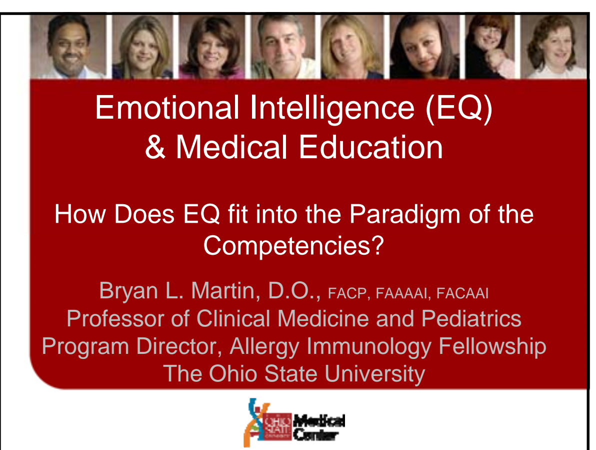


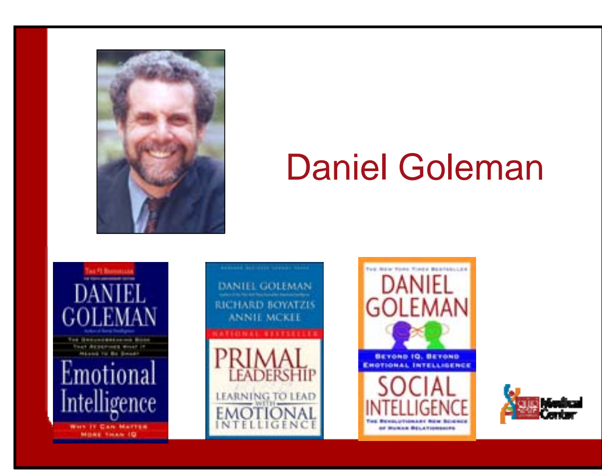
Emotional Intelligence (EQ) & Medical Education

How Does EQ fit into the Paradigm of the Competencies?

Bryan L. Martin, D.O., FACP, FAAAAI, FACAAI
Professor of Clinical Medicine and Pediatrics
Program Director, Allergy Immunology Fellowship
The Ohio State University

Objectives

- Define and Describe Emotional Intelligence.
- Apply the EQ concepts of self awareness and social awareness which drive our actions and influence the physician-patient relationship to enhance communication.
- Apply the EQ concepts of self management and relationship management to the competencies of communication, systems based practice, patient care and professionalism.



What is EQ?

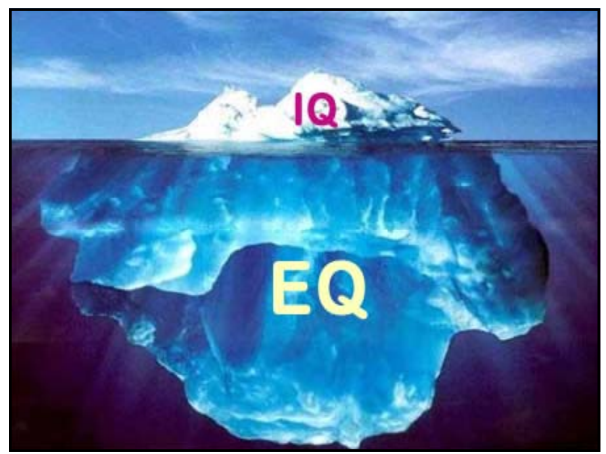
- One of the hottest buzzwords in corporate America
- A fuzzy notion that continues to be defined
- Since the 1930's those who studied intelligence realized that there were non-intellective abilities that helped predict success.
- The term "Emotional Intelligence" was coined in 1990 Salovey and Mayer
- Daniel Goleman based his 1995 book, *Emotional Intelligence,* on this work.

But, What IS EQ?

- One attempt toward a definition was made by Salovey and Mayer (1990) who defined EI as "the ability to monitor one's own and others' feelings and emotions, to discriminate among them and to use this information to guide one's thinking and actions." [10]

EQ = Success?

- “the fundamentals of EI – self awareness, self management, social awareness, and the ability to manage relationships – translate into on-the-job success.”
  - Daniel Goleman, *Emotional Intelligence—Why It Can Matter More Than IQ*, pg xv.



This is not new!

Tao Te Ching (China 6th Century B.C.)

- 知人者智， — Knowing others is intelligence,
- 自知者明。 — Knowing yourself is true wisdom.
- 勝人者有力， — Mastering others is strength
- 自勝者強。 — Mastering yourself is true power

Lao Tzu

EQ=new words for old wisdom?

Tao Te Ching	Emotional Intelligence
Knowing others is intelligence,	Social Awareness
Knowing yourself is true wisdom.	Self Awareness
Mastering others is strength	Social (relationship) management
Mastering yourself is true power	Self management

Four Keys to EQ

- Self Awareness
- Social Awareness
- Self Management
- Social (relationship) management

Self Awareness

- Emotional Self-awareness
  - Ability to understand your emotion
  - Recognize impact of emotions on performance
- Accurate self-assessment
  - Know limitations and strengths
  - Exhibit sense of humor about themselves
  - Welcome constructive criticism and feedback
- Self Confidence
  - Strong and positive sense of self worth

Social Awareness

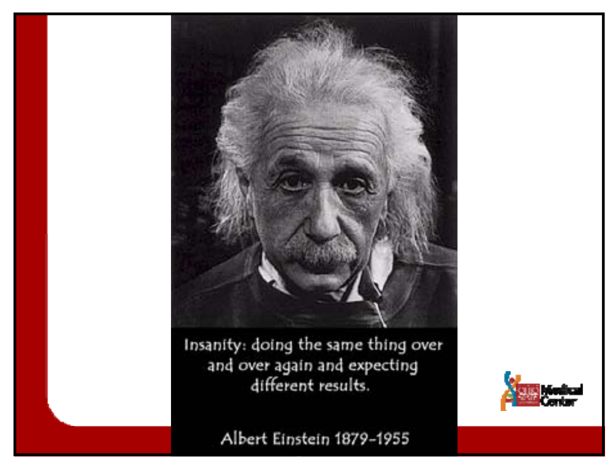
- Empathy
  - Attuned to emotional signals
  - Understand other's perspective
- Organizational awareness
  - Understand political forces, guiding values and unspoken rules of an organization
- Service Orientation
  - Foster a climate of service.
  - Monitor customer or client satisfaction
  - are available.

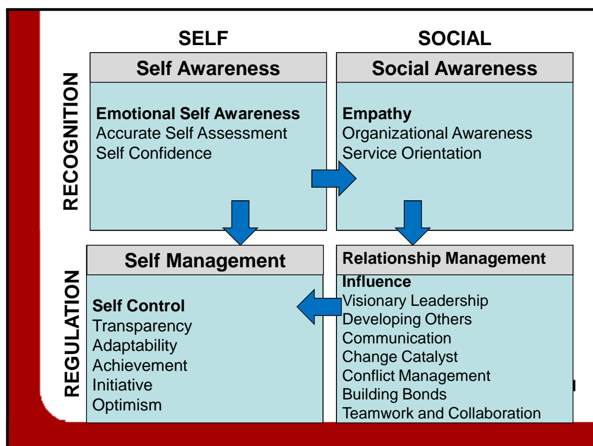
Self-Management

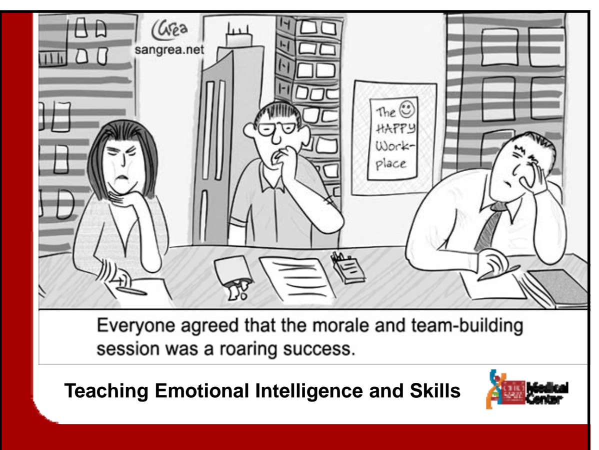
- Self Control
  - Manage and channel impulses; stays calm
- Transparency
  - Openness to others: admit mistakes or faults
- Adaptability
  - Juggle multiple demands without losing focus or energy
- Achievement
  - Drive to meet an internal standard of excellence
- Initiative
  - Seize opportunities – or create them– rather than wait
- Optimism
  - See glass half full; expect best in others.

Social Management

- Influence
- Inspire
- Develope Others
- Communication
- Change Catalyst
- Conflict Management
- Build Bonds
- Teamwork and Collaboration







Everyone agreed that the morale and team-building session was a roaring success.

Teaching Emotional Intelligence and Skills

EQ can be learned

- “While our emotional *intelligence* determines our potential for learning the fundamentals … our emotional *competence* show how much of that potential we have mastered….
- “An underlying EI ability is necessary, though not sufficient, to manifest a given competency or job skill.”
  - Goleman, EQ pg xv-xvi

Levels of Awareness

1. Unconscious incompetence: ignorance
2. Conscious incompetence: acceptance
3. Conscious competence: skills
4. Unconscious competence: habit

EQ and the Competencies

- How does EQ fit into the paradigm of the competencies
- Paradigm: The subway
- Paradigm of the competencies brings EQ into the formal curriculum for medical education.
  - Old paradigm: we teach them the hard science of medicine
  - New paradigm: we teach them how to be compassionate physicians

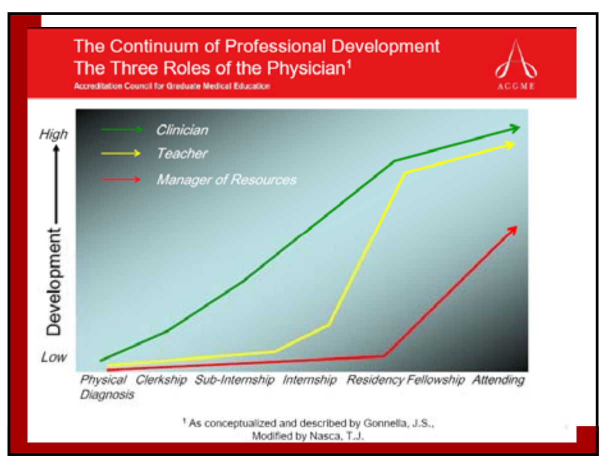
EQ meets Medical Education

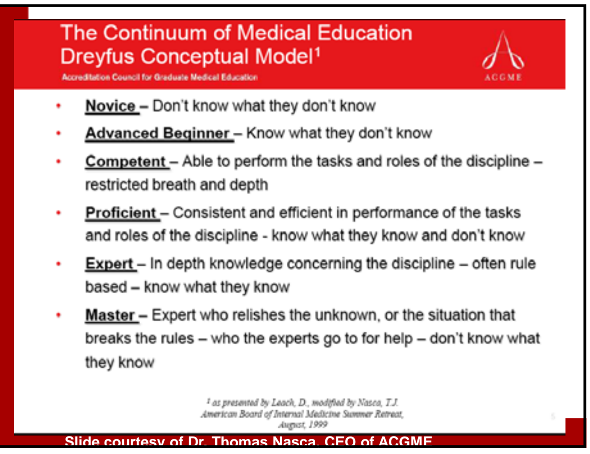
Competencies

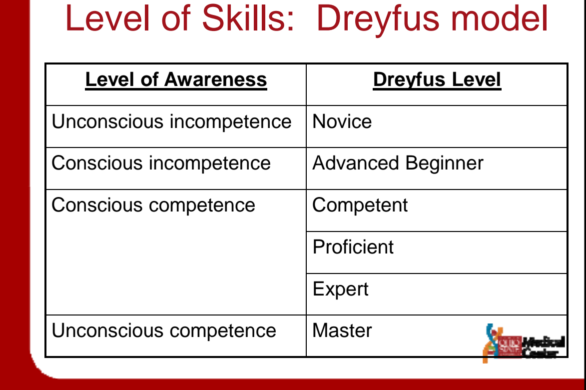
- Patient Care
- Medical Knowledge
- Practice-based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism
- Systems-Based Practice

EQ Fundamentals

- Self Awareness
- Social Awareness
- Self Management
- Relationship Management

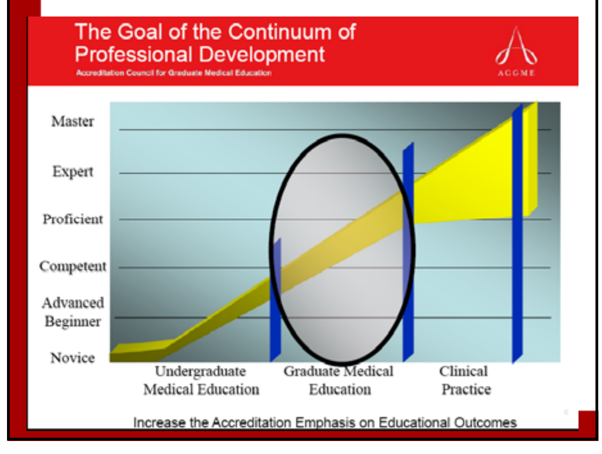


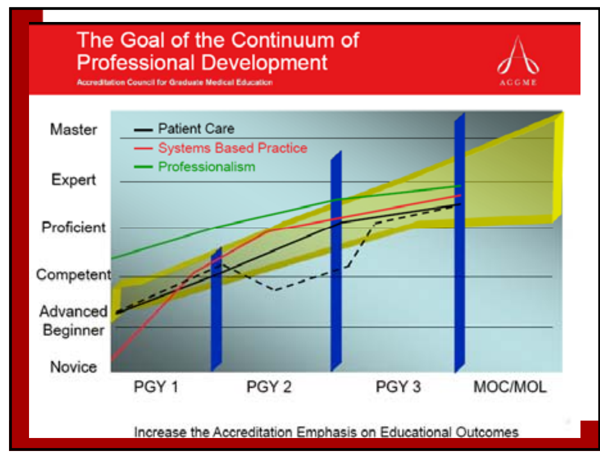




Level of Skills: Dreyfus model

Level of Awareness	Dreyfus Level
Unconscious incompetence	Novice
Conscious incompetence	Advanced Beginner
Conscious competence	Competent
	Proficient
	Expert
Unconscious competence	Master





Impact of the levels of awareness

- When the student is ready, the teacher appears…
- Unconscious incompetence is a state of innocent ignorance: "I don't know that I don't know."
- When asked why s/he misbehaved, a child will often answer: "I don't know."
  - This may be a true statement

Implications of the Levels of Awareness

1. Unconscious incompetence: ignorance
   - Teach EQ basics and provide a frame for later skills
2. Conscious incompetence: acceptance
   - Teach basic EQ skills related to the competencies
3. Conscious competence: skills
   - Provide monitored experiences -- use skills
4. Unconscious competence: habit
   - Life Long learning

Interpersonal and Communication Skills

- Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates
  - Communicating with patients and families
  - Communicating with team members
  - Scholarly Communication

Interpersonal and Communication Skills

- Some resident physicians have significant difficulty accurately assessing how well they communicate with patients
- Physician trainees rarely get feedback regarding interpersonal skills.
- Standardized patients and faculty observers may provide insight.

Assessing physician's interpersonal skills: Do patients and physicians see eye to eye?, Am J Phys Med Rehab, 2002, Dec;81 (12)

Patient Care

- Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
  - Gathering information
    - Building relationships with patients and families
  - Synthesis
  - Partnering with patients/families
    - Gaining trust

Practice-based Learning and Improvement

- Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices.
  - Life-long learning
  - Evidence based medicine
  - Quality improvement
  - Teaching skills

Professionalism

- Residents must demonstrate professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
  - Professional behavior
  - Ethical principles
  - Cultural competence

Systems-Based Practice

- Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide optimal health care
  - Health care delivery system
  - Cost effective practice
  - Patient safety and advocacy
  - Systems causes of error

We Already Have TOO Much to Teach!

- Do we really have to think about this touchy-feely mumbo jumbo?
  - Let alone Teach it…
- What does this have to do with our REAL jobs – to teach medicine (Medical Knowledge)?

HOME | SEARCH | CONTACT US | SITE MAP | CAREERS | NEWSROOM | QUALITY CHECK

The Joint Commission

SEARCH GO

ACCREDITATION PROGRAMS | CERTIFICATION PROGRAMS | STANDARDS | PATIENT SAFETY | SENTINEL EVENT | PUBLIC POLICY REPORTS | PERFORMANCE MEASUREMENT | LIBRARY | ABOUT US

Printer-Friendly

Home » Sentinel Event » Sentinel Event Alert

Advisory Group
Forms and Tools
Policy and Procedures
Reporting Alternatives
Sentinel Event Alert
Statistics

Sentinel Event Alert

Issue 40, July 9, 2008

Behaviors that undermine a culture of safety

Intimidating and disruptive behaviors can foster medical errors,(1,2,3) contribute to poor patient satisfaction and to preventable adverse outcomes,(1,4,5) increase the cost of care,(4,5) and cause qualified clinicians, administrators and managers to seek new positions in more professional environments. (1,6) Safety and quality of patient care is dependent on teamwork, communication, and a collaborative work environment. To assure quality and to promote a culture of safety, health care organizations must address the problem of behaviors that threaten the performance of the health care team.

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. Intimidating and disruptive behaviors are often manifested by health care professionals in positions of power. Such behaviors include reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. (2) Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients. (7, 8, 11) All intimidating and disruptive behaviors are unprofessional and should not be tolerated.

Intimidating and disruptive behaviors in health care organizations are not rare.(1,2,7,8,9) A survey on intimidation conducted by the Institute for Safe Medication Practices found that 40 percent of clinicians have kept quiet or remained passive during patient care events rather than question a known intimidator.(2,10) While most formal research centers on intimidating and disruptive behaviors among physicians and nurses, there is evidence that these behaviors occur among other health care professionals, such as pharmacists, therapists, and support staff, as well as among administrators. (1,2) Several surveys have

AMA American Medical News

August 18, 2008

VOLUME 51 · NUMBER 31

www.amednews.com

AMA News: August, 2008

New Joint Commission standard

Hospitals told to squelch disruptive behaviors

Doctors worry about the new requirement, saying hospitals could misuse bad-behavior policies.

Kevin B. O'Reilly
AMNEWS STAFF

One physician had the social skills of a 2-year-old, said a nurse in an anonymous survey on disruptive behavior published last year. A cardiologist

clinician orders.

The Joint Commission is calling on hospitals to crack down on "disruptive" health care professionals, over concerns that such behavior impacts patient care. A new commission standard taking effect in January 2009 will require hospital administrators to adopt codes defining disruptive behavior and develop procedures to discipline medical staff and other health professionals who behave badly.

carry a significant chance of a serious adverse outcome."

The moves are drawing fire from doctors. They say disruptive behavior policies, which can cover everything from criminal assaults to condescension, are often too vague and used

Continued on page 4

AMERICAN MEDICAL NEWS
515 NORTH STATE
CHICAGO, IL 60654

AMA News: Dec 1, 2008

Disruptive behavior standard draws fire

The AMA will ask for a one-year hold on the Joint Commission rule. Delegates seek to shift the focus to behavior that harms patients.

Kevin B. O'Reilly
AMNEWS STAFF

Orlando, Fla. A Joint Commission standard on disruptive behavior could lead to "arbitrary and capricious enforcement" against physicians, the AMA House of Delegates warned.

Delegates at the Interim Meeting directed the AMA to seek a one-year moratorium on the new standard, slated to take effect Jan. 1, 2009, to allow organized medical staffs time to change their bylaws to comply with the rule. The house also adopted policy advocating that medical staffs develop their own conduct codes and investigation and appeals procedures.

PHOTO BY TED GRUDZINSKI

Medical staffs "have got to get some definitions and we have to get a basic understanding of where we are," said Jay A. Gregory, MD.

Inappropriate Behaviors per the Joint Commission

- Often manifested by Health Care Providers in Positions of Power
- Physical Threats
- Verbal Outbursts
- Refusing to perform assigned tasks
- Uncooperative attitudes
  - Reluctance to answer questions, return calls
  - Condescending language
  - Impatience

Joint Commission "Culture of Safety"

- "Overt and passive behaviors undermine team effectiveness and can compromise the safety of patients."
  - Patient care, Practice-based Learning and Improvement, Systems-Based Practice
- "All intimidating and disruptive behaviors are unprofessional and should not be tolerated."
  - Professionalism, Interpersonal and Communication Skills

Unconscious incompetence

- Rather than be angry or dismissive of another's inability to explain their behavior:
  - Supply vocabulary for understanding and discussion
  - Model appropriate behavior
  - Provide practice scenarios

Conscious Incompetence

- What does this have to do with me?
- What does the touchy feely stuff have to do with real life medical decisions?
- I have more important things to deal with than this stuff!
- OK, I understand the concepts; but how can I use them in my day to day life?
  - The student is ready! Is the Teacher?

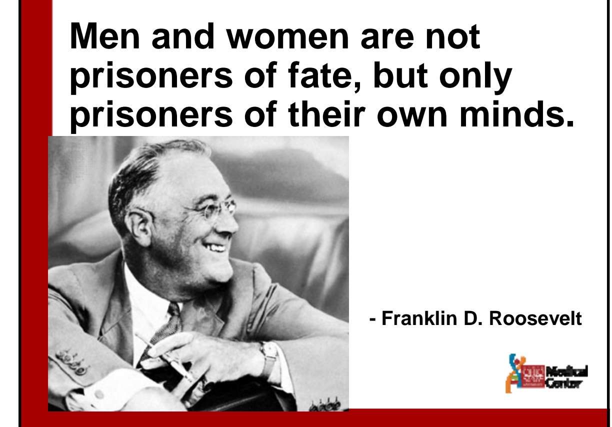
Conscious Competence

- This occurs when we get "buy in."
- At this point:
  - Terms are understood
  - People are ready to use their skills in daily interactions
- It still requires conscious effort to use skills and may sometimes feel unnatural
  - Encouragement
  - Modeling

Unconscious competence

- At this point the skills have become habit.
- There is no longer conscious thought regarding actions, but EQ skills have become unconscious.
- The trick is: How do we get to this point?
  - ?

Men and women are not prisoners of fate, but only prisoners of their own minds.



- Franklin D. Roosevelt

Remember the 4 "S's"

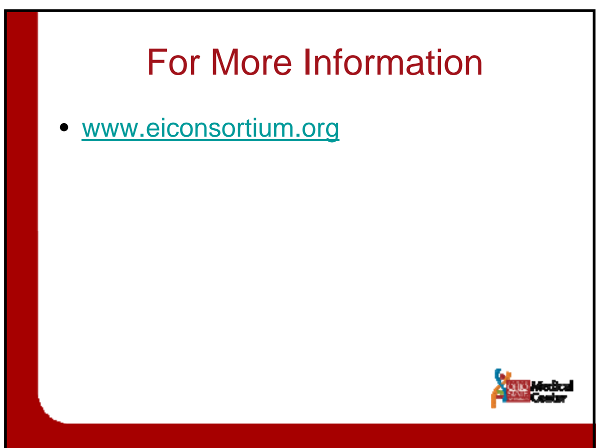
Self Awareness
Social Awareness
Self Management
Social (Relationship) Management

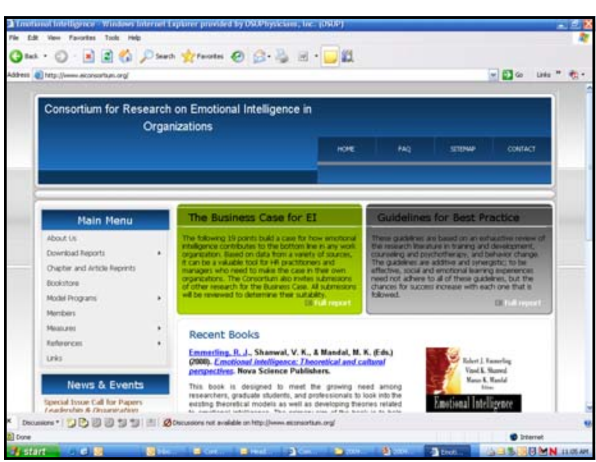
Teaching moments

- Previous personal experience
- Scenarios
  - Verbal
  - Photographic
  - Video/movie
  - Standardized Patient
  - Observation with patients and with staff

Reflections

- Residents must be aware not only of their effect on others, but of their internal messaging.
  - Portfolios
  - Case Presentations
    - In case presentation of a newly diagnosed cancer, part of the discussion can focus on how to inform the patient and family.





Primary References

- Goleman, Daniel. Emotional Intelligence: Why it can Matter More than IQ. NY, NY, Bantam, 1995.
- Goleman, Daniel, Richard Boyatzis and Annie McKee. Primal Leadership: Learning to Lead with Emotional Intelligence. Boston, MA, Harvard Business School Press, 2002.
- Goleman, Daniel. Social Intelligence: Beyond IQ, Beyond Emotional Intelligence. NY, NY, Bantam Dell, 2006.

References

- Millis, SR et al, Assessing physicians' interpersonal skills: do patients and physicians see eye-to-eye?, Am J Phys Med Rehab, 2002 Dec,81(12):946-51.
- Van Zanten, M et al, Using Standardized Patients to Assess the Interpersonal Skills of Physicians: Six years' Experience With a high Statkes Certification Examination, Health Communication, 2007 Oct, 22 (3): 195-205.
- Lee, Fred. If Disney Ran Your Hospital: 9½ Things You Would Do Differently. Second River healthcare Press, Bozeman, MT, 2004.
- Gladwell, Malcolm. Blink: The Power of Thinking without Thinking. NY, NY, Little Brown and Company, 2005.