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Research Article

Emotional Intelligence and Professional Satisfaction: Insights for the Management of Diagnostic and Therapeutic Technologists in Madeira

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ABSTRACT

The management of health facilities is complex and challenging. It´s needed a harmonization between management and leadership, results and care provided. Leadership effectiveness is increasingly associated with emotional skills, capable of positively influencing the organizational culture, climate and performance of teams. Professional Satisfaction (PS) emerges as a crucial indicator of the organizational environment that can impact an organization's results. This research explored the relationship between Emotional Intelligence (EI) and PS and whether the EI and PS vary according to their sociodemographic and professional characteristics in Diagnostic and Therapeutic Technologists (DTT) in the Autonomous Region of Madeira (ARM). Using questionnaires, we sought to ascertain whether there is a correlation between EI and PS. Corroborating other data founded in the literature, it was not possible to establish a statistically positive correlation between these two variables. This study contributed to a better understanding of EI and PS in the DTT in the ARM, highlighting the importance of research in this region and group of health professionals.

Keywords: Management, Strategic Management, Emotional Intelligence, Professional Satisfaction, Health Professionals

INTRODUCTION

The success of any organisation depends on its competitiveness. In an organisation, the management processes and activities performed by the manager/leader are fundamental for harmonizing the various perspectives of all stakeholders (Sardinha, 2023). From planning, organising, and directing, as well as controlling, the leader is essential. Adopting a proactive leadership style allows the organisation to accept change and ambiguity, creating visionary and coherent projects.

Today's literature seeks innovative approaches to the topic of leadership, simplifying them. It is agreed that leadership is the ability of an individual to exert influence over others, to guide, structure, and facilitate activities and relationships in a group or organisation (Arham and Norizan, 2024). Currently, more comprehensive theories are presented in which the leader and organisations are seen as a whole, covering measurable but also intangible indicators. An example of this innovative approach is Emotional Intelligence (EI) (Maçães, 2017). EI is understood as the ability to recognise and evaluate one's own feelings and those of others, as well as dealing with them (Lacerda et al., 2023). The success of an organisation depends on the satisfaction of its employees, as they are one of the most important assets of an organisation (Subarto, Solihin and Qurbani, 2021). The importance of understanding Professional Satisfaction (PS) is

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highlighted as it is a relevant indicator of the organisational climate and essential in assessing the quality of organisations (Ferreira, Fernandez and Anes, 2017). The concept of satisfaction has been studied in the literature, as its trends can affect and influence work productivity, turnover, and employee retention (Ribeiro, 2015). Locke (1976), mentions that PS refers to the positive emotional response of an employee in relation to their work and the work conducted individually or as part of a group.

The constant change in organisations and the need to increase knowledge fosters the complexity of these processes (Martins and Reis, 2009). An open organisational culture, which through knowledge management policies encourages knowledge sharing, boosts the organisation's intellectual capital (Martins, 2014). Intellectual capital and human capital (intangible assets) have currently become a critical success factor in human resources management within organisations (Câmara, Guerra and Rodrigues, 2007). Additionally, Martins (2014) considers that in the knowledge economy, organisations that include intellectual capital management policies as a differentiating element, enhance the success of the organisation's management and consequently add value to it, since, with the scarcity of resources, and the need to achieve productivity and competitiveness, the management of intellectual capital has become the only resource that is not exhausted with its use, but rather adds value. It is important to highlight that knowledge translates into an asset that can be transferred between the various actors in health institutions, regardless of their hierarchical position (Jacquinet et al., 2017; Sotomayor, 2021).

The management of Health Units is complex, it involves balancing the management of results with the provision of the best health care. Factors such as innovation, increasing life expectancy, changing quality of life standards influence an organisation's performance (Albuquerque et al., 2023). In addition, the new health literacy states that the health paradigm has changed and there is a culture of transparency and comparability. A Health Unit encompasses different services where technical, research, and management efforts are coordinated, provided by different professional categories (Mena and Aguiar, 2016). A manager in these organizations must seek continuous improvement in the quality of the services provided, to optimize results with the aim of assisting the user/client, promoting their well-being.

Among various health professionals, Diagnostic and Therapeutic Technologists (DTT) stand out as a key figure in Health Units, interacting daily with other professionals, users, and their families. DTT is a health professional endowed with scientific skills who promotes health and contributes to the prevention, diagnosis and treatment of disease or rehabilitation. They encompass 18 professions in various areas of diagnosis and therapy.

The study on this theme, EI and PS, applied to health professionals, namely doctors and nurses, commonly presents as a limitation and future suggestions the application of the study in other professionals or social classes (Gabal and Elhussiney, 2020; Ramli and Novariani, 2020).

There were few references to research on these professionals in Portugal and in the Autonomous Region of Madeira (ARM), specifically correlating the themes of EI and PS in the health area. In ARM, the Health Service of the Autonomous Region of Madeira, EPERAM (in portuguese Serviço de Saúde da Região Autónoma da Madeira, Entidade Pública Empresarial da Região Autónoma da Madeira from now on designated SESARAM) is the public entity providing healthcare to the entire population, through coordination between hospitals, health centres and support units in the region (SESARAM, 2022).

This research in the context of the theme of leadership, namely EI and SP aimed to contribute to the development and implementation of a human resources management strategy, with a view to optimizing and improving the provision of services. It was intended to contribute to the academic community, through the results of this study and, simultaneously, to, in a perspective of continuous improvement, add value to the provision of health services, as well as increase the well-being of employees, in a climate of positive leadership. Although studies have shown that high EI in health professionals, such as doctors and nurses, leads to greater professional involvement and reduced stress, anxiety, and depression, no research has been found that specifically addresses DTT. Authors have investigated satisfaction and PS among health professionals, such as nurses (Nicer et al., 2024), and recommend the development of management strategies that involve these professionals (Martins, 2020). However, no studies focusing solely on DTT could be identified.

The choice of DTT is relevant, since they are health professionals, with legal status of the career of DTT regulated since 1999 by Decret n.o 564/99 de 21 de Dezembro, 1999. The incipient number of academic research on EI and PS of DTT in Portugal, namely in the ARM, as well as the personal need to explore and master the theme, motivated the present research.

It is in this context that the present investigation arises, which aims to deepen understanding of the relationship between EI and PS in DTT, as a human resources management strategy, considering the optimisation of the provision of healthcare and answering the following question: What is the relationship between EI and PS of the DTT of SESARAM and whether the EI and PS vary according to their sociodemographic (e.g. age, gender and academic qualifications) and

professional (e.g. professional relationship and service time) characteristics? Thus, the objective was to investigate the relationship between EI and PS of DTT at SESARAM, to verify whether EI vary according to sociodemographic characteristics and professional characteristics and PS vary according to sociodemographic characteristics and professional characteristics.

To facilitate interpretation, the first part will present the literature review, followed by the methods used. The results will be presented and discussed. Finally, the conclusion, in which some final considerations about the study and its results are presented.

LITERATURE REVIEW

Emotional Intelligence

In a work context, employees develop a commitment to the organisation when they perceive a commitment from their leaders. For effective leadership, managers must outline a set of actions and policies that enable the achievement of a desirable vision. There are countless definitions of leadership; according to Stogdill (1974) cited by Ramalheira (2013, p.2) "almost as many as there are people who tried to define the concept". Supported by the literature, leadership can be considered the ability of an individual to exert influence over others, aiming to achieving specific objectives."

Sousa (2009, p.149) defined leadership as: "the process of social influence in which the leader seeks to obtain the voluntary participation of subordinates in an effort to achieve the organisation's objectives". A leader must be able to cultivate friendships and see the best in the people around them. They must serve their team and not the other way around and have maintain high ethical standards. They should lead by example and demonstrate integrity both professionally and personally. They are initiative-taking and self-motivated individuals focused on results. Excellent communicators and exceptional listeners, they deal well with pressure and keep emotions under control. They maintain positive attitudes, foster cooperation and collaboration within their team, recognise and maximise the strengths in others, and take responsibility for the results. They are creative and innovative, possess vision and are not easily discouraged (Maçães, 2017).

Contemporary approaches to leadership approach the topic from a distinct perspective, avoiding complex theories that are difficult to apply. They instead offer a pragmatic and understandable view of leadership, presenting theories that integrate the organisation and the leader within their operating context. These theories are comprehensive theories, encompassing not only measurable indicators, but also intangible aspects. A new perspective is EI initially presented by Goleman (2021).

Goleman (2021) states that initial investigations trace back to the 1930s through Edward Thorndike. Later, through Weschler and Howard Gardner, research on the subject in question deepened with the development of an intelligence measurement instrument.

Contemporary literature offers various definitions of EI concepts. According to Goleman et al. (2013) EI is the ability to recognise and manage one´s own emotions, understand the emotions of others and lead relationships. EI involves identifying, evaluating, and managing emotions within oneself, as well as within groups. It is "noteworthy" that emotions encompass feelings, the reasoning derived from them, psychological and biological states, and inclinations towards action." (Goleman, 2021, p.302).

Goleman (2021) considers a set of basic capabilities that constitute EI, supported by the work of Stone and Dillehunt (1978): Self-awareness (observing oneself and recognising one's own emotions); Making personal decisions (examining one's own actions and recognising their consequences); Managing emotions (control "self-talk" in order to detect negative messages, such as self-deprecation); Coping with stress (learning the value of exercise, guided fantasy, and relaxation methods); Empathy (understanding others' feelings and concerns and seeing things from their point of view); Communication (talking about emotions in an effective, becoming a good listener and a good question-asker); Openness (valuing frankness and establishing trust in a relationship); Introspection (identifying patterns in your emotional life and reactions); Personal responsibility (recognising the consequences of your decisions and actions, accepting your own feelings and states of mind, fulfilling commitments made (e.g., studying)); Assertiveness (Exposing your feelings and concerns without anger or passivity); Group dynamics (cooperation, knowing how and when to lead, or when to follow).

These are the abilities and skills for managing emotions and empathy that allow us to understand each other's feelings, perceive situations from diverse perspectives, and respect individual differences in how people experience various situations.

In the organisational context, EI has been presented as a strategic factor and added value. From the perspective of a leader, who aims to support individual at a cognitive level, Goleman et al. (2013), argue that efficient and effective leaders create neural harmony with those they lead. This perspective considers brain neuroplasticity, where the brain continues to develop and shape itself throughout life, the leader can develop greater strengths in EI.

EI has been related to different themes, such as decision making (Alkozei et al., 2018), organisational climate (Bassem and Majdalani, 2017), life satisfaction (Delhom, Satorres and Meléndez, 2020), well-being (Huang, Shi and Liu, 2018), stress, anxiety and depression (Kousha, Bagheri and Heydarzadeh, 2018), burnout (Lahoud et al., 2019), mindfulness (Nadler, Carswell and Minda, 2020), among others. Kotsou et al. (2019), investigated 46 interventional studies applied to adult populations and analysed the results. The results suggest that it is possible to improve EI in several aspects. Further research is necessary to confirm that EI interventions enhance work and academic performance, as well as to understand the potential mediators and moderators of such improvements. There are studies that address EI in health professionals, namely doctors and nurses, concluding that high EI results in greater professional involvement, less stress, anxiety, and depression.

Carmen et al. (2018), sought to investigate the relationship between work commitment and EI in a sample of 2126 nurses. The results showed that the nurses with a higher level of EI had a higher score in the work commitment. Conversely, Nightingale et al. (2018), explored the relationships between EI and health professionals (nurses, nurse managers and doctors) and health care behaviours. The results indicated that the nurses' EI was related to physical and emotional care, but the EI may be less relevant to nurse managers and physicians. Age, experience, burnout, and PS can also be relevant factors for both health care behaviours and EI. They safeguard that there may be differences within the professional groups.

Professional Satisfaction

The concept of satisfaction is complex, owing to its multidimensionality and the diverse perspectives from various disciplines attempting to define it, which contribute to its complexity. Ribeiro (2015, p.1) states that "some of the factors pointed out include both the characteristics and attributes of the individual himself, previous experiences, and the variables of the context and the expectations of the subjects about the different dimensions of satisfaction". PS plays a crucial role in the success of any organisation, used to evaluate the degree of accomplishment that a job brings to an employee, and which, consequently, influences the conduct and performance of that employee (Phuong and Vinh, 2020). Some authors describe PS as a set of feelings, others as an attitude towards work, others as a symbiosis between the satisfaction of needs and the emotional state resulting from work practice (Rodrigues, Filomena and Lucas, 2022).

As noted by Almeida (2020) despite the various definitions of PS, different terms have been employed, such as job satisfaction, work satisfaction and PS. Therefore, acknowledging the potential divergence in its conceptualisation, like Almeida (2020), it was decided to adopt the term PS in a broad sense.

One way to achieve the success of an organisation is aligning its objectives with those of its employees, who are considered human capital. Satisfaction is one of the fundamental elements when planning an entire strategy. PS is a complex and subjective phenomenon, as it is subject to the uniqueness of the individual and the context in which he or she is inserted. PS of health professionals has been the subject of investigation by several authors over the years.

Silva et al. (2022) conducted an integrative review on the influence of PS on the quality of nursing care, concluding that PS influences the provision and quality of care and, consequently, the quality of health service performance.

Martins (2020), investigated the satisfaction of nurses at Santa Casa da Misericórdia de Lisboa and identified its determinants. It found a statistically significant relationship with the dimensions studied. The determinants identified were age, gender, place of work, type of schedule, whether they accumulate other hours outside this institution, whether they hold a management, leadership or coordination position, and the level of income to cover family and training needs. The same author recommends the development of management strategies that involve nurses. However, no studies focusing solely on DTT professionals could be identified.

Relationship between Emotional Intelligence and Professional Satisfaction

Sensitised by the importance of human resources in an organisation, researchers have widely studied EI, originally referred by Goleman (2011), and related to other variables, namely PS. There is a growing interest in the scientific study of the relationship between EI and PS, especially in health professionals. Modern studies highlight that EI can positively influence PS, by facilitating the management of emotions in high-pressure environments (e.g. Encarnação, Soares and Carvalho, 2018; Soriano-Vázquez, Castro and Morales-García, 2023; Musio et al., 2024). However, some research also

identifies negative associations (Rocha, Pinto and Carvalho, 2021). These results highlight the complexity of this relationship and the need for further analysis. Thus, it is essential to continue exploring this theme, considering different organizational and cultural contexts.

Musio et al. (2024) studied the impact of EI on nurses, verifying that there is a strong positive correlation between EI and compassion satisfaction, indicating that professionals with higher EI have higher PS.

Sembiring et al. (2021), sought to determine whether leadership, EI, and social support have a significant effect on employee performance through PS. They found a positive and considerable influence of the variable's leadership, EI and social support on employee performance through PS.

The author Alsughayir (2021), inquired about how EI influences organisational commitment and the correlation between PS and these two aspects. The results showed that EI affects both PS and organisational engagement in a significant and positive way.

Rocha, Pinto and Carvalho (2021) applied a questionnaire to nurses in a hospital in the north of Portugal, which includes sociodemographic and professional characterization. The results indicated that there was no significant correlation between the PS and EI of nurses.

Raghubir (2018) conducted an integrative review to understand the concept of EI in nurses and found that there is consensus on the positive impact of EI on PS. The review found that professionals who effectively manage their emotions tend to experience higher PS, thereby enhancing the quality of services they provide.

In most studies, there is a consensus in regarding the benefits of EI in a professional context and its positive relation with PS.

METHODOLOGY

The present research adopts a descriptive, cross-sectional quantitative approach with a correlational design, allowing for the exploration of associations between two or more variables. The sample was non-probabilistic and convenient (Barañano, 2008; Prodanov and Freitas, 2013). Through a case study, the variables EI and PS were examined within a group sharing common characteristics. The study population included all DTT in active exercise of the profession at SESARAM, with in 315 DTT identified (Direção Regional de Estatística da Madeira, 2023). The questionnaire was disseminated via email with the collaboration of the Technical Director of SESARAM and the National Union of DTT. The questionnaire was distributed between the months of September and November 2023. The present investigation had the participation of 114 individuals from the universe of 315.

The aim of the study was to examine the relation between EI and PS among the DTT of SESARAM along with the research hypotheses: H1. There is a positive correlation between EI and PS in the DTT; H2. There is a difference in the level of EI in relation to sociodemographic factors and professional factors of the DTT; H3. There is a difference in the level of PS in relation to sociodemographic factors and professional factors of the DTT.

Purpose and Hypothesis of the Study

To enhance the understanding of the stud, it is relevant to understand the areas of activity of DTT and its importance in the health system. The Decret nº 111/2017, 2017, of 31 August, establishes the legal status of the career of DTT. In Portugal, a DTT is a health professional who performs specialized functions in the areas of diagnosis and therapy, to contribute to prevention, diagnosis, treatment and rehabilitation. DTT are responsible for performing diagnostic and therapeutic procedures, collaborating with other health professionals to decide on appropriate treatments.

They work in various health fields such as Clinical Analysis and Public Health; Pathology; Audiology; Cardiopneumology; Dietetics; Pharmacy; Physiotherapy; Oral Hygiene; Nuclear Medicine; Neurophysiology; Orthoprosthesis; Orthoptic; Dental; Radiology; Radiotherapy; Environmental Health; Speech therapy and occupational therapy.

With the legal basis and roles established for DTTs, it is equally essential to understand the organization and resources available in ARM, where these professionals perform their activity in health services. The ARM is endowed with a Political-Administrative Statute and self-government bodies: the Legislative Assembly of Madeira and the Regional Government and in the last constitutional revision, it now has a Representative of the Republic, appointed and dismissed by the Head of State (Assembleia Legislativa Região Autónoma da Madeira, 2019). In 2021, the resident

population in the Autonomous Region of Madeira was 250,744 individuals, of which 16.5% had higher education (Pordata, 2022). In the same period, there were 10 hospitals, of which 3 were public and 7 were private, 5,058 were health professionals, including 561 doctors, 1,482 nurses, 336 DTT (315 in public institutions and 21 in private institutions) and 1,537 medical assistants. The total number of complementary diagnostic and/or therapeutic acts performed in public hospitals was 6 418 128 (Direção Regional de Estatística da Madeira, 2023).

Instrument

To obtain data and measure the different variables, an online self-completed questionnaire was applied using Google Forms®. He stressed the relevance of the conditions of application and sincerity in the shared content, stressing that the data collected are for academic purposes, and it is possible, at any time, to cease participation in the study. When collecting data, the anonymity of the participants, informed consent and confidentiality of the data were ensured, based on the assumption of the General Data Protection Regulation. After completing the questionnaires, they were submitted to a pre-test (Prodanov and Freitas, 2013; Gil, 2017; Marconi and Lakatos, 2017). To assess EI and its variables, the questionnaire included the measurement instrument used and validated by Rego and Fernandes (2005). In the case of PS and its variables, the questionnaire was based on the instrument validated by Paulo (2003). After completing and submitting the questionnaire, the answers were automatically recorded in the database.

Sociodemographic and professional data

The questionnaire included a section for sociodemographic and professional characterisation consisting of two groups: (1) personal data: gender, age, marital status and academic qualifications; (2) information regarding professional status: working hours, type of hours, type of professional relationship and service time.

Professional satisfaction

PS was measured using an adaptation of the PS Assessment Instrument – IASP by Paulo (2003), on a scale of structural agreement of the Likert scale (5 options) ranging from Poor (1) to Excellent (5), and Not applicable (6), the latter not considered for analysis. The version used is structured in the following table (**Table 1**):

Table 1. Description of the scales, subscales and facets of the IASP

<table>
<tr><th>Scale</th><th>Subscale</th><th>Facets</th><th>Issues</th></tr>
<tr><td rowspan="7">Quality of your Service as a Workplace</td><td rowspan="3">Human Resources Policy</td><td>Human resources</td><td>3A a 3C</td></tr>
<tr><td>Relationship between teams and professionals</td><td>4A a 4B</td></tr>
<tr><td>Hospital management and policy bodies</td><td>7A a 7D</td></tr>
<tr><td rowspan="2">Moral</td><td>Hierarchical superior</td><td>1A a 1K</td></tr>
<tr><td>State of mind</td><td>5A a 5B</td></tr>
<tr><td rowspan="2">Technological and Financial Resources</td><td>Practice context and equipment</td><td>2A a 2D</td></tr>
<tr><td>Salary</td><td>6A a 6C</td></tr>
<tr><td colspan="3">Quality of your Service in the Provision of Care</td><td>8A a 8G</td></tr>
<tr><td colspan="3">Continuous Quality Improvement</td><td>9A a 9H</td></tr>
<tr><td colspan="3">Emotions about your Work and your Job</td><td>10A a 10I</td></tr>
</table>

Source: Adapted from Paulo (2003)

Emotional Intelligence

Based on a mixed model, the Portuguese researchers Rego and Fernandes (2005), developed and validated, for the Portuguese population, an instrument to measure EI. This model includes 6 dimensions and 23 items, whose number of items is indicated in parentheses: 1) understanding one's own emotions (4 items), 2) self-control in the face of criticism (4 items), 3) self-encouragement (use of emotions) (3 items), 4) emotional self-control (4 items), 5) empathy (4 items), and 6) understanding of the emotions of others (4 items). It presents a Likert scale with 7 answers ranging from 1 "The statement does not apply strictly anything to me" and 7 "The statement applies completely to me".

Analysis

The collected data were processed and analysed quantitatively using statistical methods with the Statistical Package for the Social Science (SPSS), version 27. The data processing included summary statistics and correlational analysis of the hypotheses. Several statistical methods, including summary measures, were employed in the analysis (e.g., mean, standard deviation, minimum, maximum), within the scope of descriptive statistics. The scores obtained showed normality ($p < 0.05$), so the correlations were analysed using Pearson's coefficient. In order to establish comparisons of satisfaction with the Quality of your Service as a Workplace, the Quality of their Service in the Provision of Care, the Continuous Quality Improvement and the Emotions about your Work and your Job, in the different groups, the One-Way ANOVA statistical tests were used, as these tests allow us to analyse the variance of different variables as well as the relationships between them.

RESULTS AND DISCUSSION

The collected data were processed and analysed quantitatively using statistical methods with the Statistical Package for the Social Science (SPSS), version 27. The data processing included summary statistics and correlational analysis of the hypotheses. Several statistical methods, including summary measures, were employed in the analysis (e.g., mean, standard deviation, minimum, maximum), within the scope of descriptive statistics. The scores obtained showed normality ($p < 0.05$), so the correlations were analysed using Pearson's coefficient.

Sociodemographic characterisation of the participants

The present investigation had the participation of 114 individuals from the universe of 315. The sample consisted of 81.4% females and 18.6% males. Regarding age, age groups were created. The largest group is between 31 and 40 years old (48.2%). Regarding their family situation, most are married or in a common-law marriage (68.1%). Regarding academic training, most DTT have a bachelor's degree (83.2%) (**Table 2**).

Table 2. Results of sociodemographic variables by gender

		Gender					
		Female		Male		Total	
		n	%	n	%	n	%
Age	Between 21 and 30 years old	8	8,7%	0	0,0%	8	7,1%
	Between 31 and 40 years old	42	45,7%	12	57,1%	54	47,8%
	Between 41 and 50 years old	21	22,8%	6	28,6%	27	23,9%
	More than 50 years	21	22,8%	3	14,3%	24	21,2%
	Total	92	100,0%	21	100,0%	113	100,0%
Marital status	Single	28	30,4%	4	19,0%	32	28,3%
	Married/ Common-law marriage	61	66,3%	16	76,2%	77	68,1%
	Divorced/Separated/Widowed	3	3,3%	1	4,8%	4	3,5%
	Total	92	100%	21	100,0%	113	100,0%
Academic Qualifications	Bacharel/Bachelor's degree	78	84,8%	16	76,2%	94	83,2%
	Masters	14	15,2%	4	19,0%	18	15,9%
	Doctoral	0	0,0%	1	4,8%	1	0,9%
	Total	92	100%	21	100,0%	113	100,0%

Professional characterisation of the participants

Regarding the professional relationship, the majority has as an "Individual Employment Contract" (62.3%). Regarding the distribution of respondents, in relation to service time, it is verified that most have between 1 and 5 years of service time (21.9%), followed by 11 to 15 years (18.4%) and 16 to 20 years (15.8%) of service time. It is also noted that the vast majority work 35 hours a week (91.2%). Lastly, concerning the type of schedule, it was found that 71.1% had a fixed schedule and 28.9% worked in shifts (**Table 3**).

Table 3. Results of professional variables

		n	%
Professional Status	Staff Worker	39	34,2%
	Individual Employment Contract	71	62,3%
	Fixed-Term Employment Contract	3	2,6%
	Other	1	0,9%
	Total	114	100,0%
Service Time	Less than 1 year	3	2,6%
	1 year to 5 years	25	21,9%
	6 years to 10 years	16	14,0%
	11 years to 15 years	21	18,4%
	16 years to 20 years	18	15,8%
	21 years to 25 years	5	4,4%
	26 years to 30 years	13	11,4%
	Over 31 years old	13	11,4%
	Total	114	100,0%
Working Hours	Less than 35 hours per week	4	3,5%
	35 hours per week	104	91,2%
	42 hours per week	3	2,6%
	More than 42 hours per week	3	2,6%
	Total	114	100,0%
Schedule Type	Fixed Schedule	81	71,1%
	Shifts	33	28,9%
	Total	114	100,0%

Global Professional Satisfaction Assessment

In a global perspective, respondents demonstrated global satisfaction, since the values of the mean, median and mode are close to the midpoint, with room for improvement in PS in general. Regarding the "Quality of Service as a Workplace", it is the only scale that presents mean values above the midpoint (**Table 4**). Regarding the subscales, both the "Human Resources Policy" and the "Moral" have the mean like the midpoint, while "Technological and Financial Resources" expresses global mean values below the midpoint (**Table 5**). Finally, regarding the facets, only "The responsible person" presents mean values like the midpoint, and all the other facets present global mean values below the midpoint (**Table 6**).

When analysing the scales, it was found that the "Quality of your Service as a Workplace" received the highest global average score. The one with the lowest global average score was the scale "Quality of your Service in the Provision of Care". As for the subscales, the one with the highest score is the "Moral" subscale and the one with the lowest score was the "Technological and Financial Resources" subscale. Regarding the facets, the highest average values were observed for "The person in charge" and "Workplace and equipment". The facets that scored the least were "Relationship between teams and professionals", "State of Mind" and "Salary" (**Tables 4, 5 and 6**).

Table 4. Global mean values of the responses attributed by the DTT to the Professional Satisfaction scales

	Global Professional Satisfaction	Quality of your Service as a Workplace	Quality of your Service in the Provision of Care	Continuous Quality Improvement	Emotions about your Work and your Job
n	25	101	88	107	29
Midpoint	155	76,5	21	24	31
Mean	154,24	79,06	20,91	22,31	29,66
Mediana	147	79	20,5	21	28
Mode	128,00	80,00	19	21	22,00
Standard deviation	26,15	22,50	5,86	7,71	9,26

Table 5. Global mean values of the responses attributed by the DTT to the Professional Satisfaction subscales

	Human Resources Policy	Moral	Technological and Financial Resources
n	108	104	113
Midpoint	22,5	39	21,5
Mean	22,02	39,95	17,72
Median	21	40	17
Mode	19	28,00	16,00
Standard deviation	6,40	14,10	5,65

Table 6. Global average values of the responses attributed by the DTT to the facets of Professional Satisfaction

	Human resources	Relationship between teams and professionals	Hospital managemen t and policy	The person in charge	State of mind	Workplace and equipment	Salary
n	111	114	109	104	114	113	114
Midpoint	9	6	10,5	33	6	12,5	9
Mean	8,23	5,52	8,26	33,96	5,96	11,58	6,12
Median	8	5	8	33	6	11	6
Mode	7	4	8	24	6	8	3
Standard deviation	2,79	2,13	3,24	12,74	1,86	3,62	3,04

Global Emotional Intelligence Assessment

When analysing EI behaviours, it is verified that respondents, in general, adopt EI behaviours, since the mean, median and mode values of the scores obtained on the global scale are higher than the midpoint of the respective range of variation. Despite the evidence of these behaviours, it is highlighted that there is still room for improvement (Table 7).

Table 7. Global average values of the responses attributed by the DTT to the Emotional Intelligence scale

	n	Midpoint	Mean	Median	Mode	Standard deviation
Emotional Intelligence	114	98,5	109,39	110,5	110	12,43

Hypotheses Analysis

H1. There is a positive correlation between Emotional Intelligence and Professional Satisfaction in DTT

To achieve the objective: "To investigate the relationship between EI and PS of the DTT of SESARAM", the data treatment was elaborated using several statistical methods. After applying the Kolmogorov-Smirnov test with Lilliefors correction, considering a significance level of 0.05, it was found that the sample followed a normal distribution. For this reason, the correlations established were performed using Pearson's coefficient (Table 8).

Table 8. Pearson's correlation coefficient values

	Global Professional satisfaction	Global Emotional Intelligence	Quality in the Workplace	Quality of Care Delivery	Continuous Quality Improvement	Emotions
Global Emotional Intelligence	0,215					
Quality in the Workplace	,948**	0,067				
Quality of Care Delivery	,618**	0,036	,649**			
Continuous Quality Improvement	,810**	,205*	,750**	,786**		
Emotions	-0,376	0,29	-,539**	-,597**	-,649**	

**. p< 0,01 (bilateral test)
*. p< 0,05 (bilateral test)

Through this analysis, it is verified that, in the global sample of EI and PS, there is no significant correlation between the variables in question. Conversely, when analysing the overall EI in relation to the scales comprising PS, a significant positive correlation was found between EI and the 'Continuous Quality Improvement' scale. Therefore, Hypothesis 1 is not supported by these findings. These results align the results of (Rocha, Pinto and Carvalho, 2021).

H2. There is a difference in the level of EI in relation to sociodemographic factors and professional factors of the DTT

It was possible to verify that in relation to all the sociodemographic factors considered for this study, there were no significant mean differences (p<0.05) in EI (**Table 9**).

Table 9. Assessment of Emotional Intelligence by Sociodemographic Factors

Sociodemographic factors	**Gender**	Female	110,15
		Male	106,62
		F	1,39
		p	0,24
	Age	Between 21 and 30 years old	118,38
		Between 31 and 40 years old	107,15
		Between 41 and 50 years old	110,63
		More than 50 years	110,13
		F	2,18
		p	0,10
	Marital status	Single	110,09
		Married/Common-law marriage	108,69
		Divorced/Separated/Widowed	117,00
		F	0,92
		p	0,40
	Academic Qualifications	Bachelor/Degree	109,72
		Masters	107,61
		Doctorate	110,00
		F	0,22
		p	0,81

It was possible to verify that in relation to all professional factors considered for this study, there are no significant mean differences (p<0.05) in EI (**Table 10**).

Table 10. Evaluation of Emotional Intelligence by professional factors

Professional Factors	**Professional Status**	Staff Worker	112,15
		Individual Employment Contract	107,65
		Fixed-Term Employment Contract	113,67
		Other	112,00
		F	1,25
		p	0,30
	Service Time	Less than 1 year	111,33
		1 year to 5 years	111,08
		6 years to 10 years	109,88
		11 years to 15 years	103,19
		16 years to 20 years	110,11
		21 years to 25 years	115,00
		26 years to 30 years	109,92
		Over 31 years old	111,38
		F	1,04
		p	0,41
	Working hours	Less than 35 hours per week	107,75
		35 hours per week	109,38
		42 hours per week	112,00
		More than 42 hours per week	109,00
		F	0,07
		p	0,98
	Schedule Type	Fixed	110,09
		Shifts	107,67
		F	0,89
		p	0,35

H3. There is a difference in the level of PS in relation to sociodemographic factors and professional factors of the DTT.

The scale that measures PS has 4 scales: “Quality of your Service as a Workplace", "Quality of your Service in the Provision of Care", " Continuous Quality Improvement" and "Emotions about your Work and your Job".

According to the information in **Table 11**, there are statistically significant differences in the "Continuous Quality Improvement" scale in relation to gender (p<0.05). It is observed that in relation to the "Continuous Quality Improvement" the female gender is the one that presents the greatest satisfaction. From the perspective of age, there are statistically significant differences only in terms of "Continuous Quality Improvement" (p<0.05). On this same scale, it was between 21 and 30 years old that there was greater satisfaction. It was possible to verify that in relation to marital status there are no significant mean differences (p<0.05) in PS. In relation to academic qualifications, there were no significant mean differences (p<0.05) in PS.

Regarding the professional relationship, statistically significant differences were found in terms of "Emotions about your Work and your Job" (p<0.05). In relation to this scale, it is found that the "Staff worker" is the one who presents the greatest satisfaction. Concerning to service time, there are statistically significant differences in the scale "Emotions about your Work and your Job" (p<0.05). The respondents who are most satisfied are between 21 and 25 years old. In relation to working hours, there were no significant mean differences (p<0.05) in PS. Finally, in relation to the type of schedule, there are statistically significant differences (p<0.05) in terms of the "Quality of your Service as a Workplace". The "Fixed Schedule" has a higher average ($\bar{x}$ = 83,59) (**Table 11**).

Table 11. Analysis of Variance of Sociodemographic and professional factors

		Quality of your Service as a Workplace*		**Quality of your Service in the Provision of Care***		**Continuous Quality Improvement***		**Emotions about your Work and your Job***	
		F	p	F	p	F	p	F	p
Sociodemographic Factors	Gender	1,44	0,23	1,89	0,17	5,41	0,02	0,04	0,84
	Age	0,48	0,7	1,48	0,23	3,15	0,03	1,53	0,24
	Marital Status	0,54	0,58	0,2	0,82	0,14	0,88	3,07	0,06
Professional Factors	Academic Qualifications	1,00	0,37	0,02	0,90	0,41	0,67	0,23	0,64
	Professional Status	0,34	0,8	2,33	0,08	1,07	0,36	8,21	0,01
	Service Time	1,02	0,42	2,13	0,05	1,15	0,34	7,59	0,00
	Working Hours	0,62	0,61	1,37	0,26	1,56	0,21	1,73	0,20
	Schedule Type	11,82	0,00	1,58	0,21	3,12	0,08	0,39	0,54

*Dependent variables

CONCLUSIONS

The PS of health professionals has a direct impact on their quality-of-life Martins (2020). However, PS is sometimes neglected. Within organisations, PS is essential since, for example, it influences the quality of care, as well as significantly impacting the health and well-being of users.

Regarding EI, Goleman (2021) considers that it is not an innate ability, but a learned one, and should be developed to acquire exceptional performance. In the context of health care, Raghubir (2018) states that EI is a concept that is not always recognised by professionals in this area. The importance of understanding and sharing feelings among professionals to reduce professional stress and consequent improvement in emotional competence Rocha, Pinto and Carvalho (2021), allows the integration of technical knowledge, empathy, and interpersonal skills, resulting in compassionate and effective care for the well-being of users.

To date, it has not been possible to verify the existence of studies that reflected on the themes of PS and/or EI only in DTT. However, it was possible to verify the existence of national and international studies on the themes in other health professional classes, which are presented as a theoretical and practical reference for the present article, as well as for comparison and discussion of the results obtained.

It is in this context that the importance of considering EI and PS with the DTT arises, emerging an innovative approach as a source of competitive advantage. Observing labour relations from this perspective represents a disruptive vision considering new ways of understanding the well-being, the mental health of this professional category.

The main objective of this research was to contribute to the increase of knowledge about EI and PS in the DTT of SESARAM. This study resulted in evidence that EI does not correlate with PS (**Table 8**), aligned with the results of Rocha, Pinto and Carvalho (2021). However, other studies report positive correlations between IE and PS (e.g. Encarnação, Soares and Carvalho, 2018; Lo et al., 2023; Soriano-Vázquez, Castro and Morales-García, 2023; Musio et al., 2024).

In the present research, when comparing EI with the scales that make up the PS instrument, a statistically positive correlation ($p<0.05$) was found for EI and "Continuous Quality Improvement" (**Table 8**). As Raghubir (2018) found that EI has a significantly positive effect on continuous quality improvement.

Emotional Intelligence did not present statistically significant differences in sociodemographic and professional factors (**Tables 9 and 10**), while Professional Satisfaction in some of the factors presented statistically significant differences (**Table 11**).

We sought to evidence a relationship between sociodemographic factors and EI and PS. In terms of EI, in relation to all sociodemographic factors considered in this study, there were no significant mean differences ($p<0.05$) (**Table 9**). Regarding PS, there were statistically significant differences in the "Continuous Quality Improvement" scale, in relation to gender and age (**Table 11**). The other sociodemographic factors studied did not present significant mean differences ($p<0.05$) in relation to PS (**Table 11**).

Finally, concerning professional factors and their relationship with EI and PS, it was found that EI in relation to the factors studied did not present significant mean differences ($p<0.05$) (**Table 10**). From the perspective of PS, it was found that in the scale " Emotions about your Work and your Job" there were statistically significant differences considering the factor of professional employment and service time (**Table 11**). On the other hand, the scale "Quality of your Service as a Workplace" presents statistically significant differences considering the type of schedule factor (**Table 11**).

In summary, the present research allowed us to reflect on EI and PS in a specific professional class, the DTT.

One of the limitations of this study was the difficulty in finding scientific documents related to EI, PS and DTT. Another limitation is related to the fact that the data collection instrument is self-reporting. One of the major problems with self-report measures is that they are susceptible to intentional distortion or falsification, so if there is no such intention, it may be present even if involuntarily (Hough and Johnson, 2013). This limitation can be overcome by applying the same self-report instrument in other populations. Other studies may use other data collection tools, such as direct observation. The questionnaire was administered at a single time, making it impossible to draw conclusions about its stability over time. It is recommended to perform a test-retest at least another time in future studies.

The fact that the sample is not random is also considered as a limitation, so the results are only indicative, and it is not possible to guarantee its generalization to the population. This fact can be mitigated by conducting additional research in different contexts, with larger and preferably random samples.

If, on the one hand, considering cultural factors and their possible influence on EI and PS constitute a differentiating factor of the present research, at the same time it can be considered a limitation, since it is not possible to generalize it to all DTT in Portugal. Research on the themes of EI and PS is not exhausted with this study, so new studies replicating methods and using new research designs that seek to complement and deepen the study in EI and PS, as well as organize and implement training in emotional intelligence is proposed.

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