. Many ED chiefs say that all they do is put out fires all day. These are reactive tasks. An ED chief who is putting out fires all day rarely has time to lead. The role of a leader is to set the agenda. Rushing from one crisis to another means that others are setting the agenda. For some ED chiefs, putting out fires all day is very rewarding because they can use it like a shield to avoid the harder work of planning, innovating, and thinking about change. Moreover, not all fires that are brought to the ED chief are important. Triage is as important for the leader as it is for the clinician. Working on a small finger laceration when another patient is having a myocardial infarction would be horrible patient care, but this is no different from spending all your time dealing with minor problems when quality is low in the ED. People soon learn that the only way to get your attention is by bringing larger and larger problems to you every day, reinforcing your role as firefighter. The ED leader soon finds that

a lot of energy is being spent to accomplish very little. It usually makes more sense to empower people to solve their own problems, allowing ED leaders time to create vision and innovations such as new ways to treat patients, to deal with strategic issues such as building a new department, or to re-engineer the model of emergency medicine practiced in the department.

Theories of leadership

It would be easy to tell the ED leader, "Do the following things and you will be successful in your new job" – but, like medicine, leadership is both art and science. While it would be folly to expect a physician or nurse to work in the ED without basic courses in chemistry and biology, it is also ridiculous to talk about leadership without a brief discussion of leadership's history and theory. Until the twentieth century, most countries and companies were governed by the ruling classes. This gave credence to the *great man* theory of leadership, also called the *trait* theory, which held that people were born into the leader's role and therefore possessed the personal traits necessary to lead from birth.¹¹ One of the interesting parts of this theory, and its name, was that it excluded women from leadership positions. Much research was conducted on this theory to try to understand what gave these "great men" their superiority. The great man theory persisted until the early 1920s, when studies indicated that there was no universal set of leadership characteristics and that leaders did not possess a superior level of intelligence. Over time, it became more apparent that ordinary men and women could learn leadership skills.

The next leadership theory to emerge was the *style* theory, also called the *behavioral* theory of leadership. Researchers determined that leadership behavior was essentially composed of two types of behaviors: task behaviors and relationship behaviors. The task style of leader was focused on achieving objectives, while the relationship-oriented leader was focused on helping followers feel comfortable with themselves, about the job, and with each other. This led to the belief that leaders had one dominant style used in almost all situations, with another style that could be used when the first was not successful. This theory's major shortcoming was that it only described observed behaviors, instead of telling leaders how they might behave to become better leaders.

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Because of the failures of earlier theories to adequately explain or predict good leadership, research continued. The *contingency* theory, also called the *situational* theory, asserts that no single way of behaving will work all the time, and that leadership style depends on the situation.¹² Research suggested that a leader's behavior was based on understanding of the effort of subordinates, their ability to do their jobs, the clarity of their job responsibilities, the organization of the work, and the cooperation and cohesiveness of the work group. After leaders assess the above variables, they then pick a leadership style that is most appropriate. If, for example, employees are competent and have the expertise to perform their work, then an employee-oriented leadership style might be appropriate. If the employees do not possess the skills and competency, a more production-oriented style is suggested, composed of more direction, rules, and policies. This theory had promise because it forced leaders to understand culture and have a handle on what was going on in the workplace by spending time with employees. Each employee was to be treated differently according to his or her unique needs, and the way the leader treated each employee might change from the beginning of the subordinate's career to later in that career as the employee understood the job better. This theory seems on the surface to have lots of promise, but there were very few research studies done to validate it. It also failed to explain why some leaders with particular styles were more effective in some situations than in others, and also what organizations should do when there is a not a good match between the leader and the situation.

All of these earlier theories of leadership are considered *transactional*. The goal of transactional leadership styles is to get other people to do things for something in return: money, prestige, or other rewards. Contemporary theories of leadership are different. The first contemporary leadership style, studied considerably since the 1980s, was called *transformational* leadership. Transformational leadership focuses on intrinsic motivation.¹³ This style of leadership is concerned with values, standards, and ethical behavior and focuses more on long-term rather than short-term goals. Transformational leaders treat followers not as mere workers, but as human beings with issues, motivations, and needs. People are actually changed after exposure to the leader. The connection between leaders and followers

becomes almost moral in nature, and raises the conduct and aspirations of both.²

It is in writing about transformational leadership that we start to see mention of vision in leadership. Vision provides a map of where the organization is going and gives everyone a sense of purpose and identity. This style of leader is considered a change agent. Most transformational leaders have lots of charisma. Gandhi, John F. Kennedy, Winston Churchill, and Mother Theresa are prime examples, but some transformational leaders have led their followers astray, such as Adolf Hitler. Leaders like Hitler begin to act independent of their followers, or put their own interests ahead of the interests of their followers. One argument against the theory of transformational leadership is that this charismatic, visionary style may be nothing more than a personality trait.¹⁴ However, the theory is beneficial in that it partly explains what leaders can do to motivate followers, and that how they do it counts.

Emotional intelligence

Leadership is difficult. Everyone knows people that should have been superstars as leaders; they were intelligent, creative, and brave. Some of them failed miserably and were never heard from again. Just as incompetent clinicians can harm patients, incompetent leaders can damage or destroy organizations. Leadership can be lonely when the things the leader must do are unpopular or when subordinates do not share the leader's vision. But the leader must press on. In the 1995 book *Emotional Intelligence*, psychologist Daniel Goleman explored emotions and how some people were able to better manage them than others.¹⁵ Using neurobiological data, he studied why some people with lower intelligence quotients (IQ) were successful while those with higher IQs were often unsuccessful. These successful people were not at the top of their class, and yet they went on to do great things, leading innovative companies that were employee-centric and known for great products. In fact, Gardner reports that 80% of the success factors he studied had nothing to do with an individual's IQ.¹⁶ Goleman set out to study this 80%, in particular those characteristics that are defined as emotional intelligence: the ability to persist in spite of setbacks, to premeditate, to delay gratification, to regulate emotions in the daily grind of life, and to empathize and have hope.

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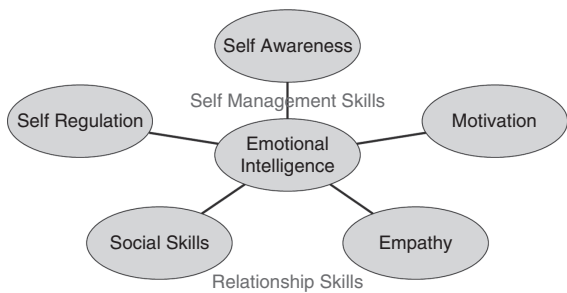


Figure 1.1 Components of emotional intelligence, after Goleman 1995, 1998.^{15,17}

Later work by Goleman translated his earlier studies into how emotional intelligence effects leadership ability.¹⁷ Goleman sought to understand how people could change their behavior to become better leaders. He broke down his theory into five major competencies: self-awareness, self-regulation, motivation, empathy, and social skills (Fig. 1.1). He calls self-awareness, self-regulation, and motivation “self management skills,” and empathy and social skills “relationship skills.” Each of these is further broken down into sub-competencies.

Self-awareness

Self-awareness comprises emotional awareness, accurate self-assessment, and self-confidence. People who have emotional awareness know how they are feeling and why, and are unafraid to let other people know. They understand what they think, do, and perceive, as well as how their emotions effect everyone around them, including patients, colleagues, and subordinates. As an emotionally aware leader, you know when you come to work that all your subordinates are aware of your moods and can tell when you are happy, tired, or emotionally drained. To have these emotions is understandable for everyone, but the leader must know when his emotions are in play in order to gauge how a particular emotion affects performance. For example, ED work is stressful; being the physician or nurse leader is stressful as well. If you see patients in addition to your administrative duties, the stresses of one part of your job can overflow into the other part. If you have just worked a stressful shift with many sick patients, it might not be the best time to conduct a subordinate’s performance evaluation.

Having emotional awareness also means understanding your values and goals. It has been said that “the most important thing in life is to know what is

important.”¹⁸ Any career decision should always be measured against your core values. If your goal is to really make a difference in emergency medicine and in the lives of your patients, then taking a job solely based on salary or prestige, even though the hospital’s leadership has no interest in moving emergency medicine forward, will usually lead to an unhappy experience. At the same time, if one of your core values is that the patient always comes first, many decisions as a leader become easier: dealing with outside consultants who do not want to come in after hours, or with recalcitrant hospital administrators who do not want to fund an essential piece of equipment.

A good leader should be able to make an accurate self-assessment and be aware of her strengths and weaknesses. Leaders often have blind spots that can put their careers at risk. According to Kaplan, some of the most common blind spots are blind ambition or the goal of winning at all costs; relentless striving at the expense of other important things in life such as family and friends; pushing others too hard; the insatiable need for recognition; or the need to seem perfect all the time.¹⁹ Blind spots cause leaders to make mistakes. The ED nursing director who feels the need to work harder than everyone else in the department (especially those he or she considers lazy) is a perfect example of this. Most workplace competencies are behaviors learned over time, and with effort the negative behaviors can be changed. Someone who is impolite and interrupts subordinates can learn to do better, through coaching, by accepting feedback from those surrounding them, or by learning new behaviors. The leader should also know her strengths. This means knowing whether you are the right person for a particular task or should instead defer to others who are stronger in that area. A good example would be an ED chief who takes the lead on the development of an ED information system because of her strength with computers while delegating the project of building a new ED to the associate chief because of his past experience with two similar building projects. Self-assessment also means seeking feedback from peers, colleagues, superiors, and subordinates. There are many tools that can be used for this, including 360-degree feedback, performance evaluations, and behavioral surveys.

Self-confidence makes up the last sub-competency of self-awareness. People who have self-confidence are able to take on big challenges and master new jobs or skills without difficulty. They feel that they

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compare favorably to others of their level but are not afraid of constructive criticism. The self-confident have charisma, which can inspire confidence in subordinates. One must have self-confidence to go to the chiefs of other services to advocate for emergency medicine, or to go to a community meeting to understand the local community’s displeasure with an event that occurred in the ED. Decisiveness is a key component of self-confidence. There are many decisions that must be made in leadership positions: hiring and firing decisions, resource allocations, and new program implementation. After you have gathered information about a problem, assembled a team to deal with it, set up a schedule, it will then be time to act. Do so with confidence, so that your subordinates can see that you are serious about the problem and dedicated to the solution.

As a leader, you must also be able to speak out with confidence when a core value of yours or the organization has been threatened. Standing up for your values demonstrates to the ED team that you are able to represent them. For example, allowing doctors from other specialties to intimidate or berate the ED staff without your intervention will demonstrate to the staff that you do not have the confidence to stand up for them.

Self-regulation

Self-regulation is another emotional competency that makes up emotional intelligence. Self-control is an important part of self-regulation. The good leader will regulate emotional upsets as well as those feelings that could cause distress. Stress is cumulative and will build up whether the source is from home or from work. The ED is an emotional place: our staff are high-energy people who do not always agree with us, many patients are very sick, and family members can be demanding. As mentioned above, it is important to have and show our feelings, but lashing out at staff members, or sulking when things do not go as planned, is counterproductive. You will have many trying moments as a leader – senior hospital administrators may not be convinced of your compelling idea, or a child may die in the ED, causing grief among your staff – but it is important to be seen as a composed role model who maintains a positive attitude. On occasion, just being the calming voice or opinion in a stressful situation is all that is needed. Even time management is considered self-regulation. As more

and more demands are placed on leaders, the ability to stay focused and keep a personal schedule becomes more important. If subordinates see the leader always being late it sets the tone for the rest of the department; consequently meetings never start on time, staff members show up late for work, and important meetings can be missed.

Another part of self-regulation is being trustworthy and conscientious. Leaders must act ethically and should not put themselves in a position where their ethics can be questioned. The practice of taking gifts from ED suppliers – forbidden in many countries – can be construed as unethical even if it is common in your region. Unethical behavior by others also must not be tolerated, even if a ban on these practices is unpopular. If the ED chief knows that staff members occasionally take small supplies like bandages home for personal use and does not act decisively to stop it early, it will be harder to stop in the future when the practice becomes commonplace and excessive. Being popular is not the goal of the ED leader; following one’s principles should be.

Everyone makes mistakes from time to time. Part of being a good leader is to occasionally take risks, some of which may have unsuccessful outcomes. The leader with emotional intelligence admits his mistakes, thus demonstrating trustworthiness. Trust in their leader is something that subordinates must have. If the leader promises to do something, he or she must follow through, or at least explain why the promise cannot be met.

Having self-control also means being adaptable and open to new ideas. The good leader seeks out new ideas not only to run the department but also to treat patients in a more efficient manner. New ways of doing things can come from journals, conferences, meetings of business executives, and even the local café. Seek ideas for longstanding problems from within the staff, as they are usually closest to the problem. The innovative leader does not always need to be the source of the next big idea. Instead, you should foster an environment in which staff feel empowered to offer suggestions.

Case study 1.2

In 2000 the US Institute of Medicine published a report called *To Err is Human: Building a Safer Health System*.²⁰ Among many things cited in the report was the cost of medication errors in hospitals. Medication

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errors caused 7000 preventable deaths, caused harm to 1.5 million people, and had an annual cost to the health system of US\$3.5 billion. Instead of trying to solve this from the top of the organization, Kaiser Permanente Health Systems' leaders took the innovative approach of going to the nurses, physicians, and pharmacists, and even patients, to enlist their support and ideas on how to prevent the problem in their hospitals. The hospital system had already studied the fact that interruptions and distractions while preparing and dispensing medicines were the biggest cause of medication errors in their hospitals.²¹ They assembled a two-day focus group with over 70 people to come up with ideas to minimize distractions. The group produced over 400 ideas, many of which are still used today, including having nurses who are preparing medications wear a bright yellow sash that signifies they are not to be disturbed and a painted zone around the medication dispensing zones indicating that those within the zone are not to be disturbed. By the leaders being innovative and allowing their subordinates to use their own innovations to solve a problem, the hospital system is saving over US\$900 000 annually.

Motivation

Good leaders are highly motivated to achieve, have commitment to a personal and organizational vision, and take initiative. The leader who is not interested in achieving excellence will usually end up as a manager, solely interested in keeping things as they are. Leaders strive to achieve excellence, both in patient care and in ED efficiency. They foster cordial relations between staff and patients, thus creating a good place to work or to get emergency treatment. The good ED leader wants to achieve quality targets and takes them seriously. An interest in achievement should belong not only to the leader but to the entire staff as well. Allowing subordinates to attend educational conferences, to take professional courses, and to try new things contributes to their personal satisfaction and a fulfilling work experience.

Leaders must have vision. Having vision means seeing the ideal future direction while realistically taking into account internal and external forces.²² The leader meshes her personal vision with the vision of the organization and, if the two visions are at odds, works to meld them. Leaders then must have the communication skills necessary to articulate the

vision to followers in a clear and concise way. Leaders should embody the vision in their values and actions each day. This vision keeps the leader going when things are difficult and acts as fuel for tired staff at the end of a long shift. Having a vision about the design of the new ED you are hoping to build and communicating it regularly to the staff can often keep them optimistic about working in an old, outdated facility. Articulating the vision is best done in person, in one-to-one or group meetings. Communicating the vision via email or text message will not work, though these methods can be used to reinforce a vision. ED workers are rarely the type to blindly follow someone without knowing where they are going; communicating your vision allows the ED staff to trust you to lead.

The motivated leader must also be optimistic. Optimism is key to vision, innovation, and risk taking. In Italy, where a residency program in emergency medicine was established in 2009, the dean of the medical school in Florence, a champion of the program, remained optimistic throughout longstanding, arduous political battles with government officials and doctors from other specialties who argued against the need for such a program (G. Gensini, personal interview, February 7, 2012). Today this residency has spread to 25 of the 26 regions of the country and first-year classes continue to grow. Optimism is the order of the day for those in emergency medicine. You must believe that the things you do benefit patients, the leadership skills you bring will make your department a good place to work, and the initiatives you begin will end in success. Your subordinates will sense your optimism and may be more optimistic because of it. Without optimism, you will give up on yourself, your causes and, ultimately, your patients and subordinates.

Empathy

Goleman describes the next two competencies of emotional intelligence as "relationship skills" because they involve working with others. Using emotional intelligence to become a better leader means having strong social skills. Building teams, empowering staff to make decisions, and knowing what is going on with your staff are important components of successful leadership that involve managing many relationships. Leaders sometimes feel "lonely at the top." Inesi and Galinsky cite many reasons for

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this, all related to trust. The main reason is that leaders sometimes believe that the only reason subordinates are nice to them or do the things they ask is because of the leader's power.²³ Many brilliant leaders are in fact loners. Research indicates that when loners become leaders they have a tendency to retreat into solitude, trying to solve vexing problems by themselves, trusting their intuition and decision-making processes rather than seeking counsel from others.²⁴ The successful leader will instead build networks that allow her to take advantage of many ideas. Empathy, the ability to sense how others are feeling, is a key leadership skill. People rarely tell us in words how they are feeling; rather, it is through their facial expressions, hand gestures, and posture that they signal their emotions. Freud said, "mortals can keep no secrets; if their lips are silent they gossip with their fingertips."²⁵ Goleman calls this "social radar," and notes that sensing emotion is not enough; the leader must also respond appropriately to the sensed emotions.¹⁷

How does this relate to the business of leading an ED? We expect our subordinates to come to work every day and do their best; yet sometimes they do not. A leader who can sense that something is wrong can help the employee perform better. For example, the doctor who is normally very good, but now seems preoccupied or short-tempered may have problems at home: a sick child or spouse, financial difficulties, and so on. Some leaders might be tempted to say, "All we care about here is performance, not what is going on in someone's personal life." But the leader who recognizes the staff's personal problems and offers appropriate assistance will engender loyalty and commitment in all employees. The leader who communicates with employees solely through voicemail and email will not be able to determine how those employees feel. Regardless of how busy the ED nursing director or ED chief might be, it is still important to spend face-to-face time with subordinates. Most employees and colleagues also are good at picking up on non-verbal signals from their leaders, so it is important not only to say empathetic words but also to demonstrate our empathy with non-verbal signals. Being empathetic should be viewed not as a weakness but as a strength.

Empathizing with people does not mean agreeing with them. Disagreements are less likely to develop into full-blown battles if the leader attempts to understand the other's position, even if it is contrary

to her own. Another thing that leaders are called on to do is arbitrate between two or more differing opinions between subordinates. When arbitrating, it is important to understand the emotional positions of all sides and to be seen to do what is best for the department rather than to take sides in the dispute.

In practical terms, being empathetic also means helping employees develop themselves. The good leader should have a sense of where subordinates want to go with their careers, not only through performance evaluations but also through direct observation of what part of the job gives the subordinates joy. Does a particular nurse who might not always have a good attitude seem to take substantial gratification in taking care of children, or does one doctor always seem to like taking on technical tasks? Caring enough about our employee's success to want to mentor them pays off in many ways. According to Orpen, mentoring employees allows them to perform at higher levels, increases their level of job satisfaction, improves loyalty to the organization, and lowers turnover rates.²⁶

Of course the good leader knows how to respect employees' privacy and should also know when not to intrude in employees' personal lives, but in the end, to be an empathetic leader means that people should know you are a caring, compassionate person who attempts to understand the feelings of those around you. A note of caution: be wary of using false empathy, or giving the appearance of understanding people's emotions without really feeling empathy towards them. People will know by your actions where you really stand. Machiavelli said, "It is unnecessary for a prince to have all the good qualities I have enumerated, but it is necessary to appear to have them."²⁷ Empathy is a quality that cannot be faked.

Social skills

The last of the five key components of emotional intelligence is having social skills. Having social skills means more than being friends with the staff, or telling jokes at a party. According to psychologist David McClelland, people have three important needs: the need for achievement, the need for power, and the need for affiliation.²⁸ They possess these needs in varying degrees. Those with a high need for affiliation wish to be part of groups, to have good

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relations with those around them, and to avoid conflicts. Often those with high affiliation needs perform poorly compared to others. Leaders are often faced with difficult decisions, and those decisions may lead to conflict. Consequently, leaders with high affiliation needs may find themselves frustrated with colleagues or subordinates after unpopular decisions they must make. It is sometimes said that it is better to be friendly with everyone than to be everyone's friend.

To lead successfully there must be group interactions between the leader and followers. The good leader gets people to willingly follow her, rather than relying solely on administrative fiat. Social skills can be further broken down into influence, communication, conflict management, and change catalyst. Those with emotional intelligence know how to influence those around them. Connecting emotionally to an audience, whether you are discussing patients at shift change, trying to sell a new policy to the staff, or convincing the CEO of the hospital to let you build a new ED, is an important part of being an influential leader. It is important to notice whether people are listening to you speak, reading your emails, or accepting your ideas. Being a leader is about making things happen in your organization. If you notice that you often fail to get buy-in, have a negative impact on things, or are being ignored, look at how you attempt to influence people. Are you open to their ideas, or are you stubborn and resistant? Do you rely on a familiar strategy to get things done, even if you know it is not always successful? Influencing people requires a positive outlook, strong communication skills, a willingness to listen, and empathy towards the audience, not a Machiavellian approach bent on winning at all costs.

Communicating openly with staff is another strong social skill that is part of the emotionally intelligent leader. It is difficult to influence people without listening first to what they have to say. Everyone knows someone who dominates the conversation, cutting the speaker off mid-sentence and ignoring the speaker's verbal or physical messages. It is always better to try to come to a mutual understanding when communicating and to make others feel free to offer suggestions. Ask good questions to show you are listening and do not shut yourself up in the office. Most ED communication is informal, so being where the workers are is necessary if you want to know what is going on in your department. Many ED leaders

today work at least a few shifts per month, including off hours, to stay in touch with their ED staff.

The ED leader must sometimes deliver bad news: hospital or department financial problems, impending lay-offs, or the death or serious illness of an employee. The leader's emotional self-control will help him deal with his own feelings about the situation. A study of more than 100 executives and managers found that their colleagues preferred leaders who best handled their own emotions during difficult circumstances.²⁹

The ED is often filled with conflict between nurses and physicians, staff and patients, ED staff and the staff of other departments, and between colleagues of equal rank. Conflict resolution is therefore a key skill for the ED leader. The best way to deal with conflict is to stop it before it starts. Often simply understanding the perspectives of all parties can lead to a mutually beneficial solution. Always strive for a win-win resolution, even though it might take longer to reach. Using tact during conflict is a sign of a good leader. Some problems, such as a disruptive physician, are difficult, and there may be no win-win solution. In such a case the leader must decide what is best for the department as a whole. A person who consistently generates conflict with other staff should not be tolerated and will often need to be replaced. Avoid resolving a conflict by simply passing an edict on the case. This often will drive the conflict underground only to surface again in the future. If no resolution can be reached between two parties, consider allowing them to "agree to disagree."

Finally, the leader with emotional intelligence needs to be a change catalyst. While some of the problems in health care today are definitely related to the poor global economy, health systems in many countries were already in crisis, and the foundering economy only exacerbated the problem. Those developing countries with improving economies have the problem of trying to provide higher-quality health care as standards of living improve and their citizens become more demanding. Heifetz, Grashow, and Linsky write in their *Harvard Business Review* article that with an improved economy, things are not likely to return to normal. They call this "leadership in a permanent crisis," and go on to say that the leader of today must be able to foster adaptation.³⁰ Today's leaders must develop not only best practices but also "next practices" to lead into the future. They advise embracing a state of "disequilibrium" to keep people