

Virtual Mentor

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Op-Ed

Does high EI (emotional intelligence) make better doctors?

by Peggy J. Wagner, PhD

Emotional intelligence (EI) is a theoretical construct that has mass appeal. First developed in the business world, EI is now viewed as an essential element for effective functioning in the market place [1]. The application of the five basic EI abilities—self-awareness, self-regulation, self-motivation, social awareness and social skills—to the practice of the art of medicine is intuitively sound and clearly applicable to the patient-physician relationship [2]. EI could be a key element in maximizing effective patient care and thus increasing patient satisfaction and clinical outcomes.

So are we ready to include EI in our selection criteria for future physicians? Six issues suggest that such inclusion may be premature. First, the current state of assessment of EI is not adequately developed, largely due to the continuing debate about the nature of its theoretical underpinnings. For example, is EI a form of intelligence that includes certain competencies? [3] Is it a cluster of skills and ability traits? [4] Or is it a group of learned capabilities that lead to outstanding performance in the workplace? [5] Each definition leads to different measurement techniques. In daily discourse, we often refer to EI, interpersonal skills and communication competencies similarly and yet they remain distinctly different in their application to the practice of medicine. Another problem with the measurement of EI is that most techniques rely heavily on self-reported data. Given that medical students are quite skilled in “presenting well” (in itself an EI skill), can we truly rely on self-reporting to identify those who are deficient in this area? As one can see, the definition and measurement of EI collapse into one another.

Second, since most measurement and theoretical approaches consider that EI itself reflects multiple dimensions, should we only consider the components or factors of EI that are most useful to the practice of medicine, for example, empathy, the ability to identify with the feelings of others? Could we as a field even reach consensus on what elements are most important in a medicine-specific EI concept? The work of Kasman and colleagues suggests that we should focus on the common emotional experiences and needs that physicians have [6]. Once we do this, perhaps we will be better equipped to identify the core emotional skills that are necessary to practice medicine.

Third, we need to understand the relationship between “technical” excellence and EI. We must consider whether by seeking out those with EI we would risk excluding persons with technical brilliance in the areas of clinical reasoning or knowledge acquisition and interpretation who have great potential to advance the field of medicine. Surely it is conceivable that the multiple aspects of intelligence are all essential to the growth of the field of medicine.

Next, EI is considered to be a more malleable construct or competency than IQ, which is thought to be relatively stable and fixed. If this is true, it might be more useful to provide effective training to raise learners’ EI to an appropriate level rather than to use EI measurement as a criterion for admission. More fundamentally we have to decide what *is* an appropriate level of EI. Is more better? One might ask whether too high an EI or “over-sensitivity” in some areas might actually function as a distraction from the effective practice of medicine.

Lewis et al present the intriguing notion that EI might be one competency among many that is essential in a team or working group [7]. These authors suggest that the most effective way to practice medicine is as part of a team with different members bringing different skills. Perhaps it is not the physician who needs the highest EI but another member of the team. Perhaps we should be constructing work groups that provide optimal levels of all elements of intelligence. Maybe it is rare to be both highly technically intelligent and highly emotionally intelligent. Are there enough of those folks to fill the applicant pool and meet the rising demand for physicians?

Finally, and perhaps most critically, there is little evidence that physicians with high EI scores have the best patient outcomes as measured in patient satisfaction and clinical outcomes. In some initial work, only the dimension of happiness from the Bar-On Emotional Quotient Inventory correlated with patient satisfaction [8]. The other factors did not. We will have to demonstrate that EI is relevant to these outcomes before we suggest that it become a critical screening admission criteria.

In sum, EI in its current state may be useful—at best—as an adjunct to the interview which remains subjective and yet is used for admission selection. The danger with quantifying EI and giving scores is that, as scientists, we are overly attracted to quantification and numbers. Perhaps we are better served to use our own EI to “sense” or “intuit” the appropriateness of the applicant.

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