

**COMPASSIONATE BEHAVIORAL TRAINING GENERAL PRACTITIONER AT
HEALTH CENTERS IN THE DISTRICT JOMBANG**Ade Armada Sutedja*¹, Jusuf Irianto² and Sunarjo²¹Postgraduate Student of Airlangga University, Majoring Human Resources Development, Indonesia.²Professor in the Faculty of Social and Political Sciences, Airlangga University, Surabaya Indonesia³Doctoral in the Faculty of Medical; Airlangga University, Surabaya, Indonesia.***Corresponding Author: Dr. Ade Armada Sutedja**

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ABSTRACT

Medical disputes arising between doctors and patients, about 80% triggered by lack of communication. Communications relating to compassionate behavior, then do compassionate behavioral training general practitioners to patients. The first phase of the research resulted compassionate behavior module based NFGDT (Nominal Focused Group Discussion Technique) and the synthesis of theory of planned behavior, self-compassion and mindfulness. Then do the test model with a second phase of research, type of research is a quasi-experimental design with non-equivalent control group designs. The study was conducted at 34 health centers in Jombang, 34 physicians were divided into 2 groups: 17 physicians were given treatment and 17 general practitioners as control. Assessment on the dimensions of cognitive, affective and behavioral conducted by questionnaire, radiesthesia and aura photos before and after treatment. Compassionate behavior training can increase cognitive dimension but can not increase the dimension affective and behavioral general practitioners. However, the measurement results with radiesthesia and aura photos resemblance pattern.

KEYWORDS: cognitive, affective, compassionate behavior, radiesthesia, and aura photo.**INTRODUCTION**

Since 2000 the number of reported cases of medical disputes to MKEK (Honorary Council of Medical Ethics) Indonesia is greatly increased. Before 2000, there were only 7-13 MKEK to report malpractice. In 2000-2001 the number increased rapidly to 20-30 cases per year (Sampurna, 2009). From these figures, approximately 80% is triggered by lack of effective communication between doctor and patient. In March 2015, the complaint case in MKDKI (Indonesian Medical Disciplinary Honorary Council) reached 313 cases, was still 80% triggered because of communication problems (Sabir Alwi, 2015).

Learning communication relation has close links with compassionate attitude (the Dalai Lama, in Berzin 2006). In some of the Faculty of Medicine at East, teaching pattern of communication between doctor and patient that are not specifically granted to the material a physician patient communication given by the model is different because there is no standardization. (Primary data, 2015).

At the Center for the Humanities, Health Policy and Community Empowerment in Surabaya has developed a health reform that sees human beings have three components that can be developed is the mind, feeling

and body (Hariadi, 2015), in the medical world is referred to as viewpoint holistic, similar to the understanding about Holistic health (Barnes et al, 2004, in Farah Shroff M., 2011). So in addition to physical then the feelings and emotions of the patient needs to be known and cared for, no less than the symptoms of the disease (Thomas Percival, 1803 in Holistic Medicine, 2013) So at the moment to communicate effectively not only by way of verbal but also by means of nonverbal (Moss, 2005) which involves feelings and emotions. Because everything we think and feel with all the attention, energy, and concentration of both positive and negative, will come into our lives (Michael J.Losier, 2006). So in educational activities / training there are three domains that should be improved, namely cognitive, affective, psychomotor / behavior (Bloom, et al, 1956.).

In the Code of Medical Ethics Indonesia in 2012 as the code of conduct of the profession in Indonesia in article 8, stated that a physician is required, in any medical practice, providing services in a competent manner with freedom technical and moral fully, with mercy (compassion) and respect for human dignity. By training the behavior of mercy (compassion behavior) a general practitioner it is expected that the doctor is able to communicate effectively with easier, therefore it is

necessary to make the training behavior that does not just stop at the level of empathy alone but more focused on the behavior of compassion (compassion behavior), which also already include empathy, on the relationship between the patient's general practitioner. Compassionate behavior training is based on the synthesis of theory of planned behavior (Ajzen, 2005), consisting of several variables back ground factors, behavioral belief, attitude toward the behavioral, normative beliefs, subjective norm, control beliefs, perceived behavioral control, intention; Self-compassion (Neff, 2003) which consists of three major dimensional, that kindness, common humanity, mindful acceptance; and mindfulness (Neff, 2003; Bishop et al, 2004), namely the skills to raise awareness by receiving, to face reality without judgment and respond in an effective manner as well as compassion.

Framework

In Figure 1, we can see the efforts made for avoiding the occurrence of medical disputes. From the standpoint of human resource development, efforts is to improve

communication between the patient's general practitioner. Medical Communications (Kurtz, 1998) with a model of patient-centered and effective communication (DeVito, 1992) uses a soft approach approach with empathy and hard approach to interaction. It is in the form of training general practitioners compassionate behavior towards patients at demensi cognitive, affective and behavioral compassion.

On compassionate behavioral training at a general practitioner who developed is an empathic concern (Batson & Ahmad, 2010), in figure 2 empathic concern is directed at the altruistic motivation not on personal distress. Altruistic motivation to reduce fears of another person (other person's distress). So-called altruistic altruistic motivation principled or compassion (Armstrong, 2013) will raise us to give sincere aid that only oriented to welfare, kindness, benefit people who helped. Relief is given by an altruistic impulse does not weigh the advantages and disadvantages, even if the results obtained are helpfulness loss (both material and immaterial) will not affect the intention to help.

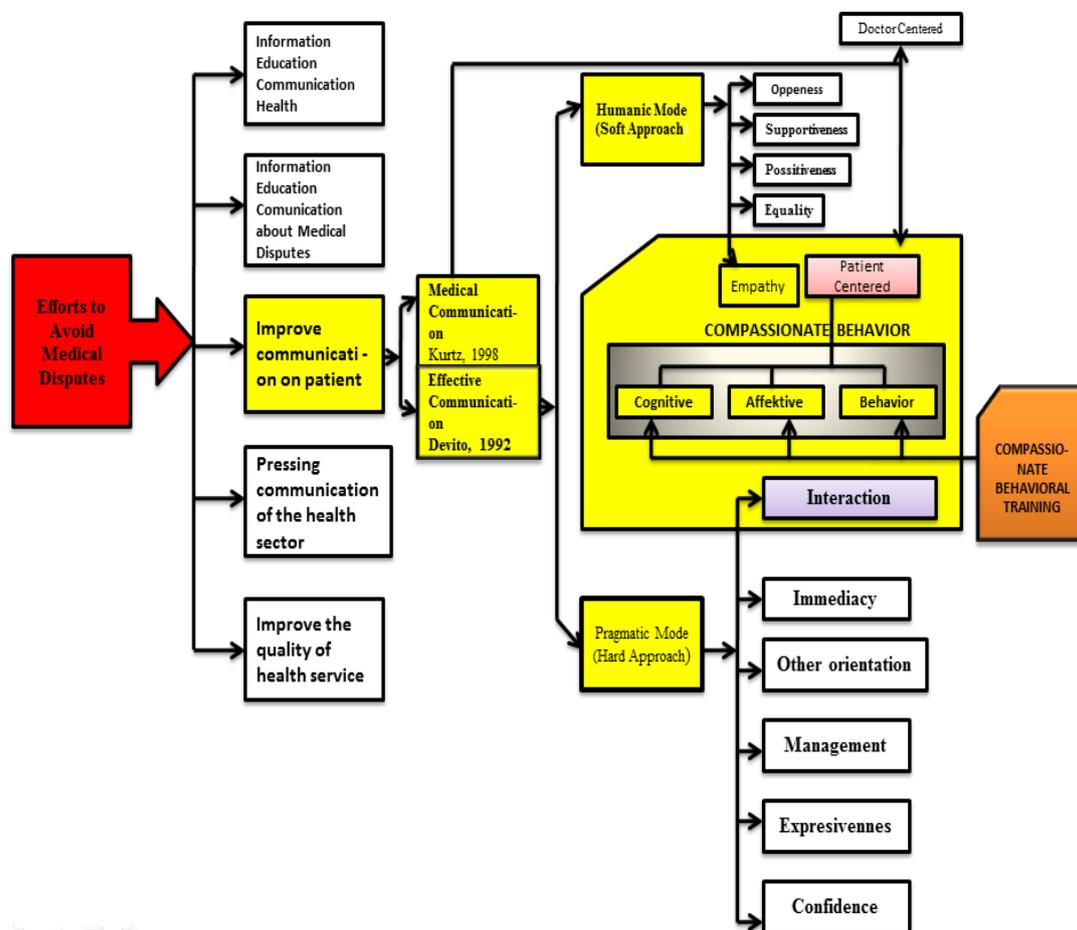


Figure: 1. Compassionate Behavior Training relationship with effective communication

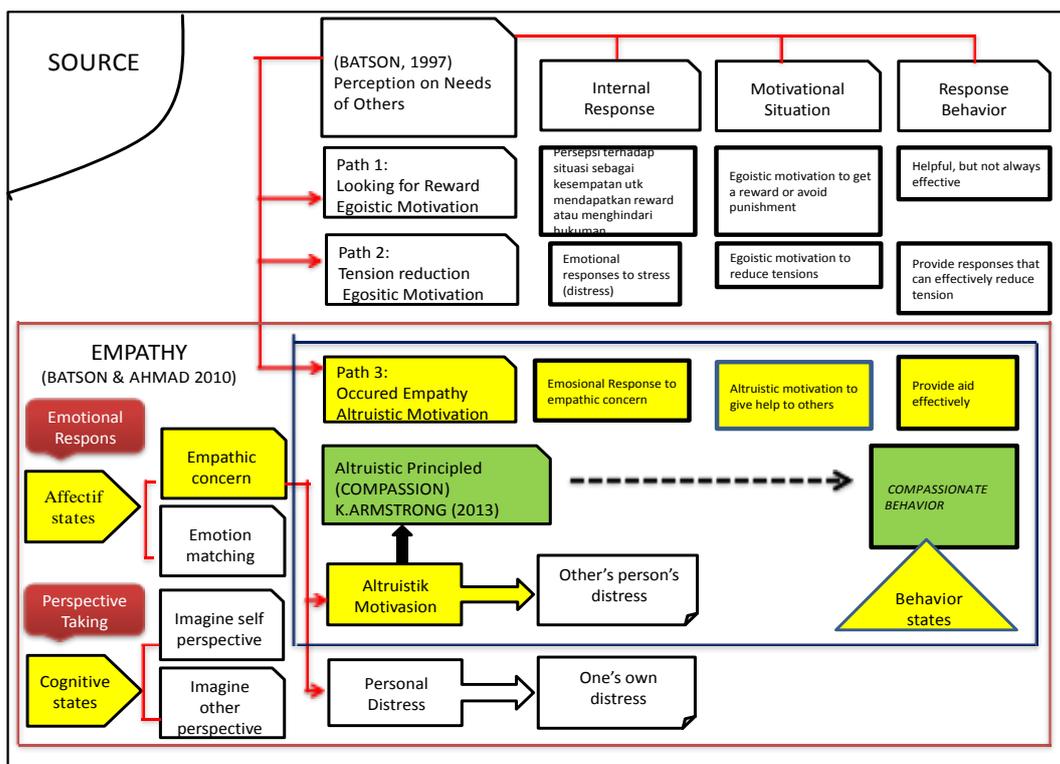


Figure: 2. Compassionate behavior response as a form altruistic behavior

Batson (1997), identified three "paths" (shortcut) to provide aid (Figure 2). The first and second is egoistic, the behavioral training compassion directed to the path to 3, the altruistic motivation in this path is the perception

of the needs of others will evoke empathic concern, which in turn is expected to appear behavior of compassion that will provide aid effectively.

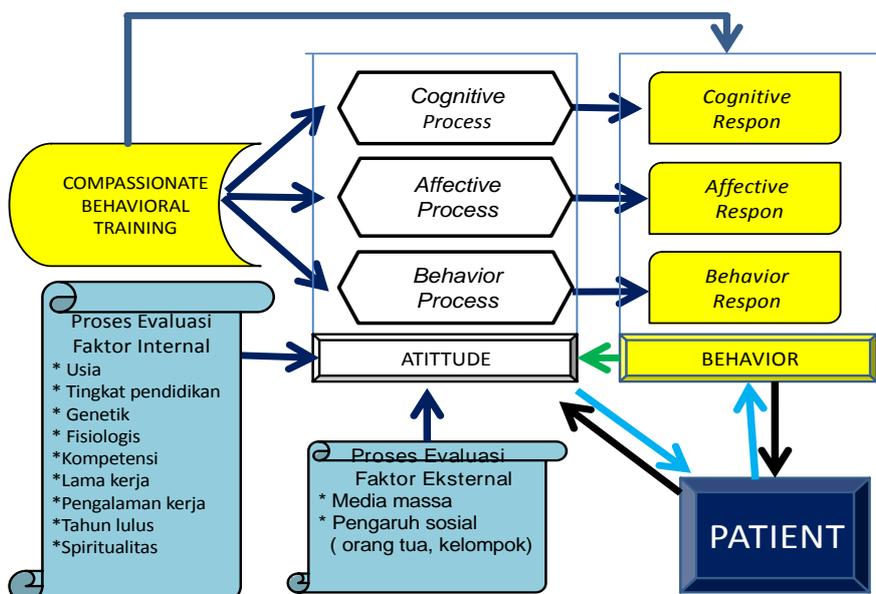


Figure: 3. Hypothesized model

Hypothesis

General Practice who receive training will be given stimulus in demensi cognitive, affective and behavioral. So in the case of individuals who are trained in the processes of cognitive, affective, and behavioral (ie,

attitudes) are antecedents of this research perilaku. Namun attitude is not discussed. The process of the process can be influenced by the evaluation of internal factors and external factors (Oskamp, 1990 in Ramdani, 2008). Internal evaluation are age, level of

education, competence, working time, work experience, spirituality, genetic, physiological, while the evaluation of external factors, namely the mass media, social influence. Next will bring increased compassion behavioral response in the form of cognitive, affective and behavior of the doctor to the patient.

Direct experience is experienced by individuals who behave in a compassionate with a patient, will receive a reply and a positive response from the patient. Bem suggests that previous behavior can affect the attitudes (Bem, 1972 Ramdhani, 2008). Bem opinion is better known as the self-perception, that people tend to show the attitude in accordance with previous behavior. In the view of self-perception theory Bem in the positive or negative attitude towards an object formed through the observation of the behavior of her own.

By following compassionate behavioral training is expected to improve the behavior of compassion, which is measured on the response that appeared, in the form of response to cognitive, affective and behavioral.

Method

This research was conducted in two stages. The first phase of the research was observational descriptive kind, which involves activities deduction and induction. Results deduction and induction activities are synthesized into a first module compassionate behavioral training general practitioners to patients. To further sharpen, strengthen and maintain the validity of the model is then subsequently conducted NFGDT (Nominal Focused Group Discussion Technique) involving communication experts, Head of the health department in Jombang, hospital management, NGO (Non Governmental Organization), IDI (Indonesian Doctors Association), community leaders and the public, After getting enter, criticisms and suggestions in NFGDT and synthesis of the theory of planned behavior (Ajzen, 2005), the theory of self-compassion (Neff, 2003) and

mindfulness (Neff, 2003; Bishop et al, 2004), then compiled a module II training compassionate physician behavior common in patients. Furthermore, this second module will do a test on a second study

In the second phase of research, type of research is a quasi-experimental design with non-equivalent control group designs. The study was conducted in a population of general practitioners working in health centers in Jombang, with an age range of 25 to 56 years. There are 64 general practitioners in 34 health centers scattered them. The sample is determined by the inclusion and exclusion criteria, obtained 34 general practitioners from the 34 health centers, further divided into two groups, namely 17 general practitioners were given treatment and 17 general practitioners as controls. In the treatment group was given the appropriate training module II development compassionate behaviors general practitioner. Whereas the control group did not do anything. Dimensional assessment is carried out on the cognitive, affective and behavioral, using a questionnaire, a method radiesthesia with pendulum and aura photo. Cognitive-dimensional assessment questionnaires, the assessment of affective demensi with questionnaires and assessment demensi radiesthesia affective and behavioral dimensional assessment by questionnaire was conducted before treatment and 1 week after the first treatment and 4 months after the second treatment. While affective appraisal with an aura photo done before treatment and immediately after treatment. The results will be analyzed by statistical test

RESULT

The good doctor is a doctor by the patient's communicative, listening to the complaints of patients and care (Delamothe, 1998) as well as taking the time to patients (Danne Berry, 2000). From the results of data collection on the desired physician behaviors of patients in Jombang are as follows:

Table: 1 People want a general practitioner who behave

People want a general practitioner who behave	%
Good behavior while serving	93,1
Care and attention to the condition being suffered ill patients	89,7
Intelligent and had a good relationship with the patient	65,6
Attention to the conversation with the patient grievances illness	89,7
Nimble and willing to understand and understand the purpose of patient	68,9
Patient	79,3
Always think for the purposes of the patients, with respect to the patient's illness	86,3
Comforting and soothing mood of patients who screwed you are suffering from diseases	79,3

(Source: Primary data, 2016)

In the second phase of the study, the results obtained:

Table: 2. Test result cognitive, before and after using the paired t test. Before being given treatment and 1 week after treatment

Group	Variabel	N	Mean \pm SD	Mean \pm SD Difference	p
Control	Cognitive Pre	17	2.94 \pm 0.854	-0.313 \pm 0.479	0.020
	Cognitive Post	17	3.25 \pm 0.931		
Treatment	Cognitive Pre	17	3.06 \pm 0.854	-14.125 \pm 1.204	0.000
	Cognitive Post	17	16.44 \pm 1.548		

Table: 3. Test result cognitive, control and treatment groups using two independent samples t test.(Before being given treatment and 1 week after treatment)

Variabel	Group	N	Mean \pm SD	p
Cognitive Pre	Control	17	2.94 \pm 0.854	0,682
	Treatment	17	3.06 \pm 0.854	
Cognitive Post	Control	17	3.25 \pm 0.931	0.000
	Treatment	17	17.19 \pm 1.223	
Difference cognitive	Control	17	-0.31 \pm 0.479	0.000
	Treatment	17	-14.13 \pm 1.204	

Table: 4. Test result for, cognitive pre and cognitive post using a paired t-test. (1 week after the first treatment and 4 months after the second treatment)

Group	Variabel	n	Mean \pm SD	Mean \pm SD Difference	p
Control	Cognitive Pre	17	3.25 \pm 0.931	-0.313 \pm 0.602	0.055
	Cognitive Post	17	3.56 \pm 0.892		
Treatment	Cognitive Pre	17	17.19 \pm 1.223	0.750 \pm 0.931	0.006
	Cognitive Post	17	16.44 \pm 1.548		

Table.5. Test result cognitive, control and treatment groups using two independent samples t test .(1 week after the first treatment and 4 months after the second treatment)

Variabel	Group	N	Mean \pm SD	p
Cognitive Pre	Control	17	3.25 \pm 0.931	0,000
	Treatment	17	17.19 \pm 1.223	
Cognitive Post	Control	17	3.56 \pm 0.892	0.000
	Treatment	17	16.44 \pm 1.548	
Difference Cognitif	Control	17	-0.31 \pm 0.602	0.001
	Treatment	17	0.75 \pm 0.931	

Table: 6. Test results for, affective pre and affective post using a paired t-test. (Before being given treatment and 1 week after treatment)

Group	Variabel	N	Mean \pm SD	Mean \pm SD	p
Control	Affective Pre	17	56,63 \pm 9,025	-0,250 \pm 2,017	0,627
	Affective Post	17	56,38 \pm 8,437		
Treatment	Affectifve Pre	17	55,44 \pm 10,893	2,875 \pm 6,323	0,089
	Affective Post	17	58,31 \pm 12,547		

Table: 7 Test result affective, control and treatment groups using two independent samples t test. (Before being given treatment and 1 week after treatment)

Variabel	Group	N	Mean \pm SD	p
Affective Pre	Control	17	56,63 \pm 9,025	0,739
	Treatment	17	55,44 \pm 10,893	
Affective Post	Control	17	56,38 \pm 8,437	0,612
	Treatment	17	58,31 \pm 12,547	
Difference Affective	Control	17	-0,25 \pm 2,017	0,076
	Treatment	17	2,88 \pm 6,323	

Table: 8. Test results, AAQ pre and AAQ post using a paired t-test. .(1 week after the first treatment and 4 months after the second treatment)

Group	Variabel	N	Mean ± SD	Mean ± SD	p
Control	AAQ Pre	17	53.06 ± 15.927	0.059 ± 1.435	0.868
	AAQ Post	17	53.06 ± 16.155		
Treatment	AAQ Pre	17	54.88 ± 18.644	-2.529 ± 14.098	0.470
	AAQ Post	17	57.41 ± 22.826		

AAQ = affective assessed by questionnaire

Table: 9. Test result AAQ, control and treatment groups using two independent samples t test. .(1 week after the first treatment and 4 months after the second treatment)

Variabel	Group	N	Mean ± SD	p
AAQ Pre	Control	17	53.06 ± 15.927	0.761
	Treatment	17	54.88 ± 18.644	
AAQ Post	Control	17	53.00 ± 16.155	0.520
	Treatment	17	57.41 ± 22.826	
Selisih AAQ	Control	17	-0.06 ± 1.435	0.457
	Treatment	17	2.53 ± 14.098	

Table: 10. Test results, AAR pre and AAR post using a paired t-test. .(Before being given treatment and 1 week after treatment)

Group	Variabel	N	Mean ± SD	Mean ± SD Difference	p
Control	AAR Pre	17	3,79 ± 0,593	0,159 ± 0,564	0,262
	AAR Post	17	3,95 ± 0,291		
Treatment	AAR Pre	17	3,89 ± 0,626	0,212 ± 0,737	0,254
	AAR Post	17	4,11 ± 0,329		

AAR = affective assessed by radiesthesia

Table: 11. Test result AAR, control and treatment groups using two independent samples t test. (Before being given treatment and 1 week after treatment).

Variabel	Group	N	Mean ± SD	p
AAR Pre	Control	17	3,79 ± 0,593	0,636
	Treatment	17	3,89 ± 0,626	
AAR Post	Control	17	3,95 ± 0,291	0,165
	Treatment	17	4,11 ± 0,329	
Difference	Control	17	0,159 ± 0,564	0,816
	Treatment	17	0,212 ± 0,737	

Table.12. Test results, AAR pre and AAR post using a paired t-test. (1 week after the first treatment and 4 months after the second treatment)

Group	Variabel	N	Mean ± SD	Mean ± SD Difference	p
Control	AAR Pre	17	20.06 ± 1.519	-3.118 ± 2.643	0.000
	AAR Post	17	23.18 ± 2.555		
Treatment	AAR Pre	17	20.76 ± 1.602	-2.941 ± 3.172	0.001
	AAR Post	17	23.71 ± 3.496		

Table: 13. Test result AAR, control and treatment groups using two independent samples t test. (1 week after the first treatment and 4 months after the second treatment)

Variabel	Group	N	Mean ± SD	p
AAR Pre	Kontrol	17	20.06 ± 1.519	0.197
	Perlakuan	17	20.76 ± 1.602	
AAR Post	Kontrol	17	23.18 ± 2.555	0.618
	Perlakuan	17	23.71 ± 3.496	
Difference	Kontrol	17	-3.35 ± 2.691	0.825
	Perlakuan	17	-3.12 ± 3.426	

Table: 14. Test results, AAAP pre and AAAP post using a paired t-test. (Before being given treatment and 1 week after treatment).

Group	Variabel	N	Mean ± SD	Mean ± SD Difference	p
Control	AAAP <i>Pre</i>	9	62,44 ± 16,920	-6,111 ± 28,838	0,543
	AAAP <i>Post</i>	9	56,33 ± 19,307		
Treatment	AAAP <i>Pre</i>	8	45,00 ± 11,820	-6,375 ± 11,173	0,151
	AAAP <i>Post</i>	8	38,63 ± 6,718		

AAAP = Affective assessment by aura photos

Table.15. Test result AAAP, control and treatment groups using two independent samples t test. (Before being given treatment and 1 week after treatment).

Variabel	Group	N	Mean ± SD	p
AAAP <i>Pre</i>	Control	9	62,44 ± 16,920	0,028
	Treatment	8	45,00 ± 11,820	
AAAP <i>Post</i>	Control	9	56,33 ± 19,307	0,027
	Treatment	8	38,63 ± 6,718	
AAAP Difference	Control	9	6,111 ± 28,838	0,264
	Treatment	8	-6,375 ± 11,173	

Table: 16 Test results, BAM pre and BAM post using a paired t-test. . (Before being given treatment and 1 week after treatment).

Group	Variabel	N	Mean ± SD	Mean ± SD Difference	p
Control	BAM <i>Pre</i>	16	26,59 ± 6,755	5,118 ± 6,936	0,008
	BAM <i>Post</i>	16	31,71 ± 4,370		
Treatment	BAM <i>Pre</i>	16	25,94 ± 7,122	5,375 ± 5,071	0,004
	BAM <i>Post</i>	16	30,31 ± 6,183		

BAM = behavioral assessment by a midwife with a questionnaire

Table: 17. Test result BAM, control and treatment groups using two independent samples t test. (Before being given treatment and 1 week after treatment).

Variabel	Group	N	Mean ± SD	p
BAM <i>Pre</i>	Control	16	26,59 ± 6,755	0,651
	Treatment	16	25,94 ± 7,122	
BAM <i>Post</i>	Control	16	31,71 ± 4,370	0,458
	Treatment	16	30,31 ± 6,183	
BAM Difference	Control	16	5,118 ± 6,936	0,729
	Treatment	16	5,375 ± 5,071	

Table: 18. Test results, BAM pre and BAM post using a paired t-test. (1 week after the first treatment and 4 months after the second treatment)

Group	Variabel	N	Mean ± SD	Mean ± SD Difference	p
Control	BAM <i>Pre</i>	17	31.71 ± 4.370	2.706 ± 5.289	0.051
	BAM <i>Post</i>	17	29.00 ± 3.873		
Treatment	BAM <i>Pre</i>	17	28.53 ± 9.481	-1.000 ± 0.866	0.265
	BAM <i>Post</i>	17	29.53 ± 8.980		

Table 19; Test result BAM, control and treatment groups using two independent samples t test. (1 week after the first treatment and 4 months after the second treatment)

Variabel	Group	N	Mean ± SD	p
BAM <i>Pre</i>	Control	17	31.71 ± 4.370	0.219
	Treatment	17	28.53 ± 9.481	
BAM <i>Post</i>	Control	17	29.00 ± 3.873	0.825
	Treatment	17	29.53 ± 8.980	

BAM Difference	Kontrol	17	2.71 ± 5.289	0.023
	Perlakuan	17	-1.00 ± 3.571	

DISCUSSION

Compassionate behavior can be trained because the human brain can be trained to be more compassionate (Simon, 2012). It would seem more obvious when viewed from neuroplasticity, William James (1842-1910) was the first to introduce the theory of neuroplasticity in his *Principles of Psychology* (James, 1890 in Demarin et.al, 2014), suggesting that the brain functions are not fixed throughout life. Neuroplasticity there are two structural and functional neuroplasticity. Neuroplasticity functionally dependent on two basic processes, learning and memory (Damarin, 2014).

In the second study, the results for cognitive as measured by questionnaires K1, the pre-test in the treatment group and control with two independent samples test not found significant differences ($p > 0.05$). At post-test in the treatment group and the control with two independent samples test found significant differences ($p < 0.05$). In the treatment and control groups with paired samples test found significant differences ($p < 0.05$). After 4 months of cognitive measured by questionnaires K1, with two independent samples and paired samples test test also found a significant difference ($p < 0.05$).

Results for affective as measured by questionnaires K2, with two independent samples and paired samples test during the first week and after 4 months is not found significant differences ($p > 0.05$).

Results for affective measured by radiesthesia in 1 week with two independent samples and paired samples test found a significant difference ($p > 0.05$). After 4 months, the pre-test and post-test in the treatment group and control with two independent samples test not found significant differences ($p > 0.05$). While in the treatment and control groups with paired samples test found significant differences ($p < 0.05$).

Results for affective as measured by the aura photos, pre-test and post-test in the treatment group and the control with two independent samples test found significant differences ($p < 0.05$). However, the treatment group and the control test with paired samples obtained a significant difference ($p > 0.05$).

Results for behavior as measured by questionnaires K3, with two independent samples and paired samples test (at 1 week of and after 4 months found a significant difference ($p > 0.05$).

Measurements with radiesthesia including veiled measurement (convert measures), which is oriented on observation of behavior, but as an object of observation is no longer visible behavior, consciously or intentionally done by the respondents, but the reaction is more physiological reaction that occurs beyond the control of

the respondent. Research on the disclosure of the feeling of internal reaction is difficult to control by individuals such as transpiration (Rankin & Campbell, 1965 in Azwar, 2015), heart rate (Katz, et al., 1965, in Azwar, 2015), dilated pupils (Hess, 1965 in Azwar, 2015), the result is the same all of that reaction bodily reaction as it only reflects the intensity of one's feelings toward an object but can not describe the feelings positive or negative direction. Petty & Cacioppo 1983 (in Brehm and Kassin, 1990) found a sense of love and hatred THAT produce a similar physiological response tape. John Cacioppo and Richard Petty 1981 (in Brehm and Kassin, 1990) found that facial electromyograph (Facial EMG), this tool can determine the contraction of the facial muscles differently when a person in a state like (positive feelings) or dislike (negative feelings) to a object. Likewise, radiesthesia, can record the direction and intensity of one's feelings. Radiesthesia is the science of using human sensitivity to vibration to obtain information from the energy level can not be accessed by our five senses Man with the ability radiesthesi receive waves from objects outside themselves. With instruments exist in the human sense of the waves can be felt by the heart. (Mike Atnip, 2012). Measurements with radiesthesia qualitative, with some measurements are then used statistical tests, can be used as a quantitative measure.

Since the beginning of the discovery there are some scientists who are pros and cons to the aura photo. Around the 1970s, interest in paranormal research peaked, Dr. Thelma Moss interested in Kirlian photography and measure the aura of a living creature. According to Kerry Gaynor, a former research assistant, "a lot of people feel the effects of Kirlian photography merely natural events" (Greene, 2010). Meanwhile, Gordon Stein has written that Kirlian photography is a hoax, nothing to do with health, vitality, or mood photographed subject (Stein, 1993).

But there are interesting findings of an aura photo. Photos aura has ability to capture high frequencies emitted by the human body. And it turns out that high frequency appear along with one's emotions. If the emotion is high, the body will be affected by the rough-frequency wave. Conversely, if it is a low emotion will appear high-frequency waves. Mental turmoil which spread to all organs, tissues and, up to the constituent atoms containing billions bioelektron body. Convincing evidence that a person's psychological condition it can be measured by using video aura. Some things can achieve bright colors or even white, which describes the absorption. (Mustafa, 2006).

Because the nature of affective measure with radiesthesia and aura photos quantify a feeling that is hidden, so in this study the results of the measurement of affective,

showed a similar pattern in the distribution of measurement data, the distribution pattern of the data is in stark contrast to the results of an affective measure using a questionnaire.

There are many limitations to this study, that is, from the standpoint of questionnaires which are affected by (a) the techniques of answering the questionnaire (b) answer choices were limited (c) language that can not provoke a response true feelings (d) human error (e) self-concept (f) social approval (g) the circumstances when filling out the questionnaire (Anwar, 2015). From the viewpoint of radiesthesia and photo aura (a) state of mind, feelings and physical researcher and respondent (b) the circumstances environments. (C) tools aura photos that have not been in kalibrasi. Dari corner treatment (a) was too short implementation mindfulness (b) the difficulty of isolation among respondents. From the point of research methods (a) necessary to study per respondent (b) need to do a comparative study (c) necessary to continue qualitative, quantitative research. From the point of assessors, by midwives (a) high subjectivity (b) a different understanding to understand the questionnaire (c) the difficulty of isolation among midwives assessors. From the difference in the natural biorhythm (Goldsmith, 2005), indicating that the cycle is individualized for the physical cycle, intellectual cycle, emotional cycle and intuitive cycle. From the onset of burnout associated with CF (compassion fatigue) and CS (compassion satisfaction) place of work (Ray et al., 2013). From the point of self-compassion difference seen from the development of cognitive, affective, and behavioral Markov chain (Zulkarnain, 2010). From the point of personality (Hauken, 1989, in Kuntjojo, 2009) of each respondent that is different.

CONCLUSION

General practice behavior needs to be addressed with regard to the high number of doctor-patient communication problems as a trigger of disputes medic (80%). When compared to a few years ago a general physician behavior as perceived by the patient, the same and do not show significant progress. On the other side of the patient's perception of the good doctor is a doctor whose patient, willing to give his time, care, attention, understanding, understand the condition of the patient, and entertaining and soothing mood.

Has prepared a training module compassionate behavioral training which integrates dimensi cognitive, affective and behavioral standpoint with humans as biopsiko-socio-spiritual. Synthesized from the Theory of Planned Behavior (Ajzen, 2005), Self Compassion (Neff, 2005), Mindfulness (Neff, 2003; Bishop et al, 2004) as well as input from NFGDT.

Compassionate Behavioral Training can improve cognitive abilities but can not increase the dimensional affective and behavior of general practitioners. Although statistical tests on the affective and behavioral dimensi

yet to show results, but from the impression impression collected at the end of the treatment session data obtained 75% were very satisfied, 18.6% satisfied and 6.4% feel normal. In addition it obtained 87.5% of the participants feel that something new and a new understanding.

Affective dimensional measurements using the pendulum method and radiesthesia with aura photos, become affective alternative dimensional measurement. In this study showed a similar pattern in the distribution of measurement data, it is very different with affective measurement using a questionnaire.

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