

Therapeutic Patient Education in the practice of physicians at the Geneva University Hospitals: a qualitative analysis of representative situations and skills

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Abstract – Introduction: Therapeutic patient education (TPE) is a patient-centered approach that requires proper training of healthcare professionals. This study aims to explore representative situations encountered by physicians in their practice where TPE training was useful, which can provide insights for the conception of TPE training programs. **Methods:** A qualitative approach with both focus groups (FG) and individual interviews with physicians trained in TPE in activity at the Geneva University Hospitals (GUH) was carried out. The data was analyzed using inductive thematic analysis. **Results:** Two FG of 9 doctors were conducted. Six representative situations emerged from our analysis: non-compliance, maintaining a comprehensive vision for overall care of the patient, the partner patient, matching the patient request to the underlying need, co-constructing the therapeutic action plan, and confronting powerlessness. **Discussion:** Training in TPE allowed physicians to develop skills to better identify and address these situations. It also favored a change in the posture of the physician, from a posture of teaching and expertise to one of co-construction and learning. **Conclusion:** These situations show how much the care of complex patients is present in the medical practice and TPE training a valuable skill to deal with this complexity. TPE training targeted at these activities could have a positive impact on the practice of physicians and patient care.

Keywords: therapeutic patient education / representative situations / skills development / qualitative analysis

Résumé – L'éducation thérapeutique du patient dans la pratique des médecins aux Hôpitaux Universitaires de Genève: analyse qualitative des situations emblématiques et compétences.

Introduction : L'éducation thérapeutique du patient (ETP) est une approche centrée sur le patient qui requiert une formation adéquate des soignants. Cette étude vise à explorer les situations emblématiques rencontrées par les médecins dans leur pratique où leur formation en ETP a été utile, ce qui peut fournir des éclairages pour la conception de programmes de formation en ETP. **Méthodes :** Deux focus groupes (FG) et entretiens individuels avec des médecins formés en ETP en activité aux Hôpitaux Universitaires de Genève ont été réalisés. Les données ont été analysées selon une méthodologie d'analyse thématique inductive. **Résultats :** Six situations emblématiques sont ressorties: la non-observance, la nécessaire vision globale du patient, le patient partenaire, le travail de la demande du patient, l'adaptation de la demande du patient au besoin sous-jacent, la co-construction du plan thérapeutique et la confrontation à l'impuissance. **Discussion :** La formation en ETP a permis aux médecins de développer des compétences pour mieux identifier et répondre à ces situations complexes. Elle a également favorisé un changement dans la posture du médecin, qui est passé d'une posture d'enseignement et d'expertise à une posture de co-construction et d'apprentissage. **Conclusion :** Ces situations illustrent comment les soins des patients complexes sont omniprésents dans la pratique médicale et la formation en ETP un atout pour faire face à cette complexité. Une formation ciblée sur ces activités pourrait avoir un impact positif sur la pratique des médecins et les soins aux patients.

Mots clés : éducation thérapeutique du patient / situations emblématiques / compétences / analyse qualitative

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1 Introduction

Therapeutic patient education (TPE) is a patient-centered approach that includes a set of organized activities that are intended to help the patient and their family understand the disease and its treatments, participate in care giving, take responsibility for their health status, and encourage a return to normal activities [1–5].

This approach requires healthcare professionals (HCP) to acquire highly specific skills [1,6–8]. The term “skills” comprises among others, communication, practical, psychomotor, clinical and technical skills. Several specific training programs are being developed in order to help HCP acquire the aforementioned skills. However, these programs are usually limited to training activities isolated from clinical practice. This type of training isn’t enough to transpose skills to clinical reality. As a consequence, most HCP have been insufficiently prepared for their TPE tasks in clinical practice [9].

Experiential learning theory emphasizes the importance of learning through experience, involving contextual and situational factors [10–12]. Mayen emphasizes the dynamic relationship between a person and a specific situation [13]. A skilled professional is a person capable of mastering a set of representative situations, that can be defined as a set of recurrent activities sharing invariable characteristics such as the identified problem, goals and environment [13,14]. For trainers, it is therefore possible to develop a new perspective of teaching, no longer based only on skills, but also on the situations that learners will encounter. The training framework based on representative situations would be built on the reality of the work environment and experience of the learners which would make it easily applicable in their clinical practice.

In the field of TPE, this referential of representative situations hasn’t been established yet. Therefore, this study explores the representative situations encountered by physicians working at Geneva University Hospitals (GUH), where TPE was useful and efficient which can provide valuable insights and guide the conception of future physician TPE training programs.

2 Methods

2.1 Context

The University of Geneva Medical School created two curricula for ongoing training of healthcare professionals in TPE: a Certificate (CAS) and a Diploma (DAS) of Advanced Studies in Patient Education. Since the creation of these curricula in 1998, over 350 caregivers have been trained in TPE, including 100 at the GUH alone [15].

2.2 Data collection

A qualitative approach with both focus groups (FG) and individual interviews with physicians trained in TPE in activity at the GUH was carried out. The FG took place inside the GUH, during working hours. To launch the discussion, at the beginning of the FG, participants were asked to take 10 minutes to reflect on the representative situations they encountered in their practice where TPE was useful and

efficient. They were informed about what a representative situation is and that they could express their own experience without thinking about what would be considered “representative”. This was followed by a roundtable discussion.

After a first FG data analysis, individual explanatory interviews [16] were held with two participants selected based on their availability. The goals of these two interviews were to better understand the situations encountered and to illustrate problematic situations by way of lived stories. A visual summary of the representative situations emerged from the FG data analysis were presented and participants commented and illustrated them.

2.3 Data analysis

To analyze the data, we utilized an inductive thematic analysis framework [17]. The FG was not recorded. ALM led the FG and wrote participants’ verbatims on cards and classified them on a metaplan board in three categories: context, context characteristics and situations. At the end of each FG, participants validated the metaplan board content.

Subsequently ALM and IF merged both FG data and created the list of all encountered situations which had emerged during the FG, classified by context. This first synthesis was sent to all participants for validation. A second inductive thematic analysis was performed by ALM and IF in order to bring out representative situations and their characteristics that cut across the different contexts.

The two interviews were audio recorded and transcribed ad verbatim. This data wasn’t included in the inductive analysis but verbatims were used to illustrate the representative situations.

After this first set of analysis the research team developed a proposition of skills, goals and activities related to each representative situation. Both the analysis and the proposition were then sent again to all participants for comments. All participants approved the final results.

2.4 Participants

We decided to focus initially on physicians working at the GUH mainly because their pre- and post-graduate training involves less TPE than other caregivers. Furthermore, we focused on physicians in an effort to make these training programs better suited to their specific needs as we see a regular decrease in the number of physicians attending these training programs contrary to other HCP, despite recent polls that show that physicians recognize the importance of TPE.

Participants recruited were thus all the physicians trained in TPE through Geneva University’s DAS or CAS currently working at GUH. They were recruited through an email invitation.

2.5 Ethics

As this study was part of a GUH quality initiative to support patients’ partnership and without patients’ direct involvement, the GUH Research Ethics Committee was not sought. All participants gave their verbal consent to participate

Table 1. Characteristics of participants.**Tableau 1.** Caractéristiques des participants.

Code	Gender	Year DAS was earned	Medical specialization	Care location
Phys 1	F	Pending	Nephrology	INP
Phys 2	F	2006	Neurology	HOSP
Phys 3	M	2011	General medicine and Cardiology	OUTP and INP
Phys 4	F	2002	Pulmonology	OUTP
Phys 5	M	2006	Diabetology	OUTP
Phys 6	F	2016	General internal medicine	OUTP
Phys 7	F	2011	Psychiatry	OUTP
Phys 8	M	2006	Surgery	INP
Phys 9	M	1998	Diabetology	OUTP

at the beginning of each focus group. No compensation was given to the participants.

3 Results

Out of the 14 eligible physicians, 9 agreed to participate in the study. The other five were not available on the scheduled date. Three physicians out of these five participated in the synthesis and analysis validation. Eight participants had earned their DAS and one was still pending. The characteristics of the different participants are detailed in [Table 1](#).

Two FG of two hours duration each were conducted. Data saturation was not sought, as the number of eligible physicians was limited. As verbatims were anonymized when transcribed on cards during the FG, quoted FG verbatim can't be relied on a code and are simple marked as "FG". Subsequently, two interviews of one-hour duration each were conducted with Phys 1 and Phys 2.

Six representative situations emerged from our analysis: dealing with non-compliance, maintaining a comprehensive vision for overall care of the patient, integrating patient's experience and knowledge, matching the patient request to the underlying need, co-constructing the therapeutic action plan, and confronting powerlessness.

They represent the types of situations encountered by the surveyed physicians on a daily basis and in which they use their clinician educator expertise. These are summarized in [Table 2](#), with our proposal of skills, goals and activities. The skills refer to one representative situation or another and should also be understood as being in a dynamic relationship with the other representative situations.

The physicians who participated in the investigation recognized themselves in the representative situations described. Of note, one outpatient physician emphasized that the breakdown into representative situations did not reflect his actual practice. For him, it concealed the essential aspect of his practice: the transversality of the educational posture.

3.1 Dealing with non-compliance

In non-compliance scenarios, the physician notes that the patient has trouble following his treatment as prescribed which could lead to complications and hospitalizations. The characteristics of the situations were often patient-related:

the patients "forgetting that they are ill" (FGX), or the patients misunderstanding their conditions or symptoms. For instance, *there was an epileptic patient who would have repeated seizures and was not taking his medications. He said that his medications did not help, because as soon as he smelled specific odors, he felt the seizure coming on. The problem was that it was his brain creating the odor!* (Phys 2)

The TPE trained physician examines the reasons behind non-compliance and integrates the social, psycho-affective, and environmental dimensions of the patient into their analysis. He tries to identify the strategies used by the patient to negotiate with their treatment in their everyday life. *We had a case with a COPD patient who would come back to the hospital every month. He was not using the non-invasive ventilation (NIV) even though we had explained to him 25 times that it is important. I selected this patient for an interview, and he explained that his wife could not sleep and would unplug the machine. If we look at this situation from another angle, it gives us additional approaches* (Phys 1).

This first representative situation illustrates how the TPE-trained physician isn't satisfied with the visible sign that is non-compliance and seeks a global understanding of the patient's situation. But as relying on the patient's resources creates conditions for a physician/patient partnership, physicians are challenged by the lack of partnership with other health professionals.

3.1.1 Maintaining a comprehensive vision for overall care of the patient

The participants expressed the difficulty that they encounter in retaining the overall vision of the patient and how they work in isolation. *"We are 'silo' caregivers. We are hyper-specialized. Each colleague reasons within their limited framework. ... there is not anyone who sees the patient from an overall perspective."* (Phys 2)

They described how they are often unaware of the patient's family and social environment and how they may be unable to benefit from knowledge and skills of other caregivers. The direction of interprofessional meetings, was often called into question. It could be the occasion to share knowledge about the patient's issues, environment and priorities. That would enable the planning of focused and coordinated therapeutic decision. Instead, it is often a strategic meeting to plan the patient's departure or care pathway. *Unfortunately, we spend so much*

Table 2. Breakdown of representative situations and skills.
Tableau . *Détail des situations emblématiques et compétences.*

Representative situations	Characteristics of the situation	Skills	Goals	Activities
Dealing with non-compliance	<ul style="list-style-type: none"> – Patient does not take their treatment consistently – “Forgets” that they are ill – Repeated hospitalizations – Several uncoordinated prescriptions 	<ul style="list-style-type: none"> – Move past the observation of non-compliance toward understanding of what is happening from the patient’s perspective – Help the patient understand himself 	<ul style="list-style-type: none"> – Use the patient’s strategies – Rely on their environment – Create a partnership 	<ul style="list-style-type: none"> – History – Prescription of a new treatment – Office visit/Patient visit
Maintaining a comprehensive vision for overall care of the patient	<ul style="list-style-type: none"> – Family and social environment are not always known by the physician – No medical coordination – Physician works in isolation 	<ul style="list-style-type: none"> – Share multiple visions of the patient – Organize and lead interdisciplinary meetings – Be aware of the work done by other professionals – Build a coordinated care plan by coordinating the various actors 	<ul style="list-style-type: none"> – Maintain an overall vision of the patient – Improve decision-making – Build a shared care plan 	<ul style="list-style-type: none"> – Social meeting – Pluri/interdisciplinary meeting – Office visit/Patient visit – Computerized file
Matching the patient request to the underlying need	<ul style="list-style-type: none"> – Implicit aspects of the relationship are not discussed – No verification of whether the details of care are understood 	<ul style="list-style-type: none"> – Have the patient verbalize their request – Identify the patient’s expectations – Identify the role attributed to the physician by the patient 	<ul style="list-style-type: none"> – Adjust the caregiving action based on patient’s expectations – Negotiate therapeutic objectives 	<ul style="list-style-type: none"> – History – Office visit/Patient visit – Shared educational assessment
Integrating patient’s experience and knowledge	<ul style="list-style-type: none"> – The physician does not integrate the patient into the various decisions to be made (treatment, follow-up, etc.) – The physician prescribes treatments without ensuring the patient’s collaboration 	<ul style="list-style-type: none"> – Listen to patient’s experience – Identify strategies used by the patient to follow up on their treatment and live with their disease – Acknowledge the patient’s expertise 	<ul style="list-style-type: none"> – Consider the patient’s skill level in the management of their disease – Encourage self-care, adaptation, and reconstruction of the patient’s body of knowledge 	<ul style="list-style-type: none"> – All types of interviews – Development of follow-up logs by the patient
Co-constructing the therapeutic action plan	<ul style="list-style-type: none"> – Often no work downstream or upstream of the prescription to understand the patients’ knowledge level – Little identification or recognition of obstacles to learning for the person regarding their care, health, and motivation 	<ul style="list-style-type: none"> – Work on the representations of the disease and its treatment – Have the patient draw up the conditions of their autonomy – Build shared care plan with negotiate objectives 	<ul style="list-style-type: none"> – Lay the groundwork for the patient’s effective and autonomous action – Deconstruction/ construction of their body of knowledge – Teach 	<ul style="list-style-type: none"> – Office visit/Patient visit – Patient group work – Motivational interviews – Shared educational assessment
Confronting powerlessness	<ul style="list-style-type: none"> – Difficult emotional experience of the physician confronted with the complexity of encountered medical situations 	<ul style="list-style-type: none"> – Acknowledge their lived experience of the therapeutic relationship with the patient 	<ul style="list-style-type: none"> – Improve the lived experience and their ability to perform caregiving work – Learn to work within affective proximity – Learn to work with a patient who is not healing 	<ul style="list-style-type: none"> – Case presentations – Supervision

time talking about continuity of care –when does he [the patient] go where... – that it would be a good thing to talk about what happens to the patient, not simply in terms of their location. A change in meeting goals would validate an interdisciplinary approach, give renewed direction, break up the physician's caregiving solitude, and contribute to a shared dynamic for the assets of all involved. (Phys 1)

In other contexts, the willingness to bring together caregivers' perspectives and capacities exists, but they need shared IT tools to be able to keep the overall vision of the patient and care. *The idea was to have one table per function where each person notes their observations: the occupational therapist, the physiotherapist, etc. However, I cannot manage to integrate the notes of each person into an overall report. We have separate tabs. We want to cross-reference them, but, for now, we have not done it. We need this kind of support to achieve the overall vision. (Phys 2)*

When dealing with complex patients, TPE-trained physicians try to remain mindful of biopsychosocial dimensions and to acknowledge other health professional skills to provide a coordinated interprofessional approach.

Providing TPE is also learning how to work as a team to put the patient at the center. Believing that each professional has their own specificity, their own way of looking at things, that deserves to be explored. It is taking an interest in each professional and in what each person is doing. (Phys 1)

But doing so may question the physician's role in the patient management, as he might not be the key-caregiver for the real patient problem.

To return to the example of the patient who was not wearing his NIV because his wife would unplug it at night... the solution does not necessarily lie with the physician, and it may fall under the purview of the social worker to help the couple find a larger apartment... We need to be more structured in planning common goals. (Phys 1)

3.1.2 Matching the patient request to the underlying need

When practicing TPE, physicians need to deeply redefine their role in the patient care and path. They may have to give more space to other health professionals in order to respond to the real patient need and also to confront the physician's and patient's role.

Focusing on the real need is a first challenge as physicians tend to answer the first expressed request and then might miss the true underlying need. The patient's real need is often implicit and unstated. It then takes to the physician to understand better the situation, to get the global vision of the patient mentioned earlier.

The imagined need is not the real need of the patient. This happens frequently. We do not have the same goals. Often, we assume a need that is not the correct one, and right away we veer onto paths that are parallel but that never cross. The patient has concerns that are not medical in nature. For example, the patient will say that their heart attack is connected to their workplace stress, and we tell them what they should do. We give them information, and we think that they have the keys for taking action. With TPE, we understand better that we are not on the same wavelength. (Phys 1)

When faced with the patient underlying need, participants often described situations when the physician was challenged

is his "healer" role. Whether patients would expect an impossible cure from them, or that they could not be the healer they wanted because the answer weren't in their hand, but in the patient's or in another health professionals.

When chronic patients return regularly to the GUH due to decompensation of their health status (e.g., chronic renal insufficiency, COPD, etc.), the hospital physician no longer knows what their role is. (Phys 1)

The physicians and patients confront the central question of the role played by each party together: the role that patients attribute to physicians and the role that physicians attribute to patients. With obese patients, this type of work is always necessary to come to an agreement. *Obese patients, who have been living with their excess weight for a long time, have tried to lose weight multiple times. They have enormous expectations of their physicians. (Phys 5)*

3.1.3 Integrating patient's experience and knowledge

As the physician is on the path to acknowledge that a great part of the patient care won't depend on him, but also on the interprofessional team and on the patient, he also has to accept that he can learn from the patient's expertise.

The participants described how physicians tend to decide and prescribe without ensuring the patient's agreement and collaboration. Inversely the TPE-trained physician integrates the patient's expertise in his disease and always seeks to work with him. *Chronic patients have often found, on their own, a treatment plan that works for them but that is not in line with the medical prescription. This presents a challenge to the physician regarding how much importance to grant the patient, their knowledge and experience, and their treatment plan within the framework of their hospitalization. (Phys 3)*

Scenarios involving the patient's experience and knowledge present a reversal of the expertise posture and power relationship which may challenge the physician but is essential for harmonious support and care. *It is not only the patient who has to do what they are told. We [physicians] need to give up some control. [...] They [dialyzed patients] are experts in their disease, and they have to be considered experts. This is the only way to work with these patients. We need to adapt to these patients who know themselves much better than we do and who are often right. It is often they who act as guides, and we follow them as best we can. We offer arguments, and then we decide together. I think that shared decision-making is crucial today in chronic disease when dealing with patients who are experts in their disease. (Phys 1)*

Considering the patient to be a partner also involves the patient's loved ones. TPE considers these individuals an active element and not an environment, particularly in an aging society in which the loved one is the primary interlocutor. *We do not connect with loved ones in these situations. I am thinking of intensive care, emergency, and medicine. Loved ones are not integrated enough into educational care. (Phys 1)* Concerning palliative care for a patient, in a hospital environment loved ones are often pushed aside, even though they play a central role. (Phys 2)

I am always interested in what we learn from the patient (Phys 2). For example, when moving past the acknowledgment of non-compliance, the physician seeks to learn from the patient and to gain from their knowledge and experiences. This

is the key to the therapeutic alliance and is crucial for engaging the patient in their care.

3.1.4 Co-constructing the therapeutic action plan

With the acknowledgment of the patient's expertise, the redefining of the physician's role and the reversal of responsibilities, true physician/patient partnership can take place. It will often translate in practice as a shared care plan. Co-constructing the care plan involves the intricacies of caregiving therapeutic action and is led by the patient. The physician's attention will henceforth shift from the content to be transmitted to the patient's capacity for action.

This approach implies an understanding of the patient's situation, particularly of the representations that the patient has of his disease and its treatment as well as their comprehension. *As internists, we take a history with a physical auscultation and a brief psychosocial history. This is when we spend the most time with the patient. It would be worthwhile to ask them, using open-ended questions, what they think happened and what caused it. We always ask highly exclusive, closed questions. It also saves time to know what the patient knows; when we do, we do not need to re-explain everything to them.* (Phys 1).

Performing therapeutic action consists of first listening to the patient reflect upon their difficulties and then understanding those difficulties together. This is the gateway to a true learning process. *In general internal medicine, we do not follow up with the patient after hospitalization. We do not know what the impact of hospitalization was. We do not know what the trigger for the decompensation was. We provide care and we make a list of recommendations, but we do not take time to try to prevent a relapse the next time. We need to focus on these exacerbations to understand what is going on. It is more work at the beginning, but we lose the chronic dimension.* (Phys 1) In a hospital situation, it is easy to lose sight of the chronic dimension of the disease.

Working on the patient's learning depends upon the setting. *In palliative care, we work on the time factor, on the speed of progression (of the disease). We work on projection in the more or less short term: validating what these patients can still do, for however long, and what I am ready to stop doing. The principle of this work is to be centered on the patient and their uniqueness.* (Phys 2)

Co-constructing the therapeutic plan seems the ultimate TPE situation, when physician needs to be skilled with the four previous situations in order to succeed.

3.1.5 Confronting powerlessness

Finally, the physicians evoked the many situations in which they must simply go where the situation takes them. This feeling of isolation, of having to bear everything alone, and of powerlessness is widely reported by physicians.

A few examples include seriously-ill chronic patients whose decline is irreversible and who elicit annoyance, incomprehension, and a feeling of powerlessness (Phys 3) and diabetic patients who refuse amputation in a context where nothing else can be proposed. (Phys 8) The patients are in a state of absolute distress, and physicians are powerless against this refusal of care. (Phys 8) Pneumological patients whose

status will unquestionably decline from a physical perspective are another example. Physicians experience this as a failure of care and do not even want to provide care to them. (Phys 4)

In cases of non-compliance, we experience a feeling of failure. It is a difficult situation, because the patients object, they challenge a proposal, or they refuse to follow the prescription. We lack resources, and we do not know how to help them, so either we close the door or we simply give up. (Phys 1)

The feeling of failure and powerlessness also concerns facing the inevitable outcome of degenerative diseases that question or disrupt the value system of the physician and of caregivers in general. *In medicine, we are trained in diagnosis and therapeutic attitude. As a result, caregivers are not used to having the situation go downhill. For caregivers, it is unbearable, and we had to put together support groups to help the caregivers. Listening and supporting are not part of care for them. They see people get worse, and they do not know what to do.* (Phys 2) Medical training does not fully prepare physicians for these situations. *In training, we are not trained in this complexity, this decline. In TPE, we are open to the idea that things break down and that we should be there. We are trained so that medicine works better.* (Phys 2)

TPE-trained physicians have shifted their perception of their role and responsibility in the patient's care. They tend to work with an interprofessional team to share the burden. They are thus better equipped to face powerlessness, accept the limit of their care and be satisfied with the patient interaction more than with the results of a healing process.

4 Discussion

We have identified six representative situations that are part of overall medical practice. According to the interviewed physicians, training in TPE allowed them to be more effective with their patients thanks to the development of skills that helped them better identify and address these complex situations, where they did not feel comfortable before.

These representative situations also illustrate that TPE training goes beyond learning a set of skills, but encompasses also a change in the posture of the physician, from a posture of teaching and expertise to one of co-construction and learning. This change in posture is the result of two shifts: one from activity-centered care, useful for acute care, to patient-centered care, more adapted to chronic care. The second shift tends toward patient activation from a passive state [6,18].

This change in posture relative to the patient in TPE is part of a care philosophy, but its primary value is operational. It fulfills a practical function: to help the patient be a partner in his care. The fragmentation of hospital structure into activities makes overall care of the patient difficult [19,20] and considering the patient as a whole requires a cohesive physician posture [21,22]. To better understand the physician/patient relationship, patients and caregivers were stratified by participant *versus* non-participant and activity-centered *versus* person-centered, respectively. Figure 1 provides a visual representation of the opposing ends of these relationships to better understand how the situations in which TPE is beneficial are interconnected and tend to the same objective regardless of the situation concerned.

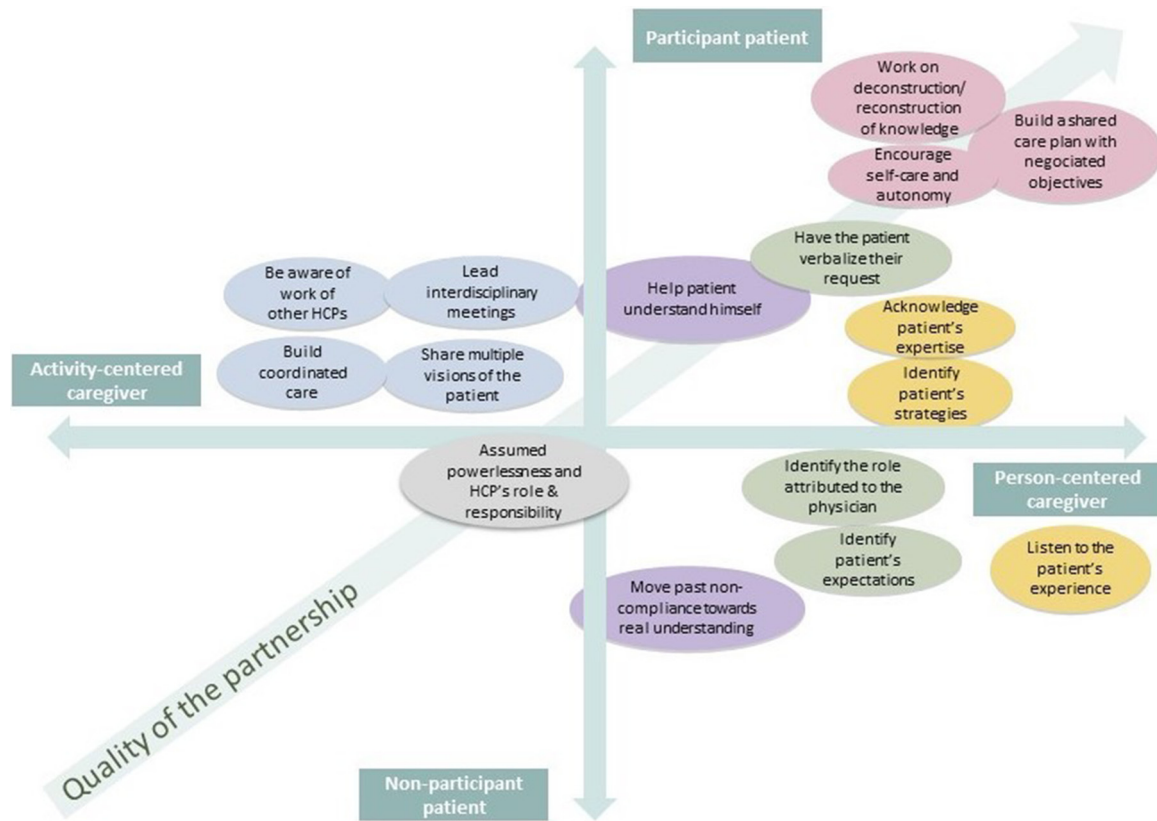


Fig. 1. Useful TPE skills in representative situations according to the patient’s participation and the centering of activities. In purple : dealing with non-compliance; In blue: maintaining a comprehensive vision for overall care of the patient; In green: integrating patient’s experience and knowledge; In yellow: matching the patient request to the underlying need; In pink: co-constructing the therapeutic action plan; In gray: confronting powerlessness.

Fig. 1. Compétences utiles en ETP dans des situations emblématiques selon la participation du patient et le centrage des activités. En violet : traiter la non-compliance ; En bleu : maintenir une vision globale de la prise en charge complète du patient ; En vert : intégrer l’expérience et les connaissances du patient ; En jaune : faire correspondre la demande du patient au besoin sous-jacent ; En rose : coconstruction du plan d’action thérapeutique ; En gris : affronter l’impuissance.

The situations identified in this study fall into one of four categories: (i) the participant patient–person-centered caregiver quadrant (partner patient); (ii) the participant patient–activity-centered caregiver quadrant (adapted for technical medical act); (iii) the non-participant patient–person-centered caregiver quadrant (building the therapeutic alliance); (iv) the non-participant–activity-centered quadrant (relation and care blockage).

In order for the chronic patient to truly be a partner in the care relationship, it is necessary for the caregiver to be centered on the person, on the patient, and for the patient to be “active” in the relationship, in his learning and in the decision making process that concern him [23,24]. Most TPE skills used by physicians fall into this category regardless of the situation (Fig. 1, upper right quadrant).

In some cases encountered, the patient is listened to, regarding his real life situation, his demands or his expectations but no need for learning is identified. Thus, even though the caregiver might be “person-centered” and in an empathic and authentic emotional relationship, the risk is to keep the patient in a passive state with regards to his illness [25] and miss the opportunity for the patient to become active and gain in autonomy [26]. In this situation, skills are more a

matter of support than of TPE (e.g. listen to the patient’s experience, identify patient’s expectations; Fig. 1, bottom right quadrant).

In the case of an acute illness or an acute episode during a chronic illness, the caregiver is of course absolutely legitimate (and effective) if he takes a task-focused posture and responds to a problem with a solution. It is the model of the medical act posed by a caregiver and which benefits a patient [27]. Nevertheless, the follow-up of a chronic patient, even if it is active and that it ensures that the treatment continues at best, cannot be reduced to a succession of problems/solutions, at the risk of reducing complexity and sending the patient to a void between consultations [28]. Maintaining a comprehensive vision for overall care of the patient is then challenging and needs interprofessional skills to build a form of partnership among healthcare professionals [29] (Fig. 1, upper-left quadrant). It needs to be thought of as true coordination and skills sharing and not as a layering of actors and actions [30,31].

Finally, when the patient is not invited to participate in his medical care and the caregiver is focused on the task, the total loss of meaning may appear to the patient, and, in the case of a chronic disease, leave it totally destitute on a daily basis. The

caregiver who observes a lack of adherence to treatment and changes in the patient's behavior may feel helpless and lead to frustration and even burnout [32]. In this context, assuming his own powerlessness and lived experience is a TPE skill useful to grow out of resignation and find a meaning in his care (Fig. 1, bottom left quadrant).

Altogether, these observations point to a repositioning of the individual patient to the forefront of medical training and to additional support and training for their physicians.

5 Conclusion

The results of this study show how much the care of complex patients is present in the medical practice, and TPE training a valuable skill to deal with this complexity. It also highlights the difficulty to develop a TPE training program that addresses all the different aspects of the problems identified.

Although this study provides valuable insights into the complexity of the practice and training in TPE, it remains limited due in part to its qualitative nature. Further analysis of this complexity will be part of a more in-depth study of the difficulties reported by the physicians, particularly the underlying elements that are not immediately apparent. Nevertheless, we strongly believe that the inclusion of themes regarding the identified representative situations in future TPE training programs could have a positive impact on the practice of physicians and patient care.

Abbreviations

CAS	Certificate of Advanced studies
DAS	Diploma of advanced studies
FG	Focus groups
GUH	Geneva University Hospitals
HCP	Healthcare professionals
TPE	Therapeutic patient education

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