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# Good to Great: Using 360-Degree Feedback to Improve Physician Emotional Intelligence

*Milton E. Hammerly, MD, MNDR, market medical director, Peoples Health, New Orleans, Louisiana; Larry Harmon, PhD, voluntary associate professor, Department of Psychiatry and Behavioral Sciences, Miller School of Medicine, University of Miami, Florida; and Steven D. Schwaitzberg, MD, professor of surgery, Harvard Medical School, and chief of surgery, Cambridge Health Alliance, Cambridge, Massachusetts*

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## EXECUTIVE SUMMARY

The past decade has seen intense interest and dramatic change in how hospitals and physician organizations review physician behaviors. The characteristics of successful physicians extend past their technical and cognitive skills. Two of the six core clinical competencies (professionalism and interpersonal/communication skills) endorsed by the Accreditation Council for Graduate Medical Education, the American Board of Medical Specialties, and The Joint Commission require physicians to succeed in measures associated with emotional intelligence (EI). Using 360-degree anonymous feedback surveys to screen for improvement opportunities in these two core competencies enables organizations to selectively offer education to further develop physician EI. Incorporating routine use of these tools and interventions into ongoing professional practice evaluation and focused professional practice evaluation processes may be a cost-effective strategy for preventing disruptive behaviors and increasing the likelihood of success when transitioning to an employed practice model. On the basis of a literature review, we determined that physician EI plays a key role in leadership; teamwork; and clinical, financial, and organizational outcomes. This finding has significant implications for healthcare executives seeking to enhance physician alignment and transition to a team-based delivery model.

For more information about the concepts in this article, contact Dr. Hammerly at [milton.hammerly@peopleshealth.com](mailto:milton.hammerly@peopleshealth.com).

## INTRODUCTION

Emotional intelligence (EI), which affects the physician core competencies of professionalism and interpersonal/communication skills, can be defined as effectively understanding oneself and others, relating well to people, and adapting to and coping with the immediate surroundings to be more successful in dealing with environmental demands (Bar-On, 2006). Unlike IQ (intelligence quotient), which measures cognitive aspects of intelligence relatively unaffected by training, EI can increase significantly with education to raise emotional awareness and management skills (Cherniss, Extein, Goleman, & Weissberg, 2006). While physicians as a group tend to have high IQs (Hauser, 2002), insufficient attention to EI training during undergraduate, medical, and postgraduate education may limit the ability of some physicians to handle the many challenging interpersonal relationships and stressful career demands.

Since physician training occurs primarily in homogenous silos, success in shifting to delivering care in a collaborative, team-based model (which could feel like being a “cog in the machine”) requires a healthy measure of EI. Investments in screening and improving the EI of physicians can enhance their effectiveness in providing healthcare. In addition, there has been an accelerating trend in recent years away from independent status (private practice) and toward employed status, which represents a major cultural shift. Employing physicians does not ensure organizational alignment—particularly if they have difficulty adapting to the new cultural environment. This article offers

a rationale to justify, and guidelines to optimize, investments in physician emotional intelligence.

## EI AND THE SIX CORE CLINICAL COMPETENCIES

The American Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) identified six core competencies in 1999: medical knowledge, patient care, practice-based learning, systems-based practice, professionalism, and interpersonal/communication skills. ABMS requires that these be assessed, documented, and incorporated into the process of maintaining certification. In 2008, The Joint Commission also adopted the six core competencies and required their use in the process of ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) for purposes of reappointment. The core competencies of professionalism and interpersonal/communication skills require effective EI, which has four basic elements: self-awareness, self-management, social (“other”) awareness, and relationship management (Goleman, 2002). One challenge for medical centers has been to find a practical methodology to measure professionalism and interpersonal/communication skills and, if there are deficits, to improve these skills.

Medical executive committees across the United States have created a code of conduct to define their acceptable behavioral standards. When a physician has received a specified number of significant behavioral or professionalism complaints, leadership presents

these issues to the offender, usually in an anonymous and often unstructured manner, commonly creating resistance, defensiveness, and denial (Lapenta, Harmon, & Beldin, 2011). When presented with behavioral complaints, physicians frequently insist on being told the identity of the complainant(s) or the specific incident(s), from which complainants could be easily identified. While “confronting your accuser” is expected in a court of law, healthcare institutions have a duty to protect the reporter from any potential retaliation. Given the adversarial dynamics often engendered by this approach, it is appropriate to ask if there are ways to provide physicians with useful behavioral feedback sooner (before major problems or incidents occur) and in a fashion that is developmental and, therefore, more easily embraced (Lapenta et al., 2011).

### **ROLE OF 360-DEGREE FEEDBACK**

Outside of healthcare, one type of program used to help improve EI and performance in management-level individuals is 360-degree surveys (Bratton, Dodd, & Brown, 2011; Sosik & Megerian, 1999). In the 360-degree survey process, an individual completes a self-assessment questionnaire. At the same time, multiple peers, colleagues, and team members—chosen by the individual and/or his or her leader—also are invited to anonymously answer an identical questionnaire regarding this same individual. A potential weakness in the 360-degree survey process is that an individual could (intentionally or unintentionally) skew the results by only

inviting participation from people who have a favorable opinion of the ratee. With this understanding, the leader’s ability to invite additional reviewers to participate helps ensure there is an adequately balanced and representative panel providing feedback.

Once the anonymous surveys are collected, the individual and his or her leader receive a summarized feedback report that compares self-perceptions with those of peers/colleagues/team members. The process of using 360-degree feedback enhances the individual’s awareness of others’ perceptions (social awareness) and provides important information that enables the person to self-improve. Enhanced social awareness informs self-awareness (creating greater alignment between the two), which in turn makes it possible to improve self-management and relationship management. Thus, 360-degree feedback can play a key role in improving EI for individuals with significant discrepancies between self-perception and others’ perceptions of the person.

Research has shown that leaders with greater self-awareness (as predicted by self-other agreement on 360-degree surveys) show higher EI scores (specifically in the self-efficacy and self-confidence components), which were significantly positively correlated with higher subordinate ratings of transformational leadership (Sosik & Megerian, 1999). Furthermore, overestimators (those who rate themselves more favorably than subordinates rate them) were found to score significantly lower in EI than underestimators (those who rate themselves less favorably than subordinates rate them) or good

estimators (those with ratings that are in agreement with subordinates) (Bratton et al., 2011). Staff members are more satisfied with their manager and their jobs when perceptions of the manager match the manager's self-perceptions. The most successful managers are *less* likely to inflate their self-ratings of leadership and performance (Alimo-Metcalfe, 1998).

For physicians, an evaluation of studies in which their self-rated assessments were compared with external observations found that "the preponderance of evidence suggests that physicians have a limited ability to accurately self-assess," and it recommended that "processes currently used to undertake professional development and evaluate competence may need to focus more on external assessment" (Davis et al., 2006, p. 1094).

The 360-degree process has been used successfully with a variety of survey tools designed for different purposes in diverse settings. In some cases, the survey questions may be entirely customized to the needs of a particular organization, while in others, standardized survey tools may be used, which offers the advantage of allowing a participant to receive nationally or specialty-benchmarked feedback. The important point is that, regardless of the survey questions used, the 360-degree feedback process provides a mechanism and an opportunity for improving EI. In this sense, the data captured from survey questions may be the main focus, and the improvement in EI is just an added benefit. Ideally, if an organization is intent on maximizing EI improvement, the survey questions would be designed

specifically to gather information about behaviors that demonstrate EI within that work setting or medical specialty.

### **360-Degree Survey Feedback With Physicians**

Even though 360-degree feedback has been used extensively in the management and business fields (Fleenor, Taylor, & Chappelow, 2008), its use in healthcare organizations is still relatively recent. The benefits over traditional methods make 360-degree survey feedback worth investigating: They are more objective and systematic, and the process of anonymizing and grouping responses into behavioral themes usually yields greater candidness and objectivity from colleagues and nurses (Lapenta et al., 2011).

A 360-degree survey tool has been developed, based on behaviors that demonstrate EI in the healthcare setting, to identify specific aspects of professionalism and interpersonal/communication skills that positively or negatively affect the healthcare team (Lapenta et al., 2011; Harmon & Lapenta, 2008; Mechaaber, Hernandez, Campo, Harmon, & O'Connell, 2011). Additionally, this tool provides a direct measure of self-awareness and allows for an indirect assessment of EI through self-other agreement on responses to numerous behavioral items. Two hospitals in Washington State using this tool, along with education and coaching in response to disruptive behaviors, have recently been able to document a significant reduction in disruptive behaviors and behavioral complaints (L. Harmon, personal communication, January 30, 2014). Although this tool

initially was used as part of an intervention to improve physician disruptive behaviors, it is increasingly employed to prevent problematic behaviors, reinforce positive behaviors, and develop all participating physicians' EI (the "good to great"). In addition to a particular physician completing the questionnaire, members of the healthcare team (including nurses, therapists, pharmacists, and other physicians) are invited by the physician and his or her supervisor to serve as reviewers and anonymously answer the same questionnaire regarding this particular physician's behaviors. The physician and his or her service chief both receive a summarized feedback report that compares self-perceptions with those of the healthcare team to identify opportunities for customized coaching.

The few studies done with physicians have revealed best practices to bolster the effectiveness of these programs:

1. Offer a clear and concise explanation of the purpose of the 360-degree evaluation (Sargeant, Mann, & Ferrier, 2005).
2. Ensure that the reviewer selection process is credible and transparent to the physicians (Sargeant et al., 2005).
3. Use the process for professional development purposes (Sargent et al., 2003).
4. Follow up the feedback with coaching, goal setting, training, and so forth.

When these prerequisites are met, physicians have shown excellent results

in response to 360-degree feedback, including improvements in interpersonal and communication skills, professionalism, self-awareness, leadership, and teamwork (Harmon & Lapenta, 2008).

Success with the 360-degree survey feedback for improving physician disruptive behaviors has prompted some forward-thinking healthcare organizations to start using these tools in a more proactive fashion. A number of community hospitals and major academic medical centers (e.g., Brigham and Women's Hospital, Massachusetts General Hospital, University of Michigan Health System) have been using automated software to efficiently administer a 360-degree survey for various departments in order to provide their physicians with feedback *before* significant complaints have occurred or worsened (Harmon & Lapenta, 2008). This validated survey tool has been used by more than 5,000 healthcare professionals, including more than 3,000 physicians, and has yielded more than 100,000 completed surveys. The survey measures interpersonally motivating and discouraging behaviors and determines how those behaviors affect others in the healthcare workplace (compared with a national normative database of about 1,000 physicians). The University of Miami Miller School of Medicine, for example, has been using a 360-degree survey for all its medical students for more than 5 years with effective results (Mechaber et al., 2011). In addition, the surgery departments at several of the hospitals affiliated with Harvard Medical School have been using an expanded 360-degree survey to assess all six

ACGME and ABMS core competencies and to provide feedback to physicians on how well they comply with their new surgery code of excellence (CRICO, 2011). While targeted interventions to improve physician EI have demonstrated improvements in professionalism, and while it intuitively makes sense that more widespread and preventive interventions would have a similar effect, this is still a relatively novel approach, and a rigorous analysis of the emerging data has not yet been published.

### **THE HEAVY COST OF PHYSICIAN DISRUPTIVE BEHAVIORS**

Since the early 2000s, research has highlighted the fact that healthcare organizations are facing a major problem due to physician disruptive behaviors (Cook, Green, & Topp, 2001; Rosenstein & O'Daniel, 2005). These behaviors have been tied to increased medical error rates, decreased nurse job satisfaction, and decreased nurse retention (Rosenstein, 2002). The Joint Commission has outlined several recommendations for dealing with physician disruptive behaviors, including the creation of policy for educating all staff on appropriate behavior, development of a behavioral feedback process, use of a surveillance system, and performance of interventions (Saxton, Hines, & Enriquez, 2009).

However, it is difficult to fulfill these recommendations because there is neither a standard definition of disruptive behavior nor a reliable and valid measure of these behaviors (Saxton et al., 2009). Many studies measure the frequency of verbal abuse experienced

by nurses but do not offer an effective way to manage or remediate it. With the extensively documented negative clinical, organizational, legal, and financial impacts of physician disruptive behaviors (Rosenstein, 2011; Johnson, 2009), it is clear that more effective prevention and mitigation strategies are needed. If disruptive behaviors can be remedied or, even better, prevented by interventions to improve EI, then we should routinely incorporate this feedback into the OPPE and FPPE process as a way to bolster professionalism and interpersonal/communication skills, teamwork and leadership skills, and even the overall culture of our healthcare organizations. Although the preventive benefits have not yet been proven, existing research correlating physician EI with improved outcomes makes this a very fertile area for process improvements as well as formal academic research.

### **The Business Case for Improving Physician EI**

Studies have linked higher physician EI to improved patient satisfaction (which can also be related to reduced medico-legal liability), improved adherence to treatment regimens, and improved clinical outcomes (Weng, Steed, et al., 2011; Coelho, 2012). Given that Hospital Consumer Assessment of Healthcare Providers and Systems scores and clinical outcomes are integral to the value-based purchasing (VBP) calculation used by the Centers for Medicare & Medicaid Services to determine reimbursement, an argument can be made that EI improves payments. With the emerging emphasis on population

health management and providers assuming financial risk, the effect of EI on improving patient adherence can be translated into dollars saved by avoiding disease progression that would require more expensive treatments. With research also suggesting that higher physician EI reduces medical errors, litigation, and provider burnout/turnover (Weng, Hung, et al., 2011; Higgins et al., 2004; Levinson, Roter, Mullooly, Dull, & Frankel, 1997), there are multiple ways that improved physician EI can reduce the costs of providing healthcare. Recent surveys documenting epidemic levels of physician burnout suggest a major opportunity for improvement (Shanafelt et al., 2012; Balch, Freischlag, & Shanafelt, 2009). As healthcare organizations employ more and more physicians to improve alignment, physician EI can be an important factor in the success of this integration strategy. An investment in routinely assessing physician EI and offering targeted interventions is quite small compared to the formidable costs of medical errors, litigation, and provider burnout/turnover.

Consider the following calculation (figures are based on certain assumptions; see the appendix at the end of the article): A healthcare organization employing 200 physicians makes an annual hypothetical investment of \$250 per 360-degree survey screening (screening investment [*SI*] = \$50,000). It spends \$2,000 apiece on an intervention, such as a remote education program or telephone coaching for the 10% of physicians with the greatest opportunity for improvement (intervention investment [*II*] = \$40,000), with repeat

screening held twice after the interventions (repeat screening investment [*RSI*] = \$10,000). The hospital's average annual medical error costs (*MEC*) are \$1,700,000 (\$8,500 per physician per year); its litigation-associated costs (*LAC*) are \$434,000 (1% of physicians per year incurring, on average, claim payments of \$217,000); and its physician turnover costs (*PTC*) are \$1,200,000 (4% annual turnover rate at a cost of \$150,000 per position).

Therefore,

$$SI + II + RSI = \$100,000 \text{ } TEII \quad \text{and} \\ MEC + LAC + PTC = \$3,334,000 \text{ } TAC$$

where *TEII* is total emotional intelligence investment, and *TAC* is total avoidable costs.

With the conservative numbers used in this scenario (all avoidable cost assumptions are less than 50% of the evidence/literature-based estimates), *TEII* completely pays for itself if it reduces *TAC* by only 3%. If physician EI screening and intervention have an impact of only 6% on *TAC*, the return on investment (ROI) will be 100%. While many other factors can influence *TAC* (as defined for the purposes of this discussion), a review of the literature on EI in healthcare suggests the impact could be significantly higher than 6%.

The basic calculations above do not include potential gains in VBP payments or population health management savings (driven by improved patient satisfaction, adherence, and outcomes). Avoidable costs of nursing turnover also are excluded. Similarly, organizational time devoted to dealing with disruptive behaviors (time filling out, reviewing, investigating, and discussing incident



reports; medical executive committee time; and other meeting time) is not factored in. If, for instance, 500 hours are spent per year managing disruptive behaviors, at \$100 per hour, this amounts to \$50,000 per year. Although a significant number, this is small in magnitude relative to the other avoidable cost variables, and the overall impact on the ROI calculation is small. It's worth acknowledging and understanding the different variables affected by disruptive behaviors, but, for purposes of illustration and persuasion, there are advantages to keeping the calculation fairly simple. An easily explainable and defensible calculation tends to get more buy-in and support than one that is overly complex.

A potential offsetting factor is the ongoing investment already being made in programs to comply with OPPE and FPPE requirements. If *TEII* is fully and seamlessly integrated with strategies for OPPE/FPPE compliance, minimal incremental investments may be needed. The book *Quality Is Free* (Crosby, 1979), though not specific to healthcare, championed the business case for quality and "doing it right the first time." Many principles from Crosby's book have been embraced in healthcare, and investments to proactively screen and improve physician EI are very consistent with the principles espoused by Crosby. Convincing one's organization that investing in physician EI assessment and improvement opportunities is free will likely generate vigorous discussions requiring concrete metrics, historical trends/baselines, and testable assumptions. Although physician EI metrics may be debated, healthcare executives

certainly know poor EI when they see it, as they often spend a disproportionate amount of time and effort resolving problems caused by this deficit.

### **Guidelines for Maximizing Emotional Intelligence ROI**

Making the business case for investing in physician EI must include determining how an organization will measure the impact and how it will test all assumptions. Shorter-term process metrics could include the number of physicians screened and the number and type of interventions offered. Physicians' scores on the 360-degree feedback survey could be correlated with measures of patient satisfaction (Consumer Assessment of Healthcare Providers and Systems Clinician & Group Surveys measures), patient and staff complaints, adverse events, and clinical performance. Intermediate outcome metrics should include increases in 360-degree screening scores over time and decreased rates of both behavioral and technical complaints. Given the random variation seen in metrics, using process behavior charts and moving range charts with calculated limits can help filter out noise and determine if observed changes are truly signaling a change in processes attributable to the intervention (Wheeler, 2000). Longer-term outcomes, though influenced by other variables, could include fewer malpractice events, reduced litigation and costs of medical errors, and less physician and staff turnover. Since it takes longer to accumulate enough data on events that occur infrequently, the ability to pool data from multiple organizations can be helpful.

Physician resistance can be minimized by integrating a 360-degree assessment tool into the OPPE process to routinely and proactively support professional development and quality improvement across entire departments or medical staffs. In contrast to the defensive and adversarial dynamics seen with an approach driven by incident-based complaints, this type of feedback can be more easily embraced. Engaging clinical leaders and stakeholders in adoption of the most appropriate tool and methodology makes it much easier to defend if objections are raised. Physicians will be less likely to push back if they have had some input into the process, a validated tool is used, and the data have a high degree of credibility.

The 360-degree feedback reports should be delivered privately to the physician by a coach and/or physician-leader trained in conducting 360-degree feedback debriefings, and they should sensitively balance communicating *both* strengths and opportunities for development. The 360-degree feedback should show how the physician's score compares with that of other physicians. One useful way to do this is to highlight outlying scores on the feedback report in red and relatively favorable results in green. A more effective approach is to provide the physician with his or her rank or a deidentified scatterplot of how the provider compares with the rest of the group (or specialty norms, if available). The most important step is raising self-awareness through sharing of the feedback results. The vast majority of physicians score quite favorably and value the positive feedback and

recognition that the feedback conveys. For the physician who scores poorly, it can be helpful to redefine this as an opportunity for development and to remind the physician that those who score poorly often show the greatest improvement in the follow-up surveys.

Based on the 360-degree feedback, the debriefer should help the physician set quality improvement goals, provide EI self-study modules to achieve those goals, and schedule periodic reminders to maintain motivation. Physicians scoring in outlying ranges and/or who have significant incident reports may be required to complete a more structured program that, in addition to the aforementioned interventions, includes formal goal setting, educational assignments, automated reminders, ongoing telephonic coaching, and frequent 360-degree survey follow-ups to monitor and reinforce improvement.

## CONCLUSION

To be successful as a physician, particularly in today's rapidly changing healthcare environment, requires both cognitive and emotional intelligence. Existing evidence suggests that investing in 360-degree screening of physician EI and offering education and other developmental interventions, where appropriate, to improve EI may bolster the historically neglected core clinical competencies of professionalism and good interpersonal/communication skills. Thinking of OPPE/FPPE as just a regulatory requirement may result in missed quality improvement opportunities. Refining how we use OPPE/FPPE to assess and enhance professionalism and interpersonal/communication skills

(along with the other core competencies) can further leverage the value and impact of these developmental tools. In light of the considerable resources and efforts expended by healthcare organizations to improve physician alignment in evolving delivery models, it would be shortsighted to ignore a critical success factor for this strategy. Just as healthcare executives understand there is a business case for quality, they should also recognize there is a business case for investing in physician emotional intelligence.

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## ASSUMPTIONS APPENDIX

MEC: Medical error costs in the United States have been estimated at \$17.1 billion annually (Van Den Bos et al., 2011). In 2012, there were 878,194 licensed physicians in the United States (Young, Chaudry, Thomas, & Dugan, 2012). Dividing the number of licensed physicians into the medical error costs yields an estimated annual mean medical error cost per physician of \$19,472. The assumption of \$8,500 used in the hypothetical scenario is 44% of the evidence/literature-based estimate.

*LAC:* Analysis of malpractice data shows that 1.6% of physicians annually have a claim leading to a payment—with a mean payment of \$274,887 (Jena, Seabury, Lakdawalla, & Chandra, 2011). The hypothetical assumption of 1% of physicians annually incurring a claim of \$217,000 is 49% of the evidence/literature-based estimate.

*PTC:* The lowest employed physician turnover rate in the past few years has been 5.9% (Lowes, 2013), with estimated turnover costs for a family practice physician of \$236,383 (Buchbinder, Wilson, Melick, & Powe, 1999). The hypothetical assumption of a 4% turnover rate with a cost of \$150,000 per position is 43% of the evidence/literature-based estimate.

## PRACTITIONER APPLICATION

*Robert C. Keen, PhD, FACHE, president and CEO, and Becky J. Molnar, PhD, organizational development specialist, Hancock Regional Hospital, Greenfield, Indiana*

**A**s a new CEO for a medium-sized community hospital, one area of leadership I (RCK) was not prepared for was physician relations. I began to introduce the concept of patient satisfaction surveys and was amazed by the reaction of some physicians. One sat in my office for an hour pounding on the desk, screaming, and telling me I was encouraging people to complain. This physician was outstanding from a clinical perspective; however, the level of emotional intelligence he displayed was disappointing. Although I discussed his behavior with the hospital's medical executive committee (MEC), it was not until he "exploded" on the president of the medical staff that action was taken. When the MEC told the physician he would be required to attend anger management counseling, the physician chose not to follow the corrective plan and left our medical staff.

Four years ago, our vice president of medical staff services came to me with a "novel" concept. I was familiar with the use of 360-degree instruments in the business world but had not thought of using them in the development of medical staff. Initially, we considered administering 360-degree assessments primarily to disruptive physicians; however, our MEC came to believe that they would benefit all medical staff. While we experienced some pushback, our board endorsed the concept and our vice president of medical staff services carried out the assessment plan.

In today's world, where most physicians are employed and respected and where teamwork is key to the delivery of excellent healthcare services, we have found the use of a 360-degree instrument to be an integral tool for developing the emotional intelligence of our medical staff. While most physicians display a high level of clinical and technical competence and emotional intelligence, any organization will have a few physicians on staff whose emotional intelligence can be enhanced. Most of our physicians, after undergoing the 360-degree process, appreciate the data and information received and take feedback from peers and hospital associates seriously. Associates working with physicians appreciate the opportunity to give anonymous

feedback they may have wanted to provide for many years but were afraid to because of a threat of retribution.

We have noted three keys to success in using a 360-degree instrument for the development of medical staff. First, although we allow physicians to suggest names of individuals whom they would like to complete the various portions of the instrument, senior leadership reviews that list and adds names as appropriate to ensure that all team members who work with that physician on a regular basis have an opportunity to give feedback.

Second, we dedicated our organizational development specialist, who is trained to provide feedback to physicians, to help them establish a development plan. Physicians receive coaching for "red zone" behaviors, and improvement plans are developed with their input. Although quantitative data are important, our physicians gain the most value from the qualitative comments on improvement, positive feedback, and affirmation.

Third, we selected a neutral individual, who was committed to maintaining confidentiality, to work with the physicians during the debriefing process. This practice builds trust and allows the physician to openly communicate and discuss issues they otherwise might not want to address.

Given our experience, I highly recommend the 360-degree feedback process as a way to develop the medical staff in any hospital.