Emotional Intelligence and Emotional Competencies for Medical Practitioners

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Abstract: Many definitions of emotional intelligence emerged in the medical literature beginning in the 2000s. Essentially, however, synthesis and simplification of these definitions led us to describe emotional intelligence as a complex set of emotions built on the components of knowledge, skills, attitudes, and competence as personal ability. This review supports the emotional intelligence construct as a complex but demonstrable integration of numerous related objectives, the latter being discrete measurable behaviors. Attainment of defined competencies helps reach a set goal, which is by definition lofty, vague, and far-reaching. The elements of emotional intelligence-based education are best understood when contrasted with the elements of the structure-and process-based system that pervades medical education today.
[S. Srividhya, G. Sharmila. **Emotional Intelligence and Emotional Competencies for Medical Practitioners.** *Life Sci J* 2013;10(9s):54-58] (ISSN:1097-8135). http://www.lifesciencesite.com. 7

Keywords: Emotional Intelligence; Emotional Competencie; Medical Practitioner

1. Introduction

In organizations, it is common to talk about how wisely people manage their emotions. Even so, it is often not obvious whether a particular act of emotion regulation is wise or unwise and, to date, research has provided little guidance to judge the wisdom of emotion regulation efforts. We develop a model that construes wise emotion regulation as a process that involves: (a) setting an effective emotion regulation goal, (b) choosing an appropriate strategy to achieve that goal, (c) implementing that strategy effectively, and (d) adapting emotion regulation over time. We also develop propositions linking emotional intelligence to wise emotion regulation. Finally, we discuss the implications of our model and propositions for research and practice.

Today's physicians continue to witness significant change in the nature of health care delivery. The roles of all health professionals, hospitals, patients, funding bodies, and governments are evolving at a hurried pace. Practice is changing daily, with literally thousands of medical journals documenting our evolving understanding of biological, social, and clinical sciences.

Patients are treated in more diversified settings. They spend less time in hospitals, and those who are there are older and sicker. We live in an era with a rising emphasis on accountability and a declining appreciation of professionals and various authorities. Never has the true nature of a physician been such at risk. The question reflects the "outcomes movement" in medical education. This is a renewed emphasis on preparation for practice, not for intellectual or medicine's sake, but for optimal outcomes for patients and society. More than a utilitarian philosophy, it involves "beginning with the end in mind". The process of identifying the core abilities involved translating the available evidence on effective practice into educationally useful elements. The result was a new multifaceted framework of physician competence that comprises numerous competencies. To be useful, these were organized thematically around "meta-competencies" or physician Roles. The practice of medicine in any discipline is a science as well as an art. Any educational framework that tries to capture this essence is by necessity organized around some arbitrary divisions. Education committees reported on evolving issues and trends in medical education. They highlighted their concerns with the new healthcare environment and offered suggestions for how physicians could best be prepared for it. They identified such forces as patient consumerism, government regulations, financial imperatives, medical information on the Internet, litigation, technology and the explosion in medical knowledge. The Fellowship reflected the concerns of contemporary medical literature. "Competencies"—important observable knowledge, skills and attitudes—were chosen as the central concept in planning medical education. Physicians possess a defined body of knowledge, clinical skills, procedural skills and professional attitudes, which are directed to effective patient-centered care. They apply these competencies to collect and

interpret information, make appropriate clinical decisions, and carry out diagnostic and therapeutic interventions. They do so within the boundaries of their discipline, personal expertise, the healthcare setting and the patient's preferences and context. Their care is characterized by up-to-date, ethical, and resource efficient clinical practice as well as with effective communication in partnership with patients, other health care providers and the community. The Role of Medical Expert is central to the function of physicians and draws on the competencies included in the Roles of Communicator, Collaborator, Manager, Health Advocate, Scholar and Professional. Physicians enable patient-centered therapeutic communication through shared decision making and effective dynamic interactions with patients, families, caregivers, other professionals, and other important individuals. The competencies of this Role are essential for establishing rapport and trust, formulating a diagnosis, delivering information, striving for mutual understanding, and facilitating a shared plan of care.

Poor communication can lead to undesired outcomes, and effective communication is critical for optimal patient outcomes. The application of these communication competencies and the nature of the doctor-patient relationship vary for different specialties and forms of medical practice.

2.THE EMERGENCE OF THE EMOTIONAL INTELLIGENCE

In addition to defining emotional intelligence-based education, early publications focused on the forces behind the paradigm shift and the process of curriculum development. The public demanded increased emotional competence, even in the professions previously immune to consumerism. Public health leaders called for emotional intelligence-based training, and sought a workforce equipped to handle the population's needs by emphasizing emotional intelligence in the context of the practice setting. Professional organizations, such as the American Dietetic Association and the State Board of Higher Education of the University of Illinois, joined this movement early, establishing guidelines and even edicts for the paradigm shift in the educational institutions over which they presided. These organizations prompted the implementation of several emotional intelligence-based programs ranging from small-scale projects, such as developing interview skills in residents, to large-scale endeavors, such as creating a emotional intelligence-based curriculum for first-year psychiatry residents, or a baccalaureate program for physical therapy students. The American Board of Pediatrics published one of the first comprehensive documents on this subject, entitled Foundations for Evaluating the Emotional intelligence of Pediatricians.

Having set the stage for the context in which emotional intelligence-based education developed, the stepwise approach to curricular design emerged as a consistent theme throughout the literature. The four steps are (1) emotional intelligence identification, (2) determination of emotional intelligence components and performance levels, (3) emotional intelligence evaluation, and (4) overall assessment of the process.

The second step involves determining emotional intelligence components and performance levels. The former includes tasks that, either sequentially or in sum, make up the emotional intelligence. These tasks are often referred to as benchmarks or performance indicators. They must be measurable and in the aggregate determine achievement of the specific emotional intelligence. Performance criteria set the threshold for demonstrating emotional competence. The expected performance level for each benchmark must be clearly defined to determine whether competence has been achieved. The educator must then determine the methods by which the emotional intelligence might be attained, such as through didactic learning, small-group discussions, or on-site experiences, or via information technology.

The third step determines how the attainment of emotional competence will be assessed. The challenge in medical education is to under-stand and identifies those emotional factors that help promote the development of effective skills, thereby allowing for the development of more effective curricula. Recently there have been demands to include training in EI in healthcare workers to improve leadership qualities, communication skills and prevent burnout, and stress. The EI abilities are building blocks that may allow students and residents to develop competence. The first step in applying an EI framework in medicine is successfully measuring EI in individuals.

While several studies furnished a practical description of the emotional intelligence-based curriculum development process, only one provided a comparison between an emotional intelligence-based curriculum and the traditional structure- and process-based one. A study from the nursing literature that evaluated participants of emotional intelligence-based workshops showed improvements in effectiveness and efficiency of specific skills.

Although the medical education process during the 1970s included generally defined competencies, corresponding curricular objectives or benchmarks to describe the emotional competencies were inadequate. Despite the prediction that

emotional intelligence-based education was an idea whose time seems to have come, the emotional intelligence movement of this era dwindled. The lack of a direct link between the desired competencies and curricular objectives, as well as inadequate assessment tools to evaluate competence, may have contributed to its demise.

3.THE LAST DECADE

The nursing literature shared the concern that emphasis on skill acquisition, which is more easily measured, may replace the development of necessary cognitive and critical thinking as well as the interpersonal skills needed for effective patient interaction.

4.PRESCRIPTION FOR THE FUTURE HEALTH AND WELL-BEING OF MEDICAL EDUCATION

Much descriptive work has defined emotional competencies and outlined processes that can be used in creating emotional intelligence-based curricula. Assessment tools to evaluate competence have received less attention. The creation of tools that are valid, reliable, and predictive of future success is our immediate challenge. Educators must take the lead in defining and studying the outcomes that result from this paradigm shift to emotional intelligence-based education with the same rigor we use in basic science laboratories and randomized clinical trials. Only then will we know whether emotional intelligence-based training produces more competent physicians, and whether the paradigm shift of the new century is as significant as the Flexnerian revolution of the last one.

Medical treatment is an essential part of recovery for many people and recovery values and principles have an important place in medical practice. All doctors may be involved in caring for those recovering from drug or alcohol use, but for some patients with more complex problems, doctors with more specialist skills and competencies are needed. The treatment of disorders related to drug and alcohol use is an internationally recognized area of medical specialism.

Doctors working to support recovery come from a variety of backgrounds (usually psychiatry and general practice), and have a range of different qualifications and specialist competencies. To satisfy regulatory requirements and to ensure the best outcomes for patients and to manage risk, doctors' competencies need to match their roles.

Specialist doctors are needed to treat the most complex patients, and also have key roles in clinical leadership – which comprises clinical governance and innovation, supervision, appraisal and training, and leading service development.

The Working Group identified three levels of competency for doctors caring for people using drugs or alcohol: generalist (e.g.doctors in emergency departments, general practitioners (GPs) working in general practice); intermediate (e.g. GPs with a special clinical interest (GPSIs)); and specialist (e.g. addiction psychiatrists). The competencies at each level are described in detail with higher levels of specialist competency needed to treat those with complex needs and to take clinical leadership roles. The specialist training for doctors working with drug and alcohol users with the greatest complexity of needs is a GMC-endorsed training in addictions psychiatry (formally known as substance misuse psychiatry, a subspecialty of general psychiatry).

The Working Group recognises that some GPs specialising in working with this patient group have, through their continuing professional development (CPD), achieved competencies which are broadly equivalent to this. Working Group's recommendations on the qualifications, training and experience required for safe and effective care at each level of competency.

The Working Group supports a proposal by the Royal College of General Practitioners (RCGP) by which doctors following an agreed programme of qualifications and experience, and who reach competencies described earlier, could be approved by the RCGP as 'primary care specialists in substance misuse'. Certificated, quality assured training is provided by RCGP, leading to competencies in a range of areas which are appropriate for intermediate doctors.

The Working Group has set out principles for commissioning which show how high-quality and cost-effective services will need to employ doctors at all levels of competency. This will require employing specialists (either addiction psychiatrists, specialist GPs or both), who have all the competencies.

5.Conclusion

Systems will need a full range of specialist and non-specialist medical competencies. This includes sufficient access to the specialist competencies required to provide direct clinical care for complex clients and provide clinical leadership, development and support for the local treatment system. It will need a workforce able to deliver a full range of evidence-based psychosocial interventions, harm-reduction interventions and effective key working' (National Treatment Agency for Substance Misuse, 2010).

The principles suggested by the Working Group are necessarily high level ones, and their implementation in practice will require a local

analysis of epidemiological data, resources and evidence on effective models of care. Nonetheless, they may offer a support for commissioners and providers considering how to deploy doctors of different competency levels and in what proportions, such that all the roles and responsibilities are adequately fulfilled. A key conclusion emerging from the Working Group's thinking in developing this document is that any local area that delivers a high-quality, cost-effective service that successfully helps people achieve recovery goals will need to employ doctors at all levels of competency.

The aim of this paper was to develop a health-care model of emotional labour that could be used to help health-care managers better deal with the causes and consequences of emotional labour or staff and patients. It has been shown that emotional labour is a crucial part of the role of many health care professionals, especially nurses, and that these skills are not adequately taught within health-care education programmes. Similarly, the stress and effects of mental health of emotional labour performance have also not been sufficiently acknowledged or addressed.

Specific recommendations from this review include the following:

1. The study of emotional labour should be widened to include other professions outside of nursing such as doctors, counsellors (Mann, 2004), clinical psychologists and other health-care providers.
2. Emotional labour and emotion management should be formally recognised as a key skill in facilitating the patient journey and training, policy and education within health-care systems should reflect this recognition.
3. Emotional skills should be taught in innovative ways outside of the formal classroom setting and in small, appropriate groups encompassing reflective learning, mentor-led experiences and patient-centred sharing.
4. Health-care professionals should be offered training on coping with the effects to themselves of emotional labour performance both as part of initial entry-level training and as part of continuing professional development.

More research should be carried out to further develop the model, particularly in identifying causes of emotional labour within health-care settings and in differentiating the effects that different kinds of emotional labour performance might have.

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7/22/2013