

This is a repository copy of *When I say... emotional intelligence*.

White Rose Research Online URL for this paper:

<https://eprints.whiterose.ac.uk/159777/>

Version: Accepted Version

Article:

Tiffin, Paul Alexander orcid.org/0000-0003-1770-5034 and Paton, Lewis William orcid.org/0000-0002-3328-5634 (2020) *When I say... emotional intelligence*. *Medical Education*. pp. 598-599. ISSN 0308-0110

<https://doi.org/10.1111/medu.14160>

Reuse

This article is distributed under the terms of the Creative Commons Attribution (CC BY) licence. This licence allows you to distribute, remix, tweak, and build upon the work, even commercially, as long as you credit the authors for the original work. More information and the full terms of the licence here:

<https://creativecommons.org/licenses/>

Takedown

If you consider content in White Rose Research Online to be in breach of UK law, please notify us by emailing eprints@whiterose.ac.uk including the URL of the record and the reason for the withdrawal request.

When I say... emotional intelligence

Paul A Tiffin & Lewis W Paton

PAT (corresponding author): Department of Health Sciences, University of York and Health Professions Education Unit, Hull York Medical School, UK, paul.tiffin@york.ac.uk

LWP: Department of Health Sciences, University of York, UK, lewis.paton@york.ac.uk

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.

Funding

PAT is supported in his research by an NIHR Career Development Fellowship. This paper presents independent research part-funded by the National Institute for Health Research (NIHR). The views expressed are those of the authors and not necessarily those of the NHS, the NIHR or the Department of Health and Social Care. LWP's research time is part funded by the UCAT Board.

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

PAT has previously received research funding from the ESRC, the EPSRC, the Department of Health for England, the UCAT Board, and the GMC. In addition, PAT has previously performed consultancy work on behalf of his employing University for the UCAT Board and Work Psychology Group and has received travel and subsistence expenses for attendance

at the UCAT Research Group. The UCAT board pay for a portion of LWP's research time, and LWP has received travel expenses for attendance at a UCAT consortium meeting.

Acknowledgements

None

References

1. Beldoch M. Sensitivity to expression of emotional meaning in three modes of communication. In: Davitz JR, Beldoch M, eds. *The Communication of Emotional Meaning*. Columbus, OH: McGraw-Hill; 1964:31-42.
2. Goleman D. *Emotional intelligence*. New York, NY, England: Bantam Books, Inc; 1995.
3. Petrides KV. Trait Emotional Intelligence Theory. *Ind Organ Psychol*. 2010;3(2):136-139.
4. Daus CS, Ashkanasy NM. The case for the ability-based model of emotional intelligence in organizational behavior. *J Organ Behav*. 2005;26(4):453-466.
5. Furnham A. The Importance and Training of Emotional Intelligence at Work. In: Stough C, Saklofske DH, Parker JDA, eds. *Assessing Emotional Intelligence: Theory, Research, and Applications*. New York, NY: Springer; 2009:137-155.
6. Moers F. Discretion and bias in performance evaluation: the impact of diversity and subjectivity. *Account, Organ Soc*. 2005;30(1):67-80.
7. Rossen E, Kranzler J, Algina J. Confirmatory factor analysis of the Mayer-Salovey-Caruso Emotional Intelligence Test V 2.0 (MSCEIT). *Pers Individ Dif*. 2008;44:1258-1269.
8. Roth CG, Eldin KW, Padmanabhan V, Friedman EM. Twelve tips for the introduction of emotional intelligence in medical education. *Med Teach*. 2019;41(7):746-749.
9. Patterson F, Tiffin PA, Lopes S, Zibarras L. Unpacking the dark variance of differential attainment on examinations in overseas graduates. *Med Educ*. 2018;52(7):736-746.

10. Weng HC. Does the physician's emotional intelligence matter? Impacts of the physician's emotional intelligence on the trust, patient-physician relationship, and satisfaction. *Health Care Manage Rev.* 2008;33(4):280-288.
11. Shahid R, Stirling J, Adams W. Promoting wellness and stress management in residents through emotional intelligence training. *Adv Med Educ Pract.* 2018;9:681-686.
12. Mintz LJ, Stoller JK. A systematic review of physician leadership and emotional intelligence. *J Grad Med Educ.* 2014;6(1):21-31.
13. Smith KE, Norman GJ, Decety J. The complexity of empathy during medical school training: evidence for positive changes. *Med Educ.* 2017;51(11):1146-1159.
14. Rimondini M, Mazzi MA, Deveugele M, Bensing JM. How do national cultures influence lay people's preferences toward doctors' style of communication? A comparison of 35 focus groups from an European cross national research. *BMC Public Health.* 2015;15(1):1239.
15. Shuttleworth-Edwards AB. Generally representative is representative of none: commentary on the pitfalls of IQ test standardization in multicultural settings. *Clin Neuropsychol.* 2016;30(7):975-998.
16. Griffin B, Auton J, Duvivier R, Shulruf B, Hu W. Multiple mini interviews: revealing similarities across institutions. *BMC Med Educ.* 2018;18(1):190.