CHARACTERISTICS OF PERSONALITY TRAITS OF YOUNG WOMEN ASPIRING TO HAVE A CAREER AS A MEDICAL ASSISTANT

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Abstract: In this paper we intend to identify personality traits and adolescence disorders in people aspiring to have a career as a medical assistant. Medical care is a professional field where communication, empathy, reliability and attention to detail are essential but difficult to measure in a potential employee.

Key words: personality, medical assistant, career

Theoretical studies

At a young age the ***development of professional skills*** is based on the development of the cognitive system. Having a ***skill*** requires both a cognitive, informational dimension, and a formative dimension, aimed at producing a change at behavioral level, as well as affective, emotional adherence to a set of personal, social and professional transformations that occur throughout career evolution.

In recent years, medical assistants have had to enrich their professional knowledge. The type of knowledge that plays an essential role in professional development in the medical field is ***declarative knowledge, procedural knowledge, conditional or strategic knowledge, metaknowledge***. Therefore, it is very important to have a desire to study and a capacity to understand what you are studying. In addition, medical assistants need to evaluate things quickly and act immediately when the situation requires it.

Training of healthcare professionals is important for the professional development process of each employee, but also for the development of the professional organization. It corresponds to several types of specific objectives: organizational change and development, adaptation to technological development, development of employee skills and habits. If a person from the organizational environment tries to define the steps they are going to take throughout their career, they may encounter smaller or larger obstacles that have or have not been anticipated. A medical assistant that was employed recently may encounter many problems of integrating herself by not knowing the rules, group norms or the way to accomplish tasks. In such situations a more experienced colleague, a manager or a person specially trained to provide this type of support can help the medical assistant analyze the situation, evaluate existing options and encourage her to promote.

Among the authors that demonstrated the importance of mentoring in the professional development of medical staff, we mention: Dolan and Schuler (1994), Cole (2000). The methods used in learning and professional development are important because they shape the personality traits of future medical assistants and they can be used inside or outside the organization through continuous professional training.

Research objective

Identifying personality traits and adolescence disorders in people aspiring to have a career as a medical assistant

Research hypotheses

1. It is assumed that there is a correlation between the school problem factor and the emotional stability factor.

2. It is assumed that there is a correlation between the generalized anxiety factor and the conscientiousness factor.

3. It is assumed that there is a correlation between the self-concept factor and the autonomy factor.

Methods of psychological investigation

FFPI Questionnaire - intended to evaluate the five suprafactors of the Big Five model (Extraversion, Emotional Stability, Conscientiousness, Kindness and Autonomy).

Adolescent disorder assessment scale (APS-SF) - a tool for evaluating psychopathology and psychosocial problems faced by adolescents aged between 12 to 19 years old. The 115 items of APS-SF directly assess the symptoms specific to the clinical disorders included in the Diagnostic and Statistical Manual

of Mental Disorders, Fourth Edition (DSM-IV, American Psychiatric Association, 1994), as well as those of other problems and behaviors that interfere with good psychosocial adaptation and personal competence. APS-SF comprises 12 clinical subscales and 2 validity subscales. Six clinical subscales focus on DSM-IV symptomatology. These were designed to reflect the main symptoms presented in DSM-IV and associated with the following disorders: Conduct Disorder (CD), Oppositional Defiant Disorder (ODD), Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), Posttraumatic Stress Disorder (PTSD), Substance Use Disorder (SUD). The other six clinical subscales assess relevant aspects related to adolescent psychosocial problems. These subscales include: Eating Disorder (ED), suicide, schooling problems, predisposition to violence / anger, self-conception, interpersonal problems. The two validity subscales regarding the defensive attitude (DEF) and the consistency of responses (CR) examine the issues related to the validity of responses.

Sample population

The population of the sample includes 1st year students at Hipocrate post - secondary school Constanta, all of them aspiring to a career of medical assistants. In this paper we have used a probabilistic sample with rational selection, comprised of 76 subjects.

Percentage of subjects based on age and gender criteria: 39.47% of research participants are under 25 years old and 60.54% are above 25 years old. 93.37% of participants are women and 2.63% of participants are men.

Ethical principles

The research in question respected the ethical principles that allow it to be undertaken in optimal conditions. We have obtained the informed consent of the research participants by providing the following information:

- Presentation of procedures used in the research,
- Presentation of risks involved in the research,
- Presentation of the nature, purposes and use of the research,
- Freedom of participants to withdraw from the research at any time.

The intimacy and fundamental rights of the study participants have also been respected. We have informed participants that the data provided is confidential.

Analysis and interpretation of results

HYPOTHESIS 1

It is assumed that there is a correlation between the school problem factor and the emotional stability factor.

The verification of the hypothesis was done based on the results obtained by the entire sample, taking into consideration the school problem factor recorded in the ***FFPI Questionnaire*** and the emotional stability factor recorded in the ***Adolescent disorder assessment scale (APS-SF)***.

Table 1

Central tendency and dispersion indices –
School problem factor and Emotional stability factor

Statistics			
		PS School problems	FFPI Emotional stability
N	Valid	76	76
	Missing	0	0
Mean		3,76	53,87
Median		4,00	55,00
Mode		0	57
Std. Deviation		2,576	11,954
Variance		6,636	142,889
Skewness		,082	-,180
Std. Error of Skewness		,276	,276
Kurtosis		-1,058	,408
Std. Error of Kurtosis		,545	,545
Sum		286	4094

The table shows the starting indices used in statistics: mean, median, mode and standard deviation. The median obtained by the participants are as follows: School problems - 4.00; Emotional stability - 55.00.

Taking into account the existing reality and the data series, by using the Statistical Package for the Social Sciences programme (S.P.S.S.), the normality of the distribution was verified first, for each factor.

Table 2

Tests of Normality – School problem factor and Emotional stability factor

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Emotional stability factor	,065	76	,200*	,986	76	,568
School problem factor	,095	76	,086	,932	76	,001
*. This is a lower bound of the true significance.						
a. Lilliefors Significance Correction						

The level of significance is **not** greater than 0.05 for the School problems factor, hence the data is not normally distributed. Therefore, the next step was to apply **Spearman's** rank-order correlation test, a nonparametric method.

Table 3

Correlation between: Emotional stability factor and School problem factor

Correlations				
			FFPI Emoțional Stability	PS School problem
Spearman's rho	**Emotional stability factor**	Correlation Coefficient	1,000	-,347**
		Sig. (2-tailed)	.	,002
		N	76	76
	School problem factor	Correlation Coefficient	-,347**	1,000
		Sig. (2-tailed)	,002	.
		N	76	76
**. Correlation is significant at the 0.01 level (2-tailed).				

The table above confirms the assumption that the two aspects correlate. There is a negative correlation with regards to the factors of School problems and Emotional stability. The correlation has a value of -0.347, at a significance level of less than 0.05, therefore the more the emotional stability decreases, the more the school problems become more intense. In this context, as stated in professional tests, emotional stability has been highlighted as a performance predictor in the workplace (Judge and Bono, 2001; Salgado, 1998; Tett et al., 1991) and as an agreeable established predictor of work accidents (Clarke, 2006). There is also other research that demonstrates its support for an association between the emotional stability of medical assistants and the quality of safety (Teng et al., 2009), as well as the perceptions of the patient regarding the quality of care (Teng et al., 2007).

HYPOTHESIS 2

It is assumed that there is a correlation between the generalized anxiety factor and the conscientiousness factor.

The verification of the hypothesis was done based on the results obtained by the entire sample, taking into consideration the generalized anxiety factor recorded in the ***Adolescent disorder assessment scale (APS-SF)*** and the conscientiousness factor recorded in the ***FFPI Questionnaire***.

Table no.4

Central tendency and dispersion indices –
Generalized anxiety factor and Conscientiousness factor

Statistics			
		FFPIConstiinciozitate	AGanxietategeneralizata
N	Valid	76	76
	Missing	0	0
Mean		56,34	7,41
Median		58,00	8,00
Mode		63	10
Std. Deviation		11,672	3,283
Variance		136,228	10,778
Skewness		-,217	-,930
Std. Error of Skewness		,276	,276
Kurtosis		-,939	-,033
Std. Error of Kurtosis		,545	,545
Sum		4282	563

Taking into account the existing reality and the data series, by using the Statistical Package for the Social Sciences programme (S.P.S.S.), the normality of the distribution was verified first, for each factor.

Table 5
Tests of Normality

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
FFPI Conscientiousness	,137	76	,001	,965	76	,035
generalized anxiety	,148	76	,000	,878	76	,000
a. Lilliefors Significance Correction						

The level of significance is **not** greater than 0.05 for both Conscientiousness and Generalized anxiety factors, hence the data is not normally distributed.

Therefore, the next step was to apply **Spearman's** rank-order correlation test, a nonparametric method.

Table 6
Correlation between: Emotional stability factor and

Correlations				
			generalized anxiety	FFPI Conscientiousness
Spearman's rho	generalized anxiety	Correlation Coefficient	1,000	-,455*
		Sig. (2-tailed)	.	,026
		N	76	76
	FFPI Conscientiousness	Correlation Coefficient	-,255*	1,000
		Sig. (2-tailed)	,026	.
		N	76	76
*. Correlation is significant at the 0.05 level (2-tailed).				

The table above confirms the assumption that the two aspects correlate. There is a negative correlation with regards to the factors of Generalized anxiety and Conscientiousness. The correlation has a value of -0.455, at a significance level of less than 0.05.

HYPOTHESIS 3

It is assumed that there is a correlation between the self-concept factor and the autonomy factor. **The verification of the hypothesis** was done based on the results obtained by the entire sample, taking into consideration the self-concept factor recorded in the ***Adolescent disorder assessment scale (APS-SF)*** and the autonomy factor recorded in the ***FFPI Questionnaire***.

Table 7

Central tendency and dispersion indices – Autonomy factor and Self-concept factor

Statistics			
		autonomy factor	the self-concept factor
N	Valid	76	76
	Missing	0	0
Mean		53,84	4,13
Median		54,00	4,00
Mode		56	6
Std. Deviation		10,488	2,830
Variance		110,001	8,009
Skewness		,027	,287
Std. Error of Skewness		,276	,276
Kurtosis		-,082	-,878
Std. Error of Kurtosis		,545	,545
Sum		4092	314

The **Table** shows the starting indices used in statistics: mean, median, mode and standard deviation. The means obtained by the participants are as follows: Autonomy – 54.84; Self-concept - 4.13.

Table 8

Tests of Normality – Autonomy factor and Self-concept factor

Tests of Normality						
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Autonomy factor	,076	76	,200*	,987	76	,629
Self-concept factor	,103	76	,044	,947	76	,003
*. This is a lower bound of the true significance.						
a. Lilliefors Significance Correction						

The level of significance is **not** greater than 0.05 for the Self-concept factor, hence the data is not normally distributed. Therefore, the next step was to apply **Spearman's** rank-order correlation test, a nonparametric method.

Table 9

Correlation between:
Autonomy factor and Self-concept factor

Correlations				
			FFPI Autonomy	CS Self concept
Spearman's rho	**Autonomy factor**	Correlation Coefficient	1,000	-,430**
		Sig. (2-tailed)	.	,000
		N	76	76
	Self-concept factor	Correlation Coefficient	-,430**	1,000
		Sig. (2-tailed)	,000	.
		N	76	76
**. Correlation is significant at the 0.01 level (2-tailed).				

The table above confirms the assumption that the two aspects correlate. There is a negative correlation with regards to the factors of Self-concept and Autonomy. The correlation has a value of -0.430, at a significance level of less than 0.05.

Conclusions

The results obtained from performing the testing come in addition to the specialized studies carried out so far. Medical care is a professional field where communication, empathy, reliability and attention to detail are essential but difficult to measure in a potential employee. Medical assistants are the primary caregivers to the patients, hence they are the most vulnerable, and the degree of medical care can make the difference between life and death, or quality of life after illness.

References:

Cole G.A. (2000). *Personnel Management*, CODECS, Bucharest

De Vries J.M. Timmins F. (2012). Psychology teaching in nursing education: a review of and reflection on approaches, issues, and contemporary practice**.** *Nurse Educ. Pract.*12:316–321.

De Vries J., Timmins, F. (2017). *Understanding Psychology for Nursing Students***,** Sage, London.

De Vries, J.M., Timmins F. (2017), Teaching psychology to nursing students-a discussion of the potential contribution of psychology towards building resilience to lapses in compassionate caring, *Nurse Education in Practice,* pg.27-32, https://www.sciencedirect.com/science/article/pii/S147159531730

Dolan S.L., Schuler R. S.(1994*), Human Resource Management*, Nelson, Canada

Driessen E., Tartwijk J.V., Der VleutenC.V., Wass V. (2007). Portfolios in medical education: why do they meet with mixed success? A systematic review, *Medical Education*, volume 41, Issue12, https://onlinelibrary.wiley.com/doi/full/10.1111/j.1365-2923.2007 . 02944.x

Pânișoară G. (2001), Two Effective Methods of Integration and Organizational Training *in the Journal of Organizational Psychology*, vol. I, no. 3-4, July, 2001, pp.59-71

Tudose F., Tudose C., Dobranici L, (2011), *Psychopathology and psychiatry treaty for psychologists*, Trei Publishing House, Bucharest