

Virtual Mentor

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Op-Ed

Should medical school applicants be tested for emotional intelligence?

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Each year medical school admissions officers try to identify the best, brightest and most suitable candidates from among the 37,000 who are competing for approximately 17,000 available slots. In so doing, these officers and their designees must determine whether applicants fit not only with the missions and priorities of their respective programs and institutions but also with the values and goals of the profession of medicine.

Admissions committees typically consider a standard set of criteria, including undergraduate institution and field of study, undergraduate grade point average, Medical College Admission Test (MCAT) scores, letters of evaluation from faculty and premedical advisors, and interview scores. The overwhelming majority of accepted students go on to graduate from medical school, suggesting that current admissions processes—largely unchanged over the last half-century—are generally effective in identifying successful *matriculants*. However, inasmuch as graduation rates are a questionable proxy for quality, a more apt measurement outcome might be how well admissions committees are able to identify students who will make good *doctors*.

Physician empathy and communication skills

The progressively proactive roles of patients and a movement toward interprofessional care have highlighted the need for physicians who possess superior interpersonal communication skills. Public dissatisfaction in this area is high; patients complain that they are not listened to and that physicians fail to demonstrate appropriate levels of caring, empathy or even tact. The potential impact of such deficiencies can be more than simply disgruntled patients. Levinson and colleagues have gone so far as to establish an empirical link between communication behaviors and subsequent malpractice litigation among primary care physicians [1].

Recognizing that the practice of modern medicine calls for a broad range of skills, aptitudes and talents makes the task of assessing applicants' qualifications more challenging. Traditional cognitive criteria reflecting intellectual ability, supplemented with emphases on interpersonal skills, have further expanded to include an evaluation of altruism, cultural sensitivity and professionalism. Perhaps the most limiting factor in these efforts is a lack of reliable and valid measurement,

that is, a means for accurately assessing such seemingly subjective constructs in individuals seeking admission to medical school.

The allure of emotional intelligence

One promising means for assessing desirable cognitive and noncognitive abilities or aptitudes is measuring emotional intelligence (EI). Psychologists John Mayer and Peter Salovey, who first coined the term, defined EI as “verbal and nonverbal appraisal and expression of emotion, the regulation of emotion in the self and others, and utilization of emotional content in problem-solving” [2]. The contention that traditional intelligence (as measured by IQ) was often trumped in real life by possession of high levels of proficiency in emotional intelligence struck an intuitive chord with many, especially those in the business and corporate world.

It makes sense that EI-related abilities might be important in physicians’ interactions with patients and in building the rapport and trust necessary to establish a solid patient-doctor relationship. EI could moderate or mediate physicians’ abilities to understand patients’ responses to various treatment regimens, thus improving adherence. Similarly, emotionally skilled physicians might interact with and relate to ancillary members of the health care team more effectively. On a personal level, EI might help physicians better react to situations by enhancing their own emotional self-awareness, potentially reducing professional burnout.

Measuring emotional intelligence

The measurement and potential relevance of EI is gradually becoming a legitimate topic of scientific investigation. Evidence of incremental validity, that is, whether EI is capable of explaining variance unaccounted for by existing personality inventories, is fairly compelling [3, 4], although results do vary by specific EI measure [5]. In particular, competing measures of EI have developed along two parallel tracks. “Ability models” view EI as a form of intelligence involving emotional perception, expression, understanding and regulation. In contrast, “mixed trait-ability models” supplement individual abilities with social-psychological traits related to emotion, such as empathy, sociability and temperament [6].

On first glance, it seems prudent to ensure that all physicians possess a modicum of emotional intelligence. Exactly where in the medical education process assessment of EI should be undertaken, however, depends largely on how mutable emotional intelligence is. Unfortunately, questions regarding the stability of EI remain empirically unresolved [7], but proponents of neither model suggest that EI is necessarily immutable to training or intervention. If EI can be instilled, nurtured or even taught during medical training—either via mindfulness exercises, mentoring or modeling—then screening for these aptitudes among medical school applicants may not be as important. If, on the other hand, EI is akin to cognitive intelligence (e.g., trait-like, developmental, etc.), assessment during the admissions process may make sense.

Even if the use of EI to select applicants at admission is not yet empirically justified, Carruthers, Gregory and Gallagher have demonstrated that, logistically, EI can be assessed during the admissions process by having interviewers rate the extent to which applicants possess specific abilities [8]. Other programs, in an effort to improve selection using 21st century tools, are developing objective standardized clinical exam (OSCE)-type exercises in which applicants are required to demonstrate certain skills [9]. Perhaps the use of performance-based EI measures like the Mayer-Salovey-Caruso Emotional Intelligence Test could be correlated with applicants' actual behaviors as demonstrated in an admissions-based OSCE.

A new tool for selection?

In our view, measurement concerns that once plagued EI-related research have become far less daunting, and empirical evidence now shows encouraging signs of incremental and construct validity. A far greater limitation to using EI as a screening criterion for medical school admission is a relative lack of companion research establishing EI as a predictor of desirable clinical outcomes. Our research found a modest but significant positive relationship between students' EI and communication skills as measured across a series of OSCE scenarios [10]. These same data also revealed EI to be significantly *negatively* correlated with students' performances on physical exam-related components. As a result, until these findings are replicated and expanded upon to further establish links between EI and measured performance, any discussion that advocates for either the unequivocal use or absolute abandonment of EI as a clinically useful criterion is premature. In our opinion, at this early stage, to deny the potential for any future relevance or application in medical education seems the greater of these two failings.

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