

Medical students and Emotional Intelligence

Attending to the emotional needs and personal development of medical students is important not only to assist in their learning and professional behaviour but to equip them to navigate in a sustainable and compassionate way through a lifetime of emotionally challenging, changing and at times uncertain practice. It is, in part, by reflecting on our own training that educators glimpse our own developmental milestones and gain insight into how our own support networks and emotional capacity is built. Attending to both students and educators own needs are part of the developmental challenge facing all medical schools and training environments.

In medicine feelings often give important information in relation to patient care (Van den Briel et al. 2012) (Goleman 1988) and offer a reliable and helpful insight into difficult situations (Heath 1999). However, emotional intelligence (EI) is rarely an explicit part of learning outcomes in medical courses. Referring to EI as an intelligence means many learners assume it is learnt and assessed like academic intelligences (Lewis et al 2005) and presenting it more as a capacity to: perceive, understand, use and regulate feelings can be more helpful (Mayer and Salovey 1995). The challenge for educators is that different individuals have variable aptitude and capacity for intrapersonal awareness, interpersonal relationships, managing of stressful situations (Barr-On 2003) or 'appetite' for growth from working through challenging situations. Goleman (1998) talks about developing EI in relation to four domains of self-awareness, self-management, social awareness, and relationship management all core aspects of working professionally. When emotional awareness is used constructively to inform and meet either your own or others needs it often leads to more creative outcomes and solutions (Ivcevic, Brackett and Mayer 2007).

Although Goleman implies that EI can be thought of as behavioural competencies, and individuals can be educated, trained and assessed in them, this behavioural approach leads many to think they are emotionally competent by mimicking the behaviour they see modelled to them. When taught without developing an insight into their feelings and capacity to respond sensitively learners often do not develop the ability to trust or act on their feelings. This may lead to detuning of learners emotional awareness during their training. Perhaps explaining the reduction in empathy many students and trainees experience in training (Neumann 2011).

What then are the priorities for medical educators and students in this area? They include using feeling to inform their reflections, exploring creative approaches to problem solving, nurturing themselves and others, exploring themselves and others through medical humanities, developing resilience and techniques to maintain physical, intellectual and emotional well-being. These along with supporting and encouraging development of formative and summative tools for assessing and feeding back on emotional intelligence and creative capacity could help students apply for, join and flourish on medical courses. If we aim to support the development of doctors prepared for a lifetime of care giving perhaps the most important thing we can do is be part of a community of learning that nurtures both students and our own emotional intelligence and creative capacity.

References

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