**The iCARE-Haaland model – a collection of resources to train health professionals to -**
***Communicate with awareness and emotional competence***

# *Part B: Starting the learning and training process*
# Phase 1: Participants discover communication habits

## *Introduction to course process; preparation; administration and Individual learning tools*

**Ane Haaland**
**University of Oslo**
**Norway**

**With Mwanamvua Boga, KEMRI, Kilifi**
**Contributions from training teams, and from Vicki Marsh and Sassy Molyneux**

# Table of Contents

# 1 Introduction to Phase 1: Discovery

**The iCARE-Haaland model is *an empowerment approach for training health professionals to strengthen their self-awareness and capacity to take responsibility for respectful interaction as a basis for trust and care***

The focus of this phase is ***individual learning for participants***. The learning needs to be facilitated by trainers/managers with good understanding and knowledge of the training process and of the tools we use. A major focus should be to establish and maintain a safe and predictable situation for the participants throughout the learning process. This includes giving clear information about what will happen, when, and what is required of them.

Careful and consistent planning is essential for the success of the iCARE-Haaland model training. **Please see chapter 8** in the background/methods manual (Part A) for a description of the planning process, and of what is needed to make the whole training function well.

In this part of the resources (Part B), we include a number of specific planning tools for trainers/managers as well as the baseline questionnaire and a series of ***13 self-observation and reflection tasks*** for participants. A set of ***eight additional new tasks*** for trainee doctors in Wales is included as a separate chapter. **Please read chapter 6 in the background/methods manual (Part A) on how to use these tools, and why to use them in the way and the sequence we have presented them.**

An important chapter is on ***how to analyse the examples contributed from the participants***, and ***how to include them in your training course***. This analysis, and the inclusion of examples in the course, are major reasons why participants feel the course is related to their own situation and work challenges. A detailed example of analysis of questions is included in the chapter.

# 2 Preparation tools for trainers and managers

## 2.1 Before the training starts: Preparation

**Decision to run the training**: Health providers, trainers, managers or invited guests can initiate the process of implementing the training in an institution, based e.g. on a formal or informal needs assessment that shows there are challenges in communication between providers and patients. There can also be an initiative from the staff who has noted that providers are burning out and are struggling with conflicts at work. The decision can also be inspired by staff having participated in a conference where the work from this manual was presented, or having direct access to the manual, or having participated in a training course where they have been exposed to these methods. Local or central health authorities can also take initiative to conduct such training, as the awareness about the need for and usefulness of skills training on communication and emotional competence is increasing, worldwide.
**See Chapter 8.**

### *2.1.1 Getting the training accepted at institutional level*

**This is a key** step for the success of the training process. The managers need to be convinced that the training is needed, and to agree to release their staff from duty to participate. They also need to understand the concept and purpose of voluntary participation, see below.

Invite managers to a meeting to introduce the idea of the training, and to discuss the relevance of such training for their institution, their staff and their patients. **See chapter 8**.

In Kilifi, we established **the relevance** of the training for managers/decision-makers in an initial meeting, where we brainstormed on communication challenges faced by the providers to be able to give patient-centred care, and by themselves in leading and supporting the providers in their work to give such care. We asked them some questions, for example:

- *What do they know and feel about how staff relate with patients?*
- *What are some of the communication problems among staff at the hospital?*
- *What problems do they as managers and supervisors experience with their staff?*
- *What do they think are possible causes of the problems?*

## 2.2 Information meetings, letters and adverts

It is important to inform everybody well in advance of the training, for managers and participants to be able to plan well and build the training into the rotas of the clinic or hospital. For managers to support their staff to take the training, they ned to be convinced that the training is useful.
***See chapter 8.***

In Kilifi, we conducted information meetings for managers and participants in the early years to discuss the need for the training, and the aims of the programme. See various chapters in the manual which gives useful information on how to do this, and which type of information is essential to give.

We used an advert (see chapter 2.2.2, below) to create awareness about the training and published this in electronic fora and on information boards. We used all available for a to spread awareness about the training.

In the first years we also used an application form for participants to ask why they wanted to participate in the training – to learn more about their motivation. This was very useful. In the later years the training has become so well known in Kilifi Hospital that the form is no longer needed. Basically – most health professionals have participated in or want to take the training course (*but the medical officers are still lagging behind, with only a few having participated).*

### *2.2.1 Advertising the training and selecting participants*

**Advertise the training** at least four weeks before the process starts, to give participants adequate time to put in their application. Prepare a formal advert and distribute to notice boards in all departments, common places where staff gathers (canteen, coffee shop), on the institutional website etc. Make sure all managers get a copy and ask them to promote the training to their staff, including mentioning it in meetings, where appropriate. Trainers, previous participants and other colleagues familiar with the training can be asked to be “ambassadors” to help recruit participants from their respective departments, also through online platforms e.g WhatsApp groups: Typically, this kind of training is most efficiently spread by “word of mouth” from people who have had personal experiences with it, directly or indirectly.

Monitor applications as they come in. If response rate is low (*this may happen when staff is unfamiliar with the process, and e.g. believe it is too long*), follow up with line managers. Go personally (as a trainer) to meet staff members in the departments and address questions they may have about the training. Clarify misconceptions and offer them the training brochure to read (see example of a brochure, chapter 2.3 below). The brochure can also be put on the institution’s website, with an invitation to the training.

Interested participants should send in their contact details to the training coordinator via phone or email.

**Selecting participants:** ***Participation in the training is voluntary – providers have to have an interest in improving their communication, to be able to learn well***. Sometimes managers may select participants to join the training if they see them being "poor communicators", using the training as an intended rehabilitation process. ***Discuss openly and discourage this practice*** as it makes participants feel judged as bad communicators, feel resentful, and will also influence other participants negatively. Participants need to be committed to the learning and this can only happen if they make a voluntary decision to join the training.

All the trainers should participate in the selection exercise to allow transparency and fair selection of participants. It is important to ensure good representation of participants across all the departments, as this helps in building a critical mass of "good communicators" who can be examples to others. Trainers should select at least two participants from each department, where possible. This helps the participants to support each other with the tasks, and to observe, discuss and give each other feedback.

**Organizing contact with participants**
The coordinator prepares a master list with personal and contact information for all the participants. This is useful for sending text messages to invite/remind participants about meetings. The coordinator can for example create a contact group in her phone for easy communication with participants throughout the process. The coordinator should send a congratulation note to all the participants who have been selected for the training, and invite them to attend the introduction session.

### *2.2.2 Example of an advert*

wellcome trust

**MINISTRY OF HEALTH**

# Communication skills course for health professionals

***The Empathetic, Effective and Emotionally Intelligent health professional***

**Course 7 Kilifi: March 2019**

***Do you sometimes communicate like this?*** ***Or is this your common approach?***

The Health Providers' Communications Skills Course is a process training that has been running at KWTRP in collaboration with KCH since 2009 as part of our CPD programs. We have so far trained over 350 health providers, frontline research staff, Subcounty health managers in Kilifi and 42 providers in the Gambia.

**The training aims to:**

- Strengthen health providers' awareness of ***what facilitates and hinders good communication with patients and colleagues***
- Strengthen health providers skills to ***build trust and communicate well In a professional relationship, and how to manage own and patients' emotions.***

The course runs from **March 2019 to November 2019** and is divided into four phases.

**Phase 1: A period of self-observation and reflection (on the Job learning - 3months)**

- **P**articipants will be asked to observe and reflect on their own communication behaviors and their effects when dealing with patients and colleagues during their routine work. They use guided reflective assignments aiming at building self-awareness. Participants give short written feedback on their observations monthly to the trainers.

**Phase 2: Intensive Skills Workshop (5days - Face to face sessions – July 2019)**

- Participants attend a 5 days' workshop that links their observations and reflections to theory. The course is practice based using experiential learning methods, building on learning needs identified during the observation and reflection period.

**Phase 3: New skills into practice (on the job learning - 3months)**

- Participants are given further observation and reflection exercises during their daily routine work to guide them in using the new skills learnt during the intensive workshop.

**Phase 4: Follow-up workshop (3days - Face to Face sessions Nov 2019)**

- Participants attend a final 3days workshop that summarizes and anchor the learning to daily challenges faced in clinical practice. Focus: Handling challenging emotions.

***Contact Time: 8 days of face to face sessions. The rest of the time is on the job learning.***

## 2.3 Brochure on the training

We include here the brochure on the training. This can be adjusted, and used as an information tool. The version here is 2 A4 pages – the overview of the modules is the second page.

*__Notes on timing for the workshops – ref the overview__: In the original course concept we run two workshops: 5 days (basic) and 3-4 days (follow-up). **In Cardiff** when training trainee doctors we ran half-day workshops: six in 2016 and eight in 2017, one of which was almost a full day. The timing was made to fit with the doctors' availability for continuing medical education. The processes ran over 8 months with 2-3 self-observation tasks in between each workshop. Learning was less "deep" than in the original course, but still experienced as very important.

# Communicating with awareness and emotional competence: Process training to strengthen skills for medical providers

***The iCARE-Haaland model; developed with doctors and nurses, implemented in 9 countries with >350 participants. 2016-17 Training trainee doctors and medical students in Cardiff, Wales***

Ministries of health in a number of countries are increasingly aware of the need to meet patients' demands for improved quality of care and committed to changing their system to make this happen. They are also aware of the need for action to reduce staff stress, burnout, conflict and high attrition rates which are depleting institutions of key personnel.
While training to strengthen patient centered care (PCC) is implemented in many countries in the North, other countries (Eastern Europe, Africa) still lack such programs. Slogans remain as good intentions on hospital walls, e.g at the Kilifi District Hospital on the Kenyan coast (picture).
In many countries, training health providers to manage their own emotions and become emotionally competent and resilient to be able to cope well with daily stress and challenges at work is strongly under-focused.


***The iCARE training enables participants to take responsibility to strengthen skills and perspectives to communicate with awareness, with respect for their own emotions as well as those of their patients and colleagues***.

## Overview of the training phases

| Phases | Activity | Duration | Aim |
|---|---|---|---|
| 1 | **Self-observation *"in action"* and reflection to discover**, using guided weekly tasks, on a set of specific aspects of communication and emotions. Monthly meetings to discuss learning; distribute new tasks | 1 -4 months*<br><br>***On the job/ during regular work hours*** | Strengthen participants' self-awareness about their own communication behaviors and the effects when dealing with patients and colleagues, and start a change process. |
| 2 | **Basic Workshop: Interactive reflection** – Experience based learning methods, including results from observation and reflection | ½ - 5 days*<br>(½ day x 4)<br>***Central place/ full time*** | Skills training, with feedback. Linking participants' own observations to a number of theories |
| 3 | **Skills into practice: Informed reflection *in and on action***. Continue self-observation + reflection during daily routine work, using specific tasks to deepen + confirm learning | 3 -4 months<br>***On the job/ during regular work hours*** | Practice new skills in their own working environment; discuss with colleagues; become a role model. Strengthen confidence to practice new skills |
| 4 | **Follow-up workshop: Interactive and informed reflection**. Further training based on results from observations, to summarize and anchor learning to daily challenges faced by participants | ½ -4 Days*<br>***Central place/ full time*** | Deepen understanding of issues, especially on handling "difficult" emotions. Confirm and appreciate learning; strengthen confidence; empowerment |

The training process lasts 6-9 months: It takes time to change behavior, and commitment over time is essential for sustainable change. **Focus: Strengthen trust and relationship with patients and colleagues by treating them with respect.** Key skills: Awareness, and emotional competence.
**Information: (contact numbers and addresses)**

## Overview of modules in the training manual describing the iCARE Model:

***The empathetic and effective health professional:***

# Communicating with awareness and emotional competence

**Note:** The first chapters give an intro to the model, background for developing it, literature and theories, methods used in observation and reflection phases, and the two workshops.

## 1. Overview of modules for workshop 1 - Basic course (12 modules)

## Basic course

### Module 1: Introduction of workshop programme and participants

a) Introduction to course concepts and contents, and introducing participants

### Module 2: Communication and conscious learning

a) How do adults learn? Using learning theory with patients and colleagues
b) Feedback from observing how you communicate
c) Gold standard communication theory, skills and strategies in practice

### Module 3: Understanding and managing emotions

a) Feedback from observing how you manage emotions
b) Communicating with awareness and emotional competence: Effects of safety, anger and insecurity on how we communicate
c) What makes people change attitudes and behavior? And why doesn't the patient do what I tell him?
d) Recognizing, managing and preventing stress with communication and emotional competence
e) Managing conflict with awareness and emotional competence to maintain dignity and respect

### Module 4: The function of research in clinical care

a) Communicating about research with awareness and emotional competence

### Module 5: Building and using communication strategies with emotional competence

a) Using communication skills and emotional competence to educate patients
b) Strategies to communicate with awareness and emotional competence

## Follow-up course

### Module 6: Introduction, celebrating growth and facing challenges

a) Introduction and review: Gold Standard communication Strategies with patients and colleagues
b) The Big Changes: Confirmation of growth, and Challenges participants still have

### Module 7: Understanding and managing strong emotions consciously:

a) The many phases of anger: Recognize, acknowledge and handle with respect.
b) Managing conflict with emotional competence: From confronting – to stepping back, and dialogue
c) Using power with awareness and emotional competence
d) Recognizing bullies in the medical profession: Using emotional competence to confront and prevent bullying
e) We can't always Cure, but we can always Care: Managing death and dying with emotional competence
f) Professional closeness or professional distance? Conscious use of personal and impersonal language
g) Using emotional competence to recognize, manage and prevent burnout

**Module 8: Building and practicing communication strategies with emotional competence**

a) Working with emotional competence in a research environment: Understanding and communicating about the difference between research and treatment (*optional*)
b) Strategies for effective information and communication: Communicating with awareness and emotional competence

# 3 Starting and meeting tools for trainers

## 3.1 Phase 1: Meeting participants, organizing baselines and tasks

Trainers meet participants for an initial meeting, and then monthly throughout the discovery phase for 1-2 hours to share and discuss experiences and challenges, hand in the tasks, and receive new ones. It is important for participants to attend these regular meetings as it helps them understand how to work on the self-observation and reflection tasks – which most of them will probably be unfamiliar with before this training. The major and essential skill to understand and practice is – ***why and how to observe themselves "In Action"*** – to observe how they communicate WHILE they communicate.
We include below, chapter 3.1.2 and 3.1.4 short powerpoint presentations for these meetings.

***See also chapter 6, on learning methods and reflective learning.***

### Logistics for each meeting

Invite participants to the meeting 3-5 days in advance by text message or email, with a copy to the Head of Department (HOD). Include in the mail the new set of observation tasks, to allow them to read through these before the meeting and discover any points that are not clear. Remind them to bring their written feedback.

For the meeting, print out the new tasks to be discussed, and other supporting documents. On the morning of the meeting day, send a reminder and let the participants know the time and venue of the meeting. (*The reminders help improve attendance).*
***Give each participant a code number***, and use this to identify their work (baseline, observation tasks, and endline). This will ensure anonymity of their feedback. The coordinator keeps a master code list to help track the assignments and monitor progress.

### General issues in all meetings

***Set up the room with small groups***: The physical set up gives an important message that this is a session where participants share ideas and learn from each other: It is NOT a lecture theatre where the trainer will tell participants what to think, and what the answers are. Thus, organize the room so people can sit in groups of 4-6, and can also discuss in pairs.
***The coordinator*** or one of the trainers should lead the session and practice the same kind of approach we use in the workshop: Welcome participants, create a safe environment, appreciate their work, be non-judgmental and encouraging, and use humour.
***Encourage participants to share experiences*** from their observations and learn from each other, but do not force anybody as they may not be very comfortable with each other, and (in the first meetings) not yet safe to share what they discovered about themselves. Appreciating their contributions helps to make them feel safe to share.
***Address any concerns***, challenges or questions they may have – and encourage participation by asking if anyone has an answer to questions raised, before the trainer answers. This stimulates empowerment and confidence.
***Introduce*** the new set of observation tasks and collect their feedback from the previous set.

### *3.1.1 The introduction meeting, and the baseline*

This meeting is very important, and all participants must attend. It will usually last about two hours. The purpose is for trainers and participants to meet and get to know each other, to introduce the participants to the training process and the baseline, and to spell out participants' roles and responsibilities.

*Note: Participants who do not attend this session usually find it difficult to carry out the self-observation and reflection tasks, and this may be a reason for them to drop out. If there are several people who do not attend, a second meeting for these individuals will be needed. For individuals who do not attend, the trainer should try to make individual meetings to introduce them to the course work or put them in touch with fellow participants in their departments. As the methods we use are new to many, and participants will be insecure about what to do, the personal contact with the trainer is essential to motivate them to work.*

**Introduce the baseline questionnaire (See below):** The baseline asks participants to make a self-assessment of what they are good at and what challenges they have when dealing with patients and introduces them to reflective practice. Explain that the purpose is to make them think and reflect about their own work, and – that this is not an exam: ***There are no "right" or "wrong" answers.***
Also assure them that their answers will be treated confidentially and explain about code numbers. Give participants 7-10 days to work on the 15 questions in the baseline and encourage them to write a small section every day to avoid feeling overwhelmed. Encourage participants to answer as many questions as possible but to feel free to omit any questions where they have nothing to report about. Open the meeting for questions and discussion about the baseline and the process.

**Explain the purposes of the baseline:**

- **For participants:** To start becoming aware of what they do and how they think and behave when they communicate with patients and colleagues and reflect about it. While, and after, filling in the baseline, they are likely to start paying more conscious attention to how they communicate with others, and what effects their communication have on others;
- **For trainers:** The baseline is a tool that helps them understand how the participants think, what they struggle with and what their learning needs are. This will help trainers adjust the workshop contents to the needs of the participants. The baseline is also a tool to measure changes in attitudes and practice, by comparing with the endline after training.

Inform participants about the date for the next meeting, where they will hand in the baseline and receive the first set of observation tasks. They can also use a soft copy and send it in electronically.

### *3.1.2 Presentation for the introduction meeting*

Below is an example of an introduction used in Kilifi to introduce the training to participants, during the first meeting with them.
It is important to give ample time for them to ask questions – you can e.g. let them sit in small groups after the presentation and discuss questions they have, and then let them ask.
Answers to the questions are found in the manual.

## Communicating about clinical care and research with patients and colleagues

Communication and emotions in theory and practice

Kilifi, Kenya
Mwanamvua Boga
Hiza Dayo

## Overview of presentation

- Overview of Problems in communication training for health providers
- Overview of the training Model, methods and tools
- Description of the course
- Tasks ahead

## Literature reviews: Problems in communication training for providers*

**Contents, methods and approach:**

- *Focus on:*
  - *Mechanistic communication*
  - *Theory*
  - *Short term interventions, few are implemented over time*
- *Lack of focus on*
  - Importance of building relationship and trust
  - Why and how to relate to patients as persons
  - **Awareness and management of emotions; building self-awareness**
  - ***Contents not based on providers' daily challenges***
  - Learner-centered methods, and practice of new skills in work context

***Recommendations:***

- ***Consideration to students needs before training***
- ***Training to adapt to the reality of nursing practice***

- **Chant S,et al.Communication skills problems in nursing education and practice: Journal of clinical Nursing 2002;11:12-12*
- *Irma P.K. Kruijver et al.Evaluation of communication training programmes in nursing care review of literature: Patient education and councelling 39 ( 2000) 129 -145*

## Studies on emotional labour*

- **Profound need:** Bridge the gap between medical and emotional aspects of care
- **Importance of emotions not acknowledged**
- **Skills not adequately taught** within health care education programmes
- Emotional labour and emotion management should be formally recognised as **a key skill**

*Mann (2005), Bagdasarov (2013), McQueen (2004), Smith and Gray 2000)

## COMMUNICATION SKILLS IN KENYA NURSING CURRICULUM

| Sub objective | Content | Time allocated | Instructional methodology | resources | Means of evaluation |
|---|---|---|---|---|---|
| The student should be able to communicate effectively with clients and others | -Introduction to communication<br>-Techniques of therapeutic techniques<br>-Verbal and non- verbal communication<br>-Ethical consideration in data collection<br>-Basic guidelines for interviewing<br>-The art of questioning<br>-Active listening | 2hrs | Lecture<br>Group discussion<br>self directed study<br>video show | Text books<br>Video<br>computers | exam |

Literature:

## Communication challenges in health care

***Common, all over the world***

**Poor communication skills can cause:**

- Poor quality of patient care
- Patient non-compliance
- Patient dissatisfaction
- Increased medical errors
- Lawsuits, and
- Decreased ability to express empathy
- ***Predictor of burnout***

**Good communication skills can:**

- Help define patients real problems
- Strengthen patient centered care
- Lessen patients' distress and their vulnerability to anxiety and depression
- Refill providers' energy thru patient feedback
- Strengthen s job satisfaction

**Literature shows clear evidence:**
**What characterizes effective communication skills training for providers?**

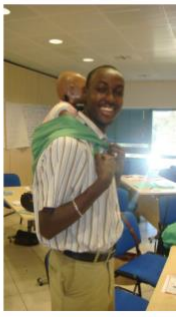
- **Longitudinal** – training over time
- **Experience-based** learning
- **Supportive** group process
- Using **critical reflection**
- **Building emotional intelligence**

**Aim:**
- **Develop professional identity and**
- **Core human values**

***Our training is based on this evidence***

**A different approach: Action research on training:**
**The model of Health communication and management of emotions – 2006-19**

- **Developed + tested with 300+ users, by Ane Haaland with Mwanamvua Boga**
- **9 countries:** (Baltic states, Africa, UK):
  - >80% medical drs and nurses
- Collaboration UiO + KEMRI 2009-19:
  ***Trained over 150 providers; 10 trainers***
  - ***42 providers - Gambia***
  - ***M. Boga is lead trainer***
- **Process training** – 9 months



## Process training – 9 months: Overview

- **Phase 1: Self-observation and reflection (4 months)**
  - ***Awareness building:*** Weekly tasks – to **discover.** Narratives.

- **Phase 2: Workshop (5 days)**
  - Links observations to theory and practice, using experience-based learning and **reflective practice**

- **Phase 3: Skills into practice (3 months)**
  - Observation and **informed reflection** in daily routine work, to strengthen self-awareness

- **Phase 4: Follow-up workshop (3 1/2 days)**
  - Summarizes and anchors learning to daily challenges

## Observation and reflection:
## Results ➡ training course

- Users identify learning needs + examples of insights
- Motivation to learn = self-defined
- Agenda set mutually:
  - Contents by users
  - Methods to facilitate further insights, by trainers

*Building sustainable competence:*
**Which methods do we use?**

**1. Observation and reflection**
- Self-observation when communicating e.g Listening
- Observing effect on others
- Discover, over time: Pattern
- Insights: Decision to change?

**Reflective practice**
- Research shows such practice stimulates learni motivation and challenges attitudes

**2. Experience based learning**

**3. Appreciation** = central: Strongly encouraging and motivating

## Aims of the training

- To strengthen providers' **awareness** of ***what facilitates and hinders good communication with patients and colleagues***
- To strengthen providers **skills** to communicate **professionally with respect and to manage own and patients emotions.**
- To strengthen providers **skills** to communicate about research.

## Aims of the training

- To strengthen providers' **awareness** of ***what facilitates and hinders good communication with patients and colleagues***
- To strengthen providers **skills** to communicate **professionally with respect and to manage own and patients emotions.**
- To strengthen providers **skills** to communicate about research.

## Frequently asked questions?

- What do we qualify as after the course?
- What is the learning model? (distant or fulltime)
- Will we get reading material/notes?
- Is there a certificate?
- Are there exams?

| | |
|---|---|
| Questions from participants<br>• How do I get to observe myself?<br>• Why not somebody else observe me ? | *See the manual chapter on observation tasks to find answers to these questions.*<br>*See also the next appendix.* |

### *3.1.3 Meeting to introduce the self-observation and reflection tasks*

**Introducing Pack 1 – listening and discussion habits**

Collect the baselines, and explain how you will use them (see above).

Introduce the purpose of using self-observation and reflection tasks to learn about how they communicate, and the method of Observation and Reflection IN Action which we are using. Explain **why** we are using this method ("Reflect WHEN"), and how it is different from Reflection ON Action ("Reflect AFTER"), see chapter 6. Both methods are used in our training.

Let participants talk together in small groups to come up with questions. Then, introduce the first set of tasks, using the PowerPoint presentation (See below) as a guide to run the session. Participants complete each task in one week. By the 4th week they reflect on their changes and choose one change which has been the most significant to them during the month. They write their story or example of change and explain why they think this change is significant to them.

It is important to give time and allow participants to ask questions for clarification after explaining each week's task. Emphasize that working on these tasks needs to be learnt, and that learning comes with time, practice and feedback. Also emphasize that there is no "right" and "wrong" when doing these observations – it is all about learning how they communicate and how others react to this. And then to reflect on how their discoveries "fit" with their ideas about themselves as kind, caring health providers: Is there anything they need to change?

Give participants a copy of the introduction for how to work with the observation and reflection tasks (see appendix). Share an example of how you learnt to carry out the tasks, if possible.

**A common question participants ask during this session is:**

- *"How is it possible for me to observe myself, I would rather have someone else observe me?"*

**Ask them to reflect and discuss the following question (in small groups):**

- *"If someone were to give you feedback about how you communicate with patients, what do you think this feedback would be like? What are the likely things that the other person would comment on first?" Bring out experiences participants have had on this.*

**A common answer to this question is** - if other people were to give them feedback, they are likely to say the bad things about them. Ask and reflect further in plenary on how they would feel if they were given bad feedback? Most participants say they "will feel bad".

Explain that when using the self-reflection tasks, they have an opportunity to look at themselves and appreciate what they do well and discover what they need to improve – without anybody pointing a finger at them. Working with these tasks enables them to feel safe in their discovery and learning process. Most people experience that this learning is useful, inspiring and motivating: They see what they need to improve and can often improve simple skills by taking conscious action (e.g. listening, without interrupting). When they see the positive impact of such communication, it usually inspires them to further learning.

**Another common question they ask is:**

- *"Am I not likely to report just the good things about myself, and not report the bad ones?"*

Refer to the discussion above, and ask what would be the reason for reporting just the good things? Explore the question, and the consequences of ignoring the problems, in the long run. Explain, and discuss, that what we have seen in other places is that gradually, as participants get to trust the method and feel safe in their discoveries, they look at their problems, and become very open and direct in their descriptions of them. Participants gain confidence to report, and then tackle these problems as they learn to trust that they are not judged or criticized when they report "bad things": They are rather asked to explore and reflect on reasons this happens, as similar problems happen to everybody. Emphasize that since they are in charge of their discoveries, THEY decide if and when to share their discoveries. When they experience that it is actually useful and helpful to share and discuss their discoveries (*and not be judged for having made mistakes*), they will get into the habit of doing so – and continue learning.

Encourage participants by saying that other colleagues have used these methods and learnt very effectively, and that using the tasks becomes easier with practice. Encourage them to find time to discuss with each other in their work place, and also advise them to use the trainers and previous participants in their departments as a resource. Building an environment of critical thinking and learning helps everyone to work consistently to improve their communication skills.

### *3.1.4 Presentation for meeting to introduce the self-observation and reflection tasks*

After the general introduction to the training (see above), the trainer(s) introduce the observation and reflection tasks. It is important to give ample time for participants to ask questions about the tasks, and to discuss how to carry them out. Most participants will not be familiar with observing themselves.

See the manual chapter 6 on observation and reflection tasks for more information on how to answer questions (especially the part on on guiding and managing the reflective process), and also see below for handout with introduction to how and why to use the tasks.

It is advisable to give hard copies of the tasks, as well as a copy of the guide on how and why to carry out the tasks.

## *What is self-observation and reflection, and reflective learning?*

- A method to ***systematically*** observe how you communicate with others, and
- How your communication affects others, and
- Reflect on what you see and feel.

- ***The aim: To discover the patterns of how you communicate and relate with others, and -***
- ***Develop self-awareness.***

## Observing IN Action
## Reflecting ON Action

- **Self-observation and reflection IN action,** i.e. **"thinking when"** you communicate
- *This is the very heart of the model*
- **Key aspect**: emotional reactions are included
- **Reflect ON Action ("thinking after")**:
  - What did you discover?
  - How well does your communication work?
  - Is there anything you need to change?

**Pack 1 – 4 tasks:**
## Communication dialogue

**Tasks**

- **Week 1**: How well do you listen to others?
- **Week 2**: How do you discuss and ask questions?
- **Week 3**:Do you inspire or hinder good communication?
- **Week 4:** What have you learnt? The most significant story

## Effects of your different methods on the other person ( Patient/colleague)

- Observe ***when*** you use the different methods, and what are the ***results*** or outcome.
- Observe especially what feelings your different listening methods seem to bring out in the other and in yourself

*Take notes*

## Observation week 1

***When discussing with another person, how well do you listen? Do you***

- *Listen "with open ears, eyes and heart" until the person has finished?*
- *Listen "with your mouth full of words", impatient to explain your own view/idea?*
- *Give your answer or your next question as the person is talking because you believe you know what he/she will say (i.e. you interrupt and "take over");*
- *Listen with the intention to really understand the other person's point of view; ask questions to find out more, appreciate his/her point of view (without necessarily agreeing), and only then offer your own ideas?*
- *Do some of each, depending on the situation and your mood?*

## Observation Week 2
## Discussion habits

***When you discuss with another person, do you usually:***

- Respond to his/her statements with your own opinions?
- Ask questions to find out more what the other person is thinking, what her opinions are, and what her experiences are - related to the topic?
- If asking questions, are they closed (inviting yes/no-answers), or open (inviting more information from the other person)
- Do you ask questions to win an argument or to get information?
- Any other pattern? (Describe)

***Take notes***

## Effect of your different methods on the other person ( Patient/colleague)

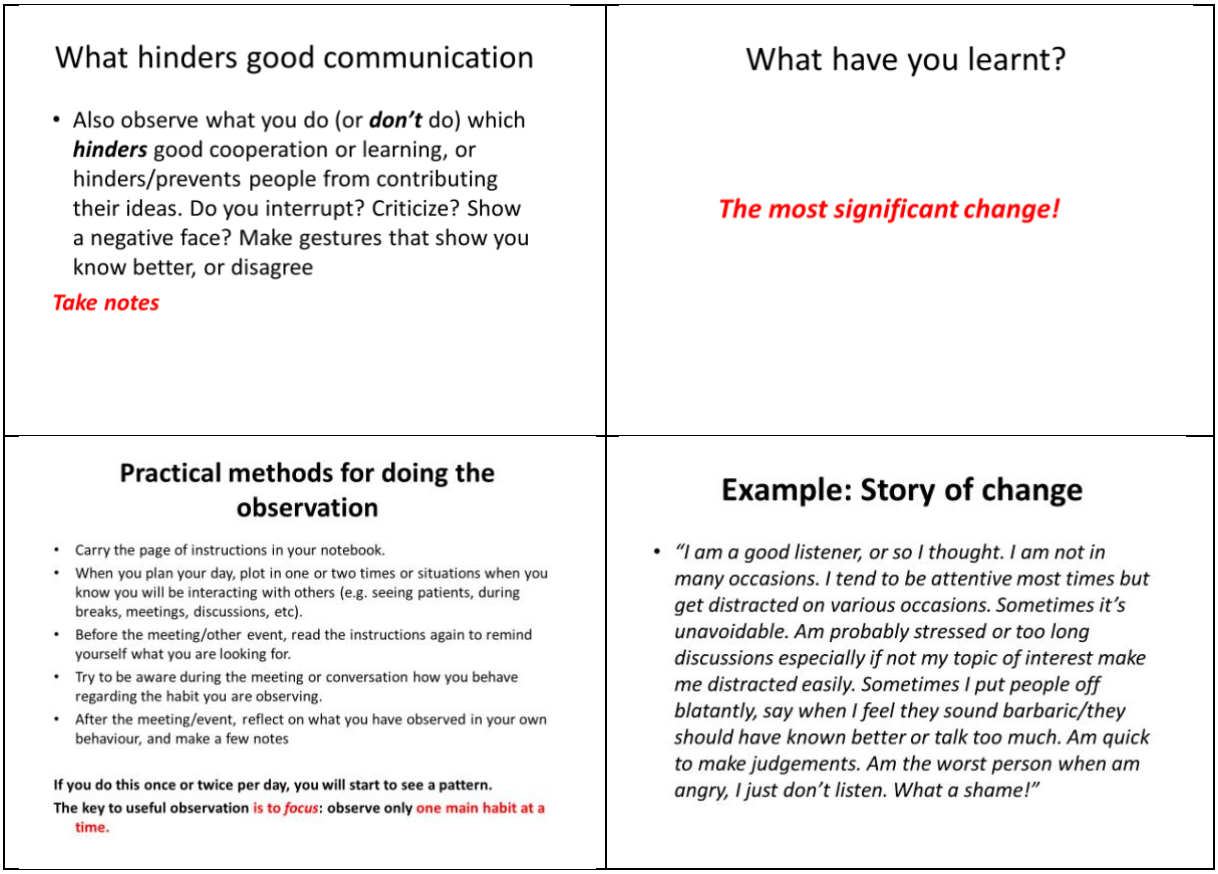
- Observe in what type of situations you use the different methods, and what are the ***effects or results*** or outcome (do you feel good/bad/indifferent?
  Does the other person feel good/bad/indifferent?)

***Take notes***

## Observation Week 3: Do you inspire or hinder good communication?

***When you participate in a task or discussion – what is it you do which causes/contributes to/inspires the following:***

- Make people open up and give their ideas and offer their cooperation/participation, etc.
- Make people feel good and positive – raise their spirits
- Create good cooperation, and learning
- Add humour (at your expense, or neutral)
- Make patients/guardians/colleagues feel safe to tell about their issue
- Make patients/guardians/colleagues feel free to ask question
- Motivate people to take action
- Facilitate clarity
- Other? (describe)




### *3.1.5 Tracking feedback from observation tasks*

Prepare a list of the participants and keep track of their progress to deliver baseline and observation task feedback, to enable you to get an overview of who has handed in their work, and who is lagging behind (see appendix for examples of such a list). Encourage participants to type their feedback and send via email for those with access to computers. For others, let them submit handwritten feedback, and sent for typing. Remind participants who delay submitting their feedback past the deadline, by text message or mail. Sometimes participants may be going through personal or work challenges that can cause them to delay handing in assignments and finding time to encourage them may help. ***The coordinator should not threaten or criticize participants who delay submitting tasks,*** but rather find out from them what the reasons are and how to facilitate that they can do their work. Often, participants may have done the observations and reflections, but have a challenge in writing down what they have learnt. Asking them if they would like to share what they have observed and discovered is often felt as very motivating and can help the participant get over a "writing block" (which is often caused by the participant being unsure about whether what she has observed, is of any importance, and whether she has done "the right thing").

Always encourage them and emphasize that the observations are key to their learning, and are the most important part of the whole training process.

### *3.1.6 Meeting to collect pack 1 and introduce pack 2 – Dealing with irritation and anger*

This is the first meeting after participants have started discovering how they communicate, and what challenges they have. Encourage them to share what they have observed and start with sharing what

they do well – this usually brings laughter and makes them feel safer to share the more problematic discoveries. Acknowledge and appreciate their learning and emphasize the need for a non-judgmental attitude to help develop an open learning environment.

Ask them how they experienced carrying out the tasks - but only after getting some good examples and sharing these – to focus on the positive achievements from the beginning rather than starting by focusing on the problems. Ask what challenges they had. When you get an example, ask if others have had similar challenges, and how they have dealt with them and solved them. By doing this, you start to build a learning environment where participants see and use each other as resources and learn from each other: This is an important purpose of these meetings. ***It is particularly important to emphasize good examples of observation "In Action", and contrast these to "On Action" examples: it is common for participants to struggle to observe In Action at the beginning. It is much more comfortable to "think about" (On Action) how you communicate and "fool yourself" that you e.g. listen really well to people – than to realize, when observing In Action, that you may e.g. have a habit of interrupting people very often, or of listening "with your mouth full of words"... These discoveries are ONLY made when you observe In Action!***

It is also common that participants want trainers to help them solve the problems they have discovered – NOW. Rather than answer the question yourself – ask if anyone in the group has a suggestion and encourage them to learn from each other: this is an important purpose of these meetings – to strengthen the practice of participants sharing and learning from each other's successes and failures. Encourage them to continue to observe and learn by themselves, and to share with and learn from each other during the whole period of observation and reflection. They can make many changes in their practice based on this learning. Remind them that based on this learning, we will further strengthen the skills and learn some theory in the basic workshop, in 2-3 months. Until then, there is no formal teaching.

The trainer can introduce the next set of tasks (*Dealing with anger and irritation*) by reading out (or asking a participant to read) the text for one task at a time or use a flip-chart and make key points about the task that she can use as a guide during the discussion. This second pack of observations contains a set of very crucial tasks that invite learning on aspects that cause problems to many: Irritation, anger and conflict. Participants observe what triggers their emotions and cause (automatic) reactions and reflect on how this can lead to conflict. Understanding and dealing with conflict is a very important area when interacting with patients and colleagues.

In these observation tasks, participants will become familiar with what and whom can trigger an (automatic) reaction in their work. They observe what they do and how they feel in these situations, and then focus on what **effect** their actions have on others. This is where many get a "shock" when they discover the impact their own emotions have on the interaction with others, and on the quality of the communication: the other person often withdraws, stops giving information, or sometimes – responds with anger. Participants then reflect on what they would like to do differently: This is where they become aware of the need to "step back" from their own automatic reactions, and listen to the other person, with the intention to understand her perspective.
In week 4, they write a story of significant change, as for pack 1.

Ask for questions and reflections, discuss, and close the meeting.
**Collect the feedback from Pack 1.**

*NB – it is usually not necessary to prepare a formal presentation for these meetings – the important task for the trainer is to make an environment for participants to feel safe in the group and feel free to share discoveries, questions and concerns. The key purpose is to encourage and motivate them to continue to discover, and learn.*

### *3.1.7 Meeting to collect pack 2 and introduce pack 3 – Patient-centred care, anxiety and research*

In this meeting, participants will usually have a lot to share: They have now discovered how much they are affected by patients' and colleagues' emotions, and how their own emotions influence the interactions and the communication with others. Many will have been profoundly surprised and will have learnt deeply. Many have already made important changes in their practice, based on their own observations. It is important to give time for sharing stories and reflections in this meeting.

Participants are by now familiar with the methods of how to observe their own communication habits. Many will have become aware of various patterns of reactions related to how they use basic communication skills (listening, asking questions, hindering and facilitating good communication), and of how they deal with anger and irritation. They will use this learning in the next month's themes.

Again, participants will often ask for skills to tackle the challenges they have discovered. Ask them to share how they have dealt with the challenges – this encourages them to learn from each other, which is an important aspect of the course process: To be teachers and role-models for each other.

***Introduce*** the next set of tasks: How do they practice "Patient-centred care" (PCC), and how do they relate to anxiety? Ask participants what they think is PCC, and how it is practiced in their institution, and discuss briefly the understanding and importance of this concept.
Also emphasize that during this final month before the basic workshop, participants should identify ***what they now see as their learning needs***, based on the last three months of focussed observation and reflection work.

The first task invites participants to identify what they actually mean by "Patient-centred care", how they practice ***giving*** this in their everyday work, and how it affects the patient, and themselves, when they give PCC. They are then asked to reflect on how it feels when ***receiving*** such care – either when being a patient themselves, or when accompanying a relative or friend to a health clinic. The task includes asking for a description of interaction that they participated in (as a patient or relative) where PCC was **not** given.

A "companion piece" to practicing PCC is awareness of how one deals with anxiety. Patients are afraid or anxious for a large number of reasons, all of which are "good" or "reasonable" - from **their (the patient's)** perspective. Patients are in a new place (the clinic/hospital), full of technical instruments and sick people. They don't know what is wrong with themselves, or their child. They don't know how long they have to stay, and if someone will take care at home. They don't know what it will cost. They may have met an unfriendly nurse who told them things they did not understand. They may have travelled for hours, and waited long, and are exhausted, hungry, etc. ***Their anxiety and fear is well founded.***

The provider's task is to become aware of how they empathise with the patient and take care of this fear, and make the patient feel safe and in good, kind, competent and caring hands. They also look at how they relate to **their own** insecurity or fear – if and how they may get "infected" with a patient's

(or colleague's) fear, and what happens to the interaction when fear "gets under your skin". They start learning to identify the signs of insecurity and fear, and how to manage these emotions better, with awareness.

***In the workshops, recognising and dealing with insecurity and fear are important topics.***
If some of your participants are involved in recruiting patients for research, you can use the task developed to strengthen their awareness of how they practice e.g. ethical aspects of this work.

### Additional tasks in pack 3

**A. Special task for providers working with research projects**

To recruit patients to take part in studies requires good communication skills and respect for people's right to say no. The assumption is that patients are scared or anxious when they come to the hospital, as they are usually quite sick (or have a sick child/relative with them), and they do not know what will happen. Their main concern is to get treatment. In this task, we ask participants to observe how they relate to these patients (or relatives), how they give information about treatment as well as research, and how well this is being understood in a difficult/stressed situation for the patient or parent. They are asked to reflect on how they manage this careful balance.

### Voluntary task: Communicating with friends and family members

Many participants have reported that the observation tasks have helped them beyond their work situations and have influenced them to make important changes in communication with their family and community. In this task we ask them to look at how the observations and reflections have affected their communication beyond the work context and ask them to share any insights.

# 4 Learning tools for participants

## 4.1 The Baseline questionnaire

**An example from Kilifi:**
***KEMRI-Wellcome Trust and Kilifi District Hospital***

# Communicating with awareness and Emotional competence:

## Process training for health providers March 2019 – Nov 2019

## Preparation 1: Baseline Questionnaire – skills and challenges

Please hand in your answers to (course leader) Mwanamvua Boga, or send to: (email address)

You have been invited to participate in a training process on "Health Communication and Management of Emotions for quality care and research" at the KEMRI-Wellcome Trust from March 2019 to Nov 2019, with the basic intensive skills training course 5th – 9th August, and the follow-up course in November 2019 (dates to be announced).

This qualitative *"Baseline questionnaire – skills and challenges*" is the first part of the course and should be handed it in after 1 week. We ask you to reflect on how you communicate, and what challenges you are facing in your work when dealing with patients and colleagues. Your answers will be used by the trainers to formulate the contents of the training course, to make sure it is tailored to your specific needs.

Learning communication skills is a process which takes time, and starts with your reflections on how you communicate with patients, colleagues and supervisors. Research has shown that short courses have limited long term effect on improving providers' communication skills. When courses are combined with investing your own efforts to reflect and observe over time, the learning has a much stronger effect. We therefore invite you to pay attention to what you do well when handling patients, parents and colleagues, and where you have difficulties, and to reflect on these methods and discuss them with colleagues. When you do this over the next four months, your learning will become conscious, and effective.

We call this a training *process* rather than a training *course*. This is because the training starts now, by you filling in the attached questionnaire. By doing so, you will reflect on the communication challenges around you, and on your own skills and *learning needs*. We read your answers carefully, and build the skills training course to meet the needs you have defined. This should be YOUR course, based on *your* problems and questions, and your ideas about what works. The trainers will discuss these, learn from each of you, add other ideas, and link the learning to relevant theories.

Only people who have completed this baseline questionnaire will be invited to continue the training process. This is because we want the course to be effective. We know that when people invest time and contribute their own ideas, insights and questions, the learning is much more effective and long lasting than when they come to a course without preparation.

We have given you lot of space in the questionnaire for you to contribute with stories or examples that describe situations of your communication with others. Stories and examples tell a lot more than just plain *yes* and *no* answers to questions. So we ask you to please answer by using specific personal examples from your work, whenever possible. General statements are less useful. For example, if you just say "I need to get better communication skills", we do not know what kind of skills you mean. If you describe a situation where you needed the skill, and your (or the patient's) reaction in the situation, it is easier for us to see what we can do to help.

**The training process consists of 4 phases**

Phase 1: Baseline, and a period of self-observation and reflection (3months, April – June 2019)

• Participants will be asked to observe and reflect on their own communication behaviors and the effects of the behaviors when dealing with patients and colleagues during their routine work, using guided weekly tasks. Participants give short notes on their observations monthly.

**Observation tasks (one per week) for 3 months.**

Pack 1: Basic communication skills (4 tasks).
Pack 2: Relating to anger, and conflict (4 tasks).
Pack 3: Practising patient centred care, communicating to allay anxiety and to explain procedures on research and surgical procedures (5 tasks).

After each pack, you write examples from your work which illustrate your learning

Phase 2: Intensive Skills Workshop (5 days - 5th – 9th August 2019)

• A 5 days' workshop links participants' own observations to theory. The course is practice based, building on learning needs identified during observation and reflection period.

Phase 3: New skills into practice while working in the ward/department (3 months)

Further observation and reflection exercises during participants' daily routine work

**Endline questionnaire**

Phase 4: Follow-up workshop (3 ½ days- class work Nov 2019)
• A final 3days workshop will summarize and anchor the learning to daily challenges faced by participants.

If you have any questions, please contact lead trainer (name/mobile no….).

Good luck!

Regards from the training team: Mwanamvua Boga, Siti Ndaa, Lennox Baya, Hiza Dayo,

*NOTE: This training process (including the baseline questionnaire) has been adjusted to the Kilifi setting from a process developed and implemented in 4 African (Tanzania, Namibia and Zambia, Gambia), three Baltic/East European (Lithuania, Latvia and Russia) countries, and Wales/UK. The process was developed by Ane Haaland for a Norwegian NGO, and implemented with the NGO partners in the different countries from 2006 – 2008. Haaland further developed the tools and the process in collaboration with colleagues in Kilifi from 2009, and trained trainers who ran the training independently from 2013. Haaland introduced and ran an adjusted process for trainee doctors in Wales in 2016-17.*

## Baseline qualitative questionnaire Kilifi, Kenya (March 28th – April 10th)

*NB – Please write clearly!*

A. Information about you:
Profession: Designation: Years of service:

*NOTE: Spaces in the questionnaire have been removed. Please add ample space when giving it to participants!*
B. Questions about you and patients on clinical care (please use more space if required)

1 a) What are you good at when communicating? Please give an example and describe a situation when you were communicating well with a patient or parent.
*b) What was the effect of your communication on the patient/parent?*

2 a) Which communication skill(s) are you not so good at with patients/parents?
b) Give an example from your experience of what happened with a patient/parent because of this.
*c) Comment on what you think is/are the cause(s) of the main communication problems, and what knowledge and skills you would need to deal better with the challenge(s)*

3 a) Do patients/clients/parents understand your information and follow your advice? Please circle one Yes/no
b) What do you do to make them understand or follow advice? Give an example.
c) Give another example of when a piece of information or advice was not understood, and reflect on *why* it was not understood.

4 a) How do you communicate with a person whom you respect?
b) How do you react when you are treated with respect?

c) How do you react when you are not respected?
*d) Are these reactions automatic or do you control them? Please describe a situation where you reacted, and describe how you reacted.*

5 a) In what situations do you feel safe?
*b) How do you communicate when you feel safe? Please give an example.*

6 a) In which situations do you feel insecure or afraid when taking care of patients?
*b) How do you communicate when you feel insecure or afraid Please give an example and reflects on how it affects you personally*?

7 How do you behave when you are Overwhelmed? Fearful? Sorrowful? Angry? (pick the ones that trigger you most, and describe your reactions, giving an example)
*b) Describe what you did to control or not control these reactions, and the effect on the situation.*

8 a) How do you handle conflict? Do you confront? Evade? Leave it to others to take the initiative? Please describe, and give an example of what you do.
b) *Reflect on how effective it is in reaching your goal, and what you would like to learn to handle conflict better.*

9 a) In your work situations, what makes patients angry?
b) How do you handle an angry patient/parent? Give an example of how you did/did not manage to calm an angry patient/parent.

10. What makes patients open up and give you the information you need, without fear? Describe what you do to make this happen.

C. Questions about research and consenting for procedures
11. Research is one of the activities that has been going on in the hospital. What would you like to learn in the course to be able to understand research better and be able to communicate with patients well about it?

D. Communicating with colleagues and supervisors
12 a) What are you good at when communicating with a colleague, and with a supervisor?
b) Please give an example of a situation (one with a colleague, one with a supervisor) when you were communicating well.
*c) What was the effect of your communication on the colleague or supervisor?*

13 a) What are your main problems/challenges in communicating with a colleague, and with a supervisor? Please give examples.
*b) Comment on what you think is/are the cause(s) of the problem(s).*

14 a) Which improvement in communication with your colleagues would make a difference to you in your daily work?
b) What could you do to make this happen?

*Thank you very much for your responses!*

## 4.2 Introduction to using self-observation and reflection tasks

***The introduction and the tasks are all part of the Communication Awareness Tools series, created by Ane Haaland. They have been used in all countries where iCARE-Haaland model is implemented.***

*NB: This introduction is important for participants to read, and for the trainer to explain during meeting(s) to introduce and/or discuss the course. The main reason is that such tasks are new to most participants, and they will not be used to doing tasks where there is "no right, and no wrong answer". It will take them time to get used to this, and to get used to observing themselves.*

**KEMRI-Wellcome Trust and Kilifi District Hospital**

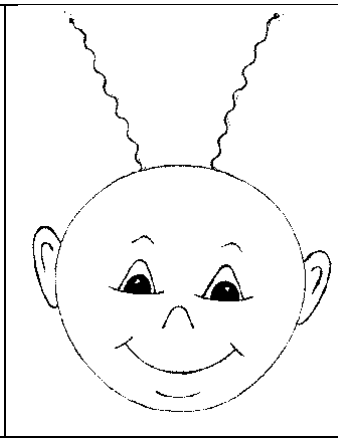
# Communicating with awareness and emotional competence

***Process training for health providers March 2019 – Nov 2019***

## Introduction to self-observation and reflection practice:

# How to become a better communicator

To communicate is an important part of our work as health providers. When interacting with others, we all have our own communication style. But how well does it work, to achieve our goals – whether the goal is to e.g. get an upset mother to agree to let her child have a lumbar puncture, or to resolve a problem with a colleague?

| | |
|---|---|
| To find out how well it works, we need to develop ***awareness*** about our own personal communication style. Understanding how we ourselves function is the first step to understanding others.<br><br>By paying conscious attention to how you communicate, and taking action to change what does not function well, you become a better communicator. The method described below is helping you to discover and reflect on your own personal style.<br><br>We have a mascot to "carry with us" to help us in this work – our "awareness friend", who was "born" in Kilifi in 1995. |  |

### *What is an observation task?*

***A method to become aware of how you interact with others***

Through a guided task, you are invited to observe ***how you communicate*** with patients and colleagues, and to observe ***the response*** to your communication in the other person. You observe a specific defined thing you do, one thing at a time. For example – how do you listen to patients? And what is the response from the patient when you listen well, or not so well? When you do this repeatedly over a week, you start to see the pattern of how you use this skill in different situations, and in different moods. For example, if you get stressed by something or somebody, or you feel sad or irritated - does this influence how you listen?

Looking not only at ***what*** you say or do, but also at ***how*** you say and do it, is crucial. The ***effect*** of what you say, on others, is the other crucial part. Start looking at this, and at the feelings you have, and at what you bring out in the other person. Understanding ***the effect of feelings or emotions*** on ***how you communicate*** is key in this learning.

## *Why is this method important?*

Because – when you ***see*** exactly that what you do, does not get the result you want (*e.g. a good collaboration with the patient*) – then you have a choice to change your habit, or decide you need to improve your skill. This decision can come from you observing your own practice and reflecting on how you influence the problem by how you communicate – or influence the solution to the challenge by communicating in a different way. You then become motivated to learn – for your own reasons.

Reflective practice has been shown by research to be an effective method to improve providers' communication skills. Essentially, you develop your own capacity to learn, which you take with you for the rest of your professional (and personal) life.

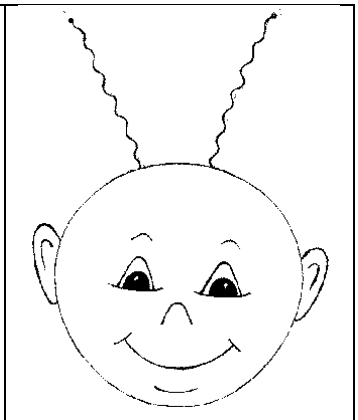
## *How do you do it?*

Observing your own practice will be a new practice for most of you, and it will take time before you become familiar with the method. But it is simply a matter of practice. Participants in previous courses tell us that when they started seeing how useful it is (and this usually happened the first few weeks), they wanted to continue to learn this way.

You can learn to look at yourself by e.g. imagining that you have "antennae" on your head, like our mascot below. Or you can think you have a little invisible observer who sits on your shoulder and sees what is going on, and helps you remember what you said and did in a certain situation. Or – anything else that enables you to create a "friend" who helps you learn about yourself.

**Some practical methods for doing the observations:**

- Carry this page of instructions in your notebook.
- When you plan your day, plot in one or two times or situations when you know you will be interacting with others (e.g. seeing patients, during breaks, meetings, discussions, etc).
- Before the meeting/other event, read the instructions again to remind yourself what you are looking for.
- Try to be aware during the meeting or conversation how you behave regarding the habit you are observing.
- After the meeting/event, reflect on what you have observed in your own behaviour, and make a few notes.



**If you do this once or twice per day, you will start to see a pattern.**

Most of you may be used to having others observe you to tell you what you are doing (focusing mostly on what you do wrongly, which can be very de-motivating). It is useful to ALSO have others observe you, but you can learn a lot by observing yourself. When you discuss your observations with colleagues, you will learn even more.

**The key to useful observation is to *focus*: observe only one main habit at a time.**
If you look for one or a few things, you will be able to see the pattern in what you are doing, and become aware of what you need to learn more about – and what you do well, and can help others

learn from. If you look at too much at the same time, you will not see the patterns. You can use a small notebook to note observations, and always carry it with you.

## *For how long do you do one task?*

Usually, you do one task for one week. During this time, you are usually able to see the pattern of how you use the particular skill you focus on.

You can, however, continue to pay attention to your skill in focus, also the following week(s). For example, you start observing your listening habits, and you can continue observing these also when you start new observations on ***how you ask questions***, until you have a clear picture of what you do. Listening and asking questions are closely connected, but you need to focus on one at a time to be able to discover your pattern well.

## *Why do you have to observe for such a long time?*

It takes years to develop habits, and it takes time and effort to change them. A main reason communication skills training rarely result in changes in providers' practice, is time: Most courses are offered from two to five days, with no preparation, and no work after the course.

There are many communication skills you use as a provider. When you become aware of how you use these, one by one, in your daily work practice, you get a realistic picture of what you need to learn to become a better communicator. After the first workshop, you use your new skills and continue to observe, and reflect on how the new skills function in your daily work, at your own pace. When you then decide the new methods work better than the old ones, change comes naturally. ***Research and experience has showed that learning about communication is more effective when it is done over time, and builds on a period of self-observation.***

## *Couldn't we have an option where we just come to the 5 days' course?*

In theory you could – but – this would mean you would be far behind the others who have observed their own habits for 3 months, and we would have to adjust the learning to your (slower) pace. The others will know from observation what they want to learn and will have many examples to contribute.

## *How can trainers know if I do my observation?*

We can't. Our attitude is – you are an adult who has decided to learn communication skills, and we assume a lot of the learning is your own responsibility – with our guidance. If you decide to put effort into doing the observations, we know that you will learn a lot better than if you don't. But how much you want to do – this is your decision. We will encourage you and support you.

## *The other person needs to change – not me!*

You can always choose to put the blame for the problem on the other person. This may be "true" in some ways, if a person has acted strange. However, in an interaction, there are always two (or more) persons. As you cannot change what the other person does, blaming the other will not help you solve the problem. You can however change ***what you do*** – by adding insights (*e.g. understanding why a sick person appears angry and "stubborn", and understanding your own natural reactions to such a situation*), and developing skills to meet different challenges. Then, you can solve the problem, and contribute to better care for patients – and for yourself.

***Good luck in your discovery! (email addresses/contacts – course leaders/coordinator)***

## 4.3 Observation and reflection tasks Phase 1: Discovery (Tasks 1- 4)

*NOTE: Whenever possible, these tasks should be sent out to participants (together with the handout above on how to carry out the tasks), and then discussed with them – in a common meeting or in smaller groups. Our experience is that when this is done, participants are much more likely to carry out the tasks in the correct way (Observation "In Action") from the beginning and get maximum benefit and learning from the course.*

### *4.3.1 Observation task 1: How well do you listen to others?*

***Note: Please include the header in all tasks, to credit the author and acknowledge source***

**Communication Awareness Tools Series – Created by Ane Haaland**
*Observation tasks: Listening skills, Discussion habits, Inspiring or hindering communication*

***KEMRI-Wellcome Trust – Kilifi County Hospital***

# Communicating with awareness and emotional competence

***Process training for health providers March 2019 – Nov 2019***

***Preparation Pack 1: A series of self-observation and reflection tasks on listening, asking questions, and influences on communication, and a story of change***

## Introduction: Communication and Dialogue

Learning about our own communication habits is a necessary step to understand how to develop and implement effective health communication strategies, how to communicate better with our patients and colleagues, as well as how to manage change in our organization. Becoming aware of what we do, and understanding the effect of our actions on others, is a first essential step for improved communication skills and for insights on how to teach others.

Thus, you are invited to **observe** your own communication practices in the weeks before the intensive skills training course in Kilifi **5th – 9th August**. This pack contains 4 tasks – each to be done during one week. You will receive a new pack of observation tasks after one month.

Please use one task per week. An important key to making effective observations is ***focus:***
If you look for one or a few things, you will be able to see the pattern in what you are doing, and become aware of what you need to learn more about – and what you do well, and can help others learn from. If you look at too much at the same time, you will not see the patterns. You can use a small notebook, or your mobile phone, to note observations. Always carry it with you.

Looking at not only ***what*** you are saying or doing, but also on ***how*** you say and do it, is crucial. The ***effect*** on others of what you say and do is the other crucial part. Start looking at this, and at the feelings you have – and at what reactions you bring out in the other person. Understanding the effect of ***feelings*** on communication ***outcome*** is key in this learning.

***NB: Research and experience has showed that learning about communication is more effective when it is done over time and builds on a period of self-observation.***

## Observation task 1: How well do you listen to others?

In the first week (*and also as a supplement in the subsequent weeks*) – notice how you use the most fundamental communication skill (*often called "the mother of communication skills"*): **Listening.**

## Observation week 1: How do you listen to others? April 10th – 16th

***When interacting with another person, how do you listen? Do you***

- **Listen politely** until the other person has finished, and then respond?
- **Listen impatiently**, and formulate your response after the first half sentence – because you "know" what he/she will say, and interrupt when you think "you got it"? ("*listen with your mouth full of words")*
- **Listen attentively** with the conscious intention to understand the other person's point of view and ask questions to find out more what the other person is thinking? And only then – offer your own ideas? (*Do you also appreciate verbally and/or non-verbally what the other person is saying, without necessarily agreeing with him/her?)*
- **Listen with "ears, eyes and heart**", also trying to understand the feelings behind the words?
- **Respond (automatically**) to his/her statements with your own opinions?
- **Other pattern?**

Observe ***when*** you use the different methods and what are the ***results*** or outcome - especially what feelings your different listening methods seem to bring out in the other. Pay attention to whether your "daily mood" (*relaxed? Stressed? Sad? Angry/irritated?)* influences how you listen.

***Have fun!*** And please make notes on your observations.

## *4.3.2 Observation task 2: How do you discuss, and ask questions?*

Listening and asking questions are the two most fundamental communication skills a health professional uses in her/his work. We often call them "*the mother and father of the communication skills*". We thus continue this "introduction round" by inviting you to look at how you use the "father skill" – how you ask questions.

You can continue to pay attention to your listening habits also when you start new observations on ***discussion habits***, until you have a clear picture of what you do.

**If you do this once or twice per day, you will start to see a pattern.**
**The key to useful observation is to *focus*: observe only one main habit at a time.**

Since the act of asking questions by many is connected to "challenging power" in countries with strong hierarchical cultures, we ask you keep an eye open for this aspect. We also suggest that you observe and reflect on how asking questions relates to your own use of power.

By paying conscious attention to how you communicate, you will become a better communicator. Understanding how we function, and what works well (and not so well) is the first step to understanding others. It is essential for developing effective strategies for teaching others, and for ensuring that the teaching leads to action.

Looking at not only ***what*** you are saying or doing, but also on ***how*** you say and do it – and this week, at how you listen to verbal and non-verbal answers, is crucial. The effect on others of what you say and do, and how you listen, is the other crucial part. Start looking at this, and at the feelings you have

– and at what reactions you bring out in the other person. Understanding the effect of ***feelings*** on communication ***outcome*** is key in this learning.

## Observation Week 2: Discussion habits *(17th – 23rd April)*

*When you discuss with another person, do you usually:*

- Respond to his/her statements with your own opinions?
- Ask questions to find out more what the other person is thinking, what her opinions are, and what her experiences are - related to the topic?
- If asking questions, are they closed (inviting yes/no-answers), or open (inviting more information from the other person)?
- Do you ask questions to win an argument or to get information?
- Any other pattern? (Describe)

Observe in what type of situations you use the different methods, and what are the ***effects*** or outcome (*do you feel good/bad/indifferent? Does the other person feel good/bad/indifferent?)* Reflect on whether you participate in a discussion with an awareness of how you want the quality of the discussion to be (*superficial – ping/pong arguments, or a deeper, more exploratory discussion?)* or if you "just discuss" - automatically.

***Have fun.*** And please make notes!

## Addition: For health professionals who work to diagnose patients *(from the set of tasks we used with trainee doctors, Wales):*

*When asking questions from a patient, do you usually:*

- Ask on "autopilot", i.e. following a standard (predetermined) line?
- Ask mainly closed questions (inviting yes/no answers)?
- Ask open-ended questions (inviting more information), followed by probing?
- Ask a mixture of closed and open-ended questions (*are you aware of when you do what, and for what reasons)*?
- Ask many "why" questions? (Why? Discover reasons behind what patients say, or do?)
- Ask questions giving only two options (*is it like this, or like that?)*
- Do you consider what "type of patient" you meet, and decide consciously what type of questions you should ask? If so – how do you decide/on which criteria?
- Or do you have other habits for asking questions? (Describe)

**Reflect on how stress/having little time (and if relevant – your mood of the day), influences how you ask questions, and gather information.**

## Optional addition – reflections on your power role

***Reflect on your possible assumptions about the other person, re how you ask questions:***

- Do you assume (or expect) your patient will ask questions if he/she wonders about something?
- To what extent do you invite patients to ask questions?
- How aware are you about the power relation between you? Influence on interaction?
- How aware are you about how "being in the doctor's office" can influence the patient, regarding giving important/sensitive information?

- If the patient is from another culture – is this a culture where there is a strong hierarchy in the school system as well as in the health system? How do you think this can influence the patient's ability or willingness to bring up questions with you?

### *4.3.3 Observation task 3: Personal communication to build relationship and trust*

We trust that observation has now become a natural part of your daily life and that you have discovered many things about yourself. If you feel you have not yet got "the hang of it" please discuss with your colleagues about how they do their observation and may be what they have found out. This is a good way to get over a (natural) resistance to this task.

The observations are a ***compulsory*** part of the preparations for the course, however, how much effort you put into them is up to you. The observation is ***an invitation to learn more*** and learn deeper – and you are the one deciding how deep you want your learning to go on this topic. It will ***not*** be compulsory to share from your observations during the workshops – what you see is yours. We do know however that if you discuss your observations and reflections with others it will help both you and the other person(s) to learn better. *(It is compulsory, however, to send in written reflections once a month.)*

In the third week, you are invited to observe ***your own successful strategies to communicate well, and especially build relation and trust with patients***. What do you do specifically that has a good effect? What do you do which seems to limit or disturb the interaction or communication?
When you have time off from work it is also often a good time to observe situations with family and/or friends, and how you communicate in this environment.

## Obs Week 3: Do you inspire or hinder good communication? *(24th- 30th April)*

*When you participate in a task or discussion with colleagues or others – what is it you do which contributes to the following:*

- ✓ Make people open up and give their ideas and offer their cooperation/participation, etc.
- ✓ Make people feel good and positive – raise their spirits
- ✓ Create good cooperation, and learning
- ✓ Motivate people to take action
- ✓ Facilitate clarity
- ✓ Other? (describe)

*When you meet a patient – what is it you do which contributes to the following (list from the Cardiff training for trainee doctors):*

- ✓ Make patients/guardians feel safe to open up and tell us about their issue
- ✓ Make patients/guardians feel free to ask questions
- ✓ Help clarify the patient's expectations
- ✓ Make patients/guardians feel seen as people
- ✓ Make patients/guardians feel good, and positive
- ✓ "Read" the patient's emotions, and respond appropriately (Use empathy? How?)
- ✓ Establish good relationships and cooperation
- ✓ Raise the patient's spirits (if appropriate)
- ✓ Add humour (at your expense, or neutral, if appropriate). Other? (describe)

Also observe what you do (or ***don't*** do) which ***hinders*** good cooperation or learning, or hinders/prevents people from contributing their ideas. Do you interrupt? Criticize? Show a negative face? Make gestures that show you know better, or disagree?

**One way to find out could be:**

- If you are in a situation/discussion which feels negative or unpleasant – ask yourself what has been <u>your</u> contribution to the situation, by what you have ***done or said***, or what you have ***NOT done or said***. Reflect on ***how*** you have said things – could this have contributed (the tone of voice is a very important communicator)? Reflect on your ***feelings*** – if and how they could have contributed to the situation/problem (look especially for feelings of being unsure, or afraid, or angry, or frustrated)?
- Or was there something you ***did*** (criticize a patient/person for what he/she had done (or not done), make fun of others at <u>their</u> expense, come late for an appointment/class, show obviously you did not like/approve of something, etc)?

***Have fun – take notes!***

### *4.3.4 Observation task 4: What have you learnt? Reflection: The Most Significant Change*

You have now been observing your own communication habits for three weeks and possibly seen some changes in how you work. This often happens when people start becoming more aware of what they do and don't do in relation to others – to patients, colleagues or superiors.

We invite you to reflect about what has happened – alone, and/or with your colleagues, and to share with us a story (or example) which describes ***the most important, or significant, change*** you have felt or experienced during this time. A story is a description of a situation that made you realize something important.

Please tell the story, and also add **WHY** you think this is significant to you.

If you feel like drawing, or illustrating, the story – please feel free to do so, and bring the drawing to the training course with you, or give a copy to Mwanamvua Boga

Please write your story and other comments on the computer and send by **8th May *to*** (name/contact) or write by hand and give to (name/contact).

***– This is a compulsory exercise!***

*NOTE: You are also welcome to share notes from your observations with us. The more we know about you, the better we can adjust the course to meet your needs and deal with your specific problems and challenges. Your notes from the observations will also give us examples to use in role-plays and exercises in the course.*

*All materials you contribute will be treated confidentially. If we use anything you have contributed for making course materials, we will make sure the situation you describe is "anonymized", so it cannot be identified back to you.*

Best regards, Mwanamvua Boga and all the course trainers

***Next meeting on 8th May in (venue)***

***Note: See chapter 3 for notes on meeting to collect pack 1 + introduce pack 2.***

## 4.4 Observation and reflection tasks Phase 1: Discovery (Tasks 5-8)

***Note: Please include the header in all tasks, to credit the author and acknowledge source***

**Communication Awareness Tools Series – Created by Ane Haaland**
*Observation tasks: Identifying and dealing with irritation, anger and conflict*

***KEMRI-Wellcome Trust – Kilifi County Hospital***

# Communicating with awareness and emotional competence

***Process training for health providers March 2019 – Nov 2019***

***Preparation Pack 2: A series of self-observation and reflection tasks on dealing with anger and irritation with (or without) emotional intelligence, and a story of change***

### Introduction

Thank you very much for your excellent examples from your baseline questionnaire and (the Most Significant Change stories) of how you have observed yourselves listening while discussing with patient's/study participants and colleagues. Your descriptions of what you have discovered and of the many changes you have already made in the way you communicate, are inspiring to read! The examples continue to show the power of "just" paying attention to what you are doing with "new eyes" and reflecting about the effect of your actions: ***These are the first important steps of developing emotional intelligence***. The "secret" is simply to continue to do it and continue to learn. And – to discuss and share with other participants who may have other experiences, or who may find it difficult to practice this new learning method. Practising this method becomes easier when you have done it for a while, and when you discuss your challenges and experiences with colleagues.

The second pack of our observations is a set of very crucial tasks which address emotional aspects of our behaviour which cause problems to many: Irritation, anger and conflict.
***Each of these tasks is adding a new aspect of the emotional intelligence skills.***

Please read through all the tasks before you start. For easy use – we are sending all tasks in an overview, and then each of tasks 5, 6 and 7 as a separate file – to enable you to download to your mobile, so they are accessible to you in your work place.

### Observation tasks 5-8: Identifying and managing irritation and anger

We hope you are finding the observation tasks useful, and that you are all learning important things about how you communicate with study participants and colleagues. Attached are further tasks to observe and reflect on what triggers your emotions, and cause reactions that can affect your communication and sometimes lead to conflict. Understanding and dealing with emotions is a very important area when interacting with study participants, patients and colleagues. ***Each task should be done for one week***.

### Emotions are natural

Emotions are natural part of life. We are faced with many small and some bigger irritations every day. Depending on how we feel and act, some of them may develop into conflicts. Dealing well with

emotions is a very useful skill for relationships with patients'/parents, colleagues and personal partners (husband or wife).

In the next three weeks, you are invited to become more familiar with what and who makes you react, what you do and how you feel in these situations, what effect your actions have on others. Then, you can reflect on what you would like to do differently.

### *4.4.1 Observation task week 5: Make an emotional reactions map*

### *WHAT* makes you react? How?

***Background:*** The first task is to define what irritates or frustrates you or makes you angry in your daily life and work, and how you react in each of these cases: ***Make your emotional map***.

**Define w**hat is it that makes you react negatively in your daily life? Who cause these reactions? Is it special people? Or is it special situations? Is it worse on certain days? Is it better when you have slept well, or feel well for other reasons? Which of these situations can result in a conflict? **Also note how you react** (see list of suggestions reactions below).

Make a map to become more familiar with your patters of reactions. Make your own system for taking notes if you want to add other aspects. The important thing is that you observe what makes you react negatively **every day during one whole week**, and that you write down quick notes several times during the day (as soon as possible after it happens). Otherwise, you will forget. At the end of the day, take five minutes to check your notes, reflect and make some notes: (***Use table 1 below to write your response)***

Write down as many as possible of the things that make you react. You could add a few aspects of your choice (e.g. how long does the irritation/anger last? What makes it go away?), but do not add too many things. The secret behind good observation it to keep the task ***simple.***

Try to identify what your pattern is, by observing your reactions. You might have different reactions depending on the situation and the person (patient/study participant, colleague, supervisor).
Be honest with yourself, as well as you can. **This is not an easy exercise, but it is a very important one**

**NOTE:** Our response to irritating situations is often ***automatic.*** It is essential to become aware of how you react automatically – when you have recognized this, you can start to take action – to change.

### Task week 5: May 8th – 14th

### Table 1: My personal emotional reactions map: WHAT do I react to? How?

| Day | Action, reaction or situation that irritates/ frustrates me, or makes me angry (WHAT do I react to) | Who/what causes it? | HOW do I react? |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | (use more space or lines, as needed) | | |

**My example (***Write down briefly a typical example of what makes you react negatively and what the result is (disagreement? Conflict? Withdrawing – you "swallow" the feeling?)):*

**Comments and reflections, including surprises, on what you have discovered and what you have learnt (*use more space if needed*)**

***This task is related to developing the first skill needed to practice Emotional Intelligence.***

### *4.4.2 Observation task week 6: My (automatic) response to irritation and anger: HOW do I react?*

### Task week 6: 15th – 21st May

***Background:*** Study the chart/map from last week and pick out a category of people you react most to and that result in smaller or larger disagreements or conflicts. Follow this group for one week.

Our response to irritating situations is often automatic. Here are some common reactions people have (you might have other reactions):

- Avoid the situation (leave, physically)
- Pretend you do not react (withdraw, hide your feelings)
- Show non-verbally that you are irritated (sigh, frown, tap your fingers, shake your head, wave your finger, etc)
- Confront in a neutral way
- Confront in an aggressive way
- Blame the other for the problem
- Discuss the problem with the other person while the problem is hot
- Ask questions to find out what is the cause of the problem (seen from the other person's point of view)
- Take a step back (i.e. consciously not react), and see what happens
- Explain that what you did was right, and that it is for the benefit of the other person
- Explain why you did what you did
- Take responsibility for a part of the problem
- Defend your action
- Invite the person(s) to talk about it when tempers have cooled down
- Other….

Try to identify what your pattern is, by observing your reactions for one week. You might have different reactions to small irritations and to larger ones, and different reactions depending on the situation and the person (patient, colleague, supervisor).

Be honest with yourself, as well as you can. **This is not an easy exercise**, but it is a very important one. If you find it difficult to decide how your reaction is (e.g. how you look – if you show a non-verbal reaction), ask a colleague you trust to give you feedback in the beginning. However – it is most important for you to learn to see for yourself how you react. This will come with practice.

***How do you feel behind the irritation or anger?***

Irritation and anger is showing on the surface. Underneath there are other reaction and feelings. What are these? Can you start to identify that little (or big) feeling which is there, and which gets

covered up by irritation or anger? Very often, the feeling goes away so quickly that we are not even aware of it.

This is the time to become aware of it again. Understanding what is behind the irritation and anger is ***key*** to learning how to deal well with disagreements and conflict.

## Table 2: My (automatic) reactions to Patients (*or colleagues):* *HOW do I react, and what are my feelings behind the reactions?*

| Day | Action, reaction or situation | My response (what do I do, including non-verbal action) | How do I feel? |
|---|---|---|---|
| 5 | | | |
| 6 | | | |
| 7 | | | |
| 8 | (use more lines and more space as needed) | | |

**My example(s) (**Please write down one or two examples of typical situations that make you react, and your response, and feelings behind it)**:**

**Comments and reflections, including surprises, on what you have discovered and what you have learnt (*use more space if needed*):**

***This task is related to developing the first and second skills needed to practice Emotional Intelligence.***

### *4.4.3 Observation task week 7: Effect of your irritation and anger on others*
### How do THEY react, and what are (possibly) their feelings behind the reactions?

## Task week 7 (22nd – 28th May)

***Background – automatic reactions:*** You are now familiar with your main automatic reactions when you are irritated or angry. You have made your reflections.

Now is the time to look at the response of the other person(s) to your different ways of expressing emotions such as irritation, frustration and anger. You can choose one group (patients or colleagues) to observe for some days, then observe the other group (colleagues) for some more days.

We cannot do this task earlier in the process. When a person is irritated or angry, she or he tends to focus on herself/himself, and not on the effect on the other person. Now that you are familiar with what you react to and how you react, these reactions may not be so strong any more: ***You have strengthened your awareness***.

You can now start to look at what is ***the effect*** of your irritation or anger on the person(s) you interact with, and on the communication between you. You can also think about (or ask about) how the other person feels (*depending on the situation, this may be easier to do when the situation has calmed down*).

**Some possible reactions you might get from the other person:**

- Avoids the situation (leaves, physically)
- Pretends he/she does not react (withdraws, hides his feelings)
- Cries, or becomes very sad
- Becomes very passive and agrees to everything you say
- Shows non-verbally that she is irritated (sighs, frowns, taps her fingers, shakes her head, waves her finger, etc.)
- Confronts you in an aggressive way
- Blames you for the problem
- Discusses the problem with you while the problem is hot
- Asks questions to find out what is the cause of the problem (seen from your point of view)
- Observes/takes a step back (i.e. consciously does not react), and sees what happens
- Explains that what he did was right, and that it is for your benefit
- Explains why she did what she did
- Takes responsibility for a part of the problem
- Defends his action
- Invites you to talk about it when tempers have cooled down
- Other….

Try to identify what the effects of your actions and reactions are by observing this for 1 week.
Also reflect about or ask about **the feelings behind the other person's reactions** (this may be easier to do when you and the other person have calmed down).
Be honest with yourself, as well as you can. Ask colleagues for assistance when it feels natural.

## Table 3: Effects of my irritation and anger on the other person(s)*:*
## *How do THEY react, and what could be their feelings behind the reactions?*

| Day | Action, reaction or situation | My response/ action (and feeling) | The action/reaction of the other person | Possible feelings of another person |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | Use more space/ days as needed | | | |

**My example(s) (***Please write down briefly an example of the effects on others of your irritation and anger*)**:**

**Comments and reflections, including surprises, on what I have discovered and what I have learnt (*use more space if needed*):**

***This task is related to developing the first, second and third skills needed to practice Emotional Intelligence.***

### *4.4.4 Observation task week 8 - Final reflections, how do you do them?*

### And - writing your reflections in a Most Significant Change story

We encourage you to meet informally with colleagues and/or friends to discuss your observations during this time. Discussing observations with others is a very good method to get feedback and share reflections, and to feel that others may have similar (and different) insights to your own.

***However – please be careful, and protect yourself***! Some of your insights might be very personal and very sensitive, and you should consider carefully whom you share them with. When you do share, it is important to agree to listen to each other ***with respect***, and to not laugh at any of the findings of your colleagues or make her/him feel that observations are not "correct", or not "true". See the last page for some practical tips on how to do this.

You might decide to meet in a group to discuss some of your findings. Such a meeting would be very useful as a preparation for the course. The group could also decide on what they suggest should be topics for the course, and what and how you want to learn.

### *Some background on anger, fear and insecurity*

- Anger is often a useful response, e.g. if someone is trying to exploit you, or to push you to do something you really don't want to do;
- Anger is about setting boundaries (or limits, to say what is OK and not OK for you)
- Anger can also be a cover up for fear

**Remember –**

- Feeling insecure (or sad, or afraid, or vulnerable), is normal
- In family and society, we are mostly trained ***not*** to feel insecure (or at least not to show it)
- We are trained to cover up when we feel bad or sad, by showing (or pretending) we can manage
- When you (or others) are irritated or angry, there is often a feeling of fear or sadness behind
- Learning to recognize and respect this fear or sadness is important to be able to manage, and later prevent - conflict.

### Week 8: Writing your reflections on learning – a new story of change

You have observed over the last 3 weeks what happens to you and others when you get angry or irritated, and how it affects feelings and communication. You may also have seen some changes in how you work when these emotions are present. This often happens when people start becoming more aware of what they do and don't do in relation to others – to patients'/study participants, and colleagues.

We invite you to reflect about what has happened – alone, and/or with your colleagues, and to share with us a story (or example) which describes ***the most important, or significant, change*** you have felt or experienced during this time. A story in this context is a description of a situation that made you realize something important. *In other words – we are asking you to write the same kind of story as after the first pack of observation tasks.*
Please tell the story, and also add **WHY** you think this is significant to you. You can also add your reflections on the effects of your different actions, on yourself and on your work.

***Please hand in your feedback by 5th June.***

# Additional ideas: How to discuss with your colleagues

- about how they do their observations, and about what you have experienced, and found out. This may help you to get used to doing this task.

***How can you do this constructively?***
**Below: Choices, and implications on what will happen/what you can learn**

## *Choice 1: Discuss to support motivation and insights*

*Learning about yourself can be a sensitive issue. When discussing observations with colleagues, show respect and appreciation – then they will feel safe, and you will help them (and yourself) learn well.*
***How do you do this?*** *Please* ***ask open ended questions*** *to understand more about what colleagues have observed, and please listen actively.*

*Help him/her explore what they have observed, and how they feel about it. What was the effect on the patient/colleague? What insight(s) did the person get from the experience?*
*Be* ***encouraging and appreciative*** *to help your colleague talk and share. Then you can share from your observations, and let him/her ask you questions. This gives a good basis for a discussion of how you can use what you have seen, to improve practice.*

## *Choice 2: "Turn your colleague's motivation off":*

*Many things we may do automatically without a bad intent, may make your colleague shut up rather than share from her/his experience of doing observations. Thus, here are some* ***Things to avoid:*** *If you judge or devalue what your colleague has seen and felt, it will hurt, and your colleague might get angry – or shut up. With good reason! You might get into a "ping-pong" exchange of what he/she observed and what it meant – this is useless, and de-motivating. The message he/she might get from you is: "I know better what this means than you do". You can imagine how this feels… and how it affects your communication.*
*Another "turn off" is when you start commenting about your own observations when your colleague has just started to describe his/her own findings. Your focus is then on getting her/him to listen to YOU, rather than you listening to him/her. You also know how this feels. Watch what it does to the communication, when you fall into this trap!*

***SO – Be respectful, appreciative and curious, and generous with your listening!***
***NB:*** *This* ***does not mean*** *you have to agree with each other - it just means you agree to try to see the other person's point of view, from his/her perspective.*
***Tip****: Take this list with you when you discuss observations. At the end – discuss how well you communicated – if you listened to each others' experiences, with respect and genuine interest. Give each other* ***feedback*** *– also this in a supportive and constructive way!*

***Please see chapter 3 for notes on the meeting to introduce Pack 3.***

## 4.5 Observation and reflection tasks Phase 1: Discovery (Tasks 9-13)

***Note: Please include the header in all tasks, to credit the author and acknowledge source***

**Communication Awareness Tools Series – Created by Ane Haaland**
*Observation tasks: Patient centred care, managing anxiety, and research*

***KEMRI-Wellcome Trust – Kilifi County Hospital***

# Communicating with awareness and emotional competence

## Process training for health providers March 2019 – Nov 2019

***Preparation Pack 3: A series of self-observation and reflection tasks on Patient Centred Care, Communicating Anxiety, Research, and story of change***

### Introduction

We hope you are finding the observation tasks useful, and that you are all discovering and learning important things about how you communicate with patients and colleagues (and perhaps family and friends). Feedback from your many observations will be a very important part of the intensive communication skills course **August 12th – 16th,** together with the information from the baselines. Thank you very much for all the hard work, and the many good examples!

Over the past 10 weeks, you have observed your basic communication skills (listening, asking questions, hindering and facilitating good communication), how you deal with anger and irritation, and how these emotions influence how you communicate with patients and colleagues. In this last set of tasks before the first workshop, you can use all your previous learning and practice to observe **"Patient Centred Care" (PCC): You can observe how you put the term into practice** in your everyday work, how you ***Take care of patients' fears,*** and ***how you communicate when patients – or you yourself - are scared.***

Please note that the observations are a ***compulsory*** part of the preparations for the course.

### Guidelines for reflection on Patient Centred Care (PCC)

***"Patient Centred Care***" is a term which is increasingly used in medical care. Please discuss with colleagues – what does this term mean for you in your everyday work as a health professional? Do you put the term into practice, and if yes - how? Share some examples of what you do when you provide "Patient Centred Care", to get a better grasp of the meaning of the concept. To help your discussion, please read the article about Patient Centred Care, below.

# What Does Patient-Centered Care Mean?

There have been many attempts to define the attributes of patient-centered care (PCC). However, there are gray areas even in the most comprehensive of definitions. The following is from NRC Picker, the company specializing in tracking patient experiences:

1. Respect for patient's values, preferences and expressed needs. This dimension is best expressed through the phrase, "Through the Patient's Eyes" and the book of the same title, and leads to shared responsibility and decision-making.
2. Coordination and integration of care. This dimension addresses team medicine and giving patients support as they move through different care settings for prevention as well as treatment.
3. Information, communication and education. This includes advances in information and social technologies that support patients and providers, as well as the cultural shifts needed for healthy relationships.
4. Physical comfort. This dimension addresses individual, institutional and system design (i.e. pain management, hospital design, and type and accessibility of ser-vices).
5. Emotional support. Empathy and emotional well-being are as important as evidence-based medicine in a holistic approach.
6. Involvement of family and friends. Care giving includes more than patients and health professionals so that the larger community of caregivers are considered.
7. Transition and continuity. Delivery systems provide for caring hand-offs between different providers and phases of care.

All of this seems praiseworthy, but what does it mean in practice? How would you know if the care you received was truly patient-centered? How would providers know if they were delivering patient-centered care? How would system managers know? What indicators best reflect patient-centeredness? PCC is in some ways in the eye of the be-holder. Providers might think they are delivering PCC but their patients might disagree. Different aspects of PCC will be more relevant to some patients than others.
The purpose of this paper is to explore PCC in practical terms and propose some possible indicators and measures that would support transparent performance reporting on its achievement. The aim is to make PCC more concrete, so that it is a living concept meaningful to those who receive, deliver, and organize care, and who make policy. Ultimately, PCC is as much about the culture of the system as specific approaches and behaviors. The challenge is translating it into understandable, consistent and valid terms and indicators.

**A. The Fundamentals of PCC**

A basic foundation of PCC is the notion of service. Many think of contemporary health care as a combination of science and technology deployed by professionals to address health problems. This is of course true, but PCC is based on a simpler premise: health care is a *service* industry. This may sound like mere common sense, but if truly embraced and built into the health care system, it is a transformative idea. In important ways health care is unlike commercial services like hair salons and hardware stores. Sick people are not shoppers and their relationship with providers is qualitatively different from their relationship with sales clerks. But one concept fundamental to the commercial world is relevant to health care: the customer is always right.
Technically, of course, the customer is not always right – customers are just as fallible as businesses. But a dissatisfied customer is a customer whose needs have not been met, and the essential insight is to recognize this as a failure. Successful businesses view an unsatisfied

customer as evidence of their own failures. That ethos lies behind no-questions-asked return policies, ironclad warranties, and personal communication to resolve problems.
Businesses adopt this attitude because it is a key ingredient to their survival and success. Publicly funded health care does not face the grim prospect of collapse due to the loss of customers. It can, and does keep the customers it fails because there is no other place to go. Most of the failures are not catastrophic (although many are and the death and morbidity tolls are high). They are rather the failures of disrespect, inconvenience, poor communication, and fragmentation. Put most simply, the system has been designed for the providers more than for the users of services, and it shows.

It is important to distinguish PCC from consumer-driven health care. The latter uses the language of the market and increased patient control as a purchaser of services, and more informed choice about where to receive care. PCC experts emphasize that while the two concepts may overlap, PCC begins with the premise that people vary in their capacity and inclination to engage in their own decision-making. Some are confident and able to direct their own care, while others are less so. PCC makes no assumptions
The Change Foundation in Ontario has done a lot of work on PCC. A major literature review confirmed that there is very little research that examines health care integration from the patient perspective. The Foundation conducted a series of focus groups to get a better understanding of the patient experience. Many implicit definitions of the elements of PCC emerged, among which were:

1. Comprehensive care – all of their needs, not just some, should be ad-dressed
2. Coordination of care – someone is in charge, there is someone to go to who knows you and will help you navigate the system
3. Timeliness – they should get care when they need it and where a sequence of services is required, the intervals should be short
4. Functioning e-health – provide information once, ensure that it is accessible to those who need it, give patients access to the records and the opportu-nity to add
5. Clear and reliable communication – listen, explain, clarify, ensure that the provider team members are on the same page, consistency of messages, access to phone or internet consultations
6. Convenience – minimize the need to go to different physical locations for services; open access, same day scheduling; no unnecessary barriers or steps to getting to the right provider
7. Respect – for their time, intelligence; for the validity of their stories; for their feedback about quality and effectiveness; for their environment and family care giving partners
8. Empathy and understanding – for their circumstances, fears, hopes, psychological state
9. Time – to express needs and be heard effectively
10. Continuity and stability – to know and be known, minimize the number of different care providers
11. Fairness – amount and timeliness of service commensurate with need.

Different initiatives and attributes are required to meet all of these needs. Some are structural: how well the system is integrated, where services are located, the nature and use of an EHR. Some are organizational: how are appointments made, how staff is deployed, are there processes for pro-active rather than reactive communication. And many are attitudinal and behavioral: whose needs come first, do providers listen, do they treat patients as equals and partners, do they welcome feedback.

**C. Provider Attributes That Promote PCC**

Achieving genuine PCC requires a cultural adjustment. Provider attitudes and behaviors can accelerate or thwart PCC. Among the provider attributes essential to trans-formation are:

1. Recognition that health care is an integrated service industry designed to respond to people's needs
2. A commitment to organizational effectiveness and collective responsibility for the processes and outcomes of care, with special focus on handoffs, communications, and follow-up
3. Willingness to participate in non-hierarchical teams to ensure that patients get comprehensive, well-integrated care from the most appropriate caregiver
4. Willingness to adopt an incentive structure that encourages spending adequate time with patients with complex needs
5. Trust in and encouragement of those patients who want to be actively engaged in the management of their own health
6. Commitment to organizing the system to provide timely care and adoption of tools and techniques that prioritize patient access over provider convenience
7. Willingness to own the failures on any of the main PCC indicators and dimensions and vigorously pursue remedies
8. Embrace of e-health and other technologies that expedite communication, flow, and efficiency.

All of these attributes come down to attitude and primarily deal with the non-technical aspects of their work. Many of the problems PCC aims to address involve fragmentation – the parts of the system don't work together. Some fragmentation arises because for over a century, professionals have put clinical autonomy at the centre of professional identity. While the exercise of clinical judgment is fundamental to quality, absolute clinical autonomy is anathema to an integrated system that delivers PCC. Because health care is not a market good, there are no "natural" market forces to drive PCC, quality and efficiency. Many values compete for priority status in any health care organization: PCC, clinical autonomy, organizational loyalty, or any number of others. The core value cannot be all of these, and if PCC is to be paramount, the others have to be modified accordingly. Either the sun revolves around the earth, or the earth revolves around the sun. Patients can orbit their providers, or providers can orbit their patients.

### *4.5.1 Observation task 9: Linking Patient Centred Care to practice in your daily care*

**June 12th - 18th**

After reading the article, observe how you practice PCC in your work at the moment. Decide on a day you will observe yourself and keep the concept with you in your mind. Observe each encounter with a patient, and reflect after each encounter:

- What did I do which was patient centred?
- What about my behaviour made it patient centred (i.e was it ***what*** I did, ***how*** I did it, or both?)
- What was/were the reaction(s) of the patient?
- How did I feel myself?

**Reflect on:**

- What were the needs of the patient, physically/medically, and mentally/emotionally, and on how you met these needs, using PCC;
- Is there anything you could/should do to make your interaction more patient centred? What could be the effect on the patient if you did this, and the effect on you?

Continue to observe for some more days, whenever possible, how you practice PCC, and how it works for you and for your patients. Are there any cultural (and/or automatic) reactions which work ***against*** you practicing PCC? Any that work ***for*** you practicing PCC? Anything you have discovered, which needs to change?

### *4.5.2 Observation task 10: Stepping into the shoes of a patient, or caregiver: How does PCC feel?*

**June 19th - 24th:**

This week we ask you to reflect on situations where you have been a patient yourself or have accompanied a patient (e.g. a family member, or friend) to a health care facility. We invite you to ***step into the shoes of a patient*** or a caretaker to a patient, and try to imagine what it would be like to be in those shoes: Observe (in action) and reflect on how it may feel to be a patient/caregiver/relative to a patient, and what you wish(ed) for, from the health provider.
If you have not recently had this experience yourself – you can talk with a friend or relative who has had this experience and ask about his/her experience of being a patient.

**The following questions can guide your reflections:**

- What happened/what was the situation/what was the context?
- How did you feel to be patient/caregiver?
- What were your/his/her needs?
- What did the health care provider do (and not do)?
- Did you feel the provider tried to see the situation and understand your need, from your own perspective as a patient or caregiver? (what could be the reasons s/he did, or did not?)
- Did you feel the provider saw you as a person, or as "just another patient/caretaker"?
- What do you wish s/he could have done differently to take better care of you, or your patient (re medical needs, information, emotional needs, etc)?
- What would have been the effect on you, if you/your patient got the care you wished for?

Please reflect on your experience(s), and on what "Patient centred care" means to you as a Patient. Compare this to your observations and reflections from last week and discuss with your colleagues.

**Task:** From your observations these two weeks, please ***pick one example***/situation where you practiced PCC, or where you experienced PCC as a patient or caregiver. Please write your example/story,you're your insights and reflections, and send/hand in to us, by **25th June**.

### *4.5.3 Observation task 11: Your methods to take care of fear and anxiety in patients and parents*

**June 26th – July 1st**

We know that being a patient or caretaker is often very difficult, and patients are afraid or anxious for a large number of reasons, all of which are "good" or "reasonable" - from their perspective: They are in a new place, full of technical instruments and sick people. They don't know what is wrong with themselves, or their child. They don't know how long they have to stay in the hospital, and if

someone will take care of their family at home. They don't know what it will cost. They may have been met by an unfriendly nurse who told them things and used words they did not understand. They may have travelled for several hours to get to the hospital. They may have waited long, and are exhausted, hungry, etc. And so on. ***Their anxiety and fears are well founded.***

*How do you take care of this fear, and make the patient feel safe and in good, competent hands?*

This week we invite you to observe what it is you do to take care of patients' and caretakers' anxiety and fears: how do you communicate verbally and nonverbally in these situations, and how do you know it "works"/have the effect that you intend. You may also reflect on whether your intention is conscious – whether you decide what it is you want to achieve with this patient or caretaker, and how you need to act to achieve what you have decided. In other words – observe how you are using emotional intelligence skills.

***Does their fear "infect" you sometimes?*** Fear is a very strong emotion, and it has many faces, and many effects. We ask you to explore more systematically what these "faces" are, how you respond, and what are the effects of your responses, on the patient or caretaker. Fear can also be contagious, and it is easy to "pick up" some of the feeling and let it affect you: Are there signs that tell you their fear is "getting under your skin"? How do you react when you are also feeling the fear?

*This observation is linked to and builds on the observations in Pack 2, on anger and irritation.*
*It is connected to the first three skills of practicing emotional intelligence.*

## Task 11: How do you take care of fear and anxiety?

**a) Observing patients' reactions:**

**Please observe the following during your interactions with patients and parents:**

- How do you ***sense that a patient is anxious or afraid***? What are the "different faces of anxiety", or signs, which you observe or sense when interacting with a patient? How do you decide or "know" that anxiety or fear is actually "the problem"?
- What do you do ***to respond to the signs, in different situations?*** Note for yourself what you do, and how you communicate – including use of non-verbal methods, and emotions.
- Do you have ***many different ways to respond***? ***How do you choose*** your method of response – is this ***automatic***, or do you "take a step back" to ***assess*** what this particular patient needs before you respond? And if so – how do you know what she needs?
- Do you ***follow up*** patients who are anxious? If yes – how?

| Day | Situation | What did the patient do? How do you know s/he was anxious or afraid? | How did you respond to the patient's emotion? | What do you think were his/her needs? | How did you feel? (when taking care of the patient fears/anxiety?) | How do you think the patient felt? |
|---|---|---|---|---|---|---|
| 1 | | | | | | |
| 2 | | | | | | |
| 3 | | | | | | |
| 4 | | | | | | |
| 5 | | | | | | |
| 6 | | | | | | |

***NOTE: Please make much more space in this table – make it in landscape format, with ample space.***

Please describe an example from your observations. Reflect on your learning and note what you want to learn more about – on your own, as well as in the workshop.

***Remember – observation is more effective (i.e. you learn more) when you focus on a small part of your communication habit to pay attention to***

***Note: This task is related to all four Emotional Intelligence skills.***

### *4.5.4 Observation task 12: Special task for providers working with research projects*

To get people to agree to take part in studies requires good communication skills and respect for people's right to say no. You can assume that people whom you ask are scared or anxious, as they are usually quite sick (or have a sick child/relative with them), and they usually do not know what will happen in the hospital. How do you manage this careful balance of giving clear information which is being understood in a difficult/stressed situation for the patient, with making sure you get your work (as a researcher, or recruiter for a research project) done?

Communicating about research and procedures (e.g. an operation) will be the topic for observations after the intensive workshop. However, some of you may want to pay special attention to how you carry out this work now, in relation to your observations on how you handle anxious patients. We will have a session on research in the workshop, where you can ask questions related to research.

### *4.5.5 Voluntary task: Communicating with friends and family members*

Over the past months, you have reported on how your communication has changed with colleagues and patients. Has your observation and reflection also affected your communication with friends and family members (including children)? We invite you to observe during this period as you continue to interact with your friends and family. You could for example observe:

- How do you listen these days?
- How do you ask questions?
- How do you deal with emotions (anger, irritation, others)?

Has anything changed in the way you interact with your family and friends? If yes – what has changed, and how? What is the effect of these changes on your relationship(s)?
***If you feel like it – you can also ask if your family and friends have noticed any changes in the way you relate with each other, and use this to discuss communication in the family.***

### *4.5.6 Observation and reflection task 13: The Most Significant Change, and Defining your learning needs*

**July 1-6th**

We are asking you to hand in ***one important example*** from this set of tasks. This should be an example that shows ***your learning and reflections*** during these weeks. It can be something you do, which has changed in an important way. It can be something which has made you realize why your present practice is effective or achieves the goal you have intended - an example which you can share, and maybe show to others.
Please also tell why these changes are important to you.

The workshop should be a place where we discuss our problems and learn from each other how to handle them better. It should also be a place where we share our "successes", and learn from what each of us does well in our practice.

***Define your learning needs:*** At the end of your Most Significant Change/Best Practice example(s), please answer the following question: **What do you now feel you need to learn about communication skills and management of emotions, from doing these observations for 3 months?**

**Important Deadline: July 6th – to enable us to read, understand and use your examples, and to analyse and respond to your learning needs!**

Best regards,
(name/course leader) and the training team

## 4.6 Observation and reflection tasks for trainee doctors - Cardiff training

These sets of tasks were used to train trainee doctors in Wales in 2016 and 2017.
We include these tasks here, as many of these were developed to directly observe use of skills related to emotional intelligence and resilience.

We do not include the first two packs here (Pack 1: Basic communication skills (1-4), and Pack 2: What makes you react emotionally – anger and irritation(5-8)), as these were in large parts the same as those described above. We have commented on the changes used in Cardiff, in the original packs 1 and 2, above.
We include here the tasks we developed especially for the Cardiff setting, ***NEW tasks 9-16 that have not been used anywhere else.*** These are pack 3 (positive emotions, values and vulnerability, kindness to yourself and MSC), pack 4 (criticism of self, and others), and pack 5 (on the influence of (other) professional cultures on your emotions, communication and behaviour). We maintain the numbers on the tasks as we used them in Cardiff, and hope they will not cause confusion with the tasks with same numbers, above. ***All additional tasks for the entire course are included here – for the 7 months the course process was run.***

The title of the programme is included only for task 9 – it remained the same for the two courses, each of which lasted 7 months. Some of the tasks were developed for the last course, only, as this course had six half day workshops, and the first course only four.

*All tasks are developed by Ane Haaland, some of them with inputs from Debbie Cohen, and in the second year – with inputs from the two trainee doctors who assisted in organising and teaching the course – Thomas Kitchen and Isra Hassan.*

***Please include reference to the original source when using the tasks:***

**Communication Awareness Tools Series – Created by Ane Haaland**
*Observation tasks: Positive emotions, values and vulnerability, kindness to yourself, and MSC*

### *4.6.1 Observation task 9: Positive emotions; their effects on you and people around you*

***Cardiff University – Wales Deanery: A pilot programme for training trainee doctors***

# Strengthening emotional intelligence and resilience in the workforce

**Reflective process training on communication for person centred care April – October 2016**

## Introduction

Your observations and reflections on emotional challenges have been extremely interesting reading – thank you all for the huge efforts you have put into these tasks. The examples show that most of you are practicing especially the first three EI skills (1. *Accurately* ***perceiving*** *emotions, 2. Integrating emotions with* ***cognition, 3.*** *Understanding* ***emotional causes and consequences).*** The challenge is now to continue the work towards using the 4th skill more consistently ***(4. Managing emotions*** *for personal adjustment*) to turn your understanding of the emotional challenge into action by changing the way you act in these situations. Some are already doing this – and can continue strengthening awareness and practice of how and when to use the full set of skills.

## Task 9: Positive emotions, and their effects on you and people around you

Being aware of what makes you feel positive at work is as important as being aware of what makes you feel irritated or angry. Learning to manage emotions is about becoming more conscious about how emotions affect the way you interact with colleagues and patients, and be able to stop automatic reactions – both the negative ***and*** the positive ones: It can be as "wrong" to act automatically on positive emotions (although less likely), as to act automatically on the negative ones. The aim is to be able to recognize the emotions as they "come", and stop and think (this can take as little as a few seconds) if you are going to "let them out" or "hold them back" (step back).

Acting automatically on positive emotions, and e.g. be compassionate "all the time", can lead to compassion fatigue. See the article on training people to be compassionate: http://www.deseretnews.com/article/865627360/Can-people-be-trained-to-be-compassionate.html?pg=alland

**This week's task (June 17-25th)**

is to become more aware of how positive emotions "operate" in your workplace, and what happens when they "show up". What kinds of emotions are likely to be there? Specifically, please observe –

- How do you recognize, experience and positive emotions?
- Are these are automatic or conscious?
- What is the effect of the positive emotions on others, and on you (e.g. is there any effect on your motivation to work or to help another person? On relationship to patients, or colleagues, or to how you feel about yourself? Effect on your energy level? Other?)
- When colleagues show positive emotions, how do you react? (do you e.g. tell her it won't last? Ask him to be realistic, and objective? Stick to the facts? Comment, sarcastically? Share the emotion, and appreciate, verbally? Smile and show you appreciate, non-verbally?

**Please reflect on** any of the incidences, and analyse ***if/how you have used the four EI skills?***

*At the end of the week, reflect on what you have discovered and learnt about how you use and experience positive emotions. Can any of your learning be related to building resilience? If so - how?* ***Finally*** *– think about which* ***values*** *underlie the use of your positive emotions.*

### *4.6.2 Observation task 10: Becoming aware of, and handling Vulnerability*

## Introduction

Vulnerability is what makes you human, it is what enables you to have a deep connection with another human being. It is why patients seek their doctor – they are sick, and vulnerable – even though in many cases they try their best to hide the vulnerability, consciously or unconsciously. So do the doctors and other health professionals treating them, due to a number of reasons.

**Some of the reasons for not relating openly and wisely to vulnerability can be:**

- Vulnerability is seen as "weakness", something to be avoided at all cost. Many **fear** it will make them powerless and helpless, and not able to do their work;
- It is connected to risk, something negative, especially in the medical "model";
- Some see it as being out of control, and this is dangerous for a doctor;
- It is a strong emotion, and some people feel that if you let people touch your deep emotions, you won't be able to set boundaries.

You can add many more reasons.

**Some dangers of not recognizing and managing vulnerability in yourself (and others) can be:**

- Making wrong decisions. You do not get to hear the "full story", either because you do not listen well (very common), or you do not have the "space of mind" to ask the right questions;
- Unrecognized vulnerability can make you not remember vital information;
- You may overlook crucial issues because the negative emotions cloud your judgment and thinking;
- Fear of dealing with or relating to death can mean patients are not getting their emotional needs met during crisis, and near the end of life;
- Patients' safety can be affected, and compromised;
- Your own wellbeing can be compromised.

**Here are some more reasons for learning to relate openly and wisely to vulnerability:**

- It strengthens your ability to be authentic and real, which are key to creating connections with patients, colleagues and partners;
- It makes you more able to learn and to practice empathy and compassion;
- It makes you better able to tolerate uncertainty, and thus strengthens resilience;
- It strengthens your ability to be courageous, with awareness;
- The ability to be vulnerable is the basis for creativity, innovation and change;
- Vulnerability is what connects people deeply to each other.

***To be able to relate well to Vulnerability, you need to be able to set functional boundaries.***
Vulnerability without boundaries can lead to burnout, and to a number of other problems.
The same goes for Compassion – you also need to be able to set healthy boundaries, and thus prevent what is common among health professionals – "Compassion fatigue".

***The key to the learning is strengthening your Awareness – over time, and deciding to focus on positive sides of the work. See https://www.youtube.com/watch?v=N2MExcvzmgU on the relationship between positivity and wellbeing, for healthcare professionals, and how humanistic health care leads to better outcome for patients.***

When people are not familiar with their own vulnerability, and do not recognize it, they are also less likely to recognize when they meet vulnerability in a patient, a friend or a partner. If you are afraid of vulnerability (without knowing it, consciously), you are likely to reject the vulnerability in others. When you reject someone's vulnerability, the person feels hurt, and will often withdraw or get angry. This can lead to conflict.

*When a conflict is brewing, look for the vulnerability on both sides, acknowledge and deal with it, and you may be able to stop it from developing. An apology can work wonders, and can communicate to the other person that you had no intention to hurt him or her.*

## Task 10: Becoming familiar with your vulnerability: June 26th – July 2nd

Reflect on your own knowledge about and relationship to Vulnerability. What does it mean to you, to feel vulnerable?
Do you see it as a weakness, or as a strength? Why?

In our course, we see vulnerability as a natural feeling which we "just" have to learn to recognize, accept, appreciate, and manage. There is much wisdom in your vulnerability. See Brene Brown's Ted-talk on Vulnerability, https://www.ted.com/talks/brene_brown_on_vulnerability?language=nb and https://www.ted.com/talks/brene_brown_listening_to_shame?language=nb

And how do you apply this to your work? The challenges are many. Here is one:
What would you have done? http://heartsinhealthcare.com/doctors-dont-cry/

**So in your daily work, and at home, pay attention to (some of) the following:**

- What makes you feel vulnerable?
- How aware are you of your vulnerability – how do you notice that you are feeling vulnerable?
- How does your vulnerability (and other emotions?) influence your work?
- How do you react to yourself not being perfect (if/when that happens)? Does it impact on your self-worthiness in any way?
- What makes you value yourself as a good doctor, in relation to vulnerability?
- When you feel vulnerable – what do you do to handle it, and how does this make you feel?

You can also look at your relationship with friends and family – how aware are you of your vulnerability, and how do you deal with it?
***See the attached article: The Wisdom of Vulnerability.***

# The MSC story to be delivered on July 6th:

## *An example, and the link between Vulnerability and Emotional Intelligence*

Please pick an example from insights you have had about vulnerability and describe what happened.
What made you pick this example – why is this significant to you?
Then, analyse your example by identifying which of the EI skills you used, and how.

Reflect on where you are re the use of the 4 EI skills, and which of the skills you still need to strengthen.

***Reflections on the link between managing your vulnerability and being resilient: Please add your thoughts on this.***

***An additional note on empathy, for further reflections***
To practice compassion, you need empathy. Empathy is a skill that can be learnt – it is the skill to feel WITH people, and it is closely connected to practicing the 4 skills of being emotionally intelligent:

- To recognize the person's feeling and perspective as true for him/her, and
- Get a perspective on the feeling, for yourself;
- Recognize your own possible judgment, and take a step back from this;
- Recognize the emotion, and possibly the causes and consequences in the other person, and
- Communicate the emotion(s) to the other person.

***To practice empathy, it requires that you can connect to vulnerability – your own, as well as theirs.***

## *4.6.3 Observation task 11: Being kind to yourself, with awareness*

### Introduction: Kindness and appreciation

It is relatively easy to be kind to others and to enjoy the good feelings and gratitude such kindness usually sparks in the other person: It makes you feel good yourself. Kindness comes as a natural action and most of us do not hesitate to be kind to others. Appreciating others for something they have done may not be common in the medical culture, but – this is a skill you can learn. When you see the positive effects of using appreciation consciously and genuinely, many adopt this skill as an important part of their communication "vocabulary". Many experience that kindness and appreciation can lead to better teamwork, less stress and less conflict. The positive emotions you introduce by being kind, are contagious.

Being kind to ourselves is another aspect of kindness. "Self-kindness" can have many similar positive effects on ourselves as kindness can have on others. When you are kind to yourself it can also have positive effects on the people around us. ***However, many of us hesitate to be kind to ourselves.*** **Why is it like this?**

### Task 11: How well do you treat yourself? July 24th – August 2nd

Please pay attention to the following:

- When were you last kind to yourself? What did you do? How did it make you feel?
- What triggers you to be kind to yourself?
- Are there times when you feel you want to be/need to be kind to yourself, and then stop, or do not do it? What happens – what are reasons you don't do it?
- The things you like to do to be kind to yourself – do you make these a priority? Or do you find reasons to set them aside and rather do something for others?
- How do you feel when do you do something well? What do you do? (Ignore? Appreciate?)
- When patients, colleagues or others thank you or appreciate you for something you have done well, how do you react? Do you acknowledge and thank them (gracefully? Shyly?), or do you "talk it down", saying eg "it was nothing", or something to diminish the importance, and their appreciation?

- Do you say No to things you know will drain you of energy/make you very tired? Why/why not? How does it make you feel?

**Also pay attention to - how much time do you spend being kind to yourself, per day? Per week?**

**Reflect on possible reasons you find it hard to be kind to yourself. Here are some ideas:**

- You find it easier to prioritize other people's stuff, rather than your own;
- You do not think it is necessary to be kind to yourself, as long as you are kind to others;
- You judge people who are being kind to themselves, as selfish. You do not want others to see you as selfish.
- When you say No to things you know will drain you of energy/make you very tired, you feel bad, or guilty. You would rather say yes, because you do not want to disappoint the other person (you would rather bear the consequences/disappoint yourself);
- You do not feel you are worth being kind to;
- Other reasons… (are they always the same, or do they differ?)

## Some further thoughts for your Reflection On Action:

- When you are being kind to yourself, is this the same or different from being selfish? How?
- Is your choice of action linked to Intention in any way? If so, how?
- How do people around you (colleagues, family) think about the idea of being kind to yourself? What kind of understanding/perception (of being kind) are their opinions based on?

**Also reflect on the effects of being kind to yourself:**

- When you were kind to yourself, how did it make you act towards others?
- When was someone kind to you? How did it make you feel? Did it make you want to be kind to others?

**MSC: Please share examples of what you have observed and learnt, and how you have handled the challenges described in tasks 9-11. Deadline: (date)**

---

### *4.6.4 Pack 4: Observation and Reflection Tasks on criticism (12,13,14), and an MSC story.*

Please include a reference to the original tasks:

**Communication Awareness Tools Series – Created by Ane Haaland**
*Observation tasks: Criticism of self and others*

---

## Introduction: Criticism

Criticism can help you grow, and it can destroy your confidence, your joy of work and your joy of life. Your attitude and practice to giving and receiving criticism can have a really important impact on your quality of life and the quality of the life of others. There are three main aspects: Criticizing yourself, criticizing others and receiving criticism. The potential to use these well is as big as the potential to make real damage.

***In this task we will talk about your "Inner Critic" as a part of you, as if it can be separated from the rest of "You". By doing this, as an exercise, it can become easier to get the "Inner Critic" in perspective – to see how it helps you and how it can limit you. This can be useful for deciding which action you need to take to use your "Inner Critic" in a constructive way. For ease, we refer to it as a "He".***

**Criticizing yourself: Recognizing your Inner Critic – Protector, Destroyer, or a Mix?**
When your "Inner Critic" is functioning well it can help you to excel, technically and non-technically, by being alert and ready to ask questions, give his opinion and help prevent you from making mistakes. However, the "Inner Critic" is usually a very rational character and often is inexperienced with (and largely insensitive to) the emotional aspects of an interaction. Through your work on this course so far, you have discovered (or confirmed) the importance of recognising and managing emotions as an essential part of your work.

The "Inner Critic" can also be a real "sabouteur" by demanding excellence (the way he defines this) in every aspect of work and life, wanting it all to be "Perfect". To achieve this, the "Inner Critic" can use a number of strong actions towards you: Judging you, condemning you, ridiculing you, or shaming, rejecting or damning your actions – or you as a person. If the "Inner Critic" is "helped" by a critical colleague (or partner) the impact can be destructive and difficult to get a perspective on, and/or shake off.

It is important to remember that the "Inner Critic" fundamentally intends to help you (e.g. to achieve excellence, or as close as possible to perfection). His role is to be critical; believing that he has the "only solution", "the Truth" – and he can be very forceful. The "Inner Critic" will almost never be satisfied – he will never give you a "pat on the back" for doing a good job, even if you managed to meet 99% of his criteria. The "script" for the "Inner Critic" is written during a person's childhood – experiences of how parents and other family handle criticism will formulate how you relate to this very central emotional behaviour.

***Most "Inner Critics" "see" vulnerability as weakness, as something to ignore or to be gotten rid of. Reflect on – how did your "Inner Critic" relate to what you observed (about vulnerability and being kind to yourself) the last weeks? (=Reflection ON action!)***

Getting to know how *your* "Inner Critic" operates can help you get him in perspective, help you to recognize him and manage him in a constructive way – adjusting your childhood "script" by learning emotional intelligence.

## *4.6.5 Observation task 12: Recognizing your Inner Critic; how (s)he operates*

**Pay attention to how you criticize yourself ( = how your** "Inner Critic" **operates). Do you –**

- Ask critical questions to help you do a better or more professional job?
- Criticize yourself for most of what you do? How does the criticism affect what you do? How does it make you feel?
- Criticize yourself for all of what you do? If yes – how does it make you feel?
- Criticize yourself for failing to do something?
- Criticize yourself for forgetting or not thinking of something you could/should have done?
- Criticize yourself when you have chosen not to do something? If yes – how does it make you feel?
- Criticize your actions, *in general?*
- Criticize yourself as a person? If yes, how does this make you feel?

- Criticize both your actions and yourself as a person?
- Feel that you need to be "perfect" most of the time? When/in which situations? How does it make you feel?
- Feel you need to be "perfect" all of the time? How does it make you feel?

**Further observations: Does your "Inner Critic" -**

- Have power over you, or do you have power over it?
- Take your emotions into account, or your patient's emotions, or your colleague's emotions? If yes – how?
- Judge, condemn, ridicule, give you a sense of shame, or reject you or your actions? In which situations? With what effect (how do you feel? What do you do)?
- Does the judging, shaming or rejection get worse if you if you feel insecure or vulnerable? Does it only happen if you feel insecure or vulnerable?

## Reflections ON action:

**When you have an overview over how your "Inner Critic" operates in you, make some further reflections on the following questions:**

- Are the questions the "Inner Critic" asks, appropriate? Do they help? Or can it be a habit that does not help you do a better job?
- Does the criticism usually make you act, or does it make you passive? Or some of both? (Identify?)
- Are the actions you take because of the "inner Critic" automatic? Are you becoming aware of this?
- How strong is the criticism from your "Inner Critic"? Too mild? Appropriate? Too strong?
- Are there any situations, or moods, where your "Inner Critic" seems to be most active? What are these, and why do you think he is most active then? What "triggers" your "Inner Critic"?

## Further Reflections on Action, using Emotional Intelligence:

Recognizing your "Inner Critic", how it operates and what kind of emotions it can cause in you and others is a "mix" of using the EI skills 1-3: You recognize the emotion (skill 1), you think and reflect (skill 2), and you discover that many of the emotions are caused by the way your "Inner Critic" operates (skill 3).

The other part of skill 3 – to look at the (potential) consequences of the "Inner Critic's" actions, can be a useful exercise to carry out: What are/can be the consequences if you act based on the opinions or suggestions of the "Inner Critic" (skill 3)?

After doing these reflections – you can look at what you do for skill 4 – taking actions based on your analysis. One of these actions might be to bounce back (skill 4), helping to protect you or heal you from the pain. There are several other possibilities.
Finally – you can take notes on your insights gained from using the EI framework to learn about your "Inner Critic".

**Taking action – bouncing back after feeling low, after being criticized by your "Inner Critic"**
**Observe further:**

- What makes you "bounce back" to feeling ok, and in balance/out of pain again?
- Do you do anything specific to help you bounce back? What? How?
- How long does the emotional effect of the "Inner Critic's" "attack" last?

There could be a number of other actions you take after being criticized – please observe what you do, and try to find your pattern! When you have seen the pattern, the next steps usually become clear.

### *4.6.6 Observation task 13: Receiving criticism/feedback: acknowledge, defend, or a mix?*

The way we react to criticism often has deep roots to how we were taught this skill as a child. Many people have never been taught well, and/or have traumatic experiences related to being criticized. Others may have a troubled relationship to power and find it difficult to relate naturally in the (medical) hierarchy.

**Some common reactions to criticism are:**

- Going into automatic defence mode when someone points out they have made a mistake, or that they should do things in a better/different way. This kind of reaction has a base in the assumption (which is usually subconscious) that the person criticizing them wants to hurt them;
- Assuming the person criticizing them is "always right", especially if he/she is a person in power (and is using it to make a point/to punish), and go automatically into a subservient role where you don't ask questions, just obey. This kind of reaction is also usually subconscious.

Such emotional reactions can reduce or block off a person's opportunity to learn from feedback, or criticism.

For others, receiving criticism is seen as a natural part of learning to improve one's practice, and they take it in stride, and integrate the learning. How well you take it in is often dependent on how the other person communicates it – if it is with awareness, kindness and a "clean" professional intent, or – if it is an emotional outburst from a colleague who is irritated and just "lashes out" at you, and/or others.

***To distinguish – we can say that criticism is often given automatically, without awareness or concern about how the other person will receive it, while feedback is usually given with awareness and a conscious intent for the other person to learn.***

### *Observation task 13: How do you receive criticism?*

**To become aware of how you react and respond to criticism and feedback – please observe:**

- When people criticize **your actions** – how do you react? (Automatic? Controlled?)
- What do you do, or say?
- How do you feel?
- When people criticize you **as a person** – how do you react? How do you feel?

**Reflect ON Action – once you have seen your patterns:**

- What influences your reactions to criticism? (e.g. the person/status of the person who criticizes? The way he/she criticizes – tone, intent, emotion behind? Your own emotions? Other?)
- How do you use the criticism? What influences your decision to use or not use it?

- Are there times or situations where you feel it is more difficult to receive criticism? Or more easy?
- Is it more difficult/easy to receive feedback from certain people? What kind of people, why?

**Reflect on how you are using EI in these situations: *Recognizing the emotions? Thinking about them? Reflecting on causes and consequences? Taking different action?***

**Some common ways people react to criticism:**

- Automatically – rejecting the criticism (especially if it is given in a destructive way);
- Automatically – accepting the criticism without thinking about whether it is "right" or "wrong";
- Listen with your mouth full of words, waiting till the person is finished, and then telling him/her that he/she is not perfect, either;
- With awareness – recognizing your emotions (=what are they?), and stepping back from them, to be able to take in the contents of what the other person says;
- Thanking the person for the feedback, acknowledging your mistake, saying you will do your best to improve.

Please take time to observe how you respond to the different opportunities for learning that life and work presents to you, every day!

### *4.6.7 Observation task 14: Criticizing others: When, Why and How do you do it, with what effect?*

Your own "Inner Critic" also has a role in how you criticize others – often without you being conscious about how this happens. The person you criticize can experience it as destructive, if the criticism is given automatically, without awareness or concern for how the other person might receive it, or for his/her emotional state, or ability to learn from it. The other person can experience criticism – or feedback - as constructive – when you give it with awareness of your own as well as the other person's emotions, and with a conscious intent.

This task is about becoming aware of what your intentions are when you criticize/give feedback, and of what are the effects of your feedback on the other person. As for most communication situations – there is no "solution" or single approach that fits all – each situation and person demands an individual approach, based on your EI analysis. ***For each situation, decide if you criticized, or gave feedback, and why.***

## Task 14: When, Why and How do you criticize, and how do they react?

**Observe the following in each situation when you criticize or give feedback to others:**

- What prompted you to give feedback (or was it criticism?)
  - Was it an automatic reaction or response?
  - Was it invited? Planned? Based on observation?
- How did the other person react? (?how do you know you "read" the reaction in the right way?)
- How did you feel yourself? (e.g righteous, balanced, pleased ….)
- How did your emotions affect the way you gave criticism/feedback?

**Reflecting ON action – for each situation:**

- What was your **intention**? Was this ***conscious*** (e.g. to help the person learn, to make the person feel better, to strengthen the team…. Etc) or ***automatic*** (eg to give praise and applause, to punish the person, make the person realize how stupid/irresponsible/etc they had been)?
- Do you do anything differently when giving "planned" criticism/feedback compared to "unplanned" criticism/feedback
- How do you choose the time and place to criticize/give feedback?

Reflect on your findings and make your notes.

**Any questions or comments?**
Ane.haaland@gmail.com; Thomas Kitchen tl.kitchen@gmail.com; Isra Hassan israhassan@hotmail.com

## Pack 5: Observation and Reflection Tasks on professional cultures

**Please include credit to the source of the tasks, in all tasks:**

**Communication Awareness Tools Series – Created by Ane Haaland**
*Observation tasks: The influence of professional cultures on emotions, communication and behaviour*

### *4.6.8 Observation task 15: Becoming aware of the influence of (other) professional cultures on your emotions, communication and behaviour*

## Introduction

Collaboration across professional cultures is an essential part of in a doctor's life, yet it can also be a common source of irritation, judgment and conflict. Doctors work with nurses, midwives, administrators, healthcare assistants, physiotherapists, dietitians, pharmacists, occupational therapists, psychologists... and the list could go on. Doctors also work with colleagues at different points in the professional hierarchy who could somehow be seen as having a "different culture".

We feel emotionally safe when people around us are ***like us*** – when they share our culture(s), values, opinions and ways of identifying and solving problems. Even though we know intellectually that we have to live and work within diversity, it does not prevent us from reacting, often automatically, when others around us think and act differently from what we believe is "right". Often reactions are based on preconceived ideas (mainly subconscious) and generalizations about other groups, which can be based on single or repeated negative experiences with members of this group by yourself and/or colleagues. We can feel emotionally unsafe, pre-judge them automatically, and expect (again often subconsciously) more negative experiences. Needless to say, this is usually a very poor basis for positive teamwork and good collaboration.

***Becoming aware of what triggers your automatic reactions to colleagues from other professions with whom you work can help you learn to recognize these reactions, step back, and learn to act with (more) emotional intelligence.***

In the next two weeks, we ask you to observe IN Action how you behave and communicate when you cooperate with e.g. nurses, midwives, administrators or medical colleagues higher up in the hierarchy.
When choosing a group to observe, ask yourself – why am I choosing this group? Is it because I am at ease with them, and therefore observing will be easy (and "not take time")? Or is it because I have a conflict with professionals in this group? Reflect – and the choose consciously.
*Observe one group for at least three days; then switch to another group – after asking the same questions.*

## Task 15: Communicating across professional cultures

### *a) Negative emotions and reactions: Oct 2nd – 8th*

Observe the issues or incidents that make you irritated or angry when communicating and collaborating with colleagues from other professions. For example:

- What is it that the nurse says or does (or doesn't say or do when you are there) that brings out irritation or judgment in you?
- Is there a (perceived) attitude to you as a doctor, which makes you react?
- If you react, is this automatic? What do you do, or say? How do you feel?
- How does the reaction(s) influence the way you communicate with that person?
- How does it influence collaboration?
- How does it affect your mood? How easily can you "shake off" such moods/emotions?

You can choose another group than nurses. *It is wise to focus on one group at a time, for at least 3 days*.

When you reflect ON Action, please consider what might be ***reasons behind*** the nurse (or other professional) acting in this way. Is there an intention to hurt or irritate? Or is the nurse operating according to standards and rules you are not familiar with? Reflect on whether you could have pre-judged that member of staff before you interacted with them? Was this based on your cultural assumptions or on something else?

**An example:** You are a young registrar working in the theatre for the first time in this hospital, and you are in charge. The nurse who is working with you has been doing the list for 10 years, and knows the operation very well. Yet, Yet, without you sharing anything other than your name when you politely introduce yourself she takes a "subordinate" role to you, as this is "how things are".
Reflect on – how do you think she feels (even though she knows this is "how things are")? What is it that you could do in this situation, as the registrar (or in another position), to facilitate a good working relationship and build the basis for good patient centred care?

Also consider the potential consequences, for example the effect on your ability to listen well to patients and colleagues, and to provide the Patient Centred Care you would like to give.

### *b) Positive emotions and reactions: October 9th – 15th*

Observe the issues or incidents that make you feel positive and open when communicating or collaborating with colleagues from other professions. For example:

- What was it that the nurse (or other staff) said or did which triggered your positive reactions or response?
- Was there a (perceived) attitude to you as a doctor from the other staff member which made you respond positively?

- When you reacted positively, was this automatic, or with awareness (and EI)? What did you do, or say? How did you feel? What was the effect?
- How did the reaction(s) influence the way you communicated with that person?
- How did it influence collaboration?
- How did it affect your mood? For how long did the positive emotion last?

You can choose another group than nurses. It is wise to focus on one group at a time, for at least 3 days.

When you reflect "On Action" – try to summarize -

- What are all the different actions you take, that encourages a good working relationship? (be specific – try to identify the different actions, emotions, moods, etc)?

Consider the reasons behind the nurse(s) acting this way, and the consequences.

***For both the negative and the positive emotions and reactions – reflect on what is/are the links to your vulnerability, and to the way you are criticizing yourself, and others?***

Please reflect on your findings and make your notes.

**Any questions or comments?**
**(names/contacts)**

## *4.6.9 Observation task 16 (voluntary): Examples of confrontation and conflict – automatic reactions, and reasons behind*

In the last workshop, several of you requested that we deal with how to confront others in a (more) constructive way. Some offered to give us examples of what situations that have irritated you.

***Please give us your examples, urgently – by October 10th.***

**For us to be able to use the examples in the workshop (of course anonymously, as usual) – here is a guide on how and what to write:**

1. **Describe what happened:** Who did what, who said what, what were reactions, and effects/outcome? Were there any automatic reactions, from anyone?
2. **What was your role:** What did you do or say, in what way?
3. **Blame:** Did anyone blame anybody, or anything?
4. **Emotions:** Which emotions were shown, from both/all sides? How?
5. **Reasons:** What do you see as the main reason(s) this situation resulted in a confrontation/ended in a conflict?

***Please write down the example(s) spontaneously, as you experienced and remember it/them.***

**Then – please reflect on the questions below**.
You can share these reflections with us, or keep them for discussion in the workshop.

6. **What were possible emotions behind what happened**: What do you think triggered or angered the other person(s)? What could have been the emotions behind her/his actions? What was triggered in you, and what were emotions behind your own reactions? Any relation to feeling vulnerable?
7. **Values**: Were any values possibly triggered, in any of the people involved? Which ones?
8. **Intentions**: What do you think was the intention of the person who showed anger (or other strong emotion)? What were your own intentions behind what you said and did? Were any of these intentions conscious?

**Further reflections to learn more about your own role in and contributions to conflicts:**

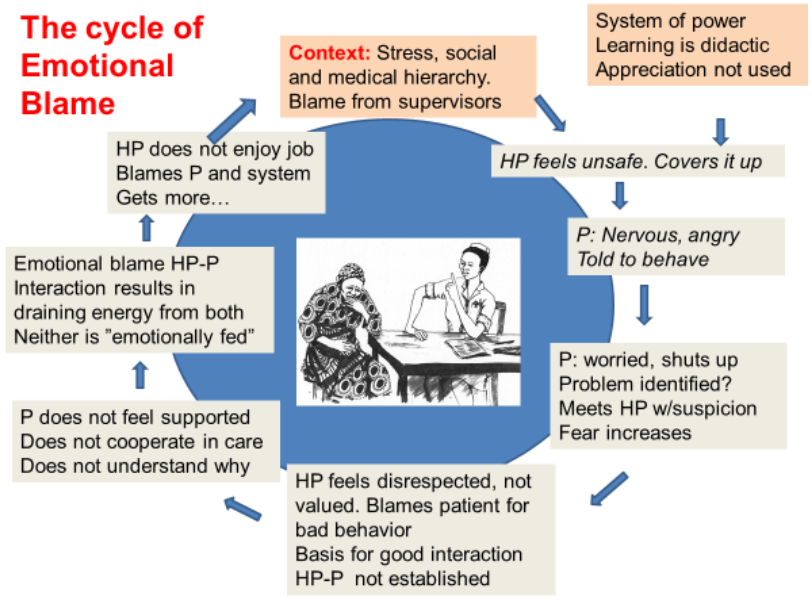
- **Your mistake:** Think about the last time you made a mistake at work. What happened?
- **Colleagues' response:** How did colleagues (from all professions) around you respond to your mistake? Were you challenged? By whom? How?
- **Your emotions**: How did you feel when you made the mistake? How did you feel when you were challenged? Any relation to feeling vulnerable?
- **Your response:** What did you do? Did you "defend" yourself? Explain why you did what you did? Blame others/blame resources/blame the situation? Acknowledge your mistake, take responsibility? Take action (what action)? Apologize?
- **Instincts and intentions:** What instincts/values were triggered? Were your intentions conscious?

NB: This is a reflection ON Action. For this theme, it can be wise to start with reflecting on the (recent) past. You can then take these questions with you and observe IN Action what happens next time you are in a confrontation, or conflict – and observe what you actually do and say, and what are the emotions behind. This is when you really learn!

**Any questions or comments? (names and addresses)**

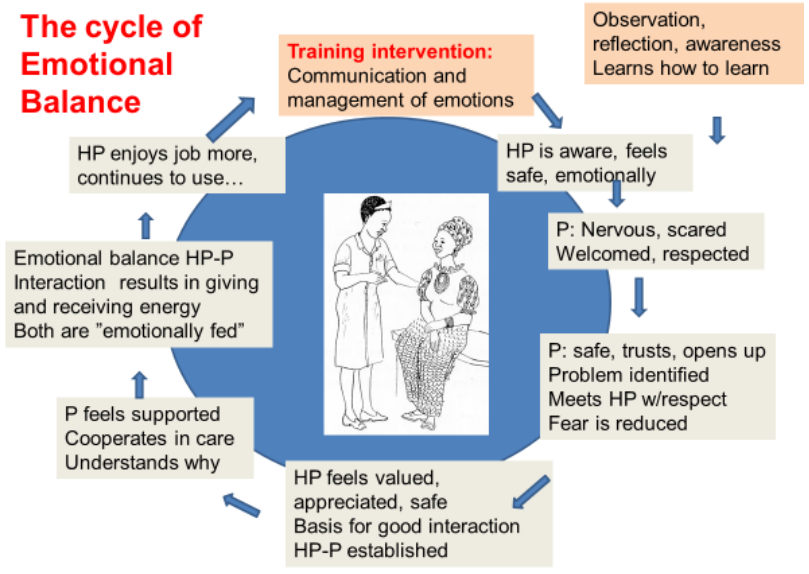
## 4.7 Examples of Most Significant Change stories, and insights

Below is a visual summary of how the self-observation and reflection tasks can function, when professionals become aware of how they communicate, what is the effect of their communication, and then take responsibility to communicate in a different way.
The first part – "The cycle of emotional blame" – shows the common situation before the course, when health providers were often unaware, and tended to blame others for (communication) problems.
The second part – "The cycle of emotional balance" – shows a common effect of the process, when providers have become aware and are practicing emotional competence.
The example shows the insight a nurse had when managing a situation in the hospital – with awareness. Her conclusion sould have been the title of this course!




***Example from a Kilifi nurse***

*"I met a couple who had been referred from maternity ward for admission due to their child (a neonate of 1/7 days) who had developed neonatal jaundice. After the examination and investigation it was suggested that the child needed admission and that the child would benefit from phototherapy.*
*This is when the problem started. Both parents refused admission and said that their fellow neighbours' child was like that and was only given treated as an outpatient and was well after 2-3 days, so they didn't see the reason as to why their child had to be admitted. After a long argument and misunderstanding even the clinician had offered a discharge against medical ground. So the parents were about to sign it.*




*But I called the parents into a separate room whereby I did a thorough counselling and decided to communicate to them and explain each and everything that was to be done and all the implications. I listened to them and found out all the worries and the reasons as to why they were refusing admission. So I learnt that misunderstanding and ignorance of the whole issue so the parents understood and they were willing to be admitted and receive any care that will be of benefit to their child.*
*I came to learn that if procedures and activities pertaining to the patient if they were not clearly explained to or communicated well to the parents, misunderstanding may arise.*

*Clinicians and staff should ensure that thorough detailed information is delivered to clients so as to prevent misconceptions of the activities. No matter the workload. LISTEN!*
***NB/ even a fool has something to say, so you better listen.***

In the above example, the provider is realising what is going on, and is stopping the clinician from blaming the parents for their ignorance, and letting them sign their child out, against medical advice. She decides to provide a safe space to talk, and treats them with respect and understanding – explaining the procedures, and listening to their worries. She understands their concerns, and is able to explain in a way that makes sense to the parent. The child is admitted, and the emotional balance is restored.

***Another example illustrates the satisfaction health professionals can experience when they act with awareness and meet patients needs:***

***Recognising emotions, stepping back, and listening with patience***

*"A client came to me from the queue carrying a baby. I'd been called to work on Saturday because of visitors and I was not happy with the idea of working. She requested me to allow her to see the clinician first because she was feeling unwell. I almost asked her why she thought she was special and what the others were here for (as was my old habit). But because I now communicate better, I became aware of that past bad behaviour and the effect on the other person and how it would make her feel. I thought "let me listen to why she felt it was good to talk to me". I put the annoyed emotion aside, listened to her as she gave a sad story and on examination the baby was wasted with bad diarrhoea, her child so dehydrated from diarrhoea also they just couldn't wait! I took her straight to the clinician who fixed a line and started her on fluids before admission. She really thanked me for saving her daughter's life. Then I thought to myself and said to myself: "(name), good. If I hadn't listened to her and just put her off the old way she would have really suffered". In fact I apologized in my heart for the others I handled in the old style. I was overwhelmed with joy, joy that I could listen to a client amidst my annoyed mood.*
*Strangely this joy energized me and I found myself just getting in a warm mood and joined my colleagues to welcome the visitors."* *Participant, Kilfi*

**What we are aiming for** in the training is to develop or strengthen awareness, insights and skills to turn the cycle of emotional blame to a positive and constructive one – the cycle of Emotional Balance. The provider is practicing emotional intelligence, as shown in the example.

This corresponds to the "Win-Win"-strategy described in the conflict modules (3e, and 2b), where you give, and receive understanding – and practice a collaborative approach.

# 5 How to analyse observation and reflection tasks and prepare for workshop

## 5.1 Why and how is this analysis important?

The reading and analysis of baselines and observation tasks is an important and inspiring task for the trainers.

**Trainers read participants' feedback with the following purposes in mind:**

- **Analyse and understand** participants' own self-assessment of communication habits at baseline, and make presentations to give feedback (modules 2b and 3a);
- **Analyse and understand** what participants have learnt during the observation and reflection period, and find good examples to feed into modules;
- **Appreciate the hard work** the participants have done, and acknowledge their learning;
- **Recognize how the reading affects them as trainers** (*e.g. they may feel empathy with participants, they are touched by some of the stories, they recognize the learning from when they were doing the same tasks themselves, they are looking forward to learning more from the group, etc*). Trainers use these reflections to establish relationship with the participants in the workshop: they share their thoughts with the group, which also communicates to the group that the trainers have read their work;
- **Discover the direct/expressed learning needs** the participants identify and **detect the unexpressed needs** – those that the providers are not aware they are having. Discuss these in the trainer group, and agree on how to approach them;

- **Pick out good examples of challenges, insights and learning**, for use in the different modules;
- **Pick out stories or examples of typical problems**/situations and turn them into role-plays or demonstrations.

***Below are guidelines and examples of how to carry out this analysis and how to make a summary of trends in the responses.*** The materials from this analysis will be included into several of the module presentations – see each presentation for details.

## 5.2 Guidelines and examples: How to analyse baselines and observation tasks, and make a summary of trends

You can use analysis of baselines for evaluation purpose (*compare baseline results with endline results, to identify changes*), and as material to include in the presentations.

**How to organize the baselines feedback**: Collate the answers into two documents: One containing all the individual documents, participant by participant, and one where the responses to the 15 questions are collated, question by question.

**It is useful to collate and analyse answers for each theme separately**. Divide and collect the questions into four themes, which correspond to the key training themes:

1. **Theme A** – Using communication skills (Questions 1, 2, 13, 14, and 15)
2. **Theme B** - Giving and receiving information and advice, and effects of this (Q 3)
3. **Theme C** – Emotions, influence of emotions on actions, and communicating with and without respect (Q 4-11)
4. **Theme D** – Research and obtaining consent for procedures (Q 12)

All trainers read the baseline feedback to get a perspective of the group's initial perspectives and needs. Distribute the themes to the trainers based on which module or module parts each trainer will present in the workshop. Each trainer will read through their allocated theme and make a summary of the trends – the **challenges**, the **questions**, and the **issues some (or many) participants handle well**. They then pick out good examples for their module(s).

This practice is related to analysing results from qualitative research. Thus, if you have a qualitative researcher in or accessible to your team, he/she would be able to guide you in this analysis process (with baselines and observation tasks).

### *5.2.1 Thinking about how to analyse: Some guidelines*

**Before reading through the answers, ask yourself: What am I, as an analyser, looking for?**

- **Trends** in the answers: What is common – e.g. challenges? Things many participants do well?
- **Insights** participants have had – AHA-experiences, when they have discovered something?
- **Examples** of what they struggle with, and what they have learnt;
- **Examples of situations,** which can be used to develop demonstrations and role-plays.

**You, the analyser, must have the contents and an understanding of the modules clearly in mind when reading - particularly:**

- **Module 1** – the introduction, where the concepts that are central to the course, are described. The analyser must look for examples of use of these concepts in participants'

answers – e.g. what have they become aware of? What have they reflected on? Any insights? Any examples of using respect, or meeting people with lack of respect, and learning from it? *It is useful to have a list of the concepts you are looking for, beside you, when reading.*

- **Module 2c** - Building the gold standard communication strategy in patient care: Basic Communication theory, skills and practice. This is the first of the core modules, and much of what participants have observed is found in this module: Listening, asking questions, giving feedback, etc. *Again, a list of the main skills and ideas you are looking for is useful as a checklist when reading.*
- **Module 3b** - Communicating with awareness to develop emotional intelligence: Effects of safety, anger and insecurity on how we communicate. This is the second and last of the core modules, where central ideas on emotions are introduced, e.g. on insecurity and anger. Reading through the module and *making a checklist of what you are looking for is useful also here.*
- **Modules 2b and 3a** – feedback on communication, and on emotions – these are the modules where the summaries of the analysis will be placed, with examples.

As you read, you will be able to pick out examples to illustrate the concepts and the ideas in the modules. See below for examples of how to make brief notes of what the answers illustrate.
It is usually necessary to read the answers at least two or three times to get a good feeling for what the feedback is illustrating. This work is very much worth investing in – as it gives you as a trainer a good understanding of what the participants are struggling with, and what they do well. When teaching in the course, you will be able to draw examples and insights from their work, and they will sense that you have read and understood what their concerns are (as well as what they have learnt) – and this is very motivating to them. They will recognise their own examples, and know that this course is ***for them***, and addresses ***their*** work and reality. This work is an important part of what makes the iCARE-Haaland model very special – it is directly related to participants' work reality.

For most trainers, it is a very good experience to read participants' work, especially when reading their insights and the pride they show in their discoveries and learning – and pick some of these out to share with the group. It is interesting to look for scenarios and opportunities for making demonstrations and role-plays, and develop these into local learning tools.

### *5.2.2 Example: Questions from baseline Theme A – analysed for main trends*

Below we are sharing with you examples of two questions (with sub-questions) from the baseline given by a group of participants to one of the courses in Kilifi. Trainers have analysed the questions to get a sense of what the participants are struggling with, and to find the common trends in the answers. During this process, the trainers make brief comments to define the theme/main point in each answer, as a first step. The trainers will then go back and read again, e.g. all the answers related to listening, and then to other themes. The notes in red are the trainers' notes.
At the end of the questions there is a summary of the key themes emerging from the participants' answers to all the questions, with examples.

*NB: We have left the quotes as participants wrote them, without editing. Most participants will have English as a second or third language, and we have chosen to let their words speak for themselves.*

**Theme A** – Using communication skills (Q 1, 2 (not showing qs 13, 14, and 15)

1. a**) What are you good at when communicating? Please give an example and describe a situation when you were communicating well with a patient or parent.**

- I'm good at ensuring that my client gets the information and understands it. I also ensure that privacy is maintained- giving information

- Speaking: at a time i had to advice and counsel an HIV positive client who had denied his status. The client could not believe it. But after a long talk and sharing with him he finally accepted his status and commenced on HAAT. – giving advice
- Active listening. Eg. During sample collection in the lab, I explained the procedure to the patient before taking the sample. -listening
- Giving clear instructions i.e. explaining clearly what it is that I want done. While giving task allocations I make sure that everyone understands what is required of them.-explaining information clearly
- When communicating, i am good at respecting other eg. When I want to do a procedure to a patient i normally address him or her as mama or babangu, I want to give you some medication or dress your wound.- showing respect
- Elaborating a problem – day to day. In a counselling session – a HIV patient who was burdened wanted to understand crisis he was going through. The calm empathy of how i handled it made the patient relaxed.-showing empathy
- Am good at giving information to parents on their child's condition when admitted and what is being done to their child. We admitted a mother with twins I was able to talk to her well on what was going on and when her second twin was deteriorating I could explain to her what was happening. – giving information
- There was a male patient aged 60 yrs with hydrocele admitted in male ward the third time for theatre. Every time he was prepared for theatre – starved – but missed theatre the last minutes because he times and takes tea when the servant serves teas at 10 am reason he was fearing death i.e. he may go to theatre and not wake up. Allaying the patient's fears
- Using the right language that the person understands either Kiswahili or English. If client does not know either Kiswahili, I use an interpreter. Using a language that the patient can understand
- I am good at listening to a person before responding. Severally I listen carefully to patient or guardians e.g. in ward 1 PCM bay concerning feeding patterns of their children and I got to know that financial constraints leads to most children being underfed or fed with unhealthy diet.- listening
- I always try my best to empathise with the parent or patient by trying to put myself in their shoes believing that through this I will understand their worries& feelings. –showing empathy
- Am good at greeting the patient and asking open ended questions. Greeting and asking questions
- I am good at communicating because I use low tone and I talk politely – I am polite
- I am good at explaining to patient and guardians about aspects about their management and procedures that I am going to perform to them or their children. For example, I explained using simple language to a mother who was hesitant to have his 1 month old baby to have a lumbar puncture. I explained how I was going to do it without hiding any detail and why it is important to do it. I explained the risks of not doing the procedure and the discomfort of the procedure as well. I also allowed the mother to ask questions in between the conversation and at the end. Explaining procedures clearly to patients
- Giving psychosocial support and adherence counselling to pts. Giving psychosocial support
- Listening. During the first visit of my clients i listen very well so that i can get the right information to arrive at diagnosis - listening
- When communicating on the patient's progress when a relative asks me how the patient is doing I explain to them well accordingly. – explaining well
- Listening and asking questions. I was at a clinic (MCH / FP) when a client came and said she just wanted to be injected Depo she was in a harry the boda was waiting for her, husband

came sending out notice I told her about examination then cooled, after counselling we came to agree on the method of her choice depo / condoms - listening

- Am a good listener. I practise active listening and probing. There came a patient who had had a problem for a long time but since she had no time or rather nobody to listen to her she had come for more than three times with same complains. When I looked back in her book she had be diagnosed of same things all this time but after probing, listening and examination I found out her problem and now she is doing well of hypertensive treatment which had not been diagnosed. listening
- Explaining and listening. Had to explain to a patient why she had to be taken for surgery after she had declined earlier –listening and explaining
- I am good in listening when am not in a hurry. When a client came and she wanted to start a F.P method and was the first client in the morning, I had time with her and discussed on all methods.- listening
- Am clear when communicating and also clarity occasionally in maintaining confidentiality. When counselling a pregnant mother newly diagnosed HIV AIDS was able to counsel her and later brought the husband who is a discordant counselled both of them now living happy. – giving clear information and maintain confidentiality
- I am good in introduction and asking questions where I don't understand, confusing language –asking questions
- Communicating am now an active listener. I am able to ask some open ended question in between to probe for more information like for a mother who brought a child with malnutrition I was able to probe and get that she was a very big family of 12 people sole provider being a widow without any help. - listening
- When communicating am good at listening, there was a patient whom colleagues termed her as very uncooperative and does not answer questions when asked. But when I sat and talking with her and listened what was bothering her, she opened up and gave information - listening
- On admission when a patient lands in the ward. Most patients feel so stressed on admission and I am good at welcoming them and orientating them with the ward environment.- good at welcoming patients at admission

***b) What was the effect of your communication on the patient/parent?***

- Patient understood the information I was giving and it led to patient opening more and got good information. Patient understood and opened up
- The effect was good. The client gained confidence, opened up and agreed to commence on treatment/therapy. Patient gained confidence, opened up and adhered to treatment
- Active listening. Eg. During sample collection in the lab, i explained the procedure to the patient before taking the sample.
- It was easy to obtain the sample despite the fear of the patient on the procedure. patient cooperated
- Patients cooperate more/better which enhances the purpose to medications. - patient cooperated
- They feel that they are recognised. -patient feel recognized
- He took "light" the situation; the stigma he was attaching to the status was alleged. - patient accepted his situation
- The mother appreciated. She came and told me that I was open to her as to what was happening to her child 2nd twin until she succumbed. – patient appreciated

- During the fourth visit I spent time with him explained to him why he was admitted i.e. for operation, and benefits of the operation and the importance of having positive thinking, that he was not the first patient to undergo the same operation but many have gone through and are still alive so to have faith that all would be well. After that conversation he was taken for theatre starved, did not eat anything and was taken to theatre and the operation was successful. - patient cooperated
- Easy understanding of what am saying then they give me their opinion. understand information
- She got the knowledge on balanced diet but she had doubts on compliance because she said she was a single mother and with other siblings. - understand information
- The patient opened up to me and I was able to know the social life and how it contributed to everything and counselled her accordingly. -opened up
- The other party feels comfortable and explains more about their problems. - opened up
- This makes a very good relationship with patient we are able to establish report. establish rapport with patient
- The mother eventually accepted that her son have the lumbar puncture. cooperated
- Appreciation. The pt says they are feeling better. Appreciate
- The client adheres to therapy and keeps all her child's appointment in therapy. adherence to treatment
- The effect is they take things in a positive manner and appreciate it. appreciate
- She had to take combined methods since the husband wouldn't stay Listening and asking questions. I was at a clinic (MCH/FP) when a client came and said she just wanted to be injected Depo. She was in a hurry the boda (*motorcycle taxi*) was waiting for he, husband came sending out notice. I told her about examination then cooled, after counselling we came to agree on the method of her choice depo/condoms.
- She was grateful and reminds me every time that I helped her discover herself. patient appreciated
- After the patient came to know (after examination) that the headache and palpation was due to the high blood pressure, she is taking medication well and she is able to take advice and take care of herself. – takes advice
- She agreed after I took time to explain why it was necessary and after listening to her fears. - cooperated
- Was able to have an informed choice on F. P method – patient made informed choice
- They understood HIV/AIDS and preventive interventions during pregnancy / labour delivery & breastfeeding. Was able to bring the husband in supporting the wife. understood her condition
- Normally they listen and accept it and fail to follow the instruction except when being monitored. - do they understand?
- I was able to get a lot of information from the parent as I could not do it before since I was using straight answer question thus could know where to refer her for help and also advise accordingly. – patient opened up
- My effect was that, she was able to open up and gave much information which was required. – open up
- Patients adopt with the hospital and ward environment very fast which also facilitates their quick recovery. – patient feels comfortable in the ward environment

**2a) Which communication skill(s) are you not so good at with patients/parents?**

- Sometimes I fail to maintain eye contact – not able to maintain eye contact
- Sometimes listening becomes too difficult for me because of being overwhelmed by work. –listening when overwhelmed
- At times am overcome by tempers especially when there is heavy work for me. handling my tempers
- Listening. At times I find myself interrupting while they are talking to me. listening
- When I am stressed I am not good at listening to patients complains tentatively. listening when overwhelmed
- Though I do not find it a problem to me; ???
- Am not good at listening. -listening
- Reflecting. reflecting
- Translating medical terms into Swahili for clients to understand. Translating medical terms
- Response to anger. handling anger
- Calm, repetition to drive in a message. patience
- Am not a good listener thus cannot paraphrase in many areas. listening
- (Attending) that is ability to listen attentively to patients' complaints or messages. listening
- I am not so good at using gestures and other non verbal techniques. non verbal techniques
- Probing. probing
- Dealing with emotions. handling emotions
- When dealing with angry/stubborn relative or patient. handling patient emotions
- Non verbal. non verbal
- Stepping back. stepping back
- Observing. non verbal
- Listening actively when am tired or when in a hurry. Listening when overwhelmed
- Listening is a challenge especially when the client has a long story and a there is a queue waiting for me to attend to them. Good example - Listening to long story
- With criminal investigation officers, politician and well oriented men / women. handling affluent patients
- At times am not good at reflecting on the information I get from patient or when I get angered or a problem arises. handling emotions
- Explaining to patients about their problems. explaining to patients
- When doing providing initiated testing and counselling and the patient's result turn out to be HIV +ve, I really find difficult in disclosing their status. Good example - disclosing HIV +v results after testing

**b) Give an example from your experience of what happened with a patient/parent because of this.**

- I lost touch/ track with the patient.
- Making a quick decision which may lead to misunderstanding the patient.
- I noticed very fast and calmed myself down and served my patient well.
- At one time I was dealing with a mentally unstable patient who had refused to take medications, because of my constant interruption, the situation became worse, he stopped talking to me. Example – listening
- I was stressed with work. Given that I had reported all alone on duty. A caretaker called me to go and check for the IVF which had stopped running, I told her to talk to

her patient to properly position the hand and the fluid will run. This is a patient who was NPO. I didn't go to check (good example on listening on the fluid and by the time I was handing over the next staff who had reported for the next shift the fluid had not run even a quarter of a bottle. The line had only blocked and only needed flashing. good example on emotions

- Though it didn't lead to a serious situation but the frequent "come again" or "drawing close" to listen clearly or remarks "I did not hear you" are constant reminder perhaps I can change or work on it.
- The parents could not ask me questions because they felt I did not give them an ear. good example on listening
- A patient with # femur (mid shaft) with open wound (awareness who had stayed for 2 months in the ward became knows it all – after discharged still remained in the ward for 1 month more. I prepared him to the social worker and administrator. Patient went on saying and spreading rumours that sister chased him out of the ward and in fact sister ordered the server not to serve him with food which was not true. I felt very bad. I didn't want to talk to the patient at all. But I had to forgive and after being given a go ahead by the social worker I had to write a waiver form for him to be released to go home.
- They kept asking the same question on and on and couldn't get my explanation.
- No Response
- There's a day I had concluded that a patient had parent. awareness
- The patients' relatives wanted to explain to me that they want to take her against medical advice. As I was exhausted, I brushed her off and later she complained that I was rude to her.
- I once tried to explain to a mother about the severity of the condition of her child of which the child was very sick and was going to die anytime. My language I believe was clear that the as a medical practitioner we had done our best and there was nothing more we could offer to the child. My tone was grave when I was explaining to her that the child was most likely going to die but for some reason the dad did not believe me and I presumed it was because I did not have a lot of facial and gestures expressions to accompany my words. non-verbal communication
- A patient lies about her status when she is in fact on treatment. Anger then prevails. patient lying – response to this
- A mother came with a child who had severe cerebral palsy and failure to thrive floppy++ and was wondering if her child would gain back all the delayed milestones and started crying in the office. showing emotions
- The relative of a particular patient insisted that I should not give the medication (IV) to the patient who was crying because of pain so the patient had to suffer coz I listened to the relative.
- You arrange a place without telling your friends why you are doing so. Somebody else changed the arrangement this shows there is no communication in between.
- There was a very sick patient (post delivery); a mother had paralysis of lower limbs 2 months post delivery. I talked to the patient, explained the importance of her being referred to the main hospital for treatment and proper care but she refused. I talked to her husband about the same but she would not listen due to the fear I had left her to make her own decision. effect of emotions/fear
- Failed to re-check the blood pressure of a patient after it had already been taken by a colleague. According to her readings the blood pressure was okay and 20min later the patient started to fit.

- No Response.
- Missed to identify a child who was positive who was once waiting for her mother outside the room.
- Patients came from politician and were blasted but because of my mute, I could not confront her and I couldn't assist on the conflict. HP evading conflict
- At one time a mother didn't follow an instruction I had given and instead of reflecting why it happened I became very angry on her instead of probing why it had happened to know where the problem is. reflecting/emotions
- Once met a patient who become very angry with me because I couldn't explain what he was suffering from. The only problem is that some terms are best explained in English than in Swahili
- The patient herself thought I was lying and blamed me for not doing my work well. She saw me as the source of her problems/condition.

***c) Comment on what you think is the cause of the main communication problems, and what knowledge and skills you would need to deal better with the challenge(s)***

- Main cause is lack of exposure to practical application of communication skills. Knowledge and skills needed are on practical application of communication skills.
- Problem: too much work, shortage of staffs, high tempers, misunderstanding between each other. Need for communication skills on how to listen and how to apply it. good example - comm skills/work load/not able to handle emotions
- Too much work and with skills on how to overcome mu emotions, will be able to deal with the challenges. Work load/ skills to handle emotions
- (Mutual) learn how to develop trust, be more patient, respect other persons point of view, be able to reconsider my views. lack of trust, respect, patience and understanding
- Main cause of communicating problems is poor listening skills and ignorance. Self control and listening skills.
- Language barriers. Work load, burn outs. – language barrier, work load, burn out Lack of training on the communication skills – to understand exactly what is required on the same – lack of communication skills
- Training, exposure.
- Time. I think I waste a lot of time listening and at times they keep asking the same questions. I need to learn to be a good listener and how to manage my emotions. good example - Learn to listen well and manage my emotions
- Reflecting skills – reflecting skills
- Controlling of emotions e.g. when you are angered by a patient or when you have conflicts with colleges or relatives or patients. – controlling emotions
- Language barrier which even the interpreter missed especially medical terms. Knowing some vernacular terms for local communities so that I place them where necessary in our dialogue. language barrier/ learning patient vernacular
- Time is a big challenge. E.g. In our ward settings you may find you are all alone in a shift and you are expected to attend to patients needs, answer queries from parents or guardians, doctors and even fellow colleagues. Being too busy can lead to one getting irritated and ending up not communicating effectively. Time /work load – skills to handle emotions
- I think the cause of the main communication problems is mostly attitude. We tend to think that we are above our patients simply because we are attending to them. Undertaking the communication course might help to realize the importance of

those who we interact with even when they are our patients. Good example - our attitude we take our patients to be below us – need communication skills

- Seeing so many patients per day. So I don't get time to listen to all of them actively. Skills I need are those of active listening, paraphrasing and giving feedback.- work load; no time to listen – need communication skills
- The main problem of communication was poor listening especially when am in pressure of work. Hence I need to learn how to listen attentively despite pressure of work.- poor listening due to work pressure/ I need to learn how to listen attentively despite pressure of work
- I think the cause of the main communication problems is refusal to listen, a 'know it all attitude' and generally lack of respect and wrong attitude during communication. I believe if I adopt the right attitude for communications and develop skills in listening without making assumptions and predetermined judgements without information I will be able to deal better with the challenges of communication. Lack of communication skills/own attitude – taking responsibility for her problem
- Anger. How to control anger when a patient openly refuses to tell the truth for fear that she will be penalised – own anger/ need how to handle anger
- Time, language barriers i.e. medical terms may not have simple words for one to understand – lack of time/language barrier
- The main communication problem is annoyance whereby I never portrayed empathy. I need good communication skills to deal with such challenges. Handling own anger/need good comm skills
- Communication barrier due to grudge, personalizing. – undealt emotions ( own)
- Own fears of the possible outcome. – fear of outcome
- Lack of knowledge
- Lack of communication, assumptions and some knowledge gaps on communications skills. –lack of communication skills
- No Response
- Workload, irresponsibility by other colleague they make me annoyed hence affecting my communication. Irritability due to a lot of responsibility. – workload/irresponsible colleague
- Hatred being the main cause of communication problem and luck of knowledge – hatred/lack of communication skills
- I think the problem is due to a little experience on the skills what I need is to practice more on the skills learnt. Lack of communication skills
- The only problem is translating some medical terms in Kiswahili, needs knowledge and skills in explaining medical terms in Kiswahili. Explaining medical terms
- Pre-test counselling was not done well or was not up to standard according to me. I need better knowledge and skills on communication so that I may interact with my client well, especially when it comes to passing the right information. – lack of communication skills

NOTE: After collating and doing the first analysis, read again, and make a summary of what you found. This summary will be a basis for entering examples and figures into various modules: See below for the summary, and see examples we have used in the modules.

### *5.2.3 Making a summary of theme A analysis*

**Theme A** – Using communication skills (Q 1, 2 (not showing 13, 14, and 15)

1. a**) What are you good at when communicating? Please give an example and describe a situation when you were communicating well with a patient or parent.**

   **Listening - 7**
   **Giving advice/information - 7**

   **Others**
   **Welcoming Patient -2, empathy-2, Allay anxiety -2, showing respect -1, Polite -1**

**Examples**

- *"When communicating I am good at listening, there was a patient whom colleagues termed her as very uncooperative and does not answer questions when asked. But when I sat and talking with her and listened what was bothering her, she opened up and gave information"*

- *"I am a good listener. I practise active listening and probing. There came a patient who had had a problem for a long time but since she had no time or rather nobody to listen to her she had come for more than three times with same complains. When I looked back in her book she had be diagnosed of same things all this time but after probing, listening and examination I found out her problem and now she is doing well of hypertensive treatment which had not been diagnosed."*

***b) What was the effect of your communication on the patient/parent?***

- Understood info- 4
- Open up- 6
- Patient feel valued, appreciated -5
- Patient Cooperate- 5

**Others**

- Patients feel comfortable - 1
- Made informed choice -1
- Accepted his status- 1

**2a) Which communication skill(s) are you not so good at with patients/parents?**

- **Listening – 7**
- **Handling emotions- (tempers/anger delivering bad news) - 8**
- **Nonverbal comm- 3**

**Others: Probing -1, Being calm-1, Handling affluent patients – 1, Explaining-1, Translating medical terms-1**

**b) Give an example from your experience of what happened with a patient/parent because of this.**

*I was stressed with work. Given that I had reported all alone on duty. A caretaker called me to go and check for the IVF which had stopped running, I told her to talk to her patient to properly position the hand and the fluid will run. This is a patient who was NPO. I didn't go to check on the fluid and by the time I was handing over the next staff who had reported for the next shift the fluid had not run even a quarter of a bottle. The line had only blocked and only needed flashing*. good example of emotions

*I feel most of my patients do not have time to explain more on what their problems are because I don't give them time to do so*. awareness

*I once tried to explain to a mother about the severity of the condition of her child of which the child was very sick and was going to die anytime. My language I believe was clear that the as a medical practitioner we had done our best and there was nothing more we could offer to the child. My tone was grave when I was explaining to her that the child was most likely going to die but for some reason the dad did not believe me and I presumed it was because I did not have a lot of facial and gestures expressions to accompany my words.* non-verbal

*Listening is a challenge especially when the client has a long story and a there is a queue waiting for me to attend to them*. Listening to long story

*When doing providing initiated testing and counselling and the patient's result turn out to be HIV +ve, I really find difficult in disclosing their status.* disclosing HIV +v results after testing

*At one time I was dealing with a mentally unstable patient who had refused to take medications, because of my constant interruption, the situation became worse, he stopped talking to me.* listening

*At one time a mother didn't follow an instruction I had given and instead of reflecting why it happened I became very angry on her instead of probing why it had happened to know where the problem is.* Reflecting/emotions

***c) Comment on what you think is the cause of the main communication problems, and what knowledge and skills you would need to deal better with the challenge(s)***

**Reasons – summary:**
**Own limitations**

- **Lack of communication skills (listening) – 12**
- **Lack of skills to handle emotions – 12**
- **Lack of trust/respect for each other – 1**
- **Our attitude towards patients (patients are below us – 1)**
- **Reflecting skills- 1**

**System limitations**
**Lack of time/ Workload leading to stress- 8**
**Patient limitation**
**Language barrier - 4**

*I think the cause of the main communication problems is refusal to listen, a 'know it all attitude' and generally lack of respect and wrong attitude during communication. I believe if I adopt the right attitude for communications and develop skills in listening without making assumptions and predetermined judgements without information, I will be able to deal better with the challenges of communication*. Lack of comm skills/own attitude. Taking responsibility for her problem

*I think the cause of the main communication problems is mostly attitude. We tend to think that we are above our patients simply because we are attending to them. Undertaking the communication course might help to realize the importance of those who we interact with even when they are our patients.* Good example - Our attitude we take our patients to be below us – need communication skills

*Time. I think I waste a lot of time listening and at times they keep asking the same questions. I need to learn to be a good listener and how to manage my emotions*. Good example - Learn to listen well and manage my emotions

*Problem: too much work, shortage of staff, high tempers, misunderstanding between each other. Need for communication skills on how to listen and how to apply it*. Good example - comm skills/work load/not able to handle emotions

*Note: We include the summary of the main trends for the last question as well – without showing the collated answers:*

**15.a) Which improvement in communication with your colleagues would make a difference to you in your daily work?**

- **Improve on Communication skills (listening, constructive feedback) – 16**
- **Attitude change – 4**
- **Self-awareness – 2**
- **Handling emotions well – 1**
- **Appreciate/respect each other - 3**

*Respecting each other's view & appreciating that each person is unique on its own.* – appreciate each other; Good example

*In any communication style I do it with awareness, treat everybody with equal respect, listen politely, ask questions where I don't understand and give constructive feedback*. communication skills

*I think I should be more patient, listen more and avoid being judgemental and giving conclusions before I have given myself time to listen to them*. communication skills. Good example taking responsibility

- *Change of attitude, and also ready to welcome changes in their lives for better results* – attitude change

- *If they can only change negative attitude*. Attitude change

**b) Please comment on what *you* could do to make such an improvement possible.**

- Put into Practice the comm. skills learnt – 10
- Be a role model – 4
- All to learn communication skills- 3
- Respect each other/teamwork, avoid negative criticism – 3
- Change our attitude - 2

**Examples**

- *Continuous practices and being a role model as far as communication is concerned.*
- *Through making changes in the way we communicate and initiate the changes –*
- *LEARN AND APPLY ALL THE SKILLS IN COMMUNICATION!*
- *Be the change I want to see, no going back to where I have come from.*

***NOTE: The same collation and analysis should be done with all the questions from the baseline. The observation and reflection tasks should be read and analysed for main points of learning and change, and then summarized for trends.***

## How we have sorted questions into other themes:

**Theme B** - Giving and receiving information and advice and effects of this (Q 3 )
**Theme C** – Communicating with and without respect/ Emotions and influence of emotions on actions (Q 4-11)
**Theme D** - Questions about research and consenting for procedures (Q 12)

### *5.2.4 Guidelines for analysing observation and reflection tasks*

Reading the examples and most significant change stories from participants is one of the most enjoyable tasks for the trainer: You will most likely be amazed and inspired by what the participants have discovered, and humbled by what they have learnt by using the tasks over time – and what they are willing to share. It is very important to treat their stories and learning with respect and make sure you protect their anonymity: sometimes their stories reveal serious mistakes they have made and learnt from, and other times – great successes that they share, with pride. All these examples need to be treated in a way that hides the participant's identity. Sometimes you need to make small changes in the stories you use as examples, to make sure the participants are not recognised (e.g. change the name or the department or place a person works).

When reading the stories, the same advice as for the baseline is useful: ***Ask yourself – what are you looking for?*** Also here, you look for trends, insights and examples. When you have summarized the findings from the baseline, you can use examples from the observations to illustrate the main points.

#### Some practical advice

Organize each observation pack feedback into one separate document (pack 1, 2, 3).
Trainers should again read through all (at least two or three times), as it is the observation and reflection task feedback that shows what participants have learnt, and what they struggle with: This is essential for the trainers to understand well, to be able to facilitate well and frequently relate to participants' reflections and questions during the work with the modules. Trainers may find examples to use in their modules, from all the packs.

While the analysis of the baseline usually can be placed in the modules described above (modules 1, 2c and 3b, as well as the direct feedback modules, 2b and 3a), the examples and insights from the observation tasks can be used in all the modules for the basic course. It is thus necessary to read through the modules and make a checklist of what you are looking for, for each module.

Give the main responsibility for analysing each pack of observation tasks to one trainer. As with the baseline, the trainer should analyse for trends, and pick out examples for illustration. In the feedback there are also frequently stories or examples that the training team can use to develop demonstrations or role-plays, or to adjust demonstrations already described in the modules - e.g. to make them even more related to the specific group you are training now.

***You will note that the more you use the feedback from the tasks actively in the workshop, the more relevant participants will experience the workshop teaching to be. Whenever possible, choose examples from as many different participants as possible.***

For phase 3 and 4, the same type of procedures can be used to analyse the endlines and the observation and reflection tasks from the "Skills into Action" period.

## 5.3 Preparing for the basic workshop

Careful attention to logistics and detail will help you prepare a workshop environment which makes participants feel safe and cared for and well informed. This will open them up to learning quickly. Issues that help create a good learning environment are:

- ***Identify and communicate dates for workshops*** at the beginning of the training process (during introduction meeting), to enable participants to plan their holidays, and line managers to plan for their release from duty (See invitation letters in appendix);
- ***Book venue, and plan for food, supplies and stationary*** (hungry participants do not learn well, and may turn against you!) Note: Attention to this – and making sure the practical arrangements are functioning well – will also signal to the participants that their institution values and sees this training as important.
- ***The dates for the TOT should also be agreed upon*** at the beginning of the process, when the dates for the workshop are set. This will allow trainers to plan their time well.

### Working in the training team to plan the workshop

The trainers should meet at least a month prior to the workshop to discuss the tasks, share roles and responsibilities and decide who will teach the different modules. The trainers' main work is to read through the feedback, analyse trends in responses, understand the concerns of the participants, and pick out relevant quotes and examples for their specific modules. This takes time, and trainers (assisted by the coordinator) need to negotiate adequate time for this work, with their line managers.

The trainer team should meet regularly (preferably weekly) during this time to assess progress, clear questions and agree on how to amend the contents for the training to reflect participants' situations. The coordinator needs to review each module with the trainers to become familiar with how the trainer has done her work, and also keep track of the process.

The coordinator draws up a program for the TOT and shares with the trainers, to make sure all relevant issues and needs are covered.

### Training of Trainers (TOT)

When trainers are new and used to lecture-based training, it takes time and effort to learn to facilitate, using experiential learning methods that are the core of the iCARE-Haaland model.

We have conducted a one week's TOT session before the basic workshop. Trainers meet and teach their modules like they would do in the main workshop, with other trainers as "participants". They receive feedback on what worked well, and where to improve their teaching. They also rehearse the demonstrations and role-plays. This practice is important for the trainers to build their skills, to strengthen the sense of team responsibility for the success of the training, and to build their confidence in facilitating the module. Please refer to chapter 5 where key skills for trainers are described (setting relevance, establishing connection, keeping the participants active and involved). **An example of a TOT programme can be found in Part C.**

The trainers also work to identify their needs on strengthening facilitation methods and skills, and the coordinator or lead trainer will facilitate several briefer sessions to deepen these skills, during the week. Good collaboration in the training team is essential for the training to be a success.

### *5.3.1 A special concern: Inviting officials to open (and/or close) the workshop*

In many cultures, there is a practice of inviting officials to open workshops and give importance to the topics to be learnt. There are a number of ways to manage these sessions to make them as positive as possible for both the participants and for the officials, who often have a number of commitments and may be late if they are invited to be present at the very start of the training. It is however important to respect traditions – and officials are often thankful for the opportunity to take a bit of a different role and maybe avoid the pre-prepared speeches they have given several times before.

We have chosen an approach to opening the workshop which works well for the participants, and which the officials coming to open our workshops have said they really enjoy and appreciate.
A main purpose with the "alternative" opening ceremony is to invite authorities to understand to some extent what we are doing in the workshop, become involved and inspired by the training approach, and get "food for thought" which may inspire them to pay more attention to health communication and emotional competence in further training. The approach also saves everybody's time and enables us to use the precious morning hours of the first day to get straight into the learning.

**The main "ingredients" of the approach are:**

- ***We contact the official and explain the purpose of the training process and the workshop*** (*which they are usually very positive to*) and give them a one page summary of the main aims. We invite them to open the workshop, OR – to come for the closing, which usually involves lunch. If the higher official come for the closing only, we invite a "lower" official to come in and give her "blessing" to conducting the workshop, on the first day.
- ***If they would like to come for the opening***: We explain that we do not want to waste their time, knowing they are busy. We ask how much time they can afford. They often say – half an hour. We then invite them to come some time during the first morning, at their convenience, and say we will stop the training soon after they arrive. We ask their permission to go on teaching for some minutes, to let them have a "flavour" of what is going on, and make sure to ask participants to share an example or a question during this time. The official is usually very interested, as he often does not take part in or is able to observe such training. We then stop the teaching, welcome and appreciate the official, and let him or her "do the opening" – which frequently results in him relating to what he has just experienced, and making the ceremony more meaningful and relevant for all. We invite the official to stay for tea, or lunch, and encourage her to talk with participants and listen to what they have been learning.
- ***This approach has been very well accepted by the authorities or officials,*** many of whom say in-officially that they are relieved to participate in a less formal way of opening a workshop, and that they enjoy talking with the participants during the break.
- ***This more in-official method has also been well accepted by the participants.*** For them, it is important to know that their leaders approve of the workshop and its aims, and this message can be communicated in a number of less time-consuming ways. When making the intention of this approach clear to the participants (and to the official), it increases their motivation: They know we have a busy programme and a lot to learn during the week and appreciate the intention to concentrate on the professional contents of the workshop.
- ***If the official participates in the closing ceremony,*** he has a chance to hear from the participants what they have learnt, and discuss the importance of this learning, for the institution. This opportunity is usually appreciated by both sides.

We highly recommend you to try out this method. It communicates an important message to the official, and underlines that this training is different. This usually causes curiosity and interest, which is needed when you work to break new ground.