Emotional Intelligence: An Old Issue and a New Look in Clinical Teaching

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Abstract

In this paper, a novel model of clinical teachers with social and emotional competency which is emphasized on the importance of clinical teacher's social and emotional competence is presented. In this model, we supposed that a teacher with social and emotional competence can manage her/his emotions and has the ability to personal development and well-being. Such teacher has the competency of empathy, communication with the patients, teamwork, and collaboration to provide successful patient-centered care and relationship-centered care. He/she will be success in clinical supervision, role modeling, and mentoring by providing appropriate relationship with students. This teacher can influence and build bonds that will be effective for clinical management and leadership. In addition, it will affect the hidden and informal curriculum with the awareness of the context. These factors establish an appropriate learning environment to achieve students' academic, professional, social, and emotional outcomes and create an appropriate health care environment that influences the successful care of patient and patient's satisfaction. We reviewed a broad body of research to support our proposed model and finally proposed agendas for future research.

Keywords: *Clinical teacher, clinical teaching, emotional intelligence, social and emotional competence*

Introduction

Emotional intelligence (EI) is known as a new criterion for assessment of people's well-being and an important competency to improve job performance.[1] It is a psychological concept which has been discussed by several scientists. At first, this concept was presented to explain the findings of the researchers which had revealed that some people with lower intelligence quotient (IQ) had achieved more success in their life as compared to others with higher IQ. In fact, these contradictions opened new horizons that other factors, except IQ, might be considered for success in life.[2,3]

Gardner, by providing multiple intelligences, suggested that intelligence is much broader than limited cognitive area. He emphasized on the intra- and inter-personal intelligence which gives human the ability to understand his/her own and others.[4] Then, Salovey and Mayer published the first scientific article on EI. They classified EI as a subcategory of social intelligence which includes emotions perception and expression, use of emotions, emotional understanding, and emotional management.[5,6] Next, Bar-On and Goleman described EI in a broader concept. In Bar-On's model, EI is defined as a set of inter-related social, personal, and emotional skills which determine our ability to deal with daily needs and pressures of life effectively.[7] Goleman also believed that EI provides the main background to achieve a range of emotional competencies that lead to individuals' excellent professional performance. In this regard, EI is the competencies of self-awareness, self-management, social awareness, and relationship management.[8,9] Collaborative for Academic, Social, and Emotional Learning, based on Goleman's definition, suggested the concept of social and emotional competency (SEC).[10,11] Then, Zins has defined SEC which includes self-awareness, social awareness, responsible decision-making, self-management, and relationship management.[12]

Although there are different definitions of EI, researchers believe that if we decide to improve individuals' performance, then we should raise their EI.[1,9,13] They realized different effective factors in this success including ability of teamwork, effective

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communication, employee engagement, ethics, innovation, and productivity.[14]

Teaching is classified in the first rank of occupations that require high EI.[15] In this regard, EI has been introduced as an essential competency for an effective teaching.[16-20] The importance of emotions in teaching and teachers' professional life has been reported, for the first time, in the literature of Nias and then Armour.[17,21] Nias believed that teaching requires human interactions, therefore it has emotional aspects.[21,22] Armour also emphasized the importance of emotions in the learning.[17] The researchers of this field suggest that if the teachers do not use the EI in their teaching, the value of their expertise on the topic and also their knowledge about teaching and learning methods reduces significantly and this leads to learners' failure.[17,18]

Jennings and Greenberg demonstrated the importance of teachers' social and emotional competence with a model. They suggested that a socially and emotionally competent teacher establishes appropriate communications with learners, manages the classroom properly, and also implements social and emotional learning successfully. They believe that by controlling these three factors and creation a positive climate in the class, such teachers contribute to improve students' SEC and academic outcomes. The lack of these competencies causes the inability of teachers to control own' negative emotions, and consequently, job burnout and health harmful effects will be developed.[23] Hence, the importance and value of EI in teacher preparation programs have emphasized in new research.[24]

In clinical teaching, teacher and student interaction is an essential component as teaching in the classroom, and it can be realized as a facilitator activity for learning. During clinical teaching, students gradually obtain clinical skills and this makes them ready to solve patient problems. In this process, usually patients and their problems are involved.[25] Clinical teacher talks about patients' problems in situations such as wards, outpatient, and emergency. Clinical teaching often takes place in the course of routine clinical care.[26] In these situations, a triad of student, patient, and tutor forms besides the personnel and patient care team.[27] When these people work together and perform their duties correctly, patients will receive effective care and students will learn more successfully.[27,28] Clinical practice stimulates students to use creative thinking for problems solving. In clinical situations, students transform theoretical knowledge to mental and psychomotor skills that are necessary for patient care.[25,29]

In this environment, several roles are defined for clinical teachers such as personal developer, patient caregiver, clinical educator, role model, mentor and clinical leader, and manager.[27,30,31] A good clinical teaching depends on noncognitive and socio-emotional characteristics including ability to build a supportive communication

with students, communication skills with patients, and enthusiasm for teaching and medicine rather than cognitive abilities.[32] Therefore, the aim of this article is to investigate the importance of social and emotional competence based on the various roles played by clinical teachers through developing a model [Figure 1] and using the evidence.

Materials and Methods

To address this purpose, we present a graphical model of clinical teachers with SEC and describe the variables and the relationships. This model was presented based on clinical teacher's roles. We supposed that a clinical teacher should be a personal developer, clinical expertise, educator, and leader or manager. In these roles, he/she should relate with patients, students, health care team members, and context. This model was proposed to explain how clinical teachers' social and emotional competences and personal development will be related to learning outcomes and patient care. In this model, clinical teacher SEC and personal development have effects on clinical teacher's relationships with students, patients, health care team members, and context. We hypothesized that the quality of these relationships mediates learning outcomes and patient care. We reviewed a broad body of researches from the educational, clinical, and psychological literature to support our proposed model. Finally, we reviewed literature that may support clinical teachers' SEC based on their roles and propose suggestions for future research in this new area. We search databases (MEDLINE, ProQuest, Scopus, ERIC, and ISI Web of Science) for relevant literature published about each of those roles. The review was selective in its approach and the selection of studies followed published guidelines to ensure rigor. This review is not intended to be a comprehensive meta-analysis; we review selected studies
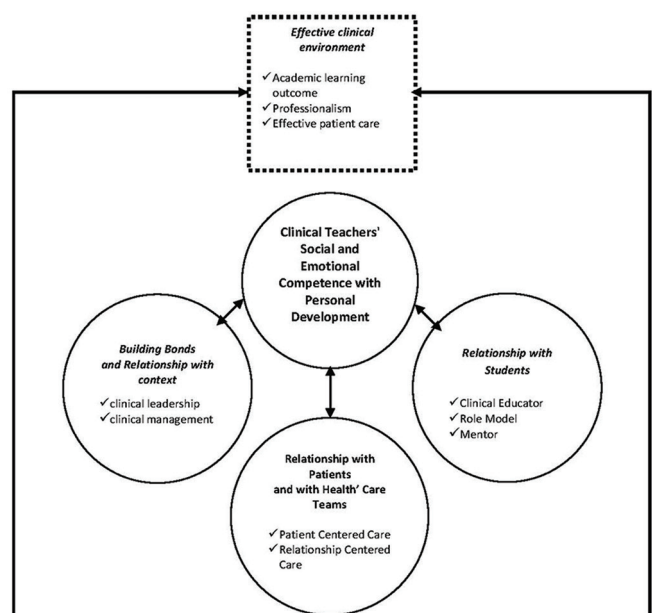

Figure 1: The clinical teacher with social and emotional competency

to provide evidence of relationships among our variables of interest (clinical teacher SEC, personal development, teacher–student relationship, patient–doctor relationship, leadership, and management).

Personal Development

Personal development is one of the essential competencies for the health professional team. They encounter large stresses daily in their interactions with patients and their families. A person who cannot tolerate the stress will be suffered from job boredom and compassion fatigue.[33] In contrast, a person with competency of personal development has compliance mechanisms to respond the environmental stress and manage conflicts between personal and professional responsibilities.[34-36] This ability is very important for clinical teachers because they play teaching role at the same time with patient-centered care. In fact, stress control is the first step to build communications that are required to start an effective teaching. On the other hand, nowadays, special features of the clinical situations have turned teaching to one of the most challenging roles for clinical teachers[37] because they should present different roles including manager, facilitator, specialist, therapist, or assessor.[38] Different levels and interests of students, unpredictability and diversity of the subject,[26,28,39] deterioration of the patient, and unpredictability of environmental conditions[25] are challenging for clinical teachers. In addition, lack of motivation among the students, lack of bonus system for educational activities, and lack of proper management in the educational system reduce their motivation for teaching.[28,40,41] Teachers require high SEC to manage this challenging situation. People with social and emotional competence control their strong emotions while they maintain composure and confidence in stressful and unforeseen conditions and make an appropriate response. In fact, this competency helps teachers to cope with stress and consequently to be less vulnerable against it.[42-44] As a result, it decreases work burnout among them while it increases well-being.[42,44,45] These teachers know their emotions and are aware how to motivate themselves[3,23] in addition to they have higher employee engagement.[3,46,47]

In addition, the individual with the ability of personal development demonstrates necessary quality for lifelong professional and personal promotion. People with social and emotional competence have the ability of self-awareness. They can recognize their strengths and weaknesses and also are informed of their knowledge, skills, and emotions. People with this competency solicit honestly the others critiques (colleagues, staff, and students) to improve their performance and ask help at the right time. Furthermore, these persons try to improve their performance after reflecting on an unsuccessful experience and change their methods based on the new evidence. These people with high EI are optimistic about the ultimate success of their efforts.[14] This competency is essential for doctor[34-36] and

is an important predictor for effective teaching[20] while it is one of the characteristics of a good teacher.[32]

Clinical Expertise

One of the most important tasks for clinical teachers is patient care. The therapeutic role requires effective communication between doctor and patient to provide patient-centered care. In this type of care, doctor and patient enter to the care process by their experiences, values, and emotions. When the doctors help the patients, they may experience negative emotion upon hearing their stories. If the doctors cannot manage their emotions, then they will experience compassion fatigue and they will lose the power of correct decision making.[33] In contrast, doctors who have the power to manage their emotions will control their behaviors. The doctor explains disease to the patient and helps her/him to express emotions, beliefs, and expectations by empathy.[48,49] Respect for the values and preferences of the patients, also giving the choosing right, and making decisions to them are the principles of this type of care.[50] An effective doctor and patient communication causes that patient feels his/her deciding is important[49] and makes patient satisfied. In fact, effective doctor and patient relationship improves the effectiveness of care activities, patient's compromise, patient's confidence, and ultimately clinical outcomes.[42,51] Reduction of unnecessary referrals and para-clinical tests along with increased doctor's satisfaction are other advantages of this type of care.[49]

On the other hand, relationship-centered care expands the range of relationship more than common doctor and patient relationship while it also emphasizes the importance of communication between the personnel providing health care, patient's family, and society. In this type of care, patient care team is committed to communicating with each other[52] and they contribute to the patient care process based on a mutual trust and respect.[53] A teacher with social and emotional competence has the ability of teamwork and collaboration to provide this type of care.[54]

EI is effective in doctor–patient communication and is considered as an essential component for increasing the effectiveness of patient care. Doctors with social and emotional competence are more aware of patients' emotions and consequently, are more successful in treatment.[51] A doctor with social and emotional competence listens to the patients' words and pays attention to their nonverbal behaviors[14] and empathizes with them by understanding their concerns and emotions.[55,56]

Effective communication between doctor and patient facilitates patient participation in education. When they are treated by students, they have concerns about physical damage and breaching their privacy.[57] A teacher with high EI is responsible for patients' expectations by recognition of these concerns and considering their rights. He/she gives the right for patients to participate conscious and voluntary

so that patients can select the time and the method of informing others and also have control on their own privacy. The patient in this environment will have a positive attitude toward education and will enjoy of participation in education.[58-65] In contrast, some factors such as lack of right choice, concerning for the confidentiality, and feeling the risk of physical damage reduce their motivation to participate in education.[61,66]

Clinical Educator

A teacher helps the learners in the clinical education to achieve necessary knowledge, skills, and attitudes based on the standards for patient care in the health system. Clinical supervisor is another term which demonstrates the meaning of a clinical educator. Clinical supervision is a process that learners experience professional and personal growth under the supervision of an expert. In the clinical environment, most of medical education happens in one-to-one communications between a supervisor and the student or assistant. There are many evidence that demonstrates the effectiveness of this supervision widely depending on the quality of relationship between the student and teacher while the interaction between the supervisor and supervisee is important in creating positive experiences in this process.[67] This communication must be in a supportive form, and learners should have opportunity to express their problems and have the emotional drain. In addition to facilitating conditions such as empathy, respect and genuineness are necessary for successful supervision. This relationship that facilitates learning is called educational alliance.[68]

A teacher with social and emotional competence is successful at the beginning and maintenance of a healthy and productive relationship. He/she has respect for students, accepts them, and is aware of their emotions.[3] He/she also considers nonverbal behaviors of students to understand the feelings and concerns of learners, listen to their words, and establish a healthy relationship by attention to their concerns. The teacher recognizes that students have a lot of emotions and stresses in the clinical environment such as fear of practical skills, empathy with ill patients, facing with the expectations more than their abilities, fatigue of the long work shifts, and stress due to time constraints that are effective to physical fatigue and reduce learning.[69] He/she is aware of the learners' enthusiasm when they solve a problem and review an important article and the fear and anxiety of students when they enter to the examination, especially when they are not aware of test references. A teacher who understands students' emotions and considers the cognitive appraisals that may be associated with these emotions knows how the learners are affected by emotions. This type of teachers can improve the motivation of students and establish positive emotions among them by planning an appropriate learning environment. He uses these emotions to increase learning of students; for example, when the teacher knows that the learner is affair of practical skills, he/she provides training opportunities in simulated conditions by representing communication and supportive care.

On the other hand, teaching is associated with complexities in clinical situations such as diversity and different levels of learners, time constraints, personnel and patient relative's traffic, uncomfortable state of patient, and unpredictability.[26] Facing with these complexities has intensified the need for adaptive and creative teacher while using new teaching methods is crucial.[70] Applying diverse and innovative methods such as puzzles, teamwork, making maps or diagram, and an artistic element meets the needs and learning styles of different learners in the educational environments.[70] These teachers provide enjoyable and satisfying experiences for own and learners[71] while they create an environment that leads to learn and motivate learners.

Goleman defines innovation, adaptability, initiative, and optimism as the competencies of the individual with high EI. Someone with these competencies uses opportunities and stimulates others through innovative efforts with optimism. These people use various sources to obtain new ideas and resolve the problems. A teacher who wants to be creative during teaching should primarily be aware of appropriate teaching-learning theories. When this knowledge is obtained, the abilities to deal with stress, adequate motivation, and EI for creative teaching are established.[71] Ashcroft quoted the results of Halliwell that creativity requires a detailed understanding of the needs, ability for realizing position, and willing to take risks.[72] In fact, in the first step of the creativity process, people should gain insight into the problem and obtain information about the problem from many different sources. At this step, the ability to communicate with other people is important to assess their opinions and also helps investigate the success or failure experiences of other people.[72,73]

Role Modeling and Mentoring

Clinical teacher, in the mentoring and role modeling, communicates with students in another way. Role model is a valuable person for imitation by students and he/she facilitates learning of clinical skills.[68] In fact, learning from role models is associated with observing the attitudes and behavior of model that is the major part of clinical environments.[74]

Bandura introduced attention process as one of the effective processes that influence observational learning. He stated that in such processes, the model must be attended to before something can be learned from it.[75,76] Some features including enthusiasm, compassion, openness, appropriate communication with patients, as respectability, and powerful of model are effective on an observer's attention.[75-77] In this environment, a teacher with high EI has transparency and is committed to ethics, principles,

and values. He/she has some attributes such as suitable communication with other people, optimism, self-esteem, flexibility, and patience that it can be a positive role model for students,[78,79] affects others by displaying desired behaviors, and has the power of attraction their respect.[14]

Teacher with social and emotional competence is also more successful to teach EI competencies. These teachers can display these skills for learners and become role models for social and emotional behaviors.[23] Promoting SEC of learners can increase their academic achievement,[55,80,81] by reducing the disruptive behavior in their learning.[82] These competencies will create a community of learners who support and care for each other and improve the general climate of the class.[12,83] These abilities are the fundamentals to teach professionalism and moral sensitivity to students[84-87] and improve the relationship between the doctor and the patient, by increasing confidence in the clinical interactions.[88]

A good clinical role model should be aware of his/her role modeling during the interaction with the patient and in the presence of students;[89,90] therefore, he/she can provide opportunities to display and explain the correct behavior for students and guide them to search for these opportunities.[90] A teacher with high EI has the ability of self-reflection and assessing his or her strengths and weaknesses in teaching.[1] He/she has the opportunity to increase own awareness about the role model process and displayed behaviors and ideas.[91]

Another type of communication in the clinical environments is mentoring that is a type of role model. Cooper and Palmer have defined it as "Mentor is an individual who causes personal and professional promotions of mentee by communicating to them."[92] This dynamic relationship is mutual and there are a lot of emotion and passion between them. Mentor guides mentee in the political and social networks and also finds the people who can help the mentee in his/her profession. Mentor helps the mentee to identify career interests and goals while involving in the life and career of mentee."[31,92] This relationship is based on common professional and personal interests and is get stronger by common interests and ideals.[93] In fact, there is a degree of intimacy and relevance that is similar to a friendship and family[94]

Mentoring is a medical complex phenomenon that has influences on mentor's and mentee's personal and professional lives. A good mentoring needs commitment and skills of interpersonal communication between mentor and mentee. Mentor with social and emotional competence shares his or her emotions and feelings with mentees honestly and helps them to express their feelings. Therefore, an effective and friendly interaction will be established between them. If EI of teacher is low despite his training for the mentor role, it seems unlikely that be recognized as a relatively skilled mentor.[95] Effective mentoring requires the EI competencies including active listening, ability

to read the others emotions, flexibility, being tolerant, optimistic mood, ability to motivate the mentee, empathy, and being responsible and availability.[94,95] Mentoring is formed by organizational culture and conditions and needs a facilitator organizational environment.[94]

On the other hand, accountability and commitment to the medical profession, patients, and learners are mentioned as effective properties of a clinical teacher[32] and a good clinical role model.[89] These teachers are available after the teaching to meet the needs and questions of patients and students and are ready to help them intensively. They observe the method of physical examinations for a long time and represent the feedback for students. They also evaluate patient and student satisfaction and control the response levels to the needs of learners during the period that have their responsibility.[32]

Goleman realized service orientation as a competency of emotionally intelligent person. He believes that people with high EI are service oriented and always are ready to help and serve others in addition to successful continuation of an efficient relationship.[9,14]

Leadership and Clinical Management

Clinical teacher carries the double burden of management and leadership in an educational environment. These roles are played at different levels. Sometimes, leadership and management occur at wide levels such as a complex educational organization or a department. On the other hand, these may happen in local levels such as in interprofessional education. However, educational or clinical leader determines visions and values as the leader of team and creates the motivation to achieve this vision in others. The main purpose of formation of this team is participating people to improve the quality of patient care[96] and achieve learning goals of students. Educational or clinical leadership is the key to improve the quality of patient care and clinical education and makes changes and improvements. Educational or clinical manager creates stability and order by setting procedures and policies and prepares resources and people to achieve learning objectives and patient care. The main role of manager is creating a positive organizational atmosphere that is responsive to achieve the mentioned vision.[31]

In addition, in clinical settings, changes such as using mobile technology, simulations, e-learning, changes in medical training programs, and new technologies are growing rapidly. Clinical teacher as a leader and manager should plan and conduct these changes and supervise them. Conduction of these changes, identifying and managing the necessary human, and physical resources to provide patient's care and student's education are challenges for a clinical teacher.[96]

Leadership requires many skills that social awareness and relationship management are of them.[42] People with

these competencies encourage others' participation to achieve their common goals while also create enthusiasm, commitment, and passion of teamwork.[97] This person is accepted, respected, and trusted by the power of influence,[98] obtain motivations with other people and inspires them.[99,100]

Sometimes, clinical management happens at the local level during the teaching round. In this situation, clinical teacher tries to create an environment that facilitates and supports scientific, social, and ethical learning of learners. Clinical teacher provides an ordered environment for students by determination of the laws, rewards, and penalties to control the behavior of learners while he/she also uses appropriate interventions to deal with behavioral problems of them. In addition, teacher establishes supportive and caring relationship between the students to achieve these goals and manages and facilitates formation of groups by encouraging students in their scientific tasks.[101] Teacher with social and emotional competence has the power of building bonds, which means he or she can link a range of people with different skills together that they motivate each other and seek common objectives. Teacher also creates a community where social interactions are established in a positive climate. He/she encourages participation and cooperation of the learners and performs good behaviors as a role model.[23] Hence, teacher can be more successful for management of interprofessional education, and students in teams of two or more professions can learn with, from, and about each other.[102] The teacher seeks solutions in the situations that conflicts arise by talking to other people and develop a classroom environment with a minimum of conflict and destructive behaviors. In this learning community, students are encouraged to know the peers, to love them, to learn how to debate, and to ask for help for problem-solving.[103] These teachers wish the academic progress of their students during teaching to them and teach them to have a moral responsibility about their peers, families, and communities and achieve the competencies and values necessary for a citizen. Moreover, these teachers know themselves accountable to train competent doctors to meet the needs of the community.

Leaders with social and emotional competence are aware of the context, informal, and hidden curriculum. They pay attention to complex social networks between doctors and different professionals with various educational backgrounds that affect social identity of them.[104] This aspect of identity formation may have a strong influence on their professional behavior.[52]

A person with high EI has organizational awareness. He/she is aware of the interactions between people, values, and culture of the school environment.[14] This person pays attention to the effect of legislations such as evaluation rules on the individuals in clinical environments and understands the causes of their professional and unprofessional behaviors. He/she can recognize and manage the challenges that learners are facing by developing discussions and reflections on the context and also affect the hidden and informal curriculum which is transferred through the context. The teacher also helps the learner to increase his or her consciousness about the network and transmitted messages.[104]

Conclusion

Teachers' social and emotional competence is effective on the outcomes of clinical teaching through three factors including relationship with himself (or herself), with others (patients, students, and patients' care teams), and with context. Socially and emotionally competent clinical teachers have self-awareness and self-management that will lead to personal development and well-being. They can manage their communications with patients and healthcare team members; as a result, they will be successful in patient-centered care and relationship-centered care. The ability to manage relationships with students helps them to provide successful educational role, mentoring, and role model. Socially and emotionally competent clinical teachers have a significant influence on the other people and have an effective leadership and clinical management. In addition, context awareness leads to impact on the hidden and informal curriculum.

These factors are effective to create an effective clinical environment for learners and patients and consequently may results a better academic performance of students, learning of professionalism, and learning socio-emotional skills as well as succession in the appropriate patient's care.

Suggestions for Future Research

A few researches in the field of medical education have demonstrated evidence of relationships among various components of our proposed model. There are some evidence that SEC is positively associated with personal development,[3,43,44,105] stress management,[42] organizational commitment,[42] patient–doctor relationship,[42,51] increased empathy,[42] and role modeling.[78,79] Patient–doctor relationship is related to patient satisfaction.[51] Higher EI was reported to positively contribute to the teamwork and communication skills and leadership. Further research is needed to determine whether clinical teachers' SEC can improve academic learning outcome and professionalism. Therefore, there are several areas that need further research that might employ multiple methods including the use of case studies, longitudinal, observational studies, and more extensive randomized controlled trials.

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Conflicts of interest

There are no conflicts of interest.

References

1. Sparrow T, Knight A. Applied Emotional Intelligence: The Importance of Attitudes in Developing Emotional Intelligence. England: John Wiley & Sons; 2006.
2. Bradberry T, Greaves J. The Emotional Intelligence Quick Book: Everything You Need to Know to Put Your EQ to Work. New York: Simon and Schuster; 2006.
3. Haghani F, Aminian B, Changiz T, Jamshidian S. Development and psychometric evaluation of a tool for assessing emotional intelligence in teaching. Iran J Med Educ 2014;13:1127-37.
4. Gardner H. Frames of Mind: The Theory of Multiple Intelligences. New York: Basic Books; 2011.
5. Salovey P. Applied emotional intelligence: Regulating emotions to become healthy, wealthy, and wise. Emotional Intelligence and Everyday Life. London: Psychology Press; 2001. p. 168-84.
6. Salovey P, Mayer JD. Emotional intelligence. Imagin Cogn Pers 1989;9:185-211.
7. Bar-On R. Emotional and social intelligence: Insights from the emotional quotient inventory. San Francisco, CA, US: Jossey-Bass; 2000.
8. Goleman D. Working with Emotional Intelligence. New York: Random House Digital, Inc.; 1998.
9. Goleman D. Emotional Intelligence. New York: Random House LLC; 2006.
10. Tom KM. Measurement of Teachers' Social-Emotional Competence: Development of the Social-emotional Competence Teacher Rating Scale [Ph.D.]. Ann Arbor: University of Oregon; 2012.
11. Elias MJ, Zins JE, Graczyk PA, Weissberg RP. Implementation, sustainability, and scaling up of social-emotional and academic innovations in public schools. School Psych Rev 2003;32:303-19.
12. Zins JE. Building Academic Success on Social and Emotional Learning: What Does the Research Say? New York and London: Teachers College Press; 2004.
13. Qualter P, Gardner KJ, Whiteley HE. Emotional intelligence: Review of research and educational implications. Pastor Care Educ 2007;25:11-20.
14. Bennis W, Cherniss C, Goleman D. The Emotionally Intelligent Workplace: How to Select for, Measure, and Improve Emotional Intelligence in Individuals, Groups, and Organizations. SanFrancisco: John Wiley & Sons; 2003.
15. Yate MJ. Career smarts: Jobs with a future. NewYork: Ballantine Books; 1997.
16. Allen DE, Ploeg J, Kaasalainen S. The relationship between emotional intelligence and clinical teaching effectiveness in nursing faculty. J Prof Nurs 2012;28:231-40.
17. Armour W. Emotional intelligence and learning and teaching in higher education: Implications for bioscience education. Investigations in university teaching & learning 2012;8:8-10.
18. Mortiboys A. Teaching with Emotional Intelligence: A Step by Step Guide for Higher and Further Education Professionals. London and New York: Taylor & Francis; 2005.
19. Sharma S, Arora S. Teaching with Emotional Intelligence in Higher Education. Opinion: International Journal of Management 2012;2(1):52-58.
20. Singh I, Jha A. Teacher effectiveness in relation to emotional intelligence among medical and engineering faculty members. Eur J Psychol 2012;8:667-85.
21. Nias J. Thinking about feeling: The emotions in teaching. Cambridge J Educ 1996;26:293-306.
22. van Veen K, Lasky S. Emotions as a lens to explore teacher identity and change: Different theoretical approaches. Teach Teach Educ 2005;21:895-8.
23. Jennings PA, Greenberg MT. The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. Rev Educ Res 2009;79:491-525.
24. Nelson DB, Low GR, Nelson K. The Emotionally Intelligent Teacher: A Transformative Learning Model; 2005. New York: Academic Press. Available at: http://eprints.qums.ac.ir/1741/1/emotionally%20intelligent%20teacher.pdf. [Last retrieved on 2005 Nov 29].
25. Spencer J. Learning and teaching in the clinical environment. Br Med J 2003;326:591-4.
26. Ramani S, Leinster S. AMEE guide no 34: Teaching in the clinical environment. Med Teach 2008;30:347-64.
27. Harden RN, Dent JA. A Practical Guide for Medical Teachers. China: Churchill Livingstone; 2005.
28. Arabshahi KS, Haghani F, Bigdeli S, Omid A, Adibi P. Challenges of the ward round teaching based on the experiences of medical clinical teachers. J Res Med Sci 2015;20:273-80.
29. Janicik RW, Fletcher KE. Teaching at the bedside: A new model. Med Teach 2003;25:127-30.
30. Parsell G, Bligh J. Recent perspectives on clinical teaching. Med Educ 2001;35:409-14.
31. Rose M, Best D. Transforming Practice Through Clinical Education, Professional Supervision, and Mentoring. New York: Elsevier Health Sciences; 2005.
32. Sutkin G, Wagner E, Harris I, Schiffer R. What makes a good clinical teacher in medicine? A review of the literature. Acad Med 2008;83:452-66.
33. Peterson J. Compassion Fatigue and Emotional Intelligence in Physicians [Ph.D.]. Ann Arbor: Walden University; 2013.
34. Ellaway R, Evans P, McKillop J, Cameron H, Morrison J, McKenzie H, *et al.* Cross-referencing the Scottish Doctor and Tomorrow's Doctors learning outcome frameworks. Med Teach 2007;29:630-5.
35. Englander R, Cameron T, Ballard AJ, Dodge J, Bull J, Aschenbrener CA. Toward a common taxonomy of competency domains for the health professions and competencies for physicians. Acad Med 2013;88:1088-94.
36. Frank JR, Danoff D. The CanMEDS initiative: Implementing an outcomes-based framework of physician competencies. Med Teach 2007;29:642-7.
37. Ende J. What if Osler were one of us? Inpatient teaching today. J Gen Intern Med 1997;12 Suppl 2:S41-8.
38. Harden RM, Crosby JR. AMEE guide no 20: The good teacher is more than a lecturer-the twelve roles of the teacher. Med Teach 2000;22:334-47.
39. Haghani F, Arabshahi SK, Bigdeli S, Alavi M, Omid A. Medical academia clinical experiences of Ward Round Teaching curriculum. Adv Biomed Res 2014;3:50.
40. Hoffman KG, Donaldson JF. Contextual tensions of the clinical environment and their influence on teaching and learning. Med Educ 2004;38:448-54.
41. Ramani S, Orlander JD, Strunin L, Barber TW. Whither bedside

teaching? A focus-group study of clinical teachers. Acad Med 2003;78:384-90.

42. 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;44:749-64.

43. Naidoo S, Pau A. Emotional intelligence and perceived stress. SADJ 2008;63:148-51.

44. Oginska-Bulik N. Emotional intelligence in the workplace: Exploring its effects on occupational stress and health outcomes in human service workers. Int J Occup Med Environ Health 2005;18:167-75.

45. Martins A, Ramalho N, Morin E. A comprehensive meta-analysis of the relationship between emotional intelligence and health. Pers Individ Dif 2010;49:554-64.

46. Nikolaou I, Tsaousis I. Emotional intelligence in the workplace: Exploring its effects on occupational stress and organizational commitment. Int J Organ Anal 2002;10:327-42.

47. Reilly NP. Exploring a paradox: Commitment as a moderator of the stressor-burnout relationship. J Appl Soc Psychol 1994;24:397-414.

48. Miller L. Towards a global definition of patient centred care. BMJ 2001;322:444-5.

49. To H. Getting it right: Why bother with patient-centred care? Med J Aust 2003;179:253-6.

50. Bensberg M. Patient centred care literature review. Dandenong: Dandenong Division of General Practice; 2007.

51. Weng HC, Chen HC, Chen HJ, Lu K, Hung SY. Doctors' emotional intelligence and the patient-doctor relationship. Med Educ 2008;42:703-11.

52. Haidet P, Stein HF. The role of the student-teacher relationship in the formation of physicians. The hidden curriculum as process. J Gen Intern Med 2006;21 Suppl 1:S16-20.

53. Suchman AL. A new theoretical foundation for relationship-centered care. J Gen Intern Med 2006;21 Suppl 1:S40-4.

54. McCallin A, Bamford A. Interdisciplinary teamwork: Is the influence of emotional intelligence fully appreciated? J Nurs Manag 2007;15:386-91.

55. Austin EJ, Evans P, Magnus B, O'Hanlon K. A preliminary study of empathy, emotional intelligence and examination performance in MBChB students. Med Educ 2007;41:684-9.

56. Satterfield J, Swenson S, Rabow M. Emotional intelligence in internal medicine residents: Educational implications for clinical performance and burnout. Ann Behav Sci Med Educ 2009;14:65-8.

57. Waterbury JT. Refuting patients' obligations to clinical training: A critical analysis of the arguments for an obligation of patients to participate in the clinical education of medical students. Med Educ 2001;35:286-94.

58. Adibi P, Enjavian M, Alizadeh R, Omid A. The effect of ward round teaching on patients: The health team and the patients' perspectives. J Educ Health Promot 2013;2:35.

59. Benson J, Quince T, Hibble A, Fanshawe T, Emery J. Impact on patients of expanded, general practice based, student teaching: Observational and qualitative study. BMJ 2005;331:89.

60. Doshi M, Brown M. Whys and hows of patient-based teaching. Br J Psychiatry 2005;11:223-31.

61. Izadi P, Pirasteh A, Shojaienejad A, Omid A. Patients' attitude and feeling toward the presence of medical students in Shahid Mostafa Khomeini educational clinics. Iran J Med Educ 2014;14:303-11.

62. Lynöe N, Sandlund M, Westberg K, Duchek M. Informed consent in clinical training – Patient experiences and motives for participating. Med Educ 1998;32:465-71.

63. O'Flynn N, Spencer J, Jones R. Consent and confidentiality in teaching in general practice: Survey of patients' views on presence of students. BMJ 1997;315:1142.

64. Stacy R, Spencer J. Patients as teachers: A qualitative study of patients' views on their role in a community-based undergraduate project. Med Educ 1999;33:688-94.

65. Thomas E, Hafler J, Woo B. The patients experience of being interviewed by first-year medical students. Med Teach 1999;21:311-4.

66. Omid A, Adibi P, Bazrafkan L, Johari Z, Shakour M, Yousefi AR. A review on some aspects of patient' rights in clinical education. Iran J Med Educ 2012;11:1299-311.

67. Kilminster SM, Jolly BC. Effective supervision in clinical practice settings: A literature review. Med Educ 2000;34:827-40.

68. Norman GR, Vleuten C, Newble DI. International Handbook of Research in Medical Education. Canada: Springer; 2002.

69. McConnell MM, Eva KW. The role of emotion in the learning and transfer of clinical skills and knowledge. Acad Med 2012;87:1316-22.

70. Vaughn L, Baker R. Teaching in the medical setting: Balancing teaching styles, learning styles and teaching methods. Med Teach 2001;23:610-2.

71. Starbuck D. Creative Teaching: Getting it Right. New York: Bloomsbury Publishing; 2006.

72. Ashcroft K, James D. The Creative Professional. London: Routledge; 2002.

73. Morgan P. Managing Yourself: Coach Yourself to Optimum Emotional Intelligence. London: Pearson Education; 2003.

74. Edward J, Friedland JA, Bing-You R. Residents' Teaching Skills. New York: Springer Publishing Company; 2002.

75. Bandura A. Social Foundations of Thought and Action. Englewood Cliffs, NJ: Prentice Hall; 1986.

76. Olson MH, Hergenhahn BR. An Introduction to Theories of Learning. United States of America: Pearson/Prentice Hall; 2009.

77. Wright SM, Kern DE, Kolodner K, Howard DM, Brancati FL. Attributes of excellent attending-physician role models. N Engl J Med 1998;339:1986-93.

78. Haghani F, Aminian B, Changiz T. Do the teachers who are selected by students have a higher emotional intelligence? J Strides Dev Med Educ 2012;8:132-40.

79. Jochemsen-van der Leeuw HG, van Dijk N, van Etten-Jamaludin FS, Wieringa-de Waard M. The attributes of the clinical trainer as a role model: A systematic review. Acad Med 2013;88:26-34.

80. Chew BH, Zain AM, Hassan F. Emotional intelligence and academic performance in first and final year medical students: A cross-sectional study. BMC Med Educ 2013;13:44.

81. Codier E, Kooker BM, Shoultz J. Measuring the emotional intelligence of clinical staff nurses: An approach for improving the clinical care environment. Nurs Adm Q 2008;32:8-14.

82. Brackett MA, Rivers SE, Salovey P. Emotional intelligence: Implications for personal, social, academic, and workplace success. Soc Personal Psychol Compass 2011;5:88-103.

83. Elias MJ. Promoting Social and Emotional Learning: Guidelines for Educators. United States of America: ASCD; 1997.

84. Labouvie-Vief G, Diehl M. Cognitive complexity and cognitive-affective integration: Related or separate domains of adult development? Psychol Aging 2000;15:490-504.

85. Morton KR, Worthley JS, Testerman JK, Mahoney ML. Defining

features of moral sensitivity and moral motivation: Pathways to moral reasoning in medical students 1. J Moral Educ 2006;35:387-406.

86. Pizarro D. Nothing more than feelings? The role of emotions in moral judgment. J Theory Soc Behav 2000;30:355-75.

87. Stoller JK, Taylor CA, Farver CF. Emotional intelligence competencies provide a developmental curriculum for medical training. Med Teach 2013;35:243-7.

88. Ogle JA, Bushnell JA. The appeal of emotional intelligence. Med Educ 2014;48:458-60.

89. Passi V, Johnson S, Peile E, Wright S, Hafferty F, Johnson N. Doctor role modelling in medical education: BEME Guide No 27. Med Teach 2013;35:e1422-36.

90. Wright SM, Carrese JA. Excellence in role modelling: Insight and perspectives from the pros. CMAJ 2002;167:638-43.

91. Kenny NP, Mann KV, MacLeod H. Role modeling in physicians' professional formation: Reconsidering an essential but untapped educational strategy. Acad Med 2003;78:1203-10.

92. Cooper AM, Palmer A. Mentoring, Preceptorship and Clinical Supervision: A Guide to Professional Roles in Clinical Practice. Oxford. England: Wiley-Blackwell; 2000.

93. Jackson VA, Palepu A, Szalacha L, Caswell C, Carr PL, Inui T. "Having the right chemistry": A qualitative study of mentoring in academic medicine. Acad Med 2003;78:328-34.

94. Sambunjak D, Straus SE, Marusic A. A systematic review of qualitative research on the meaning and characteristics of mentoring in academic medicine. J Gen Intern Med 2010;25:72-8.

95. Johnson WB. A framework for conceptualizing competence to mentor. Ethics Behav 2003;13:127-51.

96. Swanwick T, McKimm J. ABC of Clinical Leadership. London: John Wiley and Sons; 2011.

97. Shankman ML, Allen SJ. Emotionally Intelligent Leadership: A Guide for College Students. United States of America: John Wiley & Sons; 2009.

98. Bass BM, Avolio BJ, Jung DI, Berson Y. Predicting unit performance by assessing transformational and transactional leadership. J Appl Psychol 2003;88:207-18.

99. Burns JM. Leadership. New York: Harper & Row; 1978.

100. Burns JM. Transforming Leadership: A New Pursuit of Happiness. New York: Grove Press; 2003.

101. Evertson CM, Weinstein CS. Handbook of Classroom Management: Research, Practice, and Contemporary Issues. London: Routledge; 2013.

102. Hammick M, Olckers L, Campion-Smith C. Learning in interprofessional teams: AMEE Guide no 38. Med Teach 2009;31:1-12.

103. Burden PR. Classroom Management: Creating a Successful k-12 Learning Community. United States: Wiley; 2010.

104. Haidet P, Hatem DS, Fecile ML, Stein HF, Haley HL, Kimmel B, *et al.* The role of relationships in the professional formation of physicians: Case report and illustration of an elicitation technique. Patient Educ Couns 2008;72:382-7.

105. Yamani N, Shahabi M, Haghani F. The relationship between emotional intelligence and job stress in the faculty of medicine in Isfahan University of Medical Sciences. J Adv Med Educ Prof 2014;2:20-6.