

An action-research project using TABEIS and GCEA: The doctor-patient relationship

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Abstract. This paper presents an action research project under development at a Health Centre in the North of Portugal with General Practitioners. The goal of the project is to improve the doctor-patient relationship by means of the development of doctors' skills. We present the phases which have already been conducted and some ideas for the next phases of the project. Using TABEIS, Goal Corrected Empathic Attunement and Critical Incident Technique, we wish to develop a process that enhances the doctors' self-awareness and development needs and interest regarding being in a relationship with a patient and the way they feel and manage these relationships.

Keywords: Action-research, Critical Incident Technique, Doctor-patient relationship, GP, TABEIS, GCEA

Um projecto de investigação-acção usando a TABEIS e o GCEA: a relação médico doente

Resumo. Este trabalho foca um processo de investigação-acção em curso numa Unidade de Saúde Familiar no Norte de Portugal junto de Médicos de Família. O objectivo do projecto é melhorar a relação médico-doente, através do desenvolvimento das competências dos médicos. Apresentamos as fases do projecto que já foram realizadas e algumas ideias para as fases seguintes do trabalho. Baseando-nos na TABEIS, na teoria do Goal Corrected Empathic Attunement e na Técnica dos Incidentes Críticos, pretendemos desenvolver um processo que promova a capacidade de auto-consciência dos médicos acerca do *estar* numa relação com um doente e a forma como se sentem nessas relações e as gerem.

Palavras-chave: Investigação-acção, Técnica dos Incidentes Críticos, Relação médico-paciente, Médico de família, TABEIS, GCEA

1 Introduction

This paper presents an action research project we are conducting at a Health Centre in the North of Portugal. Our goal is to improve doctor-patient relationships throughout the development of doctors' self and skills, adopting as framework the Theory of Attachment Based Exploratory Interest Sharing (TABEIS) and Goal Corrected Empathic Attunement (GCEA) (Heard, Lake, & McCluskey, 2009; McCluskey, 2005).

The project adopted the methodology of action-research, which underlies the majority of processes of organizational planned changes (Cummings & Worley, 2003). This approach implies a high proximity between the person conducting the project (the investigator/s) and the system's members, that is, the organization's workers. It requires integrating the data before moving to action and reflecting on data regarding the conducted actions, conceptualizing change as a cyclical process.

1.1 The doctor-patient relationship

There is a wide range of approaches and models in health care concerning the doctor-patient relationship, namely the biomedical model, the psychosomatic, the biopsychosocial and the holistic, competencies and doctor-patient skills or patient adherence models, patient-centered and bioethics

approaches. In the present study we see the doctor-patient relationship in the light of the patient-centered approach, which favours the relationship itself. This perspective is based on the developments in psychotherapy on the 'therapeutic alliance' construct, which is, in itself, potentially therapeutic. This is consistent with the understanding of Balint (1969) that doctor and patient shouldn't be considered separately because they are always influencing each other throughout their interaction in the consultation. This counteracts the biomedical vision, whose approach can be seen as the 'medicine of one person'. We consider that the studies (and interventions) on the doctor-patient relationship should include, as stated by Winefield, Murrell, Clifford e Farmer (1996), the doctor's self-awareness of affective signs and emotional reactions throughout the interaction with his/her patient.

The growing importance given to illness prevention led to health promotion, on which the role of health professionals became central, especially for nurses and General Practitioners (GPs). This movement gave visibility to the importance of communication and relational factors on the patient adherence (Reis, 1998) and to the importance of considering the doctor-patient relationship as a therapeutic element on specific issues of certain kind of patients (e.g., the difficult patient) or certain kind of diseases (e.g., chronic fatigue). Research shows, for example, that improving doctor-patient communication improves psychological aspects of caregiving, and at the same time has a positive impact on some physiological aspects of the patient (e.g., hypertension or pain control) (Kurtz, 2000). However, it is necessary to develop and deepen our knowledge about the doctor's aspects variability impact; in addition, there are very few studies focusing on the emotional impact on the GP of aspects related to his/her patient (Hareli, Karnieli-Miller, Hermoni, & Eidelman, 2007).

1.2 Insights from TABELIS and GCEA to the doctor-patient relationship

The attachment-based theory – TABELIS – defines seven biopsychological systems which can be activated or deactivated in survival (threat to the self) or exploratory mode, always with the goal of restoring the wellbeing: 1) careseeking; 2) caregiving; 3) self-defence; 4) interest sharing with peers; 5) sexuality; 6) internal environment; and 7) external environment (Heard, Lake, & McCluskey, 2009). GCEA implies that an interaction is mutually regulated, and experienced as satisfactory when both parties achieve the goal of their respective systems of careseeking and caregiving (McCluskey, 2005). Our point of view on the therapeutic alliance is that in the dyadic interaction there is a person who is careseeking, the patient, and another person who is the caregiver.

The beneficence model in the bioethics approach is based on the trust between doctor and patient, and on the purpose of medicine as giving care to the patient as a unique human being, considering his/her fragility (Cruz, 2012). The recognition of the doctor-patient relationship as central to the health care efficacy and well-being of the parties involved underlies the importance of looking at the doctor as a person within a relationship where complex interactions occur. Despite the tendency to give to the patient role a prime factor in the medical inefficacy and non-adherence (Odgen, 1999) (or perhaps for this reason), there is a need to explore the role and dynamics experienced by the doctor on the relationship with his/her patients.

2 The intervention process

The project was planned considering four main phases, which were adopted according to action-research methodology: (1) entering and contracting; (2) diagnosis; (3) planning and implementing;

and (4) evaluating (Cummings & Worley, 2003). So far we have conducted the first two phases and have some preliminary ideas regarding the following stages of the process.

2.1 First phase of the project: Entering and contracting

The project was stimulated by the PhD of one of the authors in 2012, whose main area of research was the doctor-patient relationship (using TABELS and GCEA as a framework and Critical Incident Technique), and by the Work group “Competencies Development and Training of Carers”, at the University of Porto. One of the members of the group was working in a Health Centre where GPs had training needs in doctor-patient relationship. This represented the identification of a problem, and the organization asked the group for an intervention. Due to various constraints, the project entered a period of stagnation until the authors decided to conduct a new formalization of the project at the end of 2014. This translated itself into a written protocol to be approved by the Public Health Administration, focusing rules, ethical issues and other concerns. We also conducted a meeting with the GPs, explaining why the project had paused and what the following steps would be.

2.2 Second phase of the project: Diagnosis and feedback

Diagnosis was conducted at the individual level (Cummings & Worley, 2003), using the Critical Incident Technique (Flanagan, 1954). We gathered data from seven GPs at the health centre (including the unit coordinator), five being female.

Critical Incidents: We defined a critical incident as an event that the doctor had experienced in the context of the relationship with his/her patients, asking GPs to present a positive and a negative critical incident. A *positive incident* was presented as an event the doctor considered had a positive impact on the doctor-patient relationship; and a *negative incident* was an event that had an unsatisfactory impact, once again, according to the doctor. Specifically, we require GPs to:

Think about events you have recently experienced of interaction with your patients. Think about an event you consider positive. That means, from your personal and professional point of view, you see it as a “driving force” to achieve the goal and you would like it to happen in the future. Think also about an event you consider negative, that means, from your personal and professional point of view you see it as a “restraining force” to achieve the goal and you wouldn’t like it to happen in the future. Suggestion: Please try to distinguish when you are describing facts, thoughts you had (before, during and after the facts) and feelings.

Procedure: The critical incidents’ questionnaire was sent to the Health Centre coordinator who passed it on to the GPs, using email. Each GP sent the questionnaire to the researchers after completing it, once again using email.

Data analysis: We conducted a content analysis (Bardin, 2009) on the critical incidents, that made up our corpus of analysis. As stated by Bardin, content analysis is reinvented by the researcher, in order to fit the content that is under analysis – that is, the human communication focused on by the researcher. Nonetheless, there is a set of rules regarding how the analysis should be conducted. We decided to use as our system of categories four of the systems presented by TABELS: self-defence, caregiving, careseeking, and internal environment. We adopted these categories based on a preliminary analysis we did on the gathered incidents, and our perspective that these systems are core ones within the doctor-patient relationship. We identified the systems being activated in the dynamic between the GP and the patient, that is, how one of the actor’s systems being active

impacted the other's system; what represented a trigger in the dynamic, that is, what seemed to activate the system; the existence of GCEA in the relationship; and the emotions and cognitions of the GP in the incident. This means our coding was exhaustive. Data was coded simultaneously by the authors, which allowed us to discuss discrepancies regarding coding during the data analysis process, finding consensus.

Results from the analysis: We gathered a total of nine critical incidents from seven GPs, four positive and five negative; only two GPs reported both positive and negative critical incidents. An example of a positive critical incident describes a difficult event where the patient is a young pregnant woman (with a good previous doctor-patient relationship) who went to an appointment to show the doctor the results of an exam, which would eventually identify a serious disease. Three out of the four selected systems were identified in this critical incident:

- 1) self-defence system, when the GP describes some aspects revealing the activation of the fear system, like feelings of anger, injustice and anguish: «*I was confronted with a situation which was hard to face*» (GP)
- 2) internal environment system, when the GP shows his capacity to be aware of his own emotions and to self-regulate: «*I took some time to prepare a response*» (GP)
- 3) caregiving system, when the doctor is being supportive, telling the patient how to deal emotionally with the situation: «*have courage*» (GP).

Several insights emerged from the analysis. We identified a difference between the positive and negative events. In the positive ones, three of the systems are more present: caregiving, internal environment and self-defence; in the negative events another set of three systems are more likely to be activated: the careseeking, internal environment and self-defence. In fact, the core difference is that the 'caregiving' is more likely to be activated in the positive incidents, and the careseeking activated in the negative ones. Another difference is in the nature of the internal environment system, which appears as 'supportive' of the self in the positive events, and as unsupportive in the negative events.

It seems we can also find another pattern emerging, now related to the patient. In the positive events the patients are described as vulnerable, emotionally disturbed, submissive, and to be young or with serious illness. On the other hand, patients in the negative events are presented as dominant, confronting the GP, not following the medical rules, and demanding unreasonable tasks of their GPs. In general, for positive and negative events, the previous and future relationship with the patient seem very important for the GP.

Further analyses on these data will focus on the doctors' thoughts and feelings regarding themselves in relation to patients, to understand if we can find patterns of submission versus dominance. We will also analyse the patterns of interaction associated with effective and ineffective caregiving.

2.3 The next phases of the project: feedback, planning and implementing; and evaluating

As already mentioned, action research implies a research close to participants. Hence, the next step in the process will be to present our preliminary diagnosis results to the GPs, giving them feedback and building *with them* the diagnosis. With this we mean that the feedback will consist of a work session where the GPs become true researchers in the project, analysing and discussing the preliminary analysis conducted by the authors. This way we guarantee the project rests on a joint understanding of the situation and reflects a true collaboration between the outsiders and the inside researchers (i.e., the authors and the GPs, respectively).

At this moment we have some ideas regarding the next phases of our project, still to be discussed with the actors of the system that we are researching – our co-researchers.

Planning and implementing: The plan of action and its specific goals are to be co-constructed with the GPs, in order to guarantee their engagement and identification with the project. Nonetheless, we have some actions which we believe will be of value to this project: using the critical incidents already analysed, and discussing them in the context of group or individual sessions, according to the emergent themes.

The Critical Incident Technique is an important tool in doctors' training and development process (Branch, 2005; Brandão, Saraiva, & Miguez, 2014). It allows the exploration of the subjective dimension of the doctor's experience, which encourages his engagement in the process, creating a moment of reflection on the professional practice, from which it is possible to identify the skills or attitudes that will improve performance (Diamond, Stone, Yes, & Davis, 1995). Critical incident technique allows one to do this while considering the needs of the doctors and their context.

Evaluating: After implementing the (to be) defined actions, it is necessary to gather data in order to evaluate the impact of those actions. We plan to evaluate the impact of our intervention throughout the process and at the end co-designing with the GPs the specific strategies to be used. Nonetheless, the authors believe it would be positive to continue using the Critical Incidents technique, since it will be familiar to the GPs and the evaluation process could function as another moment of intervention.

3 Conclusions

Action research is a powerful model of knowing and changing systems in collaborative ways. At this point in the process, however, the authors feel that the involvement of the practitioners in the project has been limited and that the researchers, outsiders to the organizational system, have been more active in the process than the GPs. Action research's main feature is giving voice and power of action to practitioners, building meaning and knowledge while conducting collaborative research. This is something which needs to be made more present in this project. Despite the project's origin resting on a need felt by the organizational system (which asked for support from the authors' work group), we feel it is crucial for this project to have an active involvement of the GPs. This may be associated with the fact that the project experienced a period of stagnation, which may have activated some scepticism regarding the change effort. Also when we reactivated the process, the Health Centre was going through an auditing process, which absorbed the energy of its elements and the system under stress.

The use of the Critical Incident Technique allows us to identify specific triggers in the doctor-patient relationship and develop a contextual understanding of the phenomenon under analysis and intervention. We get to understand the behaviours specific to the activation of interpersonal and intrapersonal systems' in the doctor-patient relationship, which should be considered in relation to the doctors' thoughts and emotions. This is particularly relevant given the importance of the quality of relationship between doctors and patients, namely at the level of patient medical adherence (Bennett et al., 2011). It is also important given the fact that the doctor's sense of well-being must be intact inside and outside the medical context, considering his role as a doctor and as a person.

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References

- Balint, E. (1969). The possibilities of patient-centered medicine. *The Journal of the Royal College of General Practitioners*, Vol 17, 269-276.
- Bardin, L. (2009). *Análise de conteúdo*. Lisboa: Persona, Edições 70.
- Branch, J. (2005). Use of Critical Incident Reports in Medical Education A Perspective. *Journal of General Internal Medicine*, 20(11), 1063–1067.
- Brandão, C., Saraiva, E., & Miguez, J. (2014). A Técnica dos Incidentes Críticos em contexto de formação e desenvolvimento em medicina, *News & Views, Revista da Sociedade Portuguesa de Medicina Física e de Reabilitação*, nº 18 (Dezembro), 17-18.
- Bennett, J. K., Fuertes, J.N., Keitel, M., Phillips, R. (2011). The role of patient attachment and working alliance on patient adherence, satisfaction, and health-related quality of life in lupus treatment, *Patient Education and Counselling*, Vol 85, 53-59.
- Cruz, J. (2012). *Que médicos queremos? Uma abordagem a partir de Edmund D. Pellegrino*. Coimbra: Edições Almedina.
- Cummings, T. G., & Worley, C. G. (2005). *Organization development and change*. Mason, OH, Thomson South-Western.
- Diamond, M. R., Kamien, M., Sim, M. G. B., & Davis, J. (1995). A critical incident study of general practice trainees in their basic general practice term. *The Medical Journal of Australia*, 162.
- Flanagan, J. C. (1954). The critical incident technique. *Psychological bulletin*, 51(4), p. 327-358.
- Hareli, S., Karnieli-Miller, O., Hermoni, D., & Eidelman, E. (2007). Factors in the doctor-patient relationship that accentuate physicians' hurt feelings when patients terminate the relationship with them, *Patient Counseling*, Vol. 67(1-2), 169-175.
- Heard, D., Lake, B., & McCluskey, U. (2009). *Attachment Therapy with Adolescents and Adults: Theory and Practice Post Bowlby*. London: Karnac Books.
- Kurtz, S. (2002). Doctor-Patient Communication Principles and Practices, *Canadian Journal of Neurological Sciences*, Vol 29, Suppl 2, S23-S29.
- McCluskey, U. (2005). *To Be Meet as a Person*. London: Karnac Books.
- Ogden, J. (1999). *Psicologia da Saúde*, Manuais Universitários. Lisboa: Climepsi Editores.
- Reis, J. C. (1998). *O Sorriso de Hipócrates, A integração biopsicossocial dos processos de saúde e doença*. Lisboa: Edições Veja.
- Winefield, H., Murrell, T., Clifford, J., & Farmer, E. (1996). The search for reliable and valid measures of patient-centredness, *Psychology and Health*, Vol 11, 811-824.