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When I say... emotional intelligence

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The term 'emotional intelligence' (EI) was first used by Beldoch in 1964,¹ becoming popularised following publication of Goleman's book of the same name.² The term encapsulated previous concepts, such as 'social skills' and 'empathy'. However, the idea that it was mainly one's 'emotional quotient' ('EQ'), rather than cognitive ability ('IQ'), determining one's success in life was simple, appealing and, as it turns out, somewhat mistaken. Researchers in the field quickly settled into two camps. One conceptualised EI as a trait, in line with personality theory. That is, a behavioural disposition best measured via self-report.³ Acknowledging the subjectivity of emotional experience, those deemed to have a high EQ reported being adept at identifying and regulating emotional states in themselves and others. Assessments often captured responses relating to portrayed scenarios with an emotional or interpersonal component. The other school focussed on considering EI as a set of related skills, akin to cognitive ability, measured via performance on specific tasks.⁴ Thus, 'high EI' individuals accurately identified and influenced emotional states in themselves and others, rendering them interpersonally effective.

Relations between the 'EI as a trait' and 'EI as an ability' camps quickly became acrimonious.⁵ Critics of the EI ability model questioned if emotional tests could have 'right' answers in the sense as cognitive assessments. Moreover, it was not clear what outcomes could provide construct validity evidence for EI metrics. For example, whilst supervisor ratings of interpersonal workplace performance are often pragmatically useful, they are also prone to rater bias.⁶ Also, individual tests evaluating specific aspects of EI, such as the ability to identify emotions in others, appeared relatively reliable. However, the resulting scores tended to correlate poorly with those from other EI measures.⁷ This contrasted with cognitive ability, where facets of intellectual skills tend to covary, and can be mathematically modelled as having an underlying general ('G') ability factor. Thus, the analogy with general intelligence appeared weak. Likewise, opponents of the trait approach highlighted that individuals can learn to improve their performance on some EI-related tasks.⁵ Nevertheless, given the potential implications for physician performance, medical education has been somewhat enthralled with this concept. Indeed, it has been suggested that EI, conceptualised as a teachable ability, should be included in the medical school curriculum.⁸ Given this impetus it is wise to reflect on the usefulness of the concept within medicine.

It is now clear the idea that EI largely determines workplace success was overplayed and that the evidence suggests that, overall, IQ is the single strongest predictor of occupational achievement.⁵ However, in medicine, where there is a narrow range of cognitive ability, due to selection, it may be inter-personal skills, rather than clinical knowledge, that predominantly predicts key aspects of work performance.⁹ Thus, selecting for, and developing abilities related to social and emotional functioning will plausibly improve outcomes for both doctors and patients. To date, numerous studies, of varying methodological quality, have claimed to demonstrate various benefits related to higher levels of EI in physicians. For example, one study of 39 doctors found that nurse ratings of their EI was positively and independently related to reported levels of trust and satisfaction in their out-patients.¹⁰ A separate study reported that two EI improvement focussed workshops resulted in superior self-ratings of 'stress management' (assumed to relate to resilience) in paediatric and medical residents (N=31) two months later.¹¹ A systematic review also concluded that EI was considered relevant to the development of professionalism and leadership in physicians, though highlighted the dearth of empirical studies. Nevertheless, four studies were identified that reported associations between self-rated EI, team-working and communication skills in medicine applicants and students.¹² However, such research is not always clear about which

aspects of EI are being evaluated and the results may be highly sensitive to the measures used. Such specificity is vital given the multi-dimensional nature of EI.⁷ For example, 'emotional-empathy' tends to decrease, whilst 'cognitive-empathy' may increase in medical students during training.¹³ Also, research is yet to clearly and directly link EI-based measures or interventions to unambiguous patient or physician health outcomes. There is also increasing recognition of the culture and situation-specific influences that shape emotional expression and social behaviour.¹⁴ Indeed, there is a call for culturally sensitive IQ assessments, recognising the societal and linguistic influences on cognitive test performance.¹⁵ The cultural implications for evaluating aspects of EI in a healthcare context are undoubtedly more profound, especially regarding the expectations around doctor-patient interactions.¹⁴ It is also crucial that EI research focuses on establishing 'incremental validity'- that is the capability to predict important outcomes, over and above conventional personality and intelligence measures. Here, ability-related aspects of EI may be more valid.⁴

The increased recognition of the importance of interpersonal skills in medicine is leading to attempts to select for these traits in future physicians. However, this is challenging as many existing EI measures rely on self-report, and are thus prone to faking effects in selection settings. In contrast, the use of face-to-face assessments, such as multiple mini interviews, are more resource intensive and it is not always clear what abilities are being rated in medical school applicants, though it is likely to be a single, general factor.¹⁶

Future EI-focussed research should be clear about the 'non-academic' qualities being measured, evaluate specific interventions that target these, and select meaningful outcomes directly related to patient care and physician wellbeing. To conclude, when we say 'emotional intelligence' we should actually refer to the specific relevant trait or ability in a particular socio-cultural context.

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Author contributions

PAT led on conception and drafting the work. LWP contributed to conception and critically appraising the manuscript. Both authors approve the final version to be published, and agree to be accountable for all aspects of the work.

Ethical approval

Not applicable

Competing interests

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