International Journal of Humanities and Social Science
June 2024, Vol. 14, No. 1, pp. 182-192
ISSN: 2220-8488 (Print), 2221-0989 (Online)
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Published by The Brooklyn Research and Publishing Institute.
DOI: 10.15640/jehd.v14n1a18
URL: https://doi.org/10.15640/jehd.v14n1a18

Emotional Intelligence and Clinician Empathy: An Interdisciplinary Model for Understanding and Addressing Clinician Disruptive Behavior

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Abstract

Little attention has been given to the importance of clinician empathy and disruptive behavior in healthcare literature. Yet, disruptive behaviors in health care settings is a significant problem that can have negative implications for clinicians, patients, and families. Such misconduct in health care, in the health care field, can have adverse effect on staff interactions that can negatively impact staff satisfaction, staff performance, and patient outcomes of care. Arguably, individuals who lack empathy cause the most disruption. The literature of emotional intelligence gives us the most hope in terms of understanding the importance of empathy as a tool for managing disruptive behaviors in patient care settings. Within the Emotional Intelligence framework, empathy is an element of defense against disruptive behaviors in professional settings. In the field of social work, empathy is a skill that advances clinician capacity to maintain dignity and self-worth in the care that they provide. Therefore, the objective of this article is threefold: (1) to examine the meaning of empathy, which is defined according to the emotional intelligence framework, (2) to identify the potential significance of empathy in reducing clinician disruptive behavior (CDB)and (3) raise awareness about the capacity of social work professionals on interdisciplinary teams to advance the use emotional intelligence to increase empathy and lead with compassion in the interest of promoting quality patient care.

Keywords: emotional intelligence, empathy, clinician, disruptive behavior

1. Introduction

Emotional intelligence has a critical role in health care as it related to the quality measures for patient satisfaction and clinical outcomes that may be improved by enhancing empathy (Anderson, 2016). The patient-clinician relationship is a rapid exchange of personal and often emotional information, often in the absence of long-term engagement and interaction. The health care professional's ability to respond to patient needs may depend upon their emotional intelligence. Emotional exertion used in many clinical interactions has led to scholarly exploration of the correlation between a health care professional's emotional intelligence, clinical skills and patient outcomes (Larson & Yao, 2005). Although researchers (Rosenstein, & O'Daniel, 2008; Porto, & Deen, 2008; Joint Commission, 2008) have been studying management and mitigation of conflict and disruptive behaviors in the clinical counter for well over a decade, the challenges and appropriate interventions as still not systematically addressed across health care settings and systems. What we do know is that disruptive clinician behavior worsens communication, information transfer, interdisciplinary teamwork and patient outcomes, all of which negatively affect patient safety (Villafranca, Hamlin, Rodebaugh, Robinson, & Jacobsohn, 2021). Interventions to address unprofessional behaviors and misconduct are warranted. Improving safety in medical care requires the identification of disruptive clinical behavior and its damages (Fujimoto, Shimamura, Miyazaki, & Inaba, 2023). Arguably, the clinical empathy (Garden, 2008; Gerdes, & Segal, 2009; is a componentof emotional intelligence (Goleman, 1995) that it a viable option to consider as an interventions for addressing such behaviors.

1.1. Emotional Intelligence

Emotional intelligence as a concept directed at the psychology of performance behaviors emerged as constructs that help to explain one's ability to be aware of and accept one's own behavior, the ability to be aware

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of others' feelings and the ability to manage emotions with Their interpretation of this concept evolved to the currently define emotional intelligence as:

The ability to perceive, appraise, and express emotion accurately and adaptively; the ability to understand emotion and emotional knowledge; the ability to access feelings when they facilitate cognitive activities and adaptive action; and the ability to regulate emotions in oneself and others. In other words, emotional intelligence refers to the ability to process emotion-laden information competently and use it to guide cognitive activities like problem solving, and to focus energy on required behaviors (Salovey, Mayer, & Caruso 2002).

While the literature on emotional intelligence in the discipline of medicine has grown over time (Halpren, 2003; Garden, 2008; Nighingale, Yamold, & Greenberg, 1991; Johnson, 2015), the literature that centered social workers as interdisciplinary team members began in the realm of addressing anger management and burnout (Anderson, & Elder, 2008). Most recently, social workers introduced the intersectionality of cultural competence, emotional intelligence and social justice as a practice paradigm (Anderson, Bullock, Fitzpatrick, & Ruth, 2021). Empathy as a measurement construct involves being able to articulate one's understanding of another's perspective and behaving in a way that respects others' feelings (Parris, 2020). Therefore, to recognize, understand and appreciate how people feel, the empathy paradox (Parris, 2020) may be augmented by a level of cultural competence, which gives the clinician another lens through which to consider the importance of the clinician's awareness, skills and knowledge needed to diminish disruptive encounters.

1.2.Clinician Empathy and Emotional Intelligence

Emotional intelligence has garnered the attention of scholars in various fields for many years. In interdisciplinary settings across the globe, clinician coaches (Anderson, 2017), educational psychology (Reyes, Brackett, Rivers, White, & Salovey, 2012), medicine (Alabbasi, Alabbasi, AlSaleh, Alansari, & Sequeira, 2023), social work (Anderson, Bullock, Fitzpatrick, & Ruth, 2021 and other industrial psychiatry (Srivastava, 2013) are moving the respective fields in the direction of a shared appreciation of the relationship between patient satisfaction and emotional intelligence. Social workers have long been leading the charge of integrating clinical empathy as an intervention for addressing disruptive behaviors such as anger and stress management that can lead to clinical misconduct(Anderson, & Elder, 2008). Their skills-based education and training incorporate interdisciplinary approaches to self-guided and team taught strategies that help to reduce and redirect negative strain and tension. They teach clinical empathy techniques for recognizing warning signs and symptoms that can be used in the clinical environment and practiced outside of professional workspaces, in social encounters and clinical empathy tenets apply to individual, couples or group interventions for managing potentially disruptive encounters, situations and circumstances.

In a much earlier studies, Mercer and colleagues (Mercer, et al., 2005)examined relevance and practical use of consultation and relative empathy measures in general medical practice. They found that there was a positive correlation between physician happiness and patient satisfaction. Happiness positively corresponded with empathy that was expressed and observed in the clinical environment. In a more recent study of empathy and emotional intelligence in the clinical encounter, this research also reported a positive association. Participants noted the linkage between physician and patient satisfaction resulting from the intersection of empathy and emotional intelligence for improving patient outcomes (Burcher, 2011). Further evidence from an examination of the relationship between the emotional intelligence of dental students and patient satisfaction (Azimi et al, 2010), the results suggested a positive correlation and patient satisfaction was greater when the dental student scored higher on the emotional intelligence exam. In contrast, another more recent study (Arshad, Pahore, & Ahmad, 2023), found a wider range of variability among the emotional intelligence of dental students and related positive patient outcomes, although clinician empathy was not of particular variables of interest in this research. These studies provide evidence to build upon in continuing to explore clinician empathy and emotional intelligence as possible interventions for addressing disruptive behaviors among clinicians.

2. Background

For the purpose of explaining the relevance of empathy to emotional intelligence and its potential for addressing disruptive behaviors in the medical and health care encounter, the American Medical Association(AMA) provides a conceptual understanding of responsibility to distinguish conditions that are incompatible with safe practices for patients and the care environment. This means a health care clinician is accountable for his/her/their professional behavior, including when or if it interferes with the individual's ability to work with other members of the care team or patients and families. Such clinician disruptive behavior (CDB) may include personal conduct, verbal or physical, which ultimately has the potential to negatively affect optimal patient care outcomes. The Joint Commission has gone so far as to include actions that undermine a culture of safety; and both the Joint Commission and the AMA recognize disruptive behaviors are different from criticism

offered in good faith with the aim of improving overall patient care (John & Heitt, 2018).This article seeks to describe and summarize the existing literature on emotional intelligence in medicine and social work, by (1) examining the meaning of empathy, which is defined according to the emotional intelligence framework, and (2) identifying the potential significance of empathy in reducing clinician disruptive behavior (CDB). Finally, the purpose of this article is (3) raise awareness about the capacity of social work professionals on interdisciplinary teams to advance the use emotional intelligence to increase empathy and lead with compassion in the interest of promoting quality patient care.

2.1 Empathy as Valued Added

Empathy is well documented as having a positive correlation with patient outcomes and satisfaction (Hojat, 2007; Davis, 2009; Burcher, 2011; Kerasidou, & Horn, 2016; Decety, 2020), as well as being considered a central component of holistic care. Furthermore, empathy is viewed as value added by focusing on the patient experience (Chatterjee, Tsai, & Jha, 2015). There is also evidence that empathy reduces specific psychosocial symptoms, such as anxiety, on the part of the patients and increases their sense of positive outcome expectancy (Verheul, Sanders, & Bensing, 2010). Additionally, clinicians that value empathy are viewed by patients as being empathetic (Glaser et al., 2007; Nembhard, David, Ezzeddine, Betts, & Radin, 2023).

Some scholars agree that empathy must consist of a cognitive element (Davis, 2009). However, others suggest that clinical empathy must also include an action-oriented component (Garden, 2008). Researchers argue that empathy must result in an active response rather than an end in itself (Garden, 2008) and includes the ability to understand the emotional states of others. As a result, empathy can be a tool for problem solving (Salovey et al., 2002) when addressing disruptive behavior and aiming to achieve patient safety. Perhaps, most importantly, patients indicated that empathy was very important to them in a clinical encounter (Mercer at el., 2005; Nembhard, David, Ezzeddine, Betts, & Radin, 2023).

This finding has been highlighted among patients from diverse patient populations, including those of different socioeconomic status, illness types, gender and age (Ricoeur, 2007). Noteworthy is the fact that regardless of patient characteristics, a high percentage of patients regard clinical empathy as very important (Nembhard, David, Ezzeddine, Betts, & Radin, 2023). This is a particularly important point to make because empowerment approaches to patient engagement are few and far between, in the health care literature. Beside, intervention strategies to address clinician disruptive behavior is also. Thus, beginning with patient needs and the relationship to risk of exposure to disruptive behavior on the part of a clinician is alarming. A patient and family should be assured that there is mutual trust in a caring relationship and that one should not be concerned about misconduct in the patient-clinician relationship. Ethically, the identification and incorporation of techniques and strategies that add social care value to the uneven reciprocity of a healing relationship in which the patient speaks, the clinician seeks to understand the patient as best they can, and together the clinical relationship is formed. Empathy and compassion could be achievable goals (Vieten, Rubanovich, Khatib, Sprengel, Tanega, et al., 2024) if agreed upon with presumed accountability binding the trusting relationship. This makes empathy a key tool in the caring relationship that is at the center of the clinician-patient relationship, because it is precisely this skill that can shift what may otherwise be experienced as disempowering for the patient (Chatterjee, Tsai, & Jha, 2015).

2.2. Assimilation to Empathy

It may be challenging for clinicians to assimilate to empathy rather than engage in disruptive behaviors when feeling triggered to invoke such actions (Anderson, & Elder, 2008). Some may not have the emotional awareness to look for clues of the patient's emotional experience when they are reflecting nonverbal signals (Halpern, 2003; Burcher, 2011) of dissatisfaction with how the clinician is interacting in the clinical encounter. Empathy is multidimensional, interpersonal, and modulated by context (Decety, 2020). For the clinician to have this awareness, it must be embedded in understanding what the patient is going through, after sensing the emotions the patient has conveyed through signals and body language. The clinician should be equipped with skills and knowledge that allows for a response with both words and emotions conveyed to the patient. Some scholars view empathy as the nucleus to positive patient outcomes and suggest that awareness must be taught to doctors in training, and reinforced at an institutional level, by giving clinicians enough time with patients, and insisting upon reasonable work hours (Garden, 2008: Gerdes, & Segal, 2009; Gerdes, Segal, & Lietz, 2010). However, few clinicians participate in emotional intelligence assessment and screening, related professional development, and coaching to become competent or proficiently prepared to demonstrate emotional intelligence with patients and colleagues when they are engaged in disruptive behavior (Anderson, 2015).

In the clinician-patient encounter, as a caregiving relationship, involves both intellectually and emotionally and both are important. The clinician's emotional intelligence may contribute to better outcomes and patient

satisfaction. It is becoming more evident that empathy may be the most important component of emotional intelligence in the health care setting (Petrides, 2011) because thus far, little progress has been made in terms of systematic recommendations that show promise otherwise for addressing clinician disruptive behaviors.

3. Understanding Disruptive Behaviors and the Impact on Patient Safety

Almost two decade ago, the Joint Commission (2008) highlighted concerns about behaviors that undermine a culture of safety in hospitals and other health care settings. As a result, the Commission ruled that all hospitals should have a code of conduct for medical staff and mechanisms for addressing breaches of the rule (Joint Commission, 2008). The most compelling reason for addressing disruptive behavior has been the demonstration that it can harm patients. Additionally, it can lead to difficult work environments for employees, poor patient satisfaction and workforce retention problems (Hickson 2002; Joint Commission, 2008). The College of Physicians and Surgeons of Ontario (2008) defined disruptive behaviors as:

> 'When the use of inappropriate words, actions or inactions by a physician interferes with his or her ability to function well with others to the extent that the behavior interferes with, or is likely to interfere with, quality health care delivery. Disruptive behavior may, in rare circumstances, be demonstrated in a single egregious act but is more often composed of a pattern of behavior. The gravity of disruptive behavior depends on the nature of the behavior, the context in which it arises, and the consequences flowing from it.'

A host of strategies were developed to help organizations reduce disruptive behaviors (Rosenstein, 2009; College of Physicians and Surgeons of Ontario, 2008). It is important to understand the contributing factors that predispose individuals to disruptive behaviors. Some research suggests medical institutions may find it extremely difficult to manage such behaviors among clinicians that have highly specialized and autonomous roles within a large organization. Most would agree that hospital and regulatory organizations recognize the downstream impact these actions on patient safety. Furthermore, there are many contributors to interpersonal conflict to be managed in health care, only one of which is disruptive clinician behavior (Gerlach, Phalak, & Parkh, 2022). Some possible influencing factors are overt or passive behaviors that stem from diminished professional standards, long hours with no time off, which can lead to burnout. Then there could also be the stress of the clinician work, limited resources to provide adequate care, skill deficiencies, and other impairment. These origins of the behaviors may be personal or systemic factors that outside of the realm of administrators to understand and eliminate. Therefore, considering the existing resources that are available as a standard of practice may seem obvious, but could be easily overlooked in the organization. Opportunities and tools that can be garnered through explicit attention to such challenges include specific training through in-service, professional development and/or individualized mentoring and coaching, offering interventions during normal work hours, providing resources such as employee assistance programs, and addressing systemic challenges as identified systematically or tailored to individuals. Understanding the magnitude of the disruptive behavior requires attention to relationships between patients, colleagues, and clinical teams.

However, there is a current issue and disconnect between clinicians and their respective colleagues and patients due to lack of empathy. Empathy is an integral part of creating positive relationships and fosters collaboration and communication. The absence of empathy in the healthcare setting can correlate to an increased risk of errors, which in any case is harmful to the patient at hand. Fortunately, empathy is a skill that can be developed and improved over time through intervention (Samarasekera, Lee, Yeo, Yeo, & Ponnamperuma, 2023). Early intervention informed by emotional intelligence practices would support clinicians in developing greater empathy as a useful tool in their practices. An opposing viewpoint to emotional intelligence-informed interventions is the common misconception that empathizing with patients requires an extension of unproductive time or is too emotionally draining for the clinician. However, there are various ways in which a medical professional can think and act empathetically, in a way that improves patient care and reduces disruptive behavior, but does not require intense introspection on the part of the clinician. Enhancing empathy through training helps to ingrain empathetic thinking as a subconscious analysis rather than an additional task. Emotional intelligence training should aid clinicians in improving empathy by concerning themselves with the emotions and needs of their patients, rather than focusing on their own introspection (Halpern, 2003).

Social workers are equipped with a skill set, knowledge and values…The need for social work intervention is significant, because social work professionals are equipped with an enhanced understanding of empathy, due to the consistent relationship between empathy and the core values and practices of the social work profession (Gerdes & Segal, 2009). Stress and burnout are extremely common amongst health care clinicians, due to the intensity of their patient care especially during for those providing crisis intervention care (Thirioux, Birault, & Jaafari, 2016; D'Souza, Irudayasamy, & Parayitam, 2023). Empathy training and social work intervention would

not only provide insight on ways to improve care for patients, but would equally help clinicians with learning to manage their own work-related stress. The implementation of social work models of empathy would provide clinicians with intangible skills and perspective that would enhance their ability to provide optimal care to patients, while improving their own well-being in the process.

There was a pivot from trying to prove that clinicians need emotional intelligence to best serve their patients to a focus on creating environments and practices that allow emotional intelligence to exert an actual force in the doctor-patient relationship. Almost a decade ago, scholars examined the relationship between emotional intelligence and clinical skills, "... it is only in an organizationally supportive climate that emotional intelligence is translated into emotionally competent behaviors" (Stratton et. al, 2005). It is this framework that supports the need for external facilitative personnel, with emotional intelligence based interventions, in the field of medicine. Both medical school and other clinical training environments are obverse to establishing emotional intelligence in clinicians. It has been suggested that empathy decreases during medical school (Johnson, 2015). Other scholars have argued that the clinical and learning environments of health care practitioners are directly opposed to building emotional intelligence (Stratton et. al, 2005). This deficiency has been attributed to a few factors including, but not limited to, medical corporate models of patient care and extensive time devoted to residency. Both factors influence the amount of time spent with patients and the reduced role of emotional intelligence in determining quality of care. This deficiency leans further towards a need to explore complimentary professionals to support the external facilitation of emotional intelligence training and coaching. Carol Elam (2000) suggests that this is especially critical when examining the pressure of brief visits, because clincianss must be capable of understanding their patients' emotional states. Empathy is a skill that health care clinician need in order to understand their patients while also sustaining the dignity and self-worth (NASW, 2021) in the patient, in the clinician-patient relationship.

Evidence shows that emotional intelligence plays a key role in achieving organization effectiveness and improving workplace culture (Srivastava, 2013). For this reason, it is important for healthcare leaders to consider empathy and emotional intelligence as assets in the organizational culture.

Table 1. Spectrum of disruptive behaviors (adapted from Swiggart, 2009).

Aggressive	**Passive Aggressive**	**Passive**
Inappropriate anger	Hostile notes	Failure to return calls
Threats	Derogatory comments about institution	Inappropriate/inadequate chart notes
Publicly degrading team members	Inappropriate jokes	Avoiding meetings and individuals
Intimidating staff, patients, colleagues	Sexual harassment	Non-participation in meetings or processes
Throwing objects	Complaining	Persistent lateness
Swearing		
Outbursts of anger and physical abuse		

Previous studies have identified medical professionalism as denoted by specific types of skills and knowledge that are fostered by professional values, duties and ethical obligations. It guides clinicians' decision making and responses to challenging patient encounters defined as best practice (Kerasidou & Horn, 2016). Additionally, work culture influences the temporary interpretation of medical professionalism. In some cases, work culture inadvertently contributes to the promotion of certain disruptive behavior especially if expectations are not made clear at the time of hire and if unprofessional issues are tolerated. An environment where tolerance of low level disruptive behavior leads clinicians and their peers to believe that it is normative. Disruptive behaviors can be exacerbated by the lack of emotional intelligence support within organizations that are experiencing clinicians' concerns about safety (Hickson, 2007; Anderson& Elder, 2008).

4. Organizational Response to Disruptive Behavior

Many medical professionals report a perception that doctors make significant contributions to organizational outcomes, are treated more leniently than other medical personnel (Stewart at el., 2011). While roughly 70% of American Clinical professionals (Weber, 2004) reported that their organizations had a written code of conduct, over half of the medical professionals suggested that it applied selectively or not at all. Disruptive behaviors are either under-reported or only reported when a serious violation has occurred (Stewart at el., 2011). Results from the 2004 Institute for Safe Medication Practices (ISMP) survey demonstrated that respondents felt that their organizations did not address disruptive behavior. Also, they did not feel supported if they reported an incident. Disruptive behavior can prevent the creation of a culture of safety and hinder internal collaborations and communication. Organizations are taking risks when they choose to overlook disruptive behaviors.

Disruptive behavior (DB) can lead to reduced patient satisfaction, increased complaints, increased litigation risk, low staff morale and high staff turnover. Most complaints are related to poor communication and behavior, not clinical issues. Typically a small number of doctors, within a shared setting, generate a disproportionate volume of complaints. The doctors with the most complaints were also at the highest risk of being the subject of legal action, irrespective of specialty (Hickson, 2008). Rosenstein (2008) found that DB caused high levels of stress and frustration and a dissolving of healthy relationships between health professionals. Those who had experienced DB felt angry and frustrated and some suffered adverse effects even after several months. This is one of several costs of clinicians' DB. The cost of DB to the health profession can be expensive.

5. Cost of Ignoring Disruptive Behaviors

The medical profession requires doctors to be both clinically competent and empathetic towards the patients and peers. The image of the technically skillful, rational, and emotionally detached doctor dominates the profession, and inhibits clinicians from engaging emotionally with their patients and their own feelings, which forms the basis for empathy (Kerasidou& Horn, 2016). The expression of emotions in medical practice is perceived as unprofessional and many doctors learn to suppress and ignore their feelings (Kerasidou & Horn, 2016). Medical literature highlights the positive effects of empathy on the clinicians themselves. However, very little focus is given to the impact of the requirement for empathy on the clinicians themselves (Maben, 2014). The emotional resources required and skills necessary for empathy are not always available to doctors. The medical profession is an emotionally challenging environment, which favors the image of the emotionally detached doctor.

In practice, the open expression of feelings is perceived as weakness, an attitude that leaves little room for the active pursuit of emotional wellbeing. From early on in their training, clinicians are taught that technical skills are fundamental versus interactive skills, which are considered secondary (Coulehan & Williams; 2003). Actually, there are several arguments in favor of emotional detachment of clinicians. They learn during their studies to develop emotional detachment in order to maintain scientific and medical objectivity when dealing with distressing situations (Johnson, 2015). Conversely, emotional attachment to patients is often seen as adverse to good clinical practice. Strong emotional involvement and over-identification with patients has been linked with a tendency to over-treat without considering the side-effects (Nightingale et. al; 1991). Furthermore, emotional detachment allows clinicians to remain composed when faced with emotionally difficult situations, and guide and support the patient through it (Kerasidou & Horn; 2016). The arguments in support of detached emotions ignore the significant cost of having this disposition in medical settings.

Clinicians protecting themselves from emotional distress by disconnecting from patients, what can be described as apathy, can put good medical care at risk. Increasing emotional detachment produces an attitude of cold indifference to others' needs and a callous disregard for their feelings, which can result in the depersonalization of the patient (Maslach, 2003). Emphasis on compassionate care is resulting in a reevaluation of the role of empathy in the quality of care. Empathy and compassion have become fundamental requirements of professionalism in healthcare globally. Furthermore, in the UK, the National Health Service (NHS) could employ hundreds of thousands of staff with much-needed technological skills, but without the compassion to care, then they were viewed as not being able to adequately meet the needs of all patients (NHS, 2013). Prioritizing empathy as an essential skill for clinicians seemed to align with the value for compassionate care for patients will require experts to examine its influence on the medical industry and the implications for medical practice, globally (Vieten, Rubanovich, Khatib, Sprengel, Tanega, et al., 2024).

Research has shown that countries whose healthcare systems have a strong patient care orientation often perform better than those that lack this orientation (CT) While a correlation cannot be assumed or concluded, it is relevant to analyze the United States as an example of commercialized healthcare and the possible effects of DPB. John Hopkins conducted a study that found medical errors to be the third leading cause of death in the United

States (John Hopkins Medicine, 2016). It is unlikely that such a substantial amount of preventable deaths were due to lack of funding for proper care or skills based training. In 2018, data showed that the United States spent more of its GDP on healthcare than any other country (Tikkanen & Abrams, 2020). The United States is also home to an abundance of highly qualified, specialized, and educated clinically trained professionals. However, the United States lacks standardized prioritization of empathy training in the health care settings. In such a case, professional errors would not occur as a result of lack of competence, but rather a lack of behavioral awareness on considerable occasion and DPB.

Reluctance to report disruptive behavior is where empathy and social work become relevant and a proposed solution. Therefore, to improve this relationship, social work should be implemented as a third party in order to provide a safe space for supporting staff to share behavioral concerns. The social worker could then address such concerns with the clinician. The social worker is not subject to the authority of the clinician, which creates opportunity for direct communication. Relatively, organizational implementation is crucial, due to the nature of culture change of institutions. If organizational changes do not occur, it is difficult to request such change from individuals. (CT)

6. Emotional Intelligence and Social Work

Empathy develops through experience and by increasing self-awareness of one's identity and personal values and boundaries (Davis, 1990). The experiential aspect of empathy means that, as a professional skill, it cannot be directly taught. Its development, however, can be facilitated by creating the right conditions and providing the necessary tools and resources. Implementing such conditions and tools could help clinicians properly integrate empathy into their professional practice and relationship with patients. In the following, we discuss possible steps that can be taken to facilitate this process using the social work model of empathy.

7. Understanding the Social Work Model of Empathy

Using a social cognitive neuroscience conceptualization, Decety and Moriguchi (2007) combined cumulative, qualitative descriptions of empathy from the social sciences with the new findings in social cognitive neuroscience, which led to an understanding of empathy. According to this finding, four components must come into play for a human to experience the full extent of empathy. There are five components of emotional intelligence that social workers (Anderson, & Elder, 2008; Anderson, 2015; Anderson, 2016; Gerdes, Segal, & Lietz, 2010) are equipped to advance and promote to aid in addressing clinician disruptive behaviors.

1. *Empathy* - The experience of similar emotions between the self and another, based on automatic perception-action coupling and shared representations.
2. *Self Awareness* - Even when there is some temporary identification between the observer and its target, there is no confusion between self and other.
3. *Internal Motivation* - The cognitive capacity to imagine another's situation from the inside, to adopt the subjective perspective of the other.
4. *Self Regulation* - The regulatory processes that modulate the subjective feelings associated with emotion.
5. *Social Skills*–The tools that are used to handle your own emotions and those of others.

Based on the four components mentioned above, a social work model of empathy was developed. This model reflects the person-in-environment approach of social work and the commitment to social justice, which is a core value of the profession (NASW, 2021). The social work model of empathy consists of three components, all of which build upon the prior part: 1) the affective response to another's emotions and actions; 2) the cognitive processing of one's affective response as well as the other person's perspective; and 3) the conscious decision-making to take empathetic action.

Table 2. Gerdes & Segal (2009) Social Work Empathy (SWE) Model.

Component	Definition	Key Aspects	Ways to Develop
Affective Response	Involuntary, physiological reaction to another's emotions and actions.	Mirroring, Mimicry, Conditioning	Promote healthy neurological pathways
Cognitive Processing	Voluntary mental thought processes used to interpret one's affective response; enables one to take the other person's perspective	Self-awareness, Mental flexibility, Role taking, Emotion regulation, Labelling, Judgement, Perspective taking, Self-agency	Set boundaries, Practice mindfulness, Use role plays
Conscious Decision-Making	Voluntary choices for action made in response to cognitive processing	Empathic action, SOcial empathy, Morality, Altruism	Helping, Advocacy, Organizing Social Action

An effective response includes the involuntary physical reactions clinicians have that are triggered by their exposure to external events. The second component of the Social Work Empathy (SWE) model is the cognitive processing of mirrored emotions and actions. This process is voluntary mental thought that strives to interpret the physiological sensations as well as the thoughts that mirroring triggers. It encompasses self-awareness, mental flexibility and emotion regulation. This process results in an understanding of the lived experiences of others. Conscious decision-making is the third component that draws from social work, the need to take action. The imperative of social justice, which is clearly outlined as a value of social work practice (NASW Code of Ethics, 2021) and the demonstration of ethical and professional behavior (CSWE, 2023), requires that social workers engage in practices that advance social justice is reflective of a baseline level of competencies, with empathy being a practice standard. To empathically understand patients means to enter into their situations in ways that reveal inequalities and disparities (Gerdes & Segal, 2009). Such awareness must be followed by action to promote fairness, which is the advancement of social justice. It is this proximity, of the social work profession, that prioritizes empathy-based practices and supports the existence of an empathy-centered work culture.

Discussion and Future Direction

The role of emotions within the social work profession may appear to be intuitively obvious and critical to building an empathy-centered work culture. Indeed, Howe (2008, p.13) described the day of a social worker as 'suffused with emotional content'. Munro (2011) highlighted the centrality of the social work relationship and acknowledged the importance of workers being able to identify their own emotional responses and those of service users in achieving positive relationships. For clinicians, it is the emotional elements of social work practice which has a significant impact on the content, direction and experience of health care practice. For social workers, emotional intelligence places emphasis on the ability of an individual to identify, understand and manage the emotional content of their interactions and experiences (Goleman, 1995). Emotional intelligence involves an individual's ability to be aware of their own emotional reactions in differing situations and their abilities to manage their responses accordingly (Mayer et al., 1990). Empathy is a learned skill which can be used in the attempt to relate to, communicate with and understand others.

Professions, like the field of social work, can contribute to the centrality of empathy in the work environment and the increase of empathy in some clinicians. Although it is possible to care about someone without being able to empathize with them, empathy is necessary for the demonstration of skillful practical care. The ability to empathize with colleagues with differing views will make it easier to come to agreements about courses of action. This is concerned with the way in which individuals who are working together may pull in different directions, in ways that are detrimental to the welfare of the recipients of their care, because they do not fully understand one another's reasons for the decisions they reach, and for the actions they take.

One key point, is that empathy does not require that clinicians vicariously experience and introspect about patients' emotions. The clinician's attention should not be unduly diverted to introspection. The whole point of empathy is to focus attention on the patient. A listener who was busy having his or her own parallel emotions and introspecting about them would have the wrong focus. Emotional attunement operates by shaping what one imagines about another person's experience. In trying to imagine what the patient is going through, clinicians will sometimes find themselves resonating. This is not an additional activity to imagine, but rather a kind of

involuntary backdrop to it. Further, resonance is not a special professional skill, but a part of ordinary communication. This ordinary communication can reduce disruptive behaviors and be fostered and developed through collaboration with social work professionals.

7. Conclusion

For almost two decades, research in the field of health care has examined relationship-based care comprises a triad of critical relationships: those with the patient and family, those with self, and those with colleagues (Koloroutis, 2015). The relationships with colleagues are often underestimated. Still, achieving a degree of relationship-based care need not be a zero-sum challenge for stakeholders. We need not dilute our professional integrity but instead develop the strategic capacity to empathize with the pressures and accountabilities of others. This can lead to a healthier work and care environment. A healthy teamwork will help delineate professional expectations and boundaries while not being exclusively rigid to inhibit natural overlap and shared responsibilities.

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