



Use of Emotions by Doctor's for Enhancing Quality of Patient Care: Empirical Exploration

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Abstract

With the advancement in technology the health care scenario is witnessing major changes in deliver in affordable value- based quality medical care to patients without sacrificing on quality. Patient's perception of quality of care is impacted not only by the content of services received but also by the healing touch or relationship between the doctor and the patient. Apparently some doctors are successful in building trusting and satisfying relationship with their patients by using their emotions, thereby enhancing patient loyalty. Emotional Intelligence (EI) has been conceptualized as an ability or trait by various researchers. Trait EI is the constellation of behavioral dispositions and self-perceptions concerning one's ability to recognize, process, and use emotion-laden information (Petrides and Furnham, 2003). The present research's focus is on tapping into the typical attributes of the doctor's thoughts, feelings, and behaviors while examining patients using a self-report EI scale. It is posited that doctor's emotional skills can impact the quality of care through patient-doctor interaction, the staff performance and as well as their own performance. The present paper empirically explores the relationship between doctor's use of emotions and patient's perception of quality of care with the help of correlation and analysis of variance (ANOVA).

Key Words: Emotional Intelligence; Use of Emotions, Quality of Patient Care; Patient-doctor Relationship.

Introduction

Advancements in medical technology, ease of access to information and resultant patient awareness has transformed the Indian healthcare services. This has shifted the focus somewhat towards the doctor's behavioural skills along with their clinical skills. Both, the manner in which the care is delivered and the type of service impact the patients perception of quality of care. Health care services are continually seeking ways to improve and provide value-based affordable quality services to the patients. However, one area that is apparently receiving less attention is the emotional intelligence of the doctor's and its impact on quality of care.

The focus of the present research is on examining how doctors' use of emotions affects patient's perception of quality of care by empirically exploring the relationship between use of emotion and quality of care.

Theoretical Orientation

From a conceptual and measurement perspective Emotional Intelligence (EI) can be divided into ability, trait and mixed models. Salovey and Mayer (1990) first proposed the theory of EI as an intelligence or ability. They argued that as an ability, EI involves identifying, understanding, using and managing one's emotions for solving problems, thus facilitating decision making. They further asserted that certain individuals possess this ability of information processing of emotions and using this information of emotions as a guide for thinking and behaving more effectively than others (Mayer and Salovey, 1997).

In contrast Bar-On (1997) suggested that EI is more like a personality trait. Trait EI is the constellation of behavioral dispositions and self-perceptions concerning one's ability to recognize, process, and use emotion-laden information (Petrides and Furnham, 2003). Researches on EI have mostly focused on self-report trait measures because they are relatively easier to construct, administer, and score. The present study has used the WLEIS (Law et al., 2004) self-report trait EI measure which consist of four correlated scales; Self-Emotion Appraisal (SEA), Other's Emotion Appraisal (OEA), Use of Emotion (UOE), and Regulation of Emotion (ROE). Sample items include "I have a good sense of why I have certain feelings most



of time (SEA), “I always know my friend’s emotions from their behavior” (OEA), “I always set goals for myself and then try my best to achieve them” (UOE) and “I have good control of my own emotions” (ROE).

Research on EI in the health care services is limited and its true impact is yet to be determined. However it is argued that EI skills can impact quality of care through patient-physician interaction, their staff performance and doctor’s themselves (Weng et al., 2008). A physician who lacks emotional intelligence lacks the ability to effectively communicate with their staff which in turn can create a poor organizational climate at work and contribute to an overall increase in medical errors (Agarwal et al., 2010). Emotional intelligence can have a direct negative impact on the doctor’s themselves that is reflected in their interaction with staff and patient, thus completing the cycle.

Emotional Intelligence, Use of Emotions and Quality of Patient Care: Literature Reviewed

The Accreditation Council for Graduate Medical Education (ACGME) in the United States has identified a set of core competencies for doctors’ viz., patient care, professionalism, system-based practice, interpersonal and communication skills, medical knowledge, and practice-based learning and improvement. Most of these competencies are related to emotional intelligence that helped doctors’ or physicians gain trust and a positive doctor-patient interaction (Arora et al., 2010). Large scale observational study conducted by Weng et al. (2010) suggested that patient trust was positively correlated with a physician’s self-rated and externally rated emotional intelligence. Furthermore, the correlation between patient trust and patient’s perception of quality of care and satisfaction with the physician and the hospital remained significant on larger samples.

Researchers argue that patients often regard their doctors as one of their most important sources of psychological support (Baile et al., 2000). Doctors’ distancing behaviors can influence patients’ psychological functioning and cognitive functioning, and these can, result in more negative patient perceptions (Ambady et al, 2002). The doctors’ communication of positive or negative affect becomes more critical while breaking bad news during consultation. The manner of the delivery of information creates a negative view of a person’s health (Villagran et al., 2010). Enhanced emotional intelligence leads to better developed ability to relate and empathize with patients thus improving communication and decision making (Cherry et al., 2012).

The importance of emotions in terms of learning and focus has been investigated. Results suggested that in times of stress the ability to think and focus is diminished because the energy to emotional centers is lessened (Goleman, 2006). It is the task of the doctor to make sure that their patient is at ease so that they are able to focus on the information being given to them. In order to ensure this level of focus a doctor or physician must display emotional intelligence competencies such as empathy, mindfulness, and empathetic communication style (Cherry et al., 2012).

Published research suggests that emotional intelligence can have a direct impact on the doctors’ themselves. Doctors’ positive or negative affect, effects the individual relationships within the work setting carrying over to the entire organizational climate which in turn has an impact on employee satisfaction, employee turnover, the cost of conflict and malpractice liability (Momeni, 2009; Arond-Thomas, 2004). Hence doctors’ behavior influences individual and interconnected relationships by hindering communication which in turn can impact quality of care (Herkenhoff, 2010).

Weng et al., (2011) argued that doctors’ higher emotional intelligence was correlated with less burnout and higher job satisfaction resulting in higher patient’s perception of quality of care. Additionally those doctors’ who faked their emotional intelligence were less satisfied with their

jobs leading to more stress, psychological distress, and symptoms of depression (Psilopanagioti et al., 2012).

In sum research on investigating how doctors' use of emotions affects patient's perception of quality of care is relatively unexplored in the Indian health care organizations. The primary aim of this research was to empirically explore the role of doctors' use of emotion in the doctor-patient relationship, relationship with staff and doctors' themselves as key determinant in patient's perception of quality of care.

Rationale of the Study

Quality of care in health care has been widely researched but it involves a lot of subjective elements. Moreover, measurement scales have been developed mainly outside India that need to be researched across diverse cultures that affect patient's perception of quality of care and subsequent patient well-being. The extent to which use of emotions assist in understanding the differences in doctor's behavior, the quality of the relationship, or the relation between the doctor's characteristics and quality of care in Indian health care organizations has still received less attention. The present study is an attempt to examine the relationship between use of emotions by doctors with quality of care particularly from the patients' perspective.

Proposed Research Model

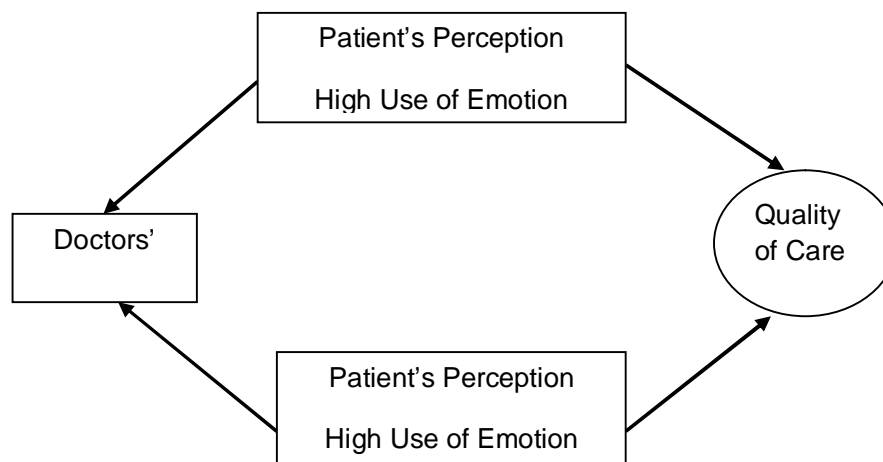


Figure -1: Proposed Research Model

Research Objectives

The literature leads to the following objectives:

- To study the relationship between patients' perception of doctor's use of emotion and quality of care.
- To study the effect of patients' perception of doctor's different levels of use of emotion and quality of care.

Hypotheses

On analyzing the literature, the following hypotheses were formulated to achieve each of the objectives:

- H_{01} : There is no significant relationship between patients' perception of doctor's use of emotions and quality of care.
- H_{02} : There is no significant difference in quality of care with patients' perception of doctor's high use of emotion and low use of emotion.

Research Methodology

The Study

The present study is an exploratory investigation to examine the relationship between the patients' perception of doctor's use of emotions and quality of care in the various hospitals of Indore city. Use of emotion is the independent variable and quality of care is the dependent



variable. Use of emotion constitutes the personal variable with two levels high and low. It was assumed that the personal variable viz., use of emotion would probably impact quality of care.

The Sample

Doctors belonging to varied specializations including surgeons, urologists, physicians, gynecologists, ophthalmologists, clinical psychologist, pediatrics, and sonologists were provided with questionnaires. A sample of 107 respondents, 13 doctors and 94 patients were taken into consideration. In the sample of doctors 10 were males and 3 were females. The average age was 40 years and experience more than 5 years (As shown in Table No.1). In the patient sample 49 were males and 45 were females. The average age of the patients was 29 years, 33 were from district areas, 19 from Tehsil areas and 42 from urban areas (As shown in Table No. 2).

Tools for Data Collection

The primary original data was collected directly from the respondents using observation and two psychometric tools which were administered on each respondent for data collection. Firstly, The WLEIS scale which is a 16-item self-report trait EI measure using a 5-point Likert-type scale (1 = totally disagree to 5 = totally agree) was used. The measure consists of four correlated scales each comprised of 4 items: Self-Emotion Appraisal (SEA), Other's Emotion Appraisal (OEA), Use of Emotion (UOE), and Regulation of Emotion (ROE). Secondly, Quality of Patient Care Questionnaire was developed on the basis of available literature and observation. The Cronbach Alpha Reliability Coefficient for the instrument is .89 which is on the higher side. A higher score indicates a greater level of a participant's emotional intelligence.

The second variable is conceptualized by the individual's attitude and perception towards quality of patient care services and is operationalized by using 5 point Likert's scale. The questionnaire was bilingual i.e., Hindi and English languages were used for the understanding of the respondents. The rating scale ranging from "strongly disagree" to "strongly agree" was used for each statement, which were 23 in number. The Cronbach Alpha Reliability Coefficient for the instrument is .76 and is acceptable for analysis purpose. A higher score indicates a greater level of a participant's quality of patient care.

Convenience sampling technique which implies a non-probability sampling was used. In depth interviews of the respondents were also conducted to ascertain their views and behavior observed during the process.

Tools for Data Analysis

Kolmogorov-Simonov Test was applied to examine the normal distribution of data and due to the normality of data Pearson's Correlation Coefficient Test and ANOVA were applied to test the various hypotheses. Statistical Package for Social Sciences (SPSS version 22.0) was used to analyze and interpret data.

Results

1 $r = .281$; $p = 0.006$ (two-tailed)

H₀₁ stands rejected.

There is a significant relationship between patients' perception of doctor's use of emotion and quality of patient care. r value indicates a moderately strong correlation between patients' perception of doctor's use of emotion and quality of patient care. (Refer Table: 3).

2 $F = 9.542$; $p = .003$

H₀₂ stands rejected.

There is statistically significant relationship between patients' perception of different levels of doctor's use of emotion and quality of patient care as determined by one-way ANOVA $F(1, 92) = 9.542$; $p = .003$. There were no outliers and the data was normally distributed for both the groups i.e., High Use of Emotion (UOE) and Low Use of Emotion (UOE) as assessed by boxplot and Shapiro-Wilk test ($p < 0.05$) respectively. Quality of care score increased from Low UOE (89.19+7.0) to High UOE (95.67+7.7) in this order. (Refer Table: 4).

Discussion



The study focused on three key determinants of patient's perception of quality of care i.e., the doctor-patient relationship, relationship with staff and doctors' themselves among many determinants. Results reveal that doctors' use of emotion is a significant contributor as perceived by the patients. This is consistent with the earlier research which describes the use of emotion by doctors' helping them focus on listening to voice of the patient rather than focusing entirely on data provided by the system (Last, 2012). Being emotionally intelligent facilitates doctors' to gain a great sense of trust from their patients resulting in a positive impact on the patients' health. Conversely doctors with lower emotional intelligence were more likely to demonstrate one or more defensive tactics common being, labeling, power play, sarcasm, and deception (Herkenhoff, 2010).

Koczwar et al., (2011) suggest that introducing the concept of emotional intelligence for general practitioner appraisal helped them to reflect on their work and identify their strengths and possible weaknesses. It also allowed fellow physicians to offer feedback to their colleagues. This would help doctors' develop into effective leaders with improved decision making and communication. Under tense and stressful conditions effective communication becomes critical. A physician's failure to consistently demonstrate respect for the staff and patients can be damaging to communication and can even influence patient's evaluation of quality of care (Arond-Thomas, 2004). If the doctors are provided training in emotional skills focusing on use of emotion and emotional regulation, the number of patients' complaints may reduce. This is supported by finding of Clarke (2006) that emotional abilities within the healthcare environment were significant. In particular the ability to manage one's emotions as well as the ability to assist others with their emotions was an important job requirement of working in an emotionally charged environment. Perhaps patients expect a warm personal touch along with a professional approach from the doctors.

Literature suggests that EI is not always innate intelligence, instead it is a competency that can be taught and enhanced through continuous training (Boylan and Loughrey, 2007). This is supported by results of study conducted on advanced-year medical students who exhibited a significant increase in the overall emotional intelligence mean while undergoing the course covering the topic. This suggests that emotional skills education prior to the work setting allows future physicians to begin preparing for emotionally charged situations early on (Hen and Goroshit, 2011). Moreover, individuals with maladaptive traits can potentially destroy up to five times the energy in the workplace in comparison to positive enthusiastic individuals who can enlighten and create energy (Hernandez, 2012).

Implications

The findings reveal that the ability of the doctors to use their emotions for furthering their performance and displaying positive feelings helps in building trusting, caring relationship with their patients and is one of the major determinants of evaluating patient's perception of quality of care. As, early training in EI can enhance these skills, therefore emphasis should be given on developing training programs that focus on creating a culture that values these emotional skills as a part of treatment besides the core clinical competencies. This may reduce burnout and stress both for the doctors' and patients alike and may increase communication between patient-doctor, resulting in increased quality of care translating it into improved business outcomes for the hospital and doctors.

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Annexure

Table: 1. Respondents Characteristics Doctors Sample (N=13)

Respondents' Characteristics	Sub-Profile	Percentage (%)
Gender	Male	84.61
	Female	15.39



Age	25-30 years	7.69
	30-35 years	Nil
	35-40 years	30.76
	40-45 years	61.53
Practice Experience	0-1 years	7.79
	1-3 years	Nil
	3-5 years	Nil
	5 years and above	92.30

Table: 2. Respondents Characteristics Patient Sample (N= 94)

Respondents' Characteristics	Sub-Profile	Percentage (%)
Gender	Male	46.06
	Female	42.3
Age	20-25 years	7.69
	25--30 years	Nil
	30-35 years	30.76
	35 & above years	61.53
Annual Income	1lac	54.25
	2-3 lacs	27.65
	3-4 lacs	6.38
	4 lacs and above	6.38
Residential Status	Tehsil	17.66
	District	31.02
	Urban	39.48

Table: 3. Correlation Result Correlations

		UOE Total	QOC Total
UOE Total	Pearson Correlation	1	.281**
	Sig. (2-tailed)		.006
	N	94	94
QOC Total	Pearson Correlation	.281**	1
	Sig. (2-tailed)	.006	
	N	94	94

** . Correlation is significant at the 0.01 level (2-tailed).

Table: 4. ANOVA Results

* Low and High UOE respectively

UOE					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00*	16	17.0	17.0	17.0



	2.00*	78	83.0	83.0	100.0
	Total	94	100.0	100.0	

Descriptive								
QOC								
	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Low UOE	16	89.19	7.045	1.761	85.43	92.94	72	98
High UOE	78	95.67	7.754	.878	93.92	97.41	80	115
Total	94	94.56	7.986	.824	92.93	96.20	72	115

Test of Homogeneity of Variances			
QOC			
Levene Statistic	df1	df2	Sig.
.168	1	92	.683

ANOVA					
QOC					
	Sum of Squares	Df	Mean Square	F	Sig.
Between Groups	557.346	1	557.346	9.542	.003
Within Groups	5373.771	92	58.411		
Total	5931.117	93			