Patient Education and Counseling xxx (2016) xxx–xxx

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

Research Information

Self-perceived provision of patient centered care by healthcare professionals: The role of emotional intelligence and general self-efficacy

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ARTICLE INFO

Article history:
Received 20 July 2016
Received in revised form 1 December 2016
Accepted 10 December 2016

Keywords:
Patient-centered care
Self-perception
Emotional intelligence
General self-efficacy
Healthcare professionals

ABSTRACT

Objective: This study aimed to investigate whether healthcare professionals' emotional intelligence (EI) is associated with self-perceived provision of patient-centered care (PCC), taking into account the potential mediating effect of general self-efficacy (GSE).
Methods: A sample of 318 healthcare professionals, recruited in 2015 among four hospitals in Italy, completed the Provider-Patient Relationship Questionnaire, the Emotional Intelligence Scale, and the General Self-Efficacy scale. A structural equation model was tested with GSE mediating the relationship between EI and self-perceived provision of PCC. Groups of participants based on gender, profession, and work setting were also compared on the study variables.
Results: EI had direct effects on the self-perceived provision of PCC dimensions. GSE partially mediated only the relationship between EI and involving the patient in care. Healthcare professionals in rehabilitation units showed higher self-perceived provision of PCC than those in acute care or ambulatory services.
Conclusion: Self-perceived provision of PCC seems to have the potential to be improved by EI and to be distinguishable from GSE.
Practice implications: Since EI can be developed, findings of this study have potential implications for improving PCC through continuing education interventions for healthcare professionals.

1. Introduction

The provision of patient-centered care (PCC) is integral to quality care and used as a quality indicator by public and private healthcare organizations all over the world [1,2]. Healthcare professionals are thus required to provide PCC [3], which is based on ensuring that patient preferences, needs, and values guide all clinical decisions [4]. This multidimensional concept includes, but is not limited to, understanding of and openness to the patient's agenda, effective communication, empathy, and involving the patient in care [5]. Among the positive outcomes of providing PCC, higher patients' satisfaction with and adherence to treatment as well as increased providers' diagnostic accuracy and wellbeing have been reported [6,7].

Different methods are currently used for assessing the provision of PCC by healthcare professionals during the clinical encounter, which include observer-, patient-, caregiver- or provider-completed tools [8,9]. Although most of such tools are based on observers or patients' rating, self-assessment by the healthcare professional has also been extensively used, to measure perceptions of some of his/her patient-centered behaviors in everyday practice (e.g., [10–12]). However, few research has considered the healthcare professional's perspective in terms of his/her perception of the provision of PCC within a specific encounter with a patient (e.g., [13,14]). In addition, only one dimension of PCC was investigated in such research, that is patient involvement in medical decision making.

Previous studies have focused on healthcare professionals' self-evaluation of their PCC behaviors in general, as a personal reflection on practice that can provide a summary of one's own knowledge, skill and understanding in a particular area [15,16]. This study aimed instead to investigate the health-care professional's reflection on his/her provision of PCC behaviors during the last clinical encounter with a patient. Such a focus on a specific

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http://dx.doi.org/10.1016/j.pec.2016.12.002
0738-3991/

encounter with a patient can be an especially valuable source of information, since the healthcare professional is asked to reflect about his/her performance in a less a-contextual manner, at a time that is not remote from the performance, and with specific reference to the last patient seen [15]. PCC self-assessment is conceptualized here as situationally relevant and distinguishable from a context-free, generalized cognitive appraisal of one-self and one's own skills or abilities [15].

Self-assessment of PCC provision within a specific clinical encounter in a real clinical setting is essential in health professional practice and continuing education, as it promotes professional growth, integration of theory with practice, critical thinking, and judgment making [16].

Common obstacles to the provision of PCC by healthcare professionals are the feeling of not being competent or skilled in using PCC skills, besides the refusal to delegate power and the fear of losing medical identity [17–20]. To explain some of the observed variation in healthcare professionals' understanding and achievement of PCC, a possible role of individual differences has also been postulated [21,22]. Providers' individual characteristics that could be associated with self-evaluation of PCC behaviors engaged in within a specific encounter with a patient have not been investigated yet. However, previous studies on providers' self-assessment of PCC behaviors as a general summative function seem to suggest a possible role of emotional intelligence (EI) and general self-efficacy (GSE).

1.1. Emotional intelligence

The personality model of EI includes domains such as emotion perception and management at the intrapersonal and interpersonal levels, self-motivation, empathy, and stress management [23–25], which are theoretically implicated in the adoption of a PCC perspective [22,26].

Indeed, doctors' EI was found to be associated with a more empathetic and compassionate care, better communication skills, higher patient's trust, and improved doctor-patient relationship, which are essential to the provision of PCC [27]. Nurses' EI was found to positively influence caring behaviors [28,29] and to be associated with caring nurse-patient interaction and growth-fostering relationship [30].

There is also evidence that EI promotes healthcare professionals' mental and physical wellbeing and professional satisfaction [31–34], and protects them from stress and burnout [35–38]. Indeed, EI facilitates stress management in medicine [27], arguably through the selection and control of positive coping strategies in demanding and stressful circumstances [39]. On the other hand, a poor stress management by healthcare professionals has been shown to negatively affect provider-patient interactions and hinder PCC [40]. It seems therefore worthwhile to investigate the association between EI and self-perceived provision of different aspects of PCC in healthcare professionals, as to fill the gap between theoretical and empirical studies on the implications of EI for PCC dimensions [23,27,41]. In addition, EI has been recognized as having a developmental nature and, thus, it appears to be trainable and learnable [42–44]. Indeed, studies showed that training interventions were effective in increasing EI among professional carers [45,46].

1.2. General self-efficacy

GSE is an individual's generalized sense of personal competence to deal with a broad range of stressful or challenging situations and reach his/her goals [47,48]. Individuals who are high in GSE are more willing to try to deal with difficult tasks and consider them as challenges rather than threats [49]. As the self-perceived ability to succeed in challenging and/or stressful circumstances, GSE is expected to be linked to, but not to overlap with, self-perceived provision of PCC. The provision of PCC requires healthcare professionals to change centuries of physician paternalism and to engage patients as active participants [50], therefore, it may be a source of stress for healthcare professionals [17]. Despite the potential role of GSE in the provision of PCC by healthcare professionals, this issue has not been investigated yet.

On the relationship between EI and GSE, some studies reported a positive influence of EI on GSE [51,52]; however, although a study on nurses found that EI explained almost 25% of the variation in GSE scores [53], this relationship has not been studied thoroughly in the medical context. Highly emotionally intelligent individuals, feeling confident in their ability to adapt to new conditions and capable of dealing with pressure and regulating stress [25], are expected to have a high sense of personal efficacy. Taking into account the relationships observed between GSE and EI and the potential relationship between GSE and perceived PCC, a mediating role of GSE in the relationship between EI and self-perceived provision of PCC could be hypothesized.

1.3. Aims

The primary objective of this study was to investigate the role of healthcare professionals' EI in self-perceived provision of PCC, controlling for the potential mediating effect of GSE. We hypothesized that the more the healthcare professionals have EI traits, the more they would be likely to perceive themselves as patient-centered [27–30]. However, since EI traits are also associated with a sense of GSE [51–53], we investigated whether GSE mediates at least partially the relationship between EI and self-perceived PCC, that is whether healthcare professionals are more likely to report higher provision of PCC if they feel self-efficacious across a variety of demanding situations. In other words, we tried to understand whether perceiving themselves as patient-centered has more to do with being emotionally competent or with feeling self-efficacious upon performance.

A secondary objective was to explore the differences in EI, GSE, and self-perceived provision of PCC between healthcare professionals based on gender, profession, and work setting. Based on previous findings we expected that females would report higher EI than males [27] while males would have higher GSE than females [48,54]. In the literature, there are few comparisons across health professions and work settings on the variables considered [5]. However, we might expect that professionals in rehabilitation units, having a more prolonged contact with patients, would perceive themselves as engaged in more patient-centered behaviors than those working in acute care or other settings.

2. Methods

2.1. Study design

This is a cross-sectional study conducted in 2015. Participation was voluntary and all respondents gave informed consent. The study was in accordance with the Helsinki Declaration II and ethical approval was given by the Ethics Committees of the hospitals involved.

2.2. Participants

Healthcare professionals such as physicians, nurses, nursing assistants, and physiotherapists working in acute care, rehabilitation units, or ambulatory services at four hospitals in Italy were invited in-person to participate in the study by completing a self-report paper-and-pencil questionnaire. The inclusion criteria were

Please cite this article in press as: M. Sommaruga, et al., Self-perceived provision of patient centered care by healthcare professionals: The role of emotional intelligence and general self-efficacy, Patient Educ Couns (2016), http://dx.doi.org/10.1016/j.pec.2016.12.002