Emotional intelligence in palliative medical education

Abstract

The death of a patient is one of the most stressful situations a healthcare professional can face for the first time at work or during training. Palliative and end of life care education aims to impart appropriate awareness and understanding of key issues arising at the end of life, but also to develop learners' interpersonal skills in leadership, communication and management of their own emotional load. There is a pressing need to be explicit around death, dying and care at the end of life and to equip clinical staff with the ability to manage the emotions that are experienced by their patients, their teams and themselves. Emotional intelligence is considered as a framework for medical educators to use in this setting with presentation of a simulated patient vignette to contextualise this.

Key words: Clinical leadership; Development; Emotional intelligence; Medical leadership; Trainees

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Background

Stress is often unavoidable in clinical practice, and death and pain can be potent provoking factors for experiencing this in caregivers and healthcare professionals (Grobecker, 2016). Healthcare professionals faced with the death of a person they are caring for often report this to be a highly emotive and stressful experience (Pulido-Martos, 2012). When considering how best to prepare healthcare professionals for this, palliative medical educators aim to impart awareness of key issues arising at the end of a person's life, alongside developing their ability to lead good quality end of life care nurturing empathy, communication and emotional self-management (Gillan et al, 2014). Alongside specialist support and available guidance, clinicians will rely on and continually develop these skills throughout their career (Tavabie et al, 2020; Davies and Hayes, 2020).

Case vignette: part 1

A woman in her 70s has arrived at hospital on a Saturday evening unwell, with an exacerbation of her severe chronic obstructive pulmonary disease. She presents via ambulance to the emergency department with signs of sepsis and needs urgent medical attention. She has been in hospital four times in the last 12 months with increasing packages of care following each admission. She lives alone and smokes heavily; she wants nothing more than to go home. Take a moment to picture her and the knowledge, skills and values with which medical and nursing students, nurses and doctors need to be equipped to provide her with the best possible care.

Emotional intelligence

Emotional intelligence is broadly defined as the 'ability to monitor one's own and others' emotions, to discriminate among them, and to use this information to guide one's thinking and actions'(Mayer and Salovey, 1997). Four emotion-related abilities have been identified: perception of emotions; integration of emotions through thought processes; understanding of relations between emotions and circumstances; regulation of emotions/emotion management (Mayer and Cobb, 2000; Figure 1). It has been shown that those with higher levels of emotional intelligence use this in developing professional

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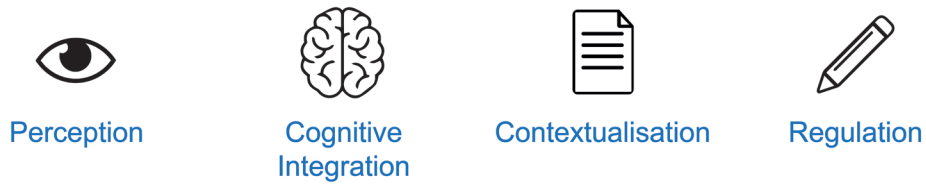

Figure 1. Mayer's four emotion-related abilities.

relationships and demonstrate desirable leadership qualities (Farshi et al, 2015). It has also been demonstrated that emotional intelligence is helpful in managing the emotions that arise from the caring process (stress, burnout and grief, for example) (Cherry et al, 2014). It is accepted that emotional intelligence is not fixed, it can (importantly for educationalists and mentors) be taught and learned and it can grow in an experiential manner or through a conscious reflective or self-developmental approach when adopted by learners (Salovey and Sluyter, 1997).

Emotional intelligence is thought to be intimately linked with social interactions and relationships, leading to improved emotional management and therefore altering the way that potentially stressful situations are faced (Codier et al, 2010). Components of emotional intelligence such as interpersonal relationships, self-awareness and self-management can be developed more readily through modalities of learning that favour an experiential and reflective approach (simulation-based education, for example) (Alconero-Camarero et al, 2018). Emotional intelligence is proposed as a correlate to effective coping styles and from this to an improved sense of fulfilment with continuing professional development and therefore self-confidence (Beauvais et al, 2014). Given that emotional intelligence can improve and is particularly likely to do so within an experiential learning environment, this would imply that simulation-based medical education around potentially stressful situations (such as those in palliative medicine) would nurture emotional intelligence in learners (Alconero-Camarero et al, 2018; Wells et al, 2019).

Case vignette: part 2

The woman outlined above is now in the acute admissions unit where her National Early Warning Score is raised. The nursing staff looking after her are concerned that she is deteriorating and follow the observations policy, which suggests a medical emergency call. When activated, this triggers attendance by the medical team who assess the patient and perform arterial blood gases and intravenous cannulation, with more blood tests sent to the lab. She is distressed by this and fighting the team off. It is difficult to calm or reassure her and she will not keep the monitoring equipment on, although she is not confused. Her voice is not being heard over the medical chatter and plan making. Imagine this situation, the stress in the room from the patient who is struggling to be heard, the medical team focused on completing the tasks assigned to them and the nursing staff who feel bound by numeric scores but uneasy at the disconnect between the doctors and the patient.

Simulation-based medical education

Simulated encounters provide learners with a safe environment in which patients cannot be harmed (Aggarwal et al, 2010). This allows learners to experiment with emotional management strategies, or practice skills such as empathy or assertiveness, before engaging with genuine patients and colleagues. These characteristics of simulation-based medical education are leading educators to incorporate its use across disciplines and professional groups to train in areas that are underpinned by emotional intelligence (leadership, professionalism, interpersonal skills and team functioning, to name a few) (Peterson et al, 2012). While there is debate around whether real world or simulated experiences allow the development of skills such as empathy more effectively, that simulation-based medical education can be designed to give learners similar exposure to high stress scenarios without the prospect of patient harm should encourage medical educationalists to consider this

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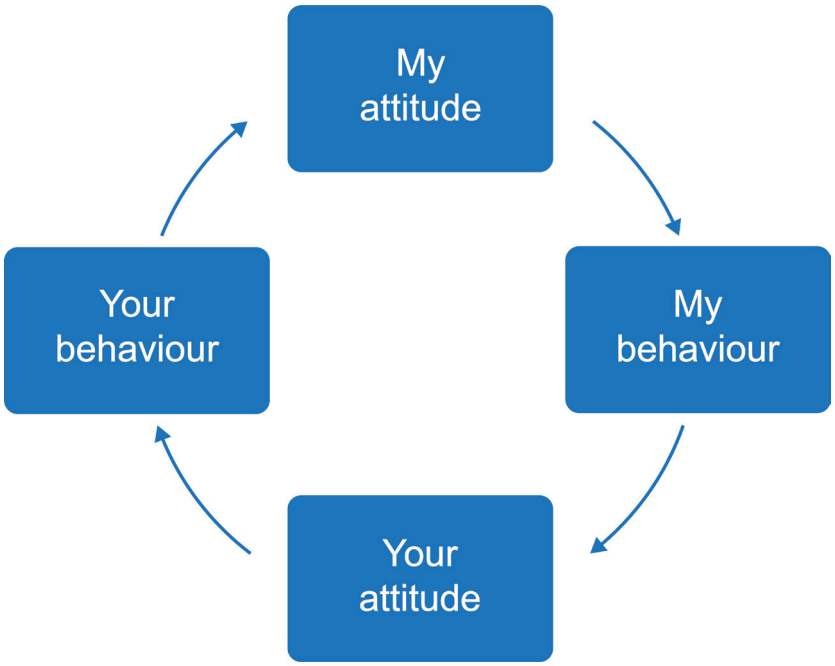

Figure 2. Betari box.

strongly (Alconero-Camarero et al, 2018). Ultimately, it is likely that an integrated approach with reflections on simulated and real-world encounters being considered by learners in tandem will best encourage learner development.

Simulation-based medical education has the potential to assist in the development of learners' emotional intelligence and this could prove a useful consideration in the design of simulation interventions, especially those with high emotional stress such as those around end of life care and dying. Simulation cases that address areas of emotional intelligence and highlight areas for development in candidates need to have their efficacy evaluated, with key elements drawn out to allow further investigation of impact. Emotional intelligence can be considered in qualitative or quantitative terms, through individuals' developmental reflections and thoughts or via standardised tools such as the 'Trait Meta Mood Scale' (Salovey et al, 1995). To allow for the difficulties in measuring emotional intelligence quantitatively, together with the potential for self-report bias, there may be a requirement for needs assessment before the simulated encounter. This approach might enable development of emotional intelligence metrics to allow for monitoring through training, using self-report subjective vs observed objective measures as grounds for reflection and development.

In the business world, it has been demonstrated that managers' emotional intelligence correlates strongly with those working for them (Momeni, 2009). The Betari box (Figure 2) is a diagram used to demonstrate how attitude is linked to behaviour within social interactions. A future consideration would be to take the tool further, considering not just attitudes and behaviours but the impact of the simulation practitioner or facilitator's emotional intelligence on group learning. This could have significant potential to impact on learner outcomes and give weight to emotional intelligence as a facet of facilitation training.

Discussion

Further research into emotional intelligence in medical education will enhance healthcare professionals' understanding of the ways in which they think, feel and behave, and whether this can be positively influenced through the design of educational interventions. Simulation appears to be a powerful tool in safely providing learners with experiences on which to reflect and grow. Thinking of healthcare professionals' holistic development and ensuring they have opportunities to grow their emotional intelligence-related abilities is vital in planning for the workforce of tomorrow. Understanding how to accomplish this better will allow educators to

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Key points

- High stress situations, such as those encountered in palliative care, evoke strong emotional responses in clinicians.
- Using experiential learning methods helps clinicians develop their emotional intelligence leading to improved clinical skills alongside self-awareness, job satisfaction and resilience.
- Future research is needed focusing, on practical applications of educational interventions with emotional intelligence as a tacit outcome.

incorporate the use of emotional intelligence in curriculum design (likely as a consideration in design and delivery of existing interventions). This in turn should encourage the development of current and future generations of healthcare professionals so that they are more resilient, manage their own emotions better and manage their patients' health and wellbeing in the most effective manner possible, including when this is at the end of the person's life.

Case vignette: part 3

This patient gets worse, despite the medical team's actions and plan. She is now on the medical ward and she has been recognised as dying. The team have changed the focus of her care to managing her symptoms. She has not been able to get home, to have her last cigarette, to see her neighbour and her dog again. Even with good quality end of life care in hospital, the team feel upset, frustrated and troubled that she is dying on a ward. Try to imagine what they would be thinking and saying as they oversee her care in her final days.

Conclusions

This simulated patient vignette has been developed as a teaching tool to illustrate the potential problems of late recognition of supportive and palliative care needs. Learners often tell us how they feel hearing descriptions of each stage of this patient's stay in hospital. Often the extremes of emotion we feel in the acute setting colour our behaviours and how we care for patients. Encouraging learners to name these emotions and acknowledge how they influence our behaviour allows guided deep reflective practice and is aimed at encouraging the development of emotional intelligence in learners. Simulated encounters with standardised patients, actors and reflecting on real world experience all have potential implications for development of emotional intelligence. Therefore the authors would encourage consideration of interventions in this way by medical educationalists and researchers.

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Conflicts of interest

The authors declare no conflicts of interest.

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