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Relational Intelligence: A Framework to Enhance Interprofessional Collaborative Care

Elizabeth Ekole
Walden University

Walden University

College of Health Sciences

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Elizabeth Ekole

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Review Committee
Dr. Lawrence Fulton, Committee Chairperson, Health Services Faculty
Dr. Susan Nyanzi, Committee Member, Health Services Faculty
Dr. Suzanne Richins, University Reviewer, Health Services Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
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Abstract

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PharmD, Ohio Northern University, 2006

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Health Services

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Abstract

Many studies have reported that the training for practitioners does not stimulate reflexes that contribute to the tenets of teamwork and collaboration. No studies were found to investigate relational intelligence (RQ) in pharmacist-physician relationships as a catalyst for collaborative and hence cost effective quality care. This study addressed the role and potential opportunity to promote RQ as a critical leadership skill in the collaboration between pharmacists and physicians. Using RQ as the conceptual framework, this phenomenological study explored how pharmacists and physicians in a hospital setting perceive RQ as a leadership skill when working collaboratively. A total of 10 participants (5 pharmacists and 5 physicians) from a 443-bed comprehensive hospital in Michigan were selected using purposive sampling. Pharmacists and physicians included had at least 4 years of hospital experience. Data were collected through semistructured in-depth interviews and analyzed using the hierarchical approach. Results indicated interest among both pharmacists and physicians to use RQ as a leadership skill to work collaboratively. Further findings highlighted the need for face-to-face communication between pharmacists and physicians, better collaboration, accountability, feedback, focus and alignment, promotion of positive relationships, and a leadership position directed by a PhD-prepared practitioner with expertise in RQ. These findings bring awareness to both pharmacists and physicians of barriers to collaboration; these findings also suggest the need for multidisciplinary training that incorporates RQ theory as a foundation for both pharmacists and physicians, which may decrease health care costs while improving communication, trust, mutual understanding, collaboration, and quality care.

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Dedication

To my wonderful husband who always has unlimited zeal and pride for my academic progress. When I was contemplating doctoral education, he encouraged me by saying, “You are a PhD chick.” That was enough to get me started.

To my smart and handsome son, Ndialle, and my beautiful and sweet girls, Hanna and Abigail Ekole, who now know what it takes to have a PhD. Hopefully, they will follow my footsteps of reaching the pinnacle of their careers.

To all those whose citizenship is in heaven, God will meet all your needs according to his glorious riches in Christ Jesus. To our God and Father be glory for ever and ever. Amen. (Phil 4:19-20 New International Version).

In Memory

This dissertation is dedicated to the memory of my dad whose life on earth was 56 years short but left indelible footprints on my path through life. He believed in me at a very young age, and taught me that nothing builds self-esteem and confidence more than accomplishments. He rejected mediocrity of any kind but rewarded hard work in school, discipline, obedience, and excellence. He never missed an opportunity to speak words of blessings into my future.

Dad wanted me to become a doctor. This PhD is my second doctoral degree after my Doctor of Pharmacy (PharmD) degree. He was a very proud man, and I know unequivocally that he would have flashed his most winning smile at my graduation, if he was not called to be with the Lord 21 years ago.

Acknowledgments

Though the following dissertation is an individual work, I could not have explored the depths or reached the heights of my research without the guidance and support of a lot of people.

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I would like to thank my handsome, loving, and caring husband, the best husband any woman can ever ask God for, for always going above and beyond in supporting me to pursue my dreams. Thanks even more for the mental, spiritual, financial, and emotional support whenever I needed reclusion. Honey, words cannot describe how thankful I am to God for you and for our very understanding kids—Ndialle, Hanna, and Abigail—for putting up with my constant excuses of "homework."

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Thanks to my uncles Dr. Fonjweng Godlove and the late Dr. Zacheriah Fomum who set the examples by reaching the pinnacle of their careers in the family by graduating with a PhD. Special thanks to all my siblings, especially big sister Coster Fombe, for her unique and indispensable expression of love and kindness to me in many ways during my dissertation journey. Thanks to my sister Victorine Fomum and my brother Solomon Fomum who always answered "yes" lovingly every time I called with errands to do in Cameroon. To Laurent Bingwe, a family member whose selflessness, loyalty, and support at home enabled me to have the right mental focus.

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To all my dear friends who encouraged and prayed for me, I say thank you.

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Chapter 1: Introduction to the Study

Background

Practitioner-based leadership education is a problem in the U.S. health care climate. According to Health Affairs (2012), a lack of health care coordination in the United States is influenced by fragmented care from a lack of interdisciplinary collaboration. According to Healthcare Policy (as cited in Reinhardt, 2013), 31% of total health care spending (amounting to $2.5 trillion dollars) was due to excessive costs of unnecessary services, missed prevention opportunities, and inefficiently delivered care. The Intercontinental Marketing Services (IMS) Institute for Healthcare Informatics (as cited in Manning, 2014) estimated that $200 billion went to wasteful spending in 2012 due to excessive health care expenditure on medication errors, misuse of antibiotics, mismanaged polypharmacy, delayed evidence-based practices, suboptimal use of generics and nonadherence to medications.

The concept of relational intelligence (RQ) in health care is new with few studies conducted in this area. According to Huseman (2012), scholars have written extensively about emotional intelligence (EQ) but not about RQ, creating a gap in the literature on RQ as a leadership skill in interprofessional collaborative care between pharmacists and physicians. Kutz (2012) found that leadership promotes the survival, longevity, and quality of care in U.S. health care. Hojat et al. (2012) concluded that teamwork and interdisciplinary interprofessional collaboration can lead to clinical outcomes that are optimal. The Institute of Medicine (as cited in Manning, 2014) also claimed that a lack of collaboration among health care professionals leads to errors, with 44,000-98,000 people dying annually from hospital medical errors. McCleskey (2014) suggested that it is

imperative for leadership scholars to continue to engage in research to challenge the tenents of modern leadership. Bottomley, Burgess, and Fox (2014) provided a framework of behaviors needed for effective leadership, including a knowledge-based and a command-and-control approach. According to Huseman (2012), more is expected from health care leaders with decreased budgets; RQ may provide the foundation for effective leadership in health care organizations.

Huseman (2012) attributed career successes to RQ, emphasizing that the concept of RQ was an evolution of EQ in the areas of empathy and social skills. Intelligence quotient (IQ) may also play a role when determining the right fit for a specific career; otherwise, IQ accounts for only 4-10% of career successes (Huseman, 2012). Huseman (2012) used RQ theory as a foundation for one-to-one coaching and to enhance the relationship skills of leaders in the health care industry. The coaching provided by Huseman (2012) and his team resulted in increased in-patient satisfaction, employee retention, and performance in more than a dozen health care systems across the United States. RQ at the micro and macro level can be a catalyst for promoting relationships within health care organizations. This RQ perspective was used in a qualitative study to examine collaborative care between pharmacists and physicians.

Huseman (2012) described how society has moved from the hunting/gathering age, an economy based on self-subsistence, to the agricultural age, an economy based on agriculture, to the industrial and informative ages, an economy focused on knowledge, and is currently transitioning to the relational age. According to Anderson and Ackerman (2011), the command-and-control and tyrannical leadership style was considered antiquated some 50 years ago. Huseman (2012) added that how leaders relate to followers

during each interaction can be translated into productivity. Huseman (2012) suggested that RQ is the new competitive edge in the health care market and added that the U.S. competitive health care market can only achieve positive outcomes in this relational age when professionals are inspired, motivated, and held accountable. Many researchers have acknowledged that effective collaborative care can produce successful outcomes. Kutz (2012) found that leadership promotes the survival, longevity, and quality of U.S. health care. Hojat et al. (2012) concluded that teamwork and interdisciplinary interprofessional collaboration can lead to clinical outcomes that are optimal. Zwarenstein, Goldman, and Reeves (2009) suggested that collaboration, as an aspect of leadership among health care professionals, will help decrease health care costs and improve the quality of care. Zwarenstein et al. (2009) emphasized that interdisciplinary collaboration leads to improved health care outcomes.

Despite all the positive outcomes reported, scholars have not explored the different leadership skills that can influence collaboration among health care professionals (Dine, Kahn, Abella, Asch, & Shea, 2011). Dine et al. (2011) claimed that researchers have focused on leadership skills in the management sciences; however, scholars have not examined leadership in the medical settings. Zhou, Zhang, and Xie (2014) explored the role of negotiation in collaboration and acknowledged that collaboration was important, even in health management. Laubscher, Evans, Blackburn, Taylor, and McKay (2009) ascertained how collaboration between family physicians and pharmacists promotes adherence to medications and concluded that the role of community pharmacists in medication adherence is pivotal, but that physicians rarely interact with community pharmacists.

Problem Statement

According to the American Society of Health-System Pharmacists or ASHP (ASHP Foundation, 2009), practitioners, especially pharmacists and physicians, are tasked with running departments, teams, and directorates without proper leadership training. These practitioner graduates are not taught how to confidently and comfortably lead in decision-making processes or how to work collaboratively with other health care professionals. Stoller (2009) added that the training for these practitioners does not stimulate reflexes that contribute to the tenet of teamwork and collaboration. Effective leadership is a catalyst for a successful organization; however, the health care system is faced with many challenges because it is a complex organization composed of different types of professionals. Health care leaders must demonstrate effective leadership within the organization to address challenges such as access, affordability, cost, and quality. Makowsky et al. (2009) emphasized that physicians and pharmacists are regarded as key players in providing successful collaborative, interprofessional care to reduce errors, improve compliance, and decrease adverse drug events.

There are many health care costs that could be reduced with the enforcement of effective collaboration of care. In addition to the monetary waste occurring through a lack of care coordination, the United States spent $650 billion in health care compared to other developed countries in 2012, adding that health care waste, through lack of care coordination, is reported to be among the top five most costly forms of waste in the United States annually (Berwick & Hackbarth, 2012). IMS Institute for Healthcare Informatics (as cited in Manning, 2014) estimated that about $200 billion was lost in 2012 due to excessive health care expenditures such as medication errors, medication

misuse, mismanaged polypharmacy, nonadherence, and delayed evidence-based practice. The Institute of Medicine (as cited in Manning, 2014) also claimed that a lack of collaboration among health care professionals leads to errors, with 44,000-98,000 people dying annually from hospital medical errors.

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Purpose of the Study

The purpose of this qualitative study was to explore how pharmacists and physicians in the hospital perceive RQ as a leadership skill in working collaboratively with each other. In examining the factors that can influence effective leadership of pharmacists in the health care system, fostering collaboration may lead to a better understanding of what skills can be included in formal trainings of leadership education for pharmacists and physicians. RQ is considered the ability to perceive cause and effect in ways that enable people to gain insights in dealing with relationships at an individual or group level. RQ also includes the ability to assess risk, perceive information, and

mentally process that information. Huseman (2012) attributed career successes to RQ, emphasizing that the concept of RQ is an offspring of EQ in the areas of empathy and social skills. IQ is also important when determining the right fit for a specific career; otherwise, IQ only accounts for about 4-10% of career successes (Huseman, 2012).

Huseman (2012) used RQ theory as a foundation for coaching and assisting leaders who were relationally aware. Huseman's (2012) coaching resulted in increased in-patient satisfaction, employee retention, and performance in different hospitals. RQ at the micro and macro level is a catalyst for promoting relationships within health care organizations. This RQ perspective was used in a qualitative approach to examine collaborative care between pharmacists and physicians.

Nature of the Study

In this qualitative phenomenological study, five pharmacists and five physicians (total of 10 participants) from a 443-bed comprehensive hospital in Michigan were interviewed to determine their experience in collaborating with each other. The primary tool for analyzing the data was inductive using the guiding principles of Moustakas (1994). Common phrases and statements directly related to the phenomenon were identified and treated with equal weight through a process called horizontalization. Emerging themes were categorized and identified. I focused on how these pharmacists make sense of their collaborative relationship based on the findings from the interviews. During the interviews, participants described their opinions based on their lived experiences. RQ was used as the leadership skill phenomenon in building the guiding questions for the interviews. A hermeneutical phenomenology was used to describe the lived experience of the participants and to interpret the meaning behind these lived

experiences. According to Nieswiadomy (1993), the researcher sets aside his or her own experience of that phenomenon to understand the lived experience of the participants.

Research Question

What is the role and potential opportunity to promote RQ as a critical leadership skill in the collaboration of pharmacists with physicians at the hospital?

Conceptual Framework of the Study

Pless and Maak (2005) noted that for leaders to have RQ, they have to possess EQ first. Huseman (2012) stated that the concept of RQ is an evolution of EQ in the areas of empathy and social skills. RQ is a new concept in leadership studies. RQ includes previous interactions, the current relational interaction, and the impact of the current interaction as well as all previous interactions on future interactions at the individual and group levels. As relationships develop over time, interactions or exchanges are based on equity. Equity is the notion that people give to receive. The level of intelligence applied to these different levels becomes a measure of how successful a person is when interacting with others. According to Pless and Maak (2005), in order for leaders to connect and interact with different people and stakeholders, they must be ethically and interpersonally competent. Leaders, therefore, need to have RQ.

Definitions

Relational Intelligence (RQ)

The term *RQ* can have different meanings. However, RQ in health care specifically can be defined as the propensity to use day-to-day dynamics within the context of collaboration to bring about an impact in cost-effective health care. In addition, RQ can be categorized into different levels: prologue, current relational

interaction, and epilogue. In health care, the central basis of an organization is interpersonal working relationships, which can be assessed through employee engagement and/or collaboration. Maccoby (2003) emphasized that intelligence is divided into system thinking, foresightedness, motivation, visionary, and partnering. All of these areas of RQ constitute visionary thinking, which is considered the highest level of thinking (Huseman, 2012).

Empathy

Empathy is defined as the awareness of the feelings, concerns, and needs of others. Empathy includes service orientation, political awareness, and developing/leveraging/understanding others (Goleman, 1995).

Social Skill

Social skill is the ability to induce desirable responses in others, focusing on communication, influence, conflict management, leadership, catalyzing change, building bonds, collaboration, and team capabilities (Goleman, 1995).

Emotional Intelligence (EQ)

EQ refers to the capacity of recognizing one's feelings and its effects on others, regulating one's emotions, internally motivating oneself, and managing relationships with others (Goleman, 1995).

Collaborative Care

Collaborative care is a joint decision-making process based on communication. Providing satisfying quality care to the patient while respecting the unique abilities of each professional is the goal of collaborative care (Oandasan et al., 2006).

Assumptions

I assumed participants were not biased. I also assumed pharmacists who collaborated with physicians would not refrain from participating. I assumed participants would answer the questions during the interview process truthfully and accurately. In addition, I assumed pharmacists would have had some type of collaborative experience with physicians. I assumed that although I am a pharmacist, my interview questions and documentation would not be biased. Finally, I assumed that in exploring the lived experiences of pharmacists and physicians by using phenomenology, I would develop a theory that would serve as a framework to assess RQ.

Scope and Delimitations

The purpose of this qualitative research was to explore the lived experiences of pharmacists and physicians in regards to RQ as a leadership skill in working collaboratively in hospitals. I did not focus on the interaction of pharmacists and physicians in the outpatient setting. Also, my study included pharmacists regardless of whether they were PharmDs or registered pharmacists. I also included physicians regardless of their specialty. Medical and pharmacy residents were not included in the study because they were still in training.

Physicians and pharmacists were selected through purposive sampling from a 443 bed comprehensive teaching hospital which is part of a health system in Michigan.

Limitations

The qualitative design was a limitation to the study because it did not allow for results to be generalized to the general public. The second limitation was the fact that I

interviewed pharmacists and physicians from the same state, and these results may not apply to other settings. Participants who agreed to be interviewed might have been more open to collaboration; as such, though the study may shed light on the assumptions made by these practitioners, it may not be appropriate to generalize the findings to all physicians and pharmacists. Because I am a pharmacist, pharmacists in the study built rapport with me faster than physicians in the study. Also, I was slightly more comfortable than participants during interviews.

Significance

This study may lead to positive social change in many ways. Kelley (2009) reported that the U.S. health care system lacks coordination of care, resulting in $25-50 billion in annual waste. This study may provide pharmacy practitioners with a better understanding of the barriers involved in interprofessional collaboration between physicians and pharmacists, which may lead to decreased waste in health care costs. Awareness of these barriers can lead to multidisciplinary training of pharmacists and physicians, the implementation of coaching programs in the hospital, and leadership courses at the undergraduate level that will help improve trust, mutual understanding, communication, and collaboration.

The coaching provided by Huseman (2012) and his team resulted in increased in-patient satisfaction, employee retention, and performance in more than a dozen health care systems across the United States. RQ at the micro and macro level can be a catalyst for promoting relationships within health care organizations. This RQ perspective was used in a qualitative approach to examine collaborative care between pharmacists and physicians. This study may also provide a foundation for the development of other

studies to determine whether RQ can be used to address the leadership crisis between pharmacists and physicians and whether it has any influence on rising health care waste.

Summary

Several researchers have affirmed that practitioner-based leadership is a problem in the current U.S. health care climate. According to Huseman (2012), more is expected from health care leaders but with less funding being provided to them; as a result, health care organizations struggle with an overload of initiatives and accountability toward employees. There are no studies that specifically investigate the application of RQ in pharmacist-physician collaborative care as a catalyst for cost-effective care. Hospitals always face the dilemma of clinical care, but this could be resolved by advocating interprofessional relationships, which could increase patient satisfaction and cost-effective care.

Chapter 2 includes an in-depth review of existing literature and how researchers are suggesting the importance of interprofessional relationships especially in health care in the relational age. I examine aspects related to collaboration in practitioner-based leadership and focus on leadership skills between physicians and pharmacists with an emphasis on RQ as a leadership skill in health care. Finally, I present ideas related to interprofessional collaboration and how it is related to global cost-effective care.

Chapter 2: Literature Review

Kutz (2012) found that leadership promotes the survival, longevity, and quality of U.S. health care. Hojat et al. (2012) concluded that teamwork and interdisciplinary interprofessional collaboration can lead to clinical outcomes that are optimal. The Institute of Medicine (as cited in Manning, 2014) claimed that a lack of collaboration among health care professionals leads to errors with 44,000-98,000 people dying yearly from hospital medical errors. McCleskey (2014) suggested that it is imperative for leadership scholars to continue to engage in research to challenge the tenants of modern leadership.

The concept of RQ in health care is new, and few studies have been conducted in this area. According to Huseman (2012), scholars have written extensively about EQ, but have not published work about RQ. There is a gap in literature on RQ as a leadership skill in interprofessional collaborative care between pharmacists and physicians. In this literature review, I examine aspects related to practitioner-based leadership, leadership skills between physicians and pharmacists with an emphasis on RQ as a leadership skill in health care, and ideas related to interprofessional collaboration and how it is related to cost-effective care globally. Because the concept of leadership between pharmacists and physicians is new, there were not many articles on this topic. Reviews are broken down into the topics of leadership, collaboration, and health care waste. This study provides a foundation for researchers to conduct further studies based on identified gaps in the literature regarding RQ as a leadership skill in the collaboration of care among professionals. Also, this study provides insight on other studies regarding the impact of the lack of collaboration between pharmacists and physicians on cost-effective care.

Literature Search Strategy

A literature review was conducted digitally through Internet databases and books with an emphasis on sources published within the previous 5 years. Because RQ is a new concept in leadership, there were few search results. Research was conducted on topics in areas related to leadership, leadership training in practitioner-based education, leadership research among practitioners, collaboration in other disciplines, collaboration between pharmacists and physicians, and collaboration as a leadership skill in a medical setting. Research was also done on the impact of a lack of collaboration on the U.S. economy. The databases that I used included MEDLINE with Full Text, CINAHL Plus with Full Text, PubMed, Science Direct, and ProQuest. I also used Google Scholar to locate scholarly articles. The following keywords were used: *relational intelligence, leadership in health care, emotional intelligence, pharmacy leadership, physician leadership, health care collaboration, health care waste, physician and pharmacist collaboration,* and *intelligence quotient in health care.* Literature was also retrieved from Huseman's (2012) book on RQ.

Conceptual Framework

The framework of this research is RQ, which is a new concept in leadership studies. Huseman (2012) stated that RQ includes previous interactions, the current relational interaction, and the impact of the current interaction as well as all previous interactions on future interactions at the individual and group levels. As relationships develop over time, interactions and exchanges are based on equity. Equity is the notion that people give to receive. The intelligence applied in these different levels becomes a measure of how successful a person is when interacting with others. According to Pless

and Maak (2005), leaders must be ethically and interpersonally competent to connect and interact with different people and stakeholders. Leaders, therefore, need to have RQ.

Goleman (2006) postulated that IQ is relevant in relating to life circumstances as a whole. Goleman noted that IQ, which is a measure of academic intelligence and was used in the past as a measure of success, has little to do with emotional life. The theory of EQ was formulated by Salovey and Mayer (1990). The emergence of the EQ concept challenged the idea that IQ was the standard of excellence in life. Gardner (1993), in the multiple intelligence theory, defined interpersonal intelligence as the ability to relate with others and to motivate them. Gardner characterized interpersonal intelligence as the key to career successes and defined intrapersonal intelligence as the ability to know oneself in order to work effectively in life. Salovey and Mayer (1993) used Gardner's multiple intelligence theory to develop the following characteristics to describe EQ: self-awareness, which is the cornerstone of EQ as the recognition of feelings as they happen; self-assurance, which is the ability to handle feelings appropriately; self-motivation, which refers to having emotional self-control; empathy, which is the ability to recognize emotions in others; and social skills, which is the ability to manage relationships. Goleman (2006) concluded that people with high EQ are cheerful, socially poised, and sympathetic in their relationships while people with a high IQ are not prone to be sympathetic or feel guilty or anxious.

Huseman (2012) emphasized that IQ is a threshold competency test, which is important to conduct when trying to find the right fit for a specific career. Huseman also acknowledged that only about 4-10% of career successes are attributed to high IQs. Huseman attributed more career successes to RQ, emphasizing that the concept of RQ is

an offspring of EQ in the areas of empathy and social skills. In a review of the evidence of EQ in medical students, Arora et al. (2010) concluded that EQ was directly related to the competencies delivered by medical curricula in the areas of EQ and doctor-patient relationship; EQ and empathy; the role of EQ in teamwork, communication, and interpersonal skills; and the role of EQ in workplace stress, leadership, and organizational commitment. The doctor-patient relationship has played a role in patient satisfaction—high EQ doctors have been correlated with patient trust, which has then been correlated with patient follow-up and ultimately patient satisfaction (Huseman, 2012).

The Advent of the Relational Age

Human socioeconomic development can be divided into five ages: hunting and gathering, agricultural, industrial, information and technology, and relational. In the relational age, the economy is based on RQ. The relational age goes beyond interpersonal relationships to include ideas, concepts, and repercussions. IQ and technology, which are functions of the left brain, are no longer the exclusive competitive advantage in the relational age; instead, the ability to sustain relationships through collaboration, which is the function of the right brain, is the new competitive advantage (Huseman, 2012).

Gazzaniga (1998) examined how the brain influences intelligence by studying brain lateralization. Gazzaniga found that the left and right brain perform different functions. People tend to use one more than the other in processing information. Left-brain dominant people are more transactional in their interactions and focus more on logical thinking and analysis (Gazzaniga, 1998). On the other hand, right-brain dominant individuals are more relational in their interactions and focus on intuition, creativity, feelings, and holistic thinking (Gazzaniga, 1998). The IQ, which is used to measure the

ability to process and evaluate information, is considered the "old smart" and RQ the "new smart" in this relational age.

Kahheman and Tversky (1979) used prospect theory to analyze how decisions are made under risk to determine whether the brain was composed of two systems of thinking. Kahheman and Tversky found that System 1 was intuitive and characterized as being effortless, fast, difficult to explain, and emotional; System 2 included reason and was characterized as being deliberate, effortful, controlled, and emotionally neutral. Intuitive thinking takes longer to form yet is accurate; however, when an error occurs, it is hard to correct. Huseman (2012) reiterated the importance of being aware of how the conscious and subconscious thought processes affect how people interact with each other. Paying attention to how a person's emotional and mental processes affect how a person relates to concepts, individuals, and groups is the nucleus of RQ.

Pless and Maak (2005) described EQ and the ethical intelligence components of RQ. EQ helps leaders to interact with empathy, and ethical intelligence leads to orientation and reflection (Pless & Maak, 2005). Therefore, EQ and ethical intelligence compliment RQ. However, Huseman (2012) postulated that empathy and social skills, instead of ethical intelligence, are complimentary to RQ. Huseman (2012) and Pless and Maak (2005) both emphasized that RQ will help leaders build lasting, trusting relationships.

According to Huseman (2012), the health care industry predominantly includes professionals with high IQs but comparatively low RQs. A lack of RQ in health care can be problematic in patient satisfaction, patient safety, employee performance, and collaboration. Practitioner-based leadership education does not exist in some U.S. health

care climates. According to Health Affairs (2012), a lack of health care coordination in the United States is influenced by fragmented care from a lack of interdisciplinary collaboration, which is a leadership skill. Using an evidence-based RQ approach, Huseman (2012) developed coaching for leaders, including ones in the health care industry. Huseman used RQ theory as a foundation for one-to-one coaching to enhance the relationship skills of leaders in the health care industry. The coaching provided by Huseman and his team resulted in increased in-patient satisfaction, employee retention, and increased performance in more than a dozen health care systems across the United States. RQ at the micro and macro level can be a catalyst for promoting relationships within health care organizations.

Relational Intelligence from a Leadership Perspective

There are many theories in leadership, and the adaptation of new management approaches has become imperative for leaders to meet the demands of their employees and customers. Leadership styles, along with a dynamic work environment, play a role in the success of an organization, which enables an organization to consistently develop, improve, and adapt to changes to gain and maintain a competitive edge (Irshad & Hashmi, 2014). Huseman (2012) emphasized that individuals with RQ possess a competitive advantage in health care, yet few studies have been conducted on leadership in the medical setting. In this section of the literature review, I examine the different areas of leadership associated with practitioner-based education, especially involving pharmacists and physicians. I also address the connection between EQ, RQ, and leadership in different countries and disciplines.

Alberto (2014) explored the differences in the various aspects of leadership to improve the understanding of the subject. Alberto reported that different perspectives of leadership include the following: leadership skills can be partially born and made, some leaders may be virtuous, some leaders can adjust their style to situations, and leadership does matter in some organizations. Hackman and Johnson (2009) emphasized that leadership is connected to what it means to be human. Human communication helps to mold the behaviors and attitudes of others to meet the common goal of the group. Johnson (2009) defined leadership as a trait that predisposes individuals in key roles to do what they can do and how they can do it in order to achieve outcomes that are socially useful. Johnson supported the need for RQ as a leadership skill to be examined among pharmacists and physicians in hospitals. Dine et al. (2011) asserted that health care is advanced by good leadership.

Shin, Heath, and Lee (2011) explored different leadership styles of public practitioners in cultures that practice individualism and collectivism, such as the United States and South Korea. Shin et al. (2011) concluded that all identified leadership characteristics and functions were perceived to be strategically useful in routine and nonroutine situations in the United States and South Korea. Skills such as strategic thinking, skillful communication, problem recognition, and problem solving were considered pivotal in leadership roles in both countries. Certain aspects of leadership may be cross-cultural.Shin et al. (2011) were able to account for the functional differences between the two countries. Strategic competency was related to aspects of leadership such as coordinated communication, collaboration, advocacy, negotiation, strategic thinking, proactive responding, and success measures. Shin et al. (2011) concluded that

U.S. public practitioners were aligned with the U.S. culture of low power distance, high individualism, high assertiveness, and high performance. U.S. leadership characteristics included strategic thinking, collaboration, advocacy for origination, skillful negotiation, and problem recognition. Shin et al. (2011) found that the South Korean counterparts held collectivistic values with an emphasis on harmonious relationships.

According to ASHP (ASHP Foundation, 2009), there is a leadership gap in doctoral pharmacy education, which is a practitioner-based degree. The curriculum is inadequate in preparing students to confidently and comfortably lead in decision-making processes or work collaboratively with other health care professionals. Dine et al. (2011) investigated elements associated with effective physician leadership at an academic center. Dine et al. concluded that the leading physician must be able to adapt to the changing team dynamics in a hospital. Also, Dine et al. recommended formal leadership training for all physicians based on vision, team, communication, and personal attributes. There is a need for leadership training for practitioners in a medical setting, and scholars have identified RQ as an essential aspect of leadership training among practitioners (Huseman, 2012).

Bickel et al. (2014) examined efforts to advance the pharmacy practice model initiative (PPMI) put forth by the Michigan Society of Health-System Pharmacists. The goal was to examine recommendations made during the 2010 PPMI summit. The recommendations included acute care, training, education, pharmacy leadership, pharmacy technicians, and information systems. Bickel et al. concluded that while a process was created to handle recommendations, most of the recommendations would take years to implement. However, when implemented, they would help pharmacists in

Michigan to provide effective, efficient, accountable, consistent, and evidence-based care for all patients in the health care system. Bickel et al. did not address how these pharmacy leadership skills would be developed, and how different leadership skills would help pharmacists define their role and be able to work collaboratively with other health care professionals. Because cost effective care was not identified as a part of the model in the practice of pharmacy, it is important to analyze whether RQ as a leadership skill is linked to health care cost.

Fuller (2012) addressed the gap in leadership training and education for students and practitioners. Fuller described different efforts developed to address leadership among pharmacy residents and emphasized the need for leadership education to become an integral part of practitioner-based education. The Nebraska Medical Center launched a systematic leadership training for pharmacy residents in 2007. The leadership program focused on trust-building exercises, physical challenges, discussions on different leadership concepts, self-assessment to help build personal strengths training on the application of different communication skills, conflict resolution, and the history of the evolution of health-system pharmacy. Fuller (2012) reported that residents in the leadership development program were exposed to different leadership principles and philosophies. After the training, the residents were assessed using a StrengthsFinder assessment and a Communication and Conflict-Mode assessment. Residents were found to have increased self-awareness. This leadership training program is similar to the training program reported by Kitzmiller, Phelps, Neideckerand, and Apseloff (2014), which offers a 2 year training fellowship program for physicians, pharmacologists, and pharmacists at Ohio State University. The purpose of the program is to provide leaders

with skills that can be used in academia, pharmaceutical industries, and in accreditation agencies. This recently accredited program is an example of an interdisciplinary fellowship that can help practitioners develop collaborative skills by training together.

Leadership training programs are important for practitioners. Fuller (2012) concluded that self-awareness was improved in all participants. Self-awareness is an important aspect of leadership as it is the cornerstone to EQ, according to Huseman (2012). Self-motivation, social skills, empathy, and self-assurance are also some of the basic competencies of EQ. EQ was described by Priya and Panchanatham (2014) as the ability for individuals to understand their emotions and that of others. Huseman (2012) considered empathy and social skills as forerunners of RQ. Scholars have used the individual concept of RQ or other leadership concepts to assess outcomes among practitioners, but RQ or its components were not used to explore RQ in collaborative care between pharmacists and physicians in a hospital setting in the United States. Priya and Panchannatham (2014) asserted that intelligence and emotions are closely related. Individuals who have balanced EQ and IQ are more likely to be successful life.

Bottomley et al. (2014) provided a framework of behaviors needed to be an effective leader, concluding that, in the past, leaders led using a knowledge-based or command-and-control approach. According to Huseman (2012), more is expected from health care leaders with less of a budget being provided to them; as such, RQ in collaborative care may provide the insight to effective leadership in health care organizations

Relational Intelligence as a Model for Collaboration

Many researchers who examined collaboration in different aspects of social sciences and in leadership have documented conclusions, regardless of the geographical location. Because little research has been done on the collaboration between pharmacists and physicians at the hospital, this section of the review will include studies on collaboration from different health care settings and in different geographically regions to shed more light on the concept of collaboration.

Makowski et al. (2009) defined collaborative care as joint communication and decision-making done with the goal to provide quality care to the patient and, at the same time, respecting the abilities each professional brings into the team. Pharmacist and physician collaboration is an aggregation of drug therapy of patients, self-care skills, drug interaction review, compliance, decreased medication errors, and the cost-effective use of medications. Hojat et al. (2012) asserted that the pharmacist-physician collaboration is a new concept. The rapid growth in pharmaceutical sciences, cost of morbidity related to drugs, complex drug interactions, and the cost of health care calls for a pharmacist-physician collaborative relationship. Mehta, Snyder, and Nikitas (2011) reviewed the guiding principles for a patient centered medical home and concluded that pharmacists can play a pivotal role in team-based integrated care with a focus on safety, quality, coordination, and access. Mehta et al. (2011) emphasized that pharmacists have an evidence-based track record in demonstrating successful outcomes when managing chronic conditions in patients. A successful initiation of team-based practice, with a collaborative relationship between pharmacists and physicians, must be developed. Zwarenstein et al. (2009) asserted that poor collaboration will cause the health care

system and patient care to plummet, and if issues affecting interprofessional collaboration are addressed, there will be an improvement in the outcomes of health care. Finally, Huseman (2012) asserted that RQ helps leaders to think and work with others better.

In a qualitative investigation of working relationships in an in-patient setting between pharmacists, physicians, and nurse practitioners, Makowski et al. (2009) defined collaborative care as joint communication and decision-making used to provide quality care to the patient. Makowski et al. applied reflective journaling by participants in addition to informant interviews. Interview questions were developed based on pivotal areas identified through the reflective journaling template. These focus areas included innovations, practice environment, challenges, and relationships/interactions. Makowski et al. concluded that the integration of pharmacists in the health care team improved patient safety and helped increase the awareness of the roles that pharmacists, physicians, and nurse practitioners played in a team. Makowski et al. provided an argument for the importance of a collaborative relationship between physicians and nurse practitioners.

Zwarenstein et al. (2009) assessed the impact of an intervention designed to improve nurse-doctor collaboration. The trial was randomized, controlled before and after, in order to improve collaboration between nursing and other health care professionals. A review of three trials included 1,945 people, 1,102 daily admissions, and a 3-month trial, which involved 843 admissions. Doctors and other health care professionals made decisions together. All admissions involved team rounds by a health care professional in order for collaborative decisions to be made. Length of stay for patients in the hospital, excluding those who died, was evaluated between the intervention groups, and the results across all three trials showed a decreased length of

stay in the hospital and decreased hospital costs. Zwarenstein et al. concluded that collaboration among health care professionals, especially nurses, will decrease costs and improve staff satisfaction. Even though this study depicted the importance of collaboration with other health care team members, it did not explore whether a skill such as RQ enhanced this collaborative care. Huseman (2012) emphasized that trust is an important aspect of RQ, with trust built on competence, affection, and dependability. In order to collaborate with others, leaders must be able to build trusting relationships with employees and other team members.

Hojat et al. (2012) examined the attitudes of pharmacists and physicians towards collaborative relationships. Collaboration between pharmacists and physicians is a new concept, and the attitudes of these professionals needed to be measured reliably and validly. A total of 210 students from one college completed the Scale of Attitudes towards Physician-Pharmacists Collaboration survey. The psychometrics of the instrument were measured using factor analysis. Correlational methods were used. Hojat et al reported the emergence of three constructs: responsibly and accountability, interdisciplinary education, and shared authority. The reliability coefficient alpha was 0.90, and the validity coefficient was 0.70. The validity was supported by the positive relationship to the scores of the entire scale. Also, reliability was supported by internal consistency and other extracted factors from the scale. This scale can be useful in examining clinical outcomes in teamwork and cross-cultural research on physician-pharmacist collaboration.

Interprofessional collaboration has been researched in other areas of international health care. Mitchell et al. (2012) examined the factors used to explore effective

interprofessional collaboration in rural Australia. Mitchell et al. focused the research in a rural area because there were limited interprofessional initiatives in rural areas. Factors that affected effective collaborative practices were generated through interviews, document analysis, and focus groups. Participants included lead clinicians, clinician managers, and policy makers. The social processes important to effective interprofessional outcomes were explored using an evaluation approach. Despite the fact that the study conclusion cannot be generalized to larger geographic populations, it provided information that is similar across rural geographical areas. Mitchell et al. also concluded that when interprofessional practice is implemented effectively, it results in decreased health care costs and an improved quality of life.

Collaboration is equally important in other areas of study. Zhou et al. (2014) equated collaboration in health care to collaboration in public managements. Zhou et al. examined the satisfaction of those involved in collaboration and the role of negotiation in collaboration. In a quantitative research study in China, Zhou et al. selected 78 undergraduate Chinese participants who had learned negotiation psychology and decision-making processes for one semester. The main goal of the study was to focus on determining the quality of collaboration during a negotiation process and to improve the satisfaction of the collaborators. Zhou et al. found that satisfaction of collaborators stemmed from two sources: type of emotions experienced and the sense of profit during the negotiation process. Even though this study was geared towards public managers, the principles can be applied to other disciplines. Pharmacists and physicians who work collaboratively may also be more satisfied with their jobs. Negotiation is an aspect of collaboration. Understanding how negotiators can be satisfied in the process of

negotiation is important. Exploring RQ as an aspect in collaboration can increase the understanding of how the process of negotiation during collaboration satisfies pharmacists and physicians.

Laubscher et al. (2009) used a 5-point Likert scale in a quantitative research in Saskatchewan, Canada to obtain the view of family physicians on medication adherence when they worked collaboratively with community pharmacists. Physicians' opinions were measured on the following perspectives: medication compliance for patients with chronic diseases, current interactions of physicians with pharmacists, and collaborative strategies between physicians and pharmacists to promote collaboration. Laubscher et al. showed that only about a quarter of physicians interacted with community pharmacists. Physicians had concerns with reimbursement for time spent interacting with pharmacists. Also, physicians with less than 10 years of experience and physicians who practiced in rural areas were more willing to interact with pharmacists on patient drug adherence issues. Physicians were willing to work collaboratively with pharmacists to promote drug adherence. For effective collaboration to occur, better communication and more funding is required.

Chui, Stone, Odukoya, and Maxwell (2014) used a descriptive, exploratory, nonexperimental study to describe face-to-face meetings between pharmacists and physicians. This study was aimed at improving cost effectiveness and coordination of care among people in the United States. Chui et al. indicated that communication of pharmacists with physicians was impeded because nurses of physicians got the request from the pharmacists. There was hardly any direct communication with physicians. Physicians reported that a lack of time to review pharmacists was an impediment. Chui et

al. found that pharmacists gained more confidence in knowing how to approach their physician colleagues. Communication negotiation will improve collaboration among health care professionals in different settings.

Marlowe and Hodgson (2013) confirmed that integrated care is increasingly in demand in health care policy and practice. Integrated care has been used in a practice-based development of a model, focusing on implementation, viability, efficacy, activation, and marketing. There is still a gap in effectively describing the competencies needed for this type of collaborative relationship.

Relational Intelligence as a Model of Health Care Cost in the United States

The health care industry makes up about 17.6% of the nation's gross domestic product. The health care industry is the most expensive and least cost effective industry in the United States. In addition, the United States has the highest per capita spending than any other developed country, and yet people in the United States have a lower life expectancy than most countries (Kane, 2012). A lack of health care coordination in the United States, according to Health Affairs (2012), is influenced by factors such as fragmented care due to a lack of interdisciplinary collaboration. Kelley (2009) added that the U.S. health care system lacks coordination, amounting to $25-50 billion dollars in waste annually. In addition to the waste through a lack of care coordination, the U.S. spent $650 billion overall more in health care compared to other developed countries in 2012.Waste in health care in the areas of care delivery, care coordination, overtreatment, administrative complexity, and pricing failures accounts for $690 billion in health care waste annually. Berwick and Hackbarth (2012) added that health care waste is reported to be among the top five most costly form of waste in the United States annually. Decreased

health care waste is a realistic and ethical way of improving the health care system with an estimated target of about 4% annual reduction (Berwick & Hackbarth, 2012).

Huseman (2012) applied an RQ approach at some hospitals. Huseman (2012) introduced physician leaders to the concept of RQ in order to improve the performance of these organizations. Surveys were developed specifically for leadership, and RQ was divided into five sections: leadership strategies, coaching and feedback, relational management skills, relational styles, and response to open-ended leadership questions. Four relational styles examined included controlling, nurturing, confronting, and engaging. Huseman (2012) concluded that training leaders must be more relationally conscious to keep employees engaged, and added that the health care industry is not cost effective because the health care industry is made of people with high IQ and low RQ. If health care professionals are trained to leverage relational skills, clinical excellence can be influenced. Huseman (2012) addressed RQ in the following relationships in the health care industry: physician and employee engagement/retention, alignment of hospital and physician, unit to unit collaboration, physician/nurse communication, and performance, but did not target the relationship between pharmacists and physicians.

Gaps in Literature

A gap that needs to be explored further is the effect of RQ in leadership training for pharmacists and physicians in regards to performance, cost, and job satisfaction at the hospital. Another gap in the literature is the effect on confidence and performance of pharmacists being addressed as doctors, and how this would affect the collaborative relationship between pharmacists and physicians. There was no literature on RQ related

to physicians and pharmacists, and few literature on collaboration related to pharmacists and physicians and on RQ in general.

Summary

In this literature review, I examined studies on different leadership styles among practitioners, reviewed collaboration in health care and other settings, and reported the impact on the lack of collaboration and RQ in pharmacist-physician performance and health care in the United States. More research is needed about the concept of RQ and leadership between pharmacists and physicians. In Chapter 3, I will present the methodology of the study.

Chapter 3: Research Method

The purpose of this qualitative study was to explore the use of RQ as a leadership skill by pharmacists and physicians in providing collaborative care at hospitals. Exploring these factors may provide a better understanding of how pharmacists and physicians can apply effective leadership skills using RQ. This study was used to determine whether RQ can be used in a leadership crisis between pharmacists and physicians, and whether the use of RQ has any influence on decreasing health care waste in the United States.

Research Question

The central research question for this research study was the following: What is the role and potential opportunity to promote RQ as a critical leadership skill in the collaboration of pharmacists with physicians at the hospital? The central research question in this study was derived from the themes found in the literature on collaboration, leadership in Huseman's (2012) coaching for RQ. The concept of RQ in health care is new, and few studies have been conducted in this area.

Research Design and Rationale

I chose a qualitative approach for this study because it allowed for the exploration and understanding of how RQ as a leadership skill was perceived by pharmacists and physicians offering collaborative care at a hospital setting. I chose not to use a quantitative design because I wanted an in-depth understanding of the phenomenon from the perspective of the participants, taking into account their subjective views and meanings.

In a qualitative study, the researcher is the key collector of data through interaction with the participants (Marshall & Rossman, 2006). Qualitative research allows

researchers to learn details about characteristic behavior to address issues from the perspective of the participants (Patton, 2002). Qualitative data analysis is inductive, and the data collected by the researcher is used to direct the study, as opposed to a quantitative approach, which is deductive, and starts with a hypothesis that is based on a theory that already exists (Creswell, 2009).

Phenomenology is a qualitative approach strategy used to explore the lived experiences of the participants (Creswell, 2009). Lester (1999) noted that phenomenology deals with the study of the experience based on the perspective of that individual. Lester (1999) added that, from an epistemological standpoint, phenomenology is subjective, based on personal knowledge, and focuses on personal perspective and personal interpretation. The core theme of phenomenology was the study of conscious experience which, according to Husserl, Heidegger, Sarte, and Merleau-Ponty, developed into seven types: (a) naturalistic constitutive phenomenology; (b) transcendental phenomenology; (c) existential phenomenology; (d) generative historicist phenomenology; (e) existential phenomenology; (f) hermeneutical phenomenology; (g) realistic phenomenology (Embree et al., 1997). Phenomenology enables researchers to assign meaning to a particular behavior. Perceptions, emotions, and actions could all be evaluated through a phenomenological approach (Lester, 1990).

I chose the phenomenological design because, in order to determine how RQ is used by pharmacists and physicians, it is important to understand the common experiences of the participants in order to develop a better understanding of the applicability of the phenomenon. Phenomenology also enabled me to gain insights into the motivations and actions of those who have experienced the phenomenon. Husserl

(1970) claimed that the main purpose of phenomenological research was to commence from a perspective-free hypothesis and focus on describing rather than explaining the experience of individuals.

I chose hermeneutical phenomenology, which is part of Heideggerian phenomenology (Heidegger, 1927/1962). According to Creswell (2007), hermeneutical phenomenology is used to describe the lived experience of the participants and to interpret the meaning behind those lived experiences. Gadamer (1998) saw hermeneutic phenomenology as the procedure for further clarification of the conditions in which understanding itself takes place. The person seeking to understand a perspective must have a bond with the subject matter. In my study, I was a pharmacist who had worked with physicians in the site hospital before. According to Nieswiadomy (1993), the researcher sets aside his or her own experience of that phenomenon to understand the lived experience of the participants. Gadamer (1998) viewed bracketing as impossible, stating it was impossible for someone to completely leave his or her immediate situation by adopting an attitude. As a researcher who may have shared some of the experiences mentioned by participants, I could not completely remove myself from the study.

Prior to selecting this qualitative strategy, I explored grounded theory, case studies, narrative research, and ethnography. I did not choose a grounded study because it is used to derive an abstract perspective of a process or interaction based on the views of the participants (Charmaz, 2006). My goal was to understand the specific interaction under study and determine what it meant to both pharmacists and physicians. I did not choose a case study or a narrative study because they focus on one or more individuals. Narrative studies involve an individual or individuals providing stories about their lives.

A case study deals with the study of events or processes, and it is bounded by time (Creswell, 2009). These studies are different from a phenomenological study, which allows for the identification of the essence of human experiences of a specific phenomenon (Creswell, 2007). I did not choose ethnography because it focuses on an individual representative of a group or members sharing the same culture in a specific setting (Creswell, 2009). The research process evolves based on the lived realities encountered in the setting (LeCompte & Schensul, 1999). I selected a phenomenological approach to explore the experience of pharmacists and physicians in using RQ as a leadership skill in collaborative care.

Role of the Researcher

My role as a qualitative researcher requires me to recruit participants, structure and carry out the interviews, collect and analyze data, and ascribe meaning based on the data that adds to the body of knowledge on a specific topic (Patton, 2002). My role in this study was to conduct a thorough literature review, develop a questionnaire on the participants' demographics, obtain approval from my university's institutional review board (IRB), recruit participants for the study, obtain consent forms, schedule participant interviews, develop guiding questions for the interview, conduct participant interviews, compare transcripts from a transcriber with my own transcribed copies and audio recordings for consistency, give transcripts to participants for review, keep participants information confidential, analyze the data, report the results, show conclusions, list implications of the study, and identify opportunities for further research. I also reflected on my experience as a former hospital pharmacist for the site hospital and currently as a pharmacist at another hospital.

Managing Bias

In order to increase the validity of the study, researcher bias and researcher effects were greatly minimized by including my own thoughts and experience in the study. This was done by reflecting on my own experiences in the discussion section, and by giving thorough information and interpretation of the phenomenon from the perspective of each participant.

Guiding questions were used to guide participants toward responding to the central question of the study. These guiding questions enabled the participants to stay on track when discussing issues related to RQ as a leadership skill during the interview. Patton (2002) emphasized that an interview guide is helpful in making sure that participants are interviewed in a comprehensive and systematic manner. This strategy also minimized bias because the same guiding questions were used with all participants.

After the interviews, transcripts were handed to participants for their personal review. One participant made a minor correction to his transcript. The transcript was updated to reflect the correction. Member checking is important as it adds to the accuracy of the study (Creswell, 2007). My committee chair checked my data for accuracy.

Ethical Concerns

As a researcher, it was important for me to consider ethical concerns involved in the study. According to Creswell (2009), researchers must identify personal issues that may affect data collection and interpretation. As a pharmacist, I tried not to allow my personal interest in pharmacy practice to influence data collection and analysis. I addressed the aforementioned risk by checking with the methodologist to ensure that the

appropriate processes were in place. Interviews were transcribed by another transcriber and me, and a comparison of our transcripts was performed.

Another ethical issue concerns the offering of incentives as appreciation for the participation of participants. My incentive was a $30 restaurant gift card. I considered it appropriate because physicians and pharmacists are usually busy, and providing them with a gift card that they could use at their convenience would help them view their participation as worthwhile. All participants, however, declined the offer and did not receive any financial benefit for participating in the study.

Methodology

Based on the phenomenological approach selected for this study, I implemented strategies that were specific to the approach based on the types of participants, sampling, data collection, and data analysis. The strategies that I used provided a basis for data analysis that explained the lived experiences of the participants.

Pilot Study (Participant Interviews)

To ensure that the guiding questions asked during the interview were understood by participants and they were able to provide adequate information for the data analysis, a pilot study was designed. A pharmacist and a physician were interviewed prior to interviewing the participants of the study using questions developed from Huseman's (2012) Leadership and Relational Intelligence Audit **(**Appendix H). These participants (D1NA and P1RO) were scheduled first for interviewing. Based on the pilot study, all of the questions were deemed necessary for the interview. Data from the pilot study was used in the study, and the same guiding questions were used in other interviews.

Study Participants

According to Polkinghorne (1989), the number of participants in a phenomenological study can range from two to 25. McCracken (1988) stated that the key in a phenomenological study was describing the phenomenon experienced by a small number of people. Thus, a total of 10 participants from a 443-bed comprehensive acute care hospital in Michigan were selected through convenience and purposive sampling, either in person or via phone. A total of 11 participants originally opted to participate in the study, but a participant was eliminated because the study called for only 6-10 participants. All 10 remaining participants were otherwise deemed eligible to be included in the study. The study required five participants to be physicians from any specialty currently working at the acute care hospital with at least 5 years of hospital experience. For pharmacists, the study called for five registered pharmacists, either with a BSc or PharmD, currently working as full- or part-time employees at this hospital for at least 6 months, with at least 4 years of hospital experience from any hospital. Participants were 18 years old or older. To accommodate the participation rubric, participants were stratified into two different groups: physicians and pharmacists. The participants were purposefully selected so that the issue of central importance to the study could be explored.

Sampling Plan

Creswell (2007) reported that there are many different types of sampling strategies, and one or more strategies may be used in a single study. When determining the type of sampling, the researcher must take into consideration the size of the study, the site, and the collection of details about each site and participants.

Criterion sampling was used because participants were individuals who had experienced the phenomenon of collaborative care. Creswell (2007) stated that all participants must meet a specific criterion to add to the quality assurance of the study. This sampling strategy does not depend on participants who will influence the building of a theory, as in grounded study (Strauss & Corbin, 1998). For a phenomenological study, Dukes (1984) recommended studying 3-10 participants. I intended to recruit between 6 and 10 participants based on their availability. A total of 10 participants participated in the study. I also remained mindful of saturation.

Recruitment Process

I recruited prospective participants by purposive selection in person and via phone (Appendix D). Phone calls to prospective participants were made from a private location. I approached prospective participants and sought their participation in a private environment. Once a participant responded to the initial contact, I shared the purpose and procedures of the study, and I reminded the participant that the entire process would remain confidential. Following initial contact, I scheduled interviews based on the availability and convenience of participants.

Approval

Walden's IRB reviewed the research methodology and approved it under the number #07-01-15-0295326.

Data Collection Instrument

RQ is a very new topic with no qualitative research on this topic. As such, relevant research questions are not defined except for the questions in Huseman's (2012) Leadership and Relational Intelligence Audit (Appendix H). The interview questions in

the study were developed based on the audit. The interview guiding questions were specifically designed to address all the different leadership and relationship management strategies that contribute to RQ as stipulated by Huseman. Questions were reviewed and approved by my committee chair and a university research reviewer (URR).

Content Validity

According to Patrick et al. (2011), content validity for this study refers to the ability for instrument design to be applicable for the concept being studied. Content validity was ensured by testing the instrument using a pilot study and by having my committee chair and committee member review the instrument.

Data Collection

The data collection procedure that I employed consisted of in-depth semistructured interviews to acquire enough information to describe the phenomenon experienced by pharmacists and physicians. Interview questions included guiding questions from Huseman's (2012) RQ questionnaire, which was tailored to answer the research questions. Permission was granted to use Huseman's (2012) Leadership and Relational Intelligence Audit (Appendix I). Interview questions were open-ended. A one-on-one, semistructured, in-depth interview was conducted in a private room in the physicians' lounge of the hospital. This location was convenient, accessible, and private. A proper recording device was used to record the interviews. Interviewees were given a consent form to sign and a demographics form to complete at the beginning of the interview. I went over the purpose of the study with them and also explained the procedure, the amount of time needed for the interview, and the plans for using the report. I developed rapport with each participant and ensured that their questions would

be answered. During the interview, I stayed focused on the questions. I made sure that I completed the interview in the allotted time (30-60 minutes). I was courteous, respectful, and tried not to interrupt the participant.

Intensive Interviewing

Semistructured, intensive interviewing was employed as my primary method of data collection for the study. Charmaz (2006) stated that an intensive interview was considered an in-depth approach of gathering and interpreting data on a particular topic. I used Huseman's (2012) Leadership and Relational Intelligence Audit to develop guiding questions for the open-ended questions. This audit consisted of leadership strategies such as communication, accountability, focus and alignment, collaboration, feedback, and executive presence. It also consisted of relational management skills such as RQ and promoting positive relationships.

Guiding questions were used to guide participants to respond to the central question of the study. The questions focused on having the physicians and pharmacists talk about their leadership and relational management skills, and how these skills are linked to their lived experiences when collaborating with each other at the hospital. These guiding questions enabled the participants to stay on track on discussing issues related to RQ as a leadership skill. A broad access question was asked in addition to 13 other open-ended questions. According to Moustaka (1994), two general questions are recommended for a phenomenological research. Patton (2002) emphasized that an interview guide is helpful in making sure that participants are interviewed in a comprehensive and systematic manner. A copy of the guiding questions developed from Huseman's (2012) Leadership and Relational Intelligence Audit are attached (Appendix B) as the interview

guide for the study. At the conclusion of each interview, I thanked the participant for their time and determined if an interviewee needed a follow-up interview.

Data Security

Participants' transcripts, demographics, consent forms, and all other confidential information are kept in compliance with stipulated research privacy guidelines and standards. Hard copies are kept in locked cabinets, and digital files are secured with password access. Data security information techniques were reviewed and approved by Walden's IRB members.

Data Analysis Plan

The data analysis of the study started after transcribing the interviews. Significant statements, quotes, or sentences that showed how participants experienced the phenomenon of RQ were highlighted. After highlighting significant statements, which is called horizonalization, clusters of meanings from these statements were developed into themes. Textural descriptions were produced by writing up the significant statements and themes of the participants' experiences. Structural description, based on the setting or context, may have influenced the participants' experience of RQ. Based on the structural and textural descriptions, I wrote an essential, invariant structure based on a composite description of the phenomenon.

As a researcher, I reflected on my experience and included the contexts and situations that influenced my experience in Chapter 5. Bracketing my personal experience was difficult, and according to van Manen (1990), this makes the interpretive approach difficult in separating the researcher from the text. Therefore, stating my experience of the phenomenon under the discussion section will help epoché my personal experience.

By having a methodological plan for the study, I was able to develop a phenomenological theory on RQ as a leadership skill in collaborative care between pharmacists and physicians.

Issues of Trustworthiness

I used validity, reliability, credibility, transferability, and objectivity strategies to ensure the trustworthiness of the research study. In other to ensure internal validity, I triangulated the data by using more than one source of data collection (Creswell, 2009). This was done by conducting interviews, noting observations, and recording interviews. I also triangulated the data collected from the initial interviews and submitted the data to my methodologist and content expert for feedback. The feedback provided was used in future interviews. I used a second transcriber's transcripts to compare my transcribed notes for consistency and accuracy. Participants were all also given a copy of their transcripts to review. In order to clarify researcher bias, I articulated my lived experience of the phenomenon in the self-reflection section. External validity was ensured through a detailed and rich description of the results and helped other researchers in the transferability of the framework for other studies (Merriam, 1988).

Reliability was ensured by explaining the position of the participant, the basis of the selection, the role of the researcher, and the context of how the data was collected (LeCompte & Goetz, 1984). Merriam (1988) added that the triangulation of data strengthened the reliability of the study. According to Creswell (2009), a detailed report of data collection and analysis strategies also helped with ensuring the reliability of the study. All sections of the research were audited by a methodologist and content expert.

Ethical Procedures

The research participants were pharmacists and physicians, regardless of their specialty, working at hospitals in the state of Michigan. According to Israel and Hay (2006), researchers must protect their participants, promote the integrity of the study, develop trust with their participants, prevent or guard against impropriety and misconduct, and deal with new challenges. Creswell (2009) claimed that ethical issues can occur in different stages of a study: research problem, purpose and questions, data collection, data analysis, and interpretation. According to Punch (2005), a researcher can encounter ethical issues like the problem statement not benefiting the participants. Participants should be empowered and not marginalized. Marginalization can be prevented by allowing the participants to read the prospectus before the study. The participants should also be provided with other necessary information in order to develop their trust and respect before starting the study. Ethical issues in the purpose statement must be guarded against by conveying, without deception, the purpose of the study to the participants (Sarantakos, 2005). Creswell (2009) added that it is important to make sponsorship disclosure to participants.

This research was submitted to Walden University's IRB for approval prior to data collection. A full board review was required for the research study, since many ethical issues are reported during the data collection process. The IRB process ensured that the participants were protected. Sieber (1998) stated that the IRB process requires the assessment of social, economic, psychological, and legal risk to the participants. The safety precautions that I took were suggesting an interview location that was conducive for the participants. Collected data was stored in a locked storage cabinet. I provided an

informed consent form for the participants to sign before participating in the study. The informed consent form acknowledged the rights of the participants during the collection of data, and it included information such as identification of the researcher and any sponsor. It stated how the selection of participants were made, the research purpose, the benefits of participating, level of participant involvement, potential for risk notation, participant confidentiality, assurance to withdraw from the study, provision of contacts for any questions, and any incentives given to participants.

During the data analysis and interpretation of the data, Creswell (2009) suggested that the researcher should consider how ethical issues that arise from protecting individuals, roles, and project incidents can be addressed. I used aliases to ensure the anonymity of participants. I will store the collected data for the next 5-10 years and then discard it. I made a written agreement with the transcriber not to share the transcripts or audio files (Appendix E). The editor and participants signed a consent letter (Appendix F & Appendix G). I assured my participants that the data collected was to be shared only with those involved in the research.

Ethical issues of writing and disseminating the research involved guarding against using derogatory or biased statements to the participants based on their gender, sex, race, sexual orientation, age, disability, ethnic group, or profession (Creswell, 2009). I used unbiased language and addressed pharmacists and physicians by pseudonyms. I ensured that the falsifying of information or reports, which can be considered fraudulent, did not occur in my findings.

Summary

In an effort to explore how pharmacists and physicians use RQ to provide collaborative care in hospitals, I used a qualitative research method. Using qualitative research and open-ended questions enabled me to understand the lived experiences of these practitioners in a natural setting. This chapter gave detailed descriptions of the research question, researcher's role, research design, participants, recruitment plan, sampling plan, data collection, and data analysis. Trustworthiness issues were addressed, as well as an explanation of the different ethical issues anticipated from the study and how they were addressed.

Chapter 4: Findings

The purpose of this qualitative phenomenological study was to explore how hospital pharmacists and physicians perceived relational intelligence (RQ) as a leadership skill that enables collaboration. In examining the factors that can influence effective leadership and RQ, I used Huseman's (2012) Leadership and Relational Intelligence Audit to craft open-ended interview questions focused on two main sections: leadership strategies and relationship management skills. This chapter presents data gathered from the 10 face-to-face semistructured interviews. Interview transcriptions were used to manually organize and analyze the data. The data were analyzed and developed from bottom to top using Moustakas's (1994) guiding principles. I started by thoroughly reviewing the transcripts for an overall understanding. Through horizontalization, significant statements, phrases, and sentences were then identified (Patton, 2002). These statements were then clustered into categories or themes representative of each participant's transcript. Clusters of meanings from the statements, quotes, and sentences were then developed into themes. Textural and structural descriptions were used in writing a composite description of the phenomenon with respect to the main question.

After briefly reviewing the pilot study, exploring the participant setting, and sharing participant demographics in Chapter 4, I outline the data collection, describe the data analysis, and address the issue of trustworthiness. Following these explanations, group textural-structural synthesis is reported.

Research Question

What is the role and potential opportunity to promote relational intelligence as a critical leadership skill in pharmacists' collaboration with physicians in the hospital?

Pilot Study (Participant Interviews)

Initially, I conducted two participant interviews to ensure that participants would understand the questions. It was important to be sure that the questions elicited fluent responses and were able to provide meaningful information for the data analysis. Two participants (P1RO and D1NA) from the hospital (one pharmacist and one physician) were first interviewed (Appendix H). An open-ended access question was used, along with 13 guiding questions developed from Huseman's (2012) Relational Intelligence Audit (Appendix B). These two participants (P1RO and D1NA) were the first pharmacist and first physician who were scheduled for the interview.

P1RO was interviewed in a private conference room in the physician lounge of the hospital. He did not have problems understanding the questions or responding to the questions. He provided detailed information during the 45-minute interview, which allowed me to conclude that the pilot instrument was valid. D1NA was also interviewed in the physician lounge at the hospital. DINA did not have issues with understanding and responding to the open-ended questions. He also provided in-depth information that ensured validity of the instrument. Both the pharmacist and the physician were eager to share their lived experiences working collaboratively with physicians and pharmacists in an acute care hospital in Michigan.

As a result of the two pilot study interviews, the data collection instrument developed from the Leadership and Relational Intelligence Audit by Huseman (2012) was deemed valid (Appendix H). Data from the pilot interview was used in the research analysis because the data collection instrument was found to be valid and the participants gave in-depth explanations of their experiences.

Setting

Participants were given the option to be interviewed in a setting of their choice. All participants agreed to be interviewed in a private conference room in the hospital's physician's lounge that provided privacy and was convenient for all participants. None of the participants seemed uncomfortable. In fact, all participants were eager to share their experiences. There were no interruptions during the interviews, and the interview location was conducive to insightful conversation. No personal or organizational conditions influenced the participants during the interview process. The gift cards were declined by all participants.

Demographic of Participants

A total of 10 subjects—five physicians and five pharmacists with at least 5 years of hospital experience—from a 443-bed comprehensive acute care hospital in Michigan were selected through convenience/purposive sampling. Ten participants were chosen because only 2-25 participants are needed for a phenomenological study (McCracken 1988; Polkinghorne 1989). Participants were stratified into two cohorts by their profession. Participant demographics are listed in Tables 1-7.

Table 1

Number of Participants in Each Group

Profession	Number of Participants
Pharmacists	5
Physicians	5

Table 2

Education Level of Participants

Education Level	Number of Participants
Bachelor of Pharmacy	0
Doctor of Pharmacy	5
Doctor of Medicine	5
Medical Specialties	4

Table 3

Number of Years Participants Practiced Within the Medical Profession

Number of Years	Number of Participants
4-9	3
10-15	3
16-20	0
21-25	4

Table 4

Area of Specialty of Participants

Area of Specialty	Pharmacists	Physicians	Number of Participants
Internal Medicine	1	1	2
Cardiology	1	0	1
Hospitalist/Clinical RPh	3	1	4
Infectious Disease	0	1	1
Nephrology	0	1	1
Physical Medicine & Rehab	0	1	1

Note. Rph = registered pharmacist.

Table 5

Age Ranges of Participants

Ages	Number of Participants
18-40	4
41-65	6
>65	0

Table 6

Leadership Training/Education of Participants

Participants	Number of Participants
Pharmacists	0
Physicians	0

Table 7

Other Training Programs/Education of Participants

Participants	Number of Participants	Type of Training/Certificates
Pharmacists	3	BCPS, fellowship, or Lean training
Physicians	1	Lean training

Note. BCPS = Board Certified Pharmacotherapy Specialist. Lean training = Lean Six Sigma training.

Data Collection

Permission was given by the hospital for its staff to be recruited for the study through convenience selection (Appendix A). The data collection process commenced by identifying potential participants through convenience/purposive selection as reviewed above and detailed in Chapter 3. I contacted each participant by phone to schedule an interview. Face-to-face interviews were conducted in a private conference room in the physicians' lounge. Before each interview, each participant was given time to read through and sign the consent forms (Appendix G). Participants also were asked to answer

demographic questions (Appendix C). All interviews were recorded for professional transcription.

Participants were given pseudonyms to protect their confidentiality. Titles starting with P were used to describe pharmacists, and titles starting with D were used to describe physicians. No reference is made in the study of the participating hospital.

I employed a semistructured in-depth interview process that included an open-ended access question and 13 guiding questions, which were developed using Huseman's (2012) Leadership and Relational Intelligence Audit. The open-ended questions enabled participants to focus on key words and information that were pivotal in describing their experiences. The interviews were recorded using a digital recorder. I took notes on nonverbal signals, such as emotional ques, body movements, and changes in tone of voice. Guiding questions were used to move participants toward the central question of the study—RQ as a leadership strategy in pharmacist-physician situations and conversations. These guiding questions enabled participants to stay focused on issues related to RQ as a leadership skill during the interview (Patton, 2002). The data collection process did not vary from that outlined in Chapter 3.

Data Analysis Process

According to Creswell (2009), data analysis can be linear or hierarchical. Data analysis was done using Moustakas's (1994) guiding principles and was developed from bottom to top using a hierarchical approach (Figure 1). Data analysis was done manually.

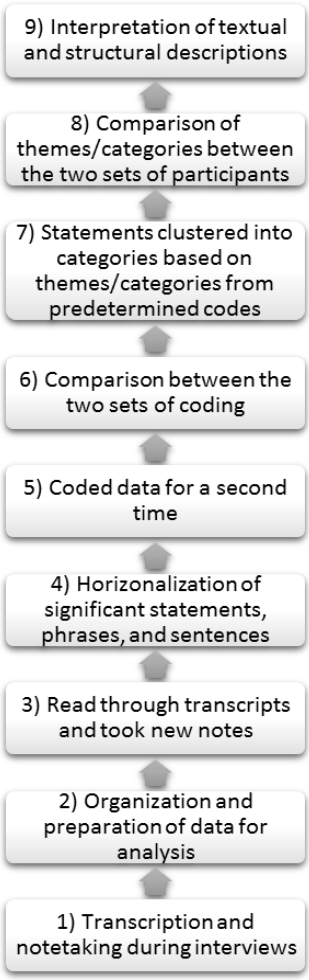

Figure 1. Data analysis process. This figure illustrates a nine-step hierarchical approach to the identification of codes and themes between pharmacists and physicians.

I started by thoroughly reading through all transcripts to gain an overall understanding of what they contained. Word frequency, common phrases, and statements that were directly related to the phenomenon were identified and treated with equal weight through a process called horizonalization as a way of coding the responses representative of each participant (Patton, 2002). Next, repetitive, irrelevant, and/or vague expressions were eliminated, which led to the identification of the codes related to the research question and guiding questions. Related codes were then clustered to

develop themes for pharmacists and physicians separately. According to Creswell (2009), health sciences researchers commonly use predetermined codes based on the phenomenon or theory being studied. I referred to characteristics or predetermined codes developed from the Leadership and Relational Intelligent Audit (Huseman, 2012) to note emerging themes (Table 8).

Table 8

Leadership Strategies and Relational Management Skills

List of Predetermined Codes	Themes	Category
Listens attentively *Communicates effectively* *Resolves conflict* *Confronts tactfully and effectively*	Communication	Leadership Strategy
Holds others accountable for performance *Holds self accountable for performance* *Voices concerns appropriately* *Challenges the system appropriately*	Accountability	Leadership Strategy
Is action oriented *Acts as a team player* *Works in alignment with the hospital's goals* *Balances issues from self, unit, and department with hospital's goals*	Focus and Alignment	Leadership Strategy
Has confidence in leading a team *Is trustworthy* *Stays calm when criticized and helps others remain calm* *Well represents the hospital internally and externally*	Executive Presence	Leadership Strategy
Initiates key relationships *Makes a priority in maintaining long-term relationships* *Aware of how current interactions can affect future relationships*	Relational Intelligence	Relationship Management Skills

Uses flexibility in order maintain long-term relationships		
Treats people in a professional manner *Is not abrasive* *Asks for recommendations/ideas from others* *Makes others feel like part of a winning team* *Offers feedback*	Promote Relationships	Relationship Management Skills

Note. Predetermined codes taken from the Leadership and Relational Intelligent Audit (Huseman, 2012).

Data was coded a second time. To enhance the reliability of the themes, both coding sets were compared and a high level of consistency was found between them. This step involved evaluating how participants experienced the phenomenon with all alternative meanings and perspectives examined. This process of imaginative variation, as described by Moustakas (1994), enabled me to consider different perspectives about the phenomenon of relational intelligence.

The next phase involved listing themes between the two groups of participants: pharmacists and physicians. Themes from each group were listed separately. In the final analysis, I constructed a textural and structural description of the phenomenon as experienced by the participants based on their responses to the research question (Patton, 2002).

Clustered responses from the participants were based on six themes and classified into two major categories. Categories included Relationship Management Skills and Leadership Strategies. Themes within the relationship management skills category included relational intelligence and promotion of positive relations. Themes within the leadership strategies category included accountability, communication, focus and

alignment, and executive presence. These response clusters were deemed the main themes from interviews with participating pharmacists (Table 9) and physicians (Table 10).

Pharmacist Codes, Comments, and Themes

Table 9

Codes, Comments, and Themes from the Five Pharmacists

Codes and Comments	Themes	Participants	Question
Initiate Relationships *Call that physician and introduce myself* *Know the way to approach them* *Introduce myself and get to know the physician*	Relational Intelligence	5 out of 5	1
Ask for Ideas *Contact the physician*	Positive Relationship Promotion	1 out of 5	3
Flexibility *Allow for not much variability* *Will take myself and sign off consult*	Relational Intelligence	3 out of 5	2
Maintain Long-Term Relationships *Go and talk to physicians in person* *Calm things down* *Call them usually* *Let them know that you are working with them*	Relational Intelligence	5 out of 5	2
Not Abrasive *Feel like they have the upper hand* *Feel like you cannot get mad at them* *Try to stay calm as much as possible* *Slow them down*	Positive Relationship Promotion	4 out of 5	13
Professional Manner	Positive Relationship Promotion	5 out of 5	10, 11

Address them as Dr. so they have the upper hand *Contact the physician and talk based on impressions* *Keep an open ear and listen*			
Feedback *Is not always great in getting a response back* *Never called me to follow-up* *Never got that message* *Get no feedback back*	Communication	0 out of 5	8
Lack the Confidence to Lead *Attend to the physicians* *Are trained in diagnosis* *Know the patients more than I do* *Feel like part of the team* *Are not going to yell at you* *Stay calm*	Executive Presence	5 out of 5	11
Alignment with Goals *Want to be more efficacious* *Want to be more cost effective* *Improves care and reduces length of stay*	Accountability	2 out of 5	5
Inability to Confront Issues *Have never been in the medical executive meetings* *Use VOICE to take it to the next level*	Accountability	5 out of 5	7
Lack of Acknowledgment *Receive no recognition* *Get no positive feedback* *Feeling as part of the team has not really happened*	Positive Relationship Promotion	5 out of 5	12
Not Addressed Professionally *Should be respected in the manner that doctors do* *Would feel really nice and good being called Dr.* *Are medication experts*	Positive Relation Promotion	4 out of 5	11

Pharmacist Relationship Management Skills

Theme 1: Relational Intelligence

All five pharmacists self-reported collaboratively working with physicians. They mentioned the importance of initiating with physicians. Some pharmacists go out of their way to create a face-to-face scenario in an effort to initiate and maintain a collaborative relationship with physicians, as is demonstrated below:

> **P1RO:** It took a few more extra encounters than usual for them to get to know as the specialist that I am and the expertise I provide…. I will go and as part of my review of the patient charts for that floor. I'll play closer attention to that patient and call that physician and introduce myself as the pharmacist reviewing that patient's chart.
>
> **P2RO** advocated for pharmacists to portray a good first impression when interacting with physicians by providing evidence based recommendations. He stated, "Set yourself from the outset a good reputation."
>
> **P3SY** suggested that how a pharmacist initiates a relationship with a physician is very important. She explained, "Very, very important. Because that's how they build their confidence and they will trust you. And based on that impression, I think they will either take your recommendation or they may not."
>
> **P4BAI: "**I think the more that you get to know the physician, the more you have a better relationship."
>
> **P5MA:** The first thing if they don't know me, I would introduce myself. Just calling to kind of get some clarification is usually what I've been using because

when you call them and say that you need to clarify something, they don't take it as offensive.

All five pharmacists also stated that they seek to have long-term relationships with physicians. Some pharmacists employ common courtesy to maintain long-term relationships with physicians. P1RO takes time out of his work schedule to meet face-to-face with physicians instead of making a phone call for a recommendation. He reported that doing so enables his recommendations to be respected, and the relationship with physicians stays strong every time he uses this approach.

P1RO stated, "Physicians don't like to be told, especially by someone over the phone that they don't know. I take the time out of my day to go and talk to them in person regarding recommendations."

P2RIC added that communication via phone affects long-term collaborative relationships with physicians: **"**Via phone, they can ignore you to a certain respect, but face-to-face, they know who's speaking, and they can realize that I've read the literature."

P3SY: "We have to talk to them. We usually call them**."**

P4BAI: "And that way, you can at least know that you're working with them."

P5MA: "I know the way that I approach them, it kind of calms things down a little bit at least a step down."

Most pharmacists (3 out of 5) are not necessarily thinking of being flexible to create a long-term relationship. These pharmacists acknowledged that they try to incorporate the practice style of each physician when consulted or when making recommendations. They also are prone to being more flexible based on how long they

have known and collaborated with a particular physician. Two of five pharmacists insisted that it was more important for them to stick with the policy and protocols of the hospital.

> **P1RO:** "I try to go by what is an evidence based practice. I don't allow for much variability. There's got to be a really good reason you want to veer off the hospital protocol."
>
> **P3SY:** "When a patient is on Coumadin, I need daily INRs until I at least get them therapeutic the first time or second time even. I can make a recommendation of what I think. But if the physician says, 'No,' then I usually will take myself off the consult and let the physician follow up with doses because I'm not agreeing to that."
>
> **P4BAI:** "The ones that don't want to listen or follow protocol, I sign off the consult. Because at this point we are not going to be agreeing and for me, there's no reason for me to follow."

Theme 2: Promoting Positive Relationships

When interacting with physicians, pharmacists are careful about how they address physicians, how they make a recommendation, and how they object to a physician's recommendation. All pharmacists agree that the manner of approach was very important and are usually not abrasive when collaborating with physicians. In fact, four of five pharmacists are very cautious not to offend physicians. When pharmacists are confronted by physicians because of their recommendations, they feel frustrated but remain calm and quiet.

P1RO: It's frustrating. It has happened. And it seems to happen repeatedly with a select group of doctors. Make them feel like they have the upper hand so that way they feed right into it, and that has worked for me.

P3SY: "I slowed them down. It happened to me one time actually, and I was very, very upset about it.**"**

P4BAI: "You can feel like you cannot get mad. What are you going to do as far as that? Because they're the ones that have the patients."

P5MA: "I don't think it should be that way if I have to call a doctor. I don't have to feel inferior to that doctor."

P5MA: "Try to stay calm as much as I can."

All participants affirmed that face-to-face interactions with physicians help decrease the disrespect pharmacists sometimes experience from physicians. Most pharmacists narrated a situation in which they were treated with disrespect, a problem that escalated when communication occurred via phone rather than within a face-to-face interaction.

P1RO: "100% I have not had an issue, if I meet with them face-to-face. Over the phone, it's probably less successful."

P2RIC: "Versus on the phone, they can ignore you to a certain respect, but face-to-face, they know who to go to, who's speaking, and they can realize that I've read the literature."

P3SY: Over the phone, this is a major problem to be honest with you that we're facing because calling them is a hassle. Getting a hold of them. They don't want

to accept the recommendation. When you're face-to-face, you can explain it more and elaborate more.

P4BAI: "Because you are in front of a group, if you can only say this is just a recommendation and then shut up…you kind of feel like you can't get mad."

P5MA: "They're not going to talk down to you when you're face-to-face."

Because of practice style of the hospital, most pharmacists stated that they lack opportunities to ask for ideas. Most conversations with physicians are done via phone. While they endeavor to seek the opinion of physicians to align the treatment or make recommendations based on specific patient needs despite this communication gap, they offered a potential corrective, too. Participant pharmacists advocated for pharmacists to participate daily in rounding with medical residents and physicians on all the floors in the hospital.

P1RO: "We don't have a pharmacist on rounds with physicians. That's ridiculous to me. I think they should be on all the physician rounds."

P2RIC: "The more we have a visual appearance and be available on the floor, I think the better the collaboration."

All pharmacists asserted that they interact with physicians in a professional manner, acknowledging them by their title and making recommendations to them properly.

P1RO: "Make them feel like they have the upper hand."

P2RIC: "I always have an open ear and listen. Sometimes they know more. They obviously have an established relationship with the patient."

P3SY: "Very, very important. Because that's how they build their confidence. Based on that impression, I think they will either take the recommendations or they may not."

P4BAI: "I contact the physician and say this is my level. This is what I was thinking to change it to that way they can at least know you are working with them**."**

P5MA: "Hi, Dr. so and so, my name is from pharmacy. "

Most pharmacists (4 out of 5) indicated that physicians do not treat them professionally when it comes to addressing them based on their credentials (Doctor of Pharmacy). Four of five pharmacists felt that addressing them by their title would make them feel respected when interacting with physicians and respected as medical experts as well as that it would increase their confidence. All pharmacists felt that they worked for their title and graduated with the expectation that they would be addressed as doctors.

P1RO: You have to introduce yourself as Dr. so and so. I'm taking care of this patient. But that doesn't happen. On a daily basis, I feel like we should be respected way more than what we are receiving.

P3SY: "When you mentioned doctor, I honestly had never thought of that. But we are doctors. We went for extra studying and extra schooling to get that doctorate."

P4MAI: "I mean I don't think it is the right approach obviously because we are the experts in medicine."

P5MA: "There were a few who were called doctors. My drug information rotation in New York, they always approached her as doctor. They approach you and call

you doctor and then you feel like you're almost at the same level as them. So it would feel good. It would feel really nice and good.

All pharmacists (5 out of 5) mentioned that there is no system to acknowledge physicians for their collaboration with the pharmacy. They also added that physicians do not have a forum to make pharmacists feel like part of a winning team.

P1RO: "I haven't received that kind of recognition here. I think they (physicians) would appreciate it too."

P2RIC: "We've never done nothing like that, sending something out."

P3SY: "It will make you feel as part of the team."

P4BAI: "That hasn't really happened. Absolutely. It feels good. I think the most people that get recognized like that are the people working under specialists."

P5MA: "In positive one, we don't get positive. They don't call us for it in fact."

Pharmacist Leadership Strategies

Leadership strategy is a category that encompasses the following themes: accountability, communication, focus and alignment, and executive presence.

Theme 3: Accountability

All pharmacists are conversant of patient care duty as part of their duty are pharmacists. All pharmacists are knowledgeable of the policies and formulary in place but do not focus on why certain policies are in place. Only two out of five pharmacists (P1RO) expressed concerns about health care waste in relationship to the pharmacy department.

P1RO: "That had driven down our costs of these two agents by 20%. So that w3as great and fantastic."

P2RIC: "We can talk on how to make things more efficacious, more cost effective."

All pharmacists discussed the lack of system to address performance issues with physicians in a face-to-face manner. One pharmacist, P1RO, who represents the pharmacy department in different committees, stated that pharmacists never directly confront physicians about physician-related issues such as problematic prescribing, cost, and medication errors. These reports are presented at pharmacy and therapeutic meetings that include a few physicians who are committee members, but pharmacists do not present these issues in a physician forum.

P1RO: "It would be great to have as part of the medical staff meeting, a standing report from their agenda to pharmacy and say these are updates to the formulary. Just a brief update of things that was done by pharmacy for the past few months that could affect them directly such as formulary changes and medication errors. I struggled here in my role for med safety for 18 months straight, prescribing errors were #1 out of phase of care and I never made it to the medical executive meeting, no matter how many times I asked. The prescribers never got that message**."**

P2RIC: "We have a system in place where you can report a physician, we can report a co-worker. VOICE is the system we use."

P3SY: "It happened to me one time actually, and I was very, very upset about it. What I did, I put him in tears."

P4BAI: "If you put it in VOICE."

P5MA: "When you have an issue with a physician that you cannot resolve, you take it to the next level like VOICE."

Theme 4: Communication

Most pharmacists (4 out of 5) expressed that they neither directly nor tactfully confront physicians about issues. When there is a conflict, pharmacists use the hospital standard reporting system called VOICE, hoping that the issue will be resolved. Pharmacist participants did not communicate their issues directly to physicians.

When a conflict of collaboration arose, most pharmacists (4 out of 5) stated that they do not get feedback when the report is made. Instead, they received a computer generated message acknowledging receipt of their complaint. They reported receiving no feedback on how the issue was resolved.

P1RO: "But the prescribers never got that message."

P2RIC: "Personally, it's not always great in getting a response back."

P3SY: "So, the end result? They never called me to follow up. I would have appreciated that."

P4BAI: "Sometimes they don't respond for a while."

P5MA: "You know, we haven't been getting feedback with our voice. We've kind of requested of some kind of feedback, but no we have not been getting any."

One pharmacist (P2RO) opined that if pharmacists round with physicians, conflicts will be diminished. He offered the example of the critical care unit, where rounding involves a pharmacist, medical residents, and sometimes physicians. When practitioners disagree, the conflicts are resolved on the spot.

P1RO: "Critical care rounds are the best because textbook rounds. So if there's a disagreement with a recommendation, then usually that launches into an academic debate."

All pharmacists emphasized that rounding with physicians, rather than collaborating via phone, would help limit conflicts and enhance collaboration.

P1RO: Because them seeing it, it's face-to-face, and I took the time out of my day to come and talk to them in person regarding this issue, they seem to be more receptive and I don't get that emotional response that I would get if I was on the phone. If I am face-to-face, 100% I have not had an issue if I meet with them.

P2RIC: "They can ignore to a certain respect, but face-to-face, they know who to go to, who's speaking, and they can realize that I have read the literature."

P3SY: "But if physicians would round with us, huge difference. Issue comes up during rounds?"

P4BAI: "They can explain to me face-to-face why they think this is not the right way or not the right recommendation."

P5MA: "Because they're not going to yell at you or talk down to you when you're face-to-face."

Theme 5: Focus and Alignment

Most pharmacists mentioned how important it was to follow hospital policies. If recommendations have to be made to physicians, pharmacists want to talk with physicians to get things done. Hospital versus department goals are not really discussed with pharmacists. Only two pharmacists mentioned coordination of care and the impact to cost.

P1RO: "But in terms of care coordination and patient care from first hand witnessing, I do believe that having that relationship does improve care and reduces length of stay and has more efficient, smoother coordination because what happens—when you don't have that kind of in a collaboration, it becomes broken and will prolong your length of stay for sure. The majority of our patients are DRG based payment."

P2RIC: "We can talk about practice and how to make things more efficacious, more cost effective."

Theme 6: Executive Presence

Executive presence was depicted by the participants' trustworthiness and ability to remain calm during a disagreement. All pharmacists acknowledged that physicians are the head of a patient care team and always feel behooved to stay calm and quiet when there is disagreements in patient care management. All pharmacists stated that it was important to stay calm in the face of pharmacist-physician disagreements because the physician has the final say when it comes to the treatment regimen that is best for the patient. Pharmacists find themselves trying to fit into the doctor's team.

P1RO: "I usually just say, okay well then. You're the attending."

P2RIC: "The physician is trained in diagnosis so there are some things I may not be aware of."

P3SY: "Yeah, I think it makes you feel like part of the team."

P4BAI: "The ultimate thing—they know the patients more than I do."

P5MA:"Yeah. Because they're not going to yell at you or talk down to you."

A pharmacist indicated that pharmacists always have to prove themselves to physicians in order to earn their trust.

P1RO: "I believe it's because they know my credentials and my credibility. It took a few more extra encounters than usual for them to get to know me as the specialist that I am and the expertise I provide."

Most pharmacists (4 out of 5) added that trust is built over time based on their collaborative relationship with the physicians**.**

P1RO: "Over the years, you get to know there is some doctors that likes things to be unique."

P2RIC: "Working with a variety of personalities and physicians and no two people are alike. So you have to understand a little bit about everyone's background and respect that."

P4BAI: "The physician. Probably knowing them over time."

P5MA: "Your personal relationship with that physician. How much you've dealt with him or her in the past based on their previous orders from before**.**"

Physicians Comments, Codes, and Themes

Table 10

Comments, Codes, and Themes from the Five Physicians

Codes and Comments	Themes	Participants	Question
Initiate Relationships *Just call me* *Is not face-to-face* *Communicate phone to phone*	Relational Intelligence	0 out of 5	1
Flexibility *Go by the book*	Relational Intelligence	5 out of 5	2

Are not a big fan of strict protocols *Are forceful and strict* *Is some resistance there between us*			
Asks for Ideas/Suggestions *Call them usually* *Ask for certain information*	Positive Relationship	2 out of 5	3
Feedback *Communicate with me* *Call me and say this is a mistake* *Is better when face-to-face* *Are typically kind of careful* *Call me back*	Communication	5 out of 5	8
Lack of Performance Feedback *Get no feedback* *Would like to see feedback*			
Respects Policies *Is hospital policy (formulary)* *Following the norm* *Is okay, but not a big fan of strict protocol* *Are perceived as guilty*	Focus and Alignment	5 out of 5	10
Understands Goals *Are guidelines (not mandatory)*	Accountability	1 out of 5	6
Challenging the System *Tried pushing having pharmacists on the floor*	Accountability	1 out of 5	5
Acknowledgment	Positive Relationship	0 out of 5	12
Ability to Lead *Can send me a text* *Sensitive to challenges* *Are liable*	Executive Presence	4 out of 5	13

Support our idea(s)			
Addressing Pharm.D.s as Dr. *Is difficult to force myself to call a pharmacist Dr.* *Had never thought about that before* *Think they should not be called doctors*	Positive Relationship	4 out of 5	11
Conflict Resolution *Say no always* *Are not a big fan of protocol* *Are a bit intrusive*	Communication	0 out of 5	4
Trustworthy *Told when there is a concern about an issue* *Do not know what is going on* *Are taking over so this could be a little bit intrusive* *Are used to give orders and move*	Executive Presence	5 out of 5	9

Physician Leadership Strategies

Theme 1: Communication

The theme communication was manifested by the following codes: conflict resolution, dominates interactions, and feedback. Like the pharmacists, all five physicians suggested the hospital lacked a system to address conflicts with pharmacists or for direct interaction with pharmacists about these conflicts. All physicians stated that talk among themselves, which means that one physician's dissatisfaction is heard by many other physicians, negatively affecting the physician/pharmacist relationship. Physicians

expressed issues about how protocols are handled, but these issues are not addressed through a formal channel.

D1NA: "Sometimes some pharmacists are strict about what they want…..physicians look at the whole picture."

D2KA: "Coumadin education for example. I ask patient if they had any education and they always say no and I have to do it myself**."**

D3KHA: "I am not a big fan of following strict protocols, but I understand protocols are important and I don't want to create exceptions."

D4MA: "I've heard personally that oh no, this is wrong. You cannot do that. But also, it depends upon the individual pharmacist too. But general with me, my experience has been good."

D5RA: "Protocols are a little bit intrusive because things may change. Sometimes protocols are okay."

Four of five physicians candidly suggested that most physicians lead in a patient care collaboration team because of the high liability they carry. While they try to make sure that each team member provides the appropriate skill, they do not like to be challenged.

D1NA: "Some physicians especially surgeons are too sensitive to challenges."

D2KA: "Maybe if they make their decision, they can send me a text that the patient will have this dose of vancomycin today at this time. That helps."

D3KH: "So if it is made in such a way that the physician does not feel like they made a mistake."

D4MA: "Because when we work as a team, oftentimes the pharmacist is not liable. We are physicians and the ones that are liable. So we want to make sure that the team that is working with us are skilled enough."

D5MA: "It's always useful to have the pharmacist to support our idea and all that."

All physicians stated that how a pharmacist approaches them is very important to building a collaborative relationship**.**

Theme 2: Focus and Alignment

Respects hospital policies.

All physicians endeavor to follow hospital policies and pharmacy department policies even when it does not work in their favor. They express their dissatisfaction or disagreement to other colleagues.

D1NA: "And the other issue is formulary drug, which I think is hospital policy, that's usually upsetting."

D2KA: "They're just following the norm."

D3KH: "I'm not personally a big fan of strict protocol following, but I think protocols are important and I don't certainly want to create an exception."

D4MA: "Always, the physician is perceived as guilty."

D5RA: "Could be a little bit intrusive because yes, following protocol is okay but things change."

Theme 3: Accountability

The importance of accountability was depicted by the following codes: feedback from pharmacists, holds others and self-accountable for performance, respect for

hospital's policy with great understanding of department goals, and challenging the system. All physicians agreed that pharmacists' feedback on their orders gives them the opportunity to justify their rationale for a specific treatment course and help promote quality care. Most physicians receive feedback consistently from pharmacists on patient care or related concerns and answers to questions asked.

D1NA: "They communicate with me. Tell me there is a concern about this….their feedback is good."

D2KA: "They call and say this is a mistake. They're straightforward about it, which is good. They communicate it."

D3KHA: "But communication, for sure, is better face-to-face."

D4MA: "They come in and they are they typically are kind of careful, tiptoeing around it. They don't want to insult you or hurt you."

D5RA: "They call me back…we looked it up and, yes, it is compatible."

Two physicians, however, mentioned that there is no system in place to give or receive formal feedback regarding pharmacists' performance necessary for coaching.

D3KH: A physician who is missing orders consistently should be accountable. A pharmacist even more so. There should be a root cause analysis, and what I think is lacking sometimes is what our physicians would like to see is a feedback of why the order was missed and we address it."

D4MA: "And the reason I demand feedback is because in the past when I did that, I did not get feedback."

When it comes to specific rationales for certain policies, two physicians suggested that pharmacists should offer an evidence-based rationale for utilizing certain policies or making certain recommendations.

D3KH: "I think there should be some clear indication of interaction."

D5RA: "It would be more useful if a pharmacist is able to say or give their recommendation with an evidence-based approach."

Another physician, D4MA, stated that pharmacists are overall behooved to make certain calls and recommendations to a physician.

D4MA: "I feel for pharmacists. Allot of pressure for them to do the right thing and to keep cost and waste down."

When it comes to challenging the system, most physicians (4 out of 5) only want to treat their patients and leave. These physicians are not generally involved in the hospital's policy-making decisions. There is no formal avenue for them to voice their concerns or to hold pharmacists accountable.

Only one physician (D4MA) indicated knowledge of the rationale for protocols and drug formularies and the rights of the physicians to override any protocol. This physician stated being part of many committees in the hospital.

D4MA: "When you have protocols, they should follow the standard guidelines. They're guidelines. They're not mandatory. They're not there to substitute the physician's expertise or knowledge or clinical decision."

Only a single physician acknowledged ever advocating for a change.

D4MA: "As a matter of fact, at one point, we tried to push to have a pharmacist on the floor at all time. Room for them to be on the floor. It didn't work out well. It wasn't feasible**."**

Theme 4: Executive Presence

The theme executive presence was denoted by the codes ability to lead and trustworthy**.** All physicians suggested that they control the direction of decisions made for their patients. They mentioned that they are the head of a health care team and know when to take charge when patient care issues arise. Physicians expect pharmacists to make recommendations, whereas physicians make the decisions.

D1NA: "Tell me there is a concern about this. That's fine. I will usually look at it again and decide."

D2KA: "I don't know what is going on especially with vancomycin dosing. Maybe when they make their decision, they can send me a text about what dose the patient will be receiving**."**

D3KA: "I think that physicians feel that sometimes pharmacists are taking over. If we reduce that fear on the part of the physician, it will improve collaboration**."**

D4MA: "Traditional physicians used to give orders and move, and they expected everybody else to work with them**."**

D5RA: "That could be a little bit intrusive. Pharmacists can extend the role of physicians but they cannot become physicians themselves."

D5MA: "You may have to customize certain things based on the patients' situation and condition."

All physicians expressed trust for pharmacists as health care professionals. Physicians also value the recommendations of pharmacists. All physician participants trust the recommendations of pharmacists based upon their working experience with them.

D1NA: "Pharmacists especially in the hospital are usually very good. They help guide us in terms of side effects which we're usually not aware of**."**

D3KA: "I have been told by pharmacists about drug interaction that I never knew about**."**

D3KH: "I think if a call has to be made to a senior physician, it should come from a senior pharmacist. There is definitely more value to it and thought process as opposed to when it comes from a pharmacy student."

D4MA: "We had great pharmacists. They were so engaged and so on**."**

D5MA: "I ask a question about an unusual drug," and "It will be more useful if a pharmacist will be able to give their recommendation with an evidence-based approach**."**

Physician Relationship Management Skills

Theme 5: Relational Intelligence

Relational intelligence as a theme was depicted by the following codes: flexibility and initiating key relationships. When it comes to the willingness for physicians to be flexible to maintain long-term relationships, all physicians self-reported a willingness to go along with pharmacists' recommendations, especially if they are policy or protocol based recommendations. These physicians do not necessarily like to be forced into using protocols, but all agreed that it is a good system to keep everyone on the same page.

Almost all physicians indicated that although pharmacists are usually very resistant, they usually are also less flexible. Some pharmacists make recommendations and insist on sticking to protocols without looking at the full picture.

D1NA: "Sometimes, some pharmacists are very strict about what they want they go by the book but you still have to look at the whole patient."

D2KA: "I guess they're just following the norm."

D3KHA: "I am not a big fan of strict protocols."

D4MA: "I have heard from other physicians of pharmacists being forceful."

D5MA: "There is some resistance there."

All physicians value the recommendations of pharmacists, but they do not tend to initiate key relationships with pharmacists. All physicians mentioned that it is important to be cordial and prudent when working with others, but they did not signal an intentional effort to create or maintain a relationship with pharmacists. Like pharmacists, physicians mentioned that most communication with pharmacists is via phone.

D1NA: "Most of the time, it's not face-to-face."

D2KA: "Usually, they just call me."

D3KHA: "The pharmacist is calling you."

D4MA: "When you have the phone conversation with them, it is completely different because really get it."

D5RA: "Most of my interactions with the pharmacist are phone-to-phone."

Theme 6: Promotion of Positive Relationships

The theme promotion of positive relationships was depicted by the following codes: asking for a recommendation, acknowledgements and addressing Pharm.D

pharmacists as Drs. When it comes to asking for recommendations from pharmacists, most physicians view pharmacists as a source of drug information, especially when it comes to drug-drug interactions. However, only two out of five physicians stated that they really take time to call pharmacy for drug related information.

D1NA: "I usually call them."

D5RA: "When I ask for certain information ….very unusual drug that I am not familiar with."

Most physicians (4 of 5) mentioned that there is no system to acknowledge pharmacists or to make them feel like part of a winning team. Some physicians indicated that while they think about it, they never verbalize their appreciation.

D2KHA: "I think about it, but I don't tell them thanks."

Most physicians (5 out of 5) stated that they have never received any recognition from the pharmacy department at this hospital either.

D5RA: "I don't think we get any recognition from the pharmacy."

All agreed that such recognition would be a positive gesture toward building collaboration between the two departments.

D2KA: "I did get a letter from a pharmacist encouraging me to talk to pharmacy department and come and come to the pharmacy department….and it opened the door of communication….it was very nice**."**

D3KHA: "I don't think physicians or pharmacists do more appreciation of each other. I don't think physicians do enough appreciation for pharmacists**."**

D4MA insisted that acknowledging people brings the best out of them and explained that she has experienced that kind of exchange only once in another

hospital: “I’ve been in practice for over 20 years. Sit in meetings days and nights, I‘ve been in P&T committees in many hospitals for years. Not a single time have I heard a pharmacist recognize a physician other than this …….hospital. Always, the physician is perceived as guilty. The good ones don’t make it to the meetings. I have to give credit to this hospital. I am a big believer that you bring the best out of people when you consider them as part of your team. I think praise should be given where it is due.”

Four of five physicians indicated that they have experienced/received letters of acknowledgements and pens from the pharmacy department of another hospital. Three acknowledged that it felt really good to receive some kind of recognition or acknowledgement.

D2KA: “Some letters of appreciation. It felt good. It was positive.”

D3KHA: “I have received a pen from a pharmacy department at another hospital.”

D4MA: “Not a single time have I heard a pharmacist recognized physicians other than pharmacy department of _____ hospital.”

D5RA: “I received a letter from another hospital.”

Most (4 out of 5) physicians recognized that the Doctor of Pharmacy is a doctoral degree, but they mentioned that addressing a pharmacist as doctor will not benefit collaborative relationship building between pharmacists and physicians. One physician made it resolutely clear that pharmacists are already trying to do the jobs of physicians, so trying to address pharmacists as doctor will impede rather than facilitate collaboration. Another physician mentioned that pharmacists do not have the kind of liability that

physicians have, making it unfair to address pharmacists as doctors because they do not have the same responsibilities and liabilities as physicians.

D1NA: "I have never thought about it."

D3KH: "I don't think they should be called doctors because there will be confusion among patients. I think there should be a clarification between a physician and a pharmacist."

D4MA: "In the workplace? And I will tell you no for the following reasons. Not until pharmacist input is regarded in the eye of the law as equal to physicians to where they carry the same liability."

D5MA: "To call anybody else. Somebody might have a PH.D. That's a different ball game altogether. But somebody who has not gone to medical school and if they are non-physician, I mean it's difficult for me to force myself to call them doctor."

All participants gave lengthy emotional responses to the question of addressing pharmacists as doctor. Because the two groups expressed vastly different sentiments on this issue, it is a sensitive issue that should be dealt with cautiously.

Discrepant Cases from Pharmacists and Physicians

In this study, discrepant cases focused around three participants (two pharmacists and one physician). One pharmacist did not concur with the idea that pharmacists should be addressed as doctors. Another pharmacist emphasized that at the hospitals where she did rotation pharmacists with PharmD degrees were addressed as doctors. One physician raised the issue that pharmacists are trying to take over medicine as a specialty, as evidenced below:

P2RIC strongly opposed being addressed as Dr. and felt that it would make him feel uncomfortable: "Some in my profession feel that they've earned the right to be called doctor. A doctor of pharmacy is not a doctor of philosophy. Is not a medical doctor. A doctor of pharmacy doesn't write a dissertation. They don't have a committee. They don't have to pass a comprehensive examination as you do in a Ph.D. but in a medical doctor, you don't go through four more years of college, three more years of residency, take a series of board exams. My own feeling is a doctor of pharmacy is rigorous but I don't believe it is of the same rigor or intensity that a doctor or philosophy or a medical doctor or a doctor of osteopathy goes through. So I have sometimes an issue, sometimes feeling a little odd about being called doctor, because I don't feel it is of the same level of work or intensity that they have gone through."

P5MA indicated that pharmacists were addressed as doctor in the hospital where she did rotation in New York. She recalled that addressing her preceptors who were Pharm. Ds as Doctor was a standard for them then and physicians also addressed them as doctors: "The preceptors that I work with, they actually were called doctors. Now that we're talking about, we were called doctors. This was in New York actually, and there were all Dr. so and So Some Doctors (physicians) called then Doctor and some internal people called then doctors. They also addressed themselves as doctor so and so on the voicemail and it was taken well. My Drug Information rotation preceptor was always addressed as doctor."

D3KH bluntly exclaimed that if a doctor addressed a pharmacist as doctor it would cause physicians to oppose the recommendations of pharmacists. He

insinuated that physicians feel that pharmacists are trying to be in competition with physicians, communicating that a **"**physician is more likely to be antagonistic to pharmacists if they start calling them doctors. I think physicians have a feeling that pharmacists wants to take over their specialty."

With the exception of these cases, pharmacists suggested that Pharm. D pharmacists be addressed as doctors because they earned it, whereas most physicians deemed it unnecessary for Pharm.D pharmacists to be addressed as doctors.

Unexpected Emergent Themes

Theme 1: Pharmacist/Physician Rounds

All physicians stated that the inability to meet with pharmacists face-to-face prevents the building of a collaborative relationship. They all stated that interacting face-to-face with pharmacists would help to decrease the number of calls they receive from pharmacists daily. Further, they claimed that face-to-face discussion enables them to express themselves better and helps them to better understand the pharmacists' point of view. All physicians strongly suggested that pharmacists need to interact with physicians more.

D1NA: "We used to have a PharmD round with us in Cleveland….I used to have a very good relationship with all the pharmacists…we used to ask their opinion."

D2KA: "I can easily ask them questions during rounds. Actually when I talk to them in person, it is better…..It's easy to have face-to-face."

D3KHA: "Face-to-face is better…..I think they should be part of the multidiscipline team**.** Pharmacists should meet with residents or attending physicians once a week."

D4MA: "I'd like to see more pharmacists on the floor because I think it makes the relationship with physicians much easier."

D4MA: "I go to more than one hospital. And one of the hospital, they implemented pharmacists rounding and it was a great experience. We had great pharmacists. They were so engaged."

D4MA: "The reason why physicians don't know pharmacists is because they don't see them. The approach to that is to have more pharmacists on the floor."

D5RA: "Pharmacists that round are in better position to help physicians**."**

Most physicians (4 out of 5) mentioned that they get interrupted by calls from pharmacists. While they respect the recommendations from pharmacists, some calls are about minor drug interactions. These physicians strongly suggested that pharmacists should call only if their recommendation or question will affect the patient. Physicians also suggested that face-to-face interaction with pharmacists would limit some of these calls. Too many calls that are unnecessary, on their view, negatively affect the physician/pharmacist relationship.

D1NA: "Yeah, it happens especially when I write the orders."

D2KA: "Usually, they just call me."

D3KHA: "Redundant questions takes time from performing my duties. Minor interactions could be taken care of when physician is ordering," and "I think there should be some clear indication of interaction. There are some minor drug interactions that pharmacists would call physicians, and that just gets annoying for some physicians."

D5RA: "Some of the drug interaction calls are redundant—I just answered this question. Why are you asking this question now?"

Theme 2: Respect of the Expertise of Pharmacists

All physicians expressed their respect for pharmacist input and recommendations. Due to a pharmacist's diligence, some physicians (3 out of 5) explained that medication errors were caught before reaching the patients. All physicians valued pharmacists as their second set of eyes for the orders they write. Likewise, all physicians mentioned that pharmacists play an important role in providing quality patient care**.**

D1NA: "I think we should respect their opinion**.** They are very good in knowing interactions."

D2KA: "They're straightforward, which is good."

D3KHA: "80% of the calls I get from pharmacists are of clinical significance."

D4MA: "They did a very good job."

D5RA: "It's been very rewarding and useful."

Theme 3: Disrespect Toward Pharmacists from Physicians

Most pharmacists (4 out of 5) narrated instances where they were talked down to and disrespected by physicians. Some of the disrespect stemmed from the fact that pharmacists made a recommendation with which the physician did not agree. Some pharmacists expressed feeling upset, sad, frustrated, or inferior as a result. They have learned accept denigration as part of the egoistic side of some physicians. Pharmacists' description of disrespectful instances were accompanied by facial expressions of discontentment and dissatisfaction. They also noted that they do not receive feedback from the organization or administration about the reports they file.

P1RO: "It is frustrating. I has happened. And it seems to happen repeatedly with a select group of physicians. It is frustrating when you know you are right because of the literature and what is best for the patient and what they know is really outdated, and you're just trying to provide them with updated knowledge and literature and they won't accept. I usually just say, okay well then**.** You are the attending."

P3SY: "It happened to me one time actually, and I was very, very upset about it. What I did, I put the physician in PEERS. And actually I know there was an issue with him. He was acting that way to even nurses and other pharmacists. So the end result, they never called me to follow up."

P4BAI: "There are a few that are set in their ways. They don't take it as good as others. They don't want the pharmacists to tell them what to do. They shut you off. I mean, you kind of feel like you cannot get made. What are going to do as far as that because there are the ones that have the patient."

P5MA: "I don't like it. I don't think it should be that way when I have to call a doctor. I don't have to feel inferior to them and they're the superior. You're calling to be talked down to or yelled at or whatever the case maybe. It-s not a very great feeling. I try to stay calm as much as I can. I never respond as rudely as they do."

During the interviews, questions by the participants were answered succinctly, and participants were allowed to provide short or long responses as desired in order to ensure completeness of response. Prompts and guiding questions were used clarify ambiguous responses (Creswell, 2007).

Evidence of Data Quality

Trustworthiness

The researcher's ability to accurately report the participants' perceptions is crucial, especially because participant interviews are the sole data source in this project. For this face-to-face interviews, digital recordings were completed and transcribed word for word. Transcription was done by a transcriber to decrease researcher bias. During the interviews, notes were jotted and researcher also transcribed interviews. Comparisons was made with transcriber transcripts to ensure that transcripts represented the ideas of the participants. Verbal pauses were not included in the transcripts in order to enhance readability. The phenomenon was well understood by the participants was well understood by the participants. Privacy concerns were adhered to and documents are available and are being securely kept as required. According to Shenton (2004), rigor was assured in this study.

Credibility (Internal Validity)

Credibility in this phenomenological qualitative inquiry was insightfully and candidly represented by the interview participants regarding their lived experiences and perceptions of relational intelligence as a leadership skill when collaborating. All participants articulated their thoughts and were able to put forth their ideas based on the questions asked (Patton, 2002). Interview questions were answered succinctly and guiding questions were asked to clarify responses that were not clear. Patton (2002) emphasized that an interview guide is helpful in making sure that participants are interviewed in a comprehensive and systematic manner. Participants were allowed to provide responses as desired with minimal interruptions (Creswell, 2007).). Peer

debriefing through regular review of dissertation by committee chair enhanced the credibility of the study. No limitations to credibility were noted.

Transferability (External Validity)

The research findings from this research can be used to further research the perceptions of lived experiences of pharmacists and physicians bestowed with leadership duties such as running departments and leading patient care teams, and collaborating with other practitioners without leadership training provided in medical or pharmacy school. With this data set, more insight will be realized as to whether pharmacists/physicians perceive leadership training as a necessity.

A quantitative research study should aim to compare the work performance of physicians, medical residents, and pharmacists who received formal leadership training were or involved in a coaching program. Impact on costs, retention, job satisfaction, and quality care should be measured over time.

Confirmability

The interview data were collected, coded, analyzed, evaluated and reported succinctly in a manner that another researcher can logically follow and clearly understands how conclusions were reached. The transcripts were manually coded and organized to aid in analysis. Data was coded twice and themes developed to ensure valid, accurate and reliable results. Researcher could not completely separate herself from the research because of her background as a pharmacist. Researcher therefore echoed her experience in the self-reflection section to limit the edge of injecting her thoughts in the research. Responses were all treated with equal weight and were combined to create codes and themes from each of the participants (Ulin et al., 2005).

Dependability

Responses from participants may vary very little or not vary at all if the research were repeated with other participants, the methods could easily be reproduced. Participants were interviewed and saturation was observed because most of their thoughts became repetitive. The process of participant selection, qualification and data collection processes were all completed in a uniform manner. All participants were interviewed at the same location and by the same researcher. Guiding questions were used during the interview. Patton (2002) emphasized that an interview guide is helpful in making sure that participants are interviewed in a comprehensive and systematic manner. Coding was done twice and same themes were developed (Ulin et al., 2005).

Triangulation

According to Patton (2002), triangulation is important during data analysis because it provides different ways of looking at the same phenomenon, therefore adding credibility to the conclusion(s) drawn. The different types of triangulations include methods triangulation (checking the consistency of data collection methods), triangulation of sources (checking the different data sources within the same method for consistency), analyst triangulation (using multiple analysts to review findings), and perspective triangulation (using different types of perspectives to interpret the data).

I triangulated the data collected from the initial interview transcripts by submitting the data to my methodologist and content expert for feedback. Interviews were transcribed by both a transcriber and I. Transcripts from the transcriber were compared to my transcripts for any inconsistencies. Two groups of participants (pharmacists and physicians) were selected for the study. The perspective of the study

was explored from both groups equally and the consistency of ideas between the two groups evaluated.

Group Textural–Structural Synthesis

Chapter 4 provided a detailed analysis of the various responses provided by the by the two groups of participants. Health care practitioners were recruited from two disciplines (pharmacists and physicians) to ensure that responses represented the perspectives of each group of participant. Physicians recruited were from different specialties or different practice setting such as internal medicine, hospitalist, Infectious disease, pain management and rehab, nephrology.Responses from pharmacists were analyzed and reported separately and responses from physicians were analyzed and reported separately. Outcomes from the analysis of the data identified six themes. The emergent themes represents the thoughts, attitude, beliefs and perceptions of pharmacists and physicians working collaboratively in a 443 bed comprehensive teaching hospital which is part of a health system in Michigan.

Research Question

What is the role and potential opportunity to promote relational intelligence as a critical leadership skill in pharmacists' collaboration with physicians in the hospital? .Six themes emerged from both groups of participants to answer the central question of the research and showed that the majority of the participants expressed the need for better communication especially face-to-face, accountability, promotion of positive relationships, relational intelligence, focus and alignment, and executive presence.

Overall, all the participants expressed the fact that they enjoyed and appreciated working with each discipline. Interviews with pharmacists lasted averagely 10 minutes

longer than interviews with physicians. Pharmacists were very detailed in their responses and were very eager to share detailed examples. Physicians were eager to share their experience but were not very big on giving detailed examples. One physician that is involved in many committees in the hospital was very detailed and passionate in expressing her perspectives for the need for better collaboration between pharmacists and physician. This physician expressed allot of understanding when it came to processes in the hospital in especially in managing cost while providing quality care. This was also observed with one pharmacist who is involved in several committees in the hospital. This pharmacist passionately shared that the pharmacy department under performs in many areas including when it comes to managing cost while providing quality care. He attributed it to the lack of collaboration brought about by lack face-to- interaction between pharmacists and physicians.

All participants did not indicate having formal leadership training or formal leadership coaching on the demographic forms. Pharmacists and physicians also had several suggestions to improve on how the hospitals' current system in place can be changed to improve collaborative relationship between pharmacists and physicians.

Participants from both group acknowledged that the current system in place impedes the ability pharmacists and physicians to collaborate and they all advocate for changes such as pharmacists rounding with physicians medical residents daily. Physicians also advocated for pharmacists to be present on all the units in the hospital.

While all physicians' participants share that they had allot of respect for pharmacist expertise, pharmacists expressed that their expertise as medication expects was underutilized. All pharmacists also reported feeling disrespected by physicians

sometimes. Most of the pharmacists in the study expressed that being addressed by their professional title as Dr. will increase their confidence when interacting with physicians and will feel respected because as Doctor of Pharmacy, they rightfully deserved that title. Most physicians made it resolutely clear that addressing pharmacists as Dr. will impede collaborative relationships with physicians.

Summary

This phenomenological study analyzed themes from the experiences of pharmacists and physicians in providing collaborative care at a hospital. Themes that emerged were evaluated based on predetermined themes derived from Richard Huseman's (2012) Leadership and Relational Intelligence Audit. Discrepant cases and unexpected themes that emerged were also noted.

The research findings showed that collaborative relationship between pharmacists and physicians is limited in this hospital by many factors. These factors stem from the role of the participants and also by the lack of resources and opportunities provided by the organization to support and promote such initiative. Chapter 5 will discuss the implication of the themes, the unexpected themes that emerged in the study, recommendation for further study social implications and recommendations for action taking into consideration the demographics of each participant, researcher's self-reflection.

Chapter 5: Overview, Findings, Recommendations, Implications, and Conclusion

The purpose of the qualitative phenomenological study was to explore how hospital pharmacists and physicians perceive relational intelligence as a leadership skill when working collaboratively with each other. The nature of the study was exploratory and qualitative. A qualitative strategy of semistructured in-depth face-to face interviews was used to understand the perception of interprofessional collaboration between pharmacists and physicians using relational intelligence as a leadership skill. Questions were based on Huseman's (2012) Leadership and Relational Intelligence Audit. The questions targeted factors, characterized by Huseman (2012), related to leadership strategies and relationship management skills. The study addressed the following research question: What is the role and potential opportunity to promote relational intelligence as a critical leadership skill in pharmacists' collaboration with physicians at the hospital?

According to Health Affairs (2012), health care coordination in the United States is influenced by fragmented care due to a lack of interdisciplinary collaboration, which is a leadership skill. In addition, more is expected from health care leaders with decreased budgets; consequently, relational intelligence may provide insight into effective leadership in health care organizations (Huseman, 2012). McCleskey (2014) suggested that it is imperative for leadership scholars to continue to engage in research that challenges the tenants of modern leadership.

I employed a hermeneutic phenomenological method (Ajjawi & Higgs, 2007) to explore the lived experiences of participants in their own words. As a researcher and pharmacist who previously worked in an acute care hospital, my insider background gave

me advantages in facilitating confidence and trust in the researcher-participant relationship and allowed me to easily establish rapport early on prior to the data collection process. As a pharmacist, I understood the terminology pharmacists used without needing further clarification. Further, their feelings and expressions were easily understood. According to Minichiello et al. (1995), this could be a disadvantage because, as a researcher, I could ascribe meanings to certain words or behaviors that differ from that of the participants. I maintained hermeneutic alertness, as described by van Manen (1997), by stepping back and reflecting on the meanings of the responses rather than accepting their interpretations at face value based on preconceived notions. Flexibility was very important when analyzing the data. Interpretation of the data included opportunities for thoughtful analysis of the research experiences of the participants, and the relationship between the participants, researcher, and the research were built into the research process and interpretation.

Research Question

The central research question, access question, and guiding questions used during the interviews were derived from the themes found in the literature on collaboration, leadership, and Huseman's (2012) coaching for RQ. The data from the research study provided detailed and thorough answers to the central question of the study. Guiding questions were used during interviews (Appendix B).

The conceptual framework of this study was RQ, which refers to with previous interactions, current relational interactions, and outcomes of current interactions at the individual and group levels. The level of intelligence determined in these two levels becomes a measure of how successful a person is when interacting with others. Relational

intelligence was developed from emotional intelligence (Huseman, 2012). Goleman (1995) described the following competencies as the basis for emotional intelligence: self-awareness, self-regulation, self-motivation, empathy, and social skills. Empathy is the ability to sense the perspective of others, read and understand different dynamics of relationships, and anticipate, recognize, and meet specific needs. Social skills include the ability to bring about desirable responses in others through collaboration, communication, influence, and relationship building (Goldman, 1995). Empathy and social skills are the bedrock of relational intelligence.

Researchers have addressed leadership in health sciences, but very few have considered relational intelligence as a leadership skill (Huseman, 2012). Kutz (2012) found that leadership promotes the survival, longevity, and quality of U.S. health care. Huseman (2012) attributed career success to relational intelligence, adding how leaders relate to followers during interactions can translate into better work productivity.

Themes from the interview data analysis were placed in two main categories: leadership strategies and relationship management skills. Common themes between pharmacists and physicians (presented in Chapter 4) included accountability, communication, promotion of positive relationships, relational intelligence, focus and alignment, and executive presence.

Key Findings

I developed the interview questions using the Leadership and Relational Intelligence Audit by Huseman (2012) to elicit responses from pharmacists and physicians who worked in an acute cate hospital in Michigan. Participants touched on the themes of communication (especially face to face), accountability, focus and alignment,

executive presence, promotion of positive relationships, and relational intelligence. Themes from interview data analysis were placed in two main categories: leadership strategies and relationship management skills.

Leadership Strategies

Accountability

Nahavandi (2012) emphasized that the ability of leaders to affect their organizations can only increase with accountability. Studer (2008) stated that organizations with an ownership mentality help to foster the creation of individual responsibility in the organization. According to Huseman (2012), accountability is upheld by leaders of an organization in two ways: by setting and communicating expectations that are clear and quantifiable, and by providing consequences for results. Pharmacists and physicians show willingness to accept accountability, but the hospital does not have clear goals and expectations, and consequences are not provided directly or communicated properly.

Accountability for performance-related costs or a clear understanding of the hospital's cost structure when providing care was reported by one pharmacist and physician. The other participants provide quality care but without any knowledge of how their performance fits into the bigger picture when it comes to the underlying cost structure of the hospital. The Institute for Healthcare Informatics (as cited in Manning, 2014) estimated that $200 billion of wasteful spending in 2012 resulted from excessive health care expenditure such as medication errors, antibiotics misuse, delayed evidence-based practices, and nonadherence. Gapenski (2012) suggested that most health care businesses such as hospitals primarily sustain themselves financially by selling services

and goods; as such, hospitals are in competition for consumer dollars with other businesses.

All five pharmacists stated that they are individually held accountable at the departmental level on performance-related issues, but there is no standard in place for accountability on pharmacists when collaborating with physicians. Pharmacists do not directly address concerns related to physicians, and physicians do not directly address performance issues with pharmacists. Only one physician (D4MA) took the time to have a conversation with pharmacists regarding performance issues.

Communication

Communication in leadership, according to Huseman (2012), includes the ability to listen attentively, confront situations tactfully, and resolve conflict. Only three characteristics of communication emerged for pharmacists and physicians: feedback, domination in interaction, and conflict resolution. However, domination in interaction was reported only by physicians.

According to Borkowski (2009), feedback is important in health care and should be used to strategically to enhance goals, learning, and awareness. When feedback is hampered, information is not shared between sender and receiver, leading to a breakdown in communication and collaborative relationships. Huseman (2012) asserted that thought-provoking feedback reinforces strong relational intelligence.

All participants reported that there is no formal system in place at the hospital for feedback to be shared between pharmacists and physicians or to deal with conflicts at the interprofessional level. Hickman (2012) reiterated the importance of communication and

conflict resolution in an organization and encouraged leadership to provide the resources and training needed to promote these behaviors.

All physicians acknowledged or insinuated that they tend to dominate clinical conversation because they are perceived as the head of patient care teams. All pharmacists reported instances in which physicians were overly aggressive, provided feedback in an inappropriate location, and were quick to assign blame. Shi and Singh (2008) stated that physicians are generally individualistic and aim for personal achievements. According to Huseman (2012), people who dominate interactions tend to give feedback in an appropriate manner, become overly aggressive, easily angered, judgmental, suddenly cause others to feel defensive, or be directly perceived as personally attacking individuals when addressing performance issues.

Borkowski (2009) explained that conflict is inherent in all work settings because it is a natural part of human relationships. The health care setting is one of the most conflictual settings because of competition, high stress, scarce resources, and excessive regulations. Conflicts can be managed through collaborative behavior and conflict resolution.

Focus and Alignment

Focus and alignment in leadership involve being a team player, being goal oriented, and being aligned with departmental and organizational goals (Huseman, 2012). Two of the four characteristics of the focus and alignment theme emerged: departmental goals and organizational goals. All pharmacists understood their role of providing quality care to patients and completing the tasks allocated to them. Only a single pharmacist (PIRO) was concerned about the importance of providing cost-effective quality care.

Focus and Alignment

All physicians expressed the desire to respect the goals of the pharmacy department and hospital but mentioned that they were not aware of pharmacy departmental goals. Only one physician (M4D4) acknowledged the importance of providing quality care at the lowest price, which is a goal of the pharmacy department. Pharmacists and physicians reported their willingness to meet organizational goals. However, there is not a system in place to communicate these goals to pharmacists and physicians.

Executive Presence

Executive presence in leadership involves inspiring confidence in others, being trustworthy, being a good representative of an organization, and staying calm under fire (Huseman 2012). Only two of these characteristics—the ability to lead and being trustworthy—emerged from the interviews. The ability to lead was depicted by all physicians as being able to lead a health care team. Domination in interactions reflected physicians leading by control. Huseman (2012) expressed the need for controllers to be trained to communicate through questions, to address issues and not individuals, to remain calm, and to provide equal treatment to all staff. Pless and Maak (2005) stated that for leaders to connect and interact with different stakeholders, they must be ethically and interpersonally competent. Enhancing the communication skills of professionals with controlling leadership styles may promote effective collaboration and encourage positive performance.

Pharmacists, on the other hand, are more nurturing in their leadership style when dealing with physicians. Pharmacists consider how to approach physicians and be

supportive without upsetting them. According to Huseman (2012), nurturers sometimes fail to address accountability issues and are ineffective when delivering developmental feedback because they place such a value on their relationship with physicians.

Trustworthiness in professional practices was reported by both pharmacists and physicians. Pharmacists trust themselves and also trust physicians, but trust increases with how long a physician has worked collaboratively with pharmacists. Physicians attributed a lot of trust on the judgement of a pharmacist's expertise. Physicians also stated that trust increases with a pharmacist's work experience. Novick, Morrow, and Mays (2008) acknowledged that maintaining trust is a moral consideration for practitioners. Huseman (2012) and Pless and Maak (2005) both emphasized that RQ will help leaders build a lasting, trustful relationship and will help leaders meet leadership challenges. Kutz (2012) found that leadership promotes the survival, longevity, and quality of U.S. health care. Hojat et al. (2012) concluded that teamwork and interdisciplinary interprofessional collaboration can lead to optimal clinical outcomes. McCleskey (2014) suggested that it is imperative for leadership scholars to continue to engage in research that challenges the tenants of modern leadership. Bottomley et al. (2014) provided a framework of behaviors needed to be an effective leader.

Relationship Management Skills

Promotion of Positive Relationships

Huseman (2012) described the promotion of positive relationships as not being abrasive, treating people in a professional manner, asking for ideas, and giving acknowledgements. All four characteristics were mentioned by all of the participants. Positive relationships were promoted more often by pharmacists than physicians.

Pharmacists are professional with physicians and are mindful of their approach when addressing or making recommendations to physicians. According to Nahavandi (2009), consideration of approach is important as it enables individuals to choose the approach type that is expected to yield a positive outcome. Pharmacists stated that earning a PharmD degree earns them the right to be addressed as doctors; one pharmacist, however, did not share that opinion. Overall, pharmacists think physicians addressing them as doctor will boost their self-image and bring more respect not only to their position but in pharmacist-physician relationships.

On the other hand, all physicians stated that how a pharmacist approaches them with a recommendation is important in building a collaborative relationship. All physicians expect pharmacists to have the right approach—not abrasive when collaborating with physicians and cautious not to offend physicians—but did not quite express the importance of their own approach towards pharmacists. Physicians do not address pharmacists with a PharmD degree as doctors. In fact, all physicians deemed it unnecessary and reported that addressing pharmacists as doctor would negatively affect collaborative relationships due to reasons ranging from the lesser liability of pharmacists compared to physicians, pharmacists competing with physicians, and the length of education of pharmacists compared to physicians.

Nahavandi (2009) emphasized that not being abrasive, or in other words being empathetic with others, and using interpersonal skills are components of emotional intelligence. Huseman (2012) asserted that relational intelligence includes empathizing with others and using interpersonal skills. Coaching physicians on how to read the

emotions of their health care team and empathize with them will help initiate and maintain positive relationships.

Giving acknowledgement is a huge part in promoting positive relationships. All physician and pharmacist participants mentioned that being acknowledged is positive feedback for them, but the hospital does not have a system in place to encourage rewards or praise of collaboration. Two physicians have had the privilege of receiving letters of acknowledgement and pens for contributing and being part of a winning team. They expressed it as a very positive gesture that promotes collaboration.

Findings from this study supports Huseman's (2012) narrative that the key to relational age is giving thought-provoking praise because people then feel empowered to make good things happen and positively influences how they and others think in the workplace. Hickman (2010) reported that high-performing companies purposefully select and reward specific systems such as collaborative teamwork.

Relational Intelligence

Characteristics of relational intelligence include the ability to initiate key relationships, placing priority in maintaining long term relationships, awareness of how current relationships affect future relationships, and the ability to be flexible to maintain long term relationships (Huseman, 2012). Only three of these characteristics emerged from the participants: ability to initiate a relationship, flexibility, and the ability to maintain long term relationship. Based on the results reported in chapter 4, pharmacists do better with relating intelligently with physicians, but pharmacists and physicians overall do not consciously utilize relational intelligence in collaborating with one another. Pharmacists are very aware of the importance of initiating key relationships with

physicians, but they report limitations to their ability to effectively do so due to the hospital's organizational set-up. Physicians state that relating to pharmacists is made difficult by limited or total lack of interaction between them.

According to Nahavandi (2009), intelligence is a factor in leadership but leaders are more successful when they are both intelligent and have interpersonal skills that is to say, having relational intelligence. Huseman (2012) explained that relational intelligence is the ability to mentally process information, assess risk, and perceive cause and effect. The heart of relational intelligence is the tenet that all relationships evolve over time and is characterized by the prologue, which are past interactions, current interactions, and the epilogue, which are the effects of past interactions and current interactions on a future relationship. Relational intelligence is hugely based on exchange and equity. Huseman (2012) added that career success is no longer attributed to IQ but highly attributed to relational intelligence because we live in an era where the ability to capture, create, and apply knowledge is pivotal in providing a competitive advantage. Dine et al. (2011) recommended formal leadership training for all physicians in training based on vision, team, communication, and personal attributes. There is a need for leadership training for practitioners in a medical setting, and based on the findings of the study, RQ is an essential aspect of leadership training among practitioners

Unexpected Emerged Themes

Lack of Face-to-face Communication

All physician and pharmacist participants expressed that the lack of face-to-face interaction is a major obstacle for creating a collaborative relationship between pharmacists and physicians. The hospital does not have a system in place that supports

the kind of interactions that pharmacists want with physicians and physicians want with pharmacists. Pharmacists and physicians value and respect each other's expertise and want more face-to-face interaction with each other at the hospital.

Borkowski (2009) emphasized that face-to-face interactions are information rich because it allows for immediate feedback and allows for emotions to be transmitted. Ean (2010) suggested that face-to-face communication is the most effective way in building relationships at a work environment. Pharmacists and physicians advocated for pharmacists to round daily with medical residents and physicians on all floors. As well, pharmacists expressed that rounding with nurses is an inefficient use of time and a poor standard to promote collaboration with physicians.

Respect for Pharmacists

All five physicians expressed respect for pharmacists, even acknowledging that they do not recognize and acknowledge pharmacists as they should. Physicians perceive pharmacists as professionals they can trust and depend on. Some physicians narrated the number of times pharmacists caught errors that they missed and how much that meant to the physicians. Mehta et al. (2011) emphasized that pharmacists have an evidence- based track record in demonstrating successful outcomes when managing chronic conditions in patients. A successful initiation of team-based practice, with a collaborative relationship between pharmacists and physicians, must be developed.

On the other hand, pharmacists are unaware of the respect physicians have of their expertise, feeling that their expertise is undermined. Studer (2008) explained that recognized behavior gets repeated and it is important for recognition to be specific and

advocated creative ways to praise team members. A written recognition system for pharmacists and physicians should be put in place and it should be consistent.

Limitations of the Study

The findings of the study were obtained from specific health care individuals about their perception of a specific phenomenon. While the analysis was focused, it was also subjective. This qualitative design thus served as a limitation to the study because they do not necessarily lead to generation in the general public. Study participants were volunteers; as such, they were possibly more open to collaboration. This limitation is significant because though the study may shed light on the assumptions made by these practitioners, it may not be appropriate to generalize the findings to all physicians and pharmacists.

The fact that the interviewer herself was a pharmacist might have made the pharmacists more comfortable and willing to give detailed examples of their work experiences compared to physicians. The interviewer being a pharmacist, certain terms and words used by pharmacists might have been easily understood without needing further clarification. According to Minichiello et al (1995), this could be a disadvantage because the interviewer could ascribe meanings to certain words or behaviors that differ from that of the participants, leading to bias.

In addition, the study participants were limited to pharmacists and physicians in this specific acute care hospital in Michigan. Their views therefore may be influenced by working in this specific hospital and may not translate to other hospitals or other states. Some physicians shared their experience working in other hospital but that was usually to emphasize on a point.

The results from the study can however be used as a starting point to support other research related to leadership and collaboration, and be further used to explore relational intelligence in other workplace settings.

Recommendations for Further Study

This study opens many avenues for further research. Recruitment of the study can be broadened to include more hospitals in Michigan, which would help understand whether the same themes are applicable within the region or not. Similarly, a quantitative research of all the hospitals who represent part of a region should be examined on the results after competitive goals were set in the hospitals at t. A follow up quantitative study is recommended that includes hospitals in the region to examine the outcomes of implementing relational intelligence as a collaborative tool for pharmacists and physicians, specifically impacts on cost and quality of care.

Further research is needed to explore the perceptions of pharmacists and physicians bestowed with leadership duties such as running departments and leading patient care teams, and collaborating with other practitioners without leadership training provided in medical or pharmacy school. With this data set, more insight will be realized as to whether pharmacists/physicians perceive leadership training as a necessity. Dine et al. (2011) asserted that health care is advanced by good leadership and, yet, physician leadership is understudied

A quantitative research study should aim to compare the work performance of physicians, medical residents, and pharmacists who received formal leadership training or involved in a coaching program. Impact on costs, retention, job satisfaction, and quality care can be measured over time.

A large quantitative study should be done among pharmacists to examine the impact of addressing or not addressing PharmDs as doctors in the hospital. Questions to consider are the impact the title of doctor to pharmacists will have on the pharmacist-physician relationship, and what impact it will have on the confidence of pharmacists and their ability to lead? On the other hand, further research should be done to examine physicians' perception of addressing PharmDs addressed as doctors in the hospital setting. This research should be quantitative and it should aim at recruiting participants nationwide.

A research study should aim to explore the perception of pharmacists/physicians collaboration after the implementation of leadership training or coaching for relational intelligence. Results should be compared to their perceptions before and after the training. Dine et al. (2011) concluded that the physician leader must be able to adapt to the ever changing team dynamics in hospital.

Implications

Hackman and Johnson (2009) emphasized that leadership is connected to what it means to be human. Human communication helps to mold the behaviors and attitudes of others in order to meet the common goal of the group. According to Irshad and Hashmi (2014), dynamic work environment enables an organization to consistently develop, improve, and adapt to changes in order to gain and maintain a competitive edge. Huseman (2012) suggested that relational intelligence is the new competitive smart in the health care market and added that the U.S. competitive health care market can only achieve positive outcomes in this relational age when professionals are inspired, motivated, and held accountable.

Positive Social Change

Positive social change relates to the propensity of research to encourage the altering of human actions and behaviors for improvement. Findings from this study may lead to positive social change in many different levels. Kelley (2009) reported that the U.S. health care system lacks coordination of care, resulting in $25-50 billion dollars annually in wasted funds. This study may provide pharmacists with a better understanding and awareness of the barriers involved in the interprofessional culture between physicians and pharmacists. Awareness of these barriers can lead to multidisciplinary training of both pharmacists and physicians to overcome them, and the implementation of leadership courses at the undergraduate/graduate level that will help improve trust, mutual understanding, communication, collaboration, and decreased costs in health care settings. For example, Huseman in 2012 developed an evidence-based coaching of a relational intelligence approach for leaders, including leaders in the health care industry, as a foundation for one-to-one coaching and to enhance the relationship skills of leaders in the health care industry. The coaching provided by Huseman and his team resulted in increased in-patient satisfaction, employee retention, and performance in more than a dozen health care system across the United States will be used in a qualitative approach to examine collaborative care between pharmacists and physicians.

From the findings of this study, the following positive social changes can be realized based on the phenomenon of RQ as a leadership skill at an organizational, societal/state, national, and international level.

A Leadership position directed by a practitioner (pharmacist or physician) with a PhD degree, and with expertise in relational intelligence be implemented in hospitals and also in pharmacy and medical school programs. Based on the research, relational intelligent leaders and practitioners are needed in the hospital workplace especially as Huseman (2012) described how society currently is slowly transitioning to the relational age. According to Anderson and Ackerman (2011), the command-and-control and tyrannical leadership style has been antiquated some 50 years ago. Huseman (2012) emphasized that individuals with RQ possess a competitive advantage in health care. This RQ leadership position should aim at developing leadership programs for practitioners in hospitals and school programs. According to ASHP (ASHP Foundation, 2009), practitioners, especially pharmacists and physicians, are tasked with running departments without proper leadership training. These practitioner graduates are not taught how to work collaboratively with other health care professionals. Stoller (2009) added that the training for these practitioners does not stimulate reflexes that contribute to the tenet of teamwork and collaboration. Effective leadership is a catalyst for a successful organization; however, the health care system is faced with many challenges because it is a complex organization composed of different types of professionals. Health care leaders must demonstrate effective leadership within the organization to address challenges such as access, affordability, cost, and quality.

Recommendation for Action at the Level of the Organization

Findings from this study indicated that pharmacists and physicians are both interested in face-to-face collaboration, but the hospital does not have provision for that. Chui et al. (2014) found that pharmacists gained more confidence in knowing how to approach their physician colleagues when face-to-face interaction was encouraged. Patient centered medical homes, according to the American Pharmacists Association (2014) or AphA, is a model that permits primary care physicians to use pharmacists as extenders through collaborative relationships. Providers in medical homes have reported improved quality of patient care, pharmacists serving as a valuable drug information resource, and empowered patients with the integration of pharmacists in the primary care practice.

Based on the results of the study, the system in place in this acute care hospital actually encourages "silo practice." Pharmacists only round with physicians and medical residents in in the CCU and ICU. Goals and expectations of the hospital are not communicated clearly to either pharmacists or physicians. Makowsky et al. (2009) emphasized that pharmacists and physicians are regarded as key players in providing successful collaborative interprofessional care that reduces errors, improves compliance, and decreases adverse drug events. Zwarenstein et al. (2009) asserted that poor collaboration will cause the health care system and patient care to plummet, and if issues affecting interprofessional collaboration are addressed, there will be an improvement in the outcomes of health care. Huseman (2012) asserted that RQ helps leaders to think and work with others better.

This study also reports that the hospital in the study lacks a system that promotes collaboration between pharmacists and physicians. Pharmacists do not attend physician related meetings such as medical executive meetings or internal medicine meetings. According to Nahavandi (2012), top executives influence their organization by providing guidelines for collaboration strategies that help shape the course of their organization. According to Studer (2008), the implementation of measurable leader evaluation tools was found to revamp the system in place that the organization originally used for appraisals. APhA (2014) reported that medication related problems accounts for 28% of hospital admissions, adverse drug events (ADE) 17%, and nonadherence 11%. The Patient Safety and Clinical Pharmacy Services (2014) or PSCP demonstrated that collaborative services of pharmacists with physicians in community health centers, rural health, and primary care associations resulted in improved outcomes and patient safety in high-cost, high-risk, and complex patients. The incidence of ADEs also dropped by 49% when medication therapy management was collaboratively offered with pharmacists (PSCP, 2014). The techniques and coaching for relational intelligence introduced by Huseman could be implemented to promote collaboration within the hospital organization between pharmacists and physicians.

Lack of accountability was echoed by most participants. Huseman (2012) stated that the ultimate goal of accountability is to create ownership of results. Hospital leaders should communicate the overall goals of each department and the goals of the hospital itself in order to provide cost containment while providing quality care, set expectations for physicians and pharmacists that are specific and quantifiable, and clearly

communicate how collaboration between pharmacists and physicians can yield results. Implementing these strategies may help resolve the lack of accountability issue in the organization.

Feedback could be regarded as an important aspect because findings from the study indicated the lack of feedback back to the physicians and pharmacists at the hospital. As reported by Huseman (2012), only 25% of non-managerial workers say they work to their fullest potential. Borkowski (2009) emphasized that relational feedback provides better interpersonal dynamics between groups that work together. Huseman (2012) emphasized that thought provoking feedback helps to reinforce a powerful relational intelligent way of thinking. Implementing feedback will help enhance mutual understanding of the different roles that each physician and pharmacist brings to the team.

There needs to be a system in place that will promote communication between pharmacists and physicians. As a start, encourage the participation of pharmacists and provide them updates from the monthly physician meetings. Involve pharmacy staff in medical executive meetings and other committees. Create the workflow of pharmacists to include rounding on the floors with both physicians and medical residents. Both pharmacists and physicians want more interaction among each other, and all indicated that face-to-face interaction will help promote collaboration. Face-to-face interaction, according to physicians, will help reduce the number of calls from pharmacy, some of which are redundant. Ean (2010) suggested that face-to-face communication is the most effective way in building relationships at a work environment. Makowsky et al. (2009) emphasized that communication between physicians and pharmacists is regarded in

providing successful collaborative interprofessional care to reduce errors, improve compliance, and decrease adverse drug events.

Rewards and acknowledgements of staff were reportedly missing in the hospital. A consistent system of recognizing and rewarding pharmacists and physicians as being part of a winning team should be implemented. Hickman (2010) reported that high-performing companies purposefully select and reward specific systems such as collaborative teamwork. Praise that is thought provoking is very pivotal to the relational age because people are then left empowered to make good things happen. Equity and reciprocity of acknowledgment is one of the foundations of relationships and relational intelligence.

There is a need for the hospital organization to provide resources and training on how pharmacists and physicians can introduce relational skills in their interactions. Coaching for relational intelligence as a leadership skill is recommended for both pharmacists and physicians at the hospital. Huseman (2012) used relational intelligence theory as a foundation for one-to-one coaching and to enhance the relationship skills of leaders in the health care industry. The coaching provided by Huseman and his team resulted in increased in-patient satisfaction, employee retention, and performance in more than a dozen health care systems across the United States.

There is a need for the organization to have a leadership position directed by a pharmacy or medical practitioner or consultant with a PhD, and who also has expertise in RQ to oversee Pharmacists-Physicians collaborative Relationships. The consultant could be responsible for implementing and monitoring different strategies related to pharmacist-physician collaboration based on the goals of the hospital. Training and

coaching should be organized and implemented to work with other hospitals in the health system to create programs such as antibiotic stewardship, waste control, pharmacist-physician collaboration and quality improvement. Standards based on best practices should be set with quarterly or biannual reports of performance reported. Rewards such as Plague could be awarded to hospitals within the system that attain best performance. The goal will be to generate competition. Borkowski (2009) stated that competitive style management is effective when implementing long-term organizational outcomes. According to Huseman (2012), relational intelligence is the new competitive edge in the health care market.

Societal or State Level

This study finds that health care systems are made of individuals with high IQs but low RQ. Physicians were more of a controlling type. Huseman (2012) acknowledged that only about 4-10% of career successes are attributed to high IQs. Career successes, in this relational age, is more attributed to the concept of RQ, empathy, and social skills. Borkowski (2009) insisted that collaboration involves behavior that is cooperative and assertive and always reflects a win-win for an organization. According to Nahavandi (2012), leaders with characteristics such as being intimidating, abrasive, arrogant, or self-centered eventually fail as leaders. This study raises several issues when dealing with leadership training for health care practitioners. No participant indicated ever receiving formal leadership education or coaching in relational intelligence as a leadership skill According to ASHP (2009), practitioners, especially pharmacists and physicians, are tasked with running departments, teams, and directorates without proper leadership training.

Leadership training should be implemented in pharmacy and medical programs in Michigan. Leadership training programs like that in Ohio and Nebraska could be implemented in pharmacy and medical residents programs across other states. Organizations and educational institutions could include coaching for relational intelligence in the leadership training for pharmacy and medical residents as well as any other student. The Nebraska Medical Center launched a systematic leadership training for pharmacy residents in 2007. The leadership program focused on trust-building exercises, physical challenges, discussions on different leadership concepts, and self-assessment to help build personal strengths training on the application of different communication skills, conflict resolution, and the history of the evolution of health-system pharmacy. Fuller (2012) reported that residents in the leadership development program were exposed to different leadership principles and philosophies. After the training, the residents were assessed and found that the residents had increased self-awareness. Self-awareness is an important aspect of leadership as it is the cornerstone to emotional intelligence, according to Huseman (2012). The Ohio leadership training program reported by Kitz miller, Phelps, Neideckerand, & Apseloff (2014) offers a 2-year training fellowship program for physicians, pharmacologists, and pharmacists at Ohio State University. The purpose of the program is to provide leaders with skills that can be used by these professionals in academia, pharmaceutical industries, and in accreditation agencies. This recently accredited program is an example of an interdisciplinary fellowship that can help practitioners develop collaborative skills by training together. These kind of programs can be implemented in universities in Michigan and other states.

Health Care Policy or National Level

Scholars have used the individual concept in relational intelligence or other leadership concepts to assess outcomes among practitioners. Prior to this research, relational intelligence and its components were not used to explore relational intelligence in collaborative care between pharmacists and physicians in a hospital setting in the United States. The findings from this study suggest that leadership issues among collaboration between pharmacists and physicians have to be addressed in hospitals from a policy standpoint at the national level.

The U.S. health care system spends $200 billion annually due to inappropriate use of medications, constituting 8% of total health care spending. Avoidable hospital admissions amounts to $10 million, $78 million for outpatient treatments, $4 million for emergency department visits, and $246 million for prescriptions (U.S. Department of Health and Human Services, 2015). According to the Centers for Medicare and Medicaid Services, the Affordable Care Act created a quality improvement program to help improve readmission rates in hospitals by robustly focusing on medication reconciliation and medication management by pharmacists. Initial results from this initiative showed a reduction in the national readmission rate (Centers for Medicare and Medicaid Services, 2013).

Zwarenstein et al. (2009) asserted that poor collaboration will cause the health care system and patient care to plummet, and if issues affecting interprofessional collaboration are addressed, there will be an improvement in the outcomes of health care. Mitchell et al. (2012) concluded that when interprofessional practice is implemented effectively, it results in decreased cost health care costs and improved quality of life.

Many researchers have acknowledged that effective collaborative care can produce successful outcomes. Kutz (2012) found that leadership promotes the survival, longevity, and quality of care in U.S health care.

The United States has the highest per capita spending than any other developed country, and yet people in the United States have lower life expectancy than most countries (Kane, 2012). A lack of health care coordination in the United States, according to Health Affairs (2012), is influenced by factors such as fragmented care due to a lack of interdisciplinary collaboration. The United States spent $650 billion overall more in health care compared to other developed countries in 2012. Waste in health care in the areas of care delivery, care coordination, overtreatment, administrative complexity, and pricing failures accounts for $690 billion in health care waste annually. Berwick and Hackbarth (2012) added that health care waste through a lack of care coordination is reported to be among the top five most costly form of waste in the United States annually. Decreased health care waste is a realistic and ethical way of improving the health care system with an estimated target of about 4% annual reduction (Berwick & Hackbarth, 2012).

Kelley (2009) reported that the U.S. health care system lacks coordination of care, resulting in $25-50 billion dollars a year in waste .The Institute of Medicine also claimed that a lack of collaboration among health care professionals leads to errors, and 44,000 to 98,000 people die annually from hospital medical errors (as cited in Manning, 2014). Huseman (2012) asserted that relational intelligence helps leaders to think and work with others better and, as such, the competitive advantage especially in health care cannot be focus only on knowledge and technology anymore but now need to look at relationships.

Based on all the findings of this research and all the statistics reported in the studies above, the health care industry needs to implement collaboration between pharmacists and physicians as best as possible for patient care management in hospitals. To aid in that effort, leadership training and coaching for relational intelligence could be made mandatory for pharmacists and physicians. Rewards from the health care system through insurance companies such as better reimbursement to physicians and hospitals that excel in this effort and those that are non-compliant could be held accountable.

International Level

Other countries could use the relational intelligence model and coaching as a foundation for research in other areas of relationship building such as global health diplomacy, health education, and global health policies. Huseman (2012) added that how leaders relate to followers during each interaction can be translated into productivity. As well, Nahavandi (2009) affirmed that the lack of people's skills due to the inability to manage relationships is one of the root cause of failure.

Self-Reflection

As the key researcher in the study, it was very difficult for me to completely remove myself from the study because of my own experience. In fact during the interview process there were moments that I felt like some participants were sharing my experience. From another standpoint, I used to be the pharmacist that made many calls to physicians some of which were just minor but I had to do it so I could document that that call was made. I understood the gravity of the concern echoed by physicians about many calls from the pharmacy. Gadamer (1960/1998) emphasized that in hermeneutics the person seeking to understand a phenomenon must have an understanding of the subject

matter. Self-reflecting on my experience helped to prevent the edge of me injecting my experience in the study but I found it impossible to completely remove myself from the study. Gadamer (1998) viewed bracketing of thoughts completely impossible.

As a practitioner, I believe that leadership training can candidly shape the future of health care professionals. Pharmacists and physicians play a pivotal role in bringing about this change. Practitioners can be better molded for their roles as leaders and collaborators by formally incorporating leadership training, especially in the area of relational intelligence.

When I graduated as a pharmacist, I was under the impression that, as a medication expert, I get to make all the drug related decisions with physicians accepting my recommendation. When that was not the case when I started working at a hospital, I felt like my expertise was underutilized. I did not also feel like I was making a difference because performance evaluation really did not include measurable impact on quality care, cost, and performance. I honestly did not know or even understood the exact goals of the hospital other than that of providing patient care which entailed not making errors. I never even gave a thought to the cost of any medication when entering orders, neither do I remember ever making a recommendation to a physician based on cost. It just was not the culture in the pharmacy department at that time.

Most of the conversation with physicians were via phone, and I never felt the importance of maintaining a good relationship with physicians that I talked to via phone. However, every once in a while, I was asked to round in the ICU and how I related to the physicians and how they perceived my expertise was very important to me. As such, I responded to those physicians differently when they were on the phone.

I did not really enjoy the physician relationship with pharmacists because I felt that the physicians could say anything they wanted with impunity and there was really no place of authority for pharmacists. I then moved to retail and opened my own pharmacy with the goal of providing medication therapy management. The purpose was to be able to directly impact patients by closely monitoring their care. This experience broadened my understanding that good patient care was not just the quality of care but how much cost was involved in that process. Good financial stewardship when offering quality care became very important to me. I had overheads to take care of and employees to pay. I hired and kept only employees that shared in the mission and vision of my pharmacy. I learned the importance of being a good steward of an organization and it starts with clear understanding of the goals of that organization.

During this same period, I felt like I could do more. Being an avid reader, I decided to channel my readings towards acquiring a Ph.D. with the encouragement of my husband. I chose a self-designed program with my focus in leadership and public health with my dissertation in leadership because as a pharmacy school student, I was never exposed to any leadership class. My coursework in the program exposed me to lots of leadership ideas. When I got a job as Director of Pharmacy for a long-term acute care hospital, I started to apply some of the leadership concepts learned in the program and the difference was astounding.

I used some of the political influence perspective of upward influence as part of my interpersonal and social skills in relational intelligences, specifically ingratiation which encompassed the following behaviors towards physicians: praise, acting humble, politely asking, making physicians feel important, and being friendly (Borkowski, 2009).

When I started, I introduced myself by writing letters to physicians and letting them know that the pharmacy department was at their service and I gave them a beautiful pen with "Thank you, from pharmacy" engraved on them. This was an attempt to repair the sour relationship between the pharmacy department and physicians at that time. The ability to initiate relationship is a factor that enhances relational Intelligence.

After about 6 months later, I created a short survey that took about 2 minutes to complete. They had to score the pharmacy department in different areas from 1 to 5 and it had a section for general comments in areas of anticoagulation, vancomycin dosing, Aranesp dosing, etc. Any area that the pharmacy department scored 3 or less, a plan of action was developed, reviewed and approved by the Medical Director. I kept to my own part of the promise by making sure that the pharmacy department was truly at their service. I proactively communicated patient care issues with physicians and took responsibility for any medication related issues (trustworthiness: relational intelligence).

Survey Results

- The infectious disease physicians all gave my team either a 4/5 or 5/5.
- All nephrologists gave us a 5/5 in Aranesp dosing.
- Most physicians gave us 4/5 or 5/5 on Coumadin dosing. Two physicians however gave 3/5 because of specific reasons.
- Physicians gave us either a 4/5 or 5/5 on MAR clean up.

- Written on the comments section and expressed verbally was mostly their appreciation for being given the opportunity to rate the pharmacy department and to express themselves.

Action Plan

My goal was to develop an action plan on any category with 3 scores. Therefore, I immediately developed an action plan for Coumadin dosing based on the specific practice style of each physician all within the realm of our protocol. I shared my action plan with my Medical Director. After I received his blessings, I immediately implemented the action plan. In relational intelligence theory, this is being goal oriented.

Follow-Up

A month later, I went to each physician that gave us a 3/5 to find out how we were doing. They appreciated the fact that their opinion was taken into consideration and that we followed through on their concerns. These physicians were astound by the fact that I took their requests and opinion very seriously. This follow up and feedback aspect in the process really helped create a very tight bond with those individual physicians. In relational intelligence theory, this is a part of communication and feedback.

Physician Comments

The physicians took the time to write wonderful comments about the pharmacy team and added that they really like the level of collaboration that is shared between us. They commented on the fact that we follow through when any issue comes up and give feedback in a timely manner. In relational intelligence theory, this builds trust.

Not long, my antibiotics were discontinued on time and pharmacists/physicians relationship blossomed. To date, that relationship continues to grow by leaps and bounds.

I never compromise patient care because of cost and the physicians all know that about my practice style. During admission, the physicians okay my recommendations for substitutions and therapeutic interchanges 99% of the time (trust and dependability: relational intelligence).

What has really touched me the most was a situation that happened in which some patient care issue fell through the crack which was not necessarily pharmacy's fault. When the physician and I reviewed the chat, it was clear that the other department missed something in the care coordination. I still remember what the physician said looking directly into my eyes, "Liza, I don't trust the system but I trust you. That is why I transferred this patient to this LTAC in her condition." I had underestimated the level of trust some of these physicians had for me and my department. From then I understood that the reason why they agreed to almost all my admission recommendations was because they trusted implicitly that I will do the right thing not just for my interest but for their interest with quality care always a priority. That experience encouraged me even more to always be that second set of eyes for the physicians.

The other thing that I do on a consistent basis is make sure I try to tailor dosing parameters based on how each physician prefers their patients to be treated. We have four infectious disease physicians so it is a little more time consuming but the benefit of gaining their trust, respect, and collaboration is worth the time invested (willingness to be flexible to maintain long-term relationships: relational intelligence)**.**

I make sure that I personally review labs, charts, and medication list of all the patients in-house every Monday night. I make recommendations during interdisciplinary team meetings (IDT) to the physicians to switch from IV to PO, switch to less costly

antibiotics, MAR-clean up, and other suggestions. I strategically sit next to my Medical Director during IDT to get his opinion sometimes before asking a question. The sitting arrangement sends a powerful message to the physicians too which is a good picture of an in-house team work and it also helps inspire my confidence. I work closely with my Medical Director and set quarterly goals which I share with him and at P&T meetings. I set goals for my department and give to my CEO from time to time. I work closely with my Director of Infection control, all in addition of working with all my leadership team members (team work and confidence: relational intelligence)**.**

Additionally, the physicians have realized that I review the charts of all the patients religiously before IDT meetings. That knowledge adds to my credibility when I make recommendations during IDT to them. They have complimented me for following through with issues regarding their patients and always providing them with honest and timely feedback. Huseman (2012) emphasized that workplace trust is constructed by how competent, how caring and how dependable they are perceived overtime (trust and respect: relational intelligence).

During interdisciplinary team meetings, I make my contributions and recommendations without trying to come across like I am challenging the clinical judgment of any physician (manner of approach and knowledge of subject matter: relational intelligence). In fact, physicians see me as someone who has their back and with that I have gained their respect. The ripple effect is my recommendations are seldom questioned and my suggestions highly appreciated. They talk about me among themselves and now other specialists try to initiate a relationship with me (consistently respect hierarchy and treating others in a professional manner: relational intelligence).

“Thank You” Letters

I frequently write customized “Thank You” letters to physicians that follow policy or both physicians and pharmacists performed well together. For example, what is praised are physicians that do not write problematic prescriptions in a whole quarter, return pharmacy calls promptly, work with pharmacy in substituting medications for what we use in the hospital, not using many non-formulary medications, participate in MAR clean up, write indications, and stop date for antibiotics. In short, any physician that contributes to the success of the pharmacy department gets a customized letter every quarter acknowledging their specific input. The letter are signed by the DOP, the Medical Director, Director of Quality, and sometimes by the Director of Infectious Disease. In relational intelligence theory, this helps recognize physicians and other staff and make them feel as part of a winning team.

This simple gesture of a pen and a customized letter has enabled the pharmacy department to have things done but has actually brought smiles to the faces of many physicians. Some mentioned that the only time they receive a letter it is when they are being reprimanded. None of them ever mentioned receiving any form of acknowledgement. Now physicians look forward to receiving a letter after each P&T meeting based on their collaboration with pharmacy in various areas. Worthy to mention is the fact that all the physicians in the study who mentioned receiving some kind of acknowledgement from another hospital, received them from my hospitals’ pharmacy department. Just listening to them describe how positive that was to them almost brought tears to my eyes. It also gave me a deeper understanding of the importance of recognition

and acknowledgement among human beings regardless of their age, experience, specialty or whether they have reached the pinnacle of their career or not.

Physician Accountability

I usually save all problematic prescriptions from physicians. At the end of the quarter, I separate them and present them to the individual physician. I let them know politely where they stand compared to other physicians in issues in non-formulary requests and other areas. The physicians usually apologize to me immediately and I usually see a complete change in their prescribing habits by the next quarter. In relational intelligence theory, this practice holds others accountable for their actions.

None of the aforementioned will be half as smooth without the right pharmacy-physician relationship. The greatest milestone so far for me is gaining the respect and trust of the physicians. Relational intelligence is an amazing concept, and I am happy to be researching this concept further in my doctoral dissertation.

Overall Success Stories/Results of Implementing Relational Intelligence

Inventory

- Recognized for drastically decreasing inventory and staying consistently below budget compared to the previous 5 years.
- Even though my inventory is watched closely, medications are adequately stocked based on hospital need.

Collaboration with Nephrologists

- Historically, we have been in either the 3rd or 4th tier in Cathflo and Albumin usage for years in the whole corporation.

- In April 2014, collaboration with the nephrologist team started by my working with the CEO for some background information and working with my Medical Director to understand why we our facility used so much Cathflo and Albumin.
- Took time and went to another facility who used no albumin during dialysis and very few Cathflo.
- I sat through their Hemodialysis process and asked their staff questions. I also sat through a complete HD session in my facility and realized what we were doing wrong. This was an effort to understand what the best practice was in another similar hospital in the area.
- I had enough information to present to the nephrologists. Information was evidence based and there was a paradigm shift in practice.
- I had to intelligently win the support of each nephrologist, whom all usually have different opinions, by strategically applying different approaches to each physician. For example, I asked for their suggestions, ideas, and recommendations after presenting our usage report and findings to them.

Results from Collaborating with Nephrologists

- Program went effective June 2014 by the 4th quarter (Dec 2014).
- Cathflo, Aranesp and Albumin that were consistently in the top 10 drug costs were completely off top 15 drug costs with huge cost savings noted.

Antibiotic Stewardship

- Recognized at the end of 2013 by Pharmacy V.P. and President as being among the most improved pharmacy department in the corporation in antibiotic stewardship.
- Moved from bottom tier to 1st tier in antibiotic stewardship for the first time in 5 years and stayed in 1st tier (June 2013 and December 2013).

Discrepancies in Results

- Results of antibiotic stewardship 2014 summary showed that we dropped to 2nd tier, which was very disappointing to me.
- Close examination showed that when I ever I took a long vacation, pharmacists collaboration with infectious disease doctors plummeted and antibiotics usage and cost increased.

2015 Goal

- My goal this year was to have even my contingent pharmacists learn my approach towards all the physicians. I decided not to take a vacation for six months so I could work hard to apply all the skills mentioned above consistently.
- Results were we bounced back to 1st tier in antibiotic stewardship and cumulatively below budget in the six months period from January through June 2015.
- My pharmacy department was recently noted to score 100% in the area of inventory/purchase and finances during an internal corporate pharmacy audit. It

was also noted that my hospital had a phenomenal physician/pharmacy relationship.

Quality Care

For 2014, special praises were given by the Director of Infectious Disease to the pharmacy department for not putting patients in renal failure. All the infectious disease physicians praised the great collaboration between pharmacists and physicians. In relational intelligence theory, the areas of initiating and maintaining long term relationships (manner of approach, knowledge of what is going on, accepting responsibility when issues arise, respectfully holding physicians accountable and providing timely feedback) are important and were consistently implemented.

An infectious disease physician even stated that this is the first time in all the years he has been with this particular hospital that he goes home not worrying about how his patients are being managed, particularly if whether his patients will end up in acute renal failure. In relational intelligence theory, this is a good example of trust.

Final Thoughts

I know without equivocation that relational intelligence has been key to my career success as a pharmacist. This is because when pharmacists nurture the right relationship with physicians, the physicians respond positively and collaboration and outcomes become better. Like the Apostle Paul became all things to all men in order to win them to Christ and by so doing he benefited or shared in the blessings (1 Cor. 9:19-23 New International Version).

It is for the aforementioned reasons that I made a conscientious decision to explore in my dissertation the role and potential opportunity to promote relational

intelligence as a critical leadership skill in pharmacists' collaboration with physicians in the hospital.

Conclusion

Based on the study, using relational intelligence as a leadership skill between pharmacists and physicians in the hospital is needed for collaboration. Pharmacists and physicians (a) desire physicians and pharmacists to interact face-to-face daily, (b) require appropriate leadership training, (c) need a leadership coaching program that meets up with the goals of the hospital, (d) need clear communication of goals and expectations between pharmacists and physicians, (e) need collaborative accountability and feedback on issues and performance, (f) need incentives and acknowledgment for performance and other initiatives, (g) need resources or the initiative to have pharmacists rounding with physicians and medical residents daily in all the units, (h) need more socialization between pharmacists and physicians, (i) need to be informed on what their input has on cost containments efforts and quality care, (j) need quality improvements and cost containment initiatives such as competition in antibiotics stewardship with other hospitals in the health system (k) need a leadership position directed by a practitioner with a PhD and expertise in RQ that focuses specifically on pharmacist-physician collaboration , (l) need communication in detailing the goals of the hospital, (m) more utilization of the expertise of pharmacists, (n) seek less frustration from calls, and (o) seek clarification on how PharmD pharmacists should be addressed (p) need RQ leadership position directed by a practitioner (pharmacist or physician) with a PhD.

Pharmacists and physicians are very similar when it comes to their passion for providing patient care. They both have respect for each other, but they also need to

further develop their relationship management and leadership skills. The training and coaching of pharmacists and physicians on leadership strategies and relationship management skills could help bolster collaborative performance especially when face-to-face communication is regarded as an important aspect in this type of relationship.

Facilitating collaboration between pharmacists and physicians can help promote and implement present and future policies. Johnson (2009) defined leadership as a concept that predisposes individuals in key roles to do what they can do and how they can do it in order to achieve outcomes that are useful socially. Johnson supported the need for RQ as a leadership skill to be examined among pharmacists and physicians in hospitals. Relational intelligence in health care specifically can be defined Huseman (2014) as the propensity to use day-to-day dynamics within the context of collaboration to bring about an impact in cost effective care in health care. In health care, the central basis of an organization is based on interpersonal working relationship which can be assessed through employee engagement or collaboration. Oandasan et al. (2006) concluded that collaborative care is a joint decision making process based on communication with the common goal of providing satisfying quality care to the patient and at the same time respecting the unique abilities of each professional.

Implementing relational intelligence at the micro and macro level can be a catalyst for the U.S. health care system to promoting relationships, increasing performance, enhancing collaboration/teamwork, bringing more accountability, bettering employee retention, improving job satisfaction, and decreasing costs within health care organizations. Relational intelligence can be a new competitive advantage especially in

health care because how leaders relate to followers during each interaction can be translated in to productivity and other outcomes (Huseman, 2012). According to the U.S. Department of Health and Human Services (2015), improving health care in America is an important public health goal and it is recognized in the national public health initiative. Therefore, pharmacists and physicians working collaboratively can make a difference in the areas of cost and quality care outcomes.

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Appendix A

Letter of Cooperation

ST. JOSEPH MERCY OAKLAND
SAINT JOSEPH MERCY HEALTH SYSTEM

44405 Woodward Avenue
Pontiac, Michigan 48341
P: 248-858-3000
stjoesoakland.org

May 11, 2015

Elizabeth Ekole, PharmD
St. Joseph Mercy Oakland
44405 Woodward Ave.
Pontiac, MI 48341

RE: Relational Intelligence: A Framework for Interprofessional Collaborative, SJMO 15-05-43

Dear Principal Investigator:

The St. Joseph Mercy Oakland Institutional Review Board/Research Committee reviewed your request for new protocol cited above at the May 11, 2015 IRB/RC meeting.

Please be aware that you should report to the committee concerning this project when you are completed with it, or when it is due for renewal or closure. You must also submit a summary of the study progress for protocol renewal within 11 months, or at the conclusion of the study if the study is concluded prior to the renewal date April 10, 2016.

Should you wish to make any further changes in your protocol, the Institutional Review Board/Research Committee must approve the changes before they are implemented. Principal Investigators are required to promptly report to the IRB all communication concerning his/her study from outside sources, such as FDA, Michigan Department of Community Health, other governmental agencies and recognized medical literature. In the case of revisions, the changes between the new and the old protocol should be submitted in detail and the pertinent areas of the changes highlighted to facilitate review by the Research Office and Chair of the IRB/RC. Should you develop abstracts, posters, or manuscripts involving the hospital, or using of the hospital's name in any way related to this work, please be aware that IRB/RC policy is that such submissions must be conveyed to the IRB Office for review at least one week prior to submission.

Sincerely,

5/13/15

Sherwin Imlay, M.D.
IRB Chairman

SJMO IRB/RC
APPROVED

MAY 11 2015

Appendix B

Question Guide for Pharmacist/Physician Interviews

Access Question:

What has been your relationship experience working collaboratively with pharmacists /physicians?

1) How do you as a pharmacist/physician initiate a professional collaborative relationship with physicians/pharmacists? How important is it for you to maintain this long term relationship with a physician/pharmacist?
2) How do pharmacists/physicians perceive being flexible in their professional collaborative practices in order to maintain a long term relationship with physicians/pharmacists? Can you elaborate with some examples please?
3) Please share your experiences on instances that you asked for suggestions or recommendations from pharmacists/physicians face-to-face.
4) Please share your experiences on instances that you asked for suggestions or recommendations from pharmacists/physicians via telephone. What were some challenges you encountered during these types of interactions compared to the face-to-face encounter?
5) How do you hold yourself accountable for performance issues related to collaboration when providing patient care?
6) How do you hold pharmacists/physicians accountable for performance issues related to collaboration when providing patient care? Please elaborate further.

7) Can you describe how you respond when your clinical judgement is under question by a pharmacist/physician?
8) How do you communicate patient care concerns involving pharmacists/physicians?
9) What does it take for you to trust the recommendations of pharmacists/physicians?
10) Can you explain what it takes for a pharmacist/physician to earn your respect?
11) How are you addressed in the hospital by pharmacists/physicians? What should be the proper way of addressing you in a professional work environment? How does it affect your confidence level when collaborating with physicians/pharmacists?
12) How important is it for you to make pharmacists/physicians feel as part of a winning team. Elaborate further please.
13) In your opinion, what will it take for a pharmacist or physician to collaborate effectively with physicians/pharmacists when providing patient care?

Reference

Huseman, R. (2012). *Relational intelligence: The new smart*. Florida: Equity Press.

Appendix C

Demographics of Participants

Pseudonym _____

Age range (< 18, 18 – 40, 41-65, >65) _____

Highest Level of Education _____

Language _____

Ethnicity _____

Type of Licensure _____

Current occupation _____

Area of Specialty _____

Number of Years Working at a Hospital _____

Number of Years Working for St. Joseph Mercy Oakland _____

List Leadership Training Courses or Programs (If Applicable)_____

Appendix D

Letter to Participants

March 31, 2015

Hello,

I am a doctoral student in health sciences specializing in Leadership and Public Health at Walden University. I am writing my dissertation to explore how pharmacists and physicians in the hospital perceive relational intelligence as a leadership skill in working collaboratively with each other. Fostering collaboration through relational intelligence could lead to a better understanding of what leadership skills can be included in the training of professionals.

I believe it is crucial for health care professionals to understand how to relate to each other intelligently and what it takes to initiate and maintain long-term professional relationships that may promote positive outcomes such as decreased health care cost, improve quality care, and improve performance.

I will be contacting you by phone within a week to determine if you agree/decline my request for a face-to-face confidential interview with you. The interview will be focused on prepared research questions relating to collaboration between pharmacists and physicians. A pseudonym will be used for you to help maintain confidentiality of information shared during the interview. Once the research is completed, you will receive a copy of my research conclusion.

Elizabeth Ekole

Appendix E

Transcriber Confidentiality Agreement

Name of Signer: Emmanuel Lucio

During the course of my activity in collecting data for "Relational Intelligence: A Framework for Interprofessional Collaborative Care," I will have access to information, which is confidential and should not be disclosed. I acknowledge that the information must remain confidential, and that improper disclosure of confidential information can be damaging to the participant.

By signing this confidentiality agreement, I acknowledge and agree that:

1. I will not disclose or discuss any confidential information with others, including friends or family.
2. I will not in any way divulge, copy, release, sell, loan, alter or destroy any confidential information, except as properly authorized.
3. I will not discuss confidential information where others can overhear the conversation. I understand that it is not acceptable to discuss confidential information even if the participant's name is not used.
4. I will not make any unauthorized transmissions, inquiries, modification or purging of confidential information.
5. I agree that my obligations under this agreement will continue after termination of the job that I will perform.
6. I understand that violation of this agreement will have legal implications.

7. I will only access or use systems or devices I am officially authorized to access and I will not demonstrate the operation or function of systems or devices to unauthorized individuals.

Signing this document, I acknowledge that I have read the agreement and I agree to comply with all the terms and conditions stated above.

Signee: Emmanuel Lucio Date: 3/30/2015

Appendix F

Editor Confidentiality Agreement

Confidentiality Agreement

This Agreement is entered into this 16 day of March, 2015 by and between Elizabeth Ekole, Author/ Discloser, and Sherry Wynn Perdue, WriteSpace Consulting, Editor/Recipient.

WHEREAS Discloser possesses certain ideas and information relating to her Dissertation that are confidential and proprietary to Discloser (hereinafter "Confidential Information"); and

WHEREAS the Recipient is willing to receive disclosure of the Confidential Information pursuant to the terms of this Agreement for the purpose of editing a Dissertation;

NOW THEREFORE, in consideration for the mutual undertakings of the Discloser and the Recipient under this Agreement, the parties agree as follows:

1. Disclosure. Discloser agrees to disclose and Receiver agrees to receive the Confidential Information.

2. Confidentiality.

2.1 **No Use**. Recipient agrees not to use the Confidential Information in any way or to manufacture or test any product embodying Confidential Information, except for the purpose set forth above.

2.2 **No Disclosure**. Recipient agrees to use its best efforts to prevent and protect the Confidential Information, or any part thereof, from disclosure to any person other than Recipient's employees having a need for disclosure in connection with Recipient's authorized use of the Confidential Information.

2.3 **Protection of Secrecy**. Recipient agrees to take all steps reasonably necessary to protect the secrecy of the Confidential Information and to prevent the Confidential Information from falling into the public domain or into the possession of unauthorized persons.

3. **Limits on Confidential Information**. Confidential Information shall not be deemed proprietary and the Recipient shall have no obligation with respect to such information where the information:

(a) was known to Recipient prior to receiving any of the Confidential Information from Discloser;

(b) has become publicly known through no wrongful act of Recipient;

(c) was received by Recipient without breach of this Agreement from a third party without restriction as to the use and disclosure of the information;

(d) was independently developed by Recipient without use of the Confidential Information; or

(e) was ordered to be publicly released by the requirement of a government agency.

4. **Ownership of Confidential Information.** Recipient agrees that all Confidential Information shall remain the property of Discloser and that Discloser may use such Confidential Information for any purpose without obligation to Recipient. Nothing contained herein shall be construed as granting or implying any transfer of rights to Recipient in the Confidential Information or any patents or other intellectual property protecting or relating to the Confidential Information.

5. **Term and Termination.** The obligations of this Agreement shall be continuing until the Confidential Information disclosed to Recipient is no longer confidential. Once the Recipient finishes editing the Dissertation, she will remove it from her email and will not use it as an example for any other clients unless given the explicit consent of the Discloser.

RECIPIENT: Sherry Wynn Perdue, Proprietor, WriteSpace Consulting

Signature: Sherry Wynn Perdue

Date: March 16, 2015

Appendix G

Consent Form

You are invited to take part in a research study to explore the lived experience on how pharmacists and physicians in the hospital perceive relational intelligence as a leadership skill in working collaboratively with each other.

You have been selected to be in the study because you work for a long term acute care hospital in Michigan, and you are a pharmacist or a physician. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by Elizabeth A. Ekole who is a doctoral student at Walden University. This study is completely separate from my current role as Director of pharmacist at my hospital.

Background Information:

The purpose of this study is to examine the lived experiences of how pharmacists and physicians collaborate with each other using Relational Intelligence as a Leadership skill. According to Health Affairs (2012), a lack of health care coordination in the United States is influenced by fragmented care due to a lack of interdisciplinary collaboration, which is a leadership skill. In addition, 31% of total health care spending amounting to $2.5 trillion dollars was due to excess cost including unnecessary services, missed prevention opportunities, and inefficiently delivered care (as cited by Reinhardt, 2013). Kutz (2012) found that leadership promotes the survival, longevity, and quality of care in U.S health care. Hojat et al. (2012) concluded that teamwork and interdisciplinary, interprofessional collaboration can lead to clinical outcomes that are optimal. The

Institute of Medicine also claimed that a lack of collaboration among health care professionals leads to errors, and 44,000 to 98,000 people die annually from hospital medical errors (as cited in Manning, 2014).

According to Huseman (2012), more is expected from health care leaders with decreased budgets; as such, relational intelligence may provide the insight to effective leadership in health care organizations. In the health care context, relational intelligence can be defined as the propensity to use day-to-day dynamics within the context of collaboration to bring about an impact in cost effectiveness and overall performance. Relational intelligence is an offspring of emotional intelligence in the areas of empathy and interpersonal skills.

Procedures:

If you agree to be in this study, you will be asked to: explain your perspectives in a 30–60 minutes face–to-face digitally recorded interview. Transcripts of the interview will be reviewed with you for accuracy. An interview will be scheduled at a time and place of your convenience preferably a private room in the physician lounge or at a convenient private location. A follow up preferably via phone will be determined after my data analysis.

Sample Questions:

What has been your relationship experience working collaboratively with pharmacists/physicians?

How do you as a pharmacist/physician initiate a professional collaborative relationship with physicians/pharmacists?

How important is it for you to maintain this long term relationship with a

physician/pharmacist?

Voluntary Nature of the Study:

This study is voluntary. No compensation will be offered by SJMO Corporation to participants and interviews will not be conducted during scheduled working hours. Everyone will respect your decision of whether or not you choose to be in the study. No one at SJMO will treat you differently if you decide not to be in the study. If you decide to join the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as the anecdotes that you tell maybe recognized by others. I will use pseudonyms for you and your hospital. All taped interviews and transcripts will be locked up in my home office for your protection. Second, an inaccurate portrayal of a participants or a situation may cause discomfort or stress. You will be provided a copy of the transcript to validate accuracy. Being in this study would not pose risk to your safety or wellbeing and you may withdraw from the study at any time and have your data destroyed.

This study may provide a better understanding and awareness of the barriers involved in interprofessional collaboration between physicians and pharmacists.

Payment:

As a thank you gift for your participation, a $30 restaurant gift card will be given to you which can be used to purchase a meal at your restaurant of choice.

Privacy:

Any information you provide will be kept confidential. The researcher will not

use your personal information for any purposes outside of this research project. Also, the researcher will not include your name or anything else that could identify you in the study reports. Data will be kept in a locked cabinet in my home office. Digital recording will be saved on a password protected drive and locked up too. Pseudonyms will be used throughout this research to help protect the identity of the participants and their hospitals. Confidential information will not be shared with anyone outside of the dissertation committee.

Confidentiality agreement will be required for anyone else that will see the analysis during the process such as the proof reader or editor. Data will be kept for a period of at least 5 years, as required by the university.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via 248-520-6667 and elizabeth.ekole@waldenu.edu. If you want to talk privately about your rights as a participant, you can call Dr. Leilani Endicott. She is the Walden University representative who can discuss this with you. Her phone number is 612-312-1210.

Walden University's approval number for this study is **07-01-15-0295326** and it expires on **June 30, 2016.** **You will be given a copy of this form to keep for your records.**

Statement of Consent:

I have read the above information and I feel I understand the study well enough to make a decision about my involvement. By signing below, I understand that I am agreeing to the terms described above.

Printed Name of Participant _____

Date of Consent _____

Participant's Signature _____

Researcher's Signature _____

Appendix H

Pilot Study Question Guide for Pharmacist/Physician Interviews

Access Question:

What has been your relationship experience working collaboratively with pharmacists /physicians?

1) How do you as a pharmacist/physician initiate a professional collaborative relationship with physicians/pharmacists? How important is it for you to maintain this long term relationship with a physician/pharmacist?
2) How do pharmacists/physicians perceive being flexible in their professional collaborative practices in order to maintain a long term relationship with physicians/pharmacists? Can you elaborate with some examples please?
3) Please share your experiences on instances that you asked for suggestions or recommendations from pharmacists/physicians face-to-face.
4) Please share your experiences on instances that you asked for suggestions or recommendations from pharmacists/physicians via telephone. What were some challenges you encountered during these types of interactions compared to the face-to-face encounter?
5) How do you hold yourself accountable for performance issues related to collaboration when providing patient care?
6) How do you hold pharmacists/physicians accountable for performance issues related to collaboration when providing patient care? Please elaborate further.
7) Can you describe how you respond when your clinical judgement is under question by a pharmacist/physician?

8) How do you communicate patient care concerns involving pharmacists/physicians?
9) What does it take for you to trust the recommendations of pharmacists/physicians?
10) Can you explain what it takes for a pharmacist/physician to earn your respect?
11) How are you addressed in the hospital by pharmacists/physicians? What should be the proper way of addressing you in a professional work environment? How does it affect your confidence level when collaborating with physicians/pharmacists?
12) How important is it for you to make pharmacists/physicians feel as part of a winning team? Elaborate further please.
13) In your opinion, what will it take for a pharmacist or physician to collaborate effectively with physicians/pharmacists when providing patient care

Reference

Huseman, R. (2012). *Relational intelligence: The new smart*. Florida: Equity Press.

Appendix I

Leadership and Relational Intelligence Audit Permission

EXECUTIVE DEVELOPMENT & EDUCATION
A RICHARD C. HUSEMAN COMPANY

March 4, 2015

Elizabeth Ekole
Walden University
100 Washington Avenue South
Suite 900
Minneapolis, Minnesota 55401

Re: Use of The Leadership & Relational Intelligence® Audit

Dear Elizabeth:

Please allow this letter to serve as written authorization for Elizabeth Ekole to utilize my copyrighted and trademarked leadership assessment instrument – **The Leadership & Relational Intelligence® Audit** – for her dissertation with Walden University.

Elizabeth may use the instrument in part or as a whole, whichever works best for her dissertation needs. This authorization to use **The Leadership & Relational Intelligence® Audit** is for Elizabeth Ekole only, and shall only apply to her dissertation work.

Sincerely,

Richard C. Huseman, Ph.D.
Founder/CEO

670 West Palm Valley Drive
Suite 100
Oviedo, Florida 32765-9215
Office: 407.365.9686
Fax: 407.365.9392
www.richardchuseman.com