Using emotional intelligence to facilitate strengthened appraiser development

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WHAT IS ALREADY KNOWN IN THIS AREA
- Medical revalidation will place greater emphasis on appraisal
- The appraiser is central to effective appraisals
- A number of skills-based models and competency checklists for appraisers exist which identify key appraiser competencies
- Well-designed and tailored emotional intelligence interventions can be effective in developing confidence and ability to deal with emotionally-charged situations

WHAT THIS WORK ADDS
- The development of an appraiser behavioural competency model which describes the specific behaviours required to demonstrate appraisal skills
- Using a behavioural competency model to design standardised development exercises and marking guidance with clear indicators of performance and specific feedback frameworks against the appraiser competency model.
- Combining development centre methods and the concept of emotional intelligence to produce a bespoke Medical Appraiser Development Centre, where participants are provided with opportunities to receive instant feedback and benchmark performance with peers to encourage reflection and increase self-awareness.
- Initial evaluation results with examples of how learning has been transferred to the workplace, enhancing skills and appraiser self-confidence.

SUGGESTIONS FOR FUTURE RESEARCH
- Long term validation study if the Appraiser Development Centre including feedback from appraisers and appraisees.
- Exploration of combining the concept of emotional intelligence and development of centre methods for personal development across other groups of primary care staff.
- Design and evaluation of follow-up materials to enhance transfer of learning from the Appraiser Development Centre to the workplace

Keywords: development centre, emotional intelligence, medical appraisal

SUMMARY

This paper describes a new approach to developing strengthened medical appraiser skills prior to the introduction of medical revalidation. We describe how we extended previous skills-based models and competency checklists to produce a behavioural model of effective appraiser performance. Development centre (DC) methods were used to produce a one-day workshop to encourage appraisers to reflect on their current level of ability and to identify and address additional required skills through observation, practice and feedback. In describing the DC, we discuss the impact of using the concept of emotional intelligence (EI) to develop appraiser skills and improve self-awareness. This aimed to support
appraisers to effectively influence appraisees' continual professional development (CPD) and review appraiser practice through audit, significant events and patient and colleague feedback, with the ultimate aim of improving patient care. Finally, we provide initial evaluation data for our DC approach.

BACKGROUND

Medical revalidation is to be introduced in the UK, a process within which appraisal will play a central role. Greater emphasis will be placed on reflective practice, CPD and patient care. This large-scale policy change will mean that practising doctors in the UK will all need to be appraised each year by approved peers, with decisions made affecting their relicensing. This is a high-stakes environment for all the stakeholders concerned. As such, there is now a fundamental need to ensure that doctors have sufficient skills and confidence in their abilities to take on the role of appraiser.

EXPLORING THE ROLE AND BEHAVIOURS OF AN APPRAISER

As many researchers have noted, the appraiser role is key in effective appraisals. Medical appraisers will need to reflect on their skills and may look to extend their current abilities to balance the individual developmental needs of appraisees with the regulatory requirements of relicensing and recertification. The first stage of this work was therefore to extend previous skills-based models and competency checklists to produce a behavioural competency model of effective appraiser performance.

Chambers et al. proposed a template for a job description and person specification of an appraiser based on the National Health Service (NHS) Knowledge and Skills Framework. They reviewed the relevant medical education literature and gained feedback on their evolving template from participants at general practitioner (GP) appraisal training workshops. This identified 11 core competencies: (1) communication skills; (2) personal and people development; (3) health and safety and security; (4) service development; (5) quality improvement; (6) equality, diversity and rights; (7) promotion of self care and peer support; (8) ability to manage the appraisal process; (9) ability to carry out needs assessment; (10) ability to contribute to the support for the appraisal process; and (11) leadership skills and protected time. More recently, Rhydderch and colleagues also carried out useful research to propose a skills-based model which identifies five areas of skills: (1) initiating the discussion; (2) reviewing progress; (3) personal development plan (PDP) construction; (4) closing the discussion; (5) advanced skills - managing difficult appraisals; and (6) generic skills.

Our work builds upon the previous work outlined above by describing the specific behaviours required to demonstrate these skills. Having a model with this level of detail provides clear examples of the expected behaviours, giving individuals a common language to describe the desirable (and undesirable) behaviours associated with the appraiser role. In addition, having a detailed behavioural framework allows us to readily design relevant exercises and marking frameworks with clear indicators of observed appropriate and inappropriate performance, which in turn ensured that feedback could be given in a structured and standardised way.

Person-oriented job analysis procedures were used to produce systematic information about the medical appraiser role, describing the behavioural requirements for the role. This was conducted in two phases following previously validated procedures. First, an extensive literature review was conducted, including publications from the medical education, management and psychology arenas. In particular, theories of goal setting and self-efficacy were used, plus research regarding appraisal skills and communication tactics to understand what makes an appraisal successful. An audit of existing frameworks to establish evidence regarding the behaviours associated with effective appraisers was also undertaken. A summary of this review is presented in Appendix 1.

Secondly, semi-structured interviews were conducted with appraisers (N = 4) and appraisees (N = 3) utilising cognitive mapping and Critical Incident Technique to identify the behaviours demonstrated by effective and ineffective appraisers. Interview notes were reviewed, and specific behavioural descriptions elicited and recorded. Following this established role analysis procedure several emergent themes were elicited. To increase construct validity of the proposed model, these were then mapped to existing theoretical models. For example, behaviours associated with empathy and self-awareness were mapped to the concept of EI.

As the concept of EI was identified as important, a further literature review was undertaken to determine the relevance and applicability of the concept in this setting. Emotional intelligence stems from earlier theories that propose that there are multiple intelligences, including a distinct intellectual capacity to understand and manage others. The term EI was coined in 1990 by Salovey and Mayer, who described it as a form of social intelligence that involves the ability to monitor one's own and others' emotions, to discriminate among them and to use this information to guide one's thinking and actions (p. 189). A critical review of the psychology and management literature suggests that despite a lack of consensus amongst researchers regarding the...
exact nature and reliable benefit of EI,\textsuperscript{18,19} well-designed and tailored EI interventions can benefit aspects of job performance, with developmental activities enhancing both confidence and ability in managing emotionally charged situations.\textsuperscript{20} More detailed findings from this review are summarised in Appendix 2. Results of the role analysis produced a behavioural competency model describing the behaviours necessary to be an effective medical appraiser. Where there was overlap with existing job analysis research in this area (e.g. from models of specialty selection), behaviours were also mapped to again enhance construct validity of the appraiser model. Six behavioural competency domains were identified and are outlined in Box 1.

THE APPRAISER DC

Development centre methods were used to provide current and would-be appraisers with the opportunity to systematically reflect upon their existing level of skill and to identify their personal development needs as appraisers. Development centres are not, as the name might suggest, buildings or physical centres, but rather foci of assessment and educational activity. In this respect they are similar to assessment centres in that, by using a multi-station approach, one aim is to observe and accurately assess behaviour. However, in a DC process immediate feedback from observers and reflection by participants are used to improve performance through increasing an individual’s self-awareness and identifying key strengths and areas for improvement. By drawing on research evidence concerning contemporary DC methods\textsuperscript{21,22} and conducive climates for developmental feedback,\textsuperscript{23,24} we were able to design a bespoke DC for medical appraisers – the Appraiser Development Centre (ADC).

The potential benefit of incorporating EI in appraiser training has previously been discussed by Loughrey and Boylan,\textsuperscript{25} who designed a workshop for four appraisers. Building on this approach, we designed the ADC using the concept of EI to facilitate development of both intrapersonal awareness (understanding and managing oneself by demonstrating self-awareness and self-regulation) and interpersonal awareness (understanding and managing others by demonstrating social awareness, empathy and social influence). Prior to attending the ADC, each participant completes a measure of EI which leads to the production of a comprehensive personalised feedback report.\textsuperscript{26} At the ADC participants complete an EI self-assessment, enabling them to compare their own view with the results derived from the tool to increase self-awareness. Opportunities to discuss results with a trained facilitator are provided.

During the ADC, participants explore the concepts underpinning appraisal and revalidation, followed by a review of the appraiser behavioural competency domains and the link to existing policy documentation (e.g. the NHS Medical Leadership Framework).\textsuperscript{27} Similarly to appraiser training designed in Scotland,\textsuperscript{7} developing feedback skills was also central to the ADC design, as was producing effective PDPs. There are opportunities to develop appraiser skills and receive instant feedback by taking part in two bespoke standardised exercises. The first exercise is a simulated appraisal meeting with a trained actor, which allows observation and feedback regarding the empathy (social and emotional intelligence), communication and developing others competency domains. The second exercise is a written exercise in which a participant reviews simulated portfolio material and is given feedback for the

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**Box 1 Medical appraiser behavioural competency domains**

**Professional responsibilities** Focus on improving patient care and an awareness of health and safety, equal opportunities and diversity considerations. Willingness to take responsibility for own actions and demonstrate a commitment to the process.

**Appraisal management** Capacity to contribute to appraisal process by protecting time and planning delivery.

**Appreciation of the impact of the national standards and of the underlying principles of appraisal and the agreed processes.**

**Self-awareness (personal emotional intelligence)** Development of self-awareness by reflecting on personal impact on others and regulating own behaviour. Awareness of own strengths and limitations and motivation to learn and develop own skills.

**Empathy (social emotional intelligence)** Capacity and motivation to take in colleague perspective and sense associated feelings. Generation of a safe and understanding atmosphere and rapport which fosters poor support.

**Developing others** Capacity to act as a leader, encouraging personal and professional development by exploring issues, challenging constructively and providing support for development planning.

**Communication** Capacity to adjust behaviour and language (written/spoken) as appropriate to the needs of differing situations. Active and clear engagement of colleague in equal/open dialogue, listening, clarifying, supporting and reporting as appropriate.

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Note: For each competency domain, positive and negative behavioural indicators were developed. See Appendix 3 for an example.
developing others, appraisal management and communication competency domains. Participants are then given opportunities to reflect on and benchmark their approach with others.

Observers are non-medics with substantial expertise in the areas of assessment and development. Observers are trained by attending a one-day workshop specifically for the ADC. During training, observers are briefed about the concept of EI and how this relates to the appraiser behavioural competencies. Observer guidance notes are provided, including details of how the behavioural indicators for each competency domain are observed in each exercise. At the ADC, observers record evidence of behaviours and then complete a participant feedback form for each exercise. This requires them to provide qualitative comments for each of the targeted competency domains. Observer feedback is mapped to the EI feedback further highlighting observed potential strengths and development areas. Simulators (who also attend specific training) provide written feedback for the simulation exercise supported by associated guidance documents.

As part of the ADC, participants also create a PDP for addressing their appraisal skills. This not only encourages participants to reflect upon their own development, but also serves to simulate the process by which an appropriate PDP might be developed.

To ensure appraisers are in a position to facilitate reflection when conducting appraisals and to emphasise its benefits, the development of reflection skills is also central to the ADC. Participants complete a learning logbook throughout the day, providing structured opportunities for reflection. To encourage transfer of learning back to the workplace, at the end of the ADC participants complete a final stage of their learning logbook where they assimilate their self-assessed and tool-derived EI profiles with observer and simulator feedback and reflections from across the ADC. By combining these sources of evidence, participants are able to reflect further on the link between EI and appraiser behavioural competencies. Participants are encouraged to review their learning log post-ADC and continue using it to record ongoing reflections after conducting appraisals.

A total of six pilot ADCs were held between February and September 2009 in the Kent Surrey and Sussex Deanery, which were attended by 71 participants who were current or future GP appraisers.

EVALUATION

There were two main phases to the evaluation, with multiple methods employed. The views and experience of participants, observers and simulators were sought to explore the extent to which the ADC supported appraiser development and to identify areas for improvement. Throughout the pilots, an action research methodology was employed to facilitate evaluation of the ADCs. This ensured that early feedback and timely evaluation were conducted so that any necessary changes could be made to subsequent ADCs. By doing so, an iterative cycle of evaluation and improvements was adopted during the pilots as recommended by Cummings and Worley.¹⁰

Evaluation questionnaires were completed following each ADC, comprising both quantitative and qualitative sections. SPSS V.15 was used to run descriptive statistics on the quantitative data and the qualitative feedback was reviewed to identify key areas of improvement. Following action research recommendations, appropriate modifications were made to the ADC after each pilot to enhance the validity of the process.

Follow-up semi-structured telephone interviews were conducted three to five months post-ADC. A content analysis was conducted to elicit broad themes relating to ADC components: learning outcomes; experience of conducting appraisals following the ADC; examples of transfer of learning; the utility of the EI concept and any areas of improvement or ways to support transfer of learning back to the workplace. As the ADCs were facilitated by the authors, their reflections were also taken into account when reviewing the feedback and considering ways to introduce improvements.

Feedback collected from observers and simulators and then participants via questionnaires at the ADCs is summarised, along with details of changes introduced during the pilots. This is followed by information elicited from the three to five-month post-ADC interviews.

QUESTIONNAIRE FEEDBACK

Simulator and observer feedback

A total of 20 evaluation questionnaires were collected from simulators and 29 from observers over the six pilots.¹ Across all ADCs, simulators rated the simulation exercise as highly relevant to the appraiser role and as targeting the correct competency domains. They also found the behavioural indicators developed from the competencies useful in structuring participant feedback. Based on qualitative comments and observations from the facilitator following the second pilot, additional guidance was provided to simulators about how to positively frame written feedback. Prior to the final pilot, a list of common GP acronyms likely to be used by participants during the simulation was produced in response to feedback.

After the first pilot, observers generally recog-

¹Please note that in some situations the same observer or simulator attended more than one ADC. However, they completed an evaluation form on each occasion.
nised the relevance of both exercises to the role, but only half agreed that the correct competency domains were being targeted. Feedback indicated this was because behavioral indicators for evaluating participant performance were not specific enough. Therefore, using this feedback and observations from the facilitators, the indicators were reviewed and updated. This had an immediate positive effect for evaluation of the simulation exercise, with all observers agreeing that the correct competency domains were targeted and that the behavioural indicators were useful at the next pilot. This remained the case for the duration of the pilots, with the majority of observers agreeing that exercises were relevant and the correct competency domains were targeted.

For the written exercise, early feedback indicated that observers felt there was too much written information for participants, which also hindered their ability to easily mark the exercise. Therefore, the amount of information was reduced where appropriate and an observer briefing document which summarised the key issues within the exercise was produced. At the second pilot, however, feedback indicated that observers would prefer the opportunity to digest the exercise content prior to the ADC since some of the context was unfamiliar to them. This resulted in more positive feedback from pilot three onwards.

Other early updates to the process based on observer feedback included modifications to the participant feedback forms to contain more qualitative feedback and enhanced briefing sessions where observers and simulators took part in joint discussions. These were conducted to ensure both groups were clear about their role on the day and were confident in providing appropriate written feedback.

**Participant feedback**

All participants (n = 71) completed a 23-item evaluation questionnaire at the end of each ADC. Again, these were analysed after each pilot to identify possible areas for improvement. From the outset feedback was positive, particularly in terms of relevance to the role, with all participants agreeing that all exercises were relevant to the GP appraiser role. Opportunities to develop and acquire skills were also positively received, particularly for the written simulation exercises. The areas that were rated slightly lower were those associated with reflection (PDP and the learning logbook), with this being perceived as more difficult. This pattern of results was generally consistent across the six pilots, with initial improvements focusing mainly on improving observer and simulator experience. For the fourth and fifth pilots, the number of participants was increased to n = 17 and n = 14, respectively, from a previous average of ten participants per ADC. This was to explore the optimum number of participants both for participant experience and cost effectiveness. However, there were a minority of GPs who were less positive at these ADCs with less certainty about whether they would be confident in applying any knowledge/skills gained when carrying out their role as an appraiser. Evaluation showed that this was likely to be a result of increasing the size of the participants group, thus reducing the amount of individual attention the facilitator was able to provide. As such, the number of participants was reduced for the final pilot, leading to much higher ratings in this area. Based on this experience, we recommend a maximum of twelve participants per ADC.

Qualitative comments identified other areas for improvement. These included increasing the length of the ADC to allow more time for discussion and exercises (n = 8), more guidance around completing Form 4 (n = 7) and more local training venues (n = 2). Some experienced appraisers said they would prefer the option to undertake a more challenging appraisal (n = 5), whilst others wanted a recording of their simulation exercise to take home (n = 3). To respond to this, at later pilots we provided the portfolio to the written exercise prior to the ADC in order to free up more time on the day at later ADCs and ensured that participants were aware of other avenues where they could receive more information about Form 4.

A summary of data collected from the quantitative questions across all pilots is presented in Table 1. Aggregated feedback is reported to provide an indication of overall perceptions of the

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Written (%)</th>
<th>Simulation (%)</th>
<th>PDP (%)</th>
<th>Learning logbook (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Content was relevant to GP appraiser role</td>
<td>97</td>
<td>94</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>Sufficient opportunity to develop skills needed to be an effective GP appraiser</td>
<td>81</td>
<td>80</td>
<td>75</td>
<td>76</td>
</tr>
<tr>
<td>I am confident I will apply any new knowledge/skills gained when I carry out my role as a GP</td>
<td>90</td>
<td>83</td>
<td>78</td>
<td>68</td>
</tr>
<tr>
<td>I enjoyed this exercise</td>
<td>82</td>
<td>83</td>
<td>65</td>
<td>71</td>
</tr>
</tbody>
</table>
ADC. It is worth noting that whilst there were changes made to the process, this was primarily in terms of materials and support for observers and simulators and not directly related to the content of the exercises. Nevertheless, results should be interpreted with this in mind. A series of questions were also asked about administration, training facilities and the facilitator's presentation skills and knowledge, all of which were rated highly.

Additional feedback from participants focused on how the ADC had stimulated learning (n = 14), and the usefulness of introducing the concept of EI (n = 11) and the opportunities for instant, observational feedback (n = 10). Seven appraisers noted that the day was well facilitated and organised, and another seven commented on how helpful the simulation exercise had been. Twelve appraisers also explicitly stated that the ADC should continue into the future. Example comments are presented in Box 2.

Interview feedback, three to five months post ADC

All participants were invited to take part in follow-up semi-structured interviews. Approximately two-thirds agreed, with 13 participating so far. The purpose was to generate feedback once participants had had time to reflect upon the workshops and transfer their skills and learning to the workplace. GPs were asked questions about their overall perceptions of the day, the introduction of EI, transfer of learning back to the workplace and areas for improvements.

All interviewees had favourable perceptions, viewing the ADC as productive, constructive and enjoyable. Echoing previous observations by Boylan and Loughrey, the role of the facilitator in ensuring the success of the project was clearly illustrated and the quality of the day was recognised. Example comments are presented in Box 3.

The ADC exercises were described as ‘challenging’ and ‘valuable’ and a good ‘opportunity for benchmarking’, while the ‘excellent use of feedback’ was described as ‘observational and not judgemental’ and ‘immediate’, serving to boost confidence levels. Participants again highlighted the usefulness of the EI concept, with many saying it was the most helpful aspect of the ADC, providing them with insight about themselves and how they go about their role as an assessor. The personalisation of EI feedback stimulated reflection by providing a comparison between how their behaviour might be perceived by others and the intended impact of their behaviour.

In terms of transfer of learning, all GPs who had delivered appraisals since the ADC gave specific examples of how they had successfully applied part of the ADC to their work as an assessor. This was particularly through their understanding of EI. Those who had yet to carry out an appraisal commented on how they intended to change their behaviour. Examples are presented in Box 4.

During interviews participants were also asked about areas for improvement. Responses included providing support for appraisers to continue development post-ADC, for example through materials for action learning sets or the development of an email discussion forum.

Box 2 Qualitative questionnaire feedback from participants

'I feel that this course has really stimulated me to learn'
'Opportunities for immediate feedback allowed me to reflect whilst the experience was still fresh'
'Doing the simulation sharpens focus and brings training to life'
'The written exercise allowed me to benchmark my responses compared to others'
'Completing the reflective (learning) log after each section is a great innovation'
'I enjoyed emotional intelligence – it has so many practical elements not only in appraisal but for relationships with patients and colleagues'
'I hope this becomes a national requirement'

Box 3 Participant interview feedback – overall perceptions

'A very well facilitated day . . . I feel well supported'
'I thought I was going to be caught out at the DC but it gave me confidence that I can do this well – I’ve changed as an assessor'
'I was amazed at the quality . . . I am a GP trainer and have been to loads of GP trainer days, this is the best training course I’ve ever been on'

Box 4 Participant interviews feedback – transfer of learning

'I have thought about how what I say and do is directly affecting the appraisee'
'I’m now more sensitive at picking up cues from appraisees, and try not to get impatient when they don’t behave in the same way as me'
'I’ve especially become aware of my reactions to a stressful situation . . .'
'I will be challenging but not judgemental, tough but supportive'
Finally, the majority of GPs also commented on how EI can and should be applied to other GP groups such as mentors or trainers as well as trainees early on in their medical education (e.g. 'You can work through EI cues in any consultation ... it's also very useful to apply EI when dealing with complaints both being sensitive to the complainant and the doctor being investigated').

DISCUSSION

Overall, results clearly show that the introduction of GP ADCs has been a useful initiative for supporting appraisers in this setting. Although there are some areas for improvement, the ADC provides appraisers with a positive learning experience and opportunities to develop appraisal skills, and helps to build confidence and a self-belief in their ability to support future appraisees effectively and efficiently. Uniquely, the use of the concept of EI combined with the introduction of DC methods has created an appropriate setting for receiving feedback and reflecting on performance, in a way that many participants reported they do not experience, or cannot access, regularly in the workplace. The provision of opportunities for immediate feedback enhances participants’ levels of self-awareness by allowing them to reflect on observations and then link this back to their EI profiles, with the incidents still fresh in their minds. Early follow-up feedback shows that the ADCs support appraisers to positively influence appraiser's learning and development, with appraisers reporting more confidence in challenging appraisees and greater awareness of their own style and the impact this has on others.

The concept of EI was effective in this setting and was particularly well received. By focusing on interpersonal awareness, it was a useful format for underpinning dialogue for the development of appraisal skills. Moreover, feedback from participants highlighted the relevance and potential benefits of using EI for personal development for a range of GP groups including trainers, mentors and trainees. Whilst we recognise that EI is not a ‘fits all’ solution, and some questions still remain about its theoretical basis, as a concept it does appear to be useful in framing dialogue regarding some personal development activities. There is clear utility in exploring EI further within this context, such as through the design of DCs to explore more generally the use of EI in enhancing medical education teaching.

Participant feedback also suggests that transfer of learning to the workplace could be further enhanced via discussions and group reflection through GP ‘learning sets’ and appraisal meetings. The next steps in addressing this may be to produce additional materials, for example filmed simulated appraisals, for groups to observe and reflect upon together and evaluate their utility.

Limitations and future research directions

A number of frameworks exist to support the evaluation of workplace training. For example, Kirkpatrick21 identifies four levels: (1) participant reactions; (2) participant learning; (3) changes to participant behaviour and (4) workplace results. Evaluation data collected at the ADCs were largely at the reaction level, suggesting that participants perceived the day to be useful and enjoyable. Data also indicated that participants believed the day had stimulated learning and allowed them to develop and increase in confidence in relation to their skills as an appraiser. Furthermore, follow-up interviews supported this with evidence of reflection and examples of how this had or would change their behaviour. However, it is important to note that the results presented here are preliminary findings with self-report data only. Whilst we have evidence of reported intentions to change behaviour, we are not yet in a position to be able to ascertain, using objective measurement, the extent to which the ADC has produced results in terms of how appraisals are conducted. To enable such data to be collected, a more substantial evaluation project following appraisers over a longer time period and including feedback from appraisers is recommended. We aim to continue this research programme and publish fuller evaluation findings in due course.

CONCLUSION

Based on the results of this pilot, the ADC will continue to be offered to GP appraisers within the host deanery and further evaluations will be undertaken. This approach was supported by participants, with some suggesting the ADC should be mandatory and a yearly event. We believe it is also likely that GP appraisers in other regions may benefit from attending similar development processes in the future or, where other appraisal training schemes are already in operation, some aspects of this work could also be incorporated. Finally, whilst the aim of the ADC was to enhance appraisal skills, similar DC methods, combining tools and techniques to increase self-awareness with opportunities for immediate feedback in a facilitated environment, could be valuable for enhancing behavioural competencies and confidence for a range of supervisory and developmental issues.

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Conflicts of interest

None.

References

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Appendix 1

SUMMARY OF APPRAISAL LITERATURE REVIEW

Appraisals have the potential to successfully identify key strengths and weaknesses, serving to boost confidence levels and redirect work efforts to improve performance. Done badly, however, they can anger, confuse and demotivate appraisees, rendering the process useless. Research indicates that it is down to the skills of the appraiser to safeguard against these potential negative consequences and these skills can be learned. The way in which feedback is delivered is critical. Goal setting, during the feedback session, needs to take account of both the predetermined goals for the job role as well as the individual goals of the appraisee to ensure feedback is accurate, relevant and useful to the specific appraisee. Furthermore, goals set should be both specific and challenging and negative feedback should be framed as progress towards a goal rather than failure to achieve it. It is important that feedback is challenging but non-judgemental. This more constructive approach to feedback is vital in ensuring the process does not lower an appraisee’s level of self-efficacy (i.e. their belief in their capacity to do something). Research indicates that appraisees high in self-efficacy are more likely to improve following feedback and engage in greater follow-up development. There are two key ways to avoid lowering an appraisee’s self-efficacy: reassure appraisees if they show signs of anxiety and engage them in a self-reflective process as they respond to feedback.

The appraiser also plays a central role in ensuring commitment to the programme. Trust in both the appraisal process and its outcomes needs to be clearly demonstrated throughout. Several authors including Carr have provided practical guidelines for appraisers.

- be clear and specific;
- emphasise the positive and be constructive;
- comment on behaviour that can be changed (i.e. not personality);
- be careful with advice – help the appraisee to reach a better understanding of any issues that arise and how they can identify actions to address these more effectively.

Furthermore, Umiker provides practical guidelines on specific communication tactics (see Table 2).

**Table 2** Umiker’s appraiser communication tactics

<table>
<thead>
<tr>
<th>Positive communication tactics</th>
<th>Negative communication tactics</th>
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<tbody>
<tr>
<td>Let the appraisee do most of the talking</td>
<td>Interrupt</td>
</tr>
<tr>
<td>Make a special effort to listen</td>
<td>Persuade appraisee to your point of view</td>
</tr>
<tr>
<td>Maintain good eye contact</td>
<td>Deny their feelings (e.g. ‘you shouldn’t feel bad about that’)</td>
</tr>
<tr>
<td>Ask open questions</td>
<td>Joke or make facetious remarks</td>
</tr>
<tr>
<td>Paraphrase to ensure understanding</td>
<td></td>
</tr>
</tbody>
</table>

Appendix 2

SUMMARY OF EMOTIONAL INTELLIGENCE LITERATURE REVIEW

From as early as 1920, psychologists have promoted the existence of multiple intelligences including a distinct intellectual capacity to understand and manage others. Emotional intelligence (EI) stems from these earlier theories, and the term was coined in 1990 by Salovey and Mayer, who described it as:

a form of social intelligence that involves the ability to monitor one’s own and others’ emotions, to discriminate among them and to use this information to guide one’s thinking and actions (p.189).

In 1995 Goleman related EI to a 'set of social competencies' and in 1997 Bar-On defined EI as 'skills that influence one's ability to succeed' (p.14). The same year saw Salovey and Mayer revise their original model, restructuring emotions into four hierarchical branches: (1) perceiving emotions; (2) using emo-
tions to facilitate thought: (3) understanding emotions and (4) managing emotions. Across the range of definitions are elements that remain consistent with the concept of EI.

- EI is built on the basis of self-awareness (or intrapersonal awareness – understanding and managing yourself and your emotions).
- Part of EI is about interpersonal awareness (understanding others) and as such EI is linked to empathy.
- EI can be conceptualised as an ability or personality trait and individuals can therefore differ in their level of EI.

Despite a lack of consensus amongst researchers regarding the exact nature and reliable benefit of EI, a critical review of the psychology and management literature suggests that well-designed and tailored EI interventions can benefit aspects of job performance, with developmental activities aimed at enhancing both confidence and ability in managing emotionally charged situations. As such, the relevance of EI to the medical arena, and more specifically to the role of the doctor, is becoming more widely recognised. Regulatory bodies such as the General Medical Council and the Association of American Medical Colleges are recommending skills and abilities consistent with those associated with EI, for example altruism, empathy, effective communication skills, uncertainty management and teamwork. Likewise, the competency model for selection into GP specialty training includes aspects of EI such as empathy, sensitivity and communication skills as key behaviours. The ability to assess and discriminate among patients’ emotional states and respond appropriately is likely to be critical in maintaining doctor–patient relationships. These skills will also lead to better interactions with colleagues and increasing self-awareness can facilitate improved self-reflection on performance and learning.

In addition, an increased understanding of EI is of interest to those involved in developing others. Understanding how others behave and react to feedback is useful in thinking about how to approach such dialogues, ensuring that the end result is recipients who feel motivated to listen to feedback and change as a result. In this sense it is clear to see why some (e.g. McMullen, 2003) suggest that, in order for students to be trained effectively, medical educators first need to develop their own EI skills, while others recognise the potential benefits of using emotional intelligence in developing both GP trainers and appraisers.

The NHS Medical Leadership Competency Framework also clearly highlights the importance of skills related to the interpersonal elements of EI under its ‘Working with others’ competency, and includes skills related to the intrapersonal elements of EI under its ‘Personal qualities’ competency with components related to ‘self-awareness’ and ‘self-management’. This framework emphasises the importance of EI-type skills throughout the career cycle of a doctor, from undergraduate to post-specialist certification.

Appendix 3

EXAMPLE APPRAISAL BEHAVIOURAL COMPETENCY DOMAIN WITH POSITIVE AND NEGATIVE INDICATORS

<table>
<thead>
<tr>
<th>Positive Indicators</th>
<th>Negative Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manages emotions, remaining calm and in control</td>
<td>Struggles to regulate own behaviour, and becomes irascible, agitated or stressed</td>
</tr>
<tr>
<td>Recognises own emotions and their impact on judgement and behaviour</td>
<td>Rarely focuses on own emotions and is unaware of the impact they have on self and others</td>
</tr>
<tr>
<td>Critically evaluates own performance and is prepared to change behaviour</td>
<td>Struggles to identify ways to improve own performance</td>
</tr>
<tr>
<td>Actively seeks and listens to feedback</td>
<td>Avoids or ignores feedback</td>
</tr>
<tr>
<td>Asks for help when necessary</td>
<td>Tries unsuccessfully to deal with situations alone</td>
</tr>
<tr>
<td>Is prepared to consider changing behaviour or trying new approaches</td>
<td>Rigid in approach, lacks willingness to change behaviour</td>
</tr>
<tr>
<td>Recognises the importance of continual development of skills</td>
<td>Sees development as a low priority</td>
</tr>
<tr>
<td>Approaches difficult situations positively and as an opportunity to learn</td>
<td>Treats issues as problems rather than challenges</td>
</tr>
</tbody>
</table>