The lived experience of medical training and emotional intelligence

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ABSTRACT

The shifting health care landscape in the United States has surfaced challenges related to increased accountability, interprofessional health care teams, and changes in federal policy—all of which compel physicians to adopt roles beyond clinician such as clinical investigator, team leader, and manager. To address these challenges, leadership development programs across the continuum of medical education aim to develop critical leadership skills and competencies, such as emotional intelligence. Such skills and competencies are largely taught through didactic approaches (e.g., classroom). These approaches often neglect the context of learning. From medical residency to a hospital or clinic, the contextual lived experience is habitually overlooked as a vehicle for developing emotional intelligence. This article highlights lived experience, such as medical residency, as an approach to develop emotional intelligence. First, we address the need for developing emotional intelligence as a leadership skill as well as the suitability of medical residency for such development. Next, we discuss the background of lived experience and emotional intelligence. Lastly, we identify future directions for leveraging lived experiences of medical residency to develop emotional intelligence.

KEYWORDS Emotional intelligence; leadership; lived experience; resident physicians

Since Abraham Flexner's 1910 report, physicians' roles in the US health care system have become increasingly complex. They have faced challenges including pressures to improve quality and control cost,¹ federal changes (i.e., Patient Protection and Affordable Care Act) requiring an elevated level of clinical coordination,² and increased involvement in interprofessional clinical teams.³ These challenges have prompted physicians to move beyond the traditional physician-patient dynamic to serve as a "clinician-investigator,"⁴ team member or leader, manager, or even architect of health care policy.⁵

The complexity and diversity of the physician's role has brought leadership development to the forefront. While content and pedagogical approaches to leadership development vary,^{6–10} the perspective that physicians are not adequately equipped to lead has been echoed repeatedly.^{8,11–13} Dickerman et al stated, "The rapid growth in the breadth and depth of the physician leadership role requires a different

skill set from that currently taught to medical students and physicians in training."⁵ While technical skill sets (e.g., suturing) are formally taught and assessed, leadership skills required for navigating the complexities of the health care system, interprofessional teamwork, and the care of patients are often relegated to happenstance observation or on-the-job experience. These skills are important to improve health care delivery, yet are historically not formally, or widely, taught or assessed in medical training.¹⁴

We recommend emotional intelligence (EI) as a way to foster a more aware and more effective leader who is equipped with the set of skills required to address the complexities of health care delivery.^{11,15} Drawing on the seminal work of Goleman,^{16,17} Nowacki et al stated that EI is "the capacity to recognize our own feelings and those of others, to motivate ourselves, and to manage emotions effectively in ourselves and others."¹⁸ Physician leaders who understand themselves can engage others (i.e., physicians, allied health

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care team members, patients) at a deeper level to enhance care in aspects such as improved communication or understanding of the nuances of the patient's perspective.

MEDICAL RESIDENCY

Although strong evidence for leadership development starting in medical school exists, counterarguments highlight barriers like a lack of time, crowded curriculum, premature context, and competing requirements.^{11,15} The context of medical residency offers a critical transition point along the medical education continuum. The Accreditation Council for Graduate Medical Education referred to medical residency as “an essential dimension of the transformation”¹⁹ because the learner transitions to a practitioner through increased responsibilities, patient interaction, and experiential learning. In the words of a resident physician, medical residency is “a long and arduous process.... Your knowledge and your confidence [are] constantly being tested, whether implicitly or explicitly.”²⁰ Thus, medical residency offers an ideal context and timeframe for intentionally developing EI.

LIVED EXPERIENCE

As noted, the lived experience of medical residency is essential and arduous. A question arises as to what is the *lived experience*, or “everyday life and social action.”^{21,22} In medical residency, it could be the first-person experience of a resident taking a history, rounding, listening to a chief complaint, or attending a lecture. In qualitative research, these everyday experiences serve to frame investigation of less tangible aspects of medicine. For example, studies in the field of medicine have illuminated the formative nature of lived experience through critical events, transitioning to medical residency, and processing the death of a patient.^{23,24}

Lived experience is also the basis for educational interventions like morbidity and mortality conferences or formal reflection.^{25–28} Whether examining factors surrounding errors or evaluating an interaction within the health care team, lived experience provides a framework for educational interventions. Thus, the following questions should be considered: What if learning from the lived experience included elevating EI in importance alongside traditional technical aspects (e.g., taking a history, rounding, suturing, medical errors) to include understanding oneself and others? How might the lived experience of medical residency be leveraged to actively educate rather than relying on historically passive approaches such as lecturing?²⁹

EMOTIONAL INTELLIGENCE

There is disagreement on whether EI is a capacity that is fixed or, as we believe, something that can be enhanced.²⁸ As a capacity that can be enhanced, EI is organized into four domains—self-awareness, self-management, social awareness, and relationship management—with 18 respective competencies (e.g., developing others).³⁰ Each domain and its

respective competencies are detailed further in Goleman's book, *Primal Leadership*.³⁰

Based on Goleman,³⁰ and as outlined in Nowacki et al,¹⁸ the domain of self-awareness in EI relates to aspects such as cognizance of one's emotions, evaluation of one's own strengths and areas of improvement, as well as confidence in one's abilities. The ability to not only be self-aware but also manage oneself in the domain of self-management involves controlling such emotions, adapting to various demands, and being authentic with emotions that arise. Empathy directed toward others, an awareness of political aspects of a group or organization, and a service orientation frame the domain of social awareness. Lastly, the domain of relationship management refers to the strategic utilization of social knowledge to influence, inspire collaboration, and develop others toward creating change within a group or organization.

In relation to medicine, in their systematic review of 144 articles, Mintz and Stoller identified 83 that endorsed EI as a critical component of leadership development for physicians.³¹ For example, the utilization of interprofessional health care teams and new models of care such as patient-centered medical homes or accountable care organizations require high levels of collaboration and may be difficult for physicians with low EI. Nowacki et al's longitudinal study¹⁸ strengthened qualitative findings by Lobas³² by connecting EI and the promotion of physicians to formal leadership roles. The importance of EI is reflected in its increasing prominence in curricula to teach resident physicians.^{6,31} Further, the complex challenges peppering the health care landscape and echoed in the literature point to the increasing importance of developing EI as a leadership skill for physicians.

LIVED EXPERIENCE AND EMOTIONAL INTELLIGENCE

In a recent study, Dewsnap investigated the nature of physician leadership through the lived experiences of family medicine resident physicians in medical residency.²⁰ Utilizing a descriptive phenomenological methodology, he engaged participants through investigation framed by reflection on lived experiences as a nonformal leader in medical residency. Following extensive analysis through seven stages, which included peer review of the study rationale and member checking, Dewsnap identified four themes—environment, leader behaviors, leader attributes, and follower-focused—with 12 subunits.²⁰ One provocative outcome of this study was alignment of findings with EI domains and competencies, more specifically, the *follower-focused* theme and subunit of *understanding followers* to the EI domain of *relationship management* and the competency of *developing others*.

For example, the EI competency of *developing others* highlights the importance of sensing followers' needs and developing their abilities.¹⁸ One participant in Dewsnap's study stated, “I think one of the biggest things is understanding the population in which you're trying to lead, right? Because not everybody may have the same viewpoints in

regards to what they perceive a leader to be.”²⁰ Another participant connected this understanding directly to development of junior resident physicians with regard to more accurately identifying strengths, weaknesses, and constructing experiences that will facilitate success. The EI of a physician leader was more explicitly highlighted by another participant who commented on the importance of understanding others’ emotional levels.²⁰

With regard to patients, another participant noted the importance of the EI competency *empathy* in processing the death of a patient. More specifically, the participant highlighted the importance of connecting with emotions during a time of loss rather than remaining stoic and disconnected.²⁰ Whether processing a patient death or working with a patient to implement a smoking cessation plan, emotionally connecting with a patient can help bridge theory and practice.

Medical trainees are learning about EI and leadership through their everyday life in medicine. Evidence demonstrates active and experiential learning as effective and important in physician training, yet much of education in medical training with regards to EI continues to be largely passive (e.g., lecture) rather than actively experiential through strategies such as coupling clinical experiences with structured introspection.²⁹ Instead of accidental learning through on-the-job modeling,³³ intentional exercises should be included in medical training that elevate positive learning from everyday experiences. Medical trainees need to learn about EI and leadership by combining their lived experience with intentional moments of introspection that a residency curriculum can offer. Adding intentionality would ensure trainees assimilate the positive lessons rather than any hidden curriculum or negative lessons about EI and leadership.

DISCUSSION

EI as a critical leadership skill for physicians is gaining broad support in health care and across the continuum of medical education.^{6,11,28,30} Although EI is widely regarded as pertinent to the training of physicians,^{18,30,34,35} barriers to implementation exist. Such barriers include, but are not limited to, (a) time, (b) funding, (c) assessment, and (d) broad awareness of the importance of EI for physicians.^{34,35} For example, parsing out time within an already busy schedule for a resident physician to be formally trained on EI may be difficult. Additionally, locating senior physicians with the time and expertise may not be feasible and may require outsourcing. Such outsourcing could be a strain on funding for a residency program.

The evidence supports lived experience^{20,23–28} and EI^{14,34,35} as essential to educating physicians. Barriers such as those listed above for training in medical residency beg the question as to how. Moreover, intentionally leveraging the lived experience of medical training as an educational approach can assist with addressing such barriers. For example, one common approach resident physicians can utilize to facilitate development of EI is reflection. Resident physicians may need help at first and might require a guided reflection until they are able to deeply

reflect on their own. Also referred to as a metacognitive technique, reflection is a powerful tool for self-assessment, personal cognitive management, and monitoring.²⁵ Beyond metacognitive utility, reflection is critical to analyzing everyday experiences that are essential to the professional and leadership development of resident physicians.¹⁸ Reflective analysis of *everyday experiences* could be conceptualized as experiential learning³⁶ or learning by *doing*.

More specifically, Moen and Prescott noted that “reflection is key to good medical practice. A reflective outlook raises consciousness, prompts movement from the routine of practice to its critical appraisal and drives change. It is central to appraisal and medical revalidation.”²⁷ Reflection offers the opportunity to self-analyze and self-regulate and should further be considered as an effective mechanism for developing EI in physicians. With regard to utilizing reflection to develop EI, Colbert et al advised medical educators to guide residents and model reflection, as some may be uncomfortable with, or unskilled in, this type of learning.²⁵

In addition to reflection, recommendations for residency programs point to strategies such as (a) single-day immersion programs during orientation, (b) retreats that offer continuing medical education credit, (c) elective time during medical residency, (d) coaching, (e) interactive scenario exercises, and (f) integrating EI into existing content.^{34,35} Additionally, Roth, Eldin, Padmanabhan, and Friedman offered 12 tips to introduce EI into medical education.³⁷ The first tip, which could be argued as the most critical, is to start with why EI is important. Starting with the *why* is important because many may not be familiar with EI’s benefits and how it can impact their personal and professional outcomes.

In closing, Souba posited that transforming health care does not begin outwardly with systemic transformation but rather inwardly with personal transformation.³⁸ Leveraging the lived experience of resident physicians to teach EI through reflection provides a rich, applicable vehicle for personal transformation. Such personal transformation is critical to creating physician leaders with the requisite complexity to face emerging challenges in health care.³⁹

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1. Orlando R 3rd, Haytaian M. Physician leadership: a health-care system’s investment in the future of quality care. *Conn Med.* 2012;76(7):417–420.
2. Hofer AN, Abraham JM, Moscovice I. Expansion of coverage under the Patient Protection and Affordable Care Act and primary care

- utilization. *Milbank Q.* 2011;89(1):69–89. doi:10.1111/j.1468-0009.2011.00620.x.
3. Morrison G, Goldfarb S, Lanken PN. Team training of medical students in the 21st century: would Flexner approve? *Acad Med.* 2010;85(2):254–259. doi:10.1097/ACM.0b013e3181c8845e.
4. Irby DM, Cooke M, O'Brien BC. Calls for reform of medical education by the Carnegie Foundation for the Advancement of Teaching: 1910 and 2010. *Acad Med.* 2010;85(2):220–227. doi:10.1097/ACM.0b013e3181c88449.
5. Dickerman J, Sánchez JP, Portela-Martinez M, Roldan E. Leadership and academic medicine: preparing medical students and residents to be effective leaders for the 21st century. *MedEdPORTAL.* 2018;14:10677. doi:10.15766/mep_2374-8265.10677.
6. Frich JC, Brewster AL, Cherlin EJ, Bradley EH. Leadership development programs for physicians: a systematic review. *J Gen Intern Med.* 2015;30(5):656–674. doi:10.1007/s11606-014-3141-1.
7. National Center for Healthcare Leadership. *Physician Leadership Development Programs: Best Practices in Healthcare Organizations.* 2014. http://nchl.memberclicks.net/assets/Website/NCHL_Physician_Leadership_Development_White_Paper_Final_05.14_uid9142015803251.pdf.
8. Neeley SM, Clyne B, Resnick-Ault D. The state of leadership education in US medical schools: results of a national survey. *Med Educ Online.* 2017;22(1):1301697. doi:10.1080/10872981.2017.1301697.
9. Stoller JK. Developing physician-leaders: key competencies and available programs. *J Health Adm Educ.* 2008;25(4):307–328.
10. Webb AMB, Tsipis NE, McClellan TR, et al. A first step toward understanding best practices in leadership training in undergraduate medical education: a systematic review. *Acad Med.* 2014;89(11):1563–1570. doi:10.1097/ACM.0000000000000502.
11. Arroliga AC, Huber C, Myers JD, Dieckert JP, Wesson D. Leadership in health care for the 21st century: challenges and opportunities. *Am J Med.* 2014;127(3):246–249. doi:10.1016/j.amjmed.2013.11.004.
12. Mangrulkar RS, Tsai A, Cox SM, et al. A proposed shared vision for leadership development for all medical students: a call from a coalition of diverse medical schools. *Teach Learn Med.* 2020;32(5):561–568. doi:10.1080/10401334.2020.1754835.
13. Mokshagundam S, Pitkin J, Dekhtyar M, Santen S, Hammoud M, Skochelak SE. Engaging medical students in leadership development. *MedSciEduc.* 2019;29(3):849–853. doi:10.1007/s40670-019-00754-w.
14. Shahid R, Stirling J, Adams W. Assessment of emotional intelligence in pediatric and med-peds residents. *J Contemp Med Edu.* 2016;4(4):153. doi:10.5455/jcme.20170116015415.
15. Stoller JK. Commentary: Recommendations and remaining questions for health care leadership training programs. *Acad Med.* 2013;88(1):12–15. doi:10.1097/ACM.0b013e318276bff1origsite=gscholar&cbl=51922&diss=y.
16. Goleman D. *Emotional Intelligence.* London: A&C Black; 1996.
17. Goleman D, Boyatzis R, McKee A. Primal leadership: the hidden driver of great performance. In: Billsberry J, ed. *Discovering Leadership.* Houdsmills: Palgrave Macmillan 2009:63–72.
18. Nowacki AS, Barss C, Spencer SM, et al. Emotional intelligence and physician leadership potential: a longitudinal study supporting a link. *J Health Adm Educ.* 2016;33(1):23.
19. Accreditation Council for Graduate Medical Education. About Us. www.acgme.org/About-Us/Overview. Accessed August 5, 2020.
20. Dewsnap MA. *Exploring the Nature of Physician Leadership for Family Medicine.* Colorado State University; 2020. <http://search.proquest.com/openview/14458862d1cbd7fd687427f4d7609816/1?pq-origsite=scholarlink>.
21. Merriam SB, Tisdell EJ. *Qualitative Research.* Hoboken: John Wiley & Sons; 2015.
22. Moustakas C. *Phenomenological Research Methods.* Thousand Oaks: Sage; 1994.
23. Coakley N, O'Leary P, Bennett D. 'Waiting in the wings': Lived experience at the threshold of clinical practice. *Med Educ.* 2019;53(7):698–709. doi:10.1111/medu.13899.
24. Whitehead PR. The lived experience of physicians dealing with patient death. *BMJ Support Palliat Care.* 2014;4(3):271–276. doi:10.1136/bmjspcare-2012-000326.
25. Colbert CY, Graham L, West C, et al. Teaching metacognitive skills: helping your physician trainees in the quest to 'know what they don't know'. *Am J Med.* 2015;128(3):318–324. doi:10.1016/j.amjmed.2014.11.001.
26. Kravet SJ, Howell E, Wright SM. Morbidity and mortality conference, grand rounds, and the ACGME's core competencies. *J Gen Intern Med.* 2006;21(11):1192–1194. doi:10.1111/j.1525-1497.2006.00523.x.
27. Moen C, Prescott P. Embedding a patchwork text model to facilitate meaningful reflection within a medical leadership curriculum. *Int J Med Educ.* 2016;7:372–374. doi:10.5116/ijme.580b.2702.
28. Arora S, Ashrafian H, Davis R, Athanasiou T, Darzi A, Sevdalis N. Emotional intelligence in medicine: a systematic review through the context of the ACGME competencies. *Med Educ.* 2010;44(8):749–764. doi:10.1111/j.1365-2923.2010.03709.x.
29. Cooper AZ, Richards JB. Lectures for adult learners: breaking old habits in graduate medical education. *Am J Med.* 2017;130(3):376–381. doi:10.1016/j.amjmed.2016.11.009.
30. Goleman D, Boyatzis RE, McKee A. *Primal Leadership.* Boston: Harvard Business Press; 2004.
31. Mintz LJ, Stoller JK. A systematic review of physician leadership and emotional intelligence. *J Grad Med Educ.* 2014;6(1):21–31. doi:10.4300/JGME-D-13-00012.1.
32. Lobas JG. Leadership in academic medicine: capabilities and conditions for organizational success. *Am J Med.* 2006;119(7):617–621. doi:10.1016/j.amjmed.2006.04.005.
33. Kuo AK, Thyne SM, Chen HC, West DC, Kamei RK. An innovative residency program designed to develop leaders to improve the health of children. *Acad Med.* 2010;85(10):1603–1608. doi:10.1097/ACM.0b013e3181eb60f6.
34. Lambert JA, Vanderbilt AA, Papadimos TJ. Improved emotional intelligence in perioperative care through simulation-based medical education during anesthesiology residency training: a call for implementation. *Adv Med Educ Pract.* 2019;10:39–42. doi:10.2147/AMEP.S164752.
35. Uchino R, Yanagawa F, Weigand B, et al. Focus on emotional intelligence in medical education: from problem awareness to system-based solutions. *Int J Acad Med.* 2015;1(1):9–20. doi:10.4103/2455-5568.172703.
36. Myers JD, Arroliga AC, White BAA, Janek H, Wesson DE. The graduate medical educational enterprise. *Proc (Bayl Univ Med Cent).* 2019;32(3):449–451. doi:10.1080/08998280.2019.1588680.
37. 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. doi:10.1080/0142159X.2018.1481499.
38. Souba WW. The science of leading yourself: a missing piece in the health care transformation puzzle. *OJL.* 2013;2(3):45–55. doi:10.4236/ojl.2013.23006.
39. Souba WW. The phenomenology of leadership. *OJL.* 2014;3(4):77–105. doi:10.4236/ojl.2014.34008.