11. The role of trait emotional intelligence in healthcare leadership

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INTRODUCTION

Emotional intelligence (EI) has become one of the most influential psychological attributes in the scientific literature and practice on a par with the older established areas of Intelligence Quotient (IQ) and personality. In fact, it is out of these two areas and their various unanswered questions as well as the pressing theoretical need for their integration whence the study of EI eventually sprung (O'Connor et al., 2019; Pérez-González et al., 2020). There are, therefore, multiple direct precursors to the construct of EI, which was widely popularized by Daniel Goleman through his international best-seller Emotional Intelligence: Why it can matter more than IQ, published in 1995 (Goleman, 1995).

Like all psychological attributes, emotional intelligence defies precise definition (see Mayer et al., 2008), although it can broadly be said that the various models focus on the perception, expression, understanding and management of emotions in oneself and others, to guide thinking and action. Those scoring highly on the construct of emotional intelligence would thus be characterized by accurately perceiving and appraising emotions, using feelings to facilitate understanding of oneself or others, understanding emotions and the knowledge that can be derived from them, and regulating emotions to promote emotional and intellectual growth and well-being (Harms and Credé, 2010; Mayer et al., 2008).

There are conceptual distinctions between different models and definitions in terms of how EI is understood. Some researchers refer to it as a constellation of emotional tendencies and classify it as a 'Trait' (Petrides, 2001), others refer to it as a set of cognitive-emotional 'Abilities' for processing emotional information (e.g. Mayer et al., 2008), and yet others see it as a mix of these two approaches. The distinction between Trait EI and Ability EI can be made according to the method of measurement used to test for the construct (Petrides and Furnham, 2000). 'Trait EI' is measured via self (or observer) reports, where the individual is rated/scored with regards to a number of behavioural tendencies and/or emotional self-efficacy (self-efficacy is an individual's belief in their ability to execute behaviours necessary to produce specific performance attainments; Bandura et al., 1997). 'Ability EI', in contrast, is meant to be measured via maximum-performance assessment, or success in solving emotion-related problems that are deemed to have a correct or incorrect answer. Because Trait EI measures tend to capture 'typical' performance (as opposed to maximal performance), they provide a better predictor of behaviours and performance in a range of real-life situations. As such, they are arguably better suited than Ability EI measures for understanding performance in situations characterized by ongoing stressors, not least within the workplace (O'Connor et al., 2019). Trait EI measures have been employed extensively in the context of healthcare

and healthcare leadership, and for these combined reasons we place a particular emphasis on Trait EI as opposed to Ability EI in this chapter.

WHAT IS TRAIT EI?

While conceptualizations of Trait EI vary slightly depending on the measure used, Trait EI is widely accepted to refer to a constellation of emotional self-perceptions measured through questionnaires and rating scales (Petrides et al., 2007). The original Trait EI model, proposed by Petrides (2001) and widely cited today, was based on a content analysis of the early EI models and related personality constructs. It conceptualizes Trait EI as a construct comprising 15 facets, 13 of which load onto four over-arching factors which relate to both *intrapersonal* ('Well-Being' and 'Self-control') and *interpersonal* skills ('Emotionality' and 'Sociability'). The proposed hierarchical arrangement of these factors and facets is displayed in Figure 11.1 and the facets are defined further in Table 11.1 to demonstrate how an individual scoring highly on each facet would perceive themselves to behave. Measures of Trait EI tend to generate scores for individual EI elements as well as a 'global' EI score. For example, the 'Trait Emotional Intelligence Questionnaire' (TEIQue; Petrides, 2009), which is based on their original Trait EI model, provides scores for the 15 facets, the four over-arching factors and global Trait EI. The TEIQue is available in full and short versions and is perhaps the most commonly used Trait EI measure because of its strong theoretical and psychometric basis, (see Petrides et al., 2016 for an overview of the theory and measurement of Trait EI more broadly).

Trait EI is not strongly related to IQ (e.g. Ferrando et al., 2010) but does show moderate to strong associations with higher-order personality dimensions such as the Big Five (negative with neuroticism and positive with extraversion and conscientiousness; e.g. Petrides et al., 2010; Vernon et al., 2008). Trait EI also has incremental validity in predicting numerous psychological and demographic variables and outcomes over and above higher-order personality
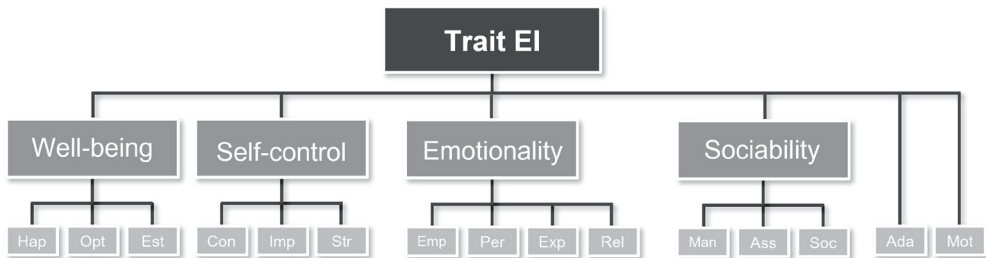
Note: Hap = happiness, Opt= optimism, Est = Self-esteem, Con = Emotion control (aka Emotion regulation),
Imp = Impulse control, Str = Stress management, Emp = empathy, Per = Emotion perception,
Exp = Emotion expression, Rel = Relationships, Man = Emotion management, Ass = Assertiveness,
Soc = Social awareness, Ada = Adaptability, Mot = Self-motivation.

Figure 11.1   *Hierarchical view of the sampling domain of trait emotional intelligence in adults*

Table 11.1   The sampling domain of trait emotional intelligence in adults

	High scorers perceive themselves as …
Well-being	
Self-esteem	… successful and self-confident.
Happiness	… cheerful and satisfied with their lives.
Optimism	… confident and likely to 'look on the bright side' of life.
Self-control	
Emotion control	… capable of controlling their emotions.
Stress management	… capable of withstanding pressure and regulating stress.
Impulse control	… reflective and less likely to give in to their urges.
Emotionality	
Emotion perception	… clear about their own and other people's feelings.
Emotion expression	… capable of communicating their feelings to others.
Relationships	… capable of having fulfilling personal relationships.
Empathy	… capable of taking someone else's perspective.
Sociability	
Social awareness	… accomplished networkers with excellent social skills.
Emotion management	… capable of influencing other people's feelings.
Assertiveness	… forthright, frank, and willing to stand up for their rights.
Independent facets*	
Adaptability	… flexible and willing to adapt to new conditions.
Self-motivation	… driven and unlikely to give up in the face of adversity.

* These two facets feed directly into the global trait emotional intelligence score without going through any factor. (Adapted from Petrides et al., 2016).

measures such as the Big Five, which confirms its theoretical and practical utility as an independent personality-based construct (Andrei et al., 2016). Of particular relevance here, a stream of publications has uncovered important Trait EI effects in relation to health, healthcare use, and healthcare leadership specifically. Below, we present an updated summary of these effects and conclude by discussing their implications for the development of training programmes that focus on EI, particularly for emerging healthcare leaders.

EMOTIONAL INTELLIGENCE AND HEALTH OUTCOMES

Mental Health

Baudry et al. (2018) conducted a systematic literature review, concluding that Trait EI is a strong positive predictor of well-being and mental health. Similar conclusions had been previously drawn in relevant meta-analyses by Martins et al. (2010) and Andrei et al. (2016). In a longitudinal study of the transition from primary to secondary school, Trait EI was a negative

predictor of psychopathology, concurrently as well as prospectively (Williams et al., 2010). Furthermore, in a study of adolescents, Mikolajczak et al. (2009) used probit regression analysis to estimate that the likelihood of self-harming is 75% if global Trait EI is below 2.47, but only 25% if global Trait EI is above 4.50 (TEIQue short form scores, ranging from minimum 1 to maximum 7).

Trait EI is a strong negative predictor of psychopathology in adults too, including people with clinically diagnosed conditions, such as Asperger's syndrome (Andrei et al., 2014) and borderline personality disorder (Andrei et al., 2016). Higher Trait EI predicts significantly lower psychopathology in psychiatric outpatients (Petrides et al., 2017), in older adults facing stressful circumstances (Lea et al., 2019), and in athletes in competitive sports (Kopp and Jekauc, 2018; Kopp et al., 2021; Laborde et al., 2011). While most studies have reported that high Trait EI is negatively linked to mood deterioration and psychological symptomatology in stressful circumstances, some studies, such as the one by Arora et al. (2011), which is especially relevant for the present review, reported that medical trainees with high Trait EI experienced more stress when performing an unfamiliar surgical procedure. This result highlights that the effects of Trait EI can be moderated by situational context and that high Trait EI scores are not always necessarily 'good' or desirable and low Trait EI scores are not always necessarily 'bad' or undesirable.

Physical Health

Compared to mental and subjective health, the relationships of Trait EI with objective indicators of physical health status tend to be weaker, and overall, they remain under-researched (Baudry et al., 2018). Mikolajczak et al. (2015) demonstrated in two large studies (N_1 = 1310 and N_2 = 9616) that Trait EI predicts incremental variance in healthcare use (including drug use, doctor consultations, and hospitalizations) over and above well-established predictors of health, such as age, gender, Body Mass Index, education level, social support and health behaviours (e.g. diet, physical activity, smoking, and drinking habits). Their findings also showed that high Trait EI beneficially moderated the impact of risk factors on health.

Trait EI has been linked to lower cortisol secretion in stressful situations (Lea et al., 2019), which is beneficial because high cortisol secretions over long periods may eventually lead to inflammatory and other somatic conditions (Iob et al., 2020; Qin et al., 2016). Individuals with rheumatoid arthritis (an inflammatory condition) score lower on Trait EI Well-being and Sociability than control groups (Costa et al., 2014). Moreover, there is a growing consensus that better-developed emotion control is associated with more effective self-management, less pain, and improved outcomes in chronic diseases (Benzo et al., 2016; Costa et al., 2014; Zysberg, 2017).

Overall, global Trait EI tends to be negatively related to behaviours with deleterious health effects, including various types of addiction (Aslanidou et al., 2018; Leite et al., 2019; Sechi et al., 2021). In contrast, it is positively related to health-promoting behaviours, such as physical activity and a healthy diet (Malinauskas et al., 2018; Mikolajczak et al., 2015).

On a related note, global Trait EI is also linked to barriers to healthcare use. For example, Costa et al. (2018) found that women with higher Trait EI scores were significantly less likely to be deterred by barriers to cervical screening like fear, anxiety, and discomfort. Importantly, this relationship remained statistically significant even after controlling for individual differences in the Big Five personality traits, emotion regulation, age, sexual intercourse experience,

and past Papanicolaou test behaviour. These and related results (e.g. Hajek et al., 2020) suggest that more attention to personality variables is merited in the effort to increase medically warranted healthcare screenings.

THE RELEVANCE OF TRAIT EI FOR HEALTHCARE PROFESSIONALS

Over the past 20 years or so, there has been a radical transformation in the understanding of the influence of emotion in the workplace, at all levels, from the level of the individual worker right through to how it impacts on organizational culture (Ashkanasy and Dorris, 2017). Traditionally, in health training programmes, medical staff were encouraged to conceal their emotions and to maintain a professional barrier from patients (McQueen, 2004). However, in the past two decades there has been a significant move toward removing those barriers in the healthcare environment. We are seeing an ongoing cultural shift from medical paternalism towards a patient partnership model, where patients are seen as equal stakeholders and contributors to their care decisions and conversations (Ocloo et al., 2021). This, alongside a growing understanding of the root causes of adverse events, has placed an emphasis on the importance of good non-technical skills on the part of healthcare workers, including good communication, situation awareness, decision-making, teamwork, and stress management (see Flin et al., 2017; Odell, 2011).

There is growing evidence of a strong positive relationship between healthcare workers' Trait EI and the quality of their non-technical skills, which is perhaps unsurprising at a conceptual level. Non-technical skills, such as forming good patient partnerships, communicating well, understanding how to engage patients in shared decision-making, working well as part of a team and managing stress all require an individual to be adept at perceiving, understanding and managing emotion in themselves and others. Studies have shown that physicians and nurses with higher Trait EI are more likely to form empathetic relationships with their patients and fellow team members and avoid emotionally charged behaviours and decisions. Their higher levels of self-control enable them to remain calm when faced with stressful scenarios and to communicate clearly and sensitively for optimal decision-making (Coskun et al., 2018; Nightingale et al., 2018). This not only directly benefits their patient interactions, but also supports clear communication and other non-technical behaviours that may go on to improve patient satisfaction, safety and treatment success (Johnson, 2015; Odell, 2011; Sharp et al., 2020). Indeed, Asiamah and Danquah (2019) demonstrated a positive correlation between healthcare worker EI and patient satisfaction in a large study in Ghana.

The beneficial impacts of emotional intelligence extend to predicting individual healthcare workers' *own* job-related outcomes. In health professionals, higher individual EI predicts greater job satisfaction (Etebarian and Omidpanaha, 2008; Ezzatabadi et al., 2012; Sharp et al., 2020), and is inversely related to the experiences of stress (Naidoo and Pau, 2008; Nespereira-Campuzano and Vázquez-Campo, 2017; Nightingale et al., 2018) and burnout (Vlachou et al., 2016). A higher level of mindfulness (the ability to maintain moment-to-moment attention to emotional and social events) in those with higher EI may be a protective mechanism in conditions of acute stress (Sharp et al., 2020).

Interestingly, several background characteristics appear to be related to EI in the healthcare workforce; women, older employees and people with greater professional experience have a tendency to higher Trait EI scores (which echoes effects in the general population).

EI AND HEALTHCARE LEADERSHIP

After a long period of neglect, emotions have also been propelled centre stage in leadership research. Leadership has been described as an 'emotion-laden process' (George, 2000), with the skilful management of followers' feelings representing a critical leadership function (Siegling et al., 2014; Thompson, 2021). A leader who can accurately identify and understand others' emotions should better grasp followers' problems and needs and, in consequence, formulate more successful (emotional) responses. Similarly, a leader who can effectively display and manage emotions can more strongly influence followers' feelings to achieve a shared objective and address concerns with greater proficiency (Walter et al., 2011). The relevance of emotions for leadership can even be observed in our evolutionary ancestors. Anthropologists note that appropriate emotional displays and recognition of the emotional displays of others are essential for functioning and leadership in primate communities (Boehm, 1999).

In the healthcare arena, and in the broader world of business, Trait EI is a significant predictor of leadership status (leader vs non-leader; Coskun et al., 2018; Siegling et al., 2014), as well as of leadership effectiveness (a leader's performance in influencing and guiding the activities of his or her team toward achievement of shared goals; Jamshed et al., 2017; Miao et al., 2021; Walter et al., 2011). Chambers and Exworthy (2020) explored the personal characteristics of a subset of hospital CEOs who had distinguished themselves from peers because of their long tenures. The researchers considered the question of 'what contributes to the staying power of these CEOs'? Interestingly, CEOs who enjoyed longer tenures were characterized by a number of personal characteristics that define high levels of trait emotional intelligence. They were more adaptable to change and functioned more effectively across a wide range of contexts, they had a generally positive mind-set, high levels of self-confidence and resilience during periods of organization flux, and they were characterized by high levels of reflexivity – implying their ability to examine their feelings, motives and subsequent actions. The relationship between EI and leadership ability applies not just at the level of these traditional leadership and management roles, but also at the level of the individual practitioner. For example, high EI is positively associated with leadership skills in surgeons, including their ability to communicate effectively, encourage trust and motivation within the workforce, adopt new ideas for future advancements and inspire their teams (Sharp et al., 2020). For healthcare managers, the positive correlation between EI and leadership competency holds even when controlling for gender, years of experience, and level of education (Weiszbrod, 2020).

Research in healthcare suggests that high emotional intelligence in leaders might also predict positive employee outcomes, including turnover intentions (Majeed and Jamshed, 2021), employee job satisfaction (Rinfret et al., 2020; Skinner and Spurgeon, 2005; Tyczkowski et al., 2015), employee effort (Skinner and Spurgeon, 2005; Spano-Szekely et al., 2016), employee empowerment (Lucas et al., 2008) and employee commitment to organizational change (Rinfret et al., 2020). While it is unclear whether these represent direct or indirect effects, there have been some attempts to explain these relationships.

Lucas et al. (2008) found that the relationship between emotionally intelligent leadership and nurse workplace empowerment was moderated by leaders' span of control (i.e. the number of people they supervise) – leaders with larger spans of control did not impact subordinates' empowerment as effectively, relative to their counterparts with smaller spans of controls (Lucas et al., 2008). Majeed and Jamshed (2021) found that the positive influence of leader EI on nursing turnover intentions was mediated by a positive impact of EI on team culture.

Leaders with higher EI were more sympathetic and ready to discuss problems, better at networking and cultivating synergy within teams, which in turn created a collaborative culture characterized by high team spirit, positive social exchange and lower turnover (Majeed and Jamshed, 2021). One finding with increasing generalizability is that adopting a transformational leadership style appears to mediate the positive relationship between leader emotional intelligence and positive employee outcomes (Prezerakos, 2018; Rinfret et al., 2020; Skinner and Spurgeon, 2005; Spano-Szekely et al., 2016; Wang et al., 2018).

Transformational leadership is characterized by the ability to inspire positive change in individuals. Transformational leaders are proactive, innovative, and intellectually stimulating; they act as charismatic role models, can communicate a captivating vision to achieve shared goals, build trusting supportive relationships, and increase motivation and organizational commitment (Crowne et al., 2017; Harms and Credé, 2010). The concepts of emotional intelligence and transformational leadership both involve the capacity to engage and work on the interpersonal level, for example, to connect with and to influence others, rendering it conceptually sensible that they should be related. Indeed, emotional intelligence consistently predicts transformational leadership style in healthcare professionals (Arunima et al., 2014; Crowne et al., 2017), and healthcare managers (Harms and Credé, 2010; Prezerakos, 2018; Rinfret et al., 2020; Skinner and Spurgeon, 2005; Spano-Szekely et al., 2016). The same relationship has been found in other sectors, even when controlling for major personality dimensions like neuroticism, extraversion, conscientiousness and others (Schreyer et al., 2021). However, the strength of the relationship between EI and transformational leadership varies partly as a function of whether the ratings come from the same source or multiple-sources; stronger relationships tend to emerge when the same source ratings are used; that is when both EI and leadership scores are provided by a common source (Harms and Credé, 2010).

EI is negatively associated with a laissez-faire leadership style, a style characterized by avoidance of decision-making, abdication of authority, and a reluctance to take action. In contrast, it has little or no relationship with transactional leadership, a responsive style focused on supervision, organization, and performance (Harms and Credé, 2010; Prezerakos, 2018; Skinner and Spurgeon, 2005; Spano-Szekely et al., 2016). More generally, all of the various types of harmful leadership (abusive, tyrannical, destructive, bullying, toxic and laissez-faire) operate through the display of dysfunctional emotions on the part of the leader, risking in turn emotional damage to the follower (Pelletier, 2010).

Unpacking the Links between EI and Transformation Leadership

Researchers have explained the relationship between EI and transformational leadership by breaking EI down into its constituent facets (see Figure 11.2) and reflecting on the qualities and skills these contribute to a transformational leader's armoury.

Starting with 'Sociability', effective transformational leaders need to spend much of their time in a liaison role, disseminating and monitoring information amongst co-workers and forming strong and cooperative social networks, internally as well as externally. They need to articulate their visions and preferences, to employ effective motivational mechanisms, to interpret non-verbal cues, to manage conflicts and to handle negotiations (Skinner and Spurgeon, 2005). They must also be able to respond to the most urgent needs of individuals in their team, dictated by their social and demographic positions and value orientations (Reshetnikov et al., 2020), and further to influence the broader culture of the organization
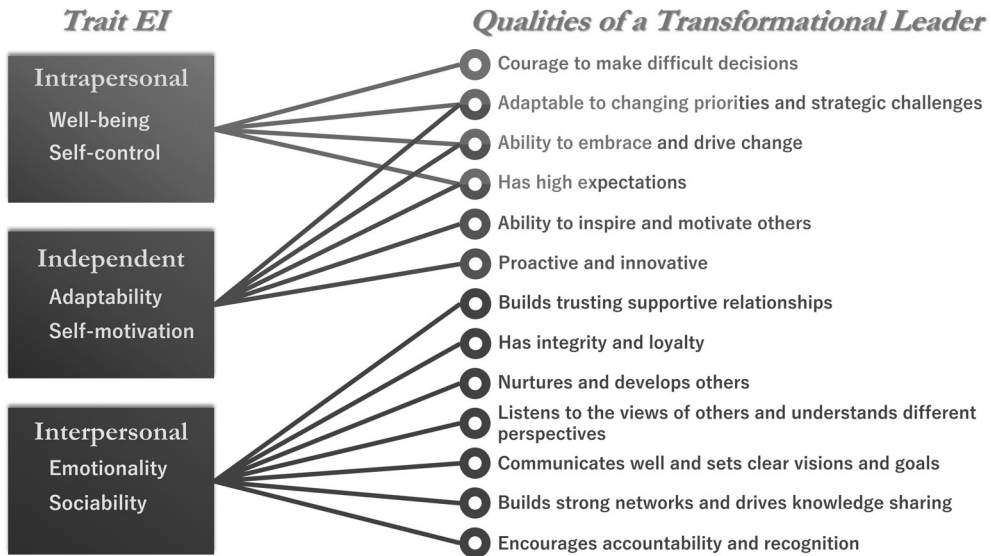
Figure 11.2   Relationships between trait emotional intelligence and transformational leadership

by engendering openness, transparency and effective teamwork and communication. Having strong sociability traits, including assertiveness and the knack for managing others' emotions will aid leaders in all of these functions and so assist them in widening their scope of influence and in accomplishing goals through others (Freshman and Rubino, 2004).

Next, 'Emotionality' involves being aware of and able to communicate one's own feelings unambiguously as well as understanding and empathizing with the feelings of others and forming strong relationships. These are further important transformational leadership skills. Leaders scoring highly on emotionality facets can use emotional appeals to motivate others and can understand employees' perspectives and requirements. They are willing to learn from others and spend time mentoring them to achieve their own goals, and are capable of forming connections and fostering trust and loyalty in their teams (Beydler, 2017).

Moving on to 'Self-control' which concerns controlling one's feelings and emotional states, responding well under pressure and engaging in reflection, rather than giving in to impulses. This collection of facets allows transformational leaders to adjust to and embrace change, to avoid foolhardiness, and to remain level-headed under stressful circumstances. It helps them to remain thoughtful and reflective and to weigh all the information before making a decision. The ability to channel negative emotions in a useful way and to pick oneself up after a setback will often distinguish an excellent leader from a good one (Goleman, 1995).

The factor of 'Well-being' brings self-confidence and a positive outlook that can support multiple transformational leadership functions, such as negotiations, rapport building, and tough decision-making. The ability to look on the bright side better enables people with high levels of well-being to take opportunities and calculated risks without it damaging them personally. Emotional well-being also correlates strongly with resilience, which is a key mediator of stress management in clinical populations (Schneider et al., 2013).

The facet of 'Self-motivation' engenders persistence and helps leaders who adopt a transformational style to overcome setbacks and failures, while minimizing deleterious knock-on effects of such adversity on their teams. It drives them to thrive on high performance without the expectation of incentives or personal rewards. Finally, the facet of 'Adaptability' delivers the requisite flexibility to manage and drive change, balance demands, and adjust to new situations with fresh ideas. Flexible leaders are more likely to modify their strategies and styles based on emerging priorities in order to meet challenges as they arise.

IMPLICATIONS FOR PERSONNEL TRAINING AND DEVELOPMENT

With a growing understanding of the importance of EI for leadership effectiveness comes the attendant question of its implications for the training and development of would-be leaders, and in particular, the all-important question of the extent to which EI can be honed. There is growing evidence both within healthcare and in workplace arenas more broadly that EI and its correlates can indeed be improved through development and training.

A study with district nurses found that EI could be cultivated through a combination of training, experience, reflection and reinforcement (Davies et al., 2010). Szczygiel and Mikolajczak (2018) reported that EI training could be implemented to mitigate negative emotions at work as a result of job burnout. During this training, particular emphasis was placed on providing nurses with information on the effectiveness of various emotion regulation strategies. Another study performed by Hurley et al. (2020), using a qualitative approach, found that training undergraduate nurses in EI had a positive impact on their non-technical skills and resilience. Reshetnikov et al. (2020) concluded that participants who received EI training had higher professional knowledge, skills and leadership qualities than peers who did not undergo such training.

Asiamah and Danquah (2019) conducted a large-scale training project in Ghana with healthcare workers who received either specialized training in EI (i.e. training designed to equip the workers with the emotional competencies relating specifically to EI) or non-specialized training (e.g. general training in communication skills). They found that both types of training resulted in an improvement in EI even after controlling for job tenure, income, education and employee rank; however, specialized training was also positively related to improved patient satisfaction scores. This suggests that specialized training in EI should supplement generic programmes, where the goal is to augment EI and its application to patient care (Asiamah and Danquah, 2019).

The incorporation of EI elements into leadership training specifically is also becoming more common. There is a growing trend of training programmes which are focused on modern concepts about leadership skills and competence, many of which acknowledge the relevance of EI as well as the role of non-technical skills in leadership effectiveness.

Crowne et al. (2017) reported that competencies of emotional, social and cognitive intelligence that predict leadership can be fostered in nurse leaders working in nursing homes via a leadership training programme delivered across a year, with three-days' worth of content focusing on concepts of EI and its development. Mintz and Stoller (2014) completed a systematic review of EI and physician leadership development. Broadly speaking, healthcare professionals were reported to desire EI training, and EI development was recommended as a way of enriching physician leadership at an executive level throughout healthcare as well as at the

individual physician level. Leadership training containing EI elements was found to improve team-based and collaborative care.

The specific approaches undertaken to improve emotional intelligence via training are varied (Luna et al., 2019; Nelis et al., 2009; Nightingale et al., 2018; Roy, 2015; Ruttledge and Petrides, 2012). Simply including EI-focused course materials in a business degree pro-gramme has previously led to EI increases in some students (Boyatzis et al., 2002; Joyner and Mann, 2011); however, experiential, practical and reflective elements of training are likely to be more effective for improving the ability to cope with emotion-laden situations, to reduce stress responses, and to maintain any benefits gained (Arora et al., 2011; Lea et al., 2019; Szczygiel and Mikolajczak, 2018; Weiszbrod, 2020). This is likely because such methods allow trainees to better engage in reflexive practice that can help them understand their emo-tional traits and how to use them in the workplace to promote processes of adaptation and learning. Simulation may be one such model for teaching EI-related concepts. Simulation is a means of allowing the deliberate hands-on practice of clinical skills and behaviours prior to, and alongside, entry into clinical environments, encompassing a breadth of approaches, from low-cost bench simulators to high-fidelity patient manikins, from patient actors for learning communication skills to complex ward simulations and haptics. Accompanied by structured de-briefing (often video-assisted), simulation allows individuals to appraise and reflect on their emotional responses, triggers, and understanding of scenarios and to identify alternative approaches if necessary (McKinley and Phitayakorn, 2015). Mindfulness meditation practices may also provide a useful adjunct to EI training, for example, helping to improve individual well-being and team function in high-stress clinical environments (Kelm et al., 2018).

In the quest to create cohorts of effective healthcare leaders, we argue that discrete, special-ized EI training courses should be underpinned by a more integrated and sustained approach to supporting the awareness and development of EI in the healthcare workforce via the incor-poration of EI content into educational curricula and continued professional development for the healthcare professions. For doctors and nurses, for example, this should begin at admission to medical/nursing school with specific components of EI (e.g. teambuilding, empathy, and negotiation) being taught across the various phases of training. Consistent with the concept of a spiral curriculum, such EI competencies should be revisited iteratively throughout training, with differing emphasis and increasing sophistication to meet evolving needs (Stoller et al., 2013). For example, self-awareness and self-management might be more important earlier on, whereas empathy and altruism may be more relevant in later stages of training (Mintz and Stoller, 2014). Roth et al. (2019) set out important practical considerations for integrating EI into medical education, including, for example, incorporating self-awareness exercises and contextualizing sessions with clinical vignettes. Given what we know about the importance of EI for leadership, setting the foundations in these skills early on in training and reinforcing them throughout will be critical for training cohorts of workers who can effectively adapt to a formal leadership role later on in their career, or who will simply be better placed to enact effective leadership behaviours within the context of their day job.

CONCLUSION

We have shown that EI, especially the Trait EI approach, assists healthcare workers in the per-ception, expression, understanding and management of emotions in the workplace to support

the provision of effective patient-centred care. It also enhances the non-technical skills required for safe team-working and helps to protect individuals from the negative outcomes of work-related stress and burnout. This is particularly pertinent for the modern healthcare workforce that is dealing with the aftereffects of the global pandemic. Furthermore, it is a fact recognized in study after study within the broader medical sector (for the latest demonstration; see Petrides et al., 2022).

We have specifically seen that EI appears to set the foundations for individuals to become effective healthcare leaders, whether in the context of a formal leadership/management role, or in relation to an individual physician's or nurse's discrete leadership behaviours. Specifically, Trait EI acts as an antecedent of the transformational leadership style that, in turn, brings many benefits to organizational and employee outcomes in healthcare settings. In the future, we may consider the implications of this for personnel selection. Some researchers and commentators have advocated the assessment of EI as a criterion for admission to medical school and others have suggested that the selection of healthcare leaders should take into consideration the EI traits that we know will support their success.

Trait EI is malleable; it can be developed and optimized via training and education. It should feature as a core component of leadership training modules as well as healthcare professional education curricula in order to build all-round capacity for effective leadership in the healthcare workforce. This message is key for those with a role in curriculum development and the commissioning of leadership training for healthcare workers. EI is not a 'nice to have' skill, it is central to building relationships, driving change and improvement, fostering skills development, improving culture, and keeping the healthcare workforce healthy and satisfied – all critical responsibilities of a leader. It seems to be absent from where it is needed most in medical workplace contexts and should therefore be embedded and integrated across all leadership training and education in the healthcare arena, not as an optional module or topic of interest, but as a central theme.

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