Health communication in clinical care and research: Introducing the iCARE-Haaland model

The Empathetic, Effective and Emotionally Intelligent health professional:

Communicating with awareness and emotional competence

An empowerment approach for training health professionals across diverse cultures –
to strengthen their self-awareness and capacity to take responsibility for respectful
interaction as a basis for trust and care

A manual for managers, decision makers and trainers

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1.1 Foreword

This manual presents the iCARE-Haaland training model. iCARE refers to the main components of the model, i.e. intelligent Communication, Awareness (and Action), Reflection and Emotions. Within Reflection is included Observation – In Action, and On Action. The name was suggested by professor Mike English in Nairobi during a training course for nurses in June 2019 – and really says what the model aims to do: *To give providers a better chance to show how much they care. Thank you, Mike!*

Health professionals who understand and manage their own emotions communicate better with patients and colleagues, and take better care of themselves. When they also recognize and appreciate patients' emotions, they are able to provide care with the necessary empathy to be heard and understood. In addition, health professionals who are emotionally competent in addition to medically competent handle stress better and are less likely to burn out and to get into conflicts.

The manual provides practical advice and training on how to build a safe and trusting relationship between the health care professional and the patient, and how to build and maintain good relationships with colleagues. It gives examples of how powerful these skills are and how important they are for providing quality care, and for communicating and working well in medical teams.

Our experience with developing this model over more than a decade together with more than 350 health care professionals in nine countries (Here: Lithuania, left, and Kenya, right) has shown that communication and emotional competence skills are essential. And – that there is no quick fix.

Change takes time. But, the investment is worth it, and sometimes – all it takes to stimulate motivation to learn more is that one moment of an **"AHA-experience",** when the course participant really feels the change and sees the impact. The many examples of how communicating with empathy changes the relationship between care giver and patient have inspired us to write this manual while we continue carrying out the training.

When presenting results from our training at national and international meetings and conferences, the response has been overall enthusiastic and positive, and participants have been curious: yes, these skills and results are what we need – please give the model to us!

Well, here it is – a manual shaped by the needs and frustrations and questions from health professionals in widely different cultures, describing a training programme they say has changed their practice and their way of relating to and interacting with patients, colleagues, supervisors and themselves. Many say it has also changed the way they relate to their families.

The author, drawn by Jeyaniroshan Jeyapalan, at the University of Oslo

1.2 Abbreviations

ABC	Attitude and Behaviour Change (From E. Rogers: Diffusion of Innovations)
ACP	Aware Communication Provider (or professional)
ARCP	Annual review of competency progression
BMJ	British Medical Journal
CHEP	Community Health Education Programme (NGO in Ndola, Zambia)
CME	Continuing Medical Education
EI or EC	Emotional Intelligence or Emotional Competence
F1, F2	Foundation doctor year 1 and 2 (UK)
FEAST	Study: Fluid Expansion as a Support Therapy
GCP	Good clinical practice – international standards for conducting clinical research.
GP	General Practice (medical doctors)
HIV	Human Immunodeficiency virus
HP/HCP/HW, HCW	Health care provider/professional (physician, nurse, councillor, physiotherapist, orthopedic technician, pharmacist); health worker, health care worker
iCARE	intelligent Communication, Awareness, Action, Reflection (including observation) and Emotions: the core features of the iCARE-Haaland model
KEMRI	Kenya Medical Research Institute
LHL	Norwegian Heart and Lung Patients' Organization
LVCT	Liverpool VCT Care and Treatment (NGO, Nairobi, Kenya)
NHS	National Health Service (UK)
NVC	Non-verbal communication
PCC	Patient-centred Care
PI	Principal Investigator
RCC	Relationship Centred Care
TB	Tuberculosis
WHO	World Health Organization

1.3 Use of gender, professional roles and model name

The decision of which gender to use in the writing must be made on some basis. To use him/her or herself/himself consistently is cumbersome for the reader as well as the writer.

Our target group of course consists of both genders, among policy makers/managers as well as among trainers and researchers. Among participants in the training courses, a majority will often be women. We have therefore decided to use "her" and "him" quite randomly in the text.

Doctors, nurses and other health and research professionals working in clinical care, research and supervision have participated in the courses. We use "health provider" or "health professional" (HP)

or just "provider" to refer to all personnel working in clinical care and/or research. When needed, the research roles are identified. We use "provider" and "participant" interchangeably in the text, assuming it will be clear when we talk about people who have been involved in the course.
In the manual, we use either "the iCARE model" or "the iCARE-Haaland model" to refer to the training model we describe.

1.4 Concepts used in the manual

Concept/idea/skill	Explanation
Action research	Action research can be research initiated to solve an immediate problem, and involves actively participating in a situation, to affect change: The purpose is to solve problems and produce guidelines for effective practices. Action research can also be a a reflective process of progressive problem solving over time.
Antennae	Visual concept of cartoon-face with antennae – used to visualize awareness and the need to pay attention. This is the "mascot" for the course, as it visualizes the most important skills aim for the participant to develop. Drawn by the artist Bosco Kahindi in Kilifi, Kenya.
Appreciation	To value what another person has done or said and express it to the person. Does not mean that one has to agree with what the person says or does.
Attention span	The time period a student/person is usually keeping focus and listening, e.g. during lecturing/presentation of a new topic. Typically, the attention span of an adult is 10-15 minutes. After this, the person's attention is often diverted and the contents presented from the lecturer is often lost.
Authenticity, or being genuine	Being true to yourself – and when you are, you will (usually) also be experienced as being true, and trustworthy, by others. It means you are being real, and not pretending to be something or someone you are not. People who are being genuine can usually engage and connect easily with others, as it feels good, and safe, to relate to a person who is being authentic.
Automatic reaction	An automatic response, usually emotional, to something another person says or does. Usually cannot be controlled (until you learn how). Often leads to misunderstandings, and sometimes to conflict.
Being present	To keep full attention on the person(s) you speak with, or the action you perform; not letting your mind wander onto other things when you are in conversation with another. This skill helps you connect with the other person. Feels good, calm, to the person who is being present and to the person(s) he is interacting with. Very important skill for a trainer/facilitator.
Burnout	A set of symptoms normally occurring from overwork, over time, without the necessary skills or ability to identify or prevent it: Emotional exhaustion, depersonalization/categorization, and lack of job satisfaction. Burnout is a severe problem in the health professions
Communication, with awareness	To communicate while paying attention to what you say and do, to whom – "using antennae". Usually includes being aware of the effect of what you say and do, on the other person. Can enable you have a good quality dialogue, and also to discover miscommunication, take a step back, and create clarity.
Communication, mechanistic	To use the skills of e.g. listening, by following the "rules" of what you should do, but without awareness, and without paying attention to the effect of what you do and say, on the other person.

Communication, relational	Communication in the context of an interaction with another person. This includes recognising the effect of emotions on how you communicate.
Critical thinking	The ability to think in a self-guided, self-disciplined way and try to reason in a fair-minded way (rather than being egocentric). People who have this skill will often try to live rationally and reasonably and use empathy.
Emotional Competence	Emotional competence refers to the essential social skills to recognize, interpret, and respond constructively to emotions in yourself and others. The term is used interchangeably with Emotional Intelligence, and also implies being at ease with other people.
Emotional Intelligence (EI) and Emotional Competence	There are many definitions. We use the following[1]: A set of four central skills: Recognizing emotions (your own, and those of your communication partner(s)); Integrating emotion with cognition; Analysing causes and consequences of the emotion(s); Taking informed action, based on your analysis. Emotional Competence is broadly used as similar to EI.
Emotions and feelings	Emotions precede feelings, are physical, and instinctual *Emotions play out in the theatre of the body.* A feeling is a mental portrayal of what is going on in your body when you have an emotion and is the by-product of your brain perceiving and assigning meaning to the emotion. Feelings are the next thing that happens after having an emotion, involve cognitive input, usually subconscious, and cannot be measured precisely. *Feelings play out in the theatre of the mind.* From www.thebestbrainpossible.com/whats-the-difference-between-feelings-and-emotions/
Emotional labour	The act or skill involved in the caring role, in recognising the emotions of others and managing our own
Empathy	The capacity to understand or feel what another person is experiencing, from the perspective of the other person, i.e. the capacity to "put oneself in the other person's shoes". There is cognitive empathy, and affective empathy.
Empowerment	Here: The active role for participants to take power over their own learning. They decide if, how, when and where to learn, and what to do about the insights they gain from their discoveries. Empowerment has a number of different meanings, depending on roles and context (e.g. patient empowerment).
Experiential learning	Learning where participants' experiences are used as starting points for understanding reasons why things happen as they do, share experiences with others, and learn skills on how to improve. Link learning to theory.
Fun/humour	Humour helps us learn better and remember better. It stimulates the curiosity, which is where learning begins. It stimulates motivation to learn.
Humanistic medicine	Emphasizes the relationship between health provider and patient. The approach includes establishing a collaboration with the patients, based on trust, and showing the patient respect, dignity and empathy.
Hidden curriculum	A collection of values, norms, traditions and beliefs which is transferred (unconsciously) to students or younger professionals from older professionals, many of whom are hardened by years of tough work and limited support. The transfer is commonly unacknowledged, often not spoken about, it "just happens". Often blamed for "killing" young

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[1] Schneider, T & al (2013): Emotional intelligence and resilience. Personality and Individual Differences 55, 909-914

	professionals' motivation to use e.g. modern methods of communication, and for making them hide or "kill" their emotions.
Inner motivation	A motivation emerging from within the person herself, after seeing that what she does, does not work well/not according to her own values. An inner motivation can empower the person to change, for her own reasons.
Intelligent Kindness	Kindness: recognition of being of the same nature as others, being of a kind, in kinship. It implies that people are motivated by that recognition to cooperate, to treat others as members of the family, to be generous and thoughtful. It means that clinical, managerial, leadership and organisational skills and systems can be brought to bear purposively to promote compassionate care. *Intelligent* kindness is a binding, creative and problem-solving force; it inspires and directs the attention of people and organisations towards building relationships with patients, recognising their needs and treating them well[2].
Management of emotions	To be able to recognise emotions (your own, and those of the other person); take a step back from (automatic) reactions, and act with awareness
Self-observation and reflection task	Guided tasks to self-observe and reflect on one communication or emotion skill at a time, systematically, for one week. The aim is to discover the pattern of how you communicate, and the effects of your communication on the other person. This becomes personal evidence for initiating learning, and change
Reflection In Action	Process of reflection that takes place WHILE one is doing it: **"Think when" – and "be present" while you communicate, to be able to take notice of what is happening, while it happens.** This method enables the practitioner to recognise how she communicates, and emotions that she experiences during the situation, as well as recognising the emotions of the other person(s). The natural inclusion of emotions enables the practitioner to develop a habit of including these in the reflections on his work. It also enables her to recognise automatic (emotional) reactions and learn to stop these and take a step back and act with awareness. The method is not yet frequently used (?) in education.
Reflection On Action	Process of reflection that takes place AFTER the event: **"Think back".** If reflecting on emotions, these will be less intense than if reflecting in action, see above, and thus be less likely to have a strong impact, and/or trigger change. This method is the most frequently used in reflective practice.
Reflection, to discover	Reflection used when self-observing own practice over time, when communicating with others. The purpose is to discover own patterns of communication, and the effect(s) of these practices on the other person(s). Used in individual practice.
Reflection, interactive	Reflection in pairs or groups, typically in the workshop, on a theme that has been discovered as a learning need by several participants. (It can also be a theme introduced by the trainers, from trends or challenges the trainers discover when reading the feedback from self-observation and reflections)
Reflection, informed	Individual reflection which takes place after the workshop, when new skills have been learnt. During this phase, participants "know" what they are looking for, and are looking at how their new skills are functioning in practice (but also frequently discovering new learning needs!)

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[2] Campling, P: Reforming the culture of healthcare; The case for Intelligent Kindness

Patient centred care	Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions
People centred care	Umbrella term which specifies that the patient should be considered across all levels of the health system.
Relationship centred care	RCC is an important framework for conceptualizing health care, recognizing that the nature and the quality of relationships are central to health care and the broader health care delivery system. RCC can be defined as care in which all participants appreciate the importance of their relationships with one another.
Relationship, professional	Relationship between a provider and a patient, or between providers as colleagues. Building a relationship of trust and respect is a good basis for finding the best way to relate to a patient and help him, and – to relate to colleagues. Such a relationship is a basis for good communication.
Resilience	Capacity to *withstand/cope well with stress* – involving behaviours, thoughts and actions that *can be learnt by and developed by anyone.* Resilience involves *connectedness* to physical and social environment, to family, and to a sense of inner wisdom. The *road to resilience* lies in acknowledging and working through the emotions and effects of stress and painful events – *not* to avoid them
Step back	When you learn to recognise automatic (emotional) reactions to what other people say and/or do, you become aware that you have a choice: To act on the automatic impulse, or – to stop the impulse and take a (mental) "step back" and not react. Learning to step back is an important aim in the course. The skill enables people to get control over their actions, and act with awareness.
Vulnerability	**In medicine**, vulnerability is commonly seen as "weakness", and is commonly feared and/or ignored. We add the other interpretation of vulnerability (from humanities and psychology) – it is the emotion that makes you human, that enables you to connect and engage with another person. Being aware of one's vulnerability and being able and willing to use it, e.g. to connect and engage with patients in vulnerable situations, requires that the provider has conscious boundaries. Awareness of vulnerability (one's own, and the other person's) is a requirement for practicing empathy.

1.5 Introduction: For whom, why, and how to use the manual

In these introductory sections we describe who the manual is for, what it aims to achieve, how it is organized, and how to use it. We also give an overview of the modules.
A prologue gives a brief history and describes why and how this work has been conducted.

1.5.1 Who is the manual for, and what are the aims?
There are two main groups we aim to reach with this manual:
1. Decision makers and managers in the health system, who want to strengthen patient-centred care, wellbeing of their staff, and collegial collaboration in their institution(s) through in-service training, and
2. Trainers of health care providers

The manual is not written primarily with academics in mind, although many academics have expressed interest in its contents – and many may find it a useful resource to inform themselves, and/or to initiate discussion and training.

The overall aim of this in-service (CME) training is to strengthen the motivation and ability of health providers to communicate well with patients and colleagues, to strengthen patient-centred care and strengthen collaboration in medical teams. Furthermore, it is to improve providers' awareness, and wellbeing. Providers develop motivation to learn through becoming aware of how their communication affects others and learn skills to communicate with awareness and respect for emotions through interactive learning with colleagues in the workshops. This strengthens collaboration in the workplace.

The aim is further that the skills are practiced on a "base" of underlying professional clinical care, and an attitude of respect and an intention to care well. Exactly how, and which skills are needed, depends on the context and on the challenges facing the health professional, in each case. As each situation and each patient is unique, there is no simple solution to communicating well: The provider must have her/his basket of skills as an invisible resource she/he carries in her heart, and in her being – knowing that using these, she/he will be providing the best care she/he can. Building the skills and confidence to assess and meet the needs in each situation is a main aim of the training.

The manual does not aim to give a complete overview of the health communication training field but does include many of the main concerns being addressed in the current debates in Europe, the US and Africa which are relevant for managers, decision makers and trainers.

The aims for decision makers and managers are –
- **To provide convincing evidence** of what can be gained by the health sector or institution by investing in a training model and process that benefits patients as well as providers and their supervisors and leaders;
- **To motivate them to invest** in such training.

To review why such training is needed, see chapter 2.
To see what the training is about, read chapters 1 (overview) and 3.
To see how to organize the training and the management requirements, read chapter 6.

The aims for trainers of health providers (nurses, Clinical Officers, physicians, medical officers, counsellors, treatment supporters, other health providers) are –
- **To motivate them to plan and carry out** this process as a CME training, and
- **To provide them with the tools** to do so.

1.5.2 Organizing the training and selecting trainers
Skilled and motivated trainers are essential for implementing a successful course, and selecting the right trainers for the course is crucial. Trainers need basic knowledge, skills and experience in planning and implementing training courses, using participatory and experiential learning methods.

The trainer has a crucial role as a role-model and facilitator of the learning processes – to demonstrate an open, exploring attitude of non-judgment, to stimulate discovery and learning, and to help rekindle the motivation to care. The trainers need to have a willingness to learn, and be emotionally intelligent – with capacity to use this competence with the participants. Furthermore, trainers should have a degree of self-confidence and be able and willing to learn by doing, and focus on participants' learning. They should be people who have the capacity to "facilitate learning", as opposed to "deliver training". See chapters 6 and 7 for background on training methods and on skills needed for trainers.

The training can be organized in several different ways:
- *A team of trained trainers (e.g from a training institution)* can be hired to use the manual to train providers in different locations. The team members would need to have skills in experiential learning methods, and to have had the opportunity to try out the modules during a Training of Trainers' course, with feedback from experienced trainer(s) – before implementing it for providers.
- *Train trainers internally in the institution*, using an experienced trainer to start the process. The institution could be a hospital, or a training institution, or others.
- *Hire external trainers.* The same requirements as described for the MOH team will be relevant for these trainers.

The advantages of using a team from an institution are that they become a resource for their area which can be used in many institutions, and strengthen the skills of an already existing team. Disadvantages may include that trainers might be "stuck" in previous approaches to training (which may often be didactic/lecture based), and be less open to the (unfamiliar) approach and the methods used in this training. *Managers may also underestimate the time and effort needed to learn how to conduct this training well – to achieve the results needed.*

The main advantages of training a team internally in an institution is that it creates a resource within the institution which will help build a strong environment for a new way of communicating with patients, to achieve patient-centred care. This team can also be used to support other types of training within the institution and ensure sustainability of the new skills and attitudes. The trainers – who are also providers themselves – know the work and the communication challenges from their own experience, and therefore have a high credibility as trainer, mentor and role models. A main disadvantage is that this approach takes time, and that selecting trainers among the providers is a challenge: Managers will often expect the trainers to continue with their regular work – AND do the training duties on top of these. A conscious process and negotiations are needed to choose the providers most suited for becoming trainers, and to prevent trainer overwork and burnout.

The primary advantage of using external trainers is that they are already professionals, e.g. from an institution, a university or an organization. They can be chosen on the basis of their suitability and capacity to lead such a training programme, and should have demonstrated that they have skills in using experiential learning methods, supportive group processes and critical thinking.
A **disadvantage** is that the trainers may not know the local situation well enough, and thus not be able to connect well with the participants' daily work and challenges. Another disadvantage could be the cost – as this training must be carried out over a long period of time. A final disadvantage is that the external trainers' skills do not stay in the institution, and organizing follow-up courses to maintain and strengthen skills learnt is more difficult.

The decision about what kind of team to select is of course also dependent on each local situation, and the opportunities available.

1.5.3 The organization of the training resources for the model
The resources are organized in five main parts.
1. **Part A: The manual** (Ch 1-10) describes why and how the iCARE-Haaland model was developed. It contains the background from the literature showing challenges for health providers to communicate and manage emotions in their work and evidence of what works. The model, its special features, the learning methods, the essential role of the trainers, and the planning process are then described.

2. **Part B: Discovery** describes the planning and preparation (phase 1) for the learning process. This part includes all the individual learning tools of Phase 1.
3. **Part C: The Basic Workshop (Phase 2)** introduces the Training of Trainers (TOT) and includes the 12 modules used in this workshop, as well as pptx presentations.
4. **Part D: Skills into Action** includes planning and preparation for **phase 3**, and the individual learning tools for this phase
5. **Part E: The Follow-up Workshop (phase 4)** includes the last 11 modules, and presentations.

1.5.4 Overview of the modules

1.5.4.1 Basic workshop: 12 modules

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 (from baselines and observations)
   c) Gold standard communication theory, skills and strategies in practice

Module 3: Understanding and managing emotions
   a) Feedback from observing how you manage emotions (from baselines and observations)
   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

1.5.4.2 Follow-up workshop: 11 modules

Deepening understanding and sharpening skills
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

1.5.5 How to use the manual
The bulk of this manual is the modules (about 400 pages), with a detailed "cook-book" advice on how to teach each of the modules to a group of participants*. See parts C and E of this resource collection.*

The trainers can use the manual in the following way:
- To prepare for the training, by reading the modules.
- Trainers should read chapters 4 and 6, to understand the thinking and theories behind the training, and chapter 7 to review and revise their own training strategies;
- Discuss with managers – help them see the need for the training and get their support.
- Invite participants, select them, call them for meeting (see chapter 8, and part B)
- Organize timing for the training
- Carry out the observation and reflection tasks, in the same time period as participants, see part B. (*NB it is essential that trainers also have had experience doing this, as so much of the training is building on participants' discoveries and learning during this period*)
- Organize a training team (minimum two, preferably four trainers)
- Organize and run a training of trainers' course, to let trainers teach all the modules to a small group of participants, and get familiar with the materials

1.5.6 How the modules are organized
Each module includes a background section for the trainer which reviews relevant knowledge the trainer needs to be able to run the module well. The module furthermore contains an overview of the contents, the slides with commentary, and the exercises, demonstrations and role-plays.

In the part containing the slides there are suggestions for points to be raised by the trainer during the session to each of the slides or set of slides. The trainer must of course use her own background and style to make the points and make the training relevant to her participants.

The exercises, demonstrations and role-plays are explained in detail after the slides, providing purpose, procedure and main points to be brought out in discussion from each activity. These can be used as is, and can also be used as "recipes" to develop your own materials.
You find all the modules in parts C and E of this resource collection.

1.5.7 Adapting the contents of the modules: Keep the relevance
Participants will feel the module is relevant to their needs when they recognize the situations, examples and quotes from the modules. It is therefore important that you spend time putting in your own examples, from the baselines and observations carried out by your participants before the workshop**. If you drop this part, chances are very high that the participants will not feel that the training is relevant to their own situation (the examples and situations in the modules will be from somewhere else), and thus they will be much less motivated to learn.**

You are of course encouraged to also adapt the modules in other ways to fit your situation.

Before you do – consider that these modules are built and revised, based on feedback from more than 20 training courses in nine countries, and that they follow a logical way of guiding the

participants to learn the theory and the skills, piece by piece, each building on previous learning. ***The sequence of the topics is important – to build competence and confidence: Participants will feel they master the topics, because they have the foundation knowledge needed to understand the next point***. When you adapt – please keep this in mind.

If you make big changes – we strongly recommend that you try out the revised module with a small group to test the logic and the flow of the learning – before you use it on a bigger group. Also, read chapter 6.1 to understand how the original learning elements build on each other, to be able to plan well how to adjust the learning contents, but as much as possible follow the logical learning sequence.

1.6   Prologue, history and professional commitment

The reflective learning methods at the core of the iCARE-Haaland model have been developed in collaboration with professional colleagues over several decades, using an action research approach. It started at a rooftop in Mombasa in 1993 where Ane Haaland, then working with Tropical Disease Research (TDR) at WHO, Geneva, and Sassy Molyneux, then a PhD student doing research in Kilifi, planned how to train field workers to communicate better with research respondents[3].
The manual has been written over a period of the last five years, based on work with the training model in six countries in Eastern Europe and Africa 2006-9, then in Kilifi, Kenya 2009-present, in the Gambia 2014-2017 and in Cardiff, Wales (UK) 2016-2017.

The consistent work with and support from the Kilifi team of trainers, researchers, managers and staff over a decade has been crucial to the continuous development and implementation of the model. The work with the team in Cardiff, Wales showed that the methods are equally useful to doctors in training in the UK as they are to nurses and doctors of all ages in African and Eastern European countries. ***When medical professionals strengthen their self-awareness when they communicate, they can learn to recognize and manage emotions. With these skills, they can improve the way they treat patients, relate to colleagues, and take care of themselves.***

The development of this training model has been an exciting journey of discovery in collaboration with good colleagues, fuelled by curiosity and by the determination to get to the core of the problems and then deal with them, in collaboration with those who experience these challenges. The model is a product of 45 years' professional work in 30 countries and is the most important work I have engaged in during my long career. ***I have, from the very early days of developing this model, insisted that real learning and change of behaviour takes time and requires reflective practice with supportive feedback.*** We have all agreed about the structure and contents of the learning process as it has emerged and has been refined over the years, using an action research approach. It has been a more challenging process to get agreement that the training needs to be conducted over a period of 6-9 months, with complex themes included, for the training to really make a difference. When given such time and complexity, the training can make a real difference to participants' understanding and practice of communication skills and emotional competence. However, most managers and institutions want a "quick fix". I am happy to see that our findings re complexity and length of the training (*i.e. the training needing to be conducted over several months, and include a broad and relatively complex mix of knowledge, skills and attitudinal challenges*) are now being supported by more and more research findings and by managers in this field – who have seen the results.

My respect for health providers has increased steadily throughout the years of working with the model, as I have experienced providers struggling with making sense of death, cruelty, difficult working conditions, unrealistic or unkind managers, babies who die and patients who have lost hope.

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[3] Communication skills for field workers (…): Ane Haaland and Sassy Molyneux

The respect was further tested as I accompanied my husband through treatment of his aggressive brain cancer from 2012 until he died in 2016, and experienced what made a difference to him and us in vulnerable situations. Many of the doctors and nurses we encountered did not know how to meet his vulnerability and emotional needs, or our needs as a couple, and made the trauma worse. Others made a huge positive difference and made it a bit easier to live with the death sentence hanging over him. Thus, this manual is primarily dedicated to all the health providers, with the hope that the methods we have described will be made available to many and help make their lives a bit easier.

It has been a privilege to carry out this work, and I want to thank everybody who has been involved and made the work possible. *See also the full story of how the iCARE-Haaland model was developed, and what triggered the focus on emotions, in the last chapter.*

1.6.1   Dedication to providers, and leaders: Sincere professional pride
This manual is dedicated to health providers who care, to their trainers and role-models who help them discover how to show it, and to the progressive leaders who saw the potential in this training model and invested in it.

During my years of working to develop this training model I have collaborated closely with medical doctors and nurses in many countries, and with their leaders, and my respect for them and for the incredible job they are doing, has kept increasing. The providers have voiced their strongly felt needs for learning to communicate better, and many have also discovered needs they were not aware of - *like learning to recognize and manage emotions, with awareness*. Working closely with them and facilitating their hard work to become better communicators, despite large challenges within the health system, has left me inspired, hopeful and humbled:

- **Inspired** – as I have seen their motivation to learn, evolving – once the learning and the methods felt relevant and respectful to them;
- **Hopeful**, as I have experienced their engagement in and contributions to building a training model that meets their needs to care well for patients with their clinical skills and their hearts, and to communicate better with colleagues, and wanting colleagues in other places to also get these skills, and
- **Humbled,** by their sincerity and pure joy when they recount stories of how they have used their new skills to relate better to patients and colleagues, solve problems, and enjoy their work – with professional pride.

Five trainers have important influence on and contributions to the work

Mwanamvua Boga and Ane Haaland, in Kilifi

From 2008: Mwanamvua Boga, a nurse manager who participated as a trainee in Zambia, helped take the training to Kenya and has been the main trainer in Kilifi since 2011. She has been a main collaborator in the development of the final version of the 23 training modules, and has contributed important thinking to the course process and to the development of this manual – supported by an experienced research team. Mwana has led the team of 10 trainers in Kilifi, and independently conducted many training courses for providers in Kilifi and in other hospitals and institutions in Kenya.

In March-April 2015, Mwana conducted her first international training course in the Gambia, together with Hiza Dayo, another of the experienced trainers in Kilifi. In 2017, she received the "Heroines of Health" award from the UN as one of 13 emerging women leaders.

Mwana has burnt endless litres of "midnight oil" to dive deeper, question herself and others – including me – with respect, and having joy in working with these skills and see the fruits of the work with participants: She has seen many nurses and doctors emerge to communicate with awareness and to enjoy their work more – and become better colleagues.

Mwana has presented the work in several national and international conferences and workshops. Since 2017 she has also trained researchers and health managers in communication and management of emotions. In 2019, she has also trained leaders and teachers on emotional intelligence.

In 2017, **Dr Thomas Kitchen and Dr Isra Hassan** took the initiative to start a second course for trainee doctors in Cardiff, Wales. They felt the training they participated in during the pilot course in 2016 met an important learning need for doctors. All places on the course were filled in two days, indicating a recognition of need for these skills. Thomas and Isra have presented the work nationally and internationally and continue to work to create awareness about the need for doctors to learn to recognise and manage emotions, and for the need for changes in the health system.

In the early years of working with the model, two trainers were particularly influential.
Dr Rita Sopiene at the TB Hospital in Siauliai, Lithuania, was part of the first course in 2006. She is a paediatrician with a vision who initially saw the potential in the model and contributed important questions and professional inputs to the development of the courses. Rita led the training team of five doctors and nurses in her hospital. The team conducted several independent training courses in Lithuania and Estonia.

2007: Esther Kamenye in Namibia, a nurse manager who saw that this training transformed the way providers treated TB patients and went on to do her PhD on developing guidelines for training of TB nurses in communication skills in her country. She received her PhD in May 2014, and is currently a lecturer at the University of Namibia, teaching community health nursing science.
In the picture, Esther is participating in a role play during the first course in Namibia.

Manuals evolve through cooperation, and several leaders have influenced the early work

This manual is also dedicated to the progressive leaders and researchers who believed in the communication training model and supported me and my colleagues to develop it further. They have understood that quality work takes time – and that the close involvement of and cooperation with the users is the key element. These leaders are:

- **Mette Klouman**, the leader of the international section in the Norwegian NGO (LHL), who in 2006 asked me to work with them on patient empowerment (which we soon turned into health provider communication training) and
- **Dr Vita Globyte**, the director of the TB hospital in Siauliai, Lithuania, who wanted all her staff to learn better communication skills, and used her management skills to ensure that her hospital became the first institution to run this training.

Several other leaders welcomed the training of their staff and contributed to the early development of the model: **Dr Vaira Leimane** in Riga, Latvia, **Dr Nina Nizovskaya** in Arkhangelsk, Russia, **Dr Neema Kapalata** in Temeke, Dar-es-Salaam, Tanzania, **Sister Nelumbo,** the regional TB coordinator in Windhoek, Namibia, and **Alick Nyirenda** of CHEP, Ndola, Zambia. These training courses were all supported by LHL.

The inclusion of research in the programme
In 2009, **Dr Vicki Marsh** in KEMRI-Wellcome Trust Research Programme in Kilifi, Kenya, applied for and received a grant from the Wellcome Trust to implement the training in Kilifi District Hospital, with her as the PI, and in close collaboration with **Dr Sassy Molyneux**. Vicki and Sassy are both social scientists, and Vicki is originally a medical doctor. They saw the potential of the training to contribute to also strengthening health providers' skills on and collaboration with the many medical research projects in Kilifi. Thus, the programme was strengthened by inclusion of research modules, and by the previous focus on TB and HIV being broadened to include other diseases and medical concerns. In the last few years, training researchers directly on communication and management of their emotions has added an exciting new dimension to the work.

Professor Debbie Cohen invited the author in 2015 to come to Cardiff, Wales to implement the model with trainee doctors, based on a presentation of the work in Kenya at a medical conference in Greece. Action research was an important aspect of this work as well – to assess how the model could be adapted to be used with a group of young doctors, with shorter workshops and a different schedule – but using the same principles as for the original training.

Susan Schwartz Senstad, a psychologist and writer, has been an important contributor to developing the model. Susan has reviewed and sharpened the contents on emotional management and educated me in the process. She has also read and commented on manual and modules, especially on the contents related to emotions.

Financing the work: The original work was financed by the Norwegian Heart and Lung Patient Association (LHL) and their partners in Lithuania, Latvia, Russia, Namibia, Zambia and Tanzania. In Kenya the work has been conducted under a grant from the Wellcome Trust. KEMRI-Wellcome Trust has also hosted and funded numerous courses over the last ten years, thus supporting with Mwana's time and involvement, administrative requirements and with links to and relationships with other institutions. In Wales, the work was financed by the Wales Deanery.

A more thorough list of dedications and of people influencing the work of this manual, as well as trainers and participants contributing to build the modules, can be found in chapter 10, together with the full history of how the model was developed.

1.7   Drawings and illustrations

The drawings in the manual are largely the same as those used in the modules. The main drawings are made by June Mehra, Italy and Bosco Kahindi, Kilifi, Kenya. Other drawings are made by Rasma Janeliuniene, Siauliai, Lithuania and Narendra Basnet, Nepal. Drawings on Tuberculosis counselling, and more, are drawn by Mosses Luhanga, Tanzania.
Drawings have also been borrowed from "Helping health workers learn" by David Wener and Bill Bower, and from the Uganda Health Manual.
The photos from training sessions are mainly taken by Ane Haaland and Mwanamvua Boga.

The drawings showing relationships between HP and patients, and more, are made by June Mehra
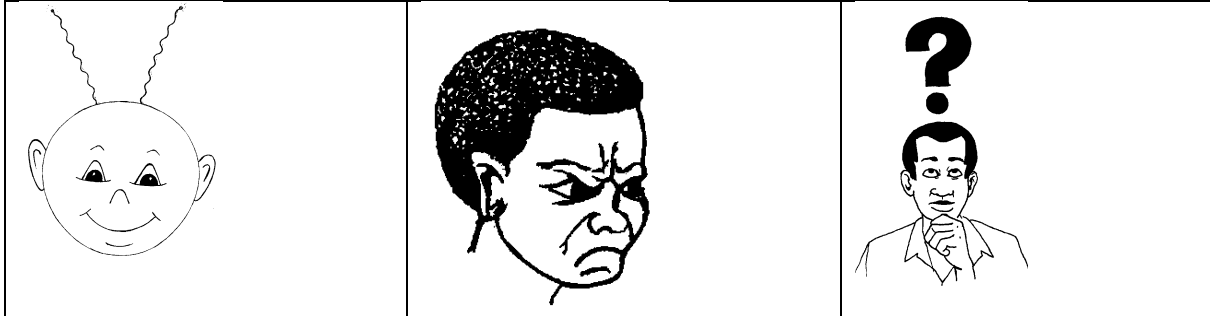
The famous awareness guy, the faces showing emotions and the questioning man – and many more - are drawn by Bosco Kahindi from Kilifi, Kenya
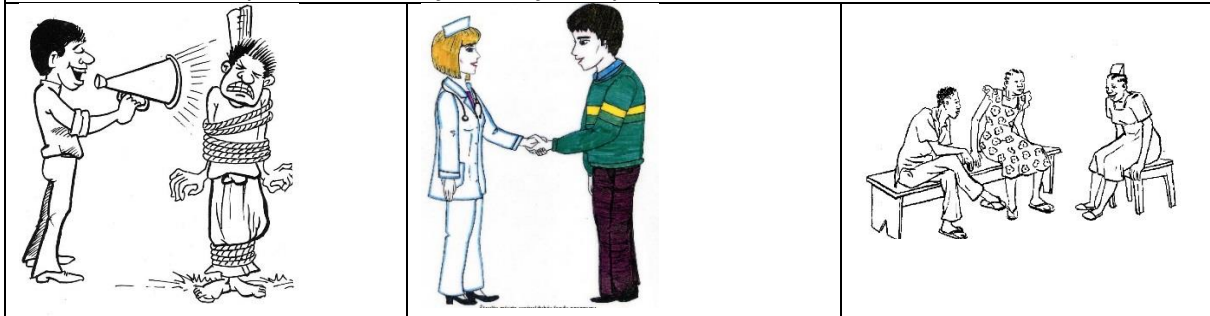
The persuasion trap, and many more, by Narendra Basnet, Nepal	*Relationship between doctor and patient, and many more, by Rasma Janeliuniene, Lithuania*	*Drawings from TB councelling, and more, by Mosses Luhanga, Tanzania.*

Thank you very much to the artists for allowing us to use their drawings in the modules and manual.

2 The iCARE-Haaland training model - Learning needs and characteristics

A Collaborative model on communicating with awareness and emotional competence – built with users over a decade; supported by research evidence

2.1 Defining and responding to providers' learning needs

The iCARE-Haaland communication skills training model refers to intelligent Communication, Awareness (and Action), Reflection (including observation) and Emotions. These are the core features of the Haaland Model, which has been developed as a Continuing Medical Education (CME) model in close collaboration with medical doctors and nurses in nine countries over more than a decade. It responds directly to their expressed needs – *to learn to communicate better with patients and colleagues – and demonstrate that "I CARE".*

Underlying the health professionals' expressed needs is an apparent lack of awareness of how emotions influence communication. Recognition of emotions and conscious management of these – i.e. emotional intelligence - has not been emphasized as a subject in medical education. Yet, it is obvious to most of us that when a person is ill, she is worried and fearful. She has a strong wish to be treated by a provider who can respond to her medical needs as well as be compassionate and have empathy with her, i.e. recognise and respond to her emotional needs. To do this well, the provider needs to be self-aware and be able to manage her own emotions.

We have thus included these skills in our model. It is striking to note that almost all the 350 professionals we have trained so far, reported in their feedback that *learning to recognise and manage emotions were the most important skills they gained in the course*, and – *they did not know they needed these skills*. The response was similar across as diverse cultures as e.g Lithuania, Russia, Namibia, Kenya and Wales (UK). *And the methods worked well across all these cultures.*

The iCARE-Haaland model is rooted in the philosophy of humanistic medicine and patient-centred care. The starting point is the health provider as a professional who wants to care well for patients and communicate well with colleagues. When he does not, there is a good reason. Exploring and understanding these reasons can rekindle the provider's conscious motivation and willingness to provide good care and to communicate well with colleagues – as well as take better care of his own health and wellbeing.

Bridging a gap: There is much research available in fields related to our training. We have chosen to focus on knowledge and skills that have practical relevance to the training, and we have tested these with the professionals who are working with patients in the health sector. Over the years, we have seen that research does support our approach on training methods and contents on developing and using communication skills. We have however not found much research related to training methods that help professionals build self-awareness and skills to recognise, understand and manage emotions, although research on emotional intelligence, emotional competence and emotional labour is emerging, but often does not include practical models on how to train health professionals to gain such skills. *Our model and this manual can hopefully contribute to bridging some of this gap.*

The foundation for the model has been the author's extensive experience of working with communication training and research; dedicated colleagues who have helped to test out what works, and what doesn't, and theories from behavioural, social and educational sciences. On this basis we

have crafted a reflective learning process that has proved useful and inspiring and to impact those who have gone through this training. The link to research has been strengthened, as our early results from action research has later been confirmed by other studies.

Does the training lead to better quality care? We do believe so – although we have not measured this, directly, with quantitative research methods. The self-reported changes in all countries clearly show that participants' own perception is that they now give better quality care, consciously. The trainers have seen and heard, from providers who have been through the training, and from many of their managers – that the trained providers communicate better with patients and colleagues now. They are more aware of emotions than they were earlier, and they show more respect. They listen better and ask more questions, to find out the reasons behind what people say and do – rather than judge and blame them for wrong actions. The providers say themselves that they give better care, because they have tools to understand themselves and their patients better. They communicate better with colleagues and get less often into conflicts. They suffer less from burnout, because they are more aware of the signs of emotional exhaustion and take better care of themselves. Many say they enjoy their work more.

The TB hospital in Siauliai, Lithuania, was the first place the model was developed.

Patients waiting at Kilifi District Hospital, Kenya. The workload is a clear challenge providers face.

Course participants report that learning through this model has helped them improve their relationships to patients, colleagues and themselves, and make them better able and more motivated to communicate with awareness and respect – to provide patient-centred care, across cultures.

The reflective learning methods have proved useful to engage them all to invest in building their own awareness and growth, and to strengthen or rekindle their motivation to care, with compassion.

All of these factors have been shown in research to have impact on how providers care for their patients, and for themselves. Examples throughout the manual will illustrate what our participants have experienced.

In chapter 3 we describe and discuss some of the literature we have used to inform methods and contents of the course. We will try to shed some light on the question of why the iCARE model seems to work so well across so many different cultures – to meet providers' needs for these skills.

2.2 Aims of the training; main skills to achieve the aims

The concerns and needs of the providers across the different cultures where the model has been implemented are surprisingly similar, despite large differences in national cultures and in access to

personnel and to resources. Thus, the overall aims of the training are to improve health professionals' capacity to provide patient-centred care (PCC), communicate well with colleagues, take better care of their own health and wellbeing, and achieve job satisfaction.

In summary, the training aims to build and promote:
- *An attitude of professional pride in communicating well with patients and colleagues, combined with –*
- *A realization that the provider is the one responsible for building and maintaining conscious relationships that can facilitate good patient-centred care and good communication with colleagues:*

Seeing the patient as a positive challenge to be helped (by using good professional medical skills, and constructive communication skills) –	*-Rather than as a "difficult patient" (where the provider has basically "given up" and blames the patient – leaving both persons dissatisfied).*
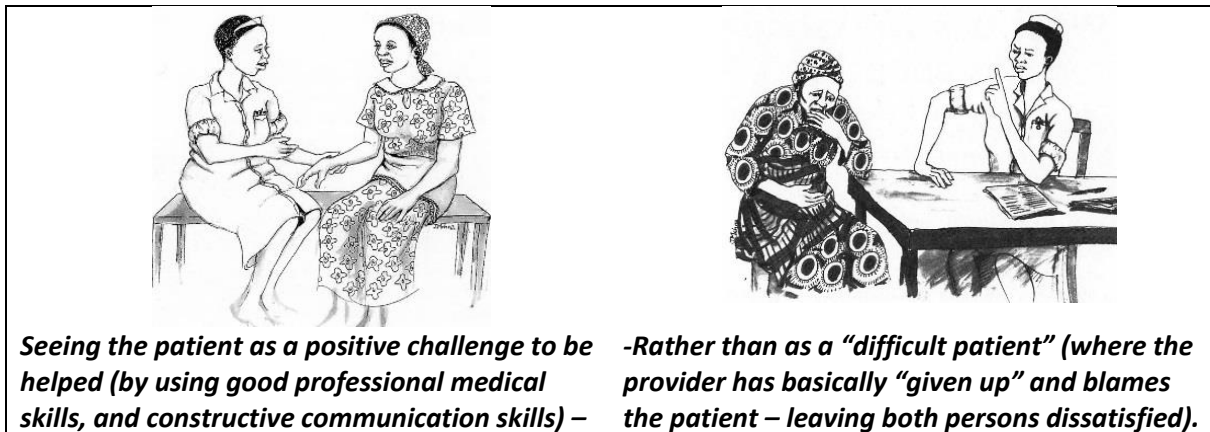
*The **conscious intent** of the provider on the left is to explore, find reasons for challenges (from the patient's perspective), and deal with them – including the emotional needs. The provider is aware of her own emotions and actions and takes responsibility for communicating well.*

*The **intent** of the provider on the right – which **may or may not be conscious** – is to blame the patient for whatever she has done (or not done), and free herself from any responsibility for the (failed) communication, and for the outcome of the interaction. Awareness and management of emotions, her own as well as the patient's, is lacking.*

To help achieve the aims we emphasize three main sets of skills throughout the training:

1. Build professional relationships with patients and colleagues:
Using principles of patient-centred care, greeting the patient and seeing him/her as a person, is the first step. This is the basis for creating safety and building trust, and for being able to give good clinical care in a cooperative partnership with the patient (or relative/caretaker of the patient).
It is also the basis for communicating well with colleagues.

2. Build emotional competence: Recognize, analyse and deal with emotions:
The provider must recognize and acknowledge the patient's emotions, and be especially aware of vulnerability, and respond to these with awareness and informed empathy – exploring reasons for why the patient has such emotions. She must also recognize her own emotions – and be able to understand and to step back from automatic reactions if needed. Being present is a key capacity to identify and get a sense of the emotional "landscape", whether relating to a patient or to a colleague. Recognising her own emotions will help her explore the reasons for them and then deal with them appropriately - she learns to acknowledge when she is stressed, tired, exhausted:
She needs to be aware and to take care of herself to avoid making mistakes or possibly getting into conflict, and – to prevent getting burnt out.

NB: These first two steps may take only a few seconds for the aware provider – but they are essential!

3. Use key communication skills and capacities well
Communicating well with awareness of and respect for emotions is a natural part of the entire interaction between the patient and the provider, and between colleagues. Various skills are used throughout: Awareness, active listening, asking open questions and being present are the basic ones, and include being aware of and managing non-verbal communication. Giving and receiving constructive feedback is also an essential skill. The skills are used in *the context of an interaction in a professional relationship* and related to real work situations of the health providers. Awareness of the *intent* of the communication is a key overall capacity.

> *We teach communication capacity as a set of interwoven, interdependent skills which need to be chosen from a "toolbox" or "basket", based on the provider's assessment of the particular situation and person(s) to be communicated with. The underlying attitudes and intentions of the communicator set the tone and determine the outcome of the interaction, to a large degree. With awareness and clarity about intention and goals, learning the "secrets" about using effective communication skills becomes a simpler task. Awareness is the main skill to develop and practice for creating this "foundation", and recognition and management of emotions are essential and natural parts of the interaction.*

2.3 The organization of the training process

While the full programme of this course takes about 9 months, most of the time spent is autonomous and self-directed, guided on-the job training. An overview:

- **Phase 1 – 3-4 months:** Self-observation and reflection on the job - participants commit to studying their own communication behaviour, and the effects of this on others (the Discovery phase). Requires monthly "nurturing" by a trainer, in meetings;
- **Phase 2 – 5 days:** Basic workshop, to link their observations to theory, share experiences with co-participants (interactive reflections) and learn and practice new skills, with feedback;
- **Phase 3 – 3-4 months:** Further observation and reflection tasks to experiment with and confirm the effects of the new skills in daily work, build confidence, and practice informed reflection;
- **Phase 4 – 3-4 days:** Follow-up workshop, to cement learning, and link further to theories, especially on emotionally challenging situations (such as anger, burnout, death and dying).

Why does the course last for 9 months?
We take years to form the communication habits we inhabit and use. It requires awareness, motivation and learning over time to change them sustainably. Research has shown that shorter courses without preparation and/or follow-up do not usually lead to sustainable behavioural changes. Our model represents a different approach, which **does** lead to changes. But – implementing the training requires an investment by managers, trainers and participants – as all quality work does. *The input is in many ways proportional to the output.*

Note: The training process for trainee doctors in Wales took 6-7 months. It followed the same overall structure as the original course with guided observation and reflection tasks to build awareness. It was followed by several shorter (half day) workshops. It is the systematic process with a carefully constructed sequence of topics which allows the participants to discover their communication patterns, to build skills naturally and to change slowly, over time. Interactive reflection in groups, and linking the skills to theory, are essential parts of this process.

The long period of time is necessary to anchor the awareness of how to integrate the learning into their regular working routine and **build the confidence** to practice the new skills. Mentoring from trainers and experienced colleagues is an important part of the process, as well as for colleagues to develop the habit of sharing communication challenges with each other in open, exploratory, non-judgmental ways at work, and over time develop emotional competence. This process is a start.

No "Quick Fix": There is unfortunately no short-cut to good quality training which challenges and helps to change health professionals' deeply held attitudes and habits. This is a slow empowerment method that gives results, because the control over the changes rests with each participant and with the pride in her work. For such changes to take place, there is no "quick fix": The training requires serious commitment. This was the case in all the different cultures.

2.4 Characteristics of the iCARE model: A summary

There are several aspects that characterize the iCARE-Haaland training model, and in important ways distinguish it from other models. The model is built on a collection of approaches and methods, and on a clearly stated philosophy and attitude to participants. Below is a summary of main points.
In chapter 4, there is an extensive description and discussion of these points.

2.4.1 *Starting points for the model*

A. Philosophy

- **Volunteering to participate:** The course is based on participants volunteering to participate, as we expect that a person who has seen the need to improve her communication skills will be motivated to learn. Those who do not think they have a problem with their communication will often find it a waste of time if they are forced by their leaders to attend the course. These participants may disrupt the course for others who are there to learn, and for the trainers who will facilitate the sessions.

- **Using their own working situation as a starting point:** Integrating knowledge and skills to the real situations they face makes the learning relevant and credible;

- **Providers want to care:** Belief in providers' ideals and intentions to give patient-centred care, with compassion and empathy. If they appear not to have such intentions, there are usually good reasons for this. Exploring and understanding these reasons can rekindle the conscious motivation and willingness to provide good care and to communicate well with colleagues.

- **Deep respect for providers and their work:** Health providers have a really difficult and challenging job. Respecting them, their work and their own range of emotions and personal stories is an important starting point. So is the need to recognise their vulnerability, and the consequences to their health and to their patients if they are pushed too far and supported too little.

- **Humanism, Patient-centred and Relationship-centred care**: It is a clear goal to see patients as persons (or individuals) and focus on building a respectful relationship that takes patients' perspectives as a natural and useful part of the medical interaction.

B. Approach to using communication skills

- **Communication in a context**: The focus is on seeing communication in natural situations at work, and taking these as starting points for identifying challenges, and better ways to communicate. What influences the communication will vary with the context.
- **Communication in relationships**: Communication in health settings happen in relationships – with patients, relatives, colleagues and supervisors. Taking these situations as starting points anchors the learning to something concrete, makes it relevant, and is easier to remember.
- **Communicating well, with emotions as a resource:** Communicating in a relationship naturally includes emotions. We take it as a starting point that recognising and understanding "the emotional landscape" – i.e your own emotions and those of your patient or colleague – will enable you to better manage emotions and to communicate with awareness.
- **"The House of Good Communication" (Chapter 4)**: This house visualizes the "foundation" - awareness, being genuine, conscious intention - and then the "rooms" filled with what the communicator needs to be aware of to function well: Attitudes and values (room 1), Practicing key communication skills (room 2) and skills to manage emotions (room 3).

C. Approach to learning – Patient, innovative, active, experiential and reflective

- **Building on existing capacities**: We start where people are, acknowledge their existing skills, and use these within the group to discover, illustrate, support and empower;
- **Learning over time:** Communication habits are developed over many years, and also take a long time to change.
- **The innovative learning method:** A carefully created sequence of guided observation and reflection learning tasks to enable participants to discover problems and build skills on how to communicate with respect for emotions, gradually, in natural ways. The skills build on each other – starting with listening and asking questions, and progressing to more complex tasks on managing emotions. Emotional competence is built, gradually.

- **Observation and Reflection-In-Action self-learning tasks:** Reflection In Action means participants observe and recognize what is happening, *while it is happening.* Participants observe how they communicate with other, while they interact with the person(s). They also look at *the effect(s)* of their communication on the other person(s) – and experience the emotional reaction(s) to what they say and do. Participants carry out these tasks independently on the job for three months and *discover* and define their learning needs: They experience how their communication can delight, help or hurt others, and this often triggers an inner motivation to learn, and to change.
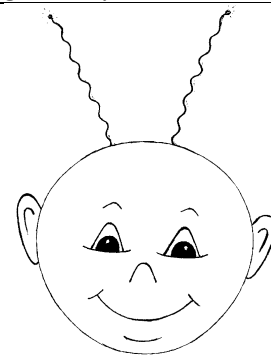
Observation "In Action" is like "having an invisible mascot with antennae on your shoulder".

- **Reflection In and On Action, in workshops:** We use experiential learning methodology in the workshops, where interactive reflection "on Action" on central topics keep participants involved and engaged. Using examples from their observation and reflection tasks, their discoveries are linked to theories, and learning deepens. Supportive group learning process and critical thinking are used throughout.

- **Informed reflection, after the first workshop**: With new knowledge understood and new skills practiced in the workshop, participants go back to work with more confidence. They will still make mistakes – but now they recognise and understand right away (or very soon) what are the reasons that their communication do not function as well as they had wanted. Critical reflection on their own (and each others') actions is an important part of the approach

- **Deepening emotional insights** – when participants are ready. In the final follow-up workshop, the focus is on learning to handle difficult emotional challenges like death and dying, anger and conflict, stress and burnout. The topics have been introduced earlier, but at this stage – with the long process of learning and reflection behind them – participants are ready to learn at a deeper level. They welcome this learning, and have the skills to handle it. They are developing emotional competence, as recognising and managing emotions become more natural.

- **Trainers' role: Facilitate, guide, appreciate and explore – rather than judge:** The trainers' role is essential in the iCARE-Haaland model. Trainers need to be genuine and skilled at facilitating awareness and further discovery: They use active learning methods and focus on exploring reasons for problems (and emotions) rather than judge the actions. When participants can share fears, mistakes and problems without being judged *(they usually know very well themselves what is right and wrong)*, they can use critical reflection to understand why incidents happened and why they reacted like they did. Then, they can put the problems behind them. Participants are free to choose different action the next time they are faced with similar problems, based on insights and growing confidence and competence.

- **Trainers make participants feel safe**, using appreciation and empathic understanding. This creates an environment where they feel safe to open up and to learn – deeply, as both the cognitive and the emotional aspects are respected and included.

- **Trainers take the fear out of learning:** Many participants are used to the authoritarian style of learning and are shy to speak up – as they are used to being ridiculed or shamed for their contributions. Trainers focus on the joy of learning and the usefulness of the skills and bring curiosity and humour into the training. With time, most participants warm to the style, feel safe, and participate freely.

- **Trainers are role-models** who inspire colleagues to communicate with awareness and respect. They enabe the participants to experience the effects of the communication skills being learnt, on themselves – thoughout the course.

- **Trainers also learn:** The trainers are faced with new situations, new stories and new insights from participants throughout the course, making it an active learning process also for them. Trainers are usually much inspired by this, as each training course is unique, they learn together with the participants, and the training never becomes routine, or boring.

D. Identifying contents: Responding to expressed needs and drawing on research

- **Recognising multiple and competing demands:** Providers are often working in contexts of high work pressure, vulnerable patients, emotional challenges, low motivation, limited resources, and lack of supportive supervision. Most of the providers are practical, busy people, with low tolerance for wasting time on training they cannot use to improve their work. The training has to make their professional work and relationships easier and better.

- **Starting from practice:** To ensure relevance, the training is based on providers' own identification of challenges they face in their daily work with patients and in interactions with colleagues and supervisors, and on strengthening successful methods they already use.

- **Theories from behavioural sciences and social sciences** (including educational psychology and social psychology) have informed the contents of the course. The educational methods are based on pedagogical principles from experiential learning theories, combined with observation and reflection from reflective practice theories, with some of our own innovative aspects added. The methods emphasize that sustainable change in behaviour has to come from *an inner motivation to change*. This motivation will be strengthened when they see the new methods working better than the old ones, and the changes made will be natural, personal – and sustainable.

- **Participatory Action Research has strengthened design:** We built the model from scratch, based on providers' needs and ideas, and with methods and experience of the author and her colleagues in several countries. As we have evolved the model further, research results have emerged and confirmed that our direction and design is conforming to "best practices" in communication skills training.

- **An innovative approach to defining training needs:** An important part of the model is the method of finding out what providers really need to be trained in. We ask participants to observe and reflect IN Action, systematically, using a pedagogical sequence of tasks over time (three months). Participants discover what they need to learn to be able to communicate better, and they also develop insights and skills on recognising and managing emotions. Their discoveries and reflections are important aspects of defining the contents of the course and making the course relevant. In the research and training literature we have not found descriptions of such use of reflective practice. These aspects are therefore the innovative contributions of the iCARE-Haaland model to the field of communication skills and emotional competence training.

- **The iCARE-Haaland model puts all this together in a practical blend** that meets the providers where they are and helps them improve practice. Everybody has his/her own communication style, and when becoming aware of their own strengths and weaknesses, each provider can work consciously to improve their authentic style, practicing the skills in a way that feels natural to them, and that meet the professional needs of their institution.

2.4.2 Key learning points when implementing the course process

- **Strengthening self-awareness of how they communicate, and recognise emotions**: When developing awareness, participants can use the insights they gain and the skills they learn to improve their own practice. The aspect of developing the "provider-self relationship[4]" has often been overlooked in training courses, which have mainly focused on strengthening the provider-patient relationship. It has recently been confirmed that the provider-self relationship is a key aspect and skill needed to strengthen patient-centred care.

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[4] In the literature on patient-centred care, four aspects of providers' relationships are described: Provider-patient; Provider-Provider; Provider-Communicty, and Provider-self. It is the last aspect which has had the least focus, and there is recognition of a need for a much stronger focus on this. The development of self-awareness comes under this aspect.

- **An example from a participant in Kilifi illustrates the effect of working with awareness:**

  ➢ *"I have noticed that when I treat patients with respect, they are easier to handle and are less fussy. They seem to gain trust and confidence in me. When I treat patients with respect, I stay stable and strong. Even when sometimes some do not appreciate, I do not feel guilty because I know I have done my best."*

- **Taking responsibility for communicating well:** Blaming others is common in hierarchical communication structures, to avoid taking the responsibility and risk being blamed oneself. We use the method of **Refection In Action** to enable participants to discover their own role in contributing to a communication problem, or success – and thus gradually develop the skills and motivation to take action to manage the communication well.
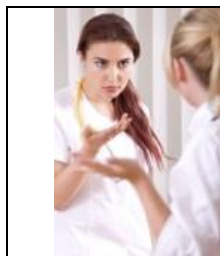
The change – from blaming others, more or less automatically or out of habit, to recognising emotions, taking a step back and communicating with awareness and respect for emotions – is probably the most important change participants make during the course.

- **Challenging cultural norms and behaviours, with respect:** Cultures shape the way people behave, often without them being aware of why they behave in certain ways. In the medical culture, the hidden curriculum influences in subtle ways how young professionals are expected to behave by following the lead of the older ones. Older professionals are themselves a "product" of their time and influence and will often practice communication in authoritarian ways. The same is the case in many national cultures – there are norms and traditions that form a culture of behaviour and communication which emphasizes hierarchy rather than patient-centred care and open, explorative communication. See chapter 4 for an example and description of an approach to challenging cultural norms and behaviours: **Challenging cultures, with respect** can facilitate a change in practice, when participants are helped to discover how the norms function, and the consequences of these norms on how they treat patients. In Kenya, a participant had the following comment:

  ➢ *"But now from the training… I'm able to see a client now wholesome. Like a human being, not just a patient. Because to me a client was a patient, me I'm a person, you are a patient. But now … I'm able to relate to a client like just a fellow human being, that human touch, yeah'*

2.4.3 Decision points: Why participants decide to change
The course approach makes learning something the participants want to do, because:

- **The methods they learn work better than the old ones.** *They discover this through observations and reflection, and then by sharing challenges and insights in workshops*;
- **Improvement is achievable**. *They have seen that it is possible to e.g. decide to listen better, with awareness, and get instant results*;
- **It is empowering**. *The method is theirs, they "learn how to learn", and can continue learning after the course process*;
- **They are in charge of learning** – *there is no external evaluator who judges them: It is an internally driven, though guided, process. They have the power to change – or not*;

- **It feels good to do good work** – *when they are appreciated by patients for good empathic care, they receive energy back. This "feeds" their energy base, and can prevent burnout*;
- **They can avoid conflict:** *With the skills to recognise and manage emotions, they will often prevent conflict by communicating with awareness and competence (rather than being carried away by automatic emotional reactions)*;
- **Better job satisfaction –** *all of the above contribute to feeling better at work, and they also use the skills to improve communication at home with family and friends.*

2.4.4 *Limitations: Communication skills cannot change the health system*

- **Many institutions and health systems perpetuate a lack of support** for the professional values and skills health professionals are learning to practice in a course like the one we describe. The purpose of the iCARE-Haaland model training is to change the way health professionals practice their work *within the system*, and then over time, enable trained professionals to influence much needed changes in health systems. Many health systems are constantly being restructured, not always resulting in better patient-centred care, or in strengthening skills and motivation of staff to work better.
- **A recent book analysing the UK health system** (Intelligent Kindness; reforming the culture of healthcare) makes a powerful case for why *intelligent kindness* should be emphasized in all training of providers – citing evidence showing effects of being met with kindness on patient satisfaction and outcome, and on providers' effectiveness.
- **A number of studies from resource-poor countries** and countries with strong hierarchical systems demonstrate the inadequacy of the systems to meet patients' need for patient-centred care, and providers' needs for skills and support to be able to give such care. They also do not learn how to use emotional competence to take care of themselves to prevent burnout.

Nevertheless, we recognise that health system change can come from the collective action of those at the front line (from "below"), particularly when supported or encouraged from "above". The learning from this manual has the potential to support that through contributing to strengthening communication and interactions with colleagues and supervisors, and building teams.

Training helps providers cope better in the imperfect system, and some draw on their new skills to take steps to improve it. Providers who have gone through our training say they are able to now work better, despite the system:

- *"I am not so tired when I go home, as I have managed my energy and emotions more effectively, and also got energy from positive interactions with patients and colleagues".*
                                        Participant from Kilifi, after practicing new skills for 2 years

Changing negativity: In Cardiff, one of the participants noted that the biggest change she had made was to now recognize the situations when her colleagues talked negatively about something, and others coming in would easily fall into the same trend of negative thinking and talking. She now recognised what was happening, and took action to change the situation by making a joke, or saying something positive – and thus being able to change the "mood" from negative to positive. She said this behaviour made a real difference to her – and to her colleagues. Several other participants confirmed that they are taking similar action to turn negative situations around, rather than get sucked into them. This, we agreed, was a good example of using emotional intelligence in practice.
Se also Challenges to implementing the method: Chapter 9

2.4.5 Summing up the model, and some reasons why it works
Practicing professional clinical care, and respect – and being genuine

The skills to communicate with emotional competence are practiced on a "base" of underlying professional clinical care, professional relationships with colleagues, and an attitude of respect and appreciation. Exactly how, and which skills are needed, depends on the context and on the challenges facing the provider, in each case. As each situation and each patient and colleague is unique, there is no simple solution to communicating well with emotional competence: The provider must have her "basket of skills" as a resource she carries in her heart and head, and in her being – knowing that using these, she will be providing the best care and be the best colleague she can. Research[5] shows that "the way you are" is more important than "what you say" to patients. Communicating genuinely – by being yourself - is what works best.

Some reasons why participants learn so well

There are many reasons, and the full picture is complex. The main elements are quite straightforward – starting with the need for the provider to *decide* that she wants to learn to communicate better. Then the key elements are:

- Guiding users to *discover* their learning needs, through self-observation and reflection over time;
- *Meeting these felt needs* in the training workshops;
- *Providing a realistic time frame* - giving time and space for self-determined change;
- Providing a *safe learning environment*, where failing is common, expected, and – is seen as creating situations to learn from (without being judged);
- Using a methodology that *respects the learners* and starts where they are – in their practical day to day work, with their present skills and behaviours;
- *Seeing emotions as a natural and positive part of life* to be expected and managed, both in relation to providers' own emotions, and those they meet in patients and colleagues;
- Acknowledging, valuing and building on their experiences, and *empowering* them to take *responsibility for their own learning, and to own it;*
- Guiding them to become aware of and further develop their *own genuine communication style* – which feels natural, and will therefore be sustainable;
- *Appreciating them for efforts and learning* – focusing on the positive (but still acknowledging and dealing with the problems)
- *Encouraging interactive reflection* with colleagues who experience the same kinds of challenges, thus creating *common goals* within the training group: strengthening self-awareness, improving collaboration with colleagues, and improving patient-centred care;
- *Supporting group processes and critical thinking* are important elements in the course
- *Having trainers who role-model respect, kindness, compassion and care,* with curiosity and skills to explore reasons for present problems – without judging the person in action.

As both trainers and participants are emotionally present with each other, are non-judgmental, and share a common goal, a remarkable *give-and-receive exchange of energy* builds during the sessions. As a result, neither group becomes exhausted. Later, after having applied the methods described in this model with patients, participants report that this practice helps increase the satisfaction and enjoyment they find in their work while also lowering their risk of becoming burnt out.

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[5] Copeland, L & al (2015): Mechanisms of change within motivational interviewing in relation to health behaviors outcomes: A systematic review. Patient Education and Counseling 98 (2015) 401–411

The challenge is to apply all of this to the **relationships** that are central to good health care – the relationships providers have with patients, with colleagues, with communities, and – with themselves. With awareness and practice, this becomes easier, and the good results encourage the providers to continue using the skills.

- *"I have no more difficult patients",* commented a Namibian nurse after going through the course process. Where previously she had blamed patients who did not want to follow her advice, she now explored their reasons for not wanting to "do as she said", and found a joint solution. "Works much better for me, and for the patients", she said, reflecting that she had no plans to return to her previous habits.
- *«I feel I am more assertive in my communication with colleagues as I become more confident in being able to do this constructively", wrote a trainee doctor in Wales after self-observation and reflection. The doctor continued: "I feel I am better at understanding what might be underlying my colleagues' actions/reactions and therefore less likely to become upset or frustrated as I don't take things so personally. I have tried to make myself more approachable to colleagues and to take the time to give them positive feedback and appreciation.»*

2.5 The evolution of the model: Personal notes from the authors

The iCARE-Haaland training model has evolved over a period of 12 years, shaped by the many health care professionals who have taken part identifying the need for, and implementing, this training. It has been influenced by strong leaders who have been determined to let their staff learn to communicate better, and by health care workers who experienced the power and freedom when they recognised and stepped back from their emotional reactions to daily challenges – and acted with emotional intelligence instead. Some told stories of how they met patients' anger with compassion and listening – and found out that managing emotions gave very good results for themselves – and their patients. *The full story of how this training model was "born", and how it evolved and became the most useful thing I (Ane) have ever done – you will find in chapter 10.*

Reflections from the co-author: The most important is the use of reflective practice
"My journey with this training has been very thrilling, it has changed me holistically as a nurse, a manager and a mother. The skills gained in this training are wholesome, I use them all round in my engagement with people. The most important thing to me in this training is the use of reflective practice. It's such a powerful approach to learning and practising the skills we teach in this training. Through practising self-reflection, I feel like I have a permanent reflective sensor in me which enables me to critically think at the different situations that I face at work and at home before making any decisions and this has really helped me handle people with awareness, putting myself in their shoes, listen and appreciate their opinions, and stay non-judgemental.

The reflective tasks are such a turn on to providers awareness. It's amazing how providers get to know who they really are when they start to pay attention to their behaviours and see where they want to change. It's so inspiring for me as a trainer when I read their feedback. The tasks set such a fertile ground for learning, I meet learners who really want to learn to improve themselves, and the learning is fun with no resistance.

*As a manger the skills have equally improved how I handle my team. Before the training I used to handle my staff head on whenever there was a problem. I remember as a young manager, I had a staff who used to call herself "**Matron**" and she would rub shoulders and bully juniors. She was*

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such a headache and I didn't know how to handle her. Thanks to the appreciation skill I learnt in the training, it made my work easy in managing this staff and the rest of my team. I appreciated her, acknowledged her as our senior most member of staff, I would introduce her to visitors when they visit our unit, and this made her feel recognized. I also gave her an opportunity to attend the communication training, and she is now a changed person and relates well with others.
I no longer carry the office home, because I have a team who know how much I appreciate their work, they don't have to call me for every problem but rather solve their problems and let me know what they have done. I stopped being the encyclopaedia of solutions, thanks to the appreciation skill – it works magical!

The skills have also helped me handle my children and siblings better. Before the training I would carry my work stresses home and shout to my children and siblings at the slightest mistake without really paying attention to how they feel but now where there is a problem, I create room for dialogue and this has improved my relationship with them and I am now slowly teaching these skills to my children. Whenever "my old self pops up" my 9-year-old daughter would remind me "mummy please think before you talk"

Sincere appreciation to Ane Haaland for the hard work she has put in developing the training model, and writing it all in this manual. It's such a great resource and may it benefit as many health providers as possible across the globe".

Mwanamvua Boga, nurse manager and lead trainer, Kilifi

Mwana with senior trainers presenting certificate to a participant after completed training, December 2019.

From left: Trainers Siti Wande, Hiza Dayo, Anthony Njenga (participant), Mwanamvua Boga, Ane Haaland and Lennox Bhaya.

3 Selected literature: Challenges in skills training for communication and emotional competence

The literature regarding what influences the way health providers communicate and manage emotions is vast and includes knowledge from a number of professional fields and theories[6]. It is beyond the scope of this manual to provide a comprehensive review of relevant literature from all these fields.

We have chosen to focus on literature relevant to some main challenges health providers experience when communicating with patients and colleagues, highlighting the gaps that the iCARE-Haaland model can contribute to filling. We have also described some key authors who have written major works on these topics. To exemplify how the model meets challenges, we have included some reflections from participants.

In this chapter we explore Benefits, challenges and gaps in health communication; Building emotional competence – definition, and challenges; Evidence and reflections on effective skills; the contributions of the iCARE-Haaland model, and some results from using the model in nine countries.

3.1 Benefits, challenges and gaps in health communication
3.1.1 Communication skills are needed for good care
Some of what good communication can contribute:
The positive effects of health professionals using good communication skills have been well documented: improvement in patient-centred care, patient outcome, communication with colleagues and also on the emotional well-being and work satisfaction of the professional[7],[8].

Good communication is essential for patients' learning, their motivation to adhere to treatment, and - e.g. for TB and HIV patients – for their ability and willingness to be open about their disease(s), and to fight stigma. The increasing focus on patient- and person-centred care[9] is putting even more pressure on the health providers to meet patients' needs, often without giving them the necessary skills to provide such care in a sustainable way.

3.1.2 Poor communication can have serious consequences
There is clear and increasing evidence showing the effects of health providers applying (and not applying) effective communication skills in their interactions with patients. An editorial in the BMJ[10] notes that most patient complaints in the US and UK are related to poor communication. Another editorial in the same journal focuses on the need for providers to also be skilled at handling emotions, and states: "…poor communication skills have been shown to be a predictor of

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[6] For example: behavioural sciences, social and educational psychology, adult learning theories, experiential and reflective learning theories, medical education.

[7] See e.g. Sandra van Dulmen: Communication in healthcare: What makes a difference? An overview of research on communication skills, presented to the third Geneva conference on Person-centered Medicine, Geneva May 3-5th 2010.

[8] Krasner, M.S. &al (2009): Association of an Educational Program in Mindful Communication with Burnout, Empathy and Attitudes among Primary Care Physicians. JAMA Vol 302 no 12, Sept 23/30

[9] See e.g. the increased focus demonstrated in the third Geneva conference on Person-centered Medicine, Geneva May 3-5th 2010, where 22 organizations participated, up from only 4 organizations in the first conference in 2008.

[10] Clinical and communication skills. Need to be learnt side by side. Editorial, BMJ 2005:330:374-375

medicolegal[11] vulnerability and also of burnout"[12]. These papers reference others that show how poor communication skills and lack of skills to manage emotions influence patient outcome. Communication and interpersonal issues have been found to be a common root cause of patient safety incidents[13]. Poor communication also has a negative effect on collaboration in medical teams.

Challenge: Lack of kindness across cultural barriers

The problem of poor communication and lack of appropriate care from providers exists worldwide and has been documented in many countries. Examples from the UK and Kenya show how expected kindness, care and compassion is replaced by insensitivity, cruelty and punishment:

In the UK, the report of the situation in the Mid-Staffordshire NHS Trust in the English Midlands shocked the country. In the executive summary of the inquiry[14], the abuses are clearly described:

> *"Requests for assistance to use a bedpan or to get to and from the toilet were not responded to. Patients were often left on commodes or in the toilet for far too long. They were also left in sheets soaked with urine and faeces for considerable periods of time, which was especially distressing for those whose incontinence was caused by Clostridium difficile. Considerable suffering and embarrassment were caused to patients as a result.*
> *There were accounts suggesting that the attitude of some nursing staff to these problems left much to be desired. Some families felt obliged or were left to take soiled sheets home to wash or to change beds when this should have been undertaken by the hospital and its staff. Some staff were dismissive of the needs of patients and their families."*

Investigations in other hospitals, following this report, showed that the Mid-Staffordshire hospital was by no means alone in mistreating patients. An analysis concluded that "…a lack of understanding and management of emotions is a major issue (…) and should be given much more attention[15]".
A number of actions have been taken to deal with the problems in UK hospitals: The NHS has e.g. recruited 7800 more nurses to the wards since 2010, and made a number of other changes.[16] However, other reports[17] show that not much has changed, and that the problems remain.

In Kenya, several recent studies and reports have shown that midwives in a number of hospitals slap and verbally abuse women when they give birth. Women respond by giving birth at home – in 2015, only 4 of 10 women gave birth in hospital[18]. The women cited the rough treatment by midwives as a main reason to give birth at home.

| | *Note: It is easy to judge the nurses and midwives for their cruelty. However – there are strong indications that a major reason for the nurses' behaviour in Kenya (and also in the UK) is – fear: Their own fear of not doing a good enough job – if the baby dies. The nurses and midwives have never learnt to recognise and manage emotions – neither their own, nor the fears and pains of a woman in labour.* |

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[11] Medicolegal involves both medical and legal aspects of medicine
[12] Communications and emotions. Skills and effort are key. Editorial, BMJ 2002:325:672
[13] https://www.gponline.com/improving-communication-skills-colleagues/article/1050179
[14] The Mid Staffordshire NHS Foundation Trust Public Inquiry. R. Francis, 2013
[15] Ballatt, J and Campling, P (2011): Intelligent Kindness; reforming the culture of healthcare, 2011
[16] Culture change in the NHS Applying the lessons of the Francis Inquiries. Paper presented to Parliament by the Secretary of State for Health by Command of Her Majesty, February 2015
[17] Review of maternity services at the former Cwm Taf University Health Board: report, April 30th 2019.
[18] Abuya, T & al (2015): Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. PLOS ONE DOI:10.1371/journal.pone.0123606 April 17

3.1.3 Challenge: Training contents and methods not meeting students' needs

"Traditional" training contents: Several reviews (e.g Chant[19] (2002), Kruijver[20] (2000), Lane and Rollnick[21] (2007)) conclude that in "traditional" communication skills training curricula and courses for health providers there is a lack of focus on

> ➢ The importance of building relationship and trust
> ➢ Why and how to relate to patients as persons
> ➢ Interaction with awareness and management of emotions
> ➢ How to recognize and relate to power, constructively
> ➢ Learner-centred methods, and practice of new skills in work context

In brief, the health provider communication skills training lacks a focus on *the relationship between patient and provider* as a basis for practicing patient-centred care, as well as skills to establish and maintain this relationship. Lack of such skills contributes to problems not only for patients but also for the health professionals themselves. Skills to recognise and manage emotions are not mentioned.

Training methods: Reviews of evaluation of nurse communication skills training[22][23] in Europe and the US show that

- There is a lack of coherent strategy for teaching communication skills;
- Trainers are uncertain about good practice in this area, and
- Training contents and methods often perpetuate hierarchical power structures and strengthen the hidden curriculum.

Training programmes have also been found to be undermined by focusing on mechanistic rather than relational communication, teaching theory rather than practical training relevant to job challenges, and using learning styles that are poorly tailored to students' workplace needs. Courses are often short - from 1-2 days to a week's workshop, with no preparatory work to encourage participants to become aware of their learning needs, and no after class work to help participants integrate new learning into everyday practice. This approach does not lead to improved skills over time. Special attention is needed to transfer skills into practice, another key area which is lacking focus in training[24].

Failure to meet students' needs was a key deficiency, and a lack of a clear theoretical base and segmentation between education and work contributed to making training ineffective.

3.1.4 Challenge: Limited research on training in resource-limited countries

Relatively little research has been conducted to identify problems related to patient-provider communication in resource-limited countries, or to conduct implementation research to demonstrate effects of interventions to deal with problems identified. A recent (2017) BMJ article[25] refers to a study investigating providers' communication skills in seven African countries. The study

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[19] Chant, S &al (2002): Review: Communication skills: Some problems in nursing education and practice. Journal of clinical nursing. 11:12-21.

[20] Kruijver, I.P.M. & al (2000): Evaluation of communication training programmes in nursing care: a review of the literature. Patient Education and Counseling vol 39, 129-145

[21] Lane, C and Rollnick, S (2007): The use of simulated patients and role-play in communication skills training: A review of the literature to August 2005. Patient Education and Counseling 67 (1-2), 13-20.

[22] Chant, S &al (2002): Review: Communication skills: Some problems in nursing education and practice. Journal of clinical nursing.11:12-21.

[23] Kruijver, , I.P.M. & al (2000): Evaluation of communication training programmes in nursing care: a review of the literature. Patient Education and Counseling vol 39, 129-145

[24] Heaven C; Clegg, J and Maguire, P (2006): Transfer of communication skills training from workshop to workplace: the impact of clinical supervision. Patient Educ Couns. Mar;60(3):313-25. Epub 2005 Oct 19.

[25] Larson, E; Leslie, H.H; Kruk, M.E (2017): The determinants and outcomes of good provider communication: a crosssectional study in seven African countries. *BMJ Open* 2017;7:e014888. doi:10.1136/bmjopen-2016-014888

concludes that there are major deficiencies in communication during sick child visits, and that there is a clear need to develop new strategies in communication.

The limited literature that does exist[26] shows similar trends to those found in Europe regarding the definition of the problems: Providers often do not communicate well with their patients, attitudes constitute a main problem, and short-term communication training programmes do not make much difference in providers' use of communication skills.

An article in the Indian Journal of Palliative Care [27] concludes that "Communication skills are as important as vital needs. Health care professionals have to be aware of their own communication practices and need to undergo periodic appraisal of the same. Training programmes in communication skills are unfortunately not part of our academic curriculum."
The article highlights the need for and gives an overview of such training programmes.

A main reason for the limited research available on communication training for providers in resource-poor countries is that very few training programmes have been evaluated and written up in scientific journals. With increased global attention being paid to the importance of communication in health care, and the significant benefits to be gained for patients and providers by improving communication skills, we hope that this manual can contribute to increasing training and research in many countries.

3.1.5 Challenge: Different ways of teaching reflective practice

In a review of the literature on teaching reflective practice across health and social care professions, Norrie et al[28] have illustrated how different professions choose certain types of reflective practice.

In the medical literature, the focus is on "measuring" reflection and finding evidence for the effectiveness of reflective practice in teaching. The researchers shape the production of knowledge by asking specific questions or posing them in a particular way, and the literature produced tend to have more positivist and pragmatic rationales. The same trends can be found in research into physiotherapy.

The research into nursing and midwifery take a different approach and show a greater interest in exploring and understanding teaching processes, using constructivist approaches. Finally, literature from social work tend to draw on wider questions from across the social sciences.

There are however a few researchers from the medical field who "break rank" and venture into the qualitative research fields. The review notes: "It is interesting to note that some of the literature identified is characterised by the intrinsic tension (usually unacknowledged) between discussion of the teaching of reflection which values experiential knowledge versus realist research approaches being used to 'assess' the practice. Close inspection of the literature also illustrates how the teaching of reflection has been taken up and developed differently across the professions to support their

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[26] See for example Labhardt &al (2009): Provider-patient interaction in rural Cameroon – How it relates to the patient's understanding of diagnosis and prescribed drugs, the patient's concept of illness, and access to therapy. Patient Education and Counselling p 196-201, Doyle, D. &al (2010): A course for nurses to handle difficult communication situations. Patient education and counselling, January 2010; Kim, Y.M & al (2000): Self-Assessment and Peer Review: Improving Indonesian Service Providers' Communication with clients. International family planning perspectives 26(1): 4-12; Roter, D. & al (1998): The effects of a continuing medical education programme in interpersonal communication skills on doctor practice and patient satisfaction in Trinidad and Tobago. Medical Education 32, 181-189.

[27] Rajashree, KC (2011): Training Programs in Communication Skills for Health Care Professionals and Volunteers. Indian J Palliat Care. 2011 Jan; 17(Suppl): S12–S13. doi: 10.4103/0973-1075.76232

[28] Norrie, C, & al (2012): Doing it differently? A review of literature on teaching reflective practice across health and social care professions. Reflective Practice: International and Multidisciplinary Perspectives. Vol. 13, No. 4, August 2012, 565–578. http://dx.doi.org/10.1080/14623943.2012.670628

separate legitimisation projects. In the medical context, the focus is on improving professional practice and competence in the light of an increasingly litigious, knowledgeable and demanding public (e.g. Wald et al., 2009). In contrast, in the other professions, reflective practice is approached more as a way of asserting each group's autonomous professional identity. This is particularly obvious in fields of practice which have been traditionally subordinated by medicine. In the nursing and midwifery literature there is an emphasis on valuing, validating and developing nursing knowledge and skills within healthcare."[29]

3.1.6 Challenges within the health system

The health system determines the framework providers operate in and has a major effect on how providers conduct their work and how they experience their workplace. Changes in health systems, especially over the last decade, have increased the pressure on health providers in many countries.

There are large challenges to overcome to reach the goal of providing patient-centred care, communicating well with colleagues, and taking care of the professionals' own health and wellbeing.

Ministries and other institutions 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. Decisions are made to strengthen patients' rights and encourage providers to give more humanistic and patient-centred care.

In many hospitals in Kenya for example, announcements of patients' rights are painted on hospital walls for all to read, in line with statements in the constitution supporting the right to the highest attainable standard of health, to equality and non-discrimination in access to health care and in access to information.

However in Kenya as in many settings these rights are often not upheld for a range of complex reasons. These include issues related to the hardware of the system (for example inadequate numbers of staff, and of financial resources and medical supplies) and the software of the system (such as relationships among those working in the health system, and staff motivations and values). For staff, challenges can seem overwhelming, and have structural drivers that are out of their sphere of influence.

The development of training courses to challenge health systems and attitudes that permit and perpetuate provider behaviour which is less than respectful, is lagging behind in many countries. The health systems need to develop training programmes that build providers' skills to engage with and meet patients' expressed needs for PCC. Such programmes would require a focus on relationship building, respect and management of emotions.

This manual does not focus on health system factors that providers cannot influence, but rather on factors that they **can** influence, to be able to function better in the system they work in.

As a manager in a recent (2018) course on the Kenyan coast put it:
> *"I used to just complain about the new political players and how they are messing up our [health management] work but now I have learned that I can use my communication skills to actually talk with them and get some of the things that I need'.*

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[29] Ibid

3.2 Building emotional competence: Definition, challenges

3.2.1 What is "Emotional Competence"?

Emotional competence and emotional intelligence (EI) are closely related, and will be used interchangeably in this manual. In practice, both concepts refer to abilities to recognize, interpret, analyse and respond constructively to your own emotions as well as those of other persons. Emotional competence also implies that you are at ease around other people.

There are two sets of skills in emotional competence – the *intrapersonal* skills which refer to something inside your self, and the *interpersonal,* which refers to relationships and interactions. The intrapersonal skills include developing self-awareness, and observing and reflecting on your own behaviour to build skills to control and regulate your emotions. This is the basis for developing emotional competence: You must be capable of understanding your own emotions before you can understand well the emotions of others, and before you can handle these emotions well.

Emotional competence (and emotional intelligence, or EI) skills can be learnt and built – based on a recognition that these skills are important, and needed. There is much evidence about the usefulness of these skills:

- **In the education field**, it has been shown that good EI helps reduce teachers' stress and burnout, raise teachers' level of engagement and their wellbeing, helps motivate students positively, encourages students to learn/open up, and increases job satisfaction.[30]
- In the business world, leaders with good EI skills facilitate better teamwork and show better results. Developing self-awareness has been shown to be a key to success.[31]

Some examples of emotional competence in practice:
The most important skills participants gained in the training were – to recognise automatic emotional reactions, take a step back to reflect, and then act with awareness and respect (i.e. -practicing emotional intelligence).

"Showing respect for patients' emotions is certainly a good way of interacting with patients.
What I have realized is that most patients/parents with sick children will show a sign of relief the moment they feel you are showing respect to them. They relax and start expressing themselves.
When this happens I feel good, it sets me in the right mood. Even when I feel overwhelmed with work it brings out some kind of positive energy in me. I feel am in control of a situation in a perfect way. I become confident.
And even if I may have had my own issues affecting me emotionally, the power of being aware, accepting and stepping back from them boosts my morale. I can even forget about my issues for a considerable length of time and when I remember, I am in a better mood to reflect and find solutions or just cope with a situation."

*"Before the course I used to be irritated when handling a difficult patient/relative. **The course has shown me that for every stubborn client, there is a reason behind,** and instead of getting irritated, I nowadays probe to get to know the reason behind. The concept of the tip of the ice-berg has made me aware of clients'/patients' needs and has help me advance with care to avoid them exploding on me."*

Both examples: Health Care Providers, Kilifi

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[30] Aurora Adina Colomeischi; Teachers Burnout in Relation with Their Emotional Intelligence and Personality Traits, Procedia - Social and Behavioral Sciences 180 (2015) 1067 – 107
[31] https://www.extension.harvard.edu/professional-development/blog/emotional-intelligence-no-soft-skill

> **Reflection on the impact of emotional competence, on a doctor's work**
>
> *"This training – first stumbled upon as a trainee and then revisited as a trainer – empowered me to consider, develop and put into practice a skill set that has almost completely changed the way I think about my work; not just in the way I think about my patient interactions, but also in the way I think about my interactions with my colleague and perhaps most importantly with myself. Coming to appreciate the immense value in recognising emotions, developing a greater emotional awareness and understanding how, through using EI, it is possible to grow and develop this across the spectrum of work and teaching I do.*
>
> *Using experiences, appreciated through the lens of in-action reflection, I realised the profound value of communicating via stories. As our memories are formed of moments so our lives are full stories. I now recognise that the opportunity to share these builds connection in a way that seems both natural and authentic in a way that other communication now seems to lack. Seeing stories and communications of emotional integrity and expressions of vulnerability I now wonder when and why we stopped using such a powerful tool.*
> *More than anything, this realisation, encouraged by the training, took me on a journey. It started from a place that saw vulnerability as something that was an exclusively negative experience and brought me to recognise its power; how fundamental it is to expressions of humanity in creating safe spaces I and those around can feel psychologically safe.*
> *As well as building quite complex conceptual models that I have found practically useful, there is an equal part that recognises the intrinsic value of the simple things that can have immediate impact. For example, recognising the value of a smile beyond being a reflection my own emotional state. The infectious nature of emotions so easily demonstrated through such a simple act."*
>
> *Dr Thomas Kitchen, Anaesthetist and communication skills trainer, Cardiff*

3.2.2 Challenge: Lack of recognition of the need for emotional competence

While the need for communication skills has been recognised, researched and taught in the medical community worldwide for a number of years, the recognition of the need for skills to recognise and manage emotions – both of the patient's and of the health provider - is still in its infancy. One reason for this can be a denial of the emotional dimensions of communication and relationship, and a rejection of the need for emotional competence because of health professionals' fear of exposing their own emotions.

> Thus, learning how to recognize and manage emotions has not been a priority in medical education. Yet, research has clearly established that *emotional care* impacts patient outcome, and that patients want **humanistic health care professionals** who are medically and technically competent as well as being compassionate and empathetic, and thus help make them feel safe to open up and share their concerns.

After a thorough analysis of the UK health system, John Ballatt and Penelope Campling[32] conclude that a lack of understanding and management of emotions is a major issue, one which demands much more attention. The book demonstrates how the health system changes in recent years have eroded this fundamental practice, contributing to events in which patients have suffered scandalous

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[32] Ballatt, J and Campling, P (2011): Intelligent Kindness; reforming the culture of healthcare, 2011

cruelty and neglect. Ballatt and Campling make the case for strengthening the practice of meeting patients with kindness.

Healthcare providers are met with a high number of emotional demands during a workday, demands which may trigger negative emotions and influence a provider's ability to make ethical decisions. This situation can result in emotional labour[33] for the provider, including negative physical and psychological health consequences. Shocking reports[34] [35] of providers treating patients with lack of dignity and respect strengthen the picture of providers lacking important skills to practice emotional intelligence in their work.

Emotional labour has been recognised as a main concern for health professionals. Research clearly documents the profound need for building a bridge between the medical and the emotional aspects of care. In the last few years, awareness has been increasing in medical communities about the need for doctors, nurses and health professional teams to learn to recognise and manage their own and their patients' emotions with competence and compassion.

In a recent article, Campling also notes[36] that "… there has been a failure to create organisations that are fit for purpose and able to facilitate the emotional work that is such an important component of the healthcare task. ***There has been a failure to acknowledge and get to grips with the way overwhelming anxiety - largely unconscious - can unhelpfully drive and undermine the system.***" (our emphasis).

Many of our course participants, from across a variety of cultures, have admitted to insensitive and unkind – and sometimes even cruel - behaviour towards patients. Such behaviour is often due to a lack of ability to manage stressful and challenging situations, most of which involve and evoke strong emotions. Few providers have ever been taught how to manage such emotions[37].

In the UK, this lack of emotional competence among medical professionals costs them dearly in the form of **increased rates of mental ill health, burnout and suicide. Many health professionals also leave their profession.** This is the case in other countries as well; the cost to health providers' wellbeing and job satisfaction of such increasingly stressful and often unsupportive environments is well documented[38]. In resource-poor countries the pressures are even worse, and the cost to medical professionals as well as to patients is very high.

> *The conclusion: There is a need for a paradigm shift in medical education. Communication skills training for health providers must focus on relationship-centred care, on building competence to recognise and manage emotions with awareness, kindness, intelligence and wisdom.*

Many aspects of medicine influence providers' ability and motivation to recognise, respond to and manage their own and their patients' emotional needs. Some of these are discussed below.

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[33] **Emotional labor** is the process of managing feelings and expressions to fulfill the **emotional** requirements of a job. More specifically, workers are expected to regulate their **emotions** during interactions with customers, co-workers and superiors.

[34] The Mid Staffordshire NHS Foundation Trust Public Inquiry. R. Francis, 2013

[35] Timothy Abuya1*, Charlotte E. Warren2, Nora Miller3, Rebecca Njuki4, Charity Ndwiga1,Alice Maranga5, Faith Mbehero6, Anne Njeru7, Ben Bellows1: Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. PLOS ONE | OI:10.1371/journal.pone.0123606 April 17, 2015

[36] Editorial Reforming the culture of healthcare: the case for intelligent kindness. Penelope Campling. BJPsych Bulletin (2015), 39, 1-5, doi 10.1192/pb.bp.114.047449

[37] See e.g BMJ article February 2019: Should doctors cry at work? *BMJ* 2019;364:l690 doi: 10.1136/bmj.l690 (Published 26 February 2019)

[38] The Mid Staffordshire NHS Foundation Trust Public Inquiry. R. Francis, 2013

3.2.3 Challenge: Need for training on emotional competence

D. Roter & al[39] suggest that "…the emotional context of care is especially related to nonverbal communication and that emotion-related communication skills, including sending and receiving nonverbal messages and emotional self-awareness, are critical elements of high-quality care." The authors conclude that "The conference devoted to articulating the nature of relationship-centered care (…) suggests that it is **the largely untapped healing power of the emotional connection between patients and physicians that can provide meaning and strength to the therapeutic relationship[40]"** (our emphasis).

The effect of engaging with the patient: In a forthcoming book[41] to be published this year, professor Saul J Weiner, who is a medical doctor and research director at the University of Illinois, US, writes about meeting the patient as a person:

> *"In nearly every patient encounter there is an opportunity to connect within the medical context in a way that acknowledges our shared human experience."*

Weiner describes the attitude with which he meets the patients, and that patients are almost always eager to engage with the clinician, but – "they do not expect it". They expect "medical detachment". Making a human connection with the patient is, according to Weiner, of benefit to the medical encounter, the patient, and the clinician: Seeing himself as a healer and a partner to the patient, the clinician gains more satisfaction from his work, and this affects his wellbeing positively. Weiner's rich description of how engagement with the patient affects both patient and clinician gives an untraditional and much needed perspective on medical work.

Weiner emphasizes that engaging with patients requires that the clinician has boundary clarity – without it, he may invade the patient's boundaries, or neglect his own. This caution is also very important in our model and course (see the core module about handling emotions, Module 3b).

Saul Weiner further notes[42] that in addition to learning to manage emotions, there is also a need for medical professionals to interpret emotions: *"For instance, I've learned that when I start to feel depressed around a patient it's usually a clue that they're depressed. It's a message to myself that I should screen them for depression."*

In Europe, emotional care is considered to be one of three primary aspects of communication that impacts patient outcome when meeting primary care physicians, and which health professionals are expected to master. The other two are "Room to talk", and "Positive communication"[43]. In a review, several studies[44] are quoted and demonstrate the need for providers to deal with patients' emotions, and positive outcomes when they do.

Much of the recent literature[45] confirming the importance of responding to patients' emotions is related to cancer care, or dealing with the terminally ill. One study showed that 65% of patients'

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[39] Roter, D & al (2007): The Expression of Emotion Through Nonverbal Behavior in Medical Visits. Mechanisms and Outcomes
[40] Roter, D (ibid)
[41] Weiner, S.J (2019): Title not yet defined
[42] Weiner, S.J, personal communication, February 2019
[43] Sandra van Dulmen, see ref xx.
[44] Fogarty, L.A & al (1999): Can 40 seconds of compassion reduce patient anxiety? J of Clin Oncol 17:371; Zimmerman, C, Del Piccolo, L, Finset, A (2007): Cues and concerns by patients in medical consultations: A literature review. Psychological bulletin 133: 438-463
45 e.g. de Haes, H.C.C.M (2009): Responding to patient emotions: The different reactions to sadness and anger. Patient Education and Counseling, editorial, Vol 76;

emotions are not responded to, with providers having particular difficulties in responding to anger. Another study of emotions and cancer care showed that oncologists were least responsive to patient fear[46].

There is a lack of research into the potential benefits of making emotional connections with patients, on the mental health of the providers. One research study[47] points out the link between burnout and the emotional demands made on nurses. While we will not be reviewing the large literature on burnout here, it is worth noting that implementing the iCARE-Haaland model seems to deal effectively with all three major symptoms of burnout: *Emotional exhaustion* and *depersonalization* are reduced, while there is an improvement in *job satisfaction*.

Why, then, is there so little literature or research available describing processes for developing and strengthening such emotional connections between patients and physicians and other health care personnel? Why are so few training programmes designed to give health professionals such skills, and why have such programmes not been documented? What might help explain this gap?

3.2.4 Challenge: Vulnerability is considered a weakness in medical tradition

Emotions are regarded in medical culture as primarily **negative,** as "emotionalism", leading potentially to misconduct or mistakes. To be vulnerable is defined in medicine as *"Capable of being physically or emotionally wounded",* or *"being open to attack or damage"[48].* It is usually seen as a weakness or an embarrassment. The presumption is that medical professionals will always remain in control, as if any acknowledgement of insecurity - that one "does not know" or "does not know what to do" represented exposure of incompetence, of not being good enough, as if one failed to fulfil the role of the perfect, all-knowing medical professional.

As one doctor, a participant in an iCARE training in Wales, wrote as part of her reflection work:
- *«There was an innate belief within, a feeling that vulnerability must be stamped out and hidden»*

The denial of vulnerability does not, however, help stimulate or develop safety. Emotions that are unacknowledged and thus unaddressed may lead providers to act insensitively or even cruelly, most likely without realizing or intending to. Not only does the literature document this, but many of our course participants across the cultures have courageously provided examples when admitting to having treated some patients cruelly. They felt they could trace their behaviour to their lack of ability to cope with stressful, challenging situations, most of which involved strong emotions, most often related to insecurity. Many providers have never been taught how to cope with these emotions – neither the ones the patients show, nor their own.

Few providers work in environments that allow or encourage the expression or discussion of emotions as a natural part of communicating in situations involving people's health. There are several studies showing that patients forget more than half of what the provider said, shortly after

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[46] Kennifer, S & al ( ): Negative emotions in cancer care: Do oncologists' responses depend on severity and type of emotion?
[47] Erickson, R.J, Grove, W, (2010): Why Emotions Matter: Age, Agitation, and Burnout Among Registered Nurses. The online Journal of issues in nursing, April 2010.
[48] Merriam-Webster dictionary: Vulnerable

the consultation. When, in addition, patients' feelings of vulnerability are left unrecognized and unacknowledged their capacity to listen to, understand and ultimately follow medical instructions may well be further compromised.

The cost of ignoring and/or judging emotions or the health of the providers themselves has been described above: a high rate of suicide, mental health problems, conflict and burnout. A young doctor from Wales contributed this reflection:

- *"(…) I was surprised by just how little patience and tolerance I exercised in certain situations. I was surprised at how I was not meeting the very expectations I have of other people. No one likes being spoken to in a rude manner. Furthermore, directing anger or frustration at others is not an appropriate reaction to stress. (…) I recognize that as doctors we are made to feel that showing stress or insecurity is perceived as a sign of weakness or incompetency and so we avoid doing this, to our detriment. (…) it is harder to be open about these feelings with your colleagues, however, this is more likely to sustain strong working relationships and trust amongst teams. Over the last four weeks I have learned to acknowledge when and why I become angry and frustrated in work and I am learning how to manage these feelings in the appropriate way."*

Vulnerability that is controlled by being ignored remains stored in the mind and body as "an unresolved problem". It may surface later as a factor contributing to a variety of physical illnesses (ulcers, heart attack…) and/or problematic mental states or conditions, depression, burnout, reactivity provoking conflict. However, when emotions – including vulnerability – are recognized, acknowledged and managed using emotional intelligence skills, they may shift from being problematic to becoming a resource.

Edvin Schei is a medical doctor and professor at the Department of Global Public Health and Primary Care at the University of Bergen, and is challenging the traditional role of the doctor and the medical culture in his practice, his teaching and his writing. Schei started the Philosophical Policlinic in Bergen in 1998 with a talk named "Fundamentalism in white. About power and submission to authority in medical culture." In a recent book simply named – "Listen"[49], he discusses the role of the doctor and the way the doctor communicates with patients. He guides the readers through practical examples to recognise, question and reflect on their role and their power, and to build relations and really SEE their patients, and to find out and communicate about their real needs.

In a lecture at the Medical and philosophical forum at the University of Oslo on April 9th, 2019, Schei gave a talk called "The philosophical policlinic. An attempt to shake up medical culture"?

Schei emphasized the need for critical reflection among medical professionals, and the need for building "inner authority" to counteract the institutionalized authority which can make it difficult to express emotions and to be the humanistic doctor most professionals wish to be. Schei advocates for doctors to become more aware of and respect their own emotions, as well as recognising and responding to patients' emotions.

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[49] Schei, E (2015): Lytt. Legerolle og kommunikasjon. (Listen. The role of the physician, and communication). Fagbokforlaget Vigmostad og Bjørke AS

Schei says many doctors have become an echo of authoritarian attitudes and are stuck in a denial of their own vulnerability. This, says Schei, works against the doctors' own interest and health, as well as against the patients' needs and wishes:

> *"When you meet people with empathy, consciously, you also receive much good energy from the patient. As doctors we need to make emotional competence a strength – and not think that emotions make us weak or unprofessional."*

In the next section, we review how vulnerability may be seen as a resource, and some potential benefits and effects of this on medical professionals.

3.3 Evidence and reflections: Effective skills training

There is solid evidence in the literature for what constitutes effective strategies for communication skills training, and some which shows the need for and benefits of including skills to train for emotional competence. Some of this evidence is reviewed in this chapter.

After reviewing the evidence, we have selected a few key authors whose work have influenced this manual: William T Branch, Donald Schøn, Jonathan Silverman, Susanne Kurz and Mary C Beach. Carl Rogers' foundational work on identifying key aspects of person-centred care and of what makes a trainer relate well to students provides the groundwork: Rogers' work defines the focus on communication in a relationship as the starting point for the work.

3.3.1 Effective training methods – a summary of characteristics

The research base for the work is communication training programmes for providers across Europe and the US. A clinical review in BMJ in 2002[50] gives an overview of key communication skills physicians need to be able to deal well with patients, and also shows how physicians use blocking behaviour to avoid dealing with patients' emotions.

Recent literature[51] [52] shows that the body of knowledge about what works in communication skills training for health professionals is growing, and consistently points to the same: ***Training needs to be conducted over time, integrating contents and skills, using experiential learning methods where participants practice skills and are given feedback and reinforcement throughout, and use critical thinking and reflection.***

The BMJ review adds that evidence of current deficiencies in communication, reasons for them and the consequences for patients and doctors, as well as evidence for the skills needed to overcome these deficiencies, must be the basis for the teaching methods used.
There is limited research assessing the need for communication skills training in countries in the South or evaluating impact of such training but a recent cross-sectional study from seven countries in Africa clearly concludes that there is a need for communication skills training for health providers[53].

[50] Maguire, P; Pitceathly, C (2002): Key communication skills and how to acquire them. BMJ 325:697-700.

[51] van Weel-Baumbarten, E (2010): Best Evidence Teaching Communication Skills. Presentation to the third Geneva conference on Person-centered Medicine, Geneva May 3-5th 2010.

[52] Branch, W. T (2015): Teaching professional and humanistic values: Suggestion for a practical and theoretical model. Patient Education and Counseling 98 (2015) 162–167

[53] Larson, E; Leslie, H.H; Kruk, M.E (2017): The determinants and outcomes of good provider communication: a crosssectional study in seven African countries. *BMJ Open* 2017;7:e014888. doi:10.1136/bmjopen-2016-014888

However, our own research and training strongly supports the notion that the principles found in the North are also applicable for training in the South.

The research concludes that ***effective communication training for medical doctors and nurses uses interaction in a relationship as a basis for the learning***. The training methods needed for the training to function optimally are:

- **Longitudinal (over weeks/months),** using reflective and **experience-based or experiential** learning methods
- **Active** small group learning, in a **safe and supportive** learning environment
- **Practicing the skills**, with effective and focused *feedback:*
- Based on and used in **clinical practice**
- **Using critical reflection** to challenge and transform perspectives
- **Integrating** knowledge and skills
- **Problem-solving,** using active and empowering methods
- **Focus on feelings**, not on thoughts alone: *Emotional intelligence and competence needed*
- **Using authenticity (being genuine), empathic understanding and appreciation** as key skills

3.3.2 Key approaches influencing iCARE-Haaland model contents and method
The foundation: Carl R Rogers, the "father" of person-centred care

Carl Rogers challenged with his research and action the medical professional view of the patient as a dependant person, and questioned the medical professionals' power over the patient in psychiatry as well as in general medicine. He argued for the view that a client or patient is a responsible person and should be included in the medical consultation as an equal. Needless to say, Rogers' work created a lot of controversy in the medical community in the 1960s and 70s, and the question of the location of power remains a hot one till today.

> *Rogers demonstrated through a number of research projects and experiences that there are three main skills that make a difference in how a medical professional relates to and connects with the patient:* *Being authentic or genuine, using empathic understanding, and using appreciation.*

This helped the health care provider see the patient as a person, and thus contributed to developing a person-centred (rather than a disease-centred) care. Rogers showed how using these skills also had a powerful effect when used by teachers with their students, and by parents with their children. He shows how being authentic is a prerequisite for personal growth.

He also described the effects of non-judgment and empathy, as contributing to healing:
"When… someone really hears you without passing judgment on you, without trying to take responsibility for you, without trying to mould you, it feels damned good… When I have been listened to and when I have been heard, I am able to reperceive my world in a new way and go on. It is astonishing how elements that seem insoluble become soluble when someone listens. How confusions that seem irremediable turn into relatively clear flowing streams when one is heard."[54]

The medical educator: William T Branch focuses on experiential learning, +3
William T Branch has published widely about medical education the last 30 years. In a position paper from 2015[55] he sums up his experience as a researcher and teacher of medical students and professionals over 30 years and provides an extensive review of the field of medical education.

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[54] Rogers, Carl (1978): On Personal Power.
[55] Branch, W. T (2015): Teaching professional and humanistic values: Suggestion for a practical and theoretical model. Patient Education and Counseling 98 (2015) 162–167

> Branch suggests adopting a practical and theoretical model for teaching professional and humanistic values which consists of and combines four main teaching methods that must be in place for effective learning to take place:
> - ***Experiential learning of skills,***
> - ***critical reflection,***
> - ***a supportive group process, and***
> - ***a sufficiently longitudinal curriculum.***
>
> He shows how these methods mutually reinforce each other to enhance commitment to core values and to optimize professional identity formation.

A review of Best Evidence teaching on Person-centred basic communication skills[56] supports these findings, and adds some, including the need to use interaction in a relationship as a basis for the learning.

Branch also shows clearly that the "Road to Professionalism" goes through reflective learning in theory and practice, and the use of critical thinking[57].

Reflection In Action: Donald Schøn focuses on learning in the situation

Schøn did his work in the US. A major method he contributed is Reflection In Action, which he describes as "***the ability of professionals to think what they are doing while they are doing it***"[58]. Using this method, Schøn asks students to be aware of their actions while at work, and then uses their observations to discuss and reflect on the situations observed (Reflection On Action). ***This method, with our additions, is an important basis for the iCARE-Haaland model.***

Learning from experience is a key skill: Systematic review

In a systematic review, Mann et al (2009) describe learning from experience as a key skill in health professions: Critical reflection on experience and practice is essential to identify learning needs; reflection is a key method to develop an active approach to learning, and to develop self-awareness and self-monitoring as professional skills. Despite these clearly documented advantages, Mann concludes:

> *"Yet, despite reflection's currency as a topic of educational importance, and the presence of several helpful models, there is surprisingly little to guide educators in their work to understand and develop reflective ability in their learners."*

Communication Skills in Medicine: Silverman, Kurz, Draper

The influential works of the authors on "Teaching and Learning Communication Skills in Medical Education" come with a companion manual, "Skills for communicating with patients", and are seen as "The Classics" for medical education[59], [60]. The manuals provide a comprehensive approach to teaching and learning throughout the three levels of medical education for physicians in family and specialist medicine (undergraduate, residency and continuing medical education). The books have become standard texts in teaching throughout the Northern world, and the methods described are all evidence based.

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[56] van Weel-Baumgarten, E.M and Brouwers, M.H (2011): Best Evidence Teaching of Person-centred Basic Communication Skills: a reflection E.M.

[57] Branch, W.T (2010): The road to professionalism: Reflective practice and reflective learning. Patient Education and Counselling 80 (2010) 327–332.

[58] Schøn, D. A (1983): The Reflective Practitioner – how professionals think in action. Basic Books, 1983 ISBN 0465068782

[59] Kurz, S; Silverman, J; Draper, J (2005): Teaching and Learning Communication Skills in Medical Education, second edition. Radcliffe Publishing, Oxfor and San Fransisco.

[60] Silverman, J; Kurz, S; Draper, J (1998): Skills for Communicating with Patients. Radcliffe Medical Press, Oxford

The manual uses the Calgary-Cambridge Observation Guide as a basis for the curriculum and is a goldmine of knowledge and methods for medical teachers. Experiential learning methods are used as the standard for teaching, and the evidence base supports the principles and practice we use in our training.

Patient-centred and Relationship-centred Care: Patients' choice
Research on patient-centred care shows that PCC has a positive impact on patient outcome[61] and is clearly preferred[62] by patients: They want to be treated with respect and to have the medical professional take their perspectives and wishes into account. Patients in the UK, Canada and South Africa have similar wishes for how they want their health professionals to communicate with them, pointing towards a global definition of patient centred care[63].

In her article on Relationship Centred Care: A constructive reframing[64], Mary C Beach writes:
"All illness, care, and healing processes occur in relationship—relationships of an individual with self and with others. Relationship-centered care (RCC) is an important framework for conceptualizing health care, recognizing that the nature and the quality of relationships are central to health care and the broader health care delivery system."

A main difference between PCC and RCC is that RCC includes a stronger focus on emotions, and also acknowledges the moral value of establishing and maintaining genuine relationships.
PCC and RCC are a basic starting point, central to the philosophy and practice of the iCARE-Haaland training model.

3.3.3 Building emotional competence and emotional intelligence
Emotional intelligence: Skills to manage emotions and strengthen resilience
There are a number of different ways of describing "Emotional Intelligence". Daniel Goleman, who has written several books on the subject, describes EI as *"the capacity for recognizing our own feelings and those of others, for motivating ourselves, for managing emotions well in ourselves and in our relationships"[65].*

In a critical review of using EI in medical education[66], Cherry & al describe that "there is increasing research evidence that doctors' EI influences their ability to deliver safe and compassionate health care, a particularly pertinent issue in the current health care climate". The review concludes that *"Emotional intelligence-based education may be able to contribute to the teaching of professionalism and communication skills in medicine, but further research is needed before its wholesale adoption in any curriculum can be recommended."* Other articles conclude similarly – that EI skills are useful, and – that there are many unanswered questions. Some of these questions relate to whether EI can be taught, and to defining more clearly the effects the practice of EI has on the learner's own health.

Patients appreciate EI: An article on EI and the healthcare staff in the US refers to a survey of more than 2.4 million patients receiving medical care which showed that patients place a high priority on

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[61] Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49:796–804. [PubMed]
[62] Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, et al. Preferences of patients for patient centred approach to consultation in primary care: observational study. BMJ. 2001;322:468–472.
[63] Stewart, M (2001): Towards a global definition of patient centred care. The patient should be the judge of patient centred care. BMJ. Feb 24; 322(7284): 444–445
[64] Beach, M.C (2006): Relationship-Centred Care. A constructive reframing. Journal of General Internal Medicine. Vol. 21 Issue 51, pp53-58
[65] Goleman, D (1995): Emotional Intelligence. Why it can matter more than IQ. Bloomsbury, London
[66] Cherry, M.G & al (2014): Emotional intelligence in medical education: a critical review. Medical Education 2014: 48: 468–478

the degree to which a medical staff meets their emotional needs. The article highlights empathy, self-awareness, self-management and social awareness as key competencies for EI training[67].

In parts of the scientific literature, EI is described as a set of four distinct yet related abilities. In an article on EI and Resilience[68], the abilities are described as:

Article on EI and Resilience: Definition of EI	EI made simple
1. Accurately perceiving emotions	1. Recognize
2. Integrating emotions with cognition	2. Think
3. Understanding emotional causes and consequences, and	3. Analyse
4. Managing emotions for personal adjustment	4. Act

The article concludes that abilities to use emotional intelligence skills facilitates resilience to stress.

These skills are what we have focused on in our training, as they relate closely to skills providers develop in the self-observation and reflection tasks. Please see chapter 6 for a description of how these skills are developed while doing the reflective tasks.

Vulnerability: A source of human connectedness, and empathy

The ability to practice emotional competence (and EI) is to a large extent dependent on skills to recognize, acknowledge, appreciate and manage vulnerability. Vulnerability may be seen as an essential aspect of being human, and the very quality that enables a health professional to establish a connection with a patient, and enables the patient to speak about her deep concerns and fears. A young doctor participating in the training in Wales shared the following reflection of discovering the positive effects of applying emotional competence:

> *"Recently I was working in a pre-op clinic for patients who were due to undergo cancer surgery within the next few weeks (…) assessing their fitness for anaesthesia/make an anaesthetic plan - a rather routine process from my point of view.*
>
> *(As) I introduced myself and my role to the patient and explained what operation they were due to have and why, (…) I recognised that this is where I feel vulnerable……the patient is feeling emotional and faced with a lot of uncertainty…… normally my defences would kick in and I would shy away from the subject and press on with the consultation.*
> *I recognised it was an emotional time for the patient and I decide to verbalise this - saying that this must be an extremely stressful time for the patient and that they must have a lot going on…..tapping in to past experiences from my past/family/friends to empathise with the patients situation. The patient opened up to me and I listened to her….giving her time to talk and reassuring her where I could. I felt like I was able to build a connection where in the past I would have avoided it."*

The connection to empathy: The American sociologist Brene Brown says that vulnerability is "…the birthplace of innovation, creativity, trust and empathy"[69], and shows how there can be no learning without vulnerability. Her extensive scientific research into vulnerability and shame has resulted in an understanding of the role and importance of vulnerability in relationships which is starting to break down the apparent taboo against speaking about the concept. Brown shows how people want to avoid negative feelings of shame, fear, sorrow, grief and disappointment by numbing them, but –

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[67]Copperman, K.B (2007): **Emotional intelligence and the healthcare staff:** Maximizing performance and patient satisfaction. Srm-ejournal Vol8 no1
[68] Schneider, T & al (2013): Emotional intelligence and resilience. Personality and Individual Differences 55, 909–914
[69] Brené Brown | Daring Classrooms | SXSWedu 2017

that when they do, they also numb positive feelings of joy, gratitude and happiness: You cannot numb feelings selectively. Brown links the avoidance or numbing of emotions to over-eating, overuse of substances like alcohol and drugs, overuse of medicine, and – to the quest for perfectionism: "Perfectionism is a self destructive and addictive belief system that fuels this primary thought: If I look perfect, and do everything perfectly, I can avoid or minimise the painful feelings of shame, judgment, and blame[70]". Perfectionism does not open one up to feeling or practising empathy.

The need for health professionals to be able to recognize and manage emotions in this "landscape" is increasingly obvious. Brown writes and speaks about emotions with humor and self-irony, and emphasizes the wisdom of being clear: "Being clear is kind, being unclear is unkind". She is an excellent communicator, and has probably done more to make knowledge about vulnerability accessible and understandable than anyone else: Her TedTalk "The Power of Vulnerability" has reached an audience of over almost 40 million viewers (April 2019).

The renowned American professor and writer Saul Weiner, who is a medical doctor and research director at the University of Illinois, US, notes that *"… in my research, I've shown that caring physicians are attentive physicians, and attentive physicians ask questions when there are discrepancies between what the patient says and what is observed, and that those questions in turn lead to information which is critical for care planning, which in turn leads to better outcomes."[71]*

3.3.4 Research into vulnerability as a potential resource
There exists some, though scarce, research on professionals' relationship to vulnerability, and its connection to ethics. Conclusions from these may be summarised as follows:

Recognising and managing vulnerability can be taught as a strength, a resource helping health providers to achieve important goals in their work:
- ***It improves the capacity to connect with and relate to both oneself and to other people***
- ***It provides a basis for experiencing empathy, including for being kind to oneself;***
- ***It helps one learn how to nurture, including oneself;***
- ***Thus, it helps one find and maintain balance in life.***

Some brief examples from the literature:
In her investigation of how doctors use vulnerability, and how it can affect patients, **Kirsti Malterud**, a Norwegian researcher who is also a GP, concluded:
> "*The doctor is expected to be detached and omnipotent, yet compassionate and empathetic. Attention is usually drawn to the negative aspects of doctors' vulnerability and emotionality related to burnout or misconduct. Focusing on the potential benefits of vulnerability in the doctor, we find that it may bring strength, but must be used with caution*.»[72]

Gjengedal[73] investigated the link for health professionals between empathy and vulnerability: She found that a strategy to help them understand the patients or families from ***their*** own perspective "…seems to make vulnerability bearable or even transform it into strength. Being sensitive to the vulnerability of the other may be a key to acting ethically". When the professional attempted to help from ***her*** own personal perspective, her attention remained on herself, and this could impair the ability to help.

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[70] Brené Brown, The Gifts of Imperfection: Let Go of Who You Think You're Supposed to Be and Embrace Who You Are

[71] Saul Weiner, personal communication, January 2019

[72] Malterud, K (2009): When doctors experience their vulnerability as beneficial for the patients. A focus-group study from general practice. Scandinavian Journal of Primary Health Care, 2009; 27: 85_90

[73] Gjengedal, E &al (2013): Vulnerability in health care – reflections on encounters in every day practice. https://doi.org/10.1111/j.1466-769X.2012.00558.x

The authors conclude:
> »However, in order to recognize vulnerability as strength, one needs help to face one's vulnerability in the first place. Then, a gradual growth process leading to flourishing might take place[74].»

Norwegian theology professor Sturla Stålsett and his colleagues write about the importance of vulnerability and security in the context of international relations:
> "Vulnerability was seen purely as a weakness to be overcome. Our main point is that vulnerability is both *the foundation of an ethical and political right to protection* and *a fundamental precondition for ethical human behavior – both between individuals and at the political level. We even dare to speak of human vulnerability as a potential strength."* [75]

They call for a new understanding of fundamental ethical questions to better enable us to protect people facing such crisis as need, abuse, and accidents:
> "Vulnerability is the unique capacity for receptivity and empathy which allows human beings to acknowledge and care for their ethical responsibility for each other, for the community and their environment. Against this aspect of vulnerability, we ought not protect ourselves."[76]

Hal and Sidra Stone[77] developed the model and method "Psychology of Selves" enabling people to become more self-aware. They consider an understanding of vulnerability as essential to becoming a balanced person able to offer empathy to others – and oneself. They describe vulnerability as "…*to be without defensive armor, to be authentic and present."* A health provider's capacity to experience and communicate respect for vulnerability may prove crucial to his developing and maintaining reliable connections with his patients.

3.3.5 Vulnerability: Approach, but with educated caution

As described above, these skills are much needed in the medical profession, enabling providers to identify more accurately with their patients, which in turn enhances the possibility for understanding them. When the health professional is able and willing to share – carefully, appropriately and with awareness – from her own life experiences and the vulnerability they evoked – the health professional becomes *a person* to the patient, potentially deepening their mutual empathy. This can influence on the quality of clinical practice. However, training is required to utilise this resource responsibly.

Boundaries needed: The awareness necessary for determining how, when, with whom and to what extent to express vulnerability – or not to do so – demands that the health professional develop well-functioning boundaries. She must ensure that there is a balance between what she takes in and what she gives out. For example, she needs to protect herself, having empathy also for herself and her own vulnerabilities and needs, as well as for those of the patient. If not, she may become emotionally exhausted and prone to burnout. To become skilled at using empathy and vulnerability with awareness, providers need to reflect personally and interactively with others about their own difficult emotional events, sensitive situations and general sensitivities.

Acknowledging imperfection: Health professionals may not be well known for acknowledging mistakes and apologizing to their patients or colleagues. To be able to determine when and how to

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[74] Gjengedal, E &al (Ibid)
[75] Vulnerability and security, p.8-9 (2000). Published by the committee for international issues, in the ecumenical (will get right info)
[76] Ibid
[77] Stone, Hal and Winkeman, Sidra (1985): Embracing our Selves. Voice Dialogue Manual.

do so, honourably, appropriately and sincerely, the HP needs to acknowledge her own vulnerability, including in the context of medical legal requirements.

3.3.6 Emotional competence to prevent and reduce burnout

The competence providers learn – often on their own – is to **control** emotions, rather than to **manage** them. This often contributes to burnout[78, 79,80,81, 82,83].

Some interventions described in the literature show clearly that giving physicians and specialists skills and insights, through awareness, reflection and communication skills training over time, may reduce provider burnout, as well as have positive effects on patient outcomes. See for example literature on Balint groups[84], to deal with challenges in physicians' practice, and an article on training physicians in "mindful communication"[85] which showed short term and sustained improvements in well-being and attitudes associated with patient-centred care. There is a lage literature on these topics, mostly concluding that causes of burnout include emotional exhaustion, depersonalization and lack of job satisfaction. Learning to manage emotions has a positive effect on limiting burnout by reducing emotional exhausition and depersonalization, and increasing job satisfaction.

The public health challenge is an important one – providers burn out or leave the profession at an alarming rate. The problem is even more pronounced in the resource-poor countries - the "care drain" from Africa is depleting scarce resources that are sorely needed to deal with the continent's many health challenges.

3.4 The iCARE-Haaland model fills a gap in training and literature

The iCARE model contributes to filling two gaps in both the literature and its application to training:
1. **A training approach** to strengthen skills on emotional competence for health providers, and
2. **Learning method to build a personal evidence base, and empower participants to change**: A sequence of guided, systematic self-observation and reflection tasks which enables participants to discover how they communicate, what are the effects of their communication (and of their automatic emotional reactions) on the other person(s), and thus develop an inner motivation to learn, and to change.

1. The training approach

Training on emotional competence and EI has become very popular, especially in the business world and for leaders. Few – if any – models take into account that these skills take time and effort to learn if they are to be internalised and work well for the individual: a "quick fix" is not the answer.
The iCARE-Haaland training approach combines communication skills training with skills to manage emotions, using emotional intelligence as a guide. The training has a number of features that distinguishes it (see chapters 2 and 4), and the approach works across different cultures. Having been

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[78] Mann, K &al (2009): Reflection and reflective practice in health professions education: a systematic review. Adv in Health Sci Educ (2009) 14:595–621. DOI 10.1007/s10459-007-9090-2

[79] Bagdasasov, Z and Connelly, S (2013): Emotional Labor among Healthcare Professionals: The Effects are Undeniable. Narrative Inquiry in Bioethics • Volume 3 • Number 2

[80] Szczygiel DD, Mikolajczak M (2018): Emotional Intelligence Buffers the Effects of Negative Emotions on Job Burnout in Nursing. Front Psychol. 2018 Dec 21;9:2649. doi: 10.3389/fpsyg.2018.02649. eCollection 2018. DOI: 10.3389/fpsyg.2018.02649

[81] McQueen, A. C (2004): Emotional intelligence in nursing work. J Adv Nurs. 2004 Jul;47(1):101-8.

[82] Smith, K.B et al (2009): Emotional intelligence and nursing: An integrative literature review. International journal of nursing studies 46(12):1624-36. DOI: 10.1016/j.ijnurstu.2009.05.024

[83] Panagiotis E Prezerakos (2018) Nurse Managers' Emotional Intelligence and Effective Leadership: A Review of the Current Evidence. Open Nurs J. 2018; 12: 86–92.

[84] See for example Kjeldmand, D. and Holmstrøm, I. (2008): Balint Groups as a Means to Increase Job Satisfaction and Prevent Burnout Among General Practitioners. Annals of family medicine Vol 6 no. 2

[85] Krasner, M.S. &al (2009): Association of an Educational Program in Mindful Communication with Burnout, Empathy and Attitudes among Primary Care Physicians. JAMA Vol 302 no 12, Sept 23/30

developed "from below", with health practitioners defining the needs and testing out the contents and methods over time, ***the model responds to the actual work situations of the health providers.*** It helps them develop practical ways to handle real challenges.

2. **Learning method to build a personal evidence base, and empower participants to change**

We have not found much guidance in the literature on – how to train health providers to observe and reflect IN Action, systematically and using a pedagogical sequence to build skills over time. We have also not found training programmes that work well to develop insights and skills on recognising and managing emotions for health providers, related to their daily work situations.

We use Donald Schøn's Reflection in action as a base, and have built a model that guides participants to build their learning about communication and emotions in a systematic way. Starting with "simple" skills like listening, participants observe and reflect systematically on one skill at a time, building their own personal evidence base on how they communicate and what are their patterns of communication in different situations. They also observe the effects of their communication on others, i.e. how they react, and then gradually include learning about how emotions influence the communication. They look at how their own emotions affect the communication and behaviour of the person they talk with, and how the other person's emotions can affect how they themselves communicate. This becomes their personal evidence base – a base from which to practice EI.

When building up this knowledge, understanding and insights based on their own experiences over time, the participants gradually build confidence in using their skills with awareness: They see that they can influence the communication, and start taking responsibility for how they communicate. This is a major shift, and is facilitated by the **emotional impact** they experience when accepting that their communication has an effect on others, and by working systematically to understand and learn from this effect. Their personal evidence is supported by evidence from theories, during workshops.

This process is empowering, and it belongs to the participants.
These factors contribute to the changes becoming, for many, a sustainable part of new behaviours.

3.5 Results from using the iCARE-Haaland model in nine countries

The training has been assessed by using a variety of qualitative tools. Self-assessment (baseline, endline) and narratives describing learning and insights from using observation and reflection tasks (Most Significant Change stories, with examples) have been used in all nine countries. In addition, an evaluation was conducted by an independent group in Kilifi, Kenya in 2011, and the training in Wales was evaluated by an independent researcher conducting a focus group discussion with participants after training.

We have included examples from participants' feedback throughout the manual, to illustrate challenges and learning. In this section, we give a summary of some of the feedback.

The trends in the feedback from participants in all training sites are remarkably similar, given the differences in cultures from Lithuania and Russia to Namibia and Kenya, and to Wales.

3.5.1 *A summary of main trends from the feedback*
Participants have experienced the training as very useful, and the most important skill they gained was – to the surprise of all – learning emotional competence: they see there is a clear link between how they manage emotions, and how they experience their work. Many say that they cope better with the emotional demands from patients when they have learnt to recognize, acknowledge and

manage their own emotional reactions and needs, and at the same time communicate well and meet the needs of the patient. When they give (effective) emotional care and in turn receive emotional nourishment or gratification from the patients, it impacts positively on their job satisfaction.

Changes during first three months of observation and reflection (before the workshop)
In all nine countries, the observation task feedback shows strengthened awareness among participants regarding how they use communication skills such as listening, asking questions and giving feedback, and of the effect of using the skills in different ways.
Some examples:

➢ *"It was amazing that I could give her a lot of time just listening to her without interrupting….. It was amazing to me how just listening could work magic."* HCW, Kilifi

➢ *"When listening to patients before, I always had things to do, and did them while I listened, not thinking about how the other person felt. Then I tried the observation task and listened fully to the patient and saw how it worked: I caught more of what the other person said, I understood deeply, not only the facts. When I listened with full attention, I would understand why this patient has a problem, e.g. why he is without family. When listening like this, I do not judge, I listen to understand deeply, I listen with empathy. I can also communicate my emotions – and tell him "I worry about you, how are you really?" Then the patient will tell. And then we can deal with the problems – together."* HCW, Kilifi

• *"Patients open up if they are talked to nicely, politely and given time to express themselves and their views without fear. I try to put myself in their situations and this helps me to understand them better."* HCW Kilifi

Another key point is – participants strengthened awareness of **the influence of emotions on communication**, especially related to their own insecurity, and their anger:

• *"Anger and fear after an HIV positive husband became aggressive when his wife tested negative and he was saying our machine and the health workers don't know what they are doing and are unskilled, it can't be possible. I withheld my anger and fear and after he had expressed his feelings I asked for his opinion whether he accepts the results or not. He calmed down and cried then later accepted."* HCW, Kilifi

"I think mainly communication becomes a problem when we don't know how to deal with our self in the 1st place. If I knew how to deal with my own emotions, I would treat others better" HCW group 3, Kilifi

"When I'm very busy in the ward, I wear a stone face so that clients don't approach me to tell me anything which will disrupt my days program. So these clients normally look at me on the face and fear so much such that even if they have very burning issues they cannot tell me because I'm unapproachable" HCW Kilifi, group 3

Many made improvements on their own during the first three months of observations
Most participants have **made improvements in how they communicate** with patients and colleagues, based solely on discoveries they make through observations and reflections during the first three months, or during the first phase of the course process. Below is a selection of such changes, chosen to show major trends in the changes.

Examples of key changes, Lithuania (where the first course was held, in 2006)

Before training process (April)	After observations and reflections (October)
"It is most important to inform the patient about treatment and hospital routines."	*"It is most important to listen to the patient"*
"Feelings are not important"	*"Feelings are important"*
"I have to solve all problems by myself"	*"I have to cooperate with others"*
"Seeing the patient as 'just a patient'"	*"Seeing the patient as a whole person"*

Participants discovered what they wanted and needed to learn, in all countries, as a major outcome of working with the observation and reflection tasks*. In all countries, participants discovered the need for learning about emotions, and to all – this was a surprise.*
Their questions and examples are used in the course, to create role-plays, demonstrations and exercises.

Changes throughout the process
A majority of the participants say that in the course of the learning process, they have strengthened their awareness in all the work they do – and they especially recognise and manage their emotions in a better way by stepping back from automatic emotional reactions. This has led to the participants experiencing improved relationship with patients and colleagues and having a strengthened confidence in their work. Many report that they have fewer conflicts.

Burnout symptoms[86]: Many report changes in all three major symptoms leading to burnout: They have reduced emotional exhaustion, they treat patients as persons (=stop depersonalisation), and they experience an increased job satisfaction.

The extent to which participants have experienced the changes has varied, but all say the focus on strengthening awareness to improve their communication skills have had positive outcomes for themselves and for their work.

More specifically, the assessment shows that participants after the nine months training process have strengthened their skills to -
* *Give and receive* respect
* Build *trust* with patients
* Treat patients as *persons*
* Look for *reasons* for patients' actions; dialogue with them (rather than judge them)
* Take **responsibility** for improving communication (stop blame)
* *Stop automatic reactions*; focus on patient
* *Understand, respect and take care of their own + patients emotions*
* Increased awareness of *effects of showing respect*, on patients *emotions,* and consequently on *cooperation and care*.

In Kilifi, Health care Managers confirmed participating providers' assessment of change (in interviews in an independent evaluation of the courses after two years (2011).

An essential skill: Stepping back
One specific skill was consistently gained across all countries – learning to recognise emotions, and automatic emotional responses, and control them by taking a step back (in effect – practising EI):

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[86] Maslach, C. (1982): Burnout: The Cost of Caring. Englewood Cliffs, NJ: Prentice-Hall

"In an ordinary situation you can take so much, you just bottle it up and then….you just give up on that person…But with stepping back…you become aware of this person's emotional status and more important you become aware of your own. So you tell yourself 'oh, now I'm getting irritated'… you will not just write off that person…From what we learned in the course, emotions are a part of life but if you don't take care of them…they can come in the way….so just being aware of them and trying to be in control over them…."

HCW, Kilifi, reported to the independent evaluation group

There were clear changes shown in all four aspects of patient-centred care: The providers' relationships with patients, with colleagues, with the community, and – with themselves. In this last dimension of patient-centred care the provider's relationship with herself (or: developing self-awareness) there has been a lack of practical training models and opportunities. In this aspect the iCARE-Haaland training model has had a real impact on the participants across all the cultures.

Changes at home: Many participants note that communication skills learned in this course could also be used at home. They saw for example that using constructive criticism and managing automatic reactions improved relationships at home (e.g. with partner and with children). One provider in Kenya was asked by her church to talk to other members about communication skills, recognising the usefulness of what she had learned, to the service of the community.

Some other examples of the changes experienced in the later stages of the course process:
An example of empowerment:

"Thanks to this course, I have learnt a lot and have broken the barriers that are hindering me to communicate effectively. I have realized that I am the problem when it comes to communication. I have decided to have a change and that change is me!"   *HCW, Kilifi*

From the independent evaluation in Kenya, 2011:

'Some of them used to be very arrogant in talking to patients, they were rude but now they are polite…When a patient has refused a procedure they take time to understand why they have refused, to express their fears…maybe they have not understood the importance.' (23N)

3.5.2 Special note on training of trainee doctors in Wales (2016-17)

This was the first training held for medical doctors, only (the others were for a mixture of medical professionals). The first round of training (2016) indicated that the trainee doctors experienced the same type of challenges as the professionals in the other countries. In addition, three of 11 participants were very dissatisfied with their jobs and considered leaving medicine. At the end of the training – no one did, indicating a link between emotional management and job satisfaction.

"The fuel for resilience"
The Wales training courses focused specifically on strengthening resilience, and evaluation showed clear links in this direction. Participants used positive emotions as "the fuel for resilience", and especially changed their perceptions of vulnerability from being a threat to fear and ignore, to appreciating it as a powerful resource to recognize and manage. The examples below illustrate the use of emotional intelligence skills – especially to step back from emotional reactions.

«Positive feelings are the fuel for resilience»

BUT: Genuine positive emotions are only possible if you learn to acknowledge and go through negative emotions – by practicing the four EI skills!

Examples of changes from Wales:

- ***"I saved my own sanity and retained control****: Today I worked with a consultant with whom I have previously argued and cried as a result (very non resilient!!) I was dreading today but thought it a good opportunity to practice my emotional intelligence especially in how I respond to people and being kind to myself.*
   This consultant can be argumentative and belligerent. I suppose it helped that I knew this before we even started. However, when the consultant argued against things that were said I listened to his reasoning behind why he was being argumentative. Previously I would have been overly defensive but listening and contemplating his reasoning had two effects; it made the consultant slightly more tolerable to work with and by listening it gave me the time to control my emotions and not respond in such a drastic way as I would have done previously. I also chose when to provide a counter argument which I think saved my own sanity and allowed me to retain some control."

- ***"My journey to becoming a more resilient doctor:****Over the last six moths I have actively and consciously started listening to the people around me. I have started picking up on subtle clues which I may have been blind to before. Through listening and observing I came across a fellow trainee who was suffering with her confidence and I helped her adopt the resilience model. Another revelation that I have had is that some criticism that I may hear has very little to do with me and a lot of do with person giving it. I now take my time to process information before reacting and tend not to have very emotional reactions but rather measured ones. This portrays a very professional image to the seniors and they usually respect it and find it easy to teach me.*
   It's very easy to say that I am resilient now but sadly I don't think that's the case. It's a journey for me and my emotional intelligence is something I have to work on daily. I do however believe that training is something to be enjoyed and by making certain tweaks I can change my inner critic to practice emotional intelligence."

- ***"I no longer take rudeness so personally****: I now accept that I am good at my job and am open to criticism as an opportunity to learn and develop and become better. I no longer take rudeness so personally, I am able to more effectively manage the emotions provoked in me when people behave in a rude manner and adjust my behaviour accordingly."*

The learning in Cardiff is however less deep and thorough than the learning for the groups who go through the full course. Some main reasons for this are the shortness of the sessions together (three hours per workshop) and the subsequent lack of time to dive into the theories and reflect on them in a substantial way. We have used much time to affirm the learning through using examples from the tasks, and while this has been important – it has also prevented us from going into the theory in any substantial manner. It also prevented the group from establishing the deep, trusting relationships which we saw in the groups who were given the chance to work together over several days. With no follow-up for the groups – except informally – there is thus a question about how much of the learning turned into sustained new behaviour

4 The iCARE-Haaland model to Communicate with awareness and emotional competence: Approaches, Core elements and Use of Power

The training model has a number of approaches, methods and features that define it, and in important ways sets it apart from other communication training for providers. In this chapter we give an overview of six specific features that define the iCARE-Haaland training model, and why:

1. The holistic approach: Communication in a context
Communication is seen in the context of the regular work situations, influenced by a number of different aspects, as illustrated in "**Building the House of Good Communication**", chapter 4.1.2. *The "House" is a new creation as a part of the model and is described here for the first time.* The choice of approach influences the course process (chapter 4.1.4) and contents (chapter 4.1.5).

2. The humanistic approach: Using Patient centred and Relationship centred care
- as the underlying "philosophy" regarding patient care. See chapter 4.1.3.

3. The process approach: Training over several phases
The training process has distinct phases that build on each other, each with its own aim.

4. Key concepts and contents
The concepts and contents define what we teach participants.

5. Core elements and features that define the training (see chapter 4.2):
- *Communicating in professional relationships*, using the interaction as a starting point for developing awareness about how best to communicate with the other person(s);
- *Seeing emotions as a natural part of communicating well in relationships,* and building emotional competence as a main aim;
- *Becoming aware of the intention of the communication*;
- *Strengthening self-awareness:* Seeing effect of your communication. Participants strengthen skills to create awareness and develop a confident basis for giving patient-centred care and communicating well with colleagues. See chapter 6;
- *Experiential learning methods*, using self-observation and reflective tasks as a foundation for developing awareness, gaining insights, and finding inner motivation to learn. In the workshops, we use interactive reflections and add theory, to deepen the learning. Chapter 6;
- A focus on *attitudes, values and skills of the trainers*, acknowledging that trainers need to be (progressive) role-models who practice what they preach, if they are to have credibility with the participants and make them feel safe to open up, share, reflect – and learn (Ch7).
- **To see the provider as a resource person -** and a human being with an inherent motivation to care and to do good work. If she does not, there are strong reasons. The underlying attitudes, norms and values (often subconscious) also strongly influence the provider's behaviour. It is in becoming aware of, and then exploring and dealing with these reasons that providers will understand and have the choice to act differently, with awareness.

6. Changing the power practice: from blame to balance (see chapter 4.3)
The further sections in this chapter are related to a main aim for the whole learning process – empowering participants gradually with awareness and skills to enable and motivate them to get a

perspective on the power practice within the medical culture, and the implications of this for their daily practice. With this perspective, they also learn **to take responsibility for the communication in an interaction**. When they do, a major shift takes place – they look at and question their own process of communication (and where they could have improved), rather than (use their power position to) blame others for lack of a good result. With these perspectives and skills, they are ready to **question and challenge cultural norms** that affect the quality of care, and relate this to the use of power. With these insights, they decide to change. And for this to happen – they need to experience learning as safe: We **take the fear out of learning**.

All these features are supported by research, much of it having been defined and reinforced in the last few years, confirming what we have seen to be the case during our training courses.

4.1 Overview of training approach, contents and process

4.1.1 The holistic approach: Communication in a context

Communication always happens in a context, and in health care, the context is usually a relationship between a health provider and her patient, or two health providers, or with people in a community.

Understanding the context of the providers' own everyday work challenges is a central building block for the course, and for the iCARE-Haaland model. This requires addressing providers' attitudes and values, and how these influence work and relationships. *We teach the health providers skills that are directly related to their own work situations, to the professional relationships with patients, colleagues and supervisors, and the interactions they have with all of these*.

Differences: Communicating with awareness and emotional competence in a context, <u>vs</u> Communication as a set of mechanistic skills

	Communicating in a context: **No "recipe" or standard response – must use emotional intelligence to assess**	**Communication as mechanistic skills: Closer to standard response – "This is what you must do"**
Description	Communication skills in the context of working relationships within the actual health care settings of the daily work: **a collection of choices you make,** based on your reading and understanding of the context, and of the needs of the person you relate with	Communication skills as **a set of techniques** you learn, independent of context, e.g.: Listening, asking questions, non-verbal communication, giving feedback. Commonly used in communication skills training.
Emotions	Recognising the emotions (your own, and those of the person you communicate with), and manage them consciously, with awareness and respect	Usually does not include learning about emotions. The participant is expected to sort these out on his own.
Basis	Being **aware of** and comfortable with the **foundation for good communication** (your attitudes, values and ability to be authentic or genuine), **the intention** to find a common goal and handle the problem, and *then – and only then* – choose the communication skills and emotional approach which are needed	Usually does not address attitudes, values or intentions, or the effects of these, on patients

We teach communication skills in relation to work contexts where they have important functions to create safety, build trust, and to establish a professional relationship with the patients to help them to cooperate as partners in care. *Communication skills are an essential part of almost any*

interaction with patients and colleagues and are best learnt when understood and discussed in these contexts, where every context and challenge requires a different set of skills to be used. Providers learn to use their own awareness to observe and assess the situation, and to choose which approach is appropriate for each context and situation. Participants learn to practice constructive communication and awareness and management of emotions as a natural set of skills, employed to establish and maintain the relationship with the patient, and to build a basis for providing professional medical care.

4.1.2 Building the House of Good Communication

Building the House of Good Communication

Attitudes and Values: Respect, Responsibility, Fun: Build trust and relationship

Communication skills: Listening, questions, Presence

Managing emotions: Insecurity, safety, appreciation

The Foundation: Awareness, authenticity/being genuine, Conscious Intention

"Building the house of good communication" is a central piece in the iCARE-Haaland model. To build trust and create a good relationship, we pull together the different elements that influence how a health provider communicates, using concepts and illustrations from the 23 modules for the course (see parts C and E in the resource collection). Showing the elements as "rooms" in and "Foundation" of a "House" is a way of visualizing the context, and may enable you to remember better and to "pull up" the image when you need it: Most people remember pictures in a context much better than they remember words alone.

The house is built in the following way:
- **The Foundation** is built on you as the competent communicator: You act with awareness, you feel safe in yourself as a person (you are being genuine, authentic, "yourself"), and you know your goal, e.g. to make the worried patient (a mother with a sick baby) in front of you feel safe and cared for (conscious intention);

- **The First/Left Room** is filled with attitudes and values (*we could call it "the bed room", as most of our attitudes and values are "just there", sleeping, but nonetheless influencing our action and communication strongly*): These "set the tone" for what kind of communication is being used. If the mother with the sick baby is poorly dressed, and dirty, your attitude of respect, and your values of seeing the patient as a person will make her feel welcomed and cared for. These attitudes are important for making her feel safe and to build trust, which is essential for building a professional relationship as a basis for constructive communication. The picture of the nurse scolding the patient is the opposite of what we are aiming for – and is included to show the contrast to what is needed. Scolding or disapproving of the patient is common in many cultures, and occurs in all cultures.

- **The Second/Central room** contains the communication skills (*we could call it "the living room", as this is where a lot of the action takes place*): What you say and how you say it will further influence the interaction between you: When you are present, with the intention to understand her situation, you listen actively to her story and ask good (often open) questions – then you have a good basis for understanding and making good medical choices;

- **The Third/Right room** is filled with emotions (*we could call it "the kitchen", because emotions are often "messy", but when recognised and well appreciated, they can turn to "meals" and actions that give much joy*): Using EI to recognise and analyse the emotions before taking action will further enable you to determine the right thing to do: You recognise the mother is worried and insecure (*and maybe you get irritated that she looks dirty, but realise what you feel, and set it aside*). You welcome her warmly and appreciate her for bringing the baby to you, and you make her feel safe by being aware and showing her kindness, care and competence.

"Living in the house of Good Communication" makes life different – as you experience the impact of this combination of skills, on the outcome of an interaction. For each interaction, you need a different set of skills. When you think of "**Good Communication**" as a skill you have built up over time, you will gradually be able to select the best tools and skills to manage the interaction wisely.

4.1.3 The humanistic approach: Patient-centred and Relationship Centred Care

The training focuses on developing skills and insights to strengthen relationships in the four aspects defined in Patient-centred Care (PCC): between –

- the provider and the patient,
- the provider and her colleagues,
- the provider and the local community, and
- **the provider with herself** *(which is where our training starts).*

What is Patient-centred Care?

Being "patient-centred" is in essence to see the patient as a human being, and to take his or her perception and experience of the medical problem as a starting point for a consultation. There are several different definitions of the concept – one of the first was authored by Edith Balint in 1969[87]. She describes patient-centred medicine as "understanding the patient as a unique human being". Subsequent definitions all focus on seeing the patients' perspective as a crucial point.

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[87] Balint, E (1969): The possibilities of patient-centred medicine. Royal College of General Practitioners, 17, 269-276.

Research in a number of countries[88], mainly in the North, has shown that the majority of patients clearly want PCC. It also shows that there are still misperceptions among medical personnel that patients may not prefer a person-centred approach. There is a strong agreement between UK studies[89] and reflections on practice by clinicians in South Africa and Canada re how to define PCC, and also – that PCC is best assessed by the patients themselves. Much of the research has been carried out in general practice settings.

Patients in the UK[90] want Patient-centred care which –
- Explores the patient's main reasons for the visit, concerns, and need for information;
- Seeks an integrated understanding of the patients' world – that is – their whole person, emotional needs, and life issues;
- Finds common ground on what the problem is and mutually agrees on management;
- Enhances prevention and health promotion, and
- Enhances the continuing relationship between the patient and the doctor.

The development of the PCC concept is linked to a growing realization of the limitations of the conventional way of doing medicine – often referred to as "the biomedical model". This model is usually connected to being doctor-centred, disease-centred, hospital-centred and/or technology-centred. Patient-centred medicine differs from this perspective in terms of five key dimensions, according to a conceptual framework and review of the literature[91]:
- "The biopsychosocial perspective",
- "The Patient as a person",
- "Sharing power and responsibility",
- "The therapeutic alliance", and
- "The doctor as person".

These dimensions are closely connected to the interpersonal aspects of care, and to the relationships the provider needs to manage.

Our training strengthens participants' awareness and skills related to all these dimensions.

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[88] Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, Ferrier K, Payne S (2001). Preferences of patients for patient centred approach to consultation in primary care: observational study. BMJ 2001;322:468-472.
[89] Stewart M. (2001) Towards a global definition of patient centred care. BMJ 2001;322:444-5.
[90] Little, ibid
[91] Mead, N, Bower, P (2000): Patient-centredness: a conceptual framework and review of the empirical literature. Soc Sci Med. 2000 Oct;51(7):1087-110.

Most patients want patient-centred care -	*..rather than "disease-centred" care, where the HP focuses on the medical problem, only, and often blames the patient*
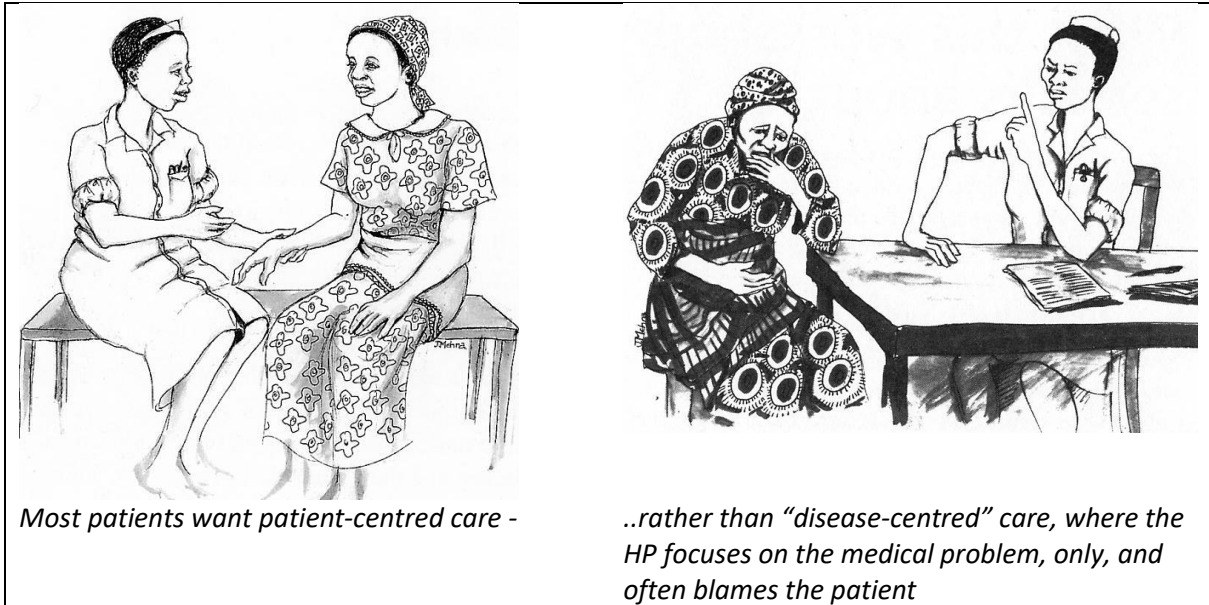
Focus on the last aspect of PCC: The provider with herself

 "**The provider with herself**" - this is where our training starts: to enable the provider to become aware of her way of communicating, and the effects of this communication, on others. The provider strengthens her **"foundation" of awareness** of how communication and management of emotions function in a relationship where health care happens. On this foundation, as shown in "The House of Good Communication", she gradually builds, or strengthens, other skills.

The provider's relationship with herself is crucial: Her ability to be authentic and genuine in herself, and to have a conscious intention with her actions, will influence the quality of her work. Her awareness of the attitudes and values that shape her as a person and as a professional, are equally important. A professional who is faced daily with patients who are scared, hurting and often demanding, needs to be familiar with her own responses to the stress of clinical care. She needs to be aware of her emotions, and of her automatic reactions to common situations and challenges. She must learn to manage her own emotions, and to recognize and respond to the patients' emotions – with awareness and respect, to be able to provide adequate PCC. In other words – she must use emotional intelligence skills. ***And in the midst of all this – she must master the central skills of communicating with emotional competence: listening actively with ears, eyes and heart, asking open questions, and being present.***

The other three aspects of PCC are integrated in the course throughout the process – the focus is on understanding the dynamics of how to communicate well in an interaction, or in a relationship:

- **Relationship between provider and patient**: This is the central theme throughout all four phases of the training, and is the starting point in examples brought up by participants, and in demonstrations and role-plays in a majority of the modules for both workshops;
- **Relationship between the provider and her colleagues**: The theme is central to providers' work efficiency as well as to their wellbeing at work: if relationships with colleagues are good, there is less stress and more positive collaboration. The theme is covered throughout the modules, often as a "complication" when dealing with patients. It is specifically covered in the conflict modules, in stress and burnout, and in power and bullying modules. In the observation and reflection tasks after the first workshop ("Skills into practice"), the provider-provider relationship has a strong focus. Communicating in teams is a central aspect which the manual does not specifically address – beyond the fact that when strengthening

interpersonal communication between colleagues, this also affects how these colleagues communicate in teams;

- **Relationship between the provider and the local community**: A good relationship with the community is important for the reputation of any health institution, and for community members to trust they are treated well and with respect – and thus recommend to neighbours and others to seek help there. When the institution is conducting research in the communities surrounding the hospital or institution, the relationship is especially important. Here, the researchers are dependent on a positive relation between the hospital and the community, to be able to recruit respondents for their research projects.

The relationship with community medicine, and in some countries with traditional medicine and traditional practitioners, are important aspects of the relationship with the local community. In Kilifi, providers who participated in the training have reported changing their earlier practices of blaming and shaming parents who had used traditional practitioners in the care of their children. They are now recognising the parents' intention to help their child and are collaborating with parents (and sometimes with the traditional practitioners) to reach a common goal: to cure the child. (*Please also refer to the book "Intelligent Kindness" for a thorough discussion on the relationship to community medicine.*)

Concept related to PCC: Relationship-centred care
To provide "Relationship-centred care" (RCC) has increasingly been an aim and an ideal for health systems, and is closely related to PCC. M. Beach[92] states that "*RCC is an important framework for conceptualizing health care, recognizing that the nature and the quality of relationships are central to health care and the broader health care delivery system. RCC can be defined as care in which all participants appreciate the importance of their relationships with one another*".

When providing RCC, the following principles are in focus:
1. Relationships in health care should include the personhood of the participants
2. Affect and emotions are important components of these relationships
3. All health care relationships occur in a context where the people involved influence each other
4. Formation and maintenance of genuine relationships in health care is morally valuable.
(adapted from principles quoted by M. Beach).

A main difference between Patient-centred and Relationship-centred care is that the latter includes a stronger focus on emotions, and also acknowledges the moral value of establishing and maintaining genuine relationships.

A practical marriage: In our training model, the emotional aspects are strongly in focus, and participants are facilitated and encouraged to find their own, authentic communication style – which resonates with their own values. Thus, to take a shortcut – as this manual is not an academic discussion about styles, but rather a pragmatic response to what providers say they need to be able to communicate well – we suggest that the model has **"married Patient-centred with Relationship-centred care",** and incorporated additional methods and approaches of our own.

Reflections on patient-centred care
"There was a patient aged 15 years who was brought to the hospital due to severe anemia. The mother who had brought the patient to the hospital was not willing for him to be admitted; she

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[92] Beach, M.C (2006): Relationship-centred care. A constructive reframing. J GEN INTERN MED 2006; 21:S3–8 DOI: 10.1111/j.1525-1497.2006.00302.x

claimed the father had to give consent, that is the mwenye factor[93]. Then she said she had other children to take care of at home, so she wanted to go back home to sort out with the father of the boy (patient), then to arrange for the other children on who to remain with them and be able to take care of them at home as she comes back to the hospital for the admission process.

*I was the nurse covering and I was called by the nurse in casualty, for the mother had refused completely, and they were exchanging words with the nurse. The mother was saying the patient was her own child and **she** could make decisions for her boy **not** the nurse, and if the boy was to die because of the disease let him die.*

I had to intervene in that, I had to cool down the tempers of my nurse first. Then I called the parent of the patient, I talked to her, explained the consequences of all the process she wanted to undertake; but she still insisted to go home. Therefore I asked her how long she would take to set her things in order till when she would bring the patient back to the hospital for admission. She said she would take only 4 hours and I emphasized to her to make a promise and not to fail.

So I took the particulars of the parent i.e. name, id no., residence – nearest land mark to their home, the name of chief, sub chief and village elder, the location sub location and village. The parent had to sign besides these particulars and she promised to come back in the evening at 6 pm. So I left her to go home to settle her issues, first hoping she would turn up. For I felt it that she was undergoing a very big challenge, her being a caretaker of the patient at the same time a parent of the other children at home. She had a right to go home and set things in order.

I told the nurse at casualty to include the incidence in the incidence book. So the parent and the patient went home and came back to the hospital for admission on the following day. The patient was admitted on the following day, but this time the mother was settled, no complaint, and was very cooperative."

HCW, Kilifi

4.1.4 The process approach: Activities and aims of the four phases

There are four main phases in the iCARE-Haaland model training. Phases 1 and 3 are the observation and reflection phases which are carried out while on the job (and sometimes at home), while phases 2 and 4 are about the workshops. Further details about the contents of the workshops can be found in section 4.1.5, below, and in parts C and E – the modules. Details about methods used in the different phases can be found in chapter 6.

Phases	Activity	Duration	Aim
1	**Baseline questionnaire**	1-2 weeks	To assess level of awareness, and training needs.
1	**Self-observation and reflection to discover**, using guided weekly tasks, on a set of specific aspects of communication and emotions. Monthly meetings to discuss learning and distribute new tasks.	3 -4 months *On the job/ during regular work hours*	Strengthen participants' self-awareness about their own communication behaviours and the effects when dealing with patients and colleagues, and start a change process.
2	**Basic Workshop: Interactive reflection** – Experiential learning methods, including results from observation and reflection	5 days *Central place/ full time*	Skills training, with feedback. Linking participants' own observations to a number of theories

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[93] "Mwenye" means "owner": The father in the family is the owner of everything; thus, the mother cannot make a decision to admit or keep a child at the hospital without his consent.

3	**Skills into practice: Informed reflection**. Continue self-observation and reflection during daily routine work, using specific tasks to confirm and deepen learning	3 -4 months *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	**Endline questionnaire**	1-2 weeks (one month before f-up workshop)	To assess growth and define further learning needs (identified in phase 3) .
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	3-4 Days *Central place/ full time*	Deepen understanding of issues, especially on emotions. Confirm and appreciate learning; strengthen confidence; empowerment

NOTE: Both workshops (Phase 2 and 4) are evaluated to assess participants' immediate reactions, and issues for follow-up. All tools are found in parts B - E.

Training trainee doctors in Wales: An adjusted approach

In collaboration with professor Debbie Cohen[94] at the school of Medicine in Cardiff, Wales, the model was adjusted and implemented with two groups of trainee doctors in 2016 and 2017, through the Wales Deanery. The core methods were the same – using self-observation and reflection tasks with intermittent workshops to deepen learning. Experiential learning methods were used, and the young doctors' work challenges and examples were used to develop learning situations. The same theories were used to put the situations and examples into a framework where they could be explored and explained.

A main difference to the original model was the length of the workshops, and there was shorter time between each workshop. In the first year, four workshops of three hours each were conducted, and in the second year – six half day workshops, one of which was five hours. The main reason for the short workshops was that trainee doctors have limited amount of time available for study leave. Another difference was the topics of the observation and reflection tasks, which in the second part of the course became more directly linked to topics like discovering and relating to positive emotions, vulnerability, kindness, and dealing with perfectionism and criticism. A list of the topics can be found in chapter 6 and the tasks are found in Part B in the resource collection.

Need for this training: The first pilot course was conducted in 2016 with 11 participants, many of whom were quite sceptical to the concepts and programme at the onset of the training. Three of the young doctors were seriously considering leaving medicine. At the end of the course, the three doctors had gained new skills to revitalise their joy in their work and decided to stay in medicine. Two participants from the group (Drs Thomas Kitchen and Isra Hassan) requested that a new course be organized, as the need for and interest in the training among their colleagues was strong. Within two days of publishing the new course, it was fully booked with 25 participants. Kitchen and Hassan organized the course in 2017 and participated in the training and facilitation with Ane Haaland, who led the course with professor Cohen as the key professional support and organizer in the Deanery.

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[94] Professor **Debbie Cohen** is the Director of the Centre for Psychosocial Health and the Director of Student Support at the School of Medicine in **Cardiff**.

4.1.5 Key concepts and contents used in the training

In the 23 modules for the workshops, the detailed contents of the two workshops are spelled out. Some of the key contents and concepts that are taught throughout the course process are summarized below:

a) The concepts underlying the training

- **Eleven main concepts** are described and visualized (in Module 1 of the training), with examples from the reflective tasks the participants have contributed, to create relevance and illustrate the different concepts: Awareness (1); Critical thinking, Reflection, Insight (2); Respect (3); Empathy (4); Humanistic Medicine (5); Appreciation (6); Responsibility (7); Motivation (8); Empowerment (9); Handling conflict through conscious communication (10) and Have Fun (why?) (11).

b) Contents: Communication and learning skills

- **Building the foundation for good communication in a professional relationship**: becoming aware of what influences the way you communicate (attitudes, values, ability to be authentic, and often – your moods)
- Awareness of **own communication habits**, and of effects of these habits on other persons, and on Patient-centred care
- Basic communication *theory and skills* related to clinical care (and research)
- *Specific communication techniques*, like active listening, asking good questions, being aware of non-verbal communication, giving constructive feedback, being present
- When and how *adults learn best,* and how this theory *relates to providers' work with patients*
- *Critical thinking*, to question perceptions and assess a situation; explore and evaluate solutions, learn from mistakes, and communicate with patients and colleagues to find better solutions

c) Contents: Management of emotions – understanding Emotional Intelligence

- Understand the need to create a *safe situation to build trust and relationship* with patients, as a basis for providing Patient-centred care and for communicating well with colleagues
- **Understand Emotional Intelligence – the four skills**: 1. Recognizing and acknowledging emotions (your own and those of the person(s) you talk with); 2. Connecting this recognition to the cognitive – thinking about the emotions; 3. analysing (possible) causes of the emotions, and consequences of different actions, and finally – 4. taking action based on the full understanding of the situation.
- Skills to communicate with *awareness and emotional competence*
- The effect of *emotions* on communication, and on the ability to provide PCC and to communicate well with colleagues
- The effect of authenticity, kindness, respect and appreciation on patients, and on PCC
- The effect of *blaming and judging* patients, on them being able to learn – e.g. about why they need to adhere to taking a full course of medicine. Furthermore, the effect of blaming and judging patients, on providers' ability to give PCC, and on their ability to communicate well with colleagues.
- Recognize that patients who come to the hospital or clinic feel *vulnerable and require empathy*
- Understanding and managing strong emotions (*anger, fear*, *insecurity, death and dying, stress, and burnout*)

d) Contents: Skills and strategies – practicing Emotional Intelligence (EI)

- How to *create a safe situation and build trust*, to develop a professional relationship where you can practice emotional intelligence
- How to recognize and *step back* from automatic reactions to emotional challenges, to see a situation clearly and handle it with awareness and respect and EI – to provide PCC
- Why and how to respect patients and *treat them as persons* (not as "medical cases")
- Why and how **to find a common goal:** The provider needs to recognise the patient's action as the intention to solve her problem and handle it in her own best interest. The provider must add her competence and skills to this, acknowledging that the common goal is to find a the best treatment (*rather than – blaming the patient for not having taken the "right" action*);

*Appreciate and **explore patients' concerns**, and find reasons behind their actions*

- Why do **conflicts** occur, how to recognize and handle them, and how to prevent them
- How to *recognize and handle stress* with awareness and EI, and prevent stress from leading to burnout;
- How to *recognize and handle power* with awareness; how to recognize and *stop bullying*

- Understand how people *change attitudes* and behaviour, and how to relate this to patients' learning and to practicing PCC, as well as to how to communicate constructively with colleagues
- How to become aware of the *intention* behind what you say and do, reflect on it, and communicate clearly, with awareness, to reach a defined goal
- *Communication strategies* defined through active exploration and put together from the "basket of skills" they have built up during the course process. Aim: Practice PCC and EI
- *Learning how to learn*, through self-observation and reflection on the job to discover how they communicate, through interactive reflection on experiences and methods in the workshops, and through discussion with mentors, role-models and colleagues.

These skills and concepts are applied to a number of different work situations, where participants will pick the skills needed for each challenge. There is *no "recipe"* for or standard response to how to meet each situation. Participants are encouraged to identify the needs and pick from their "basket of skills" to handle each challenge with awareness, and to find a common goal with the patient or the colleague they interact with and relate to. *Learning to recognize and "read" a situation – including its emotional landscape – is thus a prerequisite for choosing the right tools to handle the situation. This requires emotional competence, and skills to put the competence into practice.*

We build a foundation which can enable providers to assess and make decisions with awareness, rather than having to use a formulated "recipe" of what to do in different situations – a recipe that may or may not apply to the situation they are in.

This approach helps build confidence gradually in using their own authentic way to communicate and relate naturally to the person they interact with: *They can create a dialogue where they are aware of their power position, and can take steps to equalize this, when needed.*

RESEARCH: Working with research is a special challenge for many providers working in hospitals where research is being conducted. Using the PCC approach is appropriate also for research situations. A special section later in this chapter describes issues related to working with research in a hospital, and two of the modules are also dealing with this topic.

4.2 Core elements and features that define the iCARE training

4.2.1 Communicating in professional relationships

Since every interaction about health happens in a relationship between two or more people, it is only natural and necessary to take communication in the context of the relationship as a starting point for our work and relate all the skills to situations within various relationships. The provider's own personality, attitudes and values form the foundation on which the interaction is taking place, and awareness about this will help the provider use the communication skills more effectively with the other person(s).

Research has established that the relationship-focused approach to teaching communication skills functions better than the mechanistic approach and leads to more applied and sustained learning.

4.2.2 Communication and emotion as natural partners

Emotions are a natural part of health care, and of relationships that occur in health settings. Patients come to the hospital or clinic with their disease, their worries, their fears and their hopes. Health providers want to provide professional and patient-centred care. They carry their own emotions and worries about e.g. competence, relations in the work place, (non)availability of equipment and resources and/or a number of other aspects. They are also influenced by the emotions of the patients they meet. When relating to colleagues and supervisors, a number of other emotions can be present, many of these connected to functioning in a hierarchy, and many being unconscious and beyond control at the moment.

Communicating well in such situations requires emotional competence: *awareness of how emotions influence communication and behaviour*, and emotional intelligence skills to manage these influences in a good way. Our training model sees communication and emotions as natural "partners" in effective health care work – whether the task is –

- *To create safety and establish trust and relationship* with a patient and facilitate openness to find out what the health problem really is, and ensure cooperation to deal with the problem, or
- *To be aware of colleagues' "bad" moods* and take initiative to explore the problem and possibly prevent conflict or burnout, and ensure good collaboration in the team (rather than e.g. taking her bad mood personally), or

- ***To step back from automatic reactions*** to a supervisor's critique of you or a colleague in front of others, and talk privately to the supervisor about the detrimental effect of such behaviour on the provider's emotions, confidence, and ability and motivation to provide patient-centred care,
- Or a large number of other everyday situations in the health care setting.

The participants in the training courses have pointed to their learning about communicating with awareness and respect for the emotions to be the most important part of the course – the part that has had the most significant impact on their work, and on their life:

> *'This training has made me realise that most of the time as we deal with people they also have their emotional part of it that we might not be aware of, and which can actually make them behave the way they are behaving, and dealing with emotions is one key to better communication.'*   *Health care worker, Kilifi*

> *'In an ordinary situation you can take so much, you just bottle it up and then….you just give up on that person…But with stepping back…you become aware of this person's emotional status and more important you become aware of your own. So you tell yourself 'oh, now I'm getting irritated'… you will not just write off that person…From what we learned in the course, emotions are a part of life but if you don't take care of them…they can come in the way….so just being aware of them and trying to be in control over them….'*
> *Health care worker, Kilifi*

At the beginning of the training, many providers were very skeptical to learning about emotions – often confusing it with "being emotional" which was something they considered negative and had to be controlled – often by telling the patient that she is not the first one to be in such a situation. A midwife was telling a woman in labour with her 4th child, who was in a lot of pain:

> *"There is a 16yr old girl over there in labour, and she is not making as much noise as you are, can you keep quiet!"*   *HCW, Kilifi*

Other patients could be told to stop being silly, if they complained about pain. A few months into the process, the providers talk naturally about becoming aware, recognizing the emotions and what is happening, stepping back and ***managing the emotions*** – with professional pride, and a deep understanding of what lies behind the emotions, and of the importance of practicing these skills. In essence, they are demonstrating EI when they use the following skills: Recognising and acknowledging the emotions (the patients', and their own); knowing that they have to find a way to deal with them (rather than react automatically); analysing the reasons behind the emotions (e.g understanding the fear), and then choosing to act, based on their understanding: They step back and act with compassion for the fear behind the anger rather than react automatically to the anger – as they did before.

An example:
- *"The most important thing for me was to realize that emotions can be controlled only when they are recognized. Only knowing what the patient's aggression means (and it means that the patient is scared) enabled me to escape from the vicious circle when we react to aggression by aggression, negation or attack.*
- *I learned to control my reaction to conflicts. I try not to demonstrate automatic anger but to count silently to 10 – 15, breathe deeply and only then comfort and console the patient. Usually I manage it at once."*   *Health care worker, Kilifi*

There is a long history about why mainstream health care professions in many countries have not adequately trained their providers in practical communication skills, and especially not included skills to handle emotions – neither the patients', nor their own. Research over the last 20 years has shown repeatedly the many negative effects of this neglect, and slowly the number of training programmes for health providers at all levels that now include these aspects is increasing. Where training has been conducted, the effects on patient-centred care have proved to be very good – but it is sometimes very difficult to describe exactly what it is that has improved, and what caused it.
See Module 3b (and many others) for more information and a discussion on emotions.

4.2.3 Becoming aware of the intention of the communication

Communicating clearly is much easier when the provider is aware and conscious of what **their own intention** (or goal) with the patient is. Some examples:

- "*make the patient feel safe and welcomed, and then identify her problem*";
- "*find out why the mother does not want her child to have a lumbar puncture, and then address her reasons, while leaving the option for her to continue to say no*";
- "*my colleague has acted grumpily the whole morning and I am irritated with her – I wonder what is going on, I want to find out and see if I can help her in any way*".

The key is to **be aware** of and recognise one's own emotions and those of the patient (or other person), **decide** what you want to achieve (the intention), and then **communicate** and **act consciously** with the person.

When the provider is clear (in her head) about the intention with the interaction, she will be more able to be present and act with respect and openness towards the other person. This intention is usually communicated non-verbally and will influence how the other person experiences the communication with the provider. A clear intention will usually contribute to creating a safe situation, and a good basis for constructive communication.

Good communication goes "hand in hand" with awareness of, appreciation for and skills to analyse and handle emotions (=EI), and awareness of the intent behind the communication.

**Skills needed when you communicate
with Awareness of Intent**

- **CREATING SAFETY AND TRUST: When you communicate your positive intent (mostly non-verbally, e.g. through kindness), you help create a safe situation for the patient**, and for communicating verbally: The aim is to establish trust and a professional relationship, with the ultimate and conscious goal of identifying the medical problem, and handling it.
- **USING A SET OF SKILLS: Communication and emotional competence skills are added to the core skills of developing awareness and being present**, and include active listening, asking good questions (open, and sometimes closed), non-verbal communication, and constructive feedback – and all related to the emotions which patient and provider may have in the situation. *We see communicating well with a patient, providing Patient-centred Care, as using a set of skills, consciously, applied in a context where emotions are naturally present and are managed well. This happens on a base of aware attitudes, values, intentions and goals, where the aim is to establish safety and trust and a professional relationship as the basis for communicating and cooperating about the medical problem*.

With awareness of and clarity about intention, and of their own prejudice, learning communication skill becomes a simpler task.

Discussion about the intention is an important part of the learning, and an important part of getting perspectives on automatic (emotional) reactions that are based on norms and traditions. For example, many providers in Kilifi reacted with fear and judgment when mothers came to the hospitals with sick children after having been to the traditional healer. The children carry the charms from the healer around their wrists, feet and neck. Providers used to shout at the mothers and tell them to remove the "filthy charms". Providers would also react automatically to patients who come in dirty (maybe after having travelled 5 hours on motorbikes or public transport on dusty roads), maybe "just" with a nonverbal sign. These providers would commonly assume that the patients had no respect for the medical staff when they could appear dirty and dusty at the hospital.

When looking at such situations together and reflecting interactively about them during workshops, participants would question their own reactions and see that they were often based on prejudice. They would conclude that neither the mother with the baby with charms nor the dirty looking patients had the intention to show disrespect: These patients would have their own problems and focus on themselves, and thus "forget" to show their respect to the providers. Participants learnt to recognise this, take a step back, and acknowledge that the intention was not to show disrespect. The focus could then shift to finding the common goal to explore the problem and find a solution. They could then communicate genuinely, with a "clean" and conscious intent – which can be communicated clearly to the patient (or mother/relative).

Note: In Kilifi, after working with these situations in the course, many providers are now collaborating better with parents regarding traditional practices. Mothers with sick children sometimes want to leave the hospital to go and seek further care from the healers, as they see their child is not getting well. Providers are now negotiating with the mothers (who often face pressure from older relatives at home) to discuss with the traditional healer what he advises, and then let the mothers perform non-invasive traditional practices at the hospital, e.g. tying charms on the child's body, or use herbal oil or waters for bathing the child. They do not allow giving traditional medicines by mouth, – in case of this conflicting with medicines given at the hospital. The staff acknowledges that they and the traditional healer, and the mother all have the common goal of healing the child, and will weigh what is feasible to do within the hospital and then come to an agreement with the mother, or parent. This practice has in many cases allowed seriously ill children to stay in hospital, and also taught staff to respect traditional healing practices.

The contrast between an *Aware Focus*, and *Unaware Automatic reaction(s)*

> a) **The Aware (positive) approach –**
> *Focus on Relationship, Common Goal and seeing the Patient as a Person*
> - **Communication happens in a context** where the relationship between patient and provider is at the core of the interaction, and where the emotional aspect is a natural part of – and influences - the communication.
> - **An underlying *positive intention* or *goal*** of the provider is communicated to the patient (automatically), through the provider being aware, authentic and present to understand her concerns and needs. This non-verbal, conscious intention is felt by the patient, and "sets the tone" for the interaction.
> - **The non-verbal communication (about the intent) happens *in an instant***, and sends an (unspoken, positive) message from the provider, e.g "*I am here for you, we will take good care of you. I can see you are worried. You came to the right place*", or "*I am fully with you, we are here to help you, I am someone who will do my best for you, I am trustworthy. You are in safe hands*". With awareness of the intent and the goal, the provider will focus her

full attention on the patient and be present with her. She will approach the patient with awareness, confidence, kindness, empathy, compassion and care.

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b) **The Unaware (often negative) approach -**
Focus on Self/own needs, seeing the Disease but not the Patient as a Person

- **Some common (negative/judgmental, subconscious) messages** from the providers to patients before the course were e.g "*I am very busy, tell me your problem, fast*", or "*I can see your child is very sick, why did you not come before?*", or "*You have been to the healer? That is SO unacceptable! WE are the ones who know about how to cure people!*", or "*There are so many patients here, just get on with it, so I can get to the next one, and finish my work.*" These messages were sometimes spoken, and sometimes unspoken, but the negative approach is often clearly felt by the patient – in an instant - and has a number of possible consequences (such as the patient closing up, not giving full information, or simply leaving)**.**
- *NB – we call this an "approach", which can be sub-conscious and unaware, rather than an "intent", which is usually conscious.*
- **What negative/judgmental reactions have in common**: the provider is focusing on her own needs and opinions without "seeing" the patient as a person, and (apparently) without having concerns for her feeling welcome, safe and cared for, or seeing these actions as important. Awareness, compassion and kindness are absent. She is often acting automatically.
- **Without a conscious intent to help and to see the perspective**, using communication skills can be perceived by the patient as "just mechanistic" (or false) – i.e. "*she is pretending to listen, but I can sense she just wants to finish with me/I sense that her attention is somewhere else*".

Using (trained, "good") communication skills "on top of" the unaware approach will not "make up for" the negative/judgmental attitudes and values underlying the use of the skills. The patient will sense the negativity, and usually respond to that. Providing PCC in such a situation isdifficult, or even impossible.

4.2.4 Strengthening self-awareness: Seeing effect of your communication

An important core feature is for the providers to become aware of how they communicate in a professional relationship. The aim is to develop a confident basis for giving patient-centred care and communicating well with colleagues. See chapter 6 for a description of the methods for developing awareness, reflection and insights.

The skill to become aware of the intent behind an interaction is developed or strengthened during the preparatory phase. Using the observation and reflection tasks requires participants to focus on *the effects* of the way they are communicating, on the other person. When they discover how patients and colleagues may be feeling in response to the way they act, "something" happens: They do not like the effects they are causing – hurt, fear, or disappointment. Often, when they become aware of the negative effect, and reflect on it – they conclude that they had no intent of causing such harm or hurt: *it "just" happened, because they acted, or reacted, automatically*. When they reflect on this privately, they are free to see and to think about their own role – no one is telling them they did something bad, and they do not have to become defensive. And they usually know very well when they have failed or done something wrong – if they let themselves think about it. They are free to learn, and to enjoy the learning – or be shocked about themselves! They carry the insights and examples into the workshop with them, and are ready to share, and to learn emotional competence.

Once the awareness and the skill to observe and reflect is awakened, it cannot be forced to go away again. Many participants describe how they begin to recognize and control their automatic reactions, and start stepping back, using emotional competence (see emotions module, 3b). They start analysing the situation and decide to use empathy more consciously, since they are aware of how the other person may be feeling and know they can do something about it. Constructive communication with respect can flow naturally from this base – and with a positive and conscious intent.

> *"Constructive feedback to all my colleagues is about awareness; awareness is the number one key point of life. If you have the awareness you can use it any were you go. My advice to all health workers and caregivers is that let us all have the awareness!".*   *HCW Kilifi*

Experiential methods link learning to context and makes it relevant
The self-observation and Reflection In Action method provides the basis for developing awareness and strengthening emotional competence. Participants gain and share experiences that are used for insights and learning during the whole process, and in the workshops. With real situations from their working life as the starting point, the context for the learning is clear and the relevance of the topics is obvious. The methods stimulate the inner motivation to learn.
In the workshops, we use interactive reflections and add theory, to deepen the learning. See Chapter 6 for a thorough description and discussion of these methods.

Focus on attitudes, values and skills of the trainers
Trainers need to be (progressive) role-models who practice what they preach, if they are to have credibility with the participants and make them feel safe to open up, share, reflect – and learn. They need to be aware of their attitudes and values, and of how these influence their own communication and emotions as well as those of the participants they are to guide. See chapter 7 for a discussion of the trainers' role.

4.2.5 Seeing the provider as a resource person who cares
We see the provider as a resource person and a human being with an inherent motivation to care and to do good work. If she does not, there are strong reasons. The underlying attitudes, norms and values (often subconscious) also strongly influence the provider's behaviour. It is in becoming aware of, and then exploring and dealing with these reasons that providers will understand and have the choice to act differently, with awareness.

How do we define "care"? Providers we have worked with come from a wide variety of professional and cultural backgrounds. They have experiences from institutions with the most modern resources, and from institutions where resources are at a bare minimum, and often lacking. Common to them all is that they relate to patients on a daily basis, and – in the context of giving care – we define it here as providers "*doing the best they can, with the genuine intention to give the best possible help.*" To show that you care is in the approach to the patient: By being present with the patient, recognising the emotional "landscape" and asking questions with real interest and intention to find out what is going on, the provider can collaborate with the patient to identify the problem and give the best help that is available. To care is to check out with the patient, and **then** take action – rather than assume you as the provider automatically know exactly what is going on, and what to do.

In this section, we give a brief overview of some of the myths, facts and attitudes that influence people's opinions of health providers, some reasons behind these, and some experiences from developing the model with providers who want to change.

A. "Providers are cruel to patients, and they don't care"

Is this true? Many providers show cruel behaviour, and there is ample evidence of this in reports, literature, and stories of patients' experiences. In a recent book (2011) describing and discussing the health care system in the UK: "Intelligent Kindness. Reforming the culture of healthcare", authors John Ballatt and Penelope Campling refer to the report from Mid Staffordshire NHS Trust (UK) where nurses acted cruelly to patients, over time, and nobody took action to stop them (see chapter 1). The literature is also ripe with articles and books showing how health professionals mistreat patients and bully each other. Ballatt and Campling also show how kindness is essential to patients' satisfaction, wellbeing and to the outcome of their illness, as well as to providers' own health and well-being, but that being kind also carries an ambivalence.
So yes, it is true that some health providers sometimes act cruelly to patients. But is it true that they don't care?

B. Why do providers act cruelly and communicate badly?

There are many reasons. Providers in Kilifi identified[95] the workload and working in context of illness and death as having a major influence. **Lack of training and mentorship** contributed to a culture of poor communication which was seen as self-perpetuating, where new providers acquire poor communication habits from senior colleagues (see Hidden Curriculum, below). This situation, the providers felt, **generates feelings of** uncertainty, **lack of confidence**, low morale, helplessness, irritation, anger, fear and **exhaustion. The situation leads to** high level of stress, and **emotional outbursts; continuing patterns of negative interactions** with patients and other staff, and **low ability to practice empathy.**
Below are some further comments on a few of the major reasons.

- **The "Hidden Curriculum"**

When providers start their practice after completing their education, they are usually highly motivated to provide patient-centred care. They are fully informed about the ethical code of conduct spelt out by e.g. the ICN code of ethics[96] which they are expected to adhere to. But when they start their work in an institution and are met with matrons and leaders who practiced old, power-based communication, their motivation is trampled on, eroded and buried. They are faced with high workloads, and with colleagues and supervisors who criticize and use power, often in cruel or degrading ways, and in front of colleagues. Their new ideas about patient-centred care and open communication often have to be buried. This is "the hidden curriculum" at work - a pattern that is described as "the attitudes and values of older, established professionals who often occupy power positions". It is a major barrier to change. The structures for supporting and appreciating the young providers and help them grow and gain confidence in their profession – and be effective and respected role-models – are often lacking. The impact on the young providers' confidence can be devastating, as described by a trainer in Kilifi, commenting on supervision when being an intern:

- *"The way our lecturers did it left us feeling harassed, humiliated, put down."*

- **No skills to recognise and manage emotions**

The cruel behaviour – which many of our participants have admitted to (and also often been victims to themselves) – is often due to a lack of ability to cope with stressful and challenging situations, most of which are related to strong emotions. Many providers have never been taught how to cope

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[95] LVCT evaluation, 2011
[96] The ICN code of ethics for **nurses' professional conduct in Kenya stipulates that:**
- *all nurses must treat patients with dignity, respect and compassion,*
- *regardless of their health condition, economic status, gender, race or personal attributes.*
- **Enforces that:**
  - *all patients are entitled to the dignity and rights of human beings and so*
  - *should not be discriminated against for any reason while under a nurse's care*

with these emotions – neither the ones the patients show, nor their own responses. These skills can be learnt, and this is what the manual is about. We do not, of course, mean to imply that teaching the providers skills to communicate and to manage emotions is enough: Unkind behaviours are also related to the structure of health care systems, where providers are often required to work very long hours with limited personnel, high work loads and limited resources and support.

Ballatt and Campling conclude that "..a **lack of understanding and management of emotions** is a major issue in the current situation (Mid Staffordshire, see A, above) and should be given much more attention".

- **Low resources, high work pressure, no appreciation**

Increasing work pressure is a challenge for health personnel in many countries and leads to stress and burnout (see below). Without personal skills and professional support to handle the pressure, many providers struggle to stay in the profession, or stay "sane" in difficult work situations: Higher suicide and mental health problem rates than the rest of the population speak clearly of a system in crisis. In low income countries especially, lack of equipment and logistical support exacerbates the problems.

- **Burnout, and moral injury**

An increasing number of health professionals experience burnout in their work. Levels of burnout vary from 30-80%, and was recently (January 2019) described as "The Crisis in Health Care"[97]: In a 2018 survey conducted by Merritt-Hawkins, 78 percent of physicians surveyed said they experience some symptoms of burnout. The paper was published by the Massachusetts Medical Society in the US. Similar reports from a number of other countries paint the same picture of health professionals under pressure, and few "remedies" to counter the emotional exhaustion, depersonalization and lack of job satisfaction the professionals experience. But training can help:

> *"Giving information to parents/patients by use of communication skills with awareness really helps in communicating effectively with patients/parents as it improves understanding, it saves time, prevents burnout and there is job satisfaction to the service provider"*   *HCW, Kilifi*

Talbot and Dean[98] are suggesting that physicians are not suffering from burnout, which they see as something very negative. They suggest physicians suffer from moral injury, and that it is urgent to address this problem through challenging the health system itself: *"We believe that burnout is itself a symptom of something larger: our broken health care system. The increasingly complex web of providers' highly conflicted allegiances — to patients, to self, and to employers — and its attendant moral injury may be driving the health care ecosystem to a tipping point and causing the collapse of resilience."*

C. The need and wish for change

The process training model was developed in collaboration with users in the field and responds both to their identified challenges and to problems identified in the literature. During a number of discussions and reflections in several countries, it became very obvious that the many bad communication habits that have been described in the literature were recognized and acknowledged by the providers who joined the courses – as habits several of them had also engaged in, and which negatively influenced the quality of care. Some habits were influenced by "the system" and the

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[97] A Crisis in Health Care: A Call to Action on Physician Burnout. Harvard T.H. Chan School of Public Health, the Harvard Global Health Institute, the Massachusetts Medical Society and Massachusetts Health and Hospital Association has deemed the condition a public health crisis. http://www.massmed.org/burnoutpaper/?fbclid=IwAR2H3Zm-I-bybzOBsrgnq1qCUgU0FSvakclu7g99PToNi0NbQyNcKVNUIrw#.XEg3yFVKj3h

[98] Talbot, S.G and Dean, W (2018): Physicians aren't burning out. They are suffering from moral injury. STAT, reporting from the frontiers of health and medicine, July 26th 2018. https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury/

culture, and by individuals who were more concerned with protecting themselves and their own interests than with facing mistakes and improving PCC.

It also became obvious that the providers were concerned and bothered about the consequences of these habits, and that **ill-will was not the issue to be addressed**. The providers wanted change, and to acquire new skills, and were keen to explore how to achieve better communication and better PCC.

The design and teaching in our training programme is constructed to facilitate providers in getting back in contact with their original wish to care. The training aims to help participants strengthen this motivation in themselves and in each other, as well as get "fuel" for continuing to practice the new skills by experiencing the positive impact on patients, colleagues and on themselves. The wish to care and to be kind – which is closely connected to their own emotions – is an important resource for the providers.

Older professionals as resources – not barriers: The older professionals exercising the values and practices inherent in "the hidden curriculum" are an important part of this picture. To ensure that new practice and change has a chance, the older professionals have to be acknowledged and included as resource persons and participate in the courses. When these managers and individuals see that the new methods work better, they are often the first to ensure that providers using these methods are supported. Others acknowledge their own shortcomings by asking trained providers for help to handle "difficult patients" – as they have observed their colleagues dealing well with patients where they themselves give up. They are, in essence, all concerned about patients getting good quality care.

Some of the older (and sometimes younger, ambitious professionals) appear uninterested in changes that seem to influence their power base. However, we have seen that when enough (about 50%) of the providers in an institution have been trained to communicate and manage emotions with awareness and respect, they influence a change in the older generation as well. But – change takes time and changing ingrained destructive power structures cannot be done overnight. Systems need to change – but while waiting (and working) for that to happen, training providers to relate better to patients, themselves and everyday challenges will improve efficiency and job satisfaction. And – it will usually improve PCC.

In summary - the underlying premises and assumptions for the iCARE model are:
  ➢ Providers want their patients to **get well**
  ➢ They want to care and communicate **with respect and kindness,** and build professional relationship where they **engage with the patients: They show that "*I CARE*"**
  ➢ For communication skills to improve sustainably, the learner has to have a **strong inner motivation to learn,** and to use the skills (*therefore, the **participation is voluntary***)
  ➢ Communication habits providers are using now are built up over a period of many years, and will **take time to change**
  ➢ **Awareness of how they communicate**, and the **effects** of this communication on patients and colleagues, can be created over time, using guided observation and reflection
  ➢ **Awareness of how emotions** (patients', and their own) **affect communication**, can also be developed, using observation tasks
  ➢ When providers experience that their communication habits are hurting patients and are also preventing patients from being open (and thus often preventing the proper diagnosis and treatment of their problem), they get a "wake-up call": *They don't want to hurt patients*. They want to engage in a professional relationship and give quality care – and

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➢ This awareness will **motivate providers to learn** more effective communication and management of emotions, based on what they see they need to improve: They learn to practice emotional intelligence

➢ Using examples from their own observations as the basis for teaching theories and skills will make the course contents and methods feel, and actually be, **relevant: It meets their felt needs,** and thus facilitates good learning

➢ Trainers **role modelling** good communication skills and a non-judgemental attitude during sessions will allow the providers to **experience the power of this approach on their own learning.** They become skilled and motivated to use a similar approach with their patients to facilitate understanding and learning.

➢ Providers will also be able and motivated to **become role models** for their colleagues, and facilitate further learning (plus gain status themselves)

These premises translate into the process training model. The training is effective in challenging attitudes and behaviour, based on the participants' own awareness, because –

- **Decision to change** comes from within each person, it is not imposed from outside
- **Participants own the process and the results** (and therefore – results are more sustainable)
- **The process is empowering,** and participants (mostly!) enjoy the learning
- **Learning to use awareness systematically and to practice emotional intelligence** usually influences the providers' personal lives as well: Providers experience improvements in personal relationships, and this again affects their professional lives in a positive way.

4.2.6 Finding the balance: The need for emotional nourishment

Providers in their work have to give a lot of care. ***When you give a lot, you also need to receive – to keep your balance, over time.*** Health providers are expected to give care continuously, and to possess a "source of care", as if there existed some sort of eternal source which never runs empty, as if the skills to deal with the many difficult emotions (*the patients', as well as one's own*) were somehow "inbuilt". *One of three main symptoms of burnout is emotional exhaustion.* We know – e.g. by looking at statistics for how many health providers burn out in their profession (see section above), that the old "myth" does not fit today's challenging reality: ***The providers' source runs empty***. It needs nourishment, and a way to work which does not exhaust providers' emotions but rather maintains a balance - one which must be developed, practiced and maintained.

How the iCARE model addresses the need for emotional nourishment:
- **Providers' own emotional needs are addressed** – and taken care of. They are then more free to give emotional care to patients, with awareness and respect. They also share emotions with colleagues, when appropriate;
- **Providers who practice the new skills and provide care with awareness and respect usually receive appreciation, cooperation and positive reactions** from the patients. This response "feeds" providers' own emotional needs. When sharing emotions with colleagues, they help build stronger teams and often help prevent burnout;
- **When her own needs are met, she is also more likely to focus on the patients' needs,** and thus to maintain the new behaviour. When colleagues communicate better, they also nourish each other, emotionally.
- They also get **positive reactions from some colleagues and supervisors**, though others may initially respond negatively – as they see changes as challenging and threatening.

> *"Showing respect to my colleagues and patients contributes to a safe situation to work in and interact, this brings job satisfaction leaving me feeling great and the reverse is true"   HCW Kilifi*

A trainee doctor in the pilot course in Wales had contemplated leaving medicine before joining the course. After the course, the doctor decided to continue her work. In the story below, the doctor describes how an initial perception and fear about emotions and vulnerability is changed, through her conscious reflective work. The story is slightly shortened, and was written as a response to an observation and reflection task about handling emotions:

"I have not been branded as weak and pathetic, as I feared"
"I initially didn't want to talk about what was making me feel most vulnerable, and the irony was not lost on me; I didn't think that a few weeks' of reflection will be enough to fix that, unfortunately. But I've changed my mind, and I certainly feel I am aware of what makes me feel exposed. Even prior to this task, I noticed that I have been more willing to open up to people, and in return have definitely noticed a change in how people have responded to me. (……)

So in a nutshell, before starting this resilience training, I cried in my interim ARCP. Spent a long time trying to figure out why, and couldn't quite get a handle on it. Put it down to just burning out; I've worked reasonably hard and non stop through school, uni, F1 and F2 without a break. I put it down to having anxieties of being on this NHS conveyor belt and one day waking up, retired, having done nothing except work my entire life, at the opportunity cost of so many other things I want to do; travelling and climbing, mainly. I've since then built upon that and I think that another aspect of it is that I tend to put a tremendous amount of pressure upon myself to succeed, and to excel, and perhaps that was a bit overwhelming on top of everything else. I crumbled under my own pressures. (Describing how she got help from the counselling service for trainee doctors…..)

I've been more open about how I feel; no one wants to sit there and listen to my woes, but I have been happy to talk about it if asked, rather than pretending everything is okay. And I have had other CSTs approach me in a wonderfully supportive way to tell me that they've heard I'm feeling a bit rough about it all, and that they wanted to let me know I wasn't the only one. That they felt the same. I had one colleague who said she felt like I was the only one they could talk to because I was the only one who understood what she was going through too (which is definitely not true, but perhaps I was the only one she knew who was openly talking about it) (…..). The response from colleagues and seniors has been surprisingly fantastic, and I haven't been branded as weak and as pathetic, as I originally feared. An anxiety rooted in nothing but stigma that I don't even excise myself, just stigma that I perceive other people to have.

Allowing myself to be vulnerable, as I now recognise it, seems to have allowed other people to feel they can open up and be vulnerable themselves too. It's as if they're relieved to know they aren't alone either (hence perhaps the reason behind wanting to let me know I'm not alone), and whilst no flood gates have opened, I seemed to have opened a tap and let some of the steam off. Being vulnerable and honest with myself has had more of an impact than I would have imagined. Previously, I used to sit on my own anxieties, ruminate over and over again on them without talking to anyone, for a) fear of being judged and b) confident that no one could help me anyway as the situation was so fixed.

As it turns out, with regards to CST, the outcome hasn't changed; I am still stuck and I still have to finish my two years here, but now I am in a position to be kinder to myself and to let myself be helped, and hopefully help others. I'm beginning to really understand that there are certain things

> *that can't be changed, but I can always change my frame of mind and my approach or attitude or coping mechanisms towards the situation. I wish I'd known about this earlier, as I think back to situations in the past where I have ploughed on through in the resolute knowledge that no one could ever help me, whereas with the benefit of a slightly different lens, I feel that talking and opening up may have made a lot of difference."*

The capacity to give and receive with respect is a skill involving communication and emotional competence, and is learnt through a process of awareness building, reflection and skills training.

4.2.7 Trusting providers' ideals as a foundation for good care: Potential consequences

We suggest that when providers are respecting themselves and learn to recognize, acknowledge and manage their own emotions, respect for the patients is a natural consequence.
Providers in our courses acknowledge the problems they have had regarding treating patients badly, and many tell stories about how they took out their frustrations on patients and "put them in their place". They also noted that this way of treating patients contributed to frustrations, guilt, conflicts and burnout. They knew very well that what they did was not right.

After acquiring knowledge and skills to manage emotions, they no longer take out their frustrations on patients or colleagues:
> ➢ *"When angry, I always felt like breaking up into tears, and I would put a grudge on the one who had angered me. After undertaking the communication course, I have learnt how to control my anger and take things positively."*
> 　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　*HCW, Kilifi*

The approach of this course is to trust in the underlying ideals of the health providers and assume that providers want to care for and communicate with patients, with respect. When emotions cloud this intention, the emotions must be recognised and acknowledged, and then explored – with emotional competence.
> ➢ *"There have been changes, I have seen in my case the many people I have interacted with respect they have been able to open up and when I'm also treated with respect, I feel good."*
> 　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　　*HCW, Kilifi*

This approach leads to a balance through which providers receive appreciation, respect and positive feedback and cooperation from the patient. The result can be a reduction in everyday stress, a higher job satisfaction, and – a motivation to give even better quality care for the patients.

Are problems being ignored in this "Positive outlook"?
NO – on the contrary. Problems are more likely to be acknowledged and can be dealt with. According to participants, they now deal much more effectively with problems because they are more likely to recognize and face them rather than hide or ignore them – and they have tools to handle them. They look for reasons behind the problems and then for solutions, rather than for someone to blame. This brings them a sense of achievement, and more satisfaction – which again gives them good energy.

4.2.8 Summing up: The starting point and the professional base

The starting point for our training is neither the quest for a quick fix nor the assumption that providers don't care. The starting point is to see the provider as a vital human resource, and to acknowledge that the human aspects of the medical encounter will have an important influence on the quality of care the patient will receive. The starting point is furthermore a belief in providers' deep motivation to care, and the knowledge of a training process that makes them want to learn – together with the proven "track record" of this model to help them learn deeply and sustainably and

enjoy the process. The process, and the methods of reflective and experiential learning, help the providers to re-kindle their motivation to care, with respect, empathy and compassion in a non-judgmental way, while also taking care of her own emotional needs and building emotional competence. It also helps create role-models and mentors who practice respectful patient-centred care in their daily work: when colleagues experience and observe the effects of their skills on patients and on themselves, awareness increases, and many become interested to copy the skills they see are working so well.

The base: Professional clinical care, and respect – with authenticity
The skills are practiced on a "base" of underlying professional clinical care, professional relationships with colleagues, and an attitude of respect. *Exactly how, and which skills are needed, depends on the context and on the challenges facing the provider, in each case.* As each situation and each patient and colleague is unique, there is no simple solution to communicating well: The provider must have her/his "basket of skills" as a resource she/he carries in her heart and head, and in her being – knowing that using these, she will be providing the best care and be the best colleague she can. *Research shows that "the way you are" is more important than "what you say" to patients[99].* Communicating genuinely, with awareness, is what works best.

- *"I have no more difficult patients",* commented a Namibian nurse after going through the course process. Where previously she had blamed patients who did not want to follow her advice, she now engaged with them and explored their reasons, and found a joint solution. *"Works much better for me, and for the patients",* she said, commenting that she had no plans to return to her previous habits.
- *«I feel I am more assertive in my communication with colleagues as I become more confident in being able to do this constructively",* wrote a trainee doctor in Wales after self-observation and reflection. The doctor continued: *"I feel I am better at understanding what might be underlying my colleagues' actions/reactions and therefore less likely to become upset or frustrated as I don't take things so personally. I have tried to make myself more approachable to colleagues and to take the time to give them positive feedback and appreciation.»*

When presenting results from our training at national and international meetings and conferences, the response has been overall enthusiastic and positive, and participants have been curious: yes, these skills and results are what we need – please give the model to us! This manual shaped by the needs and frustrations and questions from over 350 providers in nine countries, describing a training programme they say has changed their practice and their way of relating to and interacting with patients, colleagues and supervisors. Many say it has also changed the way they relate to their families.

- *"This course has been an eye opener to me. It has brought a lot of changes in me, which make me to be appreciated and respected. Especially by my husband. It was meant to help me in my work place but it has done wonders to my home and family as a whole".* HCW Kilifi

4.3 Shifting the power practice: From blame to balance

The automatic use of power, which is inherent in the medical culture, is being challenged and adjusted in the iCARE-Haaland model. We have identified areas where changes can empower the health professionals and positively influence their professional practice and their wellbeing. The changes will also benefit the patients.

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[99] Copeland, L & al (2015): Mechanisms of change within motivational interviewing in relation to health behaviors outcomes: A systematic review. Patient Education and Counseling 98 (2015) 401–411

With respect for the learner and for the patient as a base, we have created a learning culture which aims to be safe and inspiring, and help the participants to learn well. We have created a reflective learning method that invites the participants to experience the need and motivation to take responsibility for communicating with awareness (rather than from an automatic power base), and we have questioned cultural practice based on hierarchical power habits. The result is – empowered providers who enjoy their learning and their work more than before.

4.3.1 Taking the fear and boredom out of learning
From being the victims of power (ab)use, to
being empowered and inspired to teach, and learn
Trainers and supervisors in medical hierarchies are often accused of displaying and (ab)using power when guiding juniors to learn medical practice. Criticizing juniors harshly in front of colleagues and patients is a common habit, and the consequences can be serious, as expressed by one of the trainers in Kilifi:

- *"The way our lecturers did it left us feeling harassed, humiliated, put down."*

The trainer described how these incidences created fear and insecurity, and prevented many from learning good medical practice, and from developing confidence in their profession. It also leads to people leaving the profession, and thus for the Government to lose precious professionals they have invested large funds to educate.

Exercising "The hidden curriculum": The supervisors/lecturers who guide students during their training in practical medicine are often "just" continuing to use the teaching methods that they themselves were subjected to during their own education. Many have not learnt how to teach in a more constructive and effective way, or how to use experiential learning methods to guide students to learn. It may not be their conscious intention to ridicule or shame the students, and to shatter their fragile confidence. However, this is often the consequence when using power in these ways, maybe with the intention to "toughen up" young professionals to a difficult life of practicing medicine. This is often referred to as "the hidden curriculum" – continuing old power structures aimed at keeping the status quo in the hierarchy.

When students are subjected to harsh criticism repeatedly, they will naturally associate learning with fear, and must learn to completely bury and set aside their emotions to be able to cope with the work. Learning to un-earth the emotions later, with the aim of becoming self-aware and of using them wisely with patients and colleagues in their own practice, is usually not on the agenda of training institutions.

While much of the use of power may be unconscious, some lecturers and supervisors are also using the power they have, consciously, for their own reasons. This is often referred to as "Bullying" and has serious negative effects on providers' mental, and sometimes also physical, health. Bullying is common, especially among nurses. The reasons for bullying is often related to lack of emotional competence, and insecurity. The fear caused by bullying often has serious negative consequences on those subjected to it. Bullying often leads to conflicts, and burnout. (See modules 7c and 7d). Training on emotional competence can contribute to preventing bullying, and to handling bullying with awareness.

Passive learning: Fear can create the feeling of being a victim, and the automatic instinct or reaction can be for the provider to protect herself and become either passive or re-active. This is often connected to not taking initiative to learn, to seeing learning as boring, as a compulsory and unpleasant duty connected to fear. Participation in training courses is often seen as a privilege because of having time off from work, eating well, and receiving a daily allowance – rather than as an

opportunity to learn. When the training consists preliminary of lectures with no or minimal interaction with the learners, providers do not need to engage or participate, and do not need to fear being ridiculed for not knowing an answer or for making a mistake. One of the providers in Namibia expressed a humorous "complaint" after the second day of training in our workshop:

➢ *"In this workshop, I cannot sleep! You don't give me a chance. Usually, such a course should be a real time to rest!"*

The provider gradually became very active and said the course process had changed his idea of learning.

Participants have fun while learning – it becomes a joy rather than something they fear. From Kilifi, left, and Siauliai, right.

Our iCARE training model acknowledges this "baggage" many of the participants from cultures with didactic learning traditions carry. We know that we need to define and name this fear of and resistance to learning. We need to make participants aware of the consequences of the learning methods they have been exposed to, on their attitudes to and confidence in learning (and often, extending to the way they treat patients, and prevent patients from learning). We need to **take the fear out of learning**, and replace it with methods that inspire, ignite their (buried) passion, make them feel good and safe, have fun – and be motivated to work hard, ask questions and take initiative. We need to inspire them to turn **from passive to active learners.**

The main factors responsible for taking the fear out of learning in our training are the training approaches, and the attitudes and methods of the trainers that enable participants to build up trust and relationship with them, over time. This nurtures the participants' (often fragile) motivation to share problems, and to learn.

The training approach: Creating safety and facilitating empowerment
The training approach allows participants to feel safe throughout the process:
- They **volunteer** for the course, have decided they want to learn, and take initiative to enrol in the course
- They **observe, reflect, and assess** their own performance and progress
- They **decide** whether or not to share their observations with trainers, and/or with colleagues
- They **decide** what their own learning needs are, based on their own observation and reflection work. They do not become defensive, as no one tells them that they have to learn.
- They **decide** how much effort they will invest, and experience that the more they invest (*in terms of time they spend during periods of self-directed learning, and in terms of willingness to reflect and go in depth into emotional issues*), the more they will learn from the process.

- They learn to **become aware of, recognise and understand** their automatic emotional reactions and gradually to be able to step back and reflect instead of acting out, thus keeping safe from emotional "outbursts": They learn to practice emotional competence
- They recognise that the training is **relevant** as it deals with problems they experience
- They **engage, reflect and learn** at a deep level, without fear of being judged or shamed for lack of knowledge or skills, or for being "slow learners"
- The process is **internally motivated and driven** – the learning is their own, and the achievements and progress come as a result of their investment
- Once the process of in-depth reflection and learning has started and participants experience the results, **there is no "going back":** The awareness is there to stay. Thus, the learning becomes sustainable.

"Making the environment safe by handling my emotions and anger"
"I'm using communication skills and knowledge attained during the intensive learning to make my environment safe through being aware of myself, for example how to handle my own emotion and anger. In so doing it helps to make the environment of my colleagues and patient safe because there will be less conflicts.
Also the knowledge has helped me to appreciate patients and value their belief. Personally i used to feel bad when children wear charms (from traditional practitioners) around their waist, hands and wrist, but nowadays I value them because I understand people are doing whatever they are doing to ensure their relative/children will recover. Before the learning I used to tell them to remove the charms but nowadays I leave them.
Currently I am on a night duty covering the hospital. We have had several cases in maternity whereby expectant mothers are given traditional herbs and also they are massaged at home when they are in labour. I have learnt to step back and avoid to confront them while they are in pain. After delivery and ensuring she is safe and also the baby, I would respectfully advise the mother against such practices. But before I learnt the skills I used to put them off there and then.
HCW, Kilifi

The trainers are essential in facilitating the process – see chapter 7 for a discussion of their role. Their attitudes of curiosity, openness and non-judgmentalism make participants feel seen and respected as individuals and makes them free to engage in deep learning. The methods of reflective and experiential learning throughout the course process enable trainers to guide the learning process, with awareness and emotional competence.

4.3.2 Taking responsibility for communication: From blame to empowerment

When participants are being inspired to learn because they see and feel it is useful and enjoyable – their attitude to learning changes. The fear is being replaced with motivation and curiosity.

A main challenge for providers in hierarchical systems is – to choose consciously to take responsibility for problems in the communication with others, especially patients. In all the countries where we have worked with this training, "blaming the patient" was a common habit when we started working with a group. Providers commonly commented that –

- *The patients were difficult.*
- *The patients would not follow the advice.*
- *The patients were illiterate, and ignorant.*
- *The patients do not have the right understanding of disease*
- *They did not know what was best for them and did not want to listen.*

Some main reasons behind the providers' perceptions and attitudes were commonly insecurity (which was not recognised), lack of awareness about their own communication habits, and lack of skills to respond to the patients' problems in a constructive way. And – old habits of using power, which were ingrained in the system. It is easy to blame others, and this requires less work than to look at and question one's own communication and behaviour. Blaming others also leads to less problem-solving, and less work satisfaction.

The "blame-game" extended to colleagues *("she is always making me do her work for her")* and supervisors *("he is always criticizing us harshly in front of patients"),* and these situations frequently left providers feeling hopeless, powerless – and angry. The anger from being treated badly by a supervisor abusing his power was often taken out on those below the provider in the hierarchy, commonly a junior colleague - or a patient.

Something important happened to participants when they experienced that the new skills enabled them to turn these situations around, and that the other person usually responded well when providers communicated with awareness and respect for emotions and focused on building trust and relationships. ***They became empowered***. They experienced that when they took responsibility for the communication, the results were usually positive, and they could solve the problem(s). They had power in a different way – a way that left everyone satisfied, and problems easier solved.

Some comments from the providers in their endline questionnaires in Siauliai, Lithuania after the course (2007), during the early days of working with the model:
- *"We talk to our patients too little"*
- *"We lack respect to patients as personalities"*
- *"We do not manage to create safe environment"*
- *"Very often we lose patience and judge our patients for their bad behaviour"*

The providers defined Communication between health providers and patients as the problem, while they earlier had defined the patients and their behaviour as the problem. This problem of gaining skills, they could handle: They felt empowered.

As a nurse in Namibia commented soon after the course process, with a hint of humour – and with professional pride: *"Now we have no more difficult patients!"*

The old insecurity was gradually replaced by practical communication skills, confidence in using them, and experience that the new skills work better than the old ones. Many participants also learnt to handle supervisors with awareness and respect, turning old patterns of negative interactions which often involved power abuse, into learning situations (*see story in module 3c, What makes people change*).

The essential change - summarized

> ***The change from "blaming the patient" to taking responsibility for the communication in the interaction is one of the most important changes that happens to the providers during the course process. They change is from seeing the patient as "a problem", to seeing him/her as "a partner" and a resource to solve the problem together with (the problem is medical – and also possibly social and psychological).***
> ***The training process is carefully built to facilitate, encourage and sustain this change.***

The cycle of Emotional Blame

Context: Stress, social and medical hierarchy. Blame from supervisors

System of power Learning is didactic Appreciation not used

HP does not enjoy job Blames P and system Gets more…

HP feels unsafe. Covers it

P: Nervous, angry Told to behave

Emotional blame HP-P Interaction results in draining energy from both Neither is "emotionally fed"

P: worried, shuts up Problem identified? Meets HP w/suspicion Fear increases

P does not feel supported Does not cooperate in care Does not understand why

HP feels disrespected, not valued. Blames patient for bad behavior Basis for good interaction HP-P not established

In this "Emotional Blame" circle, the health provider (HP) acts automatically to "control" the patient's (P) behaviour.

Both HP and P feel unsafe, emotionally.

The consequences for the interaction are negative, and both HP and P are frustrated.

Main cause: HP is unaware of and unskilled in handling emotions. She is unsupported by her supervisors in this.

The cycle of Emotional Balance

Training intervention: Communication and management of emotions

Observation, reflection, awareness Learns how to learn

HP enjoys job more, continues to use…

HP feels safe

P: Nervous, scared Welcomed, respected

Emotional balance HP-P Interaction results in giving and receiving energy Both are "emotionally fed"

P: safe, trusts, opens up Problem identified Meets HP w/respect Fear is reduced

P feels supported Cooperates in care Understands why

HP feels valued, appreciated, safe Basis for good interaction HP-P established

In this "Emotional Balance" circle, the HP has learnt to become aware of the effect of emotions, on herself and on the patient.

She creates a safe situation for the patient, to facilitate effective communication. She engages with the patient.

The consequences for the interaction are positive, and both HP and P feel good.

The main cause is – the HP knows how to recognise and manage emotions.

"After the intensive learning on communication it has helped me to be aware of myself and change the way I talk and react to patients and colleagues. I always put my antennae high as I handle people; I do it with respect valuing them as people and not things. I take time to actively listen to them even if it is just for a short time this makes the patents feels good and appreciated and in so doing they feel free to approach me when they have a problem. It feels good when you see the patient seeking help from you though sometimes it burdens ones because the patients communicates to one another and most of them they approach you to solve their problems.

Being non-judgemental and using non verbal communication less has really proved to be hard because I'm used to them. For instances a mother comes with a very sick child and she tells you the condition or sickness started for a day or two immediately I shake my head in disapproval resulting in judging her, but I know I will change with time and as much as possible am trying to avoid the habit."   *HCW, Kilifi*

The process of taking responsibility for communication takes place over time during the following steps (which build on each other):

1. **Decision to join the course** – and start learning: The course is voluntary, and each participant acknowledges a need to learn about communication. This places the responsibility for learning with her – and sets the basis for the empowerment approach which is the foundation of the course. The provider *takes responsibility to learn*.

2. **Baseline – *starting the discovery***: They reflect on a) strengths (*which motivates them*); b) challenges (*which creates curiosity and an interest in meeting them*), c) patients' perspectives, e.g what makes patients angry (*inviting empathy*). *Responsibility is maintained: The participants begin the process of identifying their own learning needs*.

3. **Observation and *reflection tasks to discover (months 1-3)*:** They look with awareness at their own communication habits when they work, and at the effects of their communication on others. They discover how their own emotions affect others and also affect their own way of communicating: They become aware of their shortcomings. This increases their motivation to learn and gives clarity about what they need to learn. *Responsibility to learn is strengthened*.

4. **Basic workshop (month 4) – theory related to their own examples, and *interactive reflection*:** The workshop strengthens awareness on a number of topics and relates it to their own experiences and observations. We facilitate learning and practice new skills in a supportive environment, where interactive reflection with colleagues and trainers creates a safe basis for deep learning. *The responsibility for using the skills to change is theirs*. They take on that challenge – when they see their own need, get confidence in the possibility to change, and experience the positive effects of changing.

5. **A second round of observation and reflection tasks, in order to put new skills into practice - *Informed reflection (months 5-8)*:** "Armed" with new skills and insights, participants practice the new skills with more confidence, and see how they function in relation to patients and colleagues. When they see the skills working well, they know why, and can see the fruits of their efforts – this strengthens motivation to continue. When they have a problem, they know why they have the problem, they can analyse it, possibly using the emotional intelligence framework (alone, or with colleagues), and take steps to solve it. *They have the communication tools to keep learning and have taken the responsibility to continue.*

6. **Endline questionnaire – *informed reflection* on their own practice, and identification of further learning needs: By month 8,** they "take stock" of where they are in their learning – what functions well, where do they still need to learn. This *"cements" the responsibility for continuing their own learning*, they are in charge of their own progress, and experience that they have the tools to continue to practice the skills well, and to learn further: they have the power of awareness. When they define their further learning needs for the follow-up course, it is from a basis of knowing much more clearly (than before the basic workshop) what they need.

7. **Follow-up workshop (month 9) – sharing best practices, and interactive informed reflection**: The workshop confirms their learning and appreciates and celebrates their growth and change: We contrast the present level of skills with the situation participants identified and described in the baseline and those they discovered in early observation and reflection tasks. This strengthens motivation to continue practicing the skills – by sharing experiences and exchanging useful skills learnt. Workshop sessions deepen their learning, especially on practicing communication skills when dealing with challenging emotional issues (e.g. dealing with anger, stress, conflict, power, burnout and death). *The responsibility to communicate well is now naturally theirs*, and they practice the skills with pride, because they see they get better results in their work. They often

acknowledge changes at home as well (communicating better with partners, family and children), although this is not part of the course structure.

> *"For the first time I was so patient and just listened to the mother pour out her heart. I went to an extent of apologizing to the parent for the break-down in communication. This is so unlike me. I have never taken the blame at my position. I had the time to listen calmly and did not object her and I believe it was our mistake that we did not explain to her nicely."*
>
> *HCW, Kilifi*

When participants take responsibility for their communication and see the patient as a partner, it becomes natural to see the patient as a person and treat him/her with respect – as a resource with extensive knowledge about her condition, and maybe what contributed to causing it and what she can do to heal. These changes lead to the use of patient-centred care, as a natural consequence. The provider also becomes an active learner who will continue to develop her skills to communicate with awareness, and with respect for emotions. The changes extend to the colleagues – more aware interactions, less tendency to blame each other, more constructive problem solving. The result is – less conflicts at work, better job satisfaction, and over time – less burnout.

> *"Before it was a matter of shouting at each other, but I have learnt to take the patient as an individual, calmly and politely explain to them in detail about what is making him anxious or angry, let them ask questions as I listen attentively and answer them as required."*
>
> *HCW, Kilifi*

4.3.3 Challenging cultural norms: Respecting the patient as a person?
The ICN Code for nurses: Commitment to respect
The nurse's code of professional conduct (internationally) stipulates that all nurses must treat patients with dignity, respect and compassion regardless of their health condition, economic status, gender, race or personal attributes. Giving and receiving respect is fundamental to establishing a good professional relationship, and to practicing constructive communication and emotional competence.

Providers are not in doubt when asked how it feels to be respected. Some examples from the baseline questionnaires:

- *"I feel so happy and satisfied with what has been done to me, and I get trust to that person"*

Experiencing disrespect causes equally strong reactions:
- *"I feel rejected, abused, not motivated, embarrassed, discouraged, dishonoured and frustrated"*
- *"Demoralized and wish to avoid interaction with that person"*

Yet, a main complaint from patients in many countries and cultures is that they feel they are not being respected by the providers. Patients are being categorized, depersonalized, labelled medically by their disease ("*the lung cancer patient", "the diarrhoea case*"), rather than being seen and respected as a person. They can be seen as "a bother", someone who "disturbs the provider", or in the case of well-informed patients who asks questions – a "know-it-all". Such reactions from the providers are often automatic, they are part of a common way many providers talk about, and with, patients in the medical and cultural hierarchy. These "cultural rules" or traditions are often internalised or subconscious. They are unwritten, unspoken, and expected to be followed – this is also a legacy of the hidden curriculum. If there is no awareness in the provider group about the consequences of such behaviour on patient-centred care and on their own emotional wellbeing, the

behaviour may continue. Potential consequences on the providers include stress and burnout, as two of three major symptoms of burnout are **emotional exhaustion** and **depersonalization**. When nurses and doctors are overwhelmed and under-supported, they often use depersonalization as a defence mechanism: They then do not have to relate to the patient.

There are many factors influencing the way providers have learnt to distance themselves from patients. A functional, professional distance is useful when chosen, and practiced with awareness. It is also needed in many situations. However, lack of attention to effects of the distancing is often lacking: Taking distance is a common behaviour in the medical hierarchy, and functions to maintain and cement power structures – and prevent providers and patients from making a connection that can help both parts.

Some major factors influencing these behaviours:
- **Educational and economic factors:** In higher education and medical education, an attitude of "being better than the less educated" is often implied, as an unspoken norm. Economic status is also important – the rich and educated expect to be respected by the poor and uneducated. The educated provider expects to be respected by the uneducated farmers;
- **The medical hierarchy and environment**, where older colleagues and leaders educated and brought up in authoritarian and patriarchal systems set the norms and function as role models in a strict culture. If they shout and show disrespect, this behaviour can be "contagious" and is often taken as a "licence" for those being disrespected to dispense such treatment to those below – i.e. the patients, or the juniors, or medical students;
- **The (national) culture,** where in many countries there may be rules of e.g. letting the older people speak first and letting them always be "right"; or not questioning authority (including supervisors), or following patriarchal rules where men are respected more than women;
- **A lack of recognition and understanding of needs for and benefits of learning emotional competence.**

See chapter 1, describing how lack of kindness and respect for patients as persons have been documented to show serious negative effects.

The communication skills training challenges and discusses cultural norms, and the consequences these may have when providers use them with patients or colleagues, usually without conscious intent to harm the other person. After the iCARE model training, one of the providers reflected:

➢ *"But now from the training…I'm able to see a client now wholesome. Like a human being, not just a patient. Because to me a client was a patient, me I'm a person, you are a patient. But now … I'm able to relate to a client like just a fellow human being, that human touch, yeah"*
HCW, Kilifi

4.3.4 Kenya example: Changing perceptions of how to practice respect
This section describes an example of how to work with the intention to challenge deeply held (cultural) attitudes which impact strongly on PCC. It takes a very conscious trainer who practices non-judgmental exploration, with respect, and takes the time it takes to do so: There is no shortcut to facilitating a group to developing deep insights, and it may not happen without the preparation of strengthening awareness by working with self-observation and reflection, over time.

Attitudes are contagious – also the positive ones. The following is a narration of how we worked with a group of providers in Kilifi, Kenya to stimulate awareness by exploring present perceptions and practices around existing unspoken rules about giving and receiving respect from patients. We

narrate it here as an example of how cultural rules and norms can be explored and challenged respectfully, without judgment. ***The conclusion by the providers at the end of the session was that they wanted a change, and when they did – they could implement it: It was THEIR decision.***

This session was held in the second training course (of 8, since 2009) in Kilifi, and has not been repeated. The issue of strengthening awareness about using respect has been consistently integrated into and strengthened in all the modules, following this work. The session was run as a part of the Emotion module – created there and then by the trainers – as a response to the discovery of how providers expected to be treated with respect by patients but did not feel that they themselves had to show respect to patients. The session took two hours.

We are using this example to show how you can use the EI framework to guide a group to important insights on e.g. practicing cultural norms, and to understand the consequences of such behaviour, on PCC as well as on their own wellbeing. The group can then, as a professional group, decide to change – and help each other to do so. We have referred to the four EI skills, throughout the session.

Trainers' attitudes essential: An important part of this session was trainers demonstrating the principles of respect they were teaching about: Exploring participants' perceptions and practices and the emotions attached to this, with respect; opening up for sharing examples of showing lack of respect **without judging** the participants for their actions; looking together for reasons behind this behaviour, and looking at consequences of their behaviour – for patients, and for themselves. Having understood and acknowledged the (often shocking) actions participants contributed, without accepting them as "right" (*participants knew very well that their actions were not ethical, or right*) – participants were free to put the actions behind them, together with their feelings of guilt and shame, and choose another way of acting in the future.

An overview of group and plenary sessions, in sequence from the workshop:
- *Group session 1: How do you practice respect in your work?*
- *Group session 2: How do you feel at work – and what are your expectations from patients?*
- *Plenary session 1: What happens to the patient, and who is responsible?*
- *Group session 3: We asked them to discuss briefly some questions in their groups – to explore possible reasons for the patient's (or parent/caretaker's) behaviour*
- *Group session 4: Additional reasons you may treat patients with lack of respect?*
- *Plenary session 2: Potential consequences for providers themselves, and for patient-centred care?*
- *Group session 5: Further exploring consequences of the rule, and a way forward*
- *Plenary session 3: What do we do now?*
- *Further thoughts: Continuing the work to strengthen awareness on practicing respect*

Group session 1: How do you practice respect in your work?
Participants discussed this question in small groups, and shared experiences of being met with and without respect – as well as practicing respect towards colleagues and patients. They agreed that in the medical hierarchy, respect is usually shown upwards, and staff expect to be respected according to their status – not necessarily according to their actions. Medical doctors are at the top of the hierarchy. Some of the comments from participants:

- *"Culture trains us to respect people above us, or with authority"*
- *"We are not trained to respect people below us"*
- *"Patients are below us"*

Group session 2: How do you feel at work – and what are your expectations from patients?
These questions caused much inspired discussion, in the same groups. Participants were ready to talk about their feelings – finally, they could talk about how THEY felt about their work! They recognised many strong feelings in themselves and were relieved to be able to "let off some steam". They also talked about how these feelings affected the way they communicate (*EI skill 1*). Some comments:

- *"We are overwhelmed and stressed, become irritated. What we want to do is a clearing and forwarding job;*
- *"Respect is not a priority."*
- *"The culture dictates our norms. The patients coming to the facility need to greet us as she found us there."*

Plenary session 1: What happens to the patient, and who is responsible?
A plenary discussion followed (*EI skills 2 and 3*). Participants concluded that these feelings often made them treat patients without respect: If they met a patient who did not, in their opinion, show them the expected respect (e.g. not greeting them "properly"), they also treated the patient without respect. This was their present way of "justifying" not showing respect to patients: The responsibility was on the patient (who was "below"); the provider "just responded" to what she was being faced with. **They did not take responsibility for the communication, they explained it as a "response".**

Group session 3: We asked them to discuss briefly some questions in their groups – to explore possible reasons for the patient's (or parent/caretaker's) behaviour:
- *"What do you think a patient, or a parent with a very sick child, feels when she comes to the hospital? How may these feelings make her act?*
- *What are her needs?*
- *Do you think this patient, or parent, respects you?*
- *If yes, what could be reasons she does not show it?"*

Participants quickly came to the conclusion that the patient or parent was most likely very worried, and that her need was to get quick help for her or her child. We invited them to reflect back on their own observations (*in the preparatory work for the course, when asked to observe and reflect on how their emotions influenced the way they communicate*), from how they themselves reacted when they were worried or scared: They realized that they were focussed on themselves, on their own needs to take care of their worries, and they often did not "see" the needs or concerns of people around them. (*EI skills 2 and 3)*

The group unanimously agreed after this analysis: The patient or parent most likely DID respect them, but – this was not in the front of her mind to show at the moment. *She was vulnerable, and she came for their help, from professional providers she respected and feared.* What she often met was – a display of power, based on expectations of being shown respect, punishing her for not "behaving properly", and thus not providing her with kindness, empathy, care and compassion. Instead, she was met with judgment based on a set of cultural "rules" that were part of the automatic behaviour of the provider.
An awareness about the consequences of this cultural behaviour was dawning, quickly, for the participants. (*EI skill 3)*

Group session 4: Additional reasons you may treat patients with lack of respect?
Participants now were invited to look at their own lack of skills, and at their need to learn. They concluded, after another discussion in the groups, some reasons for their behaviour were (*EI skill 3*):

- *"Poor communication skills"*
- *"Lack of understanding of and respect for patients' norms and beliefs"*
- *"Lack of awareness of effects of handling patients with and without respect"*
- *"Lack of skills to handle our own and patients' emotions"*
- *"It's just about our attitude, there is one nurse working in a cancer ward who does not interact or greet the patients. She is a 'sterile nurse'.*

Plenary session 2: Potential consequences for providers themselves, and for patient-centred care?

We asked the group to reflect further on the potential consequences of the medical and national cultural and hierarchical rules and attitudes they have explored. The trainer suggested that these rules are often "hidden", or assumed, and become part of the natural way people behave – and expect others to behave. The behaviour becomes automatic, and part of a practiced and accepted (by the other providers) norm. The work we have done here is to uncover and analyse one such rule with the intent to understand reasons why it is there, and consequences of its function on patients and providers, but without judgment. With this analysis, participants can develop an "evidence-based" way forward (**EI skill 3).**

Group session 5: Further exploring consequences of the rule, and a way forward

The groups then discussed the consequences for developing safety, trust and a professional relationship with the patients, and for providing patient-centred care. They now saw clearly how these (unspoken) rules affected their work with the patients in relation to respect and saw a number of negative consequences (**EI skill 3**).

They described consequences on **themselves**:
- *"Felt dissatisfied, and often stressed;"*
- *"The negative emotions often spilled over to how we deal with colleagues"*

They also described negative consequences on **patients**:
- *"They closed up, did not give all the relevant information"*
- *"Sometimes they received wrong diagnosis"*
- *"Often, they did not receive patient-centred care."*

At some level, the providers knew that something was "not right" about their own behaviour.

Plenary session 3: What do we do now?

Participants' conclusion was now clear, and unanimous:

- ***"We need to change this culture in our hospital"***

There was a lively discussion about how the change should take place. Participants agreed that awareness and further focus on respect and kindness was the key: they had already started the change, and many had become aware through their observations and reflections about what had happened when they showed respect and disrespect to patients. The seeds for change had been planted during this time. This discussion in class made participants realize deeply where their behaviour came from, and – made them free to continue to change (***EI skill 4, and continue to use skills 1-3).***

NOTE: The key to this guided discussion is an aim to identify, recognise and explore causes and consequences of a cultural behaviour in a process with the participants, and leave them free to come to their own conclusion from their analysis: They will then own it, and possibly implement it.

This is felt as an empowering process. The trainer must be careful to "only" ask and guide the discussion, but not influence the conclusion.

Further thoughts: Continuing the work to strengthen awareness on practicing respect
The awareness of the need to change affected their work strongly, and in the period between the basic workshop and the follow-up workshop, the participants experienced a number of situations where they related differently to patients, with respect and with a clear intention to create a more equal partnership. "Real equality" is not realistic, given the educational and status differences: The providers will remain privileged, compared to the majority of their patients. However, when providers become more aware of these inequalities, and how they affect communication, they can take steps to reduce them. They can use more humility in their actions – with awareness and intent to create a basis for open and constructive communication – in other words – using their emotional competence.

Examples from their reflections on what happens when they treat patients with awareness and respect, all from health care workers in Kilifi:

- ✓ *"Before doing the course I used to expect patients to greet me when they walk into the ward. Nowadays I am the one who greet them and ask them how I can help them.*
  This makes them feel good, accepted, and I also feel good when they open up to me"

- ✓ *Yes, when people are greeted and recognised it takes no time for them to adjust to the new environment. They don't fear and are free to express their concerns. They in return appreciate and respect me. "*

- ✓ *«Yes, great changes. If one is respected, they respond with respect. I managed to make a client who was giving up on his care relax, accept that he is of value and that his family needs him most. I showed him respect throughout the counselling session until he opened up and told me there was a communication break down between him and the wife and he was unable to comply with medication due to lack of support from the wife and poor nutrition. He was feeling judged by the wife for being HIV positive when she was negative and so he felt neglected and thought he'd rather be dead than live with the frustration».*

- ✓ *"When I treat patient with respect, they also respect me and it builds their confidence to me hence good working environment."*

The awareness of how participants relate to power and respect started developing in the first period of observation and reflection tasks (Phase 1) before the basic workshop, when they saw how their own emotions and use of power affected how they communicated with the patients. In the basic workshop, they learnt the skill to recognize and step back from automatic reactions to emotions (*e.g. when feeling hurt – stepping back instead of covering it up by judging the other person and using power*). In the observation period after the workshop, "Skills into Action", Phase 3, participants got repeated confirmation of how their new skills to build relationship and partnership with the patients helped to develop trust and establish good cooperation. Most told stories of how they were shedding their old habit of using power to judge and "punish" the patients, or "keep them in their place". Respect worked a lot better to establish good relationships and develop trust, and thus enabled them to practice PCC and meet professional goals.

5 The role of research in an institution, using the iCARE training to support research staff

Good health research in low income settings is important to understanding health problems and developing appropriate and practical solutions to health challenges in complex social, cultural and economic contexts. To be able to carry out such research in an institution, there needs to be a team of researchers who collaborate with health providers to collect information and to recruit and manage study participants. The team members need good skills in communication and management of emotions, and thus the course described in this manual is relevant for research teams as well.

An example: In Kilifi, a research project aimed to understand new-born care practices and mothers' experiences with sick babies hospitalized in new-born care units. Research managers observed that researchers working in these units experienced many emotional challenges, including seeing many babies dying, making it even more of a challenge to talk with the mothers. The researchers interviewing the mothers experienced difficulties in carrying out the interviews, both in relation to managing their own emotions, and in responding appropriately to the emotions the mothers showed.

Our team planned and conducted a training course for this group, and the group responded very well – they found it really helpful to learn how to recognise and manage their own emotions as well as the emotions of others, and to learn how to communicate well in challenging situations:

> *"Looking back, I appreciate the efforts I have put in this. For me it has been an eye opener and a great journey of being aware of my emotions and the effects it has on me and my colleagues/ study participants/family. I have learnt that before I react to something I need to try and understand why it happened that way, and that way I would avoid hurting others and much more – not be judgmental every time."* Research staff, Kilifi

The Kilifi team has conducted several iCARE-Haaland model training courses for researchers, and also presented these ideas and concepts in international conferences. There is a growing recognition in the research community about the need for researchers to become more self-aware and to learn better skills on interpersonal communication, and on managing emotions – especially related to conducting research on sensitive issues. These skills will have an influence on the quality of research data the interviewers are able to collect, as well as on the researchers' wellbeing.

A course participant in Kilifi commented in an evaluation of the course:
- *"The most valuable learning I have had is the importance of active listening. As I have been doing in-depth interviews I realised that I wasn't doing much active listening to participants. Sometimes I would repeat a question already answered and the response from the participants would be, "I have already told you that!".* Research Staff, Kilifi

The role of research in an institution
Health research learning can be beneficial to a range of players in a number of ways:
- **Research participants, and other patients**, can gain from any clinical benefits built into the study design and ancillary care plans, and the patient population as a whole can gain in the long run benefit from the outcomes of what is learned.
- **Wards and health institutions** can benefit from research-related funding, training and other resources, including access to additional professionals

- **Researchers** can develop a deeper understanding about what the main health problems facing people in the area are and contribute to finding shorter and longer term solutions to major health problems.

Each research project should always be carefully checked for science and ethics before it begins through competent local and national review processes. All team members, including any health providers involved, should receive training on technical and ethical aspects of their particular approved research projects. For research staff interacting with patients as research participants, this training is ideally in addition to general communication and EI skills described in this manual. Communicating well with patients, respecting their concerns, questions and emotions and explaining complex processes in a simple way is as much a challenge when dealing with issues related to participating in research as it is in daily clinical care.

Providers involved in research projects need to be able to use their communication skills to –
- *Screen patients* to establish if they are eligible for inclusion in studies and make relevant recommendations;
- *Explain the purpose of the research* and *request consent* for participation by patients or parents/relatives of patients in the various projects, when they are emotionally stable enough to make such a decision;
- *Ensure all study patients are aware of their rights* and have signed consent forms;
- *Explain clearly the difference between research and treatment*;
- *Continuously advise and inform* patients or parents of the patient's illness, their participations in the studies, and their progress and treatment throughout the hospital stay.

Health research is common across many health institutions in resource poor settings. We therefore assume that a number of the users of this manual will be in contact with research projects during their working life. We thus provide here a brief global look at why we need research in resource-poor countries. We also provide an overview of the process we use to lead our participants through to strengthen their skills specifically related to research.These are added on to the skills participants are trained in throughout the course process. Readers are also referred to research modules in the basic course and in the follow-up course.

Where possible, the Principal Investigators who lead the research projects should be involved in some of the learning processes on research communication with the participants. Frequently, there may be a communication gap with this group, many of whom are used to speaking mainly to scientific communities. Many PIs may have a lot to gain from facilitated communication with the providers, to learn more about their concerns about the research, and to break down some of the status and power gaps that often prevent providers raising (often very important and pertinent) questions with the PIs. This can be important because research hierarchies often have similar power inequities and imbalances to health systems which can make raising issues 'up the system' particularly challenging and demanding. Nevertheless it is important to be able to do so, because the power to change study plans and designs is often held at that level.

A brief global look: Why do we need research in resource-poor countries?
Health research is aimed at producing new health related knowledge, and ultimately health. There are a diverse range of studies conducted globally, ranging from interview-based research, through observational studies, through to many different kinds of trials, e.g trials to develop new products, compare different treatment options, or assess different mechanisms to improve patient adherence to therapy). Although developing countries have far higher morbidity and mortality rates than developed countries, and therefore greater potential to benefit from research, these parts of the world are hugely under-represented in the proportion of total health research budgets

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and levels of research activity (Lang et al., 2011). Recognition of this gap, and of the urgent need to evaluate available and affordable interventions in developing countries, has contributed to efforts to strengthen capacity in developing countries to lead and conduct research.
Numerous policies and guidelines have been formulated to help identify and deal with ethical issues and dilemmas that arise from involving people in research[1]. Many issues and recommendations can be broadly grouped under meeting key principles of conducting research, including: : 1) treatment of individuals and communities with respect; 2) ensuring that any risks of being involved in the research are minimised and that the benefits of the research outweigh the disadvantages; and 3) ensuring fairness in who is involved and who gains from in research.

Frontline staff include those who explain studies, administer consent processes, conduct research and clinical care procedures, and feedback test and study findings. These staff are essential to how studies are actually administered and unfold over time, and therefore are key to scientific quality and ethical practice. Frontline staff face many practical, technical and emotional challenges in their day to day research activities, many of which require significant communication skills. Many fundamental concepts of health research (eg randomisation, equipoise) are challenging to explain and understand in any setting, but further complicated in clinical settings by the stress of illness and being away from home, and by health providers often wearing 'two hats': both a research roles and a clinical care role. There is potential for patients to think that research activities being proposed are primarily for their own therapeutic benefit as opposed to for learning at a population level ('therapeutic (mis)conceptions').

Health workers may also feel that principles of research come into conflict with or have to be balanced with their own personal or professional ethics. The need to share experiences and strategies to cope with challenges and conflicts has been highlighted in our setting for fieldworkers. It is also clearly a need for health workers involved with research, or who have questions about research conducted by their colleagues and researchers on 'their patients' or in 'their' health facilities and wards.

5.1.1 An example from the process of learning about research in Kilifi:
Part 1: An "open day" on research for health providers

Participants in the communication training courses who were directly involved in research activities in the hospital expressed a need to learn more about these activities to strengthen their understanding and enable them to communicate research issues better to patients. However, the needs raised by participants were way above what the communication training team could accommodate within the time available in the workshops (half a day in each workshop on specific research topics, and connection to research from almost all the modules).

Thus, the training team came up with the idea of organizing an open day for the participants to learn more about research activities currently going on at the hospital as an added activity to the main training modules. The open day on research took place during the first three months of the learning process.

The open day was organized in collaboration with the community liaison group and the hospital administration. The community liaison group has the mandate to strengthen relationship between researchers and communities within Kilifi. The open day is meant to be used as a forum for participants to learn about and discuss broader issues related to research, thus strengthen their knowledge and understanding about research before attending the communication workshops, where the aim is to strengthen their skills to communicate about clinical care and research.
The brief programme and specific aims are included here. For a detailed version, see module 4.

The specific aims and objectives of the open day were for participants:

To strengthen knowledge, awareness and understanding of:
- **The KEMRI-Wellcome Trust programme:** Basic organizational structure and link with MOH: Who we are, what we do, and why we are here in Kilifi. How KEMRI interacts with communities around Kilifi and how the providers are considered as part of the Kilifi community. History of KEMRI growth – from 1979 till now.
- **The Community Liaison Group**: The main goals of improving understanding with the community, and main activities the group is involved in.
- **Hospital based research and why it is important**
    - What a research project is in a clinical care setting. Examples of research studies going on in the hospital, and the aims of these studies.
    - Major research which has been conducted, and impact it has had on health policy in Kenya, and in the world.
    - The social value of research, and why we need to conduct research in health.
- **Research quality – science and ethics**
    - How a research project is developed and reviewed, and what makes it safe for patients to participate.
    - The principles of informed consent, and why it is important to make sure to obtain voluntary consent. Obtaining consent in emergency situations.
    - The role of staff in research
- **Particular concerns locally about research and effort to redress these concerns**
    - The background for using the snake as a symbol, and why this has now been removed from KEMRI vehicles in Kilifi.
    - Community perceptions about KEMRI activities (The Takaungu video).
    - Activities and functions of the scientific labs (tour around the labs).

To encourage and facilitate
- A motivation to identify with and take pride in being part of important work at KEMRI

To strengthen skills to
- Communicate with a patient/parent about what KEMRI is and does on research, with the aim to create an understanding and a positive attitude to the aims of research in Kilifi

Notes:
- ***The aims for the open day can be flexible depending on what the participants needs are from reading their feedback.***
- **See Module 4 for a full program and presentations for the open day, and for how to plan the day.**

Timing of the open day
- To be conducted during phase 1 (observation and reflection), preferably early in 3rd month
- Participants' questions and concerns from baseline can be addressed

Part 2: Task 11b: Special observation and reflection task for participants involved in research (in 3rd month of phase 1, before basic workshop)

See Parts B and D for all the tasks. Task 11b can be found in part B.
For the full modules, see parts C and E.

Part 3: Module 4 in the basic workshop: *Communicating about research with awareness and emotional competence:*

How is a research project developed, and
how do you explain need for research to a patient?

> *A key skill for the participants is to be able to explain the need for research, and what it means to the patient, practically, to be included.*
>
> *Another key skill is to explain clearly that participation in research is voluntary.*
>
> *See module 4 for these aspects*

Difference between treatment (FOR the PATIENT, now) and research (for the COMMUNITY), long term, must be made clear to patients.

An example of a course participant explaining the need for research:

"A patient came the other day when I was on duty the patient was already screened in Ward 1 and was eligible to be recruited into the FEAST study (Fluid Expansion as a Support Therapy). The patient was accompanied by the mother and an uncle who was brother to the father. He was a boy aged 9 years with Anaemia and had all the signs to fit into FEAST A.

So the admission procedures were being done. I started by introducing myself to the parent and uncle then went ahead to explain what was being done to the patient (i.e. blood was being taken to the lab so that we are able to know what exactly is the cause of illness). Then I started explaining the study FEAST. I explained to them that it involved the use of infusion fluids Normal Saline and Albumin and the child is given either of the two, then observations are done at the first hour, 4th hour, 8th hour, 24th hour and 48th hour and the child will come for follow up on the 28th day. I also explained to them that small amounts of blood will be taken during the study and taken to the lab.

Good enough; they were asking questions as I went on e.g. "if what you want to give our child is medicine, why then are you asking for our permission?" I explained it's because the fluids are under study and because of the fact that the child will be monitored closely and is required to come for the follow up; that is why it was important for them to understand the study. I also explained that the drugs were tested not harmful to humans - all we needed is to know which one is more effective than the other.

I told them the study is not only beneficial to them alone but also to other children in the future. I also told them they will be given transport to go home and to come for follow up. All this discussion was a the bedside. I also explained to them the child will also get other necessary treatment as usual and that it is their choice to accept or refuse to be in the study and that even if they refuse, the child will still get the treatment and good care as usual.
Then I asked them what they have understood and they explained back and gave consent to the study.

I was very happy and immediately the study procedures began I assured them they could ask me questions any time during the study. HCW, Kilifi

Part 4: Module 8a in the follow-up workshop:

Working with emotional competence in a research environment:
Understanding and communicating about the difference between research and treatment

In this module, participants are trained to explain the difference between research and treatment to patients through exercises and discussions. Ethical aspects of research as well as national and international research processes are explained and discussed. Skills are brought together, and participants train to be able to practice communicating about research, with confidence.

5.1.2 Changing attitudes and practice on research: Providers more aware

In the LVCT evaluation of the training courses in Kilifi[100], the researchers concluded that there was a clear pattern of positive change in participants' self-reports i.e. all feel that the training has led to changes in the extent to which they take account of the patient's situation, try to explain as well as they can and make sure decisions are made freely, with understanding.

Changes were seen particularly regarding how participants related to promoting choice and managing refusals from patients. Before the training, for clinical research on the ward, there was a common pattern of firm personal belief amongst HW that children would benefit directly from participation in studies, i.e. participation was generally in the child's best interests. On this basis, HWs felt that it was fundamentally not important to explain too much about studies; and that mothers were being unreasonable if they refused – not acting in the child's interests. This could make HWs irritated or even angry with mothers who refused.

In addition, HW often felt that:
- Refusals were a sign of personal failure on their part, since they worked in a research institution
- They were under pressure from supervisors to recruit participants, again as part of their job
- As a background issue, getting full informed consent in a ward situation was often very difficult (anxious mothers, mwenye syndrome (*mothers believe all decisions need to be made by the father)*, traditional beliefs, illiteracy etc). As a result, taking short cuts was often seen as unavoidable.

This means that nearly all HWs often did not feel strongly motivated to spend time on the consent process and ensure that decisions were made freely. All understood the concept of voluntariness in research before the training, but this was outweighed by concerns/issues above.

In addition, a particularly serious effect of HW's negative responses to refusals was that some HWs would continue to feel resentment towards mothers who refused participation, deliberately avoiding them or treating them differently to other patients.

Following the training, all HWs spoke about an increased **realisation of the importance of voluntary informed consent** in research. On this basis, areas seen as particularly important to communicate well about were: specific study procedures, the difference between research and care, and voluntariness (in majority of participants); and the research question and benefits & risks (in many); and (in one) contact information.

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[100] LVCT (2011): **EVALUATION OF THE HEALTH PROVIDER COMMUNICATION SKILLS COURSE**

An example: Respecting a well informed "No" to a request for research consent

"A father had two children who were invited to our clinic because they were both below the age of 5 years and their mother had sputum smear positive tuberculosis. We were investigating these children for any symptoms and signs of tuberculosis. Moreover, we did some investigations on them. After all our investigations it was clear this children did not have tuberculosis but we still needed to follow them up for a few months just to be sure they don't develop something suggestive. Meanwhile, a study on finding a single and effective way of diagnosing tuberculosis in children is running whereby a blood sample is taken and biomarkers to tuberculosis infection are sought for. All children, regardless of whether they have tuberculosis or not are eligible.

I told this father about our study and its importance. I made it clear that his children were fine. I also made it clear that participating in the research is voluntary.

As we were talking, it was clear to me that this father understood what I was saying and I even predicted he would accept his children to participate in the study.

He kept on asking questions about tuberculosis and the study, which I clarified, to his satisfaction. Finally, I asked him whether we could proceed and enroll his children he said 'Daktari, I have understood all you have said and I think it would be good if scientists discovered a simpler way of diagnosing tuberculosis in children. Am glad participating in this study is voluntary. I don't mind having my children participating in the study but I just don't feel like it'

In my mind I was thinking it could probably be the bad stories that are circulating in the community about our organization. I asked him if that was the case and he told me "I am aware of such stories and please know that my elder children have participated in various studies before of which I did not see any particular problems. I am a member of the body that liaises between your organization and the community so I have the facts and wont be swayed by hearsay. I just won't let my children participate this time round and I have no bad feelings about your organization. If anything I commend what your organization does for this community".
I respected his decision.

I think most of the time I have problems with when a parent doesn't accept his/her child to be involved in a medical research. I may not show it but inside myself I usually feel – 'even after all that talking!' But slowly, I am learning to accept right from the bottom of my heart when consent is denied. What I make sure is that I give a brief overview of the organization I am working with, the importance of a particular study I wish to enroll a child into, I articulate the key points, give room for asking questions and provide my answers. I pay attention to how I am conveying my messages, the parents feelings, and finally respect their decision of whether to participate or not."

HCW, Kilifi

Two health workers described specifically feeling torn over this balance between ensuring free informed decisions were made and supporting the (perceived) best interests of the child. These two health workers and another specifically talk about the confidence they have gained from the training in *balancing these issues.*

From the data, the main underlying reason for this change seemed to be placing greater importance on the idea of people's rights to make their own decisions, based on understanding what's being proposed. This was linked to:

- **a better understanding of the 'weightiness' nature of this principle**, from talking about 'formal' requirements and review processes in research (many committees, international guidelines etc) and perhaps also by its inclusion in this training??
- **the general idea of respect for others being taken more seriously** – from the course as a whole
- **greater confidence** in being able to communicate about these issues, and to answer questions about research and research processes.
- **reinforcement/increasing confidence** through positive experience of using new skills in informed consent situations: this is a mix of situations where new approaches 'succeeded' where other HWs had 'failed' and where new approaches 'failed' but still seen as doing a good job (now feel good about that).
- **the support given by colleagues** and supervisors for using new skills in the workplace (e.g. referring 'difficult' situations).

Other changes in HWs' perceptions and behaviour included a broader understanding of the role of research in the institution. Particularly for HWs with no, or only some, direct involvement in research, perceptions of the role of research often changed from being seen as a very local activity (e.g. to support the interests of individual researchers, in 'making their names' and accessing funding) to being part of larger movement in support of health and social development.

6 Methods: Reflective and experiential learning in structured, supportive processes, over time

In this chapter, a detailed description of the sequence, the observation and reflection tasks and of experiential learning provide the background for understanding how the model works, and why it leads to the changes we have seen happening to participating providers. The links to emotional competence and intelligence are added throughout.

The iCARE-Haaland Model uses several different training methods that we combine to facilitate discoveries and insights, leading to a motivation to learn actively and to change practice. The main methods are:
- **Experiential learning** as the core training method;
- **Self-observation and reflection in action** on-the-job to discover their present communication habits and the effects of these habits on the person you talk with. As they work with this, they identify their learning needs;
- **Reflective and interactive learning methods in workshops** to link topics directly to work-based challenges;
- **Short lectures** to link work-related examples to theory and provide a theoretical foundation.

The methods are central to how and why participants become active learners who take responsibility for their own learning, and central to the function of the model. Awareness, experience and the (re)-discovery and cultivation of a deep motivation to care and learn are the key factors leading towards achieving the training aims.

The link to emotional intelligence and emotional competence
The sequence of learning builds EI over time by strengthening four main skills needed to practice this very useful combination of awareness, reflections, analyses and skills:
1. **Recognise** emotions (your own, and those of the person(s) you talk with) - starts in Phase 1, with identifications and reflections in baseline, and in the self-observation and reflection tasks. Many discover their automatic emotional reactions, to different situations;
2. **Think:** Seeing the connection between cognition and emotion – starts in Phase 1, and is firmly established during the basic course when examples are linked to theories;
3. **Analyse:** Looking at causes of emotions, and consequences of different possible actions to take – starts in Phase 1, when participants ask themselves "Why" these emotions occur, and continue to ask in the basic course when answers to questions emerge;
4. **Act:** Deciding to "step back", e.g. from automatic reactions, and take constructive action, e.g communicating based on an understanding of the situation and of the possible causes of the emotions involved. This starts in Phase 1 and continues throughout the course. In Phase 3 – Skills into Action – participants experience how the new skills work in practice. This is when new habits are formed.

We also refer to this set of skills as "emotional competence". This concept includes being able to use the skills to manage emotions with ease, but – for all practical purposes, the two concepts – emotional intelligence (EI) and emotional competence (EC) - are equal.

6.1 The learning elements build on each other
The sequence of the methods and the sequence of contents within each method is central to why the learning process functions so effectively: A carefully crafted learning period enables the participants to build awareness and skills in a natural way, piece by piece. They learn to develop

professional relationships and learn why each skill and emotion functions the way it does. The focus on ***understanding why, especially related to understanding emotions,*** is central to the deep learning and gives participants a sense of control over their own process: Curiosity is stimulated and becomes a key skill. The learning must "make sense".

The key elements in the learning sequence are:
Phase 1: Discovery, and creating active learners

- **Voluntary participation.** This ensures motivation to learn and prevents (strong) resistance.
- **Baseline questionnaire,** to start the process of reflecting on how they communicate – their strengths and challenges; on how patients communicate; how aware they are of how emotions influence communication, etc
- **Observation and reflection-in-action tasks <u>to discover</u>,** to enable insight into their own communication habits and the effects they have on others (patients, colleagues, supervisors).
- **Tasks are progressive in complexity**. They start with "simple" and straightforward topics like listening, and asking questions. Participants discover "simple", important issues like – *"I thought I was a good listener, but now I see I interrupt people very often, and this makes patients close off"*. They see that they can gradually master the technique of observation and reflection, and learn every day.
- **Writing a story of "The Most Significant Change**" (MSC[101]) after a month of observation makes them realize they have discovered important things, and that the learning is their own – and they can use it to make decisions to change. At this time, many have already changed – e.g. in how they listen to others.
- **After one month: Meeting with other participants to share experiences and get feedback on the use of the observation and reflection tasks:** Self-observation and reflection in action is a new practice for most of the participants, and a brief meeting with the trainer (one hour +) lets them ask questions and share experiences. They start to get the feeling that others are struggling with similar issues as they are. They start developing a feeling for "a learning community", and learn from each other how to carry out the tasks in the best ways. They receive the next pack of observations, for another 4-6 weeks of tasks.
- **Tasks on observing emotions start when they "know what to do**" regarding how to carry out the method of self-observation and reflection. They can then focus on the contents – observing emotions (while they occur) – which is a new topic for most of them: They of course know about emotions – but most participants have not been asked to study or reflect in-depth on emotions in their education so far.
- **Gradual learning about emotions**: The first task is "just" to observe what makes them irritated or angry – to get to know their "trigger points". When they are familiar with ***WHAT*** they react to (*through observing for one week*), they look at ***HOW*** they react (*observing this for another week*): Do they talk angrily? Show non-verbal disapproval? Withdraw, try to hide reactions? Are the reactions automatic, or can they control them? Reflections around these discoveries bring new insights. The next step is then to look at ***the effect of their reactions***, on the other person – during a third week's observation: *This is the time many get ahaaa-experiences of how they cause hurt in the other person, without wanting to do so.*
- **This slow, deliberate process gives them time to integrate the learning**, and understand deeply how their own emotions influence how they act and communicate, and how the other person responds to them. They combine this learning with the insights on how they use communication skills. At the end of the learning sequence to observe the influence of emotions on themselves and their patients and colleagues, they write about their learning

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[101] Davies, R and Dart, J (2004): The Most Significant Change (MSC) Technique, based on a method developed by the social anthropologist Gregory Bateson.

and insights and send it to the main trainer (another MSC story). They then have another meeting to share experiences, and to receive the last observation and reflection pack of tasks before the first workshop.

- **Applying the learning to Patient-centred Care, and use of empathy:** Most participants have discovered that they have communication habits which may have hurt patients – without intending to do so. They are getting more consciously in touch with their professional wish to care well for patients and many see that they need to make changes in their communication behaviour. In the final pre-workshop stage of the observation and reflection tasks, participants are reminded of the principles of Patient-centred Care and are invited to reflect on how their own practice compares to these ideals. Then, by "stepping into the shoes" of a close relative or friend who has experienced PCC (*or at least some aspects of it*), participants reflect on how this practice met the needs of the patient, and how it was felt by the patient – inviting the provider to look at the importance of empathy. Finally – the providers take the learning and applies it to their own practice of dealing with fear and anxiety in patients. Then, they send in their observations, reflections and insights on the different topics, to the trainer (the third MSC story).
  These observations give a very good basis for reflecting further on their understanding and practice of empathy in the workshop, and of recognizing and managing the many emotions that affect all actors in the health care settings.
- **Trainers read and analyse the MSC stories and examples from their observations – and identify the recognised and the hidden learning needs:** When reading these examples and reflections, trainers get a good picture of what the group has learnt. They pick out examples to use in the different module presentations, illustrating challenges and insights participants have reported. The trainers also identify the hidden learning needs or "black holes" in the learning – *what is it the participants do not know that they do not know?* For example – the importance of insecurity and vulnerability is something the trainers usually have to add to the contents, as participants are usually not aware of these emotions. However, they do recognize these emotions when they are introduced and discussed and can link them to what they have already observed and reflected on. Thus, the learning becomes a combination of what they have observed and discovered and (partly) understood, and what we as trainers know they have to add to these topics, to widen and deepen their understanding.
- **Trainers systematize the feedback from baselines and from observation and reflection tasks** to acknowledge learning, in separate presentations in the workshop. They also pick out examples to develop demonstrations and role-plays from – examples that describe strong learning situations that are common to the group. As the situations used in the course are all recognizable to the participants, the experience of relevance is strong, and this further trigger the inner motivation to learn: This is THEIR training, about THEIR situations.

Phase 2: Theory and practice, and reflective interaction: The first workshop
NOTE: An overview of the modules is found in chapter 6.6.5. This part gives an overview of contents and methods – "the thinking behind" how the workshop is built up, and of the logical progression of themes.

Note 2: An *next to a topic or title refers to a module where the theme is discussed.
- **The Basic workshop: Relevance, safety and establishing a professional relationship**: Feeling safe in the learning environment is key to effective learning. The **Introduction to course concepts and contents* gives an overview of the training. The trainer sets relevance of the training contents and methods by asking questions – inviting participants to link their work experiences to a number of central concepts underlying the workshop contents. The trainer uses appreciation and emphatic understanding to "set the tone" for a workshop where curiosity, exploration and reflection are main working tools, and where the quest to

understanding WHY we do what we do, is in focus: Looking for reasons behind an action, rather than judging it (automatically). During introduction, participants are invited to use appreciation and humour to introduce each other, again setting a "tone" which is non-judgmental and generous and aimed at including learning about emotions in a constructive way. It also introduces the main approach – to communicate well in a professional relationship. This approach reduces nervousness and invites awareness.

- **How to discuss and learn from mistakes**: The aim in the workshop (and throughout the training) is to explore and understand – not to judge each other. Participants are encouraged to share mistakes and to discuss and find reasons why they happened. Everyone knows when they have made a mistake, and many feel guilty and shameful.
Acknowledging and discussing mistakes does not mean accepting the mistake as "right", but to acknowledge that we all make mistakes and that we can learn from them, together. Understanding the (usually emotional) reasons for making mistakes can enable the participants to recognise the emotion next time and choose a different action. This approach can enable participants to put the mistakes behind them and go on – making aware choices.

- **Acknowledge and systematize participants' learning:** Examples from participants' learning and insights during the three months of discovery (baselines, and observation and reflection tasks/MSC stories) are presented in themes, to acknowledge the learning of the group:
Feedback from observing how you communicate. Participants usually experience this as very motivating and reflect interactively on their learning process.

- **Linking learning to theory**: Participants are invited to share experiences and **reflect interactively**, and examples from their work situations are analysed and linked to theory throughout the workshop. When they understand the theory, they gain new knowledge that can enable them to understand their experiences in a new way. This enables them to explore the crucial question of WHY they react the way they do, and to see that such reactions are "normal" or common – and that many others react the same way. They build a system of understanding issues or phenomena, which enables them to recognize the same issue when it reoccurs, and – prevent an automatic reaction to it: They become able to step back, reflect, and then react with awareness – using emotional competence.

d) **The further Modules: * How do adults learn? Using learning theory with patients and colleagues** is applied to understanding what characterized their own best teachers, and how they as students learnt well from teachers who cared, gave examples, respected students and involved them in practical learning, with feedback. This understanding gives a basis on which they build their own strategy to teach others – effectively.

- **Two Core modules** - *Gold standard communication theory, skills and strategies in practice* and *Communicating with awareness and emotional competence: Effects of safety, anger and insecurity on how we communicate* – introduce skills which are applied to all other themes and are used throughout the workshop.

f) To this basic knowledge we add themes and theories that deepen the knowledge – richly exemplified from their own everyday work life: *What makes people change attitudes and behavior? And why doesn't the patient do what I tell him?; *Recognizing, managing and preventing stress with communication and emotional competence, and *Managing conflict with awareness and emotional competence to maintain dignity and respect*. These modules help participants to learn to recognize emotions involved in everyday situations and take a step back from automatic reactions, and thus understand and practice EI. All these topics use the understanding of how communication happens in a professional relationship and how emotions are managed, using EI, as a basis for developing insights and forming good strategies for action. The learning is brought together by exploring how patients learn and applying the theories to various situations in the module *Using communication skills and emotional competence to educate patients*. We then build *Strategies to communicate with awareness and emotional competence* to relate to a broad range of clinical situations.

The learning is also applied to *Communicating about Research with awareness and emotional competence* and exploring challenges the providers face: Participants can use the skills to ensure that requests to patients for consent to participate in research are handled ethically, with respect for the patient's right to choose whether or not to participate – as well as to establish a good relationship with the patient, which gives a good basis for collaboration.

- **Key emotional intelligence skills taught and practiced** are: to recognise patients' emotions, analyse reasons for the emotions, and respond constructively, and recognising your own emotions, analyse and understand the reasons, and take a step back before taking action.

Phase 3: Practicing new skills, reflecting with colleagues – enjoying "Ahaa"-moments

- **Further** <u>informed</u> **reflection: Skills into practice:** In this phase, participants apply their new skills with more confidence – they now know **what** they need to do, and **why** – to meet the needs of the patients, and themselves, in various situations. They also know **how** to do it, using EI as a tool: When they reflect on their successes, they reflect from a basis of knowledge about why what they do, works well. They know they can continue to use and refine these strategies – and this builds confidence. When they reflect on what goes wrong and where they still have challenges, they also reflect with awareness on the basis of knowledge – they can analyse what went wrong, and **why**, and decide to handle such a situation better next time, using their emotional competence.

- **Participants are given new weekly observation and reflection tasks. They keep notes on their further discoveries and also note persistent behaviours they still need to work on. They send in their MSC insights and examples to trainers once a month.**

- **The Skills into practice phase programme is built to empower:** The relatively fragile mastering of skills and the confidence participants have built can be bruised and damaged by colleagues and supervisors who may be jealous, fearful, or angry with "the new communicators". To meet this challenge, participants are made aware during the course about natural resistance to change in hierarchical systems, and that they are likely to encounter such resistance. They are encouraged to build themselves up as role-models who practice good communication skills with awareness and recognize and step back from sarcasm and criticism from colleagues. *We discuss how the reasons behind such behaviour is usually fear, which should be met with awareness and knowledge rather than anger.* Such aware responses can facilitate a better work environment.

- The new series of tasks aims to strengthen EI by practicing these skills. It starts with observing and reflecting on *situations they handle well* – to strengthen empowerment. They are asked to look at *natural ways they use the skills well*, to strengthen awareness of how they already have acquired new skills and have also made important changes in their work. They also *identify barriers to practicing new skills* and reflect – often together with colleagues from the course – on how to overcome these. They start noting further learning needs.

- **Handling colleagues with awareness:** To strengthen their image as "aware communicators", participants are given suggestions for how to share information from the course with colleagues, in a structured and non-threatening way. These strategies are intended to create a positive attitude to constructive communication in the work station, and to start (or strengthen) the role of the trained provider as a role-model. Participants also have a task to give constructive feedback to a colleague, with awareness – which is usually a positive experience for them both. Such action can help turning possible negative attitudes from colleagues, to positive ones. Dealing with sarcasm is another skill they practice in this set of observations – where the EI skills come in handy. (*Sarcasm is an aggressive emotional reaction which often causes an automatic response. By using EI, participants can recognise*

their own negative emotional reaction when met with sarcasm, and discover the reason behind the colleague's sarcasm as often being insecurity. Based on this quick analysis, they can step back – rather than react with anger).

- **Handling supervisors with awareness:** The relationship to those in power is often based on deeply held fears, often related to cultural experiences of power and hierarchy in families and/or at work. After becoming aware of how they relate to colleagues who (mis)use power, and building confidence to handle these situations well, participants start mapping the patterns of how they relate to supervisors. Through the mapping tasks, they become aware of what they react to, and how they react – and they then apply some of the tools (e.g. EI) to reflect on why they react like this. These reflections and examples become important parts of the follow-up course, where dealing with power with awareness is a central theme.

- **Handling patients with (more) awareness:** The last set of tasks brings all the learning together to looking at central elements of Patient-Centred Care. Participants observe how they relate to patients feeling safe and being respected, and the effects on how they communicate. Safety and respect are key elements in PCC - they affect both patient and provider and create a basis for building trust and relationship. Participants are asked to focus on these elements – as they affect patients, and themselves, in the last set of observation and reflection tasks.

- **Collecting Best Practice Examples:** Throughout the Skills into Practice period, participants are encouraged to collect and note "Best Practice"-examples, where they feel they really use the communication skills well. These examples will be role-played and discussed in front of the class in the follow-up course, where the sessions have several important functions: They show how participants have integrated the skills into their daily practice and are using them with pride – this has a strong empowerment effect. These participants are then seen as resources or role-models on the skills or topics being shown, and other participants can continue to learn from them. Trainers can pick out the skills they use, and add further comments and theories to these. They can also use them to reflect with the group of participants on what makes a provider able to use these skills well. The examples can be further analysed, using the EI framework, and can help to make the EI skills more visible.

- **Endline questionnaire** consists of the same questions as the baseline, with some questions added to ask participants to identify and reflect on changes they have made during the course process, and on the effect of these on themselves and on patients and colleagues. This exercise makes participants reflect on their learning over the last eight months and acknowledge changes they have implemented in their practice – using **informed reflection**. The reflections throughout phase 3 build professional pride. They also help participants reflect on and point out where they still have learning challenges, which should be dealt with in the follow-up workshop. Finally, the answers to the endline questionnaires are a tool for planners and trainers to analyse the perceived learning since baseline.

- **Trainers read, analyse, and detect recognised and hidden learning needs from observation tasks/MSC stories, and endline:** The process is the same as the one before the first workshop: Trainers read all the feedback from the observations and reflections, and the endline, to get a sense of what participants have learnt, and pick out examples to illustrate the different points in the modules. Participants are now more used to, and skilled in, identifying their learning needs, and – these are included in the programme to further strengthen the relevance of the training to participants' needs. However, there are still "black spots", or hidden learning needs – issues and skills trainers know the participants need to learn about to be able to communicate better, but which participants do not see on their own. Trainers identify these, and make sure they are covered in the programme. Most of these are related to emotions.

Phase 4: Handling challenging emotions, with awareness

- *NOTE: Titles in bold italics starting with an asterisk *refer to the title of the module*
- **Follow-up workshop: Taking stock, deepening the learning through interactive reflection, and empowerment** are the central aims of this last workshop. By analysing and systematizing feedback from the endlines and presenting this at the beginning of the workshop, participants get to hear, acknowledge, reflect on and become proud of the enormous progress they have made since they started the learning process 9 months ago – individually, and as a group (see examples in the presentation: *The Big Changes: Confirmation of growth, and challenges participants still have*). Now, it has become a habit to accept that they still have more to learn, to feel ok about it, and to use the methods they have learnt to find answers to new questions. Once a process of learning has become routine, new challenges are less daunting or frightening. "Not knowing" is not as embarrassing any more – it can even be exciting, and motivate them to find out. Participants also acknowledge challenges they still have, openly – and most of these are related to dealing with strong emotions. This is also a main topic for several of the modules in the follow-up workshop.
- ** Introduction and review: Gold standard communication strategies with patients and colleagues:* A demonstration brings all the learning together by displaying constructive aware handling of a challenging patient-provider work situation involving strongly expressed emotions on both sides. This demo becomes a common reference point for the group throughout the workshop, by analysing all the elements – communication skills as well as management of emotions – which are combined in this situation. Using the EI framework and skills, we can explore and explain why the skills used by the provider did not "work" to meet the patient's needs in the first scenario, and which skills she used to handle the situation well in the second scenario.
- **Recognising, understanding and managing strong emotions:** In seven modules, common challenges related to dealing with emotions are discussed: Participants are now very much aware that they need this learning and are ready for it – although they will usually not know all the different aspects that are useful to learn about. Starting with *The Many Faces of Anger,* then *Managing Conflict with emotional competence*, enables participants to explore and reflect on how they now handle these challenges, and share advances they have made in their practice – again using EI as a tool. The next topic is *Using Power with Awareness and emotional competence* and *Recognising Bullies in the medical professions*, and how these aspects operate in a hierarchical system. These practices affect negatively and strongly participants' work life and work satisfaction - as well as their ability to provide Patient-Centred Care.
- *We can't always cure but we can always care: Managing death and dying with emotional competence* is the most difficult topic for a majority of the participants. However, sharing experiences and learning good methods to stay present in the face of death helps them cope – with less fear. The topic of death and dying is linked to *Professional closeness or professional distance? Conscious use of personal and Impersonal language* (referring to personal communication styles), which helps bring the learning to a practical point that can be directly implemented. ** Using emotional competence to recognize, manage and prevent burnout* completes the "heavy" set of sessions – which participants experience as essential to their work. Their reflections centre around the realization that management of emotions has a very central place in their work, and acknowledging that learning to deal with these, with awareness and emotional competence, has improved the way they are now able to relate to and engage with patients in all types of situations, and provide Patient-Centred Care – as well as to collaborate with colleagues and supervisors. These skills also enable them to take better care of their own emotions in such situations, and thus strengthen confidence and wellbeing.

- ****Strategies for effective communication and information: Communicating with awareness and emotional competence**: The workshop brings the learning together by applying all the skills and insights to dealing with a number of common communication challenges with patients and colleagues. The special challenge of relating to ***Working with emotional competence in a research environment: Understanding and communicating about the difference between research and treatment** and making the distinction between research and clinical care clear to potential research participants, is the focus of the first of the two final strategy modules.*

This sequence of learning has been refined over the years of working with the model, as feedback from participants and trainers has suggested where improvements could be made. The main elements (the phases, and the sequence) have been the same throughout, confirming the strength of the natural and logical learning process.

Summary of key elements in four phases

Phase 1 **Discovery + Reflection** **Create active learners**	Phase 2 **Workshop 5 days** **Theory, skills building and practice, EI**	Phase 3 **Reflective learning –** **Skills into Practice**	Phase 4 **Workshop 3-4 days** **Emotions; awareness**
Baseline questionnaire **O&R tasks:** How do you think you communicate now? How do you react to and handle emotions? How do you practice PCC? Obtaining informed consent See connection between how they communicate, and effect on others: ***Discover their challenges – and take responsibility to communicate better, with awareness***	Central concepts Basic communication and emotional competence Learning theory Changing behaviour Handling stress, conflict Communicate to educate Communication strategies Communicating about research ***Reflective interactions - Build skills to communicate with awareness and emotional competence***	**Focus: Empowerment** **O&R tasks:** Handling patients and colleagues with awareness and new skills: How do they work in practice? Handling reactions from colleagues; relating to supervisors Practicing emotional competence – how does it work? Endline questionnaire: how do you communicate now; identify changes ***Build confidence in practicing new skills, identify learning needs***	Identifying and celebrating changes Handling strong emotions with competence: Anger, conflict, burnout, death and dying Using power with awareness Stop bullying Personal and impersonal communication Communication strategy Communicating about research ***Practicing skills with confidence and joy, appreciating and celebrating selves and each other – and trainers***

When changes to the model are made, the understanding of the learning sequence should be used to guide how adjustments are made. The depth of the learning participants achieve is dependent on the thoroughness of the process – as well as on the motivation of the learners - which is also affected by the way the process is engineered! Central to the process is the observation and reflection to discover communication and emotional challenges, and to strengthen the inner motivation to learn. Without this element, the learning is less likely to be integrated into daily practice and more likely to be – another forgotten training course.

6.2 The baseline and endline questionnaires

A baseline questionnaire (mainly qualitative) is given to participants at the beginning of the process. It has two purposes:

1. **A measuring tool** for the team to be able to assess participants' learning (when comparing with endline, at the end of the process), and
2. **The first step for participants to reflect** on what they are good at when communicating, and what they need to learn:

Examples from two baseline questions:
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 am very good at listening and observing facial expression and gestures by a patient or parent. Example is when I was probing why my client was late for appointment and had missed her antiretroviral drugs and the client explained how much negligence she was undergoing back at home."*
- *"I am good at acknowledging the patient/parent concerns and reassuring them that despite all, it will be fine and that we are doing everything we can. I also give feedback of results of test done prior. E.g. several times on the ward the parents say "if it were not for you I don't know what the situation would have been" because I made them understand the problem of their child and reassured them. "*

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

- *"I am not very patient i.e. I give the parent time to explain their problem but once they start going off the context, I tend to cut them short."*
- *"Communication of death to parents, especially the unexpected death."*
- *"Not getting patients/parents to relax and be open with me and express all their concerns."*

The baseline questionnaire asks participants to reflect ON action, i.e. to think back to situations where they have communicated with others and reflect on it now.

The baseline is phrased in such a way that it invites participants to be honest about themselves, their skills, and their present perception of learning needs. As participation is voluntary, we do expect that participants deciding to join have concluded that they want to improve their communication skills. Honesty is an essential element in the whole training, and this is made clear to participants from the very start: They will learn better if they are genuinely honest with themselves and with each other, and with the trainers. As the learning process continues, and the participants experience that they are met with openness and explorative questions rather than with judgment when they are honest about mistakes or difficult questions, their confidence in being real to themselves, and with each other, grows stronger. This process strengthens their skills at being genuine, which is such an important skill when building professional relationships.

The endline questionnaire is essentially the same as the baseline, with a few questions added to invite participants to reflect on what they feel has changed, related to some of the themes and challenges they have worked with over time. They are also requested to reflect on the consequences of these, on their practice.

Some examples from the endline:

> *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 am good at listening to my clients. I'm no longer judgmental and I give due respect. I learnt how to go about asking open ended questions to gather more information from my patients. Example: In my ward we have a mother who admitted with a malnourished child and some of our staff had labelled her a difficult mother who was not caring about her child because the child was not gaining weight. I took time to talk to her and I realised she was undergoing a lot of stress. She was abandoned by a husband and left with a two year old son with no relative in Mombasa. I reassured her and she came into reality that life has to continue. She relaxed, took time to feed her child, the child gained weight and they were discharged through the social work follow–up."*
>
> - *"I am good at active listening and use of open ended questions. This makes me able to make a closed patient open up and disclose her problem, and later involvement of both me and the patient in making a plan of care."*
>
> - *"Listening actively to patients and giving them a chance to talk or ask questions"*
>
> **2a) Which communication skill(s) are you still not so good at with patients/parents?**
>
> - *"Patience"*
> - *"Dealing with disclosure of death/bad news to relatives – taking care of emotions."*
> - *"I still feel there is the old self on anger management once in a while."*

The baseline and endline questionnaires can be found in Parts B and D. The tools used with trainee doctors in Wales, UK, to assess their changes are slightly different from the original ones, and are also found in the parts B and D.

6.3 Developing evidence-based personal learning: The O&R tasks

Introduction to systematic self-observation and reflection tasks, and to reflective learning
Reflective learning is increasingly used as a method in the health professions. It is a powerful method that enables participants to develop or strengthen awareness and critical thinking skills, and link this to action. They learn to learn independently, and the learning often results in sustainable behaviour change. The most commonly used method is **reflection ON action**, i.e. **"thinking back"** on what happened some time ago, and reflecting on this alone, or in a group.

In our training, self-observation and **reflection IN action,** i.e. **"thinking when"** is the very heart of the model. We show a way of using self-observation and reflection which is *so far not described in the literature*: We are bringing in the crucial link to touching and engaging participants' emotions when they are observing, and in doing so – engaging empathy and stimulating an inner motivation to care, and to change: they are learning emotional competence. **The main addition to literature and to reflective health practice is our focus on** *systematically guiding participants to learn in-depth about one skill at a time* **and reflect on the effects of using this skill (well, or badly), on the other person.** The reaction of the other person will affect the participant's emotions.

The sequence of learning the skills is carefully built up, so participants are guided to progress from "simple" skills (such as listening) to more complex skills (such as recognising and handling anger), thus providing a cumulative effect. In each task they will observe and reflect on how their way of communicating will affect, and be affected by, the emotions in the interaction.

While learning to identify the patterns guiding their communication and emotions, participants will also discover their **learning needs**: These are communicated to the trainers through the examples and reflections participants send in at the end of each month. Trainers will use some of these examples in the workshops - to illustrate theories and emphasize learning points, and to introduce main issues for discussion.

A participant contributed this reflection after having observed her reactions to what irritated her, and how this irritation affected her communication, for several weeks (Pack 2):

"I always wondered…"
Thanks this has been the hardest exercise from the time we started this course. I have not met with colleagues to discuss this but I truly want to share my own personal experience and feelings as of now.

I have discovered that I am part of the conflicts which arise from the way I react to questions and comments which come my way. Also to how people behave towards me. My judge is too quick at bringing out from my mind the negative side of the situation or statements.

I always wondered why people react badly towards me and have now got the answer. I am too cautious with the statements. I now need to digest the message, read the inner meaning, then think of the answer and the repercussions of what I want to say and do before I deliver my actions or statements. I have to train myself to go slow until I am used to picking the message the right way. It's going to be a tough task as for years I have behaved this way.

The same patience I tried to instill to clients and patients is what I need to practice as I view my colleagues and family member differently. I am on a journey to maybe discover why I view them differently and at times negatively. But help is also to be sorted out to be able to approach the person I wish to express my feelings to whom I feel is unapproachable. Thanks, thanks, if I have not brought out the feelings yet, know there is still confusion in my mind that will be sorted out slowly as I apply the skills laid down.
                                                                                    HCW, Kilifi

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This reflection can be used to illustrate how participants discover the effects of their emotions on how they communicate, and then take responsibility for changing the way they communicate.

The process, and the reasons for constructing it this way, is described in this chapter.

We call the method "Evidence-based personal learning".

In a review of the literature on teaching reflective practice across health and social care professions, Norrie et al[102] have illustrated how different professions choose certain types of reflective practice. Please see chapter 2 for a brief discussion of how the different professions work with reflection to "measure" it (medical literature) or use it to explore and understand teaching processes (nursing and midwifery).

The literature identifies key problems in communication training for providers as not meeting their learning needs, and not using methods that are conducive to learning practical skills. Our way of integrating providers' discoveries from their observations into the training ensures that the training is

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[102] Norrie, C, & al (2012): Doing it differently? A review of literature on teaching reflective practice across health and social care professions. Reflective Practice: International and Multidisciplinary Perspectives. Vol. 13, No. 4, August 2012, 565–578.
http://dx.doi.org/10.1080/14623943.2012.670628

relevant and meet participants' needs. Experiential learning methods, with examples from observation and reflection tasks as a basis for developing demonstration, role-plays and exercises, ensure that the learning is practical and results in developing useful skills.

Several authors have described reflective practice as a useful practice for health professionals, starting with John Dewey in the early 1920s who explored the connection between experience, interaction and reflection. Kurt Lewin and Jean Piaget soon after developed relevant theories of human learning and development. Donald Schøn (1983) was the first author to define and describe "Reflection-in-action" (RiA) as "the ability of professionals to think what they are doing while they are doing it"[103]. Schøn showed how Reflection In Action could be a key method to teach health professionals to improve their work performance. Central to all the theories on reflective practice was the acknowledgment of the need to integrate theory with practice: The learning is a cyclic pattern of experience and the conscious application of lessons learnt from experience.

> **The special contribution of our work:** What Schøn and his predecessors did NOT describe was how RiA connects to the learner's *emotions*, and that in this connection lies an important part of the key to the deep learning and insights providers experience when using this method. Our method is to guide participants to observe and reflect systematically over time, using a sequence of tasks that build on each other. The aim is for the participants to carefully develop confidence in the learning, and to become used to recognising the influence of emotions on their communication. They start to recognize the effect of their own communication, on the other person's emotions. The discovery makes them reflect and ignites the inner motivation to change. *The interaction of the emotions is the key element here.*

Several other authors have later acknowledged the need to strengthen reflective learning. In a systematic review of reflection and reflective practice in health professions education, Mann et al (2009) note that "Reflection and reflective practice are frequently noted in the general education literature and are increasingly described as essential attributes of competent health professionals who are prepared to address these challenges". The review describes learning from experience as a key skill in health professions. They show how critical reflection on experience and practice is essential to identify learning needs, and reflection as being a key method to develop an active approach to learning, and to develop self-awareness and self-monitoring as professional skills. Yet, despite these clearly documented advantages of reflective learning, the review concludes:

> *"Yet, despite reflection's currency as a topic of educational importance, and the presence of several helpful models, there is surprisingly little to guide educators in their work to understand and develop reflective ability in their learners."*
> Mann & al (2009)

This manual, and especially this chapter, aims to fill parts of this hole, and to be a practical guide for educators.

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[103] Schøn, D (1983): The Reflective Practitioner: How professionals think in action. New York, Basic Books, ISBN 978-0465068746. OCLC 8709452.

The following main elements of the training are described in this chapter:

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 develop self-awareness.

How do you do it?
By looking at one aspect of communication at a time, e.g. listening. You observe how you listen in different contexts, every day for a week, and remind yourself briefly to pay attention before each time you meet a person, or you are in a meeting. You take brief notes after each encounter with another person about what you did well and where you did not listen well, or make notes at the end of the day, based on memory. The closer to the actual event you write down your notes, the more accurate will be your memory, and the more useful your observations. At the end of the week, you discover a pattern for how you listen.

The "mascot" uses «antennae» to become aware

Why is it important?
When you experience and understand how your communication affects others, you start to reflect: Is she hurt by you interrupting her, and shuts off? Is she delighted/relieved about you really listening to her with awareness and interest, and opens up to you, giving you essential (or sensitive) information? Your experience is both cognitive and emotional, and you develop an inner motivation to change. You take responsibility for making the communication function well, because you are motivated to do so, and you experience that you can actually make a difference by changing how you communicate. This is using EI, in action.

How does it work?
Observation IN action (which they do when using the weekly tasks) enables participants to discover effects of their "bad" communication habits, on others:
- *"When I shouted at the parent because of not following instructions, the parent feared me so much that she could not share with me anything, not even something to do with the patient. Hence I could not give quality of care because I did not know more about the patient."*

It also makes them discover the effects of "good" habits:
- *"It was amazing that I could give her a lot of time just listening to her without interrupting (..). It was amazing to me how just listening could work magic".*
- *"Lesson learnt: When you listen with open ears and heart, the other person will be keen on what you too have to say"*

Both discoveries are important stimulants for learning, and both are linked to emotions:
- ➢ **In the first example**, the provider discovers the effect of her own anger: strong fear, and the patient closing up. This resulted in her not being able to do her job well - which made her feel bad and made her reflect. She sees herself as a "good health provider", and to maintain this image, she sees that she has to change her behaviour. She has become aware of the conflict between her behaviour, and the image she wants to have of herself as a professional who cares about her patients.
- ➢ **In the second set of examples**, providers saw that using good listening skills, they could establish a good relationship, and create a basis for good cooperation. This made them feel good, made them feel like good providers, and made them want to continue, and to strengthen their use of active listening skills.
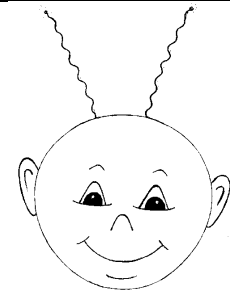
The method enables participants to recognise their own emotions as well as those of their patients and colleagues, and to analyse the consequences of these emotions. They **start developing Emotional Intelligence**, which is a key skill to be able to prevent and handle stressful situations at work, and to develop resilience. Four skills comprising EI will be highlighted throughout this chapter, linked to the aspects of the reflective learning where the development of each of the skills is primarily located.

6.3.1 What is self-observation and reflection, and reflective learning?

Self-observation in our model is to systematically observe how you communicate, while you are doing it, and how your communication affects others, and then reflect on what you see and feel ("**think WHEN**"). This is what we refer to as *Observation and Reflection IN Action (O&RiA)*. A key aspect of O&RiA is that the emotional reactions are included, and these make your discoveries very powerful. The purpose of the work is to observe systematically to discover how you communicate with others and how the other(s) react to your communication. Over time, you will recognize what your own patterns are, and then reflect and find out how you can change them to be able to communicate better. You will also discover what your learning needs are, and communicate these to the trainers. In the workshop, you will learn why and how to change how you communicate, and the theory behind.

The contrast: Reflection ON action is to "**think BACK**" to what you did some time ago and reflect on what you can learn from your successes, or mistakes. This is also useful and is used in combination with O&RiA. **A key difference is that reflection ON action usually lacks the fresh and often powerful experience of the emotional aspects.**

This method is the heart of the training model and is the "secret" behind participants developing an inner motivation to change. The method helps participants transfer the learning into sustainable new behaviour.

In practice, the method motivates and enables providers to practice several EI skills. They -
- *become aware* of their communication habits/how they communicate with others in different situations;
- *become aware* of the *effect* of their communication on the other person, and get insights on how it might feel;
- *discover the patterns* of how they communicate (when observing the same skill over time, and reflecting on how they use it), and
- *take action to and responsibility for change* – and for learning to improve their skills. They stop "blaming others" automatically for bad communication, and rather look at what they can (or could) do to make the communication more constructive.
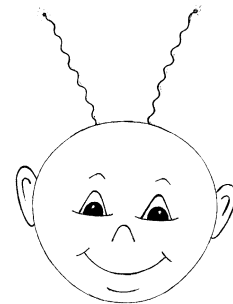
Awareness is a key skill to improve PCC

The process can be summarized as "Reflective learning". The most important aspect is that it gives you a basis for how to make links between theory and practice and make theoretical "sense" out of what you experience in practice: Participants observe and reflect on their habits and experiences in phase 1, and link these to theory during the first workshop.

The integration between self-observation and reflection on the job, and interactive reflection around theory inputs during the first workshop, provides **deep learning**. It makes the participants able to comprehend cognitively and experientially and make a bridge between theory and practice. They become aware of, and gradually understand, the **causes and consequences** of acting on their emotions (*e.g. how they communicate when they are irritated, and that this can cause the client/patient to pull back, and not give full information*). When the learning is further followed up

with informed reflection tasks *("Skills into Practice")* after the workshop, the value of the learning is further confirmed, and moves the use of new skills into behaviour and practice that can become sustainable:

- *"We see and feel it works better than the old methods – so we adopt it. Why go back to old behaviour that gives us grief?"*   *HCW, Kilifi*

The observation and reflection tasks are characterised by the following:
- ✓ *Focus*. Each task is simple, focussing on one thing (e.g. how you ask questions)
- ✓ *Repetitive*. Each task is repeated several times during a week to discover personal patterns
- ✓ *Reflective*. Reflection *in action*, and *on action*. Analysing, writing what you see, thinking
- ✓ *Purposeful*. The aim is to learn, based on own insights, and then define learning needs
- ✓ *Systematic, sequential*. Each set of tasks built up carefully to fit conceptually and practically
- ✓ *Time limited*. One or two weeks is the normal time for a task
- ✓ *Skills strengthen:* Skills to carry out the tasks strengthen over time
- ✓ *Self-directed*. You yourself decide how much time and effort to put in
- ✓ *Safe*: You are the one in charge of the situation you want to observe
- ✓ *Personal.* Belongs to the person who is reflecting, he/she owns the results
- ✓ *Empowering*. The learning can be powerful, and the power to learn, stays
- ✓ *Improves practice*. Enables you to take action to change, on your own
- ✓ *See consequences*. When you change, the effects on your work and yourself can be powerful

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6.3.2 How do you carry out the observation and reflection tasks?

In Phase 1, "The Discovery phase", we guide participants systematically through a three month's process, using weekly tasks that ask them to observe how they communicate with others. They observe while at work, doing their regular work tasks.

Practically, they learn to keep a small part of their attention on how they practice a particular skill ("**observation IN action**") during an interaction. As soon as possible afterwards, they spend anything from a few seconds to a few minutes to reflect: *"How did I listen this time? What happened to the other person when I listened this way?"* ("**Reflection ON action**"). The participants repeat this observation and reflection on interactions several times each day during the week. They make some notes, at the end of the work day, and sometimes right after the interaction. At the end of the week, they start to see the pattern, and can reflect further on implications of what they have discovered.

- "*I used to think that listening is a passive activity, but I was wrong because it is **active and it means participating and caring** by me for the listener. I learnt that I am responsible of attempting to grasp **emotions often veiled behind the spoken word.** In active listening, I have learnt that I simply **lay aside my personal feelings** in order to understand/assist the client in her conversation.*"   *HCW, Kilifi*

The tasks are specific and limited and focus on one aspect of communication at a time.

An example: the first task given to participants during a meeting with a trainer
The idea of observing themselves is new to most people – they are used to being observed by others and being told what they need to change (and – if they are lucky, they may also be told what they do that functions well). It takes a change of mind-set to observe oneself, and resistance is common.

Over time and with encouragement, the resistance is overcome, and replaced by excitement and satisfaction that they are able to learn well, alone. (See Part B for a handout of a more extensive *Introduction on how to carry out the tasks).*

Brief introduction to Observation, and The Listening task

Communication and Dialogue: Learning about our own communication habits is a necessary step to understand how to communicate better with our patients and colleagues. It is also an important aspect when planning how to develop and implement effective health communication strategies, and 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 workshop in … (Place, dates). This pack contains four observation and reflection tasks – each to be done during 1 week. You will receive a new pack of observation tasks after 1 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 discover **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 discover the patterns. You can use a small notebook we recommend you get to note observations, and always carry it with you. Some people make notes on their phones.

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 and emotions you bring out in the other person. Recognising and understanding the effect of *emotions* on communication *outcome* is key in this learning and is the first essential step in developing emotional intelligence.

 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 Week 1: How well do you listen to others? (e.g April 1-7th)
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; etc

In other words: Do you try to *really* listen to find out what *their* ideas are, or are you more concerned about getting the other person to listen to *your* opinion and ideas? Or do you do a bit of both? Do you decide when to do what, or does it happen automatically?

> Observe **when** you use the different methods, and what are the **results** or outcome. Observe especially what emotions your different listening methods seem to bring out in the other.
>
> **Have fun!** And please make notes on your observations. (**Add address/email to send reports to**)

As a part of the first task, or in the introduction meeting for the course, participants are given written instructions for how to carry out the tasks, practically. A full version is found in Part B:

How do you do these observations, practically?
Some suggested practical methods are:
  ➢ **Carry these instructions** in your notebook, or in your smartphone.
  ➢ When you **plan your day**, **plot in** one or two times or situations when you know you will be interacting with others
  ➢ **Before the meeting**/other event/patient interaction, 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:
  ➢ *Imagine you have "antennae"* on your head (see our Kilifi mascot, right), or – a little invisible observer sitting on your shoulder, or anything that helps you develop a "friend" who helps you learn about yourself.
  ➢ **After the meeting**/event, reflect (as soon as possible) on what you have observed in your own behaviour, and make **a few notes.**
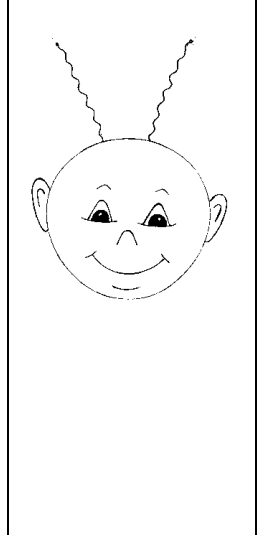
If you do this once or twice per day, you will start to see a pattern.
Discussion with your colleagues about how they do their observation, and may be what they have found out, is a good way to get over a (natural) resistance to this task!

Self-observation will be a new practice for most of you, and it may take some time before you get used to it. But – it is simply a matter of practice, and once you see how useful it is, you will (most probably!) want to continue to learn this way.

What is required of the participant to self-observe and reflect effectively?
Linking the learning to Emotional Intelligence
The attitude one approaches this learning with will determine how the individual will learn, and how the learning will affect her actions and emotions. To get the best out of the method, the learner requires:

1. **Commitment**
   You must be committed to observe yourself *"in action"*, while communicating and having feelings. You must learn to recognize what you see, and experience, in yourself as well as in the other person.
   ➔ *This is related to skill 1 in EI: Recognizing the emotions*
2. **Honesty**
   You must decide to be honest with yourself about what you see and experience yourself do, say and feel, and try to understand it. (*If you experience guilt, shame or other difficult emotions or reactions, these are yours – to keep quiet about, or to share. But you must notice they are there.*)
   ➔ *This is related to skill 2 in EI: Integrating emotion with cognition.*
3. **Curiosity**
   You need to find out **why** you feel and act and react as you do, and why it has the effect it has, on the other person(s). What is behind your outburst of anger, for example?

> ➜ *This is related to skill 3 in EI: Finding out the causes and consequences of the emotions*
>
> 4. **Action**
>   Reflecting on your (new) understanding of the situation, take action to communicate with awareness and respect for the emotions (your own, and those of the other person).
>   ➜ *This is related to skills 4 in EI: Taking action to adjust your behaviour, based on your understanding.*

6.3.3 Guiding and managing the reflective process

Participants need to be supported, especially in the first part of phase 1, to learn how to carry out the tasks and to discover the usefulness of this method: Most of them will not be familiar with self-observation as a learning method. The trainer needs to take account of this and create awareness about how they can develop the skills, and why it is essential for their learning.

The process is managed in the following way, each meeting with the trainer lasting about 1 hour:
Phase 1:

- **Meeting 1:** Introduction to the training aims and process. Distribution of baseline, and of introduction guide for self-observation and reflection tasks (see short version above, + longer version in appendix). This meeting lasts 1 ½ -2 hours.
- **Meeting 2** (1-2 weeks later): Collect baselines; Distribute pack 1. Discuss how to carry out the observation and reflection tasks; answer questions.
- **Meeting 3** (1 month later): Collect reflections/MSC stories from pack 1, let them share experiences of how to carry out the observations, discuss, and answer questions. Distribute pack 2.
- **Meeting 4** (6 weeks later): Collect reflections/MSC stories from pack 2, let them share experiences, discuss. Distribute pack 3.

The first workshop is conducted about 4 months after the initial meeting. The trainers need time to read and analyse the feedback from the baselines and from the observation and reflection tasks and put these into the various presentations for the course.

Phase 3: We repeat the same pattern of meeting after each pack to share experiences, ask and discuss questions, and handing out the next pack. See Chapter 8 (Planning), and Parts B and D.

Taking notes is essential: In the first meeting, the facilitator emphasizes the need to take notes on what they observe, and hands out a small notebook to everybody – the ***observation-notebook***.
In Wales, the trainee doctors preferred to make notes on their mobile phones, and this functioned well. Participants are encouraged to make a few notes every day, and to note examples of interactions where they have used the skill – well, or badly – and reflect on learning. At the end of the first month, participants write a story – the Most Significant Change (MSC) story, which describes an important part of their learning, with an example. The handing in of the MSC story is compulsory. For each of the other packs, participants are asked to submit further MSC stories or **written reflections** to the facilitator. The stories and/or reflections should describe what they have learnt, based on an example, and are handed in anonymously, using a participant number they have been assigned. These examples and reflections are read and discussed by the trainers before making the program for the workshop.

> *"Reflecting on the time I have worked as a doctor I can most certainly see that I have changed a great deal; I have seen a great change in myself with regards to giving and receiving criticism. Throughout my time at school and university I was a perfectionist and can*

remember dealing with criticism poorly. I quite often became defensive and refused to accept advice that was given to me. My 'inner critic' has always been very harsh and I have beaten myself up emotionally for long periods in the past over trivial things.

I have realized and accepted, especially over the last couple of months, that I am not perfect and a constant strive for perfectionism is not necessarily healthy. I have enough confidence in my own ability and I want to learn in order to be a better doctor for my patients. I feel that I have started to channel my inner critic in a more positive way and this has had a great impact on my general well-being. This reasoning has allowed me to more gracefully accept criticism, to take it more 'on the chin' and be kinder to myself at the same time. I felt my interaction with the registrar was a good example of giving criticism in a positive way and this is something I plan to emulate in the future."   *Trainee doctor, Wales*

Be prepared that it will take time for the participants to become familiar with practicing self-observation and reflection in action as a routine task on the job. It is a new and unfamiliar practice, but once they discover the sense and the usefulness of the method, they will usually continue with much motivation. The meetings are an important arena for the participants to learn from each other, and to receive encouragement and information from the trainer as well as from each other.

Note – Meeting in person is important: If participants are able to send in the MSC stories electronically (rather than hand-written), this simplifies the process – but it is still advisable to meet, to keep the motivation up. When calling the meeting, it should be emphasized that even if a participant has not been able to complete the assignment, they are welcome to join the meeting: it is often insecurity about how the tasks should be written which prevents participants from sending in their tasks. A common assumption is that there is a "right" and a "wrong" answer to the tasks, and many are scared of doing something wrong, and be criticized: This is what they have often experienced in their education. When they learn and trust that "what they observe and describe is simply OK", and that there is no right or wrong answer, they carry out the observations with much more confidence. With interactions and discussions in the meeting, they often get the answers needed to complete their tasks.

Suggested contents and main points to emphasize in each meeting, plus powerpoint presentations, are found in chapter 8 and in Parts B and D.

Some common question participants ask in the meetings:
- "*How can we observe ourselves? Is it not better to have our colleagues observe us, and comment on what they see*?"
- "*Am I not likely to report just the good things about myself, and not report the bad ones?*"

It is important to give time to discuss these and other questions participants bring up. Some points:
- ***When you learn to observe yourselves, you will always have "your observer" with you*** – as an invisible friend sitting on your shoulder and helping you to notice – and learn. You can continue learning every day. Observing yourself also means you do not have to be afraid of failing or doing something less than perfect – you will notice it yourself, and usually take action to improve. Thus, you can learn actively, without being humiliated by someone who may criticize you is un-kind ways. HOWEVER – there is also no guarantee that you are kinder to yourself than a colleague would be – many providers are extremely self-critical and set themselves too high goals of being "perfect". Reflections on this are also needed!

- ***Until participants feel safer with each other and with the trainer***, some may choose to report only the good things about themselves. However – this is also useful – as there is a lot to be learnt from how providers carry out tasks in good ways, and in the course – these examples are as useful as the ones describing the problems. After some time, most participants see that by sharing their challenges openly (but anonymously), they do get a unique opportunity to learn – in a supportive learning environment, by having other participants reflect on their situations. This gradual increase in confidence and willingness to learn is a very important reason why O&RiA tasks function so well.

Carrying out the O&R tasks and writing what they really experience , what is right **to them**, is an important method for participants to get to know better their authentic, genuine sef: The more comfortable they are with being "themselves", the more free and honest the communication will feel to the other person.

NOTE: It is important that the trainer uses the opportunity in these meetings to establish relationships and build trust with the participants. The trainer should encourage participants to start sharing experiences openly, without fear – and emphasize and demonstrate a non-judgmental attitude to what participants bring out for the group. When participants experience that they can share experiences without fear of being judged, they can start feeling free to describe mistakes and ask questions. The sooner the group can start functioning as a real learning community, the more effectively and deeply the participants will learn.

We discuss further details on management of the training process in chapter 8.

6.3.4 Overview of the observation tasks in phases 1 and 3
The self-observation and reflection work is carried out in two phases, before and after the first workshop.

Phase 1: The Discovery Phase, to discover problems, habits and what they do well when communicating with others. It is a period of 3-4 months where participants receive one pack of four separate tasks each month, after having completed the initial baseline questionnaire. The topics of the first pack of tasks are listening, asking questions, and habits that inspire or hinder good communication. Packs 2 and 3 are also given in this phase (see overview of topics, next pages).

The link to emotional intelligence: The discovery phase is aimed at developing EI skills 1 (recognizing emotions in themselves, and in the other person) and 2 (thinking about them), and start working on skill 3 (analysing, to understand causes and consequences of the emotions). Some are also starting to practice taking different action than they have done before (EI skill 4), e.g. on listening with more awareness and attention.

6.3.4.1 An overview of the topics in each task
Phase 1: Discovering communication habits and learning needs
Pack 1 consists of 4 tasks with easy topics, central to everyday communication:
- **Task 1:** How well do you listen to others?
- **Task 2:** How do you discuss, and ask questions?
- **Task 3:** What do you do to inspire good communication, and what do you do to hinder good communication?
- **Task 4:** Write a story of the Most Significant Change[104] that has happened as a result of your observations and reflections. Send this story to the trainer.

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[104] MSC is a method developed based on work by the anthropologist Gregory Bateson

These tasks build competence in EI skills 1, 2 and 3.

Example of an insight from this phase:
➢ *"I have a challenge in asking questions to find out more what the other one is saying. Most of my questions are close ended requiring yes/no answer. When I let my feelings take control over me, I end up becoming impatient and ask close ended questions, hence not listen to what the person is saying".*   *HCW, Kilifi*

Pack 2 contains a set of tasks to observe what makes the providers irritated and angry, how they deal with anger and irritation, and what are effects of their (automatic) reactions to various emotional challenges, on the other person(s).
* **Task 5:** My personal irritation and anger map: WHAT do I react to?
* **Task 6:** My (automatic?) response to irritation and anger: *HOW* do I react? What are my feelings behind the reactions?
* **Task 7**: Effect of your irritation and anger on others: How do THEY react, and what are (possibly) their feelings behind the reactions?
* **Task 8:** Writing your reflections on learning – a new story of change about these emotions.

This pack also contains additional ideas on how to discuss the work on the observation tasks with your colleagues, to help each other master the method of self-observation.
These tasks also build competence in EI skills 1, 2 and 3, and sometimes skill 4.

Example of an insight from this phase:
"I can truthfully say my undertaking the communication course has helped me better my good points and improved on my bad. I have always believed myself to be a good listener but my joining the course has helped me to be better. Am also good in discussion, I love them but I had a way of trying to dominate them, so my undertaking the course has made me learn that I do this through personal observation and reflection. I am temperamental but in some way undertaking the course has made me master my temper and be able to control it.

Discussing with friends and collegues has made it easier for me because I have learnt that when I am stressed about something be it personal or professional, when I talk it out with another it seems small and lighter!"   *HCW, Kilifi*

Pack 3 contains tasks on patient-centred care, communicating anxiety, and on dealing with research participants:
* **Task 9:** Linking *Patient-centred Care* to practice in your daily care
* **Task 10:** Stepping into the shoes of a patient, or caregiver: How does PCC feel?
* **Task 11:** Your methods to take care of fear and anxiety in patients and parents
* **Task 11b**: Special task for providers working with research projects
* **Task 12:** Hand in *one example* from this set of tasks, which *reflects your learning* during these weeks – something you do, which has changed in an important way, or something which has made you realize why your present practice is effective/ achieves the goal. Please also tell why these changes are important to you.
  Also, please define your learning needs (for the workshop).

The tasks and the sequence are carefully developed and structured to strengthen awareness and skills that build on each other. Towards the end of phase 1, participants are starting to be very much aware of their learning needs and communicate these to the trainer(s). See Chapter 8 and Part B for

how to analyse baseline and observation tasks, identify learning needs, and include these in the course programme.
These tasks build competence in EI skills 1, 2 and 3, and now more often – skill 4.

Example of an insight from this phase:
> *"On realizing this I became angry but my antennae's were up and my fear was the quality of data this colleague could produce at the end of the study. Someone could not read it from my face that I was angry but indeed I was boiling up. I went further for my lunch and when I went back to my desk I found her alone in the office. Calmly, I talked to her about the quality of work she is doing and that she is suppose to adhere to the protocol as stipulated, giving reasons as to why its necessary in a positive way"*   *Research participant, Kilifi*

Phase 3: "Skills into Action"

After the basic workshop (phase 2), participants enter **"Skills into Action".** They receive further weekly tasks for three more months to guide them to reflect on how they use their new skills, how well they work with the new skills, and to identify where they still need to strengthen skills. Participants continue to explore and confirm learning and strengthen confidence in using the new skills. The emotional competence is strengthened throughout this phase, and participants become more familiar with recognising emotions, stepping back, analysing the causes of the emotions, and taking new action based on a good understanding of the situation.

The observation and reflection packs include the following themes:

Pack 4 contains tasks to strengthen communication with colleagues, including how to share information and skills from the course with them:
- **Task 13:** Natural ways to use your skills, and barriers to using them;
- **Task 14:** Sharing information from the course with colleagues and supervisors;
- **Task 15:** Observing the reactions of your colleague;
- **Task 16:** Giving constructive feedback to a colleague, and – sending in an MSC story.

Example of an insight from this phase:
> *"I have noticed that after a series of self examination and awareness when problem arise at home or with my colleagues at work, I don't confront anymore and my blame habit has reduced. Although, it's a challenge and this has made my colleagues ask questions and others being judgmental that with time I will go back to the old ways. But calming down has helped solve problems and also avoided conflicts with colleagues"*   *HCW, Kilifi*

Pack 5 continues to focus on natural ways of using the tasks, communicating with supervisors, and then focus on taking care of safety, and of emotions:
- **Task 17:** continued from pack 4: Natural ways to use your skills, and barriers to using them (continued from pack 4 – this task to be carried out throughout the period);
- **Task 18:** Patterns of communicating with your supervisor – to find out what you react to, and how;
- **Task 19:** Taking care of safety (making patients feel safe), and effects of this on communication;
- **Task 20:** Taking care of emotions: Showing respect for patients' emotions, and effects of this on you; Taking care of your own emotions. And – sending in an MSC story.

Example of insights from this phase:
> *"My emotions, oh my! I have learnt to keep emotions to myself. **I have stopped pouring my emotions to others.** I have realised talking to myself before handling any difficult situation*

really helps. It has brought peace in my life. This part of the training has done wonders in my life. It came at the right time"

"This course has really changed me from who I was to who I am and I am very grateful. It amazes me how I can now take care of my emotions regardless of my moods and what has happened. It has changed both my personal and social communication at work and at home. This is not to say that I don't get hurt, discouraged or disappointed but am able to use my skills selectively to make me move on at times it's challenging but I have come to know that a **good routine turns into a good habit***."*   *Both: HCW, Kilifi*

Pack 6 asks participants to "sum up" their learning by sharing further reflections on how they now handle challenges related to patients' emotions; to "show and share" best practices, and to share questions and insights on research:

- **Task 21:** Dealing with patients' emotions – and the effect of this on you: Further reflections on changing the interaction with the patient.
- **Task 22:** Best Practice example – to demonstrate to the group;
- **Task 23**: Special task: Insight on and questions about research;

These tasks build competence in all four EI skills – participants are now more routinely using skills 1-3 (recognize emotions, think, analyse the situation) and take reflected action based on their understanding and analysis.

Please also refer to chapter 6.1, where you find a description of how the tasks build on each other and work together to create the aimed-for results.

The tasks used in the whole course can be found in Parts B and D. In part B and in Chapter 8, Planning and Management, there is a section to guide trainers on how to analyse the observation tasks, and how to pick good examples for presentations, demonstrations and exercises.

Managers and researchers: The tasks used in courses with researchers and with managers in Kenya will be added as part of further updates to this manual, with the revised presentations and the adjusted approach used for these different groups.

6.3.5 The process and the observation tasks used in Wales

When training trainee doctors in Wales, we had a half day workshop after each set (or pack) of observation and reflection tasks, i.e. one workshop every 5th or 6th week. The exception was a 10 weeks' gap between workshops 3 and 4 because of summer holidays.

The tasks we used followed the same structure as in the original training process but had slightly different topics, based on the emerging needs from this group: Especially in the second course (2017), we developed several tasks focusing more directly on how to become aware of and deal with their vulnerability, and how this is linked to doctors' perfectionism. Other tasks around this theme focused on becoming more aware of what causes positive emotions, and how these can affect the way they work, and feel about the work. A further set of tasks looked at giving and receiving criticism, and finally a task on the interaction between professional cultures. All tasks can be found in Part B.

In 2016, the training period ran for six months with four workshops, and in 2017, eight months with six workshops.

The tasks were:
- **Pack 1, tasks 1-4:** The first two were as original (Listening, asking questions), including a task to reflect on their power role as medical doctors. Task 3: Personal communication to build relationship and trust, and Task 4: How do you do inspire or hinder good communication. An Msc story was the last task in this pack.
- **Pack 2, tasks 5-8:** Observation tasks dealing with anger and irritation that can result in conflict. These tasks also followed the original ones but related some observations to the relationship with patients.
- **Pack 3, tasks 9-11:** These tasks differ from the original ones, and focus on identifying positive feelings:
- **Task 9:** Positive emotions, and their effects on you and people around you
- **Task 10:** Becoming familiar with your vulnerability followed by an MSC story to reflect on the link between vulnerability and using emotional intelligence.
- **Task 11**: Being kind to yourself, with awareness: How well do you treat yourself?
- **Pack 4, tasks 12-14**: Criticizing and being criticized, with awareness
- **Task 12**: Recognizing your Inner Critic and how he operates
- **Task 13:** Receiving criticism/feedback – do you acknowledge, or defend, or a mix?
- **Task 14**: Criticizing others: When, Why and How do you criticize, and how do they react?
- **Pack 5, tasks 15-16:** Tasks on professional cultures
- **Task 15:** Becoming aware of the influence of (other) professional cultures on your emotions, communication and behaviour
- **Task 16:** Examples of confrontation and conflict – automatic reactions, and reasons behind

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An example of a reflection after pack 4

"I have grown in emotional intelligence and resilience over the duration of this course.
I always felt competent in the first three EI Skills but struggled with the 4th.
Today I worked with a consultant with whom I have previously argued and cried as a result (very non-resilient!!)

I was dreading today but thought it a good opportunity to practice my EI especially in how I respond to people and being kind to myself.
This consultant can be argumentative and belligerent. I suppose it helped that I knew this before we even started. However, when the consultant argued against things that were said I listened to his reasoning behind why he was being argumentative. Previously I would have been overly defensive but listening and contemplating his reasoning had two effects; it made the consultant slightly more tolerable to work with and by listening it gave me the time to control my emotions and not respond in such a drastic way as I would have done previously.
I also chose when to provide a counter argument which I think saved my own sanity and allowed me to retain some control.

With regards to accepting criticism and being kind to myself, I failed the arterial line on the first occasion but reminded myself that there is not an issue with my competence (which I would have previously) and actually it was probably due to my anxiety of working with that consultant. Hopefully this will improve with further practice at EI. By realising that every attempt to give advice is not a criticism I was able to take advice on improving my skills with the video laryngoscope.

Overall, I am pleased with the way I handled this experience and have practiced my EI skills. This is possibly the first time I have successfully managed to reflect in action, completed the 4th EI skill and responded in a way that I am proud of."

Trainee doctor, Cardiff 2017

6.3.6 Summary of the 9 months' cycle with observation and reflection tasks

The cycle summarizes the process of working with and learning from the observation and reflection tasks.

A key feature is – the participants first observe themselves *in action*, i.e. they pay attention to an actual skill, while carrying out their normal job. For example, they look at how they listen to a patient, while assessing her medical problem.
After they have finished the work task, they reflect *on action*, and assess how well they listened, and how it affected the patient.
They take notes. Then observe again.

This method enables them to get an immediate and real assessment of their behaviour, and the impact of it: Participants carry out the same observation several times during a week, and reflect on it after every interaction *(or at least several times a day)*. By doing this, they will start to see the pattern of what they do. They will decide what they need to learn, and what they want to change – without any influence from the outside (except when they choose to discuss with a colleague). Participants are firmly the boss of their own behaviour and communication and decide on their own ambitions. The process is empowering, and stimulates inner motivation to learn, and to build confidence.

Examples of insights from health care workers in Kilifi:
➢ "*When communicating I am good at listening. There was a patient whom colleagues termed as very uncooperative and she does not answer questions when asked. But when I sat and talked with her and listened what was bothering her, she opened up and gave information*"

➢ **Listening/empathy:** "*During delivery I listen very carefully to mother's problems and complaints and empathize with them and this helps to achieve good delivery. The mother was able to follow my instructions well and this made the delivery process very fruitful.*"

➢ *Currently I am on a night duty covering the hospital, we have had several cases in maternity whereby expectant mothers are given traditional herbs and also they are massaged at home when they are in labour. I have learnt to step back and avoid to confront them while they are in pain. After delivery and ensures she is safe and also the baby I would respectfully advise the mother against such practices but before I learnt the skills I used to put them off there and then.*

The insights during the first phase are especially powerful. Participants discover that -
a) *Their skills may not be as good as they thought* ("*I am a good listener – or so I thought…..*");
b) *The effect of their lack of skills is serious, and affects their ability to perform their work well*

"I am not good at listening to long stories especially during admission. I get irritated so fast so I will only take what is important";

"When I shouted at the parent because of not following instructions, the parent feared me so much that she could not share with me anything, not even something to do with the patient. Hence I could not give quality of care because I did not know more about the patient", and

c) **They can do something about this themselves and take action on their discovery:** *"When angry – I step back. Most of the times I avoid communicating at this time. I give time for the situation to cool down. With this I have noticed that most conflicts are avoided."*

Note: Situation c is a good example of use of all the four EI skills – and the participant taking conscious action to avoid that her emotions contributes to causing a conflict.

The process is empowering, and helps them get new ideas about how they can learn in an active way, and be in charge of their own learning:

- *"The exercise on observation tasks has been an eye opener on the importance of paying conscious attention to how I communicate. It helps in becoming a good communicator."*

<div align="right">HCW, Kilifi</div>

6.4 Why are self-observation tasks so central to the model; the links to EI

There are several reasons why the self-observation and reflection tasks are at the "heart" of the training model – they teach providers to become aware, teach them how to learn, and result in them taking responsibility for their own learning, and their own change. They also help participants and trainers identify learning needs that are being addressed in the workshops. These are all factors that are central to the success of this training, and to the learning being sustainable.

The reflective learning process seems to strengthen or lead to developing emotional intelligence (EI) – the links to EI are referred to under separate points. The process they go through naturally enables the participants to build EI as they progress, without the training process originally having stated "developing EI" as a pronounced goal. However, once the connection became clear to us (as trainers and planners), we have decided to add this very useful EI framework and set of skills to our model. *NB for those who do not find the links to EI useful, it is perfectly possible to simply ignore these – and the process will also make sense without these links. The key process is about building emotional competence, which is a slightly broader concept.*

Daniel Goleman, who wrote the original book on Emotional Intelligence (1995), describes EI as "*the capacity for recognizing our own feelings and those of others, for motivating ourselves, for managing emotions well in ourselves and in our relationships".* This is an important part of what the training model is about.

The main reasons why baseline questionnaire and observation and reflection tasks are so central to the model, and how they link to EI, are described in some detail below. There is much overlap and connection between the factors, and I have chosen to rather leave it like this, despite some repetition – to underline the complexity and inter-connectivity between the factors and the skills and abilities. The sequence the factors are presented in is also chosen to illustrate the natural evolvement of the skills and abilities. The **sequence of the tasks** in most cases closely follows the development of the different skills that build EI.

What do the tasks lead to, and why are they so central?
The points are further elaborated, below is an overview

Becoming aware: The discovery process
- a) Participants reflect on what they do well, and start developing awareness
- b) Participants become aware of how they hurt others. This is not what they want to do
- c) They feel the patient's pain: they empathize, connect emotionally, and see the Person
- d) They discover the effect of emotions on communication, and feel a need to change
- e) The discoveries and reflections lead to an inner motivation to change

Exercising empowerment – taking new action, and understanding why
- f) They take responsibility for the communication in the relationship, rather than blame the other for "bad communication"
- g) They consciously look for and find the reasons behind the problems
- h) They change from passive to active learners
- i) They learn to recognise and then stop automatic reactions, step back, and communicate with respect
- j) They feel guilty for mistakes, but are not being shamed for who they are
- **k)** They may decide to change of attitudes and behaviour

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6.4.1 Becoming aware: The discovery process
a) Participants reflect on what they do well, and start developing awareness

The process of strengthening awareness and skills on how they communicate starts with volunteering for the course: Participants are motivated and ready to take a close look at how they communicate, with a critical eye.

When working on the baseline, providers identify and reflect on what they do well, as well as on what are their challenges in communicating with patients and colleagues. The baseline exercise, which they conduct individually over a period of one week, starts building their awareness about how they communicate and how it works on others. It prompts them to start looking consciously at their communication behaviour, and often makes them curious to learn more.

The question in the baseline to look at what they do well is purposively chosen (*and is followed up in the tasks and in training by also focusing on strengths*), with the intention to gradually build professional pride, and to motivate and empower the participants to learn well. In many learning traditions, the focus is mainly on detecting problems, and solving these – which is often not experienced as empowering (*although problem-solving is of course an important skill to possess).* We also emphasize **problem-solving** in our training – often by **looking at what they do well and exploring if and how these strategies can be an entry point to solving other problems.**

When observing in action how they listen, they start recognising both how they practice this skill (*e.g do they interrupt others often?),* their own emotions when they use the skill in various ways (e.g. *when they are irritated they may tend to interrupt, automatically*), and the effect on the person they listen to (e.g. *the other person becomes insecure when she is interrupted*).

Perceiving or recognising emotions accurately is an important (initial) part of the emotional intelligence skills (skill 1): Participants are guided to become aware of how they practice the "regular" aspects of communication (e.g. how do they listen or ask questions), as well as the emotional reactions that happen or are triggered by how they communicate.

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b) Participants become aware of how they hurt others. This is not what they want to do

Something important happens to the providers when they start looking at the effects of how they communicate, on the other person. They discover that they often hurt the other person, or that they confuse, or cause other unpleasant reactions - and that they have to take the responsibility for this. Once this awareness is awakened, it cannot be "un-done", there is no "way back": They have to live with, and reflect on, the consequences of how they communicate. A typical reaction is – *"I started to see how the patient withdrew when I used a harsh tone, and my antennae came up and made me ask – do I want this to happen?"* The answer is – of course not! The providers **do not have the intention to hurt**, or to cause problems.

A typical comment or insight:

- *"It was like it was another person behaving like that with the patient – it could not have been me! I was shocked!"*   *HCW, Kilifi*

The problems are caused by of lack of awareness, by automatic reactions to emotional challenges, and by lack of skills to observe and reflect on their way of communicating: They have habits that are formed by their background and personality, and influenced by the culture and environment they live in and work in and by attitudes and habits of colleagues they work with. The function and power (ab)use of hierarchical systems has a particularly strong influence: This is the hidden curriculum at work.

- *"There are times they don't want to listen, especially the supervisor, they have the tendency that a junior cannot tell them anything".*   *HCW, Kilifi*

> *The ability to perceive or recognise emotions accurately is being strengthened as they get used to observing and reflecting on their actions. The first parts of emotional intelligence is being built.*

c) They feel the patient's pain: they empathize, connect emotionally, and see the Person

The process of observing and reflecting makes the providers able to put themselves in the shoes of the person they communicate with and feel her pain – or her joy and gratitude – as a result of what they say and do. It almost "forces" them to see the other person as just that – a person, rather than e.g. "the diarrhoea case", or "the stubborn patient". It enables them to connect with the other person's emotions, to empathize, to build a professional relationship, and experience how this affects their ability to develop trust and to provide patient-centred care. It is also a useful set of skills to enable them to communicate and relate well with colleagues.

When connecting with the patient as a person, e.g "Mama Mary with her one year old daughter who is coughing strongly and can almost not breathe", the respect comes naturally, and the automatic reaction to judge the patient/parent (e.g. for coming late) can be replaced with compassion, kindness and care.

- *"The mother who appeared anxious initially now looked calm and opened up to me and we communicated freely concerning her child"*
- *"I am amazed on a daily basis how important communication is in our lives. I have discovered I have been doing things/communicating badly hence hindering information to be relayed or hurt the other party in ways unimaginable, not realizing. Self-realization is hard to find if you do not put yourself in the other person's shoes."*   *both quotes: HCWs, Kilifi*

> *Through these processes (a, b and c), participants get the opportunity to reflect on what they do well and develop awareness about how their actions can hurt others. They become aware of and*

> *can connect with the pain patients go through when treated badly, by acknowledging, respecting and empathizing with the patient. Participants develop skills that enable them to appreciate the importance and effect of their actions towards patients and strengthen their ability to recognise their own and their patients' emotions more accurately, thus building their emotional intelligence (EI skills 1 and 2).*

d) They discover the effect of emotions on communication, and feel a need to change

As they go on learning how to observe and reflect, they will discover more deeply, and start to see not only THAT they have to change, but also HOW they can change. During the second month of observations they look at how emotions affect communication, and this is when many really "wake up" to some surprises. The quote below shows how a participant has built on the understanding of the first set of tasks (*one of which is to look at how they ask questions, and if questions they ask are open or closed*). She has added an observation from the second set – where she has looked at how her feelings influence how she communicates:

> ➢ *"I have a challenge in asking questions to find out more what the other one is saying, Most of my questions are close ended requiring yes/no answer. When I let my feelings take control over me, I end up becoming impatient and ask close ended questions, hence not listen to what the person is saying".*   *HCW, Kilifi*

Other participants reflect on how emotions affect their communication:
> ➢ *"On my own observation, when I'm overwhelmed I find myself I do not have patience and I don't want to hear stories, which affect my clients seeing that I don't listen to her/him. This is bad."*
> ➢ *"Lack of effective communication skills, mostly emotional awareness. Unless I understand my emotions well, I cannot think and feel what a patient/parent goes through at that particular moment."*   *Both quotes: HCWs, Kilifi*

Many participants take responsibility for the consequences of their actions when they look at how emotions affect communication. The habit of judging others for having different opinions (colleagues) or culture and tradition (patients) is common. They become aware of the negative consequences of these habits, and continue to reflect:

> ➢ *"I become judgmental because of the traditional charms[105] on the child's waist whereby I told the mother to cut it before I could attend to her."*   *HCW, Kilifi*

They discover that the effect of their own emotions is often an automatic reaction, like blaming the mother for having been to the traditional healer. The provider acts from her own anger (*covering her fear of the spirits and of traditional healing, behind it?*) – thus often preventing her from giving appropriate patient-centred care. They reflect. They continue to observe the effects of emotions, and many become very surprised at the strong effects they see, every day, of their own automatic emotional responses to various challenges. They start to become aware and recognize **the need** to learn to step back from their own automatic emotional reactions, but not yet practicing this skill.

> *Emotional awareness and intelligence at the first three levels are described in this section – from recognising emotions (1) to seeing the link between emotions and thinking/understanding (2) to understanding the causes and consequences of emotions (3). The next and last step - managing emotions based on their learning, by adjusting personal behaviour, is "right around the corner",*

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[105] Charms are usually black pieces of cloth put on the sick person by the traditional healer, to ward off evil spirits.

> *but is the most difficult skill to learn: This is about changing behaviour which might have been practiced for decades.*

e) The discoveries and reflections lead to an inner motivation to change

A main challenge is to motivate providers to change behaviour and make the change sustainable. Planners, researchers, decision makers, patients – all may agree that providers need to change their attitudes, and change behaviour, to be able to provide patient-centred care and to communicate well with colleagues. However, when the decision or "push" for change comes from "the outside", rather than from the providers themselves *experiencing a need* for change, the "motivation" will be *external,* and often causes resentment: "*Someone else (or: Our bosses?) has determined that we need to change. They don't understand our situation, and our problems*." Skills training courses in such situations usually do not result in sustainable attitude and behaviour change.

When using observation and reflection as a method, planners understand and acknowledge that the decision to change behaviour needs to come from the providers themselves. The motivation to change must be internal *("I have seen that I need to change, and I will*") rather than external *("YOU need to change"):*

- *"Thanks to this course, I have learnt a lot and have broken the barriers that are hindering me to communicate effectively. I have realized that I am the problem when it comes to communication. I have decided to have a change and that change is me!"*   *HCW, Kilifi*

When the providers observe their own habits and discover a problem (with their behaviour) and see what the consequences of their actions are on the other person, *the problem is theirs*, and it affects their perception of themselves as a good, kind, caring health professional. *The solution is also theirs*: They own it. There is no fixed, simple technique which will solve the problem – they need to engage, and to find the solution. They do, and often become empowered. This strengthens the *inner motivation* to continue the work to change – as they experience the effect as useful to themselves and to the patient.

Examples of insights that prompt behaviour change

The decision to look for a solution is a very important step – and is connected to the point above, about taking responsibility for the change. It starts with an almost deceivingly simple task – **to listen**: Pay attention to how you listen, and to the effect on the other person. You discover for example:

> *"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."*   *HCW, Kilifi*

With this discovery, the provider has become aware that she is to "blame" for not getting the "full story" behind the patients' problems, AND – that she can take action to change this, on her own. This understanding often leads the provider to start experimenting with different ways of listening to the patients and becoming aware of the effects.

> *"I used to think that listening is a passive activity, but I was wrong because it is active and it means participating and caring by me for the listener. I learnt that I am responsible of attempting to grasp emotions often veiled behind the spoken word. In active listening, I have learnt that I simply lay aside my personal feelings in order to understand/assist the client in her conversation."*   *HCW, Kilifi*

By experiencing the effects of listening better, on the other person as well as on themselves, the provider reflects, and concludes that she/he can of course use better listening skills to achieve such

good results. It feels good: They experience the joy of learning, the moments of "Wow! This works!" When this is based on their own efforts, it is very satisfying.

The connection between the cognitive understanding of the effect of the listening, and the emotional experience (*either negative, when they don't listen well, or positive, when they do listen well*), contributes to stimulating the inner motivation to change, and/or to sustain the new behaviour. Another example describes this process:

- **Feeling the need to change:** *"After a series of self-reflections as per the observation tasks I started feeling I needed to change. In meetings for instance, I would just hear myself talk and explain things while the rest keep quiet and rarely contribute. I felt like I am sort of judgmental and conclusive. I thought to myself that this is not right. I have also learnt that in allowing people to share or give their opinion, they own it."*   *HCW, Kilifi*

> *The ability to take action to adjust your behaviour based on your understanding of the "emotional landscape" is the 4th skill in developing emotional intelligence. In the examples above, the participants in fact combine all four factors: They perceive the emotions, they understand what is going on, they understand the causes and consequences of the emotions, and – they manage the emotions and change their own behaviour. They practice all the four EI skills.*

6.4.2 Exercising empowerment – taking new action, and understanding why
f) They take responsibility for the communication in the relationship, rather than blame the other for "bad communication"
The realization of the impact of what they do makes them gradually start to take responsibility for the communication in the relationship, and for the change process. They change from being a **"victim"** (*"She was such a difficult patient, there was nothing I could do"*) to becoming an **"aware communicator"** (*"She was feeling very scared, so I could see I needed to listen and to empathize with her; I did, and we cooperated well"*) who takes responsibility for making the communication process work well.

> *"I later realized that I had been harsh to others, quick to blame other people for any mistake that happens, not realizing that I could have also contributed to the outcome of the incidence."*   *HCW, Kilifi*

The tendency to **blame others** for problems is well known and is probably one of the most important barriers to constructive communication. It is often caused by insecurity and fear – fear of what will happen if the provider acknowledges that she caused the problem: she may be criticized by supervisors, maybe colleagues, maybe the patient; there may be punishment of various sorts; she will feel like a failure, etc. The automatic reaction to blame others is natural, to protect herself and avoid the many negative consequences of taking responsibility for causing a problem. When asked about the effect of insecurity, on their own communication, a provider expressed:

> *"I result to blame game. I will result to point fingers at the other members of the team as being the cause."*   *HCW, Kilifi*

The tendency to blame others is very common in hierarchical systems and is also a consequence of lack of emotional competence.

Taking different action:

"For the first time I was so patient and just listened to the mother pour out her heart. I went to an extent of apologizing to the parent for the break-down in communication. This is so unlike me. I have never taken the blame at my position. I had the time to listen calmly and did not object to her and I believe it was our mistake that we did not explain to her nicely."   *HCW, Kilifi*

When the provider becomes aware that
   a) she probably caused the problem (*e.g. by communicating unclearly, or not listening/ understanding, or by not paying attention to the emotions*), and
   b) she has the skills to solve the problem (*e.g. by apologizing, or asking more questions, or empathizing/responding to the emotions*),

the fear is reduced, or gone: She can take action, solve the problem, and make both herself and the patient feel well. This awareness and the possession of these skills give self-confidence, and over time – job-satisfaction. The stress caused by the insecurity and the guilt feelings from blaming someone else for a problem you know (or suspect) you have caused, is also reduced, or gone.

> *The provider has developed the ability to discover the effects of her actions on the patients, and to understand how emotions influence the actions and communication of both herself, and the patient. The provider integrates emotions with cognition, i.e. she starts to understand how she uses emotions. This is the second key skill in developing emotional intelligence.*
> *(NB in the last part of this example, the "full EI", with all four skills, is referred to.)*

g) They consciously look for and find the reasons behind the problems

Participants have not been used to exploring problems from the perspective of the other person, e.g. the patient: When a parent e.g. brings in a child with charms (often black pieces of cloth tied around wrists or ankles), showing the child has been treated by a traditional healer, a common reaction has been to judge and blame the parent for their action (*of taking the child to a traditional healer, rather than coming straight to the hospital – thus delaying seeking "real help", in the mind of most providers*). The consequence is often that the parent feels judged and may not feel free to give information, and the child may not be diagnosed or treated in the most effective way.

With their new skills to recognise and step back from the automatic reaction (to judge and blame), the providers can explore the reasons behind the parent's actions and find central information that is important to treat the child in an optimal way.

- *"My journey to self-discovery has been interesting. It's amazing how much people can tell when given a listening ear. I discovered that giving others an opportunity to express themselves leads them to confide more than what they had anticipated, rather than interrupting and judging them as I used to. For me....my new Motto is "patience pays".*
  HCW, Kilifi

The skill (and attitude) to find the reason(s) behind a problem is central to deciding on appropriate action, and to establishing good cooperation with the patient:

- *"I was very busy with my work and it was about lunch time. There came in a parent with a study child and I just felt pissed off - why at this time? So I just started telling the mum the importance of coming early, reasons why she has to be there early, without even giving her time or asking her why she was late… So she just opened her mouth, innocently telling me, "Doctor, I am sorry for being late, but you are just throwing so many words at me, you could just have asked me why I came late!''*

- *Waaw! I felt bad. I had to apologize there and then. I gave her a seat and asked her why she was late and her answer made me feel I am a bad person. I just judge a person without knowledge. She said she had to use three motorcycles to reach the hospital. The first one got a tire bust, and she had to walk for at least one hour. Luckily she got the second one, and after a little distance it went out of fuel. She had to walk again for at least 45 minutes to get another one. All those motorcycles - she had to pay them. And here I am complaining she came late, not knowing the effort she made to reach here. All she asked me was - what if she gave up and went back home, what could I have done? I felt bad, it really made me realize how to appreciate all study participants (taking part in a research project) because I don't know how they struggle to reach the facility."* HCWs, Kilifi

> ***The skill to look for and understand causes and consequences of the emotional reactions (one's own, as well as those of the patient/the other person) is central in developing emotional intelligence. This is the third skill (of four) in the sequence of developing EI.***

h) They change from passive to active learners

Some colleagues may already have made changes, and this inspires others to try new methods as well. Furthermore, sharing experiences and reflections in the meetings during the discovery phase opens up for sharing with colleagues and mentors also during the individual observation periods: Participants are encouraged to do so, to share challenges and reflections, and strengthen awareness and skills over time. They gradually accept that they have responsibility for managing their own learning: after initial hesitance about why and how to use the observation and reflection, they see *the purpose and the results*, and continue with increasing motivation.

The process can be described as "**active learning**", and this is new to many providers working in a hierarchical system, where they are used to being told what to think and do and told what they have to learn. The system of passive learning is still the predominant style in many education systems, where lecturing and knowledge reproduction is the norm, rather than facilitating and encouraging individual learning, critical thinking and empowerment. But the systems are gradually changing, following research which clearly shows that active learning and critical thinking produces better professionals who have more job satisfaction, treats patients better and have better collaboration with colleagues.

Active learning[106]: Openness		Passive learning: Fear	
Characterized by	*Leads to*	*Characterized by*	*Leads to*
Open structure	Changes	(Strict) Hierarchy	No change
Humanistic and	Positive attitude to	Top-down authoritarian	Learning is a duty
democratic approach	learning	approach where teacher	Learning often
Tearcher is facilitator	Problem solving	has all answers	boring
of learning	Empowerment	Knowledge reproduction/	Students often
Taking initiative	Learns how to learn	memorization of facts	quiet: Fear of
Curious to learn	Democratic attitudes?	Lecturing	asking, and of
Feeling safe – not	Student trusting	Obedience; Punishment	making mistakes
judged as poor	teacher	Individual work, for exam	Students
communicators	Analysis of reasons	Learner does not	protecting
Taking responsibility	behind behaviours	question, or make	themselves against
for own learning	Motivation to take	suggestions	criticism
Encouragement	new action	Describing	Keeping things as
Group work	Reflection	Right and wrong	they are

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[106] Some points taken from Werner, D and Bower, B (1982): Helping Health Workers Learn. Hesperian Foundation, Berkeley, California

Collaboration Reflective learning Critical thinking Learner questions the trainers – questions are welcomed Supervision=supportive and constructive	Openness	Rules and regulations Learning not necessarily relevant or practical Large classes Competition Supervision=fault-finding, and destructive	Slower students drop out Gossiping and backbiting Denial Bullying No trust

The learning through the process with the tasks also to some extent **counteracts the fear of taking initiative:** In a hierarchical system, it is safest not to "stick your neck out" and take initiatives, because when you don't, you cannot be criticized for initiating something wrong. When conducting the tasks, and discovering a problem, the providers are the only ones who can take initiative to solve it. They are the only ones knowing they have a problem (even though it might have also been observed by their colleagues), and they have to take an initiative to understand it, acknowledge it, reflect on it, write about it to the trainers (or keep it to themselves), and then – do something to change. All this requires initiative, and all is contributing to developing active learners – who learn how to learn. In most cases they will continue to learn after the course process is finished. They have become empowered and are free to use these learning methods any time they want to. Experience has shown that they do – because they find the process useful and gain better results at work.

> *The ability and decision to change your own way of recognising and acting on emotions, based on understanding the effects of your old ways and deciding consciously to adopt new behaviour, is an expression of "full emotional intelligence", and corresponds to the fourth EI skill (which assumes the mastery (or at least the use) of the first three). These are very powerful skills that are increasingly acknowledged as central also for good management and leadership.*

i) They learn to recognise and then stop automatic reactions, step back, and communicate with respect

Automatic reactions to emotional challenges is very common. In the health professions such reactions can have very negative consequences for the patient's health – and for the provider's own feeling of managing well on the job and for her emotional wellbeing. Automatic reactions can also affect collaboration in the professional team.

The discovery of how their automatic reaction patterns can lead to a series of negative consequences comes from the series of observations on emotions (see factor d). The providers become aware of the need to **recognise and step back** from these reactions, to be able to communicate with empathy and respect. Many providers say this skill makes a very important change in how they relate to emotions, and how they are able to function in their job. An example:

> ➢ *"One day as we were attending ANC clients, one of the booklets for a client was misplaced and she was left to stay in the queue for long. Mothers who came behind her were served and left. The mother then stepped in the room. She was so angry, using abusing words, I and everybody was like "who this mother is and what was wrong with her?" She created a scene and we were the centre of interest to other clients and patients who were around. We tried to calm her down and she was so emotional. I almost went into same emotions myself, but I had put my antennae up. I stepped back, calmed down and composed myself.*
> *I requested her to just enter the room calmly; I asked her what was the problem and how I could help her. She also calmed down saying she has stayed for so long without being attended to. I apologized and tracked down her book which had been misplaced, served her, and she went home.*

My stepping back made her cool down, which enhanced the conversation. Taking care of my emotions solved the problems without worsening them."   *HCW, Kilifi*

Learning the skill to recognise and step back from an emotional reaction is a key focus in the first workshop, and the motivation to learn is very high: Everybody has experienced that emotions affect them and their patients and colleagues much more than they had realized, during the first three months of doing observation and reflection tasks. The insight that this is something they need to learn much more about, is universal in the group. They have developed a strong inner motivation to learn.

➢ *"I used to feel stressed, get angry very fast when a person comes at a time when I'm so tired and almost time to come out of work for either lunch or evening. I'm now able to step back – listen first then give answer. Stepping back when I am angry has really helped me."*
HCW, Kilifi

Feedback from the providers shows that for a majority, learning to manage emotions (*and in particular to stop automatic reactions and step back*) is the skill which enables them to make the biggest change in their work and lives. It brings them work peace and satisfaction and makes them give better and more patient-centred care. However, some struggle with their "old self popping up" and fall back to old habits. The difference is that they now have the awareness and the perspective, and see what they do, and how it works on others. Most thus try to practice the new skills.

> *The ability to step back is a "consequence" of having mastered the first three EI skills, and of now bringing this understanding together to take action, based on her understanding and reflection: The provider is able to manage his/her emotions wisely, and to communicate constructively – thus practicing emotional competence (using all four EI skills).*

j) They feel guilty for mistakes, but are not being shamed for who they are
Making another person feel shame or guilt is a power strategy frequently used, especially in hierarchical cultures (*like the medical one*). Being shamed is a very strong negative experience, one that especially young providers who are insecure (and older ones who feel insecure for different reasons), will react strongly to. For example, it has been common practice for some supervisors to shame a colleague under him/her in the hierarchy by criticizing her in front of others, commenting on her as a person: "*You are completely useless*". The effect of such criticism is severe:

➢ *"Being criticized in front of my colleagues makes me irritated and outraged. I feel like I have been undressed in the open for everyone to laugh at me. I feel so vulnerable and so much alone. The need to protect myself just automatically sets in."*   *HCW, Kilifi*

The need to protect oneself is automatic – but exactly HOW one does it, depends on the level of awareness – and on the emotional intelligence the person has developed. Below is an example of a provider who "hits back", apparently without awareness or emotional competence:

➢ *"A fellow clinician talked to me badly in the presence of patients. Oh I talked to him very badly too on the spot and ensured that they all heard what I was telling him, and I was very pleased with myself."*
HCW, Kilifi

The person who is shamed may hit back, as above, and contribute to causing conflict and bad working relationships in the team. In other cases, the provider who is criticized in front of others may feel so bad that he or she does not learn from the incident. The power behaviour of the colleague can create fear and resentment in the person who was shamed and set a bad example for her

colleagues. Many take out their frustrations and anger over such incidents, on those who are below them in the hierarchy – the patients. The lack of skills to recognise and manage emotions competently very often has consequences on PCC and patient safety.

The difference between shame and guilt

Shame: "I am a bad person"	*Guilt: "What I did, was wrong"*
Shame results from negative evaluations (real, or imagined) of who one IS, by others. It is a violation of cultural or social values. *It is a negative, painful social emotion, making the person feel small, embarrassed, scared or humiliated.*	*Guilt feelings arise from violations of one's internal values, from one's negative evaluation of oneself – of what one DID.* *You can also be ashamed of a thought or behaviour no one knows about.*

When learning through observation and reflection, providers become aware of the effect of their communication, and many are surprised, and shocked, at what reactions they cause (*usually without consciously intending to hurt the other person*). BUT – **and this is important** – they are not shamed or made to feel guilty by an external person: The discovery is their own, and therefore – the decision to share it, or keep it to themselves, is also their own. The decision whether to change is also their own – there is no one pressuring them, but themselves. When they don't like what they cause – when it is not in line with an image they would like to have of themselves as a kind and caring provider – they may feel guilty. They are free to take action to remove the guilt, and to change - without pressure. Some people may also feel ashamed of themselves.
A common reaction is to develop an inner motivation to change.

The decision to change is also influenced by colleagues and trainers. In the first observation phase (the "discovery phase"), they meet briefly every month to share experiences from the observations, and to receive the new tasks. During these meetings, they hear that colleagues are struggling with the same issues as them, and this causes relief: They are not alone with their problems, and with their guilty feelings for what they have done. They are not "especially bad", or worse than others. The problems they experience are "normal" or common, and the problems have causes that can be discussed. By becoming aware of and understanding the reasons behind their own behaviour, e.g. covering up their own fear or insecurity by anger and judgment, they can make a conscious decision to act differently.

Trainers can trigger guilt feelings: Many trainers also use power strategies in their teaching – authoritarian didactic teaching methods (*where the teacher has all the "right" answers*) can create resentment and guilt feelings, rather than an inspiration to learn. Such methods are much used, and do not contribute to honestly questioning one's own attitudes and behaviour, nor to look for the effects of what you do, on others. Providers often (*automatically*) adopt the methods their teachers used, to their own teaching of patients (*e.g. on how to manage their disease, or how to take medicines*), often with the effect that the patient does not learn. The awareness of the negative effects of such teaching methods on learning is increasing, and experiential methods are gaining ground.

> *The provider who becomes aware that her actions are hurting the patient, and feels guilty/bad, is practicing the first three skills of EI. When she takes action to step back, apologize and act consciously, (e.g. to build trust and to empathize with the patient), she is practicing the 4th EI skill. When the provider is left to discover and reflect through using this model, she may develop the EI skills naturally. If shamed by a teacher, supervisor or mentor, this natural EI development is disturbed – and maybe stopped: Being shamed is so uncomfortable, psychologically, that the person will do her best to protect herself. She may blame and judge her teacher for being cruel, and will not reflect or and learn consciously from experiencing the problem.*

> *Shaming stops reflective and natural learning.*
> *It turns the learning opportunity into a judgment game, with no winners.*

k) The tasks can lead to change of attitudes and behaviour

The key to change behaviour is our own inner motivation to do so – because we have *experienced* a need, because we know it is possible, and because the decision to change is our own. The factors above have all described various parts of this "puzzle" that leads to a sustainable behaviour change, and how the observation and reflection tasks facilitate this learning – supplemented by healthy doses of critical thinking.

The following can function as a brief review of the steps leading to behaviour change, and are related to the model of attitude and behaviour change which is described in Module 3c. Understanding this model, and how we ourselves change, has been one of the most important insights for participants: They have seen why telling people what to do, does not change their behaviour. They have stopped blaming people who do not change because they are told to do so – because they have experienced and understood how they themselves change behaviour. See module 3C.

The observation and reflection tasks provide the important **ground work** for understanding how we change behaviour.

Our way of teaching how (individual) attitudes and behaviour changes is different from what is commonly practiced in training courses. When using e.g. motivational lectures, the lecturer may aim to convince the listeners that they need to change and give them good reasons to do so. The listeners might agree and develop an *intention* to change. Research shows that most of the listeners will not follow their intention to change their habit(s) only based on such inspiration: The idea to change and the reasons for doing so belong to the (motivational) lecturer, NOT to the listener. This is an *external* motivation, not an intrinsic or inner one.

In hierarchical systems, workers are used to being told what to do, and also often – to a large extent – what to think. This may "work" in the moment but will not help to change habits over time. Critical thinking is not encouraged, and passive learning is often the norm. Changing this "culture" is a real challenge for educators.
Note: Some of the didactic information is of course necessary, to ascertain that essential rules are followed and medical work is organised in functional ways.

The difference in our training course lies in the discovery or in the slow development of **a need and a wish to change** – through observing and reflecting on our own experiences, over time. You see how you listen today, and become aware of and interested in changing. These are the first two steps in the attitude and behaviour change model, see Module 3c:

> *OOOps, I interrupted the patient again. Ooops, I could not get her to talk. Hmmm. The same happened yesterday, and I am not sure my assessment of her problem right. Hmmm. This does not feel good, I cannot do my work well if I don't get the patient to talk freely.*
> *How can I learn to tame my impatience?*

Maybe you decide to try to listen without interrupting tomorrow, which means – your experience(s) lead you to change behaviour, or to try another way of listening. Then, you experience that when you listen without interrupting, patients open up, and you get to the "bottom" of their problem, quite fast, without wasting time and effort. You reflect. This works better, and it is your own solution, which you have learnt from – and are applying on – your own work situation. Maybe you discuss it with a colleague, and explore what she has discovered, and done, and find out you have similar experiences. You are on the way to having changed your behaviour, based on experiencing a need to do so, and on trying out a different action.

You also reflect on what you have heard, and learnt, earlier:
Maybe the lecturer in that course some time ago, who said listening well is the key to good patient-centred care, was right. This may strengthen your decision to keep attention on your listening habits and continue to change.

The awareness leads to a decision to get involved in looking at yourself and your listening habits, and the subsequent awareness made you decide that you *really* needed to change:
> *You were a bit shocked when you recently experienced how a mother with her very sick baby reacted when you interrupted her brusquely and told her to get to the point about the baby's illness. She started crying and shut up. Awareness entered the scene: It dawned on you that you had really hurt her by acting on your impatience, while she was in a very vulnerable situation. You took a deep breath, apologized sincerely, and asked her to please tell you her story. She looked at you – surprised. But she heard your honest and genuine intention and told you how and when the baby got sick.*
> *You learnt your lesson, and decided that listening well, and kindly, was a better method than your old one. You started to really change your habit. (Rewritten from participants' example)*

Reformulating the learning, using emotional intelligence (EI skills used, in parenthesis):
The provider is irritated and unaware, handling the mother with the very sick baby by brusquely interrupting her. But then –
- The mother cries, and awareness and recognition of emotions sets in, with the provider: She recognises the mother feels hurt, maybe sad, maybe scared, and the provider herself is irritated (1);
- The provider knows there is a connection between thinking and emotion (2)
- She analyses quickly that her own action of being harsh and interrupting is a main cause of the mother's reaction, and that the mother is very vulnerable because of her severely ill child (3);
- She steps back from her irritation and apologizes to the mother (4). The mother accepts, and they work well together to care for the child.
- The provider reflects on this experience, and it contributes to her changing behaviour (4).

Change of habits and behaviour has to start from an inner motivation, a conviction that change is needed (*often triggered by an emotional event, like in the example above*). This is what the observation and reflection stimulate providers to do. Discussions with colleagues affirm and deepen their understanding and build confidence in using the new skills.

> ### *Summary of why the tasks are so central to the model*
> The tasks are central to the model, because the process of observing your actions and reflecting on what you see (and feel), and how the other person responds, makes the provider aware of the power of his communication and of the effect it has on others. You can facilitate a good relationship, or make the other person feel insecure and close down. When they experience this, repeatedly, and reflect on it – most of them decide to change.

6.4.3 Additional important aspects of observation and reflection
With each step, inner validation of and confidence in the method is strengthened
The validation happens at five levels, each of which strengthens participant's own inner validation:
- By trainers, in monthly meetings;
- By trainers, in basic workshop: They have quoted participants' examples in presentations
- By colleagues, who share similar observations on themes in groups
- By linking to theory
- By seeing that new skills "work", during Skills into Action phase.

The sequence of tasks is created to systematically build providers' trust in their own learning and ability to use the skills consciously and independently. Participants **validate** the learning steps, **internally** (*and in many cases – probably subconsciously*), and gradually build their confidence – both in the value of carrying out this work, and in trusting what they learn:

In the first phase, participants reflect **individually** – first, to assess their own strengths and challenges when filling in the baseline. They then start the systematic weekly guided observations and reflections, with monthly meetings to briefly share experiences, give feedback, clear questions, and give new tasks. During these meetings, **their learning is appreciated and validated by the trainer(s),** and by other colleagues who have made similar discoveries. The participants start building confidence in the importance of their learning, that it has value. As they discover more and get new insights, the confidence is strengthened.

The individual reflections are further validated externally, by trainers – who select and build examples from the reflections into **presentations in the first workshop**. The reflections are shared in groups, linked to discussion of specific aspects of communication and emotions. **The group discussions function as a third level of validation** from their colleagues: They also struggle with the same problems. They also make mistakes. Through interactive reflection, they learn from each other.

Fourthly, the reflections are linked to theory, and this external validation makes participants see that what they have experienced, is "true" – it is part of a natural phenomenon which can be explained by theory. Their guilt feelings are natural, to be expected, and can now be placed behind them. They learn and practice new skills, based on insights from the reflections, and on theories.

During phase 3, participants take **"Skills into Action"** in further observation and reflection tasks, and **new practice is validated by providers seeing the results in their work**: They see that what they have observed, shared, learnt about in theory and translated into practice is "true" – and experience the powerful effects of their new practices, on patient collaboration. They also experience that they now work better with colleagues, with more awareness and less conflict. Many report that the new skills also reduce burnout. Their confidence in using the new skills is gradually strengthened, and many report that they are much happier in their jobs:

➢ *"I used to feel stressed, get angry very fast when a person comes at a time when I'm so tired and almost time to come out of work for either lunch or evening. I'm now able to step back – listen first then give answer. By stepping back when am angry has really helped me."*
HCW, Kilifi

The final validation happens in the last workshop, when participants present "Best practice" examples from how they use the skills and get feedback from the group and the trainers – usually with a lot of appreciation and affirmation of their learning. This helps to cement the learning and reinforces the value and usefulness of observation and reflection to learn systematically how to communicate better. The new skills are firmly and systematically validated and have become new behaviour that they use and show with professional pride. The chances of the new skills turning into sustainable new behaviour, are high.

➢ *"I have realized that most of our patients had been misdiagnosed due to poor communication. I find it very enjoyable listening to my patients and also learn from them and in the long run we are both very happy. Even in the evening when I go back home I feel at ease as I left my workplace happy."* *HCW, Kilifi*

6.4.4 Limitations of using self-observation and reflection
In many cultures, the idea of observing oneself is uncommon – the power to define one's good and bad sides is commonly placed with the teacher/trainer/authority.
It takes time to learn the method of self-assessment and learn to trust one's own judgement. The main influencing factors helping them to learn well are –
- **The provider's own motivation to learn**, and to follow instructions;
- **The trainers' ability to encourage and explain**, and to be a mentor and role-model for the participants during the first phase;
- **The meeting with the trainer**, when she collects the baselines and distributes the first tasks: Her ability to explain and discuss the purpose and practice of the observation tasks, and to appreciate their learning and their questions so far;
- **The second meeting with the trainer**, to discuss the participants' first observations. The trainer explores how they have observed, appreciates their discoveries, gives feedback and answers questions;
- **Participants' own discoveries**: When they start seeing their own patterns of e.g. listening, they "see the point" of the observation and reflection tasks: They learn, get insights, and become motivated to continue exploring and learning.

Without encouragement or feedback during this first period, many participants may lose motivation. This places an important responsibility on the trainer, who needs to make sure all participants are contacted during this time, if they do not show up for the common meeting.

Author's reflection:

"The response and motivation is the best I have ever had in a training course."

"I started using observation tasks as preparation for a communication training course for field workers (whose task was to collect research data for scientists, by interviewing community members) in Kilifi in 1993, in collaboration with Sassy Molyneux and Vicki Marsh. We broke down the field worker interview into small bits and asked them to observe each bit for a week, starting with how they did their greetings of the respondent/family. We asked them to look at what worked well, and what didn't. After a week they all met to share their observations, facilitated by Sas or Vicki. They started to learn from each other – they shared good methods and debated those that did not work.
Motivation to learn more, and to learn from each other, developed quickly.

In the training course I conducted for them, there was a lot better participation than I had had before in such fora: The participants had a lot to share, and they had learnt the "magic" of how to learn systematically by themselves. They had also defined many of their learning needs, they had invested in their learning, and they were eager to learn more – about how to tackle problems THEY had described, using the observation tasks. Evaluations showed a clear improvement in their communication skills, and the learning made a big difference to the quality of the information the field workers brought back to the researchers.

The change in my training practice has become permanent – I hardly ever conduct a training course without using the observation tasks to create awareness, stimulate reflection and identify training needs among participants. I use the method at the University of Oslo and at Atlantic Medical High School, as well as in professional courses internationally. The engagement of the students is always positively influenced by them having invested in the topic and in their learning before they show up for the course. When I read their feedback I am always inspired and amazed at what these "simple" tasks can lead to in terms of awareness, insights and motivation to change. Research clearly shows that what motivates people to do something they don't earn money from, or that money is not the driving force, is enjoyment[107]: The participants using the observation tasks enjoy the learning."
                                                                                        Ane Haaland

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6.5 Teaching method: Experiential learning, based on theories

Reflective practice (see chapter 6) and experiential learning is now largely seen as the "gold standard" for teaching medical professionals to practice their skills with insight and confidence. We use this base, and add in Paolo Freire's[108] principles for adult learning, as well as evidence from reviews on effective (participatory) training methods and strategies, to craft our workshop training approach. We also build on Carl R Rogers principles of developing relations with patients. Further adjustments are made based on experience and feedback from participants and trainers during training courses in several countries.

In many countries, didactic and lecture-based teaching methods are still being extensively used to teach communication skills to nurses and medical doctors. Reviews[109] show that these methods fail to meet students' needs for learning, and that the methods are not conducive to learning practical skills – the training is too theoretically focussed. Such training has been shown to have no or limited effect on nurses' skills, their behaviour change in practice, or on patient outcomes.

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[107] Pink, D.H (2009): Drive. The surprising truth about what motivates us. Canongate Books, London
[108] Freire, P (1968): Pedagogy of the Oppressed. Published in English 1970. ISBN 9780826412768
[109] Chant, S &al (2002): Review: Communication skills: Some problems in nursing education and practice. Journal of clinical nursing. 11:12-21. Kruijver, I.P.M. & al (2000): Evaluation of communication training programmes in nursing care: a review of the literature. Patient Education and Counseling vol 39, 129-145

The purpose of referring to some of the literature in this section is to provide evidence for the appropriateness of using experiential learning methods to teach providers effective communication skills. **The aim** is that the evidence, together with the pragmatic description of experiential learning, might encourage managers and trainers to take steps in the direction of using these methods to adjust (or transform) the teaching style for medical providers. The shift is very much needed, and the knowledge base is there to draw from. However, the shift will require commitment from leaders with visions, and with a willingness to challenge training models that neither inspire nor stimulate health professionals to choose effective communication and management of emotions.

The main difference between the didactic teaching style and experiential learning is the role of the learner: When the didactic style is used, the learner is a passive receiver of knowledge. In experiential learning, the learner is active – using her own experience as a starting point and taking active part in the learning of theoretical knowledge and practical skills. She learns through studying and reflecting on what she does.

This chapter gives an overview of the background for our chosen learning methods, and of how the methods are used in the workshops. It is beyond the scope of this manual to provide a detailed description of methods used in experiential learning, for trainers not familiar with these methods. A companion manual for trainers is planned, to share the rich material used to train trainers (all coming from a didactic teaching background) in concepts and practice of these methods. The modules do provide detailed descriptions of how to teach, but – trainers would be more successful with their participants if they do have some experience in using experiential learning methods, or at the very least – using participatory techniques as part of their training tools.

6.5.1 Background on theories: Branch, Kolb, Rogers and Freire

William T Branch has been teaching professional and humanistic values to medical providers for decades. In an article which also includes an overview of the evidence of what works and does not work in medical training[110] he suggests a practical and theoretical model for this training. The evidence for his suggestion is based on two studies of the effectiveness of the combined model, his own extensive practice as a teacher (and having used the elements in the model since the 1980s), plus a thorough review of the literature. The model consists of four main components: *Experiential learning of skills, critical reflection on one's experiences, a supportive and validating small group environment, and a sufficiently longitudinal cohesive program to allow moulding of the whole.*

The importance of the supportive group process is emphasized: When students/participants trust each other in a group, they will be able to reflect deeply and disclose challenging experiences and give each other honest feedback in a climate of understanding, validation and acceptance from other group members and the facilitator.

Branch has dubbed this positive dynamic **"the counter to the hidden curriculum"**, where participants will be developing an informal "curriculum" together, which strengthens their commitment to compassion, empathy and respect. The group thus becomes a learning community. The facilitator, by constantly modelling care and respect, becomes a powerful role model for humanistic teaching.
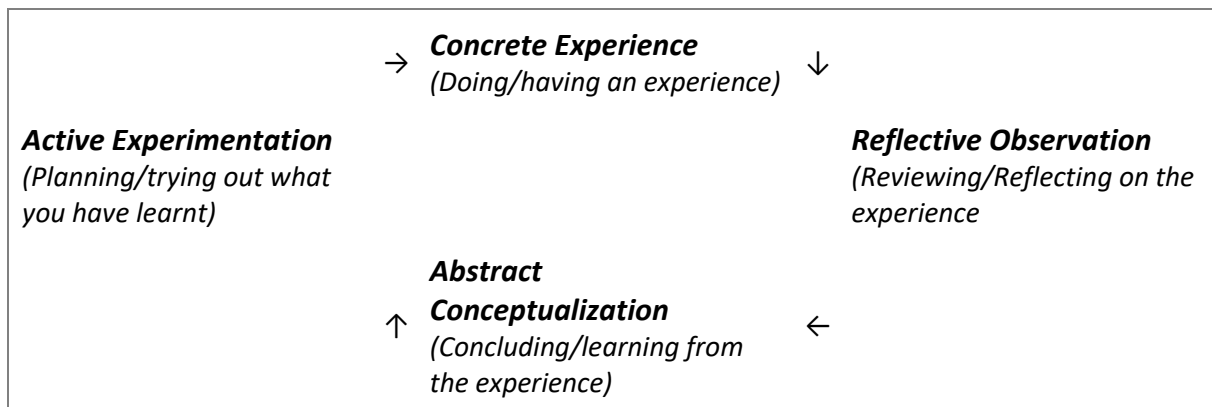

Workshop session, Riga, Latvia

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[110] Branch, W. T (2015): Teaching professional and humanistic values: Suggestion for a practical and theoretical model. Patient Education and Counseling 98 (2015) 162–167

Branch suggests that when such core professional values are practiced by a critical mass of students and trainers, they may positively influence the culture of an institution. NOTE: We saw this happening in the Tuberculosis hospital in Siauliai where the model was first used: We trained two groups of doctors and nurses, altogether 40 of 65 professional medical staff. This was enough to positively influence the way staff communicated with patients and with each other in the hospital. We had trained a critical mass: Those who had not participated in the courses were also influenced by the new ways of communicating with patients, and each other.

David Kolb developed his model of experiential learning[111] to explain the meaning-making process of an individual's direct experience. His work popularizes original ideas from as far back as Aristotle, in year 350 BCE *("for the things we have to learn before we can do them, we learn by doing them"),* and draws on the work of John Dewey, Kurt Lewin and Jean Piaget to develop the modern theory of experiential learning, in the 1970s.

Kolb's Experiential Learning Model (ELM) is one of the theoretical foundations for our training model, both for the learning during the observation and reflection phase, where participants make first-hand discoveries and experiment with knowledge and new skills), and for some of the workshop learning:

$\rightarrow$ **Concrete Experience**
(Doing/having an experience) $\downarrow$

Active Experimentation
(Planning/trying out what you have learnt)

Reflective Observation
(Reviewing/Reflecting on the experience

$\uparrow$ **Abstract Conceptualization**
(Concluding/learning from the experience) $\leftarrow$

In our training model, the observation and reflection tasks take participants through Kolb's four stages:
- Building on **concrete experiences** with a patient (e.g. listening poorly during history taking),
- the participant **observes and reflects** (e.g. the patient does not give full information),
- slowly makes meaning out of his experience/**conceptualizes the incident abstractly** (e.g. he does not get to understand the patient's problem well and connects this to his own poor listening style/habit), and then
- decides to **actively experiment** with listening better to patients.

Similar processes happen throughout the workshop as well, when participants are e.g. working with demonstrations and role-plays and experience the good (or bad) effects of their "normal" behaviours (e.g. a demonstration of a provider blaming a patient for coming late, and the patient closing up). They reflect together (interactive reflection) to analyse why such behaviour happens, and then actively experiment with patient-centred behaviours in a role-play. They get the background for the provider behaving in an irritated way and get the choice to practice emotional intelligence – to show how to recognise the emotions and step back, and act with compassion and empathy. When this

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[111]Kolb, D. A., & Fry, R. E. (1974). *Toward an applied theory of experiential learning*. MIT Alfred P. Sloan School of Management.

process happens repeatedly, also building on the process in the preparatory reflection phase, the process becomes a natural way of learning.

Kolb states that the following abilities are required in order to gain genuine knowledge from an experience:
- The learner must be willing to be actively involved in the experience;
- The learner must be able to reflect on the experience;
- The learner must possess and use analytical skills to conceptualize the experience; and
- The learner must possess decision making and problem-solving skills in order to use the new ideas gained from the experience.

Participants in our training gradually build these skills during the initial observation and reflection period (phase 1). The skills are mainly self-taught, with support from the monthly meetings with the trainer, where they ask and discuss questions related to carrying out the observation and reflection tasks. Trainers and colleagues in the institution who have gone through the course earlier are important mentors and role-models during this period. Participants who actively seek out the role-models to discuss questions and experiences tend to learn at a deeper level than those who don't.

The skills are further deepened in the workshop, through interactive reflections on experiences, and constant attention to individual and common meaning-making.

Experiential learning is mainly concerned with concrete issues related to the learner and the learning context. It is concerned with the relationship between teacher and student, and with broader issues of educational structure and objectives.

The American psychologist and psychiatrist Carl Rogers was the pioneer of "the person-centred approach" in health care[112], and devoted decades of his professional life and research to understand "the characteristics of helping relationships".

Rogers showed in his ground-breaking research in humanistic psychology how three main skills influenced the relationship between the health provider and the patient, the teacher and the learner and the parent and the child: ***Being authentic, using empathic understanding and using appreciation.*** We are teaching these skills consistently in the training, also by trainers role-modelling these skills.

The key methods to become aware of how these skills function are the observation and reflection tasks, and it is especially in the "Skills into Action" period participants learn to strengthen these skills.

The Brazilian adult educator Paolo Freire has contributed essential principles[113] to our training model. Freire was so effective in his teaching adults to read, write and demand their social and economic rights that he was jailed and later exiled from his country by the dictators running it in the 70s, and spent many years in Chile. But – his methods were so powerful that they were picked up by educators all over the world and have been used extensively in adult education – with very good results. The methods are very useful for teaching humanistic medicine, and for strengthening awareness of values and behaviour.

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[112] Rogers, C. R. (1986). Carl Rogers on the development of the person-centered approach. *Person-Centered Review, 1*(3), 257-259.
Regers. C. R (1967): On becoming a person. Constable and Company Ltd, London.
[113] Freire, P (1968): Pedagogy of the Oppressed. Published in English 1970. ISBN 9780826412768

Some of his main principles and methods of effective adult learning are:

- ✓ **Dialogue.** The teaching method is to be based on dialogue, which is a horizontal relationship between teacher and learner. Communication and empathy are the main methods in the dialogue.
- ✓ **The educator is a partner**: Freire's view of a good educator emphasizes the need for a flatter structure in the learning hierarchy, and for an exchange between teacher and learner: *"The mark of a successful educator is not skill in persuasion - which is but an insidious form of propaganda - but the ability to dialogue with the educatees in a mode of reciprocity."* (Freire, Education for Critical Consciousness, 1973)
- ✓ **The learner is the subject**. The learning should be based on an understanding of his or her situation and should lead the learner to see himself as a subject in the world, a subject who can be a maker of the world of culture. Through this, his attitude of being an object, a victim of circumstances, and thus passive with no power, will gradually change. He will become a transforming agent of his own social reality.
- ✓ **Critical thinking and analysis**. The learner describes and analyses his situation, and reflects critically on it: He questions the definition of "reality", and gain the skills to redefine this reality. Through this, he is stimulated to begin solving problems. In Freire's own words: *"We needed, then, an education which would lead men to take a new stance toward their problems - that of intimacy with those problems, one oriented toward research instead of repeating irrelevant principles. An education of "I wonder", instead of merely "I do"*. (Freire, Education as The practice of freedom, 1967)
- ✓ **Problem-posing as a pedagogical method**. Freire's central message is that one can know only to the extent that one "problematizes" the natural, cultural and historical reality in which s/he is immersed. Problematizing is the antithesis of the technocrat's "problem-solving" stance. In the latter approach, an expert takes some distance from reality, analyses it into component parts, devises means for resolving difficulties in the most efficient way, and then dictates a strategy or policy. Such problem-solving, according to Freire, distorts the totality of human experience by reducing it to those dimensions which are amenable to treatment as mere difficulties to be solved. He recognizes participants as thinking, creative people with the capacity for action: *"Problem-posing education is prophetic, and as such is hopeful, corresponding to the historical nature of human beings. It affirms people as beings who move forward and look ahead,...for whom looking at the past must only be a means of understanding more clearly what and who they are, so that they can more wisely build the future."* (Freire: Education as The practice of freedom, 1967)

These methods and principles provide a good basis for a different approach to training groups used to being taught with didactic methods.

The power and practice of experiential learning
Experiential activities are characterized as being among the most powerful teaching and learning tools available. Important characteristics of experiential learning is that ***it requires self-initiative and intention to learn, and an active phase of learning.*** The learning is most effective when it involves 1) a reflective learning phase, 2) a phase of learning resulting from the actions inherent to experiential learning, and 3) a further phase of learning from feedback. This process of learning can result in changes in judgment, feeling or skills for the individual and can provide direction for the making of judgments as a guide to choice and action.

Most educators understand the important role experience plays in the learning process. The role of emotion and feelings in learning from experience has been recognised as an important part of

experiential learning. While those factors may improve the likelihood of experiential learning occurring, it can occur without them. Rather, what is vital in experiential learning is that the individual is encouraged to directly involve themselves in the experience, and then to reflect on their experiences using analytic skills, in order that they gain a better understanding of the new knowledge and retain the information for a longer time.

Facilitators who are not very experienced in using experiential learning with their students might use the practical "5 questions" model to promote critical reflection:
* *Did you notice...?*
* *Why did that happen?*
* *Does that happen in life?*
* *Why does that happen?*
* *How can you use that?*

These questions are asked after an experience, one by one, and can gradually lead the group to reflect critically on their experience and gain an understanding of how they can apply the learning to their own life. These simple questions allow the facilitator to use the theories behind experiential learning in practice.

6.5.2 A brief selected literature review of the effects of training strategies

In an overview of systematic reviews of how training methods work to teach physicians and nurses about communication skills[114], the authors conclude that a combination of learner-centred strategies, with a focus on practicing skills in small groups, with feedback, has the best effect. The best strategies included role-play, feedback and small group discussion. Other reviews conclude similarly, with role-modelling, personal reflection and critical thinking as main strategies showing good results.

The following conclusions were drawn from extensive evidence referenced in the Berkhof review:
* The best results are achieved with longer duration, learner-centred training, and combining didactic component with practical rehearsal and feedback. To maintain skills in practice and to handle emotional situations effectively, positive attitudes and beliefs are needed.
* There is reasonable evidence that brief training is not effective. Duration should be at least three days;
* Outcomes were better in programmes that included skills practice than in purely didactic programmes
* No significant differences were found between using simulated patients and role-play

The review assessed the evidence for effectiveness of the strategies, and concluded:
No evidence for effectiveness:
* Giving oral presentations, e.g. lectures
* Written information about communication skills in handouts, or manuals, in combination with lectures.
Evidence for possible effectiveness:
* Feedback (effects most pronounced when feedback was given in response to practical rehearsal in for example role-play).
* Discussion, in small groups
Evidence for effectiveness:
* Role-play (because of the active way of learning).

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[114] Berkhof M[1], van Rijssen HJ, Schellart AJ, Anema JR, van der Beek AJ.(2011): Effective training strategies for teaching communication skills to physicians: an overview of systematic reviews. Patient Educ Couns. 2011 Aug;84(2):152-62. doi: 10.1016/j.pec.2010.06.010.

The experiences from our training sessions confirm these patterns of effective strategies: We use role-plays and demonstrations, with small group discussions and skills practice with feedback, as the main methods throughout the workshops.

6.6 Workshops: Active, supportive experiential learning

Note: We use "trainer" and "facilitator" as equal terms – they lead and guide the learning.

6.6.1 Overview of basic features

See Chapter 5 for a description and discussion of training methods and concepts central to the model.

A main basis for our workshop sessions is **creating a safe environment** where it is allowed to share success without being envied, ridiculed or ironized over: It is allowed to share mistakes and failures without being judged or shamed, and to learn at each participant's own pace. William Branch calls this **"safe insecurity"** – an environment where acknowledging vulnerability is seen as a natural – and necessary – part of reflection and learning. On this basis, developing (or strengthening) **relationships with trainers and colleagues** also becomes a natural part of the process, and becomes a working tool in the further learning.

The other main basis is the starting point – **Relevance**. Participants in our workshops come to the sessions with the bags full of experiences, challenges and questions from the last 3 months' observations and reflections from their daily work situations. The teaching uses this "base" of experiences and information as the most important contents input in the workshop. This "base" keeps the contents and context relevant and recognizable for the learners and keeps their motivation and involvement high.

We add some **basic theories** to the experiential learning practice, to give participants some theoretical "hooks" to "hang" their experiences on: When they get to understand WHY they behaved in a certain way, using experience AND theory, the learning goes even deeper. They learn about the "principle" and the "phenomenon" behind their experience and will therefore easier be able to recognise and remember a similar situation or challenge when it occurs again, and then be able to pull out the right response from their "basket of skills".

Throughout the course, our approach is to first make participants realize how a principle works on themselves – thus linking their cognitive and emotional understanding of the issue. Then, they will be able to transfer this understanding to the patient (or the colleague) and see the parallels. This will help the provider continue to see the patient as a person (as opposed to categorizing and judging "difficult patients" as a group).

The role of the facilitator or trainer is crucial in the workshop. The trainer adds structure and further challenges to the independent learning the participants have gone through during their first three months when they discovered how they **really** communicated. The facilitator will ask open questions, and guide the participants to reflect before, during and/or after an experience. This interactive reflection in groups can help open them up to new thinking, learning and insights.

Some basic features of the workshop
- ✓ *Safe learning environment*
- ✓ *Relevance: Situations and challenges are from their own practice*
- ✓ *Experiential learning and basic theories*
- ✓ *Interactive reflection and exploration of their own and patients' behaviour*
- ✓ *Understand how it works on them – then apply principle/action to others*
- ✓ *Appreciation and empathic understanding*
- ✓ *Encouraging participants to be genuine*
- ✓ *Make learning enjoyable, creative, and – real*
- ✓ *Explore reasons why, rather than judge*
- ✓ *Role-model kindness and compassion*
- ✓ ***See Module 1: Concepts used in training***

Role play, Kilifi, Kenya

During the work on the present model, more than 30 trainers in 9 countries have been trained to train practitioners by using experiential methods – all of them health professionals coming from a practice of being taught with lecture-based didactic methods in hierarchical systems. The large majority of them are nurses or medical doctors working in hospitals or out-patient clinics.

Methods and tools used to train these providers are planned to be presented in a companion manual to the present one. The trainers' manual will cover facilitation skills, with a rich base of examples of what has gone right and what has gone wrong in developing and refining the iCARE-Haaland model described in this manual and methods for trainers to learn these skills (i.e. a TOT manual). Trainers have reflected on these experiences, and on what and how they have learnt to become the trainers they are today.

The following is a detailed account of the methods and strategies used, the concepts that are at the base of the teaching, the practice of skills in the workshops, the sequence of the skills and knowledge taught, and the effects of the training, on participants. In the next section, central skills trainers need to be able to manage this process, are spelt out.

6.6.2 Training methods and strategies

Key training methods are based mainly on participatory principles and experiential learning, and on the research conducted to identify best evidence for teaching communication skills to health providers. We use examples or short lectures to introduce topics, then demonstrations, role-plays, small group work, buzzing, mutual problem solving, practice in groups with feedback, and facilitation in the large group (of 20-30 participants). In the modules, there are detailed instructions for how to use each of these methods to the best effect, with examples and exercises.

Lectures are used sparingly and are short. Research[115] has established that participants' attention span is radically reduced after 10-15 minutes, if they are not involved or encouraged to relate the contents to their own practice. This is particularly the case for practitioners who are not full-time students. We thus typically stop a lecture after some minutes and ask participants to talk with the person beside them about what they just heard and come up with questions if anything is unclear, or give an example from their work. Then, the trainer can lecture for some more time. After the lecture

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[115] Mellis, C.M (2008): Optimizing training: what clinicians have to offer. and how to deliver it. PAEDIATRIC RESPIRATORY REVIEWS 9, 105–113

(or sometimes introducing it, or in the middle), there are always exercises to practice the ideas or skills introduced.

Whenever possible, we follow the "rule":
- ✓ *Show, don't tell!*
- ✓ *"I loved the role plays – both by facilitators and the participants – they have a way of nailing the point home. I think this was a job very well done. I think as learning methods, they are great as they are practical and we are more likely to remember what we learnt compared to only lectures".* *Research staff, Kilifi*

Feedback from participants, often years after the course, show that what they still remember are:
- **The demonstrations** - e.g. of "bad practice", where they could recognize and laugh at themselves and each other; and "good practice", the "gold standard" that becomes a friendly companion and reminder to them in their work, and
- **The role plays,** where they have either tried to practice a new skill and failed to get it right – discovered through their own budding awareness, or through feedback from colleagues; or – they have managed to practice a new skill well and experienced the satisfaction of "success", with appreciative feedback.

NB: Research shows that this is how our brains function: We do remember examples, events and situations that also trigger our emotions, but we do forget facts. Thus, a training that focuses on showing good as well as bad practice in vivid demonstrations and role plays is much more likely to be remembered, and have an impact, on participants' practice.

The examples from the participants' own observations and reflections are used to illustrate theories of behaviour change, social and educational psychology, communication and information, and adult education. We focus on what they do well – as an entry point to solve problems. We discuss problems and let participants who have good ways of solving these problems describe their methods to others. This also creates empowerment, and role models – and as everyone usually is good at something – the method creates a mutual learning environment where participants use each other as resources. Using participants' own descriptions of situations from clinical practice is essential in making the course relevant to their learning needs. These examples change with each country, but the topics and issues are amazingly similar.

> *"My friend was happy to learn the active listening skill and probed where I got the skill. She was interested to join my communications skills training so that she can communicate better with clients and help them. Nowadays she tells me that I have really changed, and she wants to be like me".* *HCW Kilifi*

The approach: Learning why, rather than judging: Participants also learn *what causes their reactions*, and see that reactions to a variety of actions and emotions are "natural" or common. We don't judge what they say or do or feel – we use critical thinking and probing to look for the **reasons behind the actions or feelings**. Thus we take the guilt feelings out of the reactions. This makes it easier for participants to learn – and we then help them to transfer this insight - i.e. that they learn well when they are appreciated and understood - to their treatment of the patients, and of their colleagues.

The effect is that participants learn the theory – based on their own experience – and are taught to recognize the same type of problems when they occur in another setting. They also learn to recognize that patients react the same way as they themselves do, and thus if they treat patients

with respect and understanding, they will have a better relationship with the patient and be able to practice better patient-centred care.

"Translating" the steps in the learning methods to how Emotional Intelligence works:

- **Demonstration:** When they see a colleague showing a "typical" bad practice situation, they **recognise** the emotions in patients/colleagues, and also in themselves (skill 1)
- **Discussion:** This is what happens – we acknowledge and **think** about the situation (skill 2)
- **Analyse** reasons why, on both sides: Find out what can be the causes which can prompt the provider to feel and act the way she does, and also reasons for the patient/colleague's emotions and reactions (skill 3)
- **Role-play, to choose a different action** ("good practice"), based on having understood the reasons why "bad practice" was used, and knowing what good practice should look like (skill 4).
- **Discuss insights from the role-play**, to anchor learning and make meaning out of what happened. Use appreciative feedback to confirm good practice, and reasons for it, and emotional reactions to practicing well: Good energy and job satisfaction. (Skill 4/summary).

6.6.3 Core concepts underlying the workshop modules

The values and ideas in the course and in the workshops are based on principles for Patient-Centred Care, where respect for the patient and seeing the patient as a person is the core in the first PCC dimension (Provider – Patient). The second dimension (Provider – Provider) is equally important – communicating well in the team is crucial for the providers being able to practice good PCC, and the third dimension (Provider – Community) focuses on the relationship to the local community.

The fourth dimension – Provider – Self – is an important focus in our training.

The main and first core concept is *awareness*: When providers decide to invest in becoming aware of their own communication behaviour, and the effect this behaviour has on the other person (patient, or colleague) – she or he becomes motivated to learn, and to change with the learning and insights. The motivation evolves from within the person herself/himself – it is not something that is imposed from the outside.
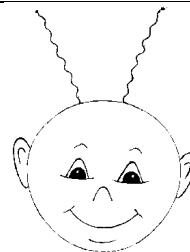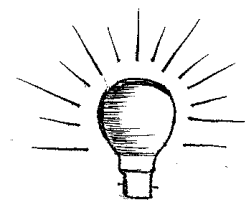
Becoming aware….   *And gaining insights*

The experience of becoming aware e.g. that the provider's own irritation and anger scares the patient and may prevent the provider from finding out what the real problem is, and thus not be able to give good care – is shocking to many participants. Reflecting on this and on many other similar discoveries motivates them to learn, and – makes them see they can make many changes by themselves, there and then. This process is empowering.

The concepts in the course are all designed to support this process of learning to communicate with awareness, with respect for and skills to handle emotions – to develop trust and establish a professional relationship with the patient. The observations and reflections they have made the last 3-4 months, to discover problems (and some solutions) and reflect individually – will now be deepened by reflecting interactively with colleagues in the workshop.

The sequence of the concepts is carefully constructed – to make them build on each other.
The idea is to introduce the concepts briefly in the introductory session, to give an overview of the thinking behind the course, and to show what are the values and directions we will follow.
The examples from the participants' observations link the concepts to their reality.

The other core concepts are:

- **2. Critical thinking, reflection, insights**

Critical thinking is an essential part of the course, as an underlying concept or approach used throughout the four phases of our training process. It is a key skill when learning emotional intelligence. The Foundation for Critical Thinking (http://www.criticalthinking.org//) is an organization dedicated to teach the skill of critical thinking to students and professionals in a number of areas, including health. The following quote is a description of their concept – which is very much in line with how we look at the aim for the observation and reflection tasks to build awareness:

- *"Our basic concept of critical thinking is, at root, simple. We could define it as the art of taking charge of your own mind. Its value is also at root simple: if we can take charge of our own minds, we can take charge of our lives; we can improve them, bringing them under our self-command and direction. Of course, this requires that we learn self-discipline and the art of self-examination. This involves becoming interested in how our minds work, how we can monitor, fine tune, and modify their operations for the better. It involves getting into the habit of reflectively examining our impulsive and accustomed ways of thinking and acting in every dimension of our lives."*

An example of an insight from one of the participants:
➢ *"I left the place while full of anger and I could not control it. I went straight to my bed without taking anything. I tried to meditate on the story, "How has it started? The way I am tired? How should I handle this case?" After settling the issue I took time to go through myself over the whole situation. I visualized how it started, how I contributed and what I went through in the process".* *Health Care Worker, Kiifi*

- **3. Respect**

Respect is the main attitude and skill which help providers build trust and establish a professional relationship with patients. Respect shapes the quality of the interaction between the provider and the patient, colleague or supervisor. When respecting the other person is a natural starting point, it becomes natural to check the emotional "landscape" in the interaction, and take the necessary steps to manage this competently, using the emotional intelligence skills. **The ability to show respect** is in all of us, and respect is often "contagious", as expressed by a provider in Kilifi who was asked how she felt when met with respect:

- *"I feel good and appreciate it, I also ensure I give that person twice the respect they gave me"*

A person who is feeling vulnerable (e.g. sick) is especially sensitive and needs to be shown respect. **The willingness to practice respect** is based on awareness about its importance, and the perception participants have about how respect should be shown in their culture. "***Culture***" here can be national, or professional/medical. This perception is often ***subconscious*** and automatic – many have not thought and reflected about it. See section on challenging the cultural traditions for how respect is seen and practiced, chapter 4.3.3 and 4.3.4.

- **4. Empathy**

Empathy is to step into the shoes of the other person, with awareness, and step out again, with the ability to act. **When using empathy**, they see the patient as a person, and as partner in care:
Establishing relationship, based on communicating with respect.
This concept is central in the course.

- *"I carry so much of the patient's burden (sickness) and really feel for the patient and most of the time I put myself in the patient's shoes".* *Health Care Worker, Kilifi*

- **5. Humanistic medicine**

Humanistic medicine shifts the focus from disease-centred to patient-centred care. It is interdisciplinary, and aims for open communication, mutual respect, and assumes an emotional connection between the health provider and the patient.

An example from a participant, on patient-centred care (PCC).

➢ *"I can now have ample time with a client and get to know his/her other needs apart from what has brought him like the physical needs which is the sickness, because if you don't meet all her needs she will be there physically and be disturbed emotionally and she won't really take good care of the sick child.*

➢ *PCC is a very good element and if well applied we will have such a good world to live in where patients will never be mismanaged but will be taken care of very well."*

Health Care Worker, Kilifi

- **6. Appreciation**

Many of us don't use appreciation very often. It is a simple skill that can be used more – **BUT** – you have to *mean it*. False/non-genuine appreciation used to obtain an effect – ***"stinks",*** *and the other person feels the falseness immediately, and reacts negatively.* Honest appreciation is a very effective communication method that makes people feel seen and motivates to communication and action.

Examples:

➢ *"If a person is appreciated for what he/she is, and her/his opinion is respected, there is always positive attitude in them that motivates them to give more input."*

Effect of appreciation:

➢ *"I feel safe when patients show and explain their faith in you and in what you are doing to help. Also when they explain their gratitude to you after getting better."*
Both: Health Care Workers, Kilifi

- **7. Responsibility**

Providers often want people to change behaviour. A common method is to ***tell them what to do***, and expect change. Providers take the ***responsibility*** for determining their change.
However, we see that ***often, people don't change.*** Often, we **blame them** for "not knowing what is best for them" (*implying that YOU know what is best, THEY don't, i.e. they are ignorant, and we judge them for not taking "rational" action – i.e. rational, from our perspective*).

In this course, we will learn ***how people change***, and how we can work to ***encourage and empower*** people to make their own decisions to change. This includes to take responsibility for the communication, based on their understanding of why people change, and why they don't.

Example:

➢ *"Thanks to this course, I have tried to learn a lot and have broken the barriers that are hindering me to communicate effectively. I have realized that I am the problem when it comes to communication. I have decided to have a change and that change is me!"*
HCW, Kilifi

- **8. Motivation**

Motivation to act is a powerful partner in our work: We should work with patients in a way that motivates – and enables - them to collaborate with us to care for them: ***Partners in care.***

This will make it more likely that they continue to take care of themselves/their disease when they go home. We are finding ways to stimulate their inner motivation to change – for their own reasons. Communication with awareness and EI is a powerful skill to help this happen.

Example:
> ➢ *"When I am treated with respect, I feel happy, absolutely honoured, my levels of motivation are usually high, and I naturally take to my heart the whole situation."*   *HCW, Kilifi*

- **9. Empowerment**

Empowerment means to ***give or delegate power*** to someone, to enable that person to take the power and decide how to act on her own, based on her own perception of what she needs and wants. (Or – something that has been added on to you – to strengthen someone's ***ability to act.)*** **Providers are used to having power** over patients. If we want patients to be able to take action on their own at home (*e.g. to continue to give medicines in the right way, identify danger signs in their child, etc*) – they will do this better if you ***"share the power"*** with them: Show that you believe in them and respect them. To be able to do this, participants need the EI skills – to recognize the emotional need to "keep the power", decide consciously to step back from it because they want the patient (or colleague) to be empowered to act independently – and then act on this understanding.

Example:
> ➢ "I *have adopted a pattern of seeking to know what my clients already know from what subject we are discussing.   I encourage them to tell me everything so that I only add to what they may have forgotten or omitted. When I respond in my own opinion, the client feels left out of a decision, unlike when I make the client an active participant, I realize that he owns the decision made and if it requires change, he becomes a forerunner for the change expected".*   *HCW, Kilifi*

Empowerment is an important aim of the entire training model. The approach is to facilitate and stimulate self-awareness, to encourage the person to learn actively, to take initiative to change when she sees there is a good reason to do so. And then – to enjoy and own the pride when she experiences success from using the new methods – which she has decided on using, herself. When she feels empowered, she will more naturally inspire patients and colleagues to be empowered, too.

- **10. Handling conflict through conscious communication**

Dealing with conflict by communicating with awareness is a key skill. Participants explore reasons ***why conflict occurs***, what makes people (ourselves, and patients/colleagues) ***react***, and how to ***recognise*** and ***stop our own automatic reactions.*** The course teaches practical ways to handle conflict constructively, through using emotional competence: Conflict is fuelled by emotions, from both sides, and learning to recognise and deal with these constructively can reduce the level of conflict in the work place.

Example:
> ➢ *"It doesn't matter how hurt we are. Approaching the other person in a calm manner and with respect can help solve a problem. We should stop thinking of the person who irritates us and focus on way forward to solving the problem. We always need change immediately when (we are) angered but it's good to have self-control otherwise the end could be destructive."*
> *HCW, Kilifi*

- **11. Having Fun**

Having a good atmosphere in a workshop is important for good learning. This includes having fun, laughing at ourselves and laughing with each other. Participants do not need to worry – also having a good time does not mean "wasting time" – it simply means they are learning well. This fact is seriously proven by research!

6.6.4 Practicing skills in the workshops

Practicing new skills is central to the training. Communication skills are learnt through practice, with constructive feedback, and practice is a part of all exercises. Participants have a good basis for new practice, as many of them have already changed how they communicate from having discovered e.g. how ineffectively they listen, and have thus experimented with new practice. What they need now is clarity about "the gold standard" – what good practice for each skill "looks like" and feels like, and what effect it has on the patient. Then, they work to further adjust their skills as well as they can, within their personal style.

The skills training often starts with **sharing of experiences** in a group, to identify challenges related to the particular skill (*e.g. asking open questions, and what makes it easy – or difficult – to practice this skill*). Participants or trainers then **demonstrate or show the skill** and asks the group to relate it to their own work in the clinic. Participants practice the skill through an exercise, or role-play, and then reflect together (using constructive feedback) about how well they did, and what they still have to improve. Reflections on insights from doing the exercise, and on the way forward, closes the session. All exercises are directly related to participants' own context and practice.

An important part is then **to link the practice to theory**. For example, the research which is the basis for constructing the Meta Model is explained: The research showed that people who communicate well use open descriptive questions, and ask many more questions than those who do not communicate well. See module 2c for a full explanation of the model.

6.6.5 The modules in the workshops: An overview of the sequence

The sequence of learning is carefully built up as a natural progression. It starts with building the foundation for understanding all the modules (see Chapter 4 – Building the House of Good Communication), and then goes deeper into each of the main challenges. The parts marked with * refer to the modules.

The Basic workshop
*The introductory module** in the basic workshop explains and discusses the **key concepts** underlying the course (**Module 1**). It then applies some of the concepts to introduce the participants to each other – through using appreciation with awareness and discussing appreciation as an important communication and motivation concept to be used in patient-centred care (and with colleagues).

Having put the participants into the right "frame of mind" to learn, the topic is ***HOW do adults learn (Module 2a)**. They realize this through an analysis of methods used by good teachers who inspired them to learn, and by linking this to adult learning theory and principles. They use their experience of what is "effective learning" for themselves to analyse how this applies to their work with patients. Their first session of experiential learning has brought important insights, and decisions: Concluding that patients ALSO learn best - e.g how and when to take the medicines, and why, or how to deal with their chronic condition - when these principles of effective adult learning are adhered to, participants can decide to apply them in their work.

The presentation with ***Feedback on observing how you communicate** from their baselines and observation tasks (**Module 2b**) acknowledges participants' hard work during phase 1, as well as their challenges and insights. This overview signals to the participants that trainers have thoroughly read and analysed their work in preparation for the workshop, and that their examples and work situations are an important basis for the workshop. The presentation of challenges AND accomplishments further motivates participants to learn.

The CORE modules: The next two modules provide the other part of the core basis for the workshop and for the whole course: ***Gold standard communication theories, skills and strategies in practice (Module 2c)**, and ***Communicating with awareness and emotional competence** (**Module 3b**). A brief overview of ***Feedback on use (and misuse!) of emotions** (**Module 3a**) from the observation and reflection tasks introduces participants to the group's present perceptions of the topics on emotions, and of their many struggles to get to grips with their automatic reactions. Through practicing the different communication techniques in situations with familiar context, participants strengthen awareness and skills to communicate with confidence, and include recognition and management of emotions in the process.

The emotions module explores and draws the emotional "landscape" of clinical consultations, negotiations and treatments, and provides a basis for how to recognise, understand, interpret and handle common day to day challenges at work. Emotional intelligence skills are gradually built up. Demonstrations and exercises show the (potentially) devastating effects of automatic use of power (*like putting patients "in their place" or showing anger or irritation at them not following "orders", or withdrawing to show disapproval*), and the good effect of acting with awareness to recognize and handle emotions with respect. Participants link this to their discoveries during the observation and reflection period and build the skills that most of them say have made the biggest difference to their professional (and often also personal) life: *Recognition and management of emotions, by stepping back from automatic reactions and handling emotions in themselves and in patients with respect, as a natural part of their work.*

> - *In all the nine countries where the model has been used, participants conclude the same: Learning to recognise and manage emotions was the most important aspect of the course, and – they were not aware that they needed these skills.*

The core modules are followed by an introduction to ***What makes people change attitude and behaviour** (**Module 3c**), where the theoretical model is explained through participants' own experiences of change. Important insights include that behaviour change takes time (often months, or years), and is most often influenced by someone who is close to the person changing and/or is respected by her. The other main influence that inspires change is an emotional event. Sometimes, the two go together.

"Armed" with a basket of conceptual and practical tools and skills, participants are now ready to tackle challenges related to stress: ***Recognising, managing and preventing stress with communication and emotional competence (Module 3d)**, and conflict ***Managing conflict with awareness and emotional competence to maintain dignity and respect** (**Module 3e**), which are important parts of their everyday life. Again, emotional competence is essential and help them get into the habit of recognising emotions that can lead to stress or conflict and taking steps to manage

them before they get out of hand. Challenging situations described in their observation period are "translated" into exercises and role-plays, and participants practice handling these situations, with awareness and new EI skills. The interactive reflections enable them to start integrating the skills into their practice.

The next module (**Module 4**) applies the skills learnt to ***Communicating about research with awareness and emotional competence,** in the hospital. Participants are involved in recruiting and treating research respondents among their patients, and skills are used to strengthen awareness of how to recognise and practice ethical aspects of this work.

The last two modules "bring it all together": ***Using communication skills and emotional competence to educate patients (Module 5a)**, and ***Strategies to communicate with awareness and emotional competence** (**Module 5b**). In these two modules, participants use what they have learnt to practice their skills in various challenging situations, and reflect on the outcome, and on further learning they need to focus on. These sessions also help to cement relationships among the participants and make plans for how to continue to work together to support each other when they are back in their wards: *The continued contact between participants, with support from trainers and other role-models, is important to provide a solid alternative to values and attitudes communicated through the "hidden curriculum". The three months' period of "Skills into Action" is crucial for the skills to gradually become a sustained pattern of behaviour among the participants. With their awareness about how ingrained practice and "accepted" rules are often setting the standard for how fellow professionals work, they can now consciously challenge the **"hidden curriculum"** with their new skills: They can inspire colleagues to (consider) change through acting constructively, not judging, and being role models who practice good patient-centred care, communicate well with colleagues, and take good care of their own health.*

The follow-up workshop

This workshop follows a similar pattern of logic as the basic one: **The introduction (Module 6a): *Introduction and review: Gold standard communication strategies with patients and colleagues** reviews the main elements from the basic workshop and puts them together to a "Gold Standard" interaction between a patient and a provider. This interaction is thoroughly analysed for its parts - how it works, what are the elements, and why does it work well - and becomes the common reference point for the further work throughout the workshop.

Module 6b is titled ***"The Big Changes – Confirmation of growth, and challenges participants still have"** and outlines the analysis of the changes participants have made between the baseline (before the course) and the endline (at month 8, a set of the same questions, with added questions to reflect on and describe own changes). The module also includes insights from the observation and reflection tasks during the "Skills into Action" period. This provides an empowering moment, when participants share real pride - and some astonishment! - at the changes they as a group have made in their practice since they started working on their communication skills. The mutual acknowledgment and appreciation of these accomplishments is a strong and empowering moment in the training process, and further motivates them to learn with an open mind in the next three days.

A number of "heavy" modules follow. These modules deal with emotional challenges providers face in their work, and using constructive communication skills and strategies to approach them, with awareness. The modules are: ***The many faces of anger: Recognize, acknowledge and handle with respect (Module 7a), Managing conflict with emotional competence: From confronting – to stepping back, and dialogue (7b); *Using power with awareness and emotional competence (7c) and *Recognizing bullies in the medical profession: Using emotional competence to confront and prevent bullying (7d).**

In these modules we address the issue of power and status in the relationship, and look at the effects of using power, on the outcome. Participants learn to look at what they want to achieve in the meeting with the patient or colleague and choose their communication strategy (including how they deal with their power role) accordingly.

The "heavy" modules continue with ***We can't always Cure, but we can always Care: Managing death and dying with emotional competence (7e); *Professional closeness or professional distance? Conscious use of personal and impersonal language (7f) and *Using emotional competence to recognize, manage and prevent burnout (7e).** The many exercises and practices with feedback in each of the modules help participants to strengthen confidence in the use of these skills. Their interactive reflections confirm that they see the skills work well to practice patient-centred care and to communicate constructively with colleagues, using emotional awareness. In the module on death and dying (7e), the concept of vulnerability and how to relate to it is especially discussed.

The last two modules on ***Working with emotional competence in a research environment: Understanding and communicating about the difference between research and treatment (8a) and Strategies for effective information and communication: Communicating with awareness and emotional competence (8b)** complete the course. In these modules, participants again use their basket of skills to apply to situations from their practice and reflect on how they now work.

The sequence has been adjusted as the course has taken its final shape, especially in Kilifi.

NOTE: Shortened versions of the full course have been conducted for researchers in Kilifi and Nairobi, and for managers and leaders in Kilifi. These courses will be outlined in further manuals. The experience and results from these courses are very similar to the courses run for health providers: All participants appreciate the learning and see the need for learning to communicate and manage emotions as central skills for their professions. They recommend further learning of these themes for colleagues.

6.6.6 The contents and sequence of learning the iCARE model in Wales

In the second year of training trainee doctors in Wales we ran six workshops over a period of seven months. Each workshop ran for three hours, with one running for five hours. The first and last workshops included filling in baseline and endline assessment tools. The last workshop also included a focus group discussion by independent researchers to assess outcome of the training, and thus the actual facilitation session with participants was only 1 ½ hours.

In between the workshops, participants worked on self-observation and reflection tasks, see an overview of topics in chapter 6.

The modules had the following main themes:
1. Strengthening emotional intelligence and resilience: An introduction to the model and the methods.
2. The foundation for good communication: Listening, being present and practicing Emotional Intelligence
3. Emotions affect communication: *How, why, and what to do?*
   Vulnerability: a positive force to build Resilience
4. Communicating with awareness and emotional intelligence: Enough to build resilience?
   Summing up, Linking learning to resilience + burnout. Focus on positive action
5. Criticism and Conflict: Finding reasons behind, and Managing with Emotional Intelligence
6. Demonstrating awareness and EI competence: Sharing insights and strategies. Impact on confidence and resilience?

7 The role of trainers: Essential guides and role-models in the learning process

In this chapter, we describe and discuss attitudes and skills trainers need to have and to practice to be able to stimulate critical thinking and facilitate good learning, which are essential skills in the iCARE-Haaland training model. When using experiential methods the trainer must create an environment that is safe and inspires the mind, the body and the heart to learn. This she does by e.g. establishing and maintaining relevance, keeping connected to the participants and by being present and genuine, and by managing the emotions of the group with empathy and appreciation. And – linking it all to theory.
These points are further elaborated in this chapter, and should be discussed in more depth in a forthcoming TOT manual.

7.1 Trainers must go through their own learning process first

A good trainer is worth her weight in gold. To be able to guide this training well, the trainer must have gone through the process of learning from experience herself and believe deeply in this method as being the best way to guide participants to learn. When trainers are experiencing, recognising and acknowledging their own process of change as communicators, they are much more able to use these insights and skills to teach others. Thus, it is crucial for the trainers to go through the process of observing and reflecting on their own communication and emotion attitudes, skills and behaviour first, and only then train others. The process will give them insight, confidence and – the much needed humility for how complicated (but also inspiring and fulfilling) the process of learning is, and how much awareness, patience and skills are needed to guide it well. The trainer needs a good dose of emotional competence to be efficient in his work.

Please also refer to the article on how to optimize training in continuing medical education, by M. Ellis[116]. A number of principles of adult learning theory are discussed and exemplified here, and are also discussed in Module 2a (How do Adults Learn?) in the basic course.

Trainers in Kilifi reflected together on what are the essential elements in the training that make participants (and also they themselves) learn so well. Their answers:

- ✓ *«You are your own teacher, your own student. You rate yourself, you motivate yourself. The moment you realize you have made a breakthrough, it is like – WOW!»*
- ✓ *"Participants change because they have decided to – not because they have been told to"*
- ✓ *"This approach is empowering: Participants own the results, and the methods to continue learning – with and without the trainers and mentors."*

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[116] Ellis, M (2008): Optimizing training Optimizing training: what clinicians have to offer and how to deliver it. PAEDIATRIC RESPIRATORY REVIEWS (2008) 9, 105–113

Good trainers know that facilitating such insights and change in their participants is their main task. They have felt on their own bodies and mind the power of learning and inner motivation and experienced what the consequences can be for their own practice.

In the picture we see a group of trainers trained in Kilifi – from left Stevenson Chea, Lennox Bhaya, Hiza Dayo, Siti Wande, Francis Kombe (sitting at the computer) and Ayub Mpoya.

7.2 The crucial role of trainers: Consciously non-judgmental

In this training, the knowledge, skills, attitudes, values and personality of the trainer will to a large degree determine to what extent the training process will be successful. The trainer's commitment to the process and to helping participants learn is an essential factor in making this happen. The trainer needs to role-model attitudes, values and skills she is teaching in the course, with compassion and care for the participants. She needs to demonstrate openness, respect, fairness, appreciation and a non-judgmental attitude, and motivate and encourage participants to explore reasons behind their actions. In brief – she needs to role-model the practice of emotional intelligence on a humanistic foundation. These attitudes and skills will help to strengthen participants feeling of emotional safety and help calm their fears. They will open them up for real sharing and learning on difficult topics like handling conflicts, stress, vulnerability, death – and in general, dealing with the challenge of being a kind, caring, compassionate and emotionally intelligent professional.

Trainers' mindset: Conscious non-judgmental attitude to explore reasons behind behaviour
Trainers' most important job is to provide a safe learning environment by meeting participants with awareness, respect and appreciation for their work and their challenges. Their main tools are an open and non-judgmental attitude, and EI skills. This job starts from the very first orientation meeting with the new group, where participants receive their baselines, and the orientation about the self-observation tasks.

The non-judgmental attitude and approach of the trainers is experienced as a relief by participants – most are not used to this, but they like it very much once they sense it is genuine, and real. It opens them up to deep learning. Their initial scepticism and careful defence against sharing and discussing their own mistakes is replaced by relief when they experience that other colleagues have also made mistakes and have similar stories. This makes them open up to real sharing - to explore the reasons behind their (negative) actions and to understand why they behaved this way. They start to see their – and others' – mistakes as learning opportunities. They can then put the incidences behind them and learn alternative strategies that work better both for themselves and for the patients and colleagues. They have started the process of discovery during their observation period, and are now in the workshop, ready to share with and learn from colleagues, and from the trainers.

The thinking behind this very conscious non-judgmental attitude of the trainers is –

• There are ***actions providers take*** in their work (many of them wrong, or harmful to patients or colleagues), and there are ***reasons behind taking these actions***; • ***These reasons are very often hidden*** (even to the provider, who may have acted automatically), or not reflected upon; • ***By finding out what these reasons are***, through interactive reflection, and understand them without judging them, participants are then free to choose other action, based on reasons they can be proud of – professionally.	*Training session, Siauliai, Lithuania*

The providers know that the action they took was wrong – no one needs to tell them that. They have strong guilt feelings – which they hide. When bringing the feelings out in the open and discovering that others have also acted badly towards others, they can acknowledge what they did, learn from it, and put in behind. This conscious process will enable them to recognise an urge to do something similar next time they are faced with such a challenge, and then to choose a different action.

An important distinction: Non-judgment does not mean you "accept" as "good" what a provider did. It means that you consciously use non-judgment as a (part of a) method to guide the reflective learning from the incidents.

7.2.1 Guiding the learning about providers who punish patients

Several participants in the courses have contributed examples where they had punished patients for their "misbehaviour": one provider admitted to having held back antibiotic treatment to a sick child in the ward because the child's mother showed up late for the treatment round, and the provider got very irritated. She had had a rough day, been criticized by the supervisor, and "took it out on the patient". She knew it was wrong, but the emotions made her act – she covered them up with anger: **«My own emotions lead me to wrong decisions that hurt patients»:**

- *"I was allocated to give antibiotics to patients, it happened that one of the patients was not on bed when I was giving the treatment. After I had completed balancing my antibiotics books the patient came and asked for the injection. I was very, very annoyed because I was busy doing other things. I was annoyed and decided not to give the injection to the patient, so my anger made the patient miss the injection and that was wrong."*

Another provider admitted to injecting normal saline water (sterile water) instead of antibiotics into a patient for several days, after she had a conflict with the patient – feeling she had no other "outlet" for her anger against this "difficult patient" who had made what she experienced as unreasonable demands on her.

Participants from all the countries shared similar actions they had not been proud of. By being able to share these, they could explore and reflect on the reasons and emotions behind the actions they took. *Trainers were careful to communicate that the purpose was not to accept these actions, but to explore and explain the reasons providers acted in this way. The purpose was to learn, rather than simply judge the actions and make people feel guilty: every provider had felt plenty of guilt after the incidents.* This process enabled the providers to gradually feel they were ready and able to choose other ways of managing their emotions, and more constructive and respectful ways to relate to "difficult patients". A common conclusion is "*We now have no more "difficult patients!"* And many add: *"They were not really difficult in the first place, it was just – we did not know how to handle them, especially when they come in with strong emotions, or we have strong emotions ourselves!"*

The changes were often acknowledged and appreciated by the managers:

"My supervisor noticed the way I was working and the change in me. She developed a habit of referring all difficult patients to me".   *HCW Kilifi*

Previously, fear and shame because of their wrong actions kept these incidences "buried" in shame and guilt, and the bad behaviour continued. Once it was "out in the open", and providers saw and heard they were not the only ones who sometimes used methods to punish patients who "misbehaved", they could focus on learning why such things happened, and to recognize the fear that is often behind the anger. They gradually learnt about the power of emotions, and how these

can contribute to making us do bad things to others. When learning the alternative – to recognize the emotions, step back from automatic reactions, and take constructive action – most of them would choose this approach to dealing with challenging situations. When they experienced the good outcome of this approach on **patients,** *who maintained good communication and cooperation*, and on **themselves** - *they felt satisfied with their work, and had no regret or shame*, providers said it was easy to choose the new methods:

- *"The change I have seen is that when handled well they calm down, but if not well handled, they remain with their tempers. It brings conflict between the health worker and the parent. As result the patient ends up missing proper management (care)".*   *HCW, Kilifi*

The old self pops up – but is met with (delayed) awareness
Sometimes, providers say, the "old self pops up", and they revert to making old mistakes, like punishing patients who will not "cooperate". However, they are immediately aware when this happens, and can reflect afterwards, and make a decision to try to step back in a similar situation, next time: They are using EI skills to analyse what happened.

Some examples:
"It's a pity that I still cut short a colleague when doing things the wrong way. The only thing that I have now improved on is that I never continue saying negative statements once I have cut him or her short. I use the stepping back skill to recollect my words before I make any corrections".   *HCW, Kilifi*

"Sometimes I find yourself back to 'normal', when i sit and reflect i regret on the way i responded to the issue but with time I think I will be able to adjust and always try to be aware of the scenario before I continue".   *HCW, Kilifi*

The trainer approaches this issue as a natural part of the process – "we take time to change". The re-occurrence of the "old self" then becomes something else to not fear or be ashamed of, but to see as natural, and expected. This makes it easier for the providers to accept the process of change, and to continue to work on it – in a natural way, and to change gradually.

When participants learn to recognize their own fear and understand the reasons behind it, as well as the various automatic ways they have used to cover it up, e.g. by showing anger, and/or being judgmental, they are free to act in a different way. The responsibility for change is their own, and – so are the rewards for the patients and themselves when they handle emotions well, with awareness and respect.

7.3 Trainers as colleagues and role models

Trainers who work in the same institution as course participants have an important role as colleagues and role-models, showing in practice how to use the skills that are taught in the communication course. As action speaks louder than words, the trainer's behaviour will inspire the course participants to learn the methods and can also make them establish mentoring relationship with the trainers, and/or with former participants to the course. The trainers can encourage reflection on practice as a natural part of the daily clinical work.

It is essential that the majority of the training team members have background from clinical practice and are familiar with the working situation of the participants. Participants must be able to trust that the trainer has the necessary knowledge and skills in the topics to be taught. This will give the trainer credibility. However, it is also possible for a professional communication trainer with good

knowledge about the field, to facilitate the process well, in collaboration with trainers with clinical background.

7.3.1 *Foundational skills and attitudes needed to be a role-model*
The trainer as a professional and as a person is important, because her methods, approach, behaviour, attitudes, values and humour will be in front of students for a week. The trainer needs to be a role-model who participants can trust and look up to and want to be like.

"My friend was happy to learn the active listening skill and probed where I got the skill. She was interested to join my communications skills training so that she can communicate better with clients and help them. Nowadays she tells me that I have really changed, and she wants to be like me".
HCW Kilifi

The trainer needs to behave as a good professional who deserves being looked up to, and display attitudes and skills defined as essential in the training – including using emotional competence consciously and consistently.

The key attitudes or attributes the trainer needs to demonstrate as a role-model are:

- ✓ **Being respectful**. Respect is "contagious". When participants are consistently met with respect throughout the training, and become increasingly aware of how it feels to be respected and to show respect to others - they feel safe, and become open to learning – and to challenging themselves beyond their "comfort zones". Being in a respectful environment for an extended period of time can have an important impact on their behaviour.
- ✓ **Being authentic and genuine**: The trainer must be aware of his behaviour and be authentic, genuine and real. If she is not, it shows, nonverbally – and the other person feels it. To use a Kenyan proverb: "*The trainer must not preach water, but drink wine.*"
- ✓ **Being open, friendly and accessible**: The trainer should make it clear that the whole training process (from the initial meeting to the final workshop) is a "learning laboratory", where everybody, including the trainer, learns from each other. Encourage participants to be open to learning and to each other and be appropriately open herself.
- ✓ **Being supportive, and kind – with good boundaries:** The attitude of the trainer is positive, and supportive – within boundaries. Participants must feel that it is safe and acceptable to bring their concerns to the trainer, whether during plenary, or informally, during breaks. Many are used to being dismissed automatically if they bring up their requests (e.g. with supervisors) and may use the same behaviour with their patients or juniors. When met consistently with a kind and supportive attitude and encouraged to reflect consciously on the effect of this attitude on her own learning and wellbeing – it can influence the providers' behaviour, over time.
- ✓ **Being understanding – encourage empowerment.** The trainer should "practice what she preaches", look for the reason(s) behind issues being brought by the participants, and try to help – primarily, by empowering participants to come up with their own solutions. The trainer should also use his role to facilitate solutions to problems, when necessary.
- ✓ **Curious, interested and concerned.** A good trainer has an attitude of a learner, one who is interested in the subject she is teaching, cares about it, and is always open for new learning to broaden her horizons. A good trainer does not believe he has "all the answers", he is able to acknowledge if there is something he does not know (without feeling he is "losing face"), and ask if anyone else in the group knows the answer. If not, the trainer will then go and find out. The trainer cares for her participants as providers care for patients – wanting the best for them, wanting them to learn, and guiding them in the process.

- ✓ **Compassionate and empathetic:** Role-modelling compassion, kindness and empathy – and being conscious about setting boundaries.
- ✓ **Being fair:** Small conflicts or disagreements will often arise during the training period. The trainer must strive to again practice what she preaches – to step back, listen to both sides, and try to facilitate agreement or solution to problems. It is essential that the trainer is not seen to "take sides", e.g. with participants she is working closely with, or participants which are more "like her". She must practice emotional intelligence.
- ✓ **Humorous:** Using humour is a good skill in training – and can lighten the mood of the participants after e.g. a "heavy" session, or when tensions are high. It requires clear awareness to be able to use humour well – never using it to make fun of specific participants, but taking the opportunity to "make fun of" e.g. "us, as health professionals". When the trainer includes himself in the group he is making fun of, it takes the edge off the joke, and people will usually not be offended. The trainer can also take the opportunity, whenever possible, to laugh at herself.
- ✓ **Confidential:** Participants share some very personal experiences and challenges during the course process, both through their written observation and reflection tasks and verbally during the workshops. They open up their hearts – and it is very important to take well care of these gifts and protect them well: The trainer must make it clear to the group that the stories told belong to the group and should not be shared outside without permission, thus showing respect to their colleagues.

Skilled trainers help participants reflect on insights, and use these to discuss and inspire:
- • *"Before the course I used to be irritated when handling a difficult patient/relative. The course has shown me that for every stubborn client, there is a reason behind and instead of getting irritated, I nowadays probe to get to know the reason behind. The concept of the tip of the ice-berg has made me aware of clients / patients' needs and has helped me advance with care to avoid them exploding on me."*   *HCW, Kilifi*

The trainer uses the following main communication skills:
- ✓ **Presence:** Probably the most important skill – to be fully there, with them, in the training – taking them seriously, thinking with them. A trainer who is fully present is a powerful – and yet approachable - professional, with access to her whole range of knowledge;
- ✓ **Appreciation:** Appreciating participants and colleagues for questions, actions, performances or concerns makes people feel good, and often stimulates awareness – and pride. Participants are often not used to being appreciated, and it is a skill that needs to be learnt to be practiced well. Be generous with appreciation – and make sure it is *genuine*: False appreciation is easily detected and will feel awkward for everybody;
- ✓ **Listening:** Active listening, with awareness, is a main skill to practice for a trainer. Participants who feel listened to, and have their concerns taken seriously, will be much more likely to be open to new learning – and to challenging themselves on difficult issues;
- ✓ **Critical thinking, and open questions**: Posing good questions to make participants think and reflect is a key skill;
- ✓ **Using emphatic understanding to look for reasons behind, rather than judge:** The trainer practices this skill throughout the workshop, always seeking to explain WHY things are as they are: In understanding the reason lies the key to finding a good solution. The use of emphatic understanding emphasises the practice of exploring, without judging.

The trainer also uses the emotional intelligence skills when communicating:
- ✓ **She recognises participants' emotions, acknowledges them and works with them:** The emotions are a natural part of communicating in a relationship;

- ✓ **He recognises his own emotions, acknowledges them, and decides what to do:** He steps back from the emotions, or uses them consciously – depending on the situation;
- ✓ **She works naturally with emotions:** She helps the group think about and discuss emotions as occurring naturally in most situations, and influencing the communication;
- ✓ **He analyses and explores the possible causes of emotions** that come up, or that are discussed from experiences participants share. She explores and discusses potential consequences of taking action on the emotions (e.g. by giving space to automatic reactions), and uses this analysis to decide on which action to take;
- ✓ **She takes action on her analysis**, or discusses which action to take, and why;
- ✓ **He reflects consciously**, throughout the session.
- ✓ **She practices confidentiality** and protects the participants and their stories from being exposed inappropriately.

7.4 Using the skills in the workshop: Some main points

Central skills for trainers start with the abilities to **create a safe environment**, **establish and maintain relevance** for the participants throughout the session, and to **keep connecting with them** and **keep them involved and active**. This requires for the trainer to be able to manage her emotions (and step back from automatic reactions), and to be present with the participants and the issues they bring to the group. It also requires good **skills to handle criticism, with awareness**. In other words – to practice using emotional intelligence. Below is a further elaboration of why and how to use these key skills.

In the modules, the use of these skills is applied to each specific topic.

In part B there are examples of trainer's own analysis and advice on how to handle specific challenges, like choosing the right volunteers for an exercise, running exercises, and writing on flipcharts.

7.4.1 Creating a safe environment

A safe learning environment is the essential starting point for a trainer to be able to establish trust to work well and facilitate learning and insights with participants. A safe environment is a place where you **create a foundation for constructive communication**, and where **emotions can be explored and included in a natural and positive way.** When participants feel safe, emotions are also less likely to take over in a negative way. Key elements in creating and maintaining such an environment, where participants feel safe to recognise, acknowledge and discuss their insecurities, are:

- **Seeing the participants as individuals**, learning their names, and building relationships;
- **Respecting participants as fellow professionals**, and empathising with their struggles;
- **Exploring reasons for their actions** – assuming they HAD a reason, and that the work is to make it conscious, and assess its effectiveness to reach the desired goal;
- **Looking for, and respecting, the intentions behind their actions**: Mostly, people try to do their best (*and sometimes – "shit happens", and it does not turn out the way they wanted*): Trusting that they have a good intention for what they do will help create a safe learning environment. Mistrust can create emotional instability;
- **Criticize/debate actions, but not persons**: People know when they have done something wrong, or unethical or immoral. Focus: The analysis of reasons why it could happen, and then – the (different) way forward;
- **Use appreciation, consciously** – and honestly;
- **Maintain a positive attitude**, but without hiding or ignoring problems
- **Acknowledge and celebrate** progress – and acknowledge challenges remaining;

- **Use humour**, where appropriate. Let people laugh at themselves – and laugh **with** them, as colleagues. (*NB do not laugh AT them – this can create hurt, and strong resentment!*)

When participants are exposed to such a constructive and safe environment for a whole week (or for the duration of the workshop), and they become aware of why and how these elements help to create such safety, they will be more likely to use these same elements to create safe situations for their patients – and with their colleagues.

7.4.2 Creating and maintaining relevance

Motivation to learn is high when participants feel the contents of the training are **relevant** to their work and their needs, and the training method enables them to **engage actively** in the learning. They will know that much of this material comes from their own work situations rather than from textbooks (although of course has contents related to the curriculum). *Creating and maintaining relevance for participants throughout the training process is thus the single most important task of the trainers to get the participants engaged and make them experience that this training is useful for them, consistently, throughout the training period.*
The literature emphasises the need to make the situations relevant for the participants to learn optimally.

> "....it was very useful because from other people''s reflections I would actually learn. Because these experiences are almost the same, but the way we handle them is different. Everybody have, people have developed their own ways of handling situations. So if somebody share an experience and reflects, I would also you know, relate with it." **HCW Kilifi, in LVCT evaluation**

Creating relevance must also be done with managers, and with other decision makers/ bodies in the institution where the training is proposed to be conducted. It is important that all main actors view the training plan as an important intervention and support its implementation. See the Planning chapter (8) for more information on this.

Participants experience relevance of the training contents and methods throughout the training process:

Before the training:
- **Participating in the training process is voluntary**. Providers wanting to take part in the training must feel a need to improve their communication skills, and that the training is relevant to their job situation. ***This is a key starting point*** to establish the training as relevant for each of them.

During the training process:
- **Introduction meeting (where baselines are handed out):** The facilitator asks participants what made them want to join the training, to assess ***their*** perception of relevance (*ask them to buzz in pairs, then get ideas out in plenary*). Their points are discussed – and facilitator continues to emphasize that this is THEIR training, and that they will participate in shaping it – to assure that the training stays relevant to them and will result in real improvements in how they communicate at work. Baselines are handed out. See the Planning chapter (5) for description of how to conduct this meeting.
- **The baseline exercise** is the first to enable participants to reflect on their skills and actions. The exercise strengthens their sense that the training is relevant to their job. Participants are given 1-2 weeks to complete the baseline, which is compulsory for taking part in the training.

- **Observation and reflection tasks** are carried out by participants while on the job. The tasks enable participants to discover the effects of their communication, on others, and experience that they have a need to learn to communicate better in their job. When they come to the meeting, after having observed themselves communicating on the job for a month, they have really seen their need to learn. Their sense of the training being relevant continues to be strengthened throughout phase 1, with the continuation of the observation and reflection tasks.

In the workshops:
- **The facilitator establishes relevance for each topic** – during the presentation of the first slide of each module, to enable participants to make initial connection between the topic and their work. For example, in Module 3b, on Emotions, facilitator asks: "*Have you been in a situation where emotions have affected your work? Please discuss among yourselves, and then share your examples with us*." The examples participants contribute links the topic firmly to their work situation and can be used as reference points throughout the module. Participants will continue to see the direct and practical relevance to their work.

The facilitator continues to link each topic to participants' work situation, and thus maintains relevance throughout the modules. There are many ways of doing this, and these are explained in detail in the modules. A brief overview:
- **Showing a demonstration of a problem**, and asking if this happens in their ward/place, then discuss;
- **Showing a picture/drawing**, asking if this situation is happening in their place, then discuss;
- **Asking a question about something that you know** (from having read baselines and observations) **is a problem** for them and ask how they handle it – for example – does it happen that colleagues are angry, leading to a conflict? When the trainer raises an issue as a question, she is not accusing them, but inviting them to acknowledge a problem that they have. They can then be free to explore and learn about it, rather than having to be defensive.
- **Giving them a topic and asking how this affects their work,** for example: How well do we listen to our colleagues? Please discuss/buzz. Then you get a few points and establish that this is a problem that is felt by many.

Keeping attention on relevance keeps participants alert and interested to learn – as it is clear that the aim continues to be – improvement of THEIR work situation, and a better professional life – for THEM as health providers.

> *"…for me the workshop was, I think it was useful because in that workshop what you do is you relate your practical experiences with the theory now. So you link up the two and you really get a very firm foundation. Yeah the skills that you have observed yourself, now you relate them with theory and they stick somehow…"* **HCW Kilifi, in LVCT evaluation**

For trainers, the interactions created with participants by keeping focus on relevance are important. **A senior trainer in Kilifi expressed it like this:**
- ✓ *"When I see they "get the point", and are with me, really curious about what I am going to say – I feel good, I feel connected with them. We are going to talk about something which is important to all of us, something that affects our work/how we can serve our patients/how patients learn/how we can prevent getting stressed/etc: anything you feel is appropriate. This makes me feel confident and safe, I know they are with me, and they know that I know…"*
Hiza Dayo, senior trainer, Kilifi

An example from a trainer who now establishes relevance:

> *"What I do differently is that first and foremost I pose questions to these students. I'm aware these are medical engineering students, so I ask them questions – "Do you see any link between this anatomy and physiology and your base?" Yes, so I try to get that conjecture from there. As they establish that, I now shed more light on the relevance and we move on very well. Unlike before when I used just to go "I've got my notes and I'm introduced to the class and I just say I'm going to take you through anatomy and physiology and we move on".*
>
> *Stevenson Chea, trainer, Kilifi*

In an interaction, the learning happens when participants relate the topics to themselves and their own practical life/work situation. When the trainer's focus is on creating and maintaining relevance, her focus is on the learners, and what they need to learn and what they can relate to.

When the trainer comes to the class with a script and is focused on "This is what I will tell them, it is important and they should listen", her focus is on her own agenda and does not (usually) include or make space for what is important to the participants, or for creating relevance so that they will learn better. Interaction and learning may or may not happen.

> *Facts: Adults forget fast – unless you apply it*
>
> Learning theory gives us good reasons to make sure the learning is relevant to participants and is applied to their work situations: You forget 80% of what you have learnt within 24 hours of having learnt it[117], according to Tony Buzan who conducts research of how students learn – and forget. The normal attention span of adult learners is 10-15 minutes, which means that lecturing for more than 15 minutes is usually a waste of time[118].
>
> We use these facts in the course – by making sure we use only short lectures and ask participants to discuss what they have understood from the short lecture, and apply this to their own situation. Making sure the learning is relevant to their needs and to their work situation is key to enabling them to learn well – and to remember what they have learnt. We also provide summaries of the learning after every module. Furthermore, every day starts with a review of the important learning points from the day before – thus ensuring that the learning is remembered and can be applied.

7.4.3 Connecting with participants, and creating linkage

When using experiential learning as the basic method in a training course, maintaining relation and connection with participants are key aspects: The topics and discussions are directly linked to the participants' experience. It is this linkage which makes the learning so powerful, easy to remember, and – sustainable. Practicing these skills requires the ability to be continuously aware and to use emotional intelligence – for the trainer to recognize when the participants are (emotionally) linked with the topic, the trainer and each other, and when they are not. And then – to know what action to take, and why.

The success of the training is thus closely related to the trainer's ability to establish and maintain *a connection* with participants – through *establishing and maintaining relevance* of the subjects taught (see above), and through *connecting with and relating to the participants as persons,*

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[117] Buzan T. Use Your Memory. : BBC Books, 1995 pp. 77–82.
[118] Mellis, C (2008) Optimizing training: what clinicians have to offer and how to deliver it. Craig M. Mellis. PAEDIATRIC RESPIRATORY REVIEWS 9, 105–113

throughout the sessions. In brief – the trainer is demonstrating part of the behaviour the providers need to learn to be able to provide patient-centred care.

How does the facilitator make these connections? Here are some points:

- ***Start the work during the observation and reflection phase***. In the initial meeting and in monthly meetings - encourage participants to share examples of what they have discovered, and how they feel about it, and – to give examples of useful methods they have employed to establish good relationship with patients and/or colleagues. Appreciate examples and insights, encourage the participants to learn from each other, and to share examples of good learning.

- ***Learn participants' names as early as possible***. Use the names during preliminary meetings, and in the workshop: Being addressed by name makes the communication personal. Make them aware of what you are doing, and why – ask them how it feels, and encourage them to use the method with patients - assuming they say it feels good to be seen as a person!

- ***Create professional and collegial relationships***. If you share a work place with the participants, make a point of greeting them warmly in the corridors and asking how they are getting on – even when you are both busy! It's amazing how much important info you can exchange in only 10-20 seconds, when both are aware and focusing on the brief meeting. It is also quite amazing to note how much positive energy you can create – and receive – when communicating consciously and briefly!

- ***Appreciate active and/or challenging participants as a resource in the workshops***. Don't ridicule or overlook active participants – make connections with them, appreciate and value their points, and (sometimes) say you also want to hear from those who speak less. This can enable everybody to feel seen and heard and enable respectful and positive connections with the whole group. It requires that the trainer is aware and focussed, and consciously uses emotional competence: Very active participants are often quite insecure behind their active voices. They need to be seen, heard and valued for their contributions. When the trainer uses emotional intelligence skills to a) recognize (to herself) that she is irritated about the participant who want to speak "all the time", steps back from this irritation, and analyses the (possible) reasons behind the active participant's contributions (=he is insecure/needs to be noticed), she can take conscious action to appreciate and value him and make him feel seen and heard, and thus feel more secure.

- ***Such action from the trainer creates safety in the group and with the participant – by avoiding power play***. Such action also enables the trainer to feel safe – as challenging participants can often "rattle" the trainer and make him feel unsafe: the challenge can sometimes be experienced (especially by trainers with limited experience) as an attempt from the participant to take over power (*and sometimes it really IS just that – the active participant wants to "show off" and take power, he may see himself as knowing more or be better qualified than the trainer. And – sometimes he is – which then needs to be acknowledged, and a conscious negotiation needs to take place to recognize and settle roles and set boundaries*). If the trainer falls into the "trap" and engages in a power play – the connection to the participants is lost. A sense of insecurity can quickly grow in a group – it is contagious when coming from the trainer. In such a situation, it is often very difficult to re-establish connection with the group and make everybody feel safe again. So – work on preventing this from happening, and – strengthen skills to handle active participants, with EI!

- ***Read participants feedback and refer to it***. Even when you have not used their feedback in the modules, you can refer to it in the sessions: *"Some of you said….."; "Some of you described problems related to……."*. When doing this, participants will feel seen, valued, understood and appreciated. Be generous and sincere with your acknowledgments: The participants have trusted you with their vulnerability and shared their insights and learning as well as their mistakes with you in their feedback. This is a gift, and an important action for

everybody to be able to learn from each other's mistakes – you can bring up the examples (anonymously), for the whole group to learn from.

- ***Encourage exploration of reasons for making mistakes, rather than judging***. By creating an atmosphere of respect and trust, participants will be open to sharing mistakes, and learning from them: When the group can look at, acknowledge and understand situations where providers have made mistakes (often consciously), including the reasons behind such actions, these (often shameful) mistakes can be explored, understood and laid to rest, and participants are relieved. And – they will most likely choose a different action next time they are in such a situation: *Our participants have commented that these sessions where they "confessed" the mistakes they made were very powerful, and always reminded them of what to do, later.*

- ***Maintaining connection with the participants*** means that you as a trainer are open to explore a situation, rather than judge it. **NB – this does NOT mean** the trainer should look at mistakes as "acceptable" – but that the focus is to learn from them, and to go on with an understanding that enables participants to choose a different action, next time.

- ***Use humour and laughter – but never at the expense of a participant!*** During role-plays and demonstrations, be sure to "de-role" the participants from the roles you show – and talk about the situation, and the role-figure – NOT about the participant who played the role (by naming him/her). It is often a great relief to laugh at some of the ridiculous actions participants take, and then discuss how to change/take different action. When you as a trainer have good connection with the participants, you have "license" to use humour, consciously – as no one will feel that you are "laughing at them". You are laughing together, ***at the situation*** – and give each other permission to do so. Laughter makes you able to get distance and new perspective – and to put difficulties behind you.

Thus, creating relevance and maintaining connection to the participants are key emotional competence methods the trainer needs to use, consciously and with respect, throughout the training process. Feeling secure in oneself as a trainer and a professional is the best foundation for being able to use these skills. Another important skill is – to be present, see below.

7.4.4 Keeping participants involved

Participants' experiences and the discussion of these are a central part of experiential learning – these experiences contain the challenges (and often the "solutions") participants will learn from. When participants are involved, you have their full attention, and they learn well. There are however many ways to "lose" them, and each time you do, it is difficult to get them back into the learning. If you lose them too often, they may lose trust in and patience with you, and simply "turn off". When participants get irritated, they start judging you, and the learning environment suffers and becomes "unsafe". There may be sarcastic comments, and an atmosphere of cautiousness and insecurity will take over. This is not a good basis for learning.

Common ways of losing participants' attention:
You can notice that you "lost" connection if participants start nodding off, talking with each other, fiddling with their cell-phones, etc – you see and sense they are no longer "with you". There can be many reasons this happens: As a trainer, it is easy to "get involved in yourself", i.e. – to tell too many of your own (good) examples, or to go too much into details on something you really enjoy talking about, but which is not so relevant to the participants. You can also lose them by being too technical, or explaining too much in detail, or lecturing too long, or telling too many of your own stories and examples rather than encouraging them to share *their* stories – by a number of other ways.

Useful methods to re-connect (after you get your antennas up, and recognize what has happened):
First, use emotional intelligence methods to *recognize* your emotions: the situation when you lose

the connection with participants usually makes a trainer feel insecure. You need to **step back** from your insecurity and decide to *take action* – and which action to take. *DON'T get defensive and blame it on them being lazy or inattentive – then you have certainly lost them!* Some methods:

- **Acknowledge that you are "off track",** without explaining or making excuses – but simply stating what everybody feels, e.g. by asking – "Do we need a break?" or "Did I lose you? Please talk together and tell me where you got lost, and why". Or - "Where are we? Let us get back to the main points here", or "I have three more slides – can we go through these before we have a break?" - or something in this direction. By doing this, you acknowledge that you see them and take their reactions seriously: You are a team and you have a common goal, to learn. Participants also have responsibility for keeping the course on track - although the main responsibility is of course the trainer's! If you have a good basic connection with them, they will usually respond positively to such a request.
- **You can also link to something they have said**, or done – e.g. one of the demos, or one of their examples; make the point, and ask a question – and see if this brings them back on track.
- **Meet their needs –** and tell them this is what you aim to do.

7.4.5 Managing emotions: The trainer becoming emotionally competent

Learning to manage emotions is a skill featuring in several chapter in this manual. It is a very central skill for the trainers, as their abilities to establish and maintain a safe environment for the participants will to a large degree determine how successful the training will be, or – how deep participants will allow the learning to go. Thus, the trainer must be very aware of her emotions, and be able to use emotional intelligence to recognise and manage them with insight and wisdom. She must be a role model to the providers by identifying and talking about emotions as a part of all the topics discussed in the workshop, in a natural way that communicates the meta-message: "*Emotions are common and natural. They are crucial to good patient-centred care, to good collaboration with colleagues as well as to providers taking good care of themselves and not burning out*."

According to many of our participants – being able to handle emotions effectively makes a big difference in their job: They feel more confident, they have more energy, and although the job pressure is the same – many say they handle challenges more effectively, and – leave the job without being exhausted. The trainers' skills to facilitate this learning is crucial.

The basic understanding of how emotions affect communication is developed through observation and reflection, and it is therefore essential that trainers have themselves gone through the period of discovery of their own communication habits before they teach others.

An example, which the trainer can use in her class to illustrate the need to recognise and manage emotions – and to apologize:
➢ *"The time I talked to the mother very irritated I didn't even want to listen to why the parent was refusing her son to be inserted with an IV line, thus she thought like we are forcing her to accept things and the son is hers. When I discovered I was running by becoming so mad, I calmed down asked for pardon, talked to the mother in a better way and explaining all the importance. The mother opened up and told me that we were harassing her a lot and she promised to cooperate when we attend to her with calmness."*   HCW, Kilifi

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To be able to practice the strategy to create a safe learning environment based on communicating with respect and appreciation, the trainer must learn emotional competence: She must learn to recognise her own emotions, and be able to acknowledge, analyse and manage them in such a way that she can focus on participants' emotional safety, needs and

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> *learning process. She must be able to practiceemotional intelligence skills and be present with the participants, without being side-tracked by e.g. her own thoughts and/or fears. This gives a basis for good facilitation.*

Recognising and Stepping back from automatic reactions

Automatic emotional reactions to how people behave are common and can create major problems in the patient-provider interaction and in trainer-participant relationships. A main challenge and task for the trainer is to learn to recognise, acknowledge, analyse and step back from her own automatic (emotional) reactions – i.e. to practice emotional intelligence. She needs to learn to handle her own and course participants' emotions constructively to be able to establish and maintain a safe learning environment in the classroom. We call this skill **to "step back" from the automatic reactions to emotions**. The basis for the skill is best developed through awareness training over time, to gain the necessary self-insight and confidence to be able to handle such challenges wisely. The trainer needs to be able to recognize and acknowledge her own emotions (e.g. frustrations, disappointment, anger, fear), and step back from them, and also to recognize and handle such emotions in the participants.

When using the skills of awareness and stepping back, the trainer creates the "mental" space to choose the right action to guide the class.

The challenge: Providers say they often react with anger if e.g. patients don't follow advice, or don't give the necessary information, or have their own ideas about their illness and treatment: this is experienced as a challenge to providers' authority, and can cause an automatic emotional reaction:

> ➤ *"When I shouted at the parent because of not following instructions, the parent feared me so much that she could not share with me anything, not even something to do with the patient. Hence I could not give quality of care because I did not know more about the patient."*
> *HCW, Kilifi*

Many also react automatically to criticism from patients, colleagues or supervisors, and react with anger or "attack", covering up the painful feelings. When faced with dying patients and their relatives, insecurity and helplessness can be covered up by coldness, covering up an inability to relate to emotions of the patient or relatives.

Based on learning from the preparatory exercises (observation and reflection tasks), and on the work we do in the course, participants learn to recognize, acknowledge and respond to the emotions "on the surface" by stepping back from the automatic reactions and communicate in an open and respectful way – they learn to practice EI. Understanding the emotions behind the reactions (in themselves) enables them to find ways to respect and take care of these and be able to react constructively.

Participants say that the skill of stepping back is the one which has enabled them to make the biggest change in their practice with patients. Many also say that this skill has helped reduce the number of conflicts with patients and colleagues and has reduced burnout.

> ➤ *"When angry I usually feel very disturbed, irritated like I can swallow someone. One time a colleague annoyed me, and I felt very bad. Nowadays when angry I step back, accommodate, then reflect and with a lot of respect I approach the person for dialogue hence solve the problem."*
> ➤ *"I step back. If it's at work I take a little time away from the situation causing the anger (a short break). Then if it needs assistance by second person I discuss with my colleagues and later plan on possible best ways to handle the situation."* Both quotes: HCW, KIlifi

Managers in several sections of the hospital have confirmed that trained providers use these skills, during feedback meetings with the project, and in an independent evaluation report in 2011.

Background: Why is understanding emotions central to trainers' skills?

Emotions are a natural part of life – and of being sick. It is very normal to be worried (*or scared or desperate or angry*) and feel vulnerable when your child or you yourself are ill.
Patients have a need for these emotions to be recognized, respected and met with kindness, skills and concern. When patients are met with empathy and given emotional care - *in addition to receiving medical care for the disease*, it has a positive impact on the outcome for the patient.
It also has a positive effect on the provider.

Understanding emotions is also a central skill relating to how you relate to colleagues and supervisors – and the trainers need to have good skills in managing their own emotions and in guiding others to recognize and manage **their** own emotions. These aspects are described more fully in the module on emotions (Module 2c), and are a core part of the iCARE-Haaland model.

These are important aspects of patient-centred care (PCC), where a healing relationship between the provider and the patient and his/her family is the basis for good communication and shared decision-making.

There are of course a number of other reasons for the problems faced by staff and patients in health institutions. These problems are severe in countries where providers work under pressure of limited resources and a high disease burden. However, the problems are also severe in countries where resources ARE available: In the UK, the Mid-Staffordshire report showed how staff acted in cruel ways to patients and were allowed to continue their behaviour over a long time, despite colleagues knowing what was happening. Lack of recognition of management of emotions as a key challenge for health personnel is a global problem which is gaining increasing attention.

Communication skills alone cannot solve these problems. However, learning these skills, and learning emotional intelligence to be able to recognise and manage emotions, do seem to make a large difference in how providers relate to their challenging situation, how they treat patients, and how they build up their own confidence. The trainers' skills in these areas are essential to them being able to plan and implement a good training course and help providers learn to handle emotions.

Does caring about patients' emotions take time?

Initially – yes – as with any new skill you try to include in your routine work. As you learn to manage emotions with more confidence, it actually saves a lot of time: When you know how to handle patients' emotions, establishing trust and good collaboration effectively from the start saves time for longer term management. Patients also understand and learn quicker when they can have an open dialogue with the provider and are free to ask questions. This also frees up providers' own time, by preventing her from a number of worries: She has a functional and positive professional relationship with the patient, they are partners in care.

"Before, I believed I did not have time to explain issues to patients but have realized we don't need that much time to talk to patients. I realized if I communicate well with patients my work is so much easier"
HCW Kilifi

Communicating with colleagues and supervisors also improves
Participants have also noted that communicating with awareness with colleagues also saves time: There are fewer misunderstandings, and the collaboration in the team is often improved. Open, clear communication helps build trust and good relationships among colleagues.

In the hierarchical system, communicating with supervisors is often a challenge which is highly influenced by fear. However, awareness and skills to recognise and manage emotions can change this:

➢ *"Before, I used to treat these people with unknown fear and cowardice for no reason at all. But now I am very free with people I respect especially my supervisors. Thanks to this training. I am now very free and I am in a better position to discuss."* *HCW Kilifi*

Some participants have also given feedback to supervisors on how they experience the way they and their colleagues are being addressed, and thus giving supervisors who misuse power – often based on this being "just the way things are", or old habits, a chance to change:

➢ *My supervisor acts and addresses people, regardless of how you feel. After sharing my knowledge and skills with him from the training, he's really changed."* *HCW Gambia*

7.4.6 Being present and genuine
Being present is yet another central training skill that makes an important difference to the quality and effectiveness of facilitation in our training course. We have chosen to describe this skill in some detail here, as it is difficult to find material describing this skill, and as it is so essential to this training. As with most skills, the ability to be present comes with experience and practice, but – there are many good reasons to try to increase the speed of the learning process. This section gives some suggestions for how to do this.

Being present requires that the trainer is able to recognise and manage emotions. With these skills as the basis, the rest comes easier.

It is in many ways difficult to describe exactly "what happens" when you are present, and how it works. The key aspect is that being present seems to **reduce or remove fear and judgment** – in the trainer (e.g. for not being able to do a good job/explain well enough) and in the participants (e.g. for not appearing "clever" enough) – and frees everybody up to focus on learning together, and to trust

the process. Being present makes the creativity flow, and it helps making a connection to the other person(s), and to build good relationships.

When the trainer is being present, she focuses the full attention on the participants and on the learning process and does not let the mind wander. This skill enables her to understand well what participants are saying and ask questions to focus an issue for the group. The participants will feel that the trainer respects and values them and what they are saying and are concerned about – which again sets the stage for learning deeply: The trainer and the participants all learn by exploring issues together, without judgment or fear.

Learning to be present, and use the skill in the training, requires conscious effort and practice.

When working with patients, being present is also a very useful skill – it has the same effect on patients as a trainer's presence has on course participants: **Creating a feeling of safety and calm which enables an open communication, without (personal) judgment**. Thus, what the trainer demonstrates, participants should also be encouraged to start practicing.

Being present is also an important skill to practice, to prevent stress and burnout. The skill is useful when faced with challenging situations related to emotions (e.g. when meeting a person who is anxious), and in recognizing and stepping back from automatic reactions. The skill depends on having good boundaries – to focus on self-control. You do not control others, and you do not let others control you.

How being present works for the trainer:
➢ *"To be present is to focus your full attention on what you are doing – with your mind, your emotions and your body, and to shut out everything else which is going on in your life. As a trainer, this is a most essential skill, and a main tool to connect with the participants and facilitate their learning."* *Trainer, Kilifi*

It is very comfortable to be faced by someone who is present – the participants feel seen as persons, and – very importantly – they are not judged. A trainer who is present is exploring the subject with participants, with the intention to learn, together.

For the trainer, "something" happens when you are fully present: You are fully aware and have full access to all your knowledge and information. It seems almost effortless – by not "trying hard" to remember, the knowledge will "come to you" when being fully present and focusing on the issue or challenges of the moment. The fear or concern about what to say next is reduced or disappears, and makes you feel at ease with what you are teaching. Focusing on "being there" somehow frees the mind and opens it up to remembering what you need. The skill is not easy to learn, but becomes better with practice.

NB: This DOES assume that you know your subject well – that you have all the information and the background needed. Sometimes, being in front of a group fills a trainer with fear or insecurity, and she may forget what she knows. By learning to be present, many experience that their knowledge then just "comes" or "flows" through them naturally, and they are not afraid of failing, or not being "good enough".

Being present happens in an instant. So does <u>not</u> being present, e.g when an upsetting thoughts triggers emotions based on past hurts or future fears. With practice, you can learn to control it.

What happens when the trainer is being present

The trainer who is present can connect with and guide the participants effectively. The implications and practical effects of being present are many:

- **The agenda is to learn – you have no other agenda**: This frees you, and make you credible
- **You are in complete balance**, emotionally, and are open to receive any feedback or issue participants bring up: you easily connect emotionally with others, and manage the connection in a natural way;

The lead trainer in Kilifi, Mwanamvua Boga, practicing being present. Kilifi, Kenya

- **When present**, you have the ability to connect with and guide participants with respect, and you do not make them feel intimidated;
- **You listen well,** with the intention to understand;
- **You perform** better under pressure;
- **You are able to solve conflicts well**, as you are not "triggered" emotionally;
- You are more **patient and tolerant** of difficulties;
- **Makes the learning sequence natural** – you can follow their contributions, and derive learning: For example, when a participant tells a story, being present enables you to follow the story without being afraid of missing the point. It becomes easy to pick out or follow up on the main issues;
- Enables you to **pick out non-verbal communication cues**;
- Helps you to **stay focused**;
- Makes **the learning more creative, and enjoyable**;
- Makes it **easier to use appreciation as a natural, conscious motivation** and learning tool;
- Makes you **more effective** – the work gets done faster;
- **You do not judge** – neither yourself nor the participants. This enables the participants to be honest, and to share without fear of being judged. This does not mean you are not able to see what is "right" and "wrong". It means you do not reject what participants say, but rather acknowledge a point, and explore it – thus making the learning process "flow", and the learning feel safe.

Effects of being present, on participants

Presence is to some extent "contagious" – when the trainer is being present, the participants are more likely to be focused on the task being discussed, and to be connected with the trainer. The connection becomes very natural and very direct when you are present. It helps to make participants able to concentrate and inspires them to think, and to think critically.

Participants will experience the facilitator as **authentic and credible**, and will feel safe, without fear – helped also by the safe environment the trainer has created. Being present helps the trainer to be just there, not interrupting, but listening actively with body, mind and soul, as the participants pour out their heart and share very personal and often painful emotional experiences. The participants will feel that the trainer is caring and respectful, and acknowledges and understands what they went through, without judging them. When the trainer does not judge them for their actions or contributions, participants are also more likely to start listening and exploring an issue or challenge – with the intention to find out and to understand, rather than to judge someone for what they did, or did not do (which many people do quite automatically).

A note on judging

It is of course essential to be able to judge when working with medical issues, and judging is necessary to make the right decision e.g. on what to treat for, and how to treat. The judging we suggest has a negative effect on interpersonal relations and on communication is the (often automatic) **judgment of actions people take**, and (again automatic, or implicit) **of the person taking these actions.** This judgment is often made without asking about or exploring the reasons behind what the person does. ***When looking for and finding out the reason, empathy and understanding most often replaces the automatic judgment***: ***There is a reason the person did what he did, and that reason makes sense – from <u>his</u> perspective. With this understanding as a foundation, a fruitful discussion can take place.***

An example:

- *"Before the course I used to be irritated when handling a difficult patient/relative. The course has shown me that for every stubborn client, there is a reason behind and instead of getting irritated, I nowadays probe to get to know the reason behind. The concept of the tip of the ice-burg has made me aware of clients/patients' needs and has helped me advance with care to avoid them exploding on me."*   *HCW, Kilifi*

If the trainer judges what participants say and do, the atmosphere and energy in the training will feel "poisonous", and good learning cannot take place. Everybody will instinctively and automatically protect themselves from the judgment and will not be able or willing to share personal issues.

How do you notice when you are not being present?

When a person is not feeling comfortable, is insecure, or is having emotional concerns - it is often difficult to be present, or aware. In such a situation, the natural tendency is to focus on oneself, and therefore lose connection to others: You are not practicing emotional intelligence.

As a trainer, you can often notice this situation by you doing some of the following:
- **Struggle to explain something**, knowing you are not being clear or making sense or asking concise questions, or
- **Struggle to engage the participants**, feeling you are "losing" them – and no one is speaking up or saying they don't understand, or
- **Pushing participants too hard**, or
- **Wanting to impress**, or
- **Rush to finish all your points** - focusing on your own goals, rather than on participants' understanding and learning, or
- **Feeling irritated, getting angry**, or starting to judge what they are saying/not saying, or
- A combination of several of these points.

When you lose connection with the participants, they will pull back, emotionally, and will often not engage with the contents or with the learning. It is thus essential for the trainer to learn to recognise when she/he is losing the ability to be present (i.e. some emotions have "taken over"), and take steps to set the emotions aside, and get back on track. If the connection with the participants is in general good, then it is usually not to hard to get it back. It requires genuine openness, acknowledging what was happening, and focusing the group on the common goal – to continue learning, together.

The role of the co-trainer or assistant trainer is also to help the trainer stay present as much as possible. The most common "trap" to lose the ability is when something happens that makes the

trainer insecure – a situation, or a question, or anything else that the trainer does not feel able to handle well. The assistant trainer can then come in and help, respectfully – and **always** at the invitation of the trainer. If the co-trainer "jumps in" when the trainer has difficulties – with the best intention to help - it can easily be perceived as a power play where the trainer is not "coping" and needs to be "rescued". When invited in by the trainer, the assistant trainer can then e.g. emphasize a point that has been made, or give a question for reflection to the participants, or suggest an energizer. Such a supporting intervention gives the trainer a "breathing space" to regain her/his confidence. When a collaboration between trainers functions in this way, it provides safety for the trainers as well as for the participants, and makes everybody able to focus fully on the learning.

Learning to be present
Trainers are encouraged to look for resources (colleagues, books, articles) to strengthen their skills to be present. During the last few years, "mindfulness" has been recommended as a very useful practice (also for health professionals) to train the mind to be focused, see e.g. an article where mindfulness training was shown to reduce burnout among health personnel[119]. Mindfulness is a kind of meditation which can be practiced for shorter or longer periods.

A few practical hints on how to learn to be present:

- Being present begins with **noticing what is going on**, and focusing on the Here and Now;
- **Take a deep breath** – breathe, and pay attention: being present starts with the breath.
- **Be super attentive** - learn to focus completely on doing that one thing, with the mind and the body. Avoid letting your mind wander.
- **Observe closely** what you are doing, and stay with it, in the moment.
- **Come back to the breath**, and focus on this, when new thoughts are entering your mind (which they will).
- **Accept that you may not know the answer** to questions coming up.
- **Keep practicing**, and soon being present will become natural.
- **As you practice,** your self-confidence and self-trust grow. You feel safer, which lets you be present with others;
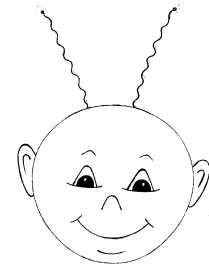
7.4.7 Encouraging participants to take responsibility for the communication

It is common to blame others for misunderstandings or for communication that does not function well – not only among health providers. This habit often leaves both persons involved, dissatisfied, and does not solve the problem or issue leading to the misunderstanding. It is frequently also dis-empowering, and drains people's energy.

During the period of self-observation and reflection, participants start to get a different perspective on this habit: They see that by paying attention to how they communicate, and to the effects of their communication on the other person, they have a choice to act differently. With a different choice in how they communicate, e.g. by listening attentively rather than interrupt the other person, they get a different effect, or response. With this knowledge and experience, they often take the step towards taking charge of the communication, and taking responsibility for the outcome: they know they can guide an interaction in a good way.

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[119] Krasner, M.S, Epstein, R, Beckman H & al (2009): Association of an educational program in mindful Communication With Burnout, Empathy, and Attitudes Among Primary Care Physicians. *JAMA*. 2009;302(12):1284-1293 (doi:10.1001/jama.2009.1384)

The trainer, who has been through the same process of discovering the effect of his communication, on others – knows that guiding the participants towards strengthening these skills is the most important outcome he can aim for. When the providers see and acknowledge these skills, they are empowered.

7.4.8 Handling criticism as a trainer

Participants in training courses make mistakes that often need to be corrected. The question is – how, to obtain a good result for them, and for you? Again, the use of emotional competence is needed – to recognize when you are about to/feel the need to criticize someone automatically, and take a step back before deciding how to deal with the situation.

It is equally important to step back from the (automatic) need to defend yourself from criticism given to you by a participant or a co-trainer. When you role-model such behaviour, it will be noticed by participants, most of whom need to learn skills to handle criticism with awareness and wisdom. The trainer can use experiences of criticism in the course as examples of how to handle criticism, constructively. Further background on this is found in the modules on how to handle conflict. Note also – in the observation and reflection tasks from the course in Wales, there are tasks on becoming aware of how you give, and receive, criticism. These can be used in a course for providers.

To criticize someone negatively is often an automatic reaction from the trainer's (or provider's, or supervisor's) side. We call it "destructive criticism", because it can have a very bad effect on the interaction, or the relationship, and on patients' and colleagues' health. When happening in class, it can poison the learning atmosphere and negatively influence the connection between trainer and participants: The other participants will often "side with" the participant being criticized, and you can get an "us, and them"-conflict which polarizes the group. When this happens, it is crucial to take time to handle the situation with humility, awareness and emotional competence, and look for the reasons behind the conflict: By exploring this, and resisting the urge to judge, the trainer may provide an important example of how to handle such situations. The trainer can add a "de-brief" afterwards, when the conflict or situation has been solved: Analysing what she did, skills she used, and why (recognise the emotions, take a step back, think, look for reasons the conflict happened, from both sides), and then look at choices she had for taking action. Such examples, where participants have been directly involved and then experience how the situation can be dealt with in a wise way, make a lasting impression they will carry with them after the course. Participants will experience that their emotions have been recognised, taken seriously and respected – and this gives them a feeling of satisfaction and pride which they will likely remember when they handle such conflicts themselves in the future. The trainer is here a very important role-model.

Example 1: Handling participants who did not want to be in the course
Why volunteering matters: The course is based on participants volunteering to participate, as we expect that a person who has seen the need to improve her communication skills will be motivated to learn. Those who do not think they have a problem with their communication will often find it a waste of time if they are forced by their leaders to attend the course and may disrupt the course for participants who are there to learn, and for the trainers who will facilitate the sessions. The example below illustrates what can happen and tells the story of how the trainer handled the "difficult participants" – using respect, setting boundaries, confronting with awareness rather than judgment, exploring reasons for their emotions, and – giving them real options to stay, or leave.

> ***When participants are "volunteered": Sabotage is often the result***
> *"There are of course some providers who are seemingly lazy, unmotivated and have their own personal problems that cannot be addressed or solved by this training. However, we assume that they are few, and that they will not volunteer for the training. We DID have some such participants*

who were "volunteered" to the course by their managers, who wanted them "to change their negative behaviour". This happened in two courses. In both situations these individuals, who were in a small group, did their best to sabotage the learning process by using sarcasm, verbal and non-verbal judgment of colleagues (and sometimes of trainers), and resistance to the learning. They clearly showed their hostility and frustration at being in the course. After two days of respecting them, giving them opportunity to learn but setting boundaries for their influence on the learning environment for the others, I decided to confront them.

I asked why they were in the course. They said they had been forced to go, "by the boss". I asked how they found the course. They said they did not need communication skills, they were doing well with their patients. I asked why their manager had then sent them. They said "She just does not understand". I acknowledged that this is often the case with managers, and that communicating with supervisors is an important topic in the course over the next days. I gave them the option to leave the course, or to stay – and that if they stayed, I would expect them to stop the negative behaviour, to participate in exercises and discussions, and to be constructive. I discussed with them the reasons for my decision – that their negative attitudes are "contagious", and that other participants are affected by these, and are thus less open to share and to learn. I said I would not tolerate this.

In the first course where this happened, two of the group of four providers came back on the third day, and participated carefully throughout the rest of the course, without sarcasm. They thanked me afterwards for showing them respect and not judging them, like they had been used to by authority figures. They acknowledged that part of the problem was their own aggressive style of communicating and said they had now got some other options they would try out. They were very genuine, and humble.

In the second course this happened, two very vocal participants were constantly challenging what we were doing and were clearly not happy being in the class. Again, I took them seriously, but confronted them in an exploratory and non-judgmental way, asking for the purpose of their behaviour (one of them appeared very angry, most of the time). They were surprised, they reflected, and responded that they had no clear purpose – they were just frustrated.

I again gave them the option to leave, but they both decided to stay. One of them told me later that the conversation they had with me, had been an eye-opener. Her anger had been acknowledged and listened to – without being judged. She had shouted so loudly, for so long, without being heard, and now she was finally being listened to. I promised her we would continue to listen if she stayed. She did – and her anger became a constructive example, someone participants could learn to listen to, and practice "hearing what was behind the anger" – rather than act automatically, on their own fear. Anger can be an important teacher – when you respect it and take it seriously, and find out what are reasons behind the anger.

The "troublesome participant" had become a very important teaching companion. She became very cooperative and constructive, once she trusted my intention – to help everyone learn, also from her."
                                                                                Ane Haaland, trainer

Example 2: Handling a participant who criticized the trainer

Trainers are often managers and supervisors, and sometimes have their juniors as participants in their training sessions. We experienced a situation where a participant brought up an example of how he had experienced a situation at work, where his supervisor, who was one of the trainers, and was present in the session as an observer, had taken action which he felt was unjust, and had negative effects on himself and other staff.

The supervisor/trainer naturally felt attacked, and the training team became unsettled. The lead trainer had to step in and calm the situation by talking to the individuals, and finding a solution to the conflict. The team was not prepared for this situation, but has reflected on it and learnt from it. We are proposing the following guidelines if something similar should happen in your course:

- **The training team should be aware** that this situation can happen, and develop strategies to handle it, with awareness;
- **A key guideline** is for the trainer to remain professional, and not take the issue personally - even though sometimes it may even be meant to hurt the trainer/manager personally.
- If the trainer in front of the group hears an example that implies a criticism of her, directly or indirectly, it is natural to feel insecure. There are three main choices the trainer can make:
  - ✓ **If she feels she is aware**, and able to handle the insecurity in front of the class: Step back, listen, and focus on getting out the learning points for the group – if there are general points to be learnt. In this case, the trainer should "pretend" that the manager causing the problem is someone else than her, and discuss it as a case, emphasizing the advantages of learning from real situations. As there are emotions on both sides involved in the conflict, it is important to make everyone aware of this. You can then use the example to demonstrate how to handle such a situation with awareness and respect for both "sides". See also chapter 9.1, where we describe how a conflict between two leaders "broke lose" during a training session in Lithuania, and how the trainer used this real example to facilitate insights and develop skills.
  - ✓ **If she feels threatened, but still aware enough to deal with the issue up front**, she could acknowledge the situation and inform that she is a part in this, thank the participant for bringing it up, and suggest that this should be dealt with in the team. She should reassure the participant that she will make sure the issue is discussed soon, after the training course is finished – and then make it a priority to do so. This will make the participants feel that good supervisors can be challenged, and have the skills to step back and deal with the issue professionally.
  - ✓ **If she feels threatened and not able to deal with the issue up front –** thank the participant, and suggest they discuss how to deal with this issue in their groups – both from the managers' perspective, and from the participants. The trainer should use the time to consult with her trainer colleagues how to handle the subsequent discussion, and get one of them to facilitate.

A key objective would be to not make the participant feel guilty for bringing up the issue, and to role-model open and responsible professional strategies of dealing with it – with respect for both parties. See also the modules on conflict.

7.4.9 The difference between TELLING ABOUT it, and SHOWING it

The most powerful and memorable moments in a training course usually happen "on the stage" - when participants or trainers demonstrate situations everybody recognises. These are also the moments and exercises that result in deep learning that often leads to behaviour change:
- **The doctor** speaking to a mother who has just lost her child, and talks about the medical reasons he could not save the child. Participants immediately empathize with the mother, and "feel" her pain, and see the doctor's inability to respond to her emotional need;
- **The nurse manager** blaming and criticizing the young nurse for a small mistake, in front of her peers: Participants empathize with the young nurse, remembering their own pain and shame from having been in similar situations. Many have probably misused their power in similar situations, and make a promise to never do it again;

- **The nurse** blames the mother of a malnourished baby who is not putting on weight, for neglecting her baby, not wanting her to get well. Participants' hearts go to the mother – most of them are mothers or fathers themselves and know that (usually) no mother will want to harm her baby. They empathize with her pain and wonder what is going on. At the same time, they understand the nurse's frustration, but experience the effect of her frustration on the mother, who is in a vulnerable position.

The demonstrations enable participants to get a perspective on everyday situations by seeing "themselves" from the outside and connect emotionally with the patient or with the nurse being criticized. The emotional link here is the clue – and this stirs an inner motivation to "protect the weaker part".

These demonstrations are usually followed by a reflective discussion, exploring possible reasons for the behaviour – on both sides. Participants are then divided in groups of three or more, and get a role play script where reasons for the behaviours on both sides are spelt out. With this knowledge, they are then asked to play the scenario again, using the knowledge and (emotional) insights they are given, and then choosing a more constructive interaction. Their experiences are then further discussed and reflected on in plenary, focusing on learning and insights from the exercise.
See also scrips for demonstrations, role-plays and exercises at the end of each module.

Such methods – especially demonstrations and role-plays - have a strong impact on the participants. When meeting "old" participants several years after the course, the demonstrations and role-plays are what they remember very clearly. And – they remember the learning points and tell stories about how they have used the insights to change their own practice.

The picture is from a role-play in a course in Kilifi in 2010.

"Telling about" a situation is much easier and takes much less preparation. Such stories are much more easily forgotten, as they require only cognitive involvement from the participants: "Thinking about it" rather than "experiencing and feeling it" – as is the case in demonstrations and role-plays. Participants may still take with them useful learning from such stories and examples, but – it is their own emotional engagement from watching and engaging with "the underdog" in a demonstration and subsequent role-play that makes the learning stay "glued" in the brain.

Thus, our clear recommendation is – whenever possible – show, don't tell.
Participants can also be invited to spontaneously show how the situation/challenge they describe, "looks like", by demonstrating it – together with a trainer og another participant. To be able and willing to do this, they require that the learning environment feels truly safe and supportive.

7.4.10 Appreciating – but not evaluating - participants' contributions

We are recommending trainers and providers to use the practice of appreciating each other in the course. Appreciation is not frequently practiced in medicine but has the potential to turn a medical situation into a humane one: See e.g. "The Power of Praise" in the Lancet editorial[120].

Criticising people is often an automatic habit we carry with us: many have grown up with this, fuelled by parents, family members and teachers who believe that being criticized will inspire the person to perform well. In some cases it might do so, but – using appreciation, consciously, has a much better potential for motivating a person to learn.

Carl Rogers, in his ground-breaking research on person-centred care, concluded that there are three aspects or skills of a health professional that make the biggest impact in the provider-patient relationship: the provider's ability to be genuine, and to use appreciation and empathic understanding in his work. The same aspects are essential in the relationship between a teacher/trainer and her students, and between a parent/caretaker and his child.

It is important to emphasize that using appreciation, consciously, does NOT imply that one should not talk about or learn from problems or challenges: This is of course essential when learning good skills to communicate and manage emotions. Using appreciation means just that – to use (almost) every opportunity to point out and appreciate when someone has contributed important points or insights.

There is a big difference between *appreciating* and *evaluating* participants' contributions in the training, and it is essential that the trainer is aware of this distinction:

- **Appreciating is to value as important what the participant contributes**: The trainer "shines a light" on what a participant has said or done. The participant may have brought in a new perspective, or spoken for the first time, or shown courage to share a very personal story which others can learn from, etc. The trainer can then **thank** the participant for bringing up the point or can **highlight it as important** – thus appreciating the participant for the contribution or insight. She can add, or ask – why is it important? She can then encourage others to discuss and reflect, and share their own examples, and appreciate the importance of these aspects.
- **Evaluating what the participant says or does brings in the <u>competitive</u> element** in the training, and this can be very disturbing: If the trainer comments on a contribution as being "very good", he evaluates the point, and sets himself as "the judge" with "the power" to judge between "right" and "wrong", or good and bad. This dynamic creates expectations of being continuously evaluated, so if the trainer does NOT comment on another contribution being "very good", the participant may start wondering if what she said was "bad", or "not good enough".

This may seem like a minor difference, but – it makes a major effect in the training course. When the trainer appreciates a participant for contributing, she invites the others to also contribute – from THEIR experience and perspective, and to bring in other important points. It is not a competition, it is an exploration, with the aim to understand and to learn from each other. When you evaluate, it sets up a system where some participants are "better" than the others – which again introduces jealousy and other non-constructive feelings.

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[120] The power of praise. Editorial, www.thelancet.com **Vol 376 September 11, 2010**

7.4.11 Trainers' reflections on why the training is important

During a meeting in Kilifi to discuss inputs to the training manual, trainers emphasized a number of aspects that had been important to them in the training (as participants), and which they now felt they had solid basis for emphasizing with their own training participants.

A few of the main points:

Feeling safe

The importance of feeling safe was emphasized as a main aspect of the training:

- ✓ *"Feeling safe – by not being judged or blamed – gave us freedom to speak out, even about bad things we had done."*

- ✓ *"The reflections gave perspective, and space and motivation to learn."*

Experienced trainers in Kilifi

Sharing experiences

It is important to give time for participants to share experiences during the workshops. These discussions made them realize that they are not alone in what they are going through, and that the discussions motivated them to find solutions – together.

Observation tasks: Building skills to facilitate informed empathy

Trainers described the gradual process of seeing and feeling the effects of their own behaviour, on patients. They increasingly saw the patient as a person, as a partner in care, and managed to establish professional relationships with the patients. They shifted the focus from themselves ("just getting the job done") to the patient ("being there for the patient"). This relationship enabled them to practice empathy, and experiencing the effects of this, further motivated them to communicate with respect and compassion. The experience of having learnt this themselves enabled them to empathise with participants and really understand their situation – and support their process.

Example: Learning from colleagues' feedback and own action:

A trainer contributed the following reflections about using the observation and reflection tasks, during a meeting when the trainer group in Kilifi discussed which aspects of the training were important for participants' learning, and why:

> **When you discover the need to change, you become committed**
> *"In my own experience I have found this method of self-observation and reflection extremely powerful in the sense that a lot of the times when you observe yourself you reflect on your own actions, it sort of comes as a discovery to you. Often when you are told you have to change this and this - because it's coming from someone else you hear it like a sort of a criticism. But when you take time to observe yourself and actually discover that there is this part of my communication that I need to change, you sort of make up a personal commitment to actually work towards that. It works hand in hand with that personal reflection of what you are doing, how you are doing it and what impact it has on yourself as a person and what impact it has on the other person/people you interact with. So for me as a person I have found this particular aspect extremely powerful in the sense that it sends a very strong message to yourself. Okay, it's like sort of… I will say for lack of words - it's like subscribing to a particular religion where you make a personal commitment to*

follow the rules and the commands in that particular religion, without anyone telling you this is what you must do."

Lead trainer: Can you tell us if there was anything in particular that you did, which made you come to this realization?

"Well, quite a number of issues, but a lot of the reflection and observation I get comes from at first getting feedback from colleagues and friends that there is something that you do that has some kind of reaction from the people you interact with. For example, I'm a community facilitator and a lot of the times I interact with community members in trainings. When colleagues observe me and they give me instant feedback, a lot of the times it is not very easy to understand what these guys are talking about. Later, I set aside some time to just reflect on what my colleagues have told me, and I make a personal commitment that next time I'm doing this I'll have a conscious effort to see what exactly I'm doing. So when I do that I discover that actually I've done what they said, and this is the reaction I get from the audience. I then say to myself – "okay can I do something different". So next time I do it, I'll do something different and I'll also observe what reaction I'll get from the audience and that sends a very strong message to me."

Lead trainer: Okay, so you are observed by your colleagues, they made you aware of something, then you take it up on you to look at how you conduct this action, for yourself?

"Yes, and then I get this strong "Ahaaa!"-experience. A more recent example is the feedback I got after facilitating in one of the sessions in our training where I was using such powerful words that were sending somehow I would say a different message from what I meant to the audience. I was using words that those who were giving me feedback said were very authoritarian. So when that came to my attention, the next session I made a conscious effort to actually ensure that I didn't use those words and all through the facilitation I was reflecting on what I was doing. I'm trying to see if there is anything that I'm doing which is having any sort of impact on the reaction of the audience. I'm sure enough after that session I didn't receive any feedback related to what have been said previously.   *Francis Kombe, field worker trainer, Kilifi*

Trainers' conclusion
- ✓ *Before, we thought the problem was with our patients, and that there was nothing we could do. Now, we find there is a lot we can do.*
- ✓ *This inspires us to continue using the methods and continue learning.*

When trainers are experiencing, recognising and acknowledging their own process of change as communicators, they are much more able to use these insights and skills to teach others. Thus, it is crucial for the trainers to go through the process of observing and reflecting on their own communication and emotion attitudes, skills and behaviour first, and only then train others.

Characteristics of a trainer who communicates and manages emotions, using the iCARE-Haaland model methods

- An aware communicator – approachable, professional
- Creates a safe, friendly learning environment
- Appreciates participants and make them feel welcome
- Learns participants names, uses them: sees every one
- Manages participants' learning well, and is organized
- Handles talkative participants with awareness, respect and appreciation
- Encourages quiet students to be involved and to talk
- Clearly enjoys teaching; is enthusiastic about subject
- Inspires participants to think, reflect and share openly
- Recognises participants emotions, including vulnerability
- Respects others' knowledge, skills and emotions
- Does not judge participants, verbally or non-verbally
- Curious, always willing to learn new things
- Good listener; asking questions that make people think
- Is a good role model
- Very knowledgable about her subject matter and can exemplify and simplify concepts: can stimulate participants to learn and get insights
- Can "read" the group and recognize when issues are not clear, and take actions to clarify
- Knows his limitations
- Ready to admit when he does not know the answer: Finds the answer and gives it to the participants ASAP
- Accepts and reflects on criticism, verbally or non-verbally
- Uses humour with awareness and wisdom
- *See also article: Optimizing adult learning[121]*

Mwanamvua Boga, lead trainer, in action

7.5 Reflections from trainers on needs for and impact of training

See also reflections from trainers throughout the manual – e.g. from lead trainer Mwanamvua boga at the end of chapter 1, and Cardiff trainer Thomas Kitchen.

"I am a better professional now"
"This training has empowered me to work as a much better professional than previously. When I reflect back on how I used to work before the training I wonder and think "what was wrong with me? What was I doing? Why wasn't I able to see what was happening?" I have developed that sense of awareness in all that I do and see clearly in every situation that I encounter. I always see my role in that encounter and how best I can proceed that will be good for everybody.

In every encounter at work (with my patients, my colleague's) I most often approach them with a lot of awareness. I have acquired communication skills and the ability of to manage emotions in myself and in others. With these skills, I am now able to step out of my comfort zone steadily, and boldly deal with many challenging situations without having to always confront in a negative way, or to ignore or run away from them! Memories of how I dealt with these situations earlier

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[121] Mellis, C.M (2008): Optimizing training: What clinicians have to offer and how to deliver it. Paediatric Respiratory Reviews 9, 105–113

sometimes could come back to haunt me and become bigger stressful situations. I have stopped reacting automatically and instead dealing with issues consciously and constructively.

At my workplace, often I have seen applying the skills has greatly improved my relationships with patients, colleagues and even supervisors. Most patients are comfortable and trust me when I am attending to them. Sometimes they would tell me problems which don't directly concern me. One day I asked a parent to a child with malnutrition who was complaining that they are not getting enough milk for their children hence the reason why they were not gaining weight. I asked her what makes her ask me all the time and not the nurse and the nutritionist who are directly involved, she said… "Daktari, truly you seem to be the boss here and we should be fearing you more than the nutritionist and nurse but they don't listen to us and never understand us. All they do is answer us rudely. You listen to us and you always make sure that whatever can be of help to our children and can be done is done as soon as possible. So we have to tell you all our problems here"…I felt appreciated and motivated! I sorted out their milk issues."

<div align="right">

Hiza Dayo, Clinical Officer and communication trainer, Kilifi

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"To stand in the patient's shoes" - I never forget these words"
Rita Sopiene is a paediatrician and an important contributor to developing the iCARE model. She was in the first group of health professionals who received the training, and helped identify the themes and contents relevant for her and her colleagues to help improve communication with patients and colleagues in the TB hospital in Siauliai, Lithuania. Describing real situations and challenges they faced, and experimenting with how to deal better with these, the course started to take shape. Rita became the first trainer, in charge of a training group of 5 trainers at the hospital.

Rita's reflections on the training:
"This training gave me the possibility to look at myself - my communication with patients, colleagues and nurses. Do people around me understand me, my intensions, and my aims? For the first time I have understood what feedback is, and how it is important in my work. I also understood better how to use active listening and open questions. It was like somebody took away the "curtain " from my habits to talk to patients and people around me: This was something quite different from the way we used to work.

"To stand in the patient's shoes" - I never forget these words - they let me feel exactly what patients might feel talking with me. Now it is more easy to understand them, listen to them and find out the reasons they do not want take their medicine, or stay in hospital and so on...

Respect - not judge – is essential. I show respect to patients, nurses, hospital cleaners and all people around me. So I am trying to communicate without arrogancy.

I do not have much experience as a trainer – I taught twice in international courses on TB and communication in Tartu (Estonia), and a few times in Lithuania. I think it is easier to work in a team with two to five other trainers. In training, role play is an essential method to show examples of real situations going on around us in the hospital. Using role play helps us to reflect on our communication habits, especially when a problem is introduced by somebody demonstrating it in front of all the participants.

And of course, talking about feelings is very important: nobody ever asked me and other people around me about our feelings while communicating. Thinking and talking about my own feelings helps me understand the other person's feelings as well."

"The training is important, because people realize their own mistakes"
Esther Kamenye was a Namibian TB nurse when she joined the training in 2006. She realized that the training is very important and conducted research to assess how nurses are communicating with patients with TB, in Namibia. She found that patient had inadequate knowledge about TB facts, despite their daily communication with nurses – who also had inadequate communication skills. Esther first became a communication skills trainer, using the Haaland methods (2007), and then decided to develop guidelines on effective communication for nurses – for her PhD, which she received in 2014. She now teaches communication skills at the University of Namibia, where she is a Lecturer for Community Health Nursing Science.

Esther's reflections on the training:
"This training is far different from all other trainings I attended so far in my life because:
- ➢ *It is conducted after a participant identifies his or her areas of improvement by undergoing the observation tasks and baseline questionnaires prior to training*
- ➢ *This training is focusing on reflection and practicing of skills.*

A real Story:
I conducted communication training in March 2015 at the local University here in Namibia, tasked by the management of the University to do so. The participants were lecturers - these are highly qualified people in the country. The day when I informed them that I am going to conduct training on communication, their responses were:

"What - a training? We are all communicating already and we know how"
"That training is not our priority"
"That training is not necessary or needed - we need training on how to set up the exam papers"

I just smiled and reported back to the management, but the management informed them that "let us all undergo that training and since you say that you are ok with communication - let us refer to it as a refresher training on communication."

The day of training I started with a role play: having a lecture, a student and an observer. The participants were in groups of three. It was so good – very good everyone was involved. The role play was about a student who is not behaving in class, but at the beginning he was a good student. They started by saying "why are you coming late? why are you…..?" Information was given - but no communication.

After the role-play we then gave feedback. No one got it right, when it comes to the basic communication skills, especially constructive feedback. Then we sat and discussed, using slides and illustrations. At tea break, I realized that one of the lecturers remained behind in the hall, then she told me that the training was an eye opener, therefore she was calling her daughter at home to apologize, because she is always commenting by highlighting only the negative points.

End of evaluation form: they all recommend follow up training. One asked me to write a proposal and send it to MOH so that I can be given chance to train all nurses in the country.

The training is very important to everyone, academics or non-academics. Is important because a participant is able to change her communication behaviours by realizing her own mistake."

Do we need communication skills?

As healthcare workers we . . . apart from giving treatments, drugs and all that, we do a lot of communication. We communicate to our clients but the communication bit of it mostly has not brought the fruits that we desire. Looking at the problems we are facing now, things like prevention of malaria, family planning, behaviour change in terms of combating HIV - these are things a lot of talking has been done on them, but the question is - have we achieved the goals? Are people using family planning the way we would like them to? Are people using mosquito nets the way we would like them to? The answers to these questions - your guess may be as good as mine - that we are not satisfied with the way our clients are responding to our communication. We tell them to do this, they don't do it. So is it not time that we changed the strategy - the communication strategy, and embrace a model that works, a model that respects our clients, a model that appreciates them as persons with problems and try to see if that will help them to follow what we are trying to tell them? That model is the one we are using in this communication process.

So I believe the moment this way of doing things as the way we do it in communication if it is rolled out throughout the republic there'll be a lot of change in terms of the quality of care that we offer. And again if you look at the millennium development goals and even the Kenyan vision 2030, the achievement of these goals are basically hinged on communication. If you want to reduce child mortality it's not only about treating mothers but you also need to communicate to them so that they know how to prevent diarrhoea, how to recognize signs of disease in their children. So how do you do that? You communicate, but you need to communicate effectively so that they can understand what you are saying, so that they can follow, and that requires conscious communication which we are doing now. So I believe the answer to greater achievements in health lies in changing our communication strategy and adopting a model that will be effective and that model is the one we are using now; that's all.

Stevenson Chea, Communication trainer, now lecturer at Pwani University, Kilifi

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I have learnt the necessity to process emotions, not box them away…

I enrolled in this workshop after starting a new role as a junior anaesthetic registrar with the intention to learn strategies to equip me to become 'immune' to the feelings I was experiencing. I often had a feeling of 'imposter syndrome' and was finding it hard to switch off my inner critic. I was hoping that this process would resolve my fears of stepping up into a new job.

Working with Ane on her workshop was unlike any other course or workshop I have been on previously. This was simply, not just a workshop to tick a box on the CV. It was a process of getting to know myself. A unique six-month programme focussing on me. Posing questions I have never asked before. What are my values? what makes me angry, upset, feel vulnerable? How do I deal with emotions? In doing so I was now also able to recognise these emotions when I saw them in my colleagues and patients.

Before this training I had always thought that communication was one of my strongest assets, that I was 'naturally a good communicator.' This training demonstrated that not only can you learn but also improve on becoming a better communicator. Now looking back on the last 4 years and what I have learnt, it is safe to say I wasn't as good as I thought I was. Through my reflections I gained insight, that when I am tired, hungry or in a time pressure situation these skills are deemed as not essential and are the first things to go. Four years later I am aware when the warning signs emerge and allow myself to refuel guilt free -to benefit myself, my colleagues and patients.

I never went on this training to become a better communicator. However, by using the concepts of appreciation, authenticity and empathy I am not only a better doctor for my patients I am a better colleague, friend and person.

I am now looking for my post as a consultant. I reflect back to see that I have both grown professionally and personally. I have learnt that emotions are important. The necessity to process them and not to box them away. I have learnt there will be days when there are negative emotions and feelings, at those time I rely on the importance of positivity to fill up my bucket, which sometimes seems a hopeless task especially in a system where it is easy to see the short comings. But it is vital to see what good is out there and what I can do to contribute to it; even if it is showing a lost patient where to go in the hospital, or making a cup of tea for a colleague who has been working the last 12 hours without a break or should of gone home 3 hours ago. It is imperative we look after each other.

After the programme I was left feeling inspired and empowered to continue to practice the skills that I learnt. I was passionate to pass on this knowledge to my colleagues and this is where I became involved in teaching with the postgraduate doctors in the Welsh deanery from various specialties and training grades.

Words can't express my gratitude to Ane for allowing me to take part in this incredible journey. Like so many people Ane has enriched my personal and professional life with this amazing opportunity.   *Dr Isra Hassan, Anaesthetist and trainer, Cardiff*

The training has been an eye opener
"Before this training, I used to think I am a good communicator. So I took the course just to justify myself that I was a good communicator. To my surprise, I had a lot of gaps, I was not aware of my bad communications habits!

Each module has taught me a big lesson. Every time I teach a module, I discover more knowledge which inspires me to continue practicing the skills .

As a research manager in the busiest ward within the county hospital, this course has been very helpful for me. I meet different clients with a variety of needs, some have emotional needs because of the state of their children who are very sick, others are worried about their children who are involved in research, and overworked staff who think research is not a priority in care.

Once an angry parent was directed to me by a fellow staff so that I could assist him with his concerns as his new-born baby was about to be discharged against medical advice. It was my first time to see this parent, although as I listened to him, I discovered the parent had seen me several times in the ward.

The parent was requesting for discharge home because his new-born baby was not receiving adequate treatment in the ward after three days of admission and the mother of the child didn't have a comfortable place to sleep. He told me the nurses are always busy and don't have time to address his concerns but keep telling him to look for a clinician who will explain the condition of the baby.

I went to one of the nurses in NBU (New Born Unit) and requested her to talk to the parent but she said that's not her work, the father has to come back the next day to see the clinician. So I requested if I could try to talk to the father on their behalf, which she accepted. I requested to see the baby's file so that I could understand the condition and why admission is important. After a lengthy discussion with the father, giving him updates on the baby's condition, ensuring him that the treatment given is the best as it is the one recommended by the World Health Organization and that the treatment will take between 3 – 5 days, the father calmed down. He said if this had been explained to him all along, he would not have caused such a scene. We both agreed that at this

time our focus should be on the sick baby, and on the mother getting someone to assist her while she stayed in hospital with the baby so that she can have time to rest. The father was happy and agreed to let the baby finish the treatment as prescribed by the clinician. He said he has been seeing me and thought that I am the supervisor for the clinicians because I have answered him all his concerns.

Before the training, I used to treat patients as patients, never asked for their opinion about the treatment and it never bothered me when the patients stayed for long in the queue.

Now after the humanistic medicine module, I imagine it's me on that waiting bench, no one paying attention to my baby's concerns, every one being busy with their routine, and I am waiting for the clinician to come and review my baby for more than an hour! I can't tolerate this and understand that if it's not good for me, it's worse for the parents who come to the hospital. I try as much as possible to ensure patients are given attention as soon as possible and also if it's not an emergency I communicate to the parents, informing them what is going on. This has made the parent – Health Worker relationship better.

The conflict module has taught me one lesson: the avoidance way for handling conflict is not healthy, especially when avoiding the conflict for a long time. Keeping quiet for the sake of peace is dangerous. It's like drinking poison, day by day, expecting it to kill the other person. It's draining yourself and may be the other person is not aware of the pain you are undergoing.

Long live Ane and Mwana, for the long hours of mentorship, it was not easy but now I tell myself, yes it was worth all of it "

Siti Wande, nurse and research manager and communication trainer, Kilifi

7.6 The result: From Automatic Blame to Conscious Balance

The culture of "blaming the patient" or blaming others for problems, rather than taking responsibility for what one might have contributed to the problem, is well known to most people working in medical hierarchies, and has been described in previous chapters. When people are blamed, both the "blamer" and the "blamed" are usually affected negatively, emotionally: it is a "lose-lose"-situation, as described and discussed in the conflict module. If we look at what happens in the training process, it may resemble this:

The cycle of Emotional Blame

Context: Stress, social and medical hierarchy. Blame from supervisors

System of power
Learning is didactic
Appreciation not used

HP does not enjoy job
Blames P and system
Gets more...

HP feels unsafe. Covers it up

*P: Nervous, angry
Told to behave*

Emotional blame HP-P
Interaction results in
draining energy from both
Neither is "emotionally fed"

*P: worried, shuts up
Problem identified?
Meets HP w/suspicion
Fear increases*

P does not feel supported
Does not cooperate in care
Does not understand why

HP feels disrespected, not
valued. Blames patient for
bad behavior
Basis for good interaction
HP-P not established

The cycle of Emotional Balance

Training intervention:
Communication and
management of emotions

Observation,
reflection, awareness
Learns how to learn

HP enjoys job more,
continues to use...

HP is aware, feels
safe, emotionally

P: Nervous, scared
Welcomed, respected

Emotional balance HP-P
Interaction results in giving
and receiving energy
Both are "emotionally fed"

P: safe, trusts, opens up
Problem identified
Meets HP w/respect
Fear is reduced

P feels supported
Cooperates in care
Understands why

HP feels valued,
appreciated, safe
Basis for good interaction
HP-P established

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.

Example from a Kilifi nurse
"I met a couple who had been referred from the 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.
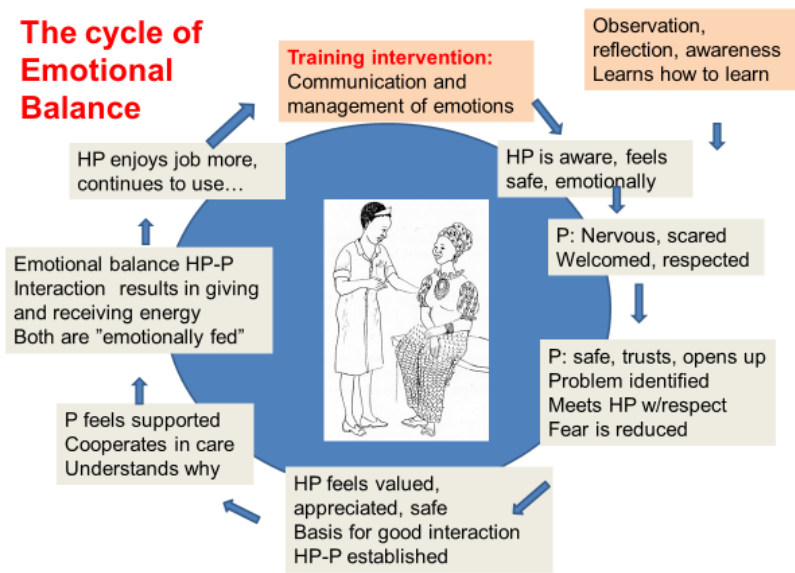
But I called the parents into a separate room whereby I did a thorough counselling and decided to communicate to them and explain each and everything that was to be done and all the implications. I listened to them and found out all the worries and the reasons as to why they were refusing admission. 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.

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.

8 Planning and organizing iCARE training process

Careful and consistent planning is essential for the success of the iCARE-Haaland model training. In this chapter, we spell out the nitty-gritty process of how we have planned the training, and what is needed to make the whole training function well.

As the process is going on over time, the planning team needs to give attention to establishing and maintaining a safe and predictable situation for the participants. The participants, as well as their managers, need to know what will happen, when, and what is required of them. When the logistics are clear and function well, participants can use their time to concentrate on discovering and learning how to communicate well.

The planning team can consist of a coordinator, trainer(s) and manager(s), with logistic support from other(s) to arrange meetings and training sessions, inform participants, collect their baselines, observation tasks and endlines, and attend to other practical tasks. If participants are not computer-literate, typing support may be required.
See Part B for examples of advertisements, invitation letters and other documents and tools.

8.1 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.

In the first site where this training was implemented, the leader of the TB hospital (in Siauliai, Lithuania), contacted the Norwegian NGO (LHL), and requested support for communication skills training for their staff. As information about the training was made available to other partner countries of LHL, institutional leaders recognized the need for communication training, and requested such training for their staff. The training thus travelled to Russia (Arkhangelsk), Latvia, Namibia, Tanzania and Zambia. Two nurses from Kilifi hospital attended the training process in Zambia (on special invitation, facilitated by Ane Haaland and Vicki Marsh) and later became the initiators of the process in their hospital, in 2009. The training has continued in Kilifi since then, and in 2015 also travelled to the Gambia – initiated by a researcher who was familiar with the good results the training has brought in Kenya.

Inviting 2-3 participants from collaborating countries to your training is a good way to get new people interested and involved, and for them to assess whether this training is appropriate for their setting. If they decide it is, they can be the initiators of the process in their own country.

8.1.1 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.

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?*

Discussion is important to be able to establish relevance of the training, create motivation and spell out expected gains. Some **points for discussion** with managers and decision makers:

- **Strengthen the feeling of relevance** by informing them that problems resulting from poor communication skills and lack of skills to manage emotions in the health professions exist worldwide, and has serious negative effects on patients, providers themselves, and supervisors. Give examples.
- **Establish clearly that the training that is offered will address these issues** and that it has in many other countries/places resulted in real improvements in providers' and managers' communication skills. Provide examples of the type of changes that have been registered by using this training model. Also provide evidence for health gains for patients and for providers themselves resulting from process training on health communication (from other projects – e.g. from review articles).
- **Invite them to be active partners in the training process**, by supporting their staff to take part in the training, and to consider taking the course themselves. Encourage managers to engage their trained staff in sharing experiences and reflections with them, and with the untrained staff, after each workshop and in relevant training fora. This will help to strengthen awareness about the use of the constructive communication methods, and to create a milieu where supportive communication and respect for patients is the norm.
- **Emphasize that the training is based on voluntary participation, and why:** A person has to acknowledge her need and interest to learn about communication, to really learn well. When participants ("bad communicators") are "volunteered" by their managers, these individuals can seriously mess up the training for the participants who DO want to learn. Trainers will have difficulties establishing a safe, constructive environment that can facilitate deep learning when there are individuals in the group who resent being there and will openly (or passively) be judgmental and resist learning.
- **Spell out how much funding is required** for initiating and implementing the process. S*ee budget note in appendix. The training is in general low cost: In Kenya, where the venue was provided by the institution and the trainers were on regular pay, the training budget was 250 dollars for lunch, refreshments and stationary for 30 people in two workshops of five plus three days.*

NOTE: No "sitting allowance" was paid in Kilifi: As the training has been voluntary and based on an acknowledgment of need for learning, participants have not been given any "sitting allowance" or per diem for taking part in the training. This has kept the cost down and has resulted in participants wanting to learn for their own purposes, not for the economic gain. The low budget has, however, also had negative consequences: It has been difficult to recruit and keep the trainers from the Government side on board, as there are competing requests for training with allowances paid. In a

resource-poor community, many trainers (and participants) have had to choose money over their own interest and motivation. In such training programmes, lecture-based methods are often used. Thus, trainers have to switch between using "old" methods with which they are very familiar, and "new" experiential learning methods which many are not yet fully comfortable with. This practice further slows down the integration of modern and more effective participatory learning methods into the communication skills training programmes run in "traditional" ways.

8.1.2 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 (see appendix) 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 Part B). 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.

8.2 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. See Part B for 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.

8.2.1 The introduction meeting

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 part B): 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.

8.2.2 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 Part B) 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 Part B). 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.

Collecting pack 1 and Introducing 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 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.

Collecting pack 2; Introducing 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 for a long time, 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.

8.2.3 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 Part B 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.

8.3 Phase 2: Analysing feedback, organising the basic workshop
8.3.1 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.

See Part B for 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. Below, we provide an overview of how we have carried out this analysis.

8.3.2 Analysis of Baseline questionnaire

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

Organize baselines feedback into two documents: One containing all the individual documents, participant by participant, and one where the responses to the 15 questions are collected, question by question.

Divide and collect the questions into 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).

8.3.3 Analysis of observation tasks

Organize each observation pack feedback into one separate document (pack 1, 2, 3).

Trainers should again read through all, 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.

Give the main responsibility for analysing each pack 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.

Please refer to the modules and presentations for examples of what kinds of topics we have focused on to illustrate concepts, ideas and theories. We have chosen examples from baselines and from observation and reflection tasks, and have included these in the course. Whenever possible, choose examples from as many different participants as possible.
For the follow-up course, examples should also be chosen from the endline questionnaires.

8.3.4 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 Part B);
- *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 managers and 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 7 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 B.**

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.

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.

8.3.5 Implementing the Basic Workshop
How to run the workshop: Please refer to the modules, and to chapter 7 – the role of the trainers, as well as to Part C.

Setting up the room for interactive learning: The coordinator should make sure the venue is ready and well arranged a day prior to the workshop. Participants should sit in groups of 5-6 people around a table. This is necessary to allow interactive reflections. It can be very useful to let participants do these arrangements at the start of the training, to involve them in making a good learning environment: When you let them do this, they are more likely to remember to make similar arrangements themselves when they run a workshop – rather than just accept the "lecture theatre" set-up which is very familiar, and common in training rooms.

On the first day, it is useful to let people sit where they want to sit - usually with colleagues they know. However, it can be useful to break up these groups and enable participants to get to know new people, e.g. starting on day 2, when they feel comfortable in the learning environment. You can re-arrange the tables e.g. by asking participants around tables to count 1-2-3-4-5 (if you have 5 tables with 5 people around each table), and then ask all the participants who have the number 1, to move together to one table, etc. It is usually best to make a random selection, to avoid any thought of bias, and there are many ways of doing this.

Preparation and logistics: Participants should be available full time throughout the week; this has to be communicated to the participants and managers in the invitation letter. Sometimes participants come to the training while working on night duty and this makes it difficult for them to get optimal learning.

The coordinator should invite senior managers from the institution to come and officially open the training in order to give it status and recognition (see above – invite them to come at a time at their convenience during the first morning/day).

Other points to remember (see each module for what is needed):
- Print all hand-outs for use during the workshop and label them well, ensure all necessary stationary is available;
- Ensure meals, snacks and drinks are available throughout the week at specified breaks on the timetable;
- Ask for consent to take photos and specify how you will use these (e.g. in presentations, to spread information about the training).

The role and organisation of the trainers:
- *The coordinator should be available* all through the sessions, and there should be a clear division of roles among trainers to make everyone feel safe;
- *At least two trainers should be available per day*, this is important for the trainers to be able support each other;
- *It is useful for one trainer to have the task to take notes* during the sessions, especially during the first course(s). Specify what she should look out for and take notes on. It is especially important that trainers take good and specific notes on how the modules are run – to be able to give constructive feedback to co-trainers;

- ***These notes are used in the trainers' feedback meeting*** at the end of every training day: Trainers meet to assess the day and give each other feedback on how the day functioned - what worked well, and where they need to improve. It is important to discuss the facilitation methods used, and use critical thinking to assess where improvements are needed – while at the same time being generous with appreciation for what worked well;
- ***During the workshop, it is useful for the trainers to sit at the tables and listen*** to what participants discuss. It is important that this role is discussed in the training team before the workshop: The trainers should only guide the discussion in the groups when needed (e.g. when procedures are not clear, or the questions to be discussed have not been understood well) – most of the time they should be "a fly on the wall" and keep quiet, and listen actively. Some trainers are used to "being in charge" most of the time – and they need to (be helped to) recognise this tendency in themselves, and step back from it while taking part in the group discussions in the workshop. If the coordinator sees that a trainer tends to dominate in the group discussion at the tables, it is better to pull him out and leave the group alone. In such cases, it is important to discuss the issue in the trainers' feedback meeting at the end of the day.

Workshop timetable and evaluation forms for the workshop: See Part B.

8.4 Phase 3: Meeting participants, organizing Skills into Action

Phase 3: Skills into Practice (or Action) tasks

Following the basic workshop, participants will receive further observation tasks for three months to put their new skills into practice in a guided way and to reflect on how the new skills work, and identify where they still need to strengthen their knowledge and skills. Participants continue to explore and confirm learning and strengthen confidence in using the new skills. The four EI skills are strengthened throughout this phase, and participants become more familiar with recognising emotions, stepping back, analysing the causes of the emotions, and taking new action based on a good understanding of the situation.

The approach to handling these tasks is similar to the approach before the basic workshop. Monthly meeting will be held to discuss the tasks with participants and hear about their experiences with using the new skills. They will submit written reflections just like what they did before the basic work shop. The following are the skills into practice tasks:

The observation and reflection packs include the following themes:
Pack 4 contains tasks to strengthen communication with colleagues, including how to share information and skills from the course with them:
- **Task 13:** Natural ways to use your skills, and barriers to using them;
- **Task 14:** Sharing information from the course with colleagues and supervisors;
- **Task 15:** Observing the reactions of your colleague;
- **Task 16:** Giving constructive feedback to a colleague, and – sending in an MSC story.

NB this pack of tasks is distributed on the last day of the basic workshop.

Pack 5 continues to focus on natural ways of using the tasks, communicating with supervisors, and then focus on taking care of safety, and of emotions:
- **Task 17:** continued from pack 4: Natural ways to use your skills, and barriers to using them (continued from pack 4 – this task to be carried out throughout the period);
- **Task 18:** Patterns of communicating with your supervisor – to find out what you react to, and how;

- **Task 19:** Taking care of safety, and effects of this on communication;
- **Task 20:** Taking care of emotions: Showing respect for patients' emotions, and effects of this on you; Taking care of your own emotions. And – sending in an MSC story.

Pack 6 asks participants to "sum up" their learning by sharing further reflections on how they now handle challenges related to patients' emotions; to "show and share" best practices, and to share questions and insights on research:

- Task 2: Dealing with patients' emotions – and the effect of this on you: Further reflections on changing the interaction with the patient.
- Task 21: Best Practice example – to demonstrate to the group;
- Task 22: Special task: Insight on and questions about research;

Note: When using the "Best Practice" task, the trainers should ask participants on the first day to find out who has an example to share. Trainers can then work with these participants to prepare how to show their Best Practice to the group. Usually, participants choose to demonstrate the situation they have handled well, and they "play themselves" in the demonstration. You (or the participant) choose another participant (or several) to play the other role(s), and then practice with them, during a break. These situations do need practice, and a main challenge is usually that the "Best Practice" participant wants too many details into the demonstration. It takes some time to prepare a demo where the main points stand out, and are not "lost in detail".
But when this session functions well, it can be one of the most powerful sessions in the course!

These tasks build competence in all 4 EI skills – participants are now more routinely using skills 1-3 (recognize emotions, think, analyse the situation) and take reflected action based on their understanding and analysis.

Please also refer to chapter 6.1, where you find a description of how the tasks build on each other and work together to create the aimed-for results.

8.5 Phase 4: Analyzing feedback, organizing follow-up workshop

The endline questionnaire

By the 8th month, participants will be given an endline questionnaire. This is similar to the baseline questionnaire but with additional questions asking them to identify and reflect on how they will have changed ideas and practice. They will submit their endline feedback before the follow up workshop. The endline questionnaires will be put into one document question by question just like the baseline. Analysis of the trends of learning in the group is done to feed into the ***Big Changes** presentation (Module 6/1b, which is a summary of the changes the group has seen over the last eight months). This is usually a very empowering moment in the course – recognising, acknowledging and celebrating the growth the group has experienced over the period of the course process. Reflections from the skills into practice tasks and the endline will also feed into the follow up modules.

Please refer to chapter 8.3 for how to analyse endline questionnaires and observation tasks.

Note: The trainer responsible for preparing the Big Changes should be responsible for collecting and organizing the endlines questionnaire. She must read all the endlines themes and observation tasks feedback to pick good examples for the presentation. It is also advisable that all the trainers read the endlines – to get insights into what participants have learnt, and what they still struggle with when practicing their communication and management of emotions skills.

A Training of Trainers' workshop
should be run prior to the follow-up workshop to prepare the trainers. Several of the modules in this workshop relate to understanding and dealing with strong emotions and it usually demanding for the trainers to prepare for and conduct these modules. The team needs to be extra sensitive to this, and make sure the trainers are given enough support – both emotional and practical – and to debrief trainers after the sessions. This TOT workshop has in Kilifi been run for three days.
Please refer to the modules for how to introduce and run the topics in this workshop.

Celebrating the achievements: The Graduation ceremony
Participants will finally graduate after nine months of intensive learning, and this is usually a moment for participants to celebrate their hard work and achievements. Arrange for the graduation ceremony to be held on the last day of the follow up workshop and invite guests and officials to participate in the celebration.

The lead trainer should prepare a short presentation to describe the process, examples of the changes the participants have made in their practice and challenges they face in the training. Plan for short speeches from the invited guests and let participants select a representative to give a vote of thanks. If other participants want to share briefly about the training, please let them do so: This should be THEIR celebration. Organize for a group photo with participants and invited guests after the graduation.
See example of presentations in the parts B and D.

Making the certificates: On the first day of the workshop, ask participants how they would like their full names to appear on the certificates. Get certificates printed and signed by the lead trainer and the head of training for the institution where applicable.
See certificate template in Part D and adjust as needed.

8.6 Refresher training

New skills need to be refreshed, especially when these skills are different to what the majority of the providers are used to practicing. It is thus recommended to have a refresher trainer once a year. This training can be 1-2 days, depending on interest and availability of the participants.

We recommend that observation and reflection tasks are given to participants for at least two-three weeks before the training, and that participants are requested to send in an example of their learning – and suggestions for topics to be discussed, based on what they are still struggling with.

During the workshop, a main part of the programme should be on sharing challenges and best practice examples and identifying which skills they are now comfortable in using. When sharing challenges, it is recommended that the trainer asks the other participants how they handle similar situations – to encourage participants to use each other as resources, and to continue the empowerment process.

Often, repetition of key skills is useful, based on participants' request. When inviting them to the training, it is recommended to emphasize that this is THEIR training, and to encourage them to help set the agenda for the training. Or even better – to take responsibility for it.
It can be a good idea for the trainer(s) to introduce one or two new (related) topics during the refresher training, to create new interest and continue to build skills.

In Part D there is an example of a refresher training programme, and of observation and reflection tasks to use prior to the refresher training.

9 Challenges to implementing iCARE training

9.1 The quest for the ”Quick fix“

Some planners, managers and providers have questioned the length of our training period. A "*quick fix"* is often requested - they wish we could achieve the same results, but in much shorter time. Unfortunately, the wish for a quick fix does not take into account the realities of how people learn, how they become motivated to change, and the time it requires to change communication patterns which have been used for years, or decades. Behaviour change theories confirm these realities. The literature also clearly shows the lack of satisfying results from short training courses and analyses the reasons for the lack of results: The short time span of the training courses is often identified as a main barrier to sustainable learning. Participants may gain new knowledge, but there is not enough time or attention given during the courses to help participants put the new knowledge into practice that fits their working realities.

> **There is unfortunately no short-cut to good quality training which challenges and helps to change providers' deeply held attitudes and habits. This training initiates and builds providers' ability and motivation to take responsibility for how they communicate with others *(instead of blaming others for the problems*). It is a slow empowerment method that gives results.**

One could of course reduce the training period, the number of observation and reflection tasks and the number of days used in the workshops in the iCARE-Haaland model. The results or outcome, however, would then be different than those we have shown in the original course. Literature strongly supports the longitudinal model and shows that training over a longer period of time gives better results. The key aspect is to acknowledge that change takes place over time and must be supported and encouraged on a regular basis. To implement this kind of training requires understanding and commitment from managers and leaders.
The model can be adapted to local needs with this understanding as a foundation.

9.2 Fitting into curriculum plans and regular learning

The model is built as a continuing medical education (CME) course, designed to give trained professionals additional skills to be able to communicate better with patients and colleagues, and to take better care of their own health. As a CME course, formats can be made based on the needs of the group one is to work with. Thus, the iCARE model schedules have been formed to fit into the cultures where it has been conducted. In some places, running a workshop for health professionals for five or three days has been a challenge, as colleagues have had to take over their work for this period. However, this has been possible, as managers and participants have seen the value of learning over a concentrated period of time, and give the participants a chance to immerse themselves in the learning. Other professional courses are also run over several days, so in most places it is a question of recognising the need for building this capacity and making the course a priority for the institution.

Fitting this sort of course into a regular curriculum can however be a challenge. In Cardiff, monthly workshops of three hours' duration were run, with one of the six workshops in the second course being run from 09 - 14.30. What was missed in these short workshops was the opportunity to develop deeper reflections that could be further explored the next day(s). We also missed the possibilities to explore emotional challenges over time: When participants had to go back to their medical work after the workshop, there was a limit to how much we could challenge.

On the longer day, when initial discussion of feedback and theories was followed by a role-play, there was a significant difference to the depth of the reflection and the learning.
Despite the limitations, important learning took place in Cardiff.

The most important features to include in a course plan in a medical institution are – running the course process over time, and basing the learning on the self-observation and reflection tasks, and on critical thinking and supportive group work. These features are already there in many institutions, and can be further developed by using the experiences and tools of this model.

9.3 Lack of trainers with experiential learning capacity

Good trainers are the heart of the model. The realisation is growing to support that experiential learning methods are the most effective ones to train professionals on communication and emotional competence. However, in cultures where the didactic learning methods are predominant, such trainers will be hard to find, and must be carefully trained – over time.
It is important that organizations and institutions invest in building trainers' skills over time, through mentorship and regular courses. Trainers must be encouraged to and given time to support each other, and to carry out regular Training of Trainers' workshops before and after the workshops for participants.

9.4 Challenges for participants

9.4.1 Balancing work and assignments

Participants in our courses are in general working full time, and must find time to carry out the assignments for the training: Filling out the baseline questionnaire (1-2hours, in the first week), carrying out the observation and reflection tasks and taking notes on their findings (5-10 minutes, daily) and then writing up the most significan change story (20-30 minutes, once a month). Some participants struggle to find this time, but – usually see this learning as essential. Common comments at the end of the process are – the assignments are tough, but please do not take them away, or reduce them: it is by doing these tasks that we really learn to see ourselves, and discover what we need to learn.

The training needs for participants to be committed to the learning, and decide to do the tasks – for their own reasons. Thus, it is essential that the training is voluntary. Still, some participants find it hard to find the time to do the writing.

9.4.2 Reflective practice may not be a tradition

Most participants struggle initially with carrying out the self-observation and reflection tasks: the tradition to look critically at their own behaviour, systematically and over time, is not a common way of learning. Many may have been observed by others, who have defined what "the problems" are in the way they have e.g. performed a task. With such practice, the power remains with the one who observes.

Most participants in our courses pick up the skills to observe themselves over time, with good support from trainers and from each other. Once they do learn these methods, they really appreciate them. But without support from someone who knows how they work, and has carried them out herself – many choose not to do this work. After all – getting to know what your challenges are, can be uncomfortable – and it usually means you do have to do something to change. Resistance to change is very common!

10 The History of the model; How it was developed – a personal story. Dedications

10.1 Background to developing the model

10.1.1 Developing the iCARE-Haaland training model: an overview

The work Ane Haaland had done over the last 45 years functions as the foundation for the development of the pedagogical approach to communication which is described in this manual. The development of the iCARE training model started in Siauliai TB hospital, Lithuania in 2006, as a response to the needs to improve communication with patients, expressed by leaders and providers in the hospital. The work was sponsored by LHL, the Norwegian Heart and Lung Patient Association. The model was then implemented in Latvia, Russia, Namibia, Zambia and Tanzania, all partner countries of LHL, from 2006-2008. In each country, adjustments and improvements were made in collaboration with the users. In 2008, two nurses from the Kilifi District Hospital in Kenya, Mwanamvua Boga and Jackson Chakaya, joined the training in Zambia to assess whether this training could also be implemented in Kenya. In 2009, work started at the Kilifi district hospital, Kenya, as a collaborative project between the University of Oslo (where Ane Haaland was working), and the Kilifi KEMRI programme, financed by the Wellcome Trust. Boga and Chakaya were trained as main trainers.

By the end of 2018, 350+ providers have been trained, about 200 of these are in Kilifi, where the model has been further developed to find its present form, and a strong institutional foundation has been established with M. Boga as the lead trainer. Communicating about research has been added to the training in Kenya, and also training managers in communication skills. In 2015, Boga and her colleage Hiza Dayo conducted the training process in the Gambia and trained more than 60 providers and three trainers there, over a two year period.

In 2016 and 2017, Haaland implemented an adapted version of the training model with trainee doctors in the Wales Deanery, Cardiff University, in collaboration with professor Debbie Cohen.

Several participants in Kilifi have made changes to how their wards function, in collaboration with their managers: Their new skills have made them see their work in new ways, and removed the fear of taking initiative to change, or to talk with their managers. Many of them comment that "people change systems", and that they want to contribute to doing this. Some of these former training participants may contribute or take initiative to a change from the bottom up – a change which so many health systems say they need and want, but for which there is no universal or cultural recipe.

10.1.2 The evolution of the model: A personal note from the author

I would like to share with you the story of how this model came to life, and show how the work with the model has provided an arena for bringing learning and insights from 45 years of working with communication in 30 countries, together to a coherent whole. It has been an amazing journey of mutual learning across cultures and professions, and – the most special has been to experience how the issues around emotions are so common to us all, and – that the learning about it brings out such joy, and gratitude.

The starting point in Tanzania: Anger, and conflict
I was in Tanzania with LHL in 2006 to find out how to help empower TB patients with knowledge and skills to handle their disease better. Many patients stopped taking their medicines too early, and there was a large problem with defaulting, and later – relapses, and development of resistant TB.

After talking with several patients, I met with the health providers - doctors and nurses, whom the patients complained strongly about, to hear their views of the situation.

"Angry patients", said the providers, when we asked what they saw as their biggest problems when dealing with TB and HIV+ patients: They did not know how to handle them, and often ended in arguments that left both parts exhausted, problems not dealt with, and HIV tests not carried out[122]

In other countries LHL worked, conflicts were common between leaders and providers, between colleagues, and between providers and patients. There was often a strong reluctance to relate to and to treat very sick and dying TB patients. Providers often blamed and shamed mothers who came to the hospital with a child who carried charms from a traditional healer, or who came late – when the child was very sick. They shouted at or used harsh words with patients who voiced their frustrations or fear when dealing with a hospital or clinic system they did not understand, and which they felt did not respect them and did not meet their needs. Many providers used angry power to "get patients to behave".

The common theme to these problems is – *management of emotions*: Providers' own emotions, and those of the patients. I soon discovered that "emotions" was almost a dirty word among providers – emotions were to be controlled and ignored and were judged harshly. They were seen as a disturbance: "She is just being emotional" was a statement indicating a "difficult patient" with an unimportant reaction that just had to be controlled, often by using blame, sarcasm or anger.

Exploring solutions: Dealing with anger and conflict
In Tanzania, I created a one day's exploratory course on "Dealing with anger", to respond to the providers' expressed immediate need. Using role-plays, exercises, interactive group work and short lectures, a group of 20 providers learnt that behind anger is very often fear. They were surprised, but – felt it made sense when exploring their own reactions to the anger they faced from TB patients who refused to take an HIV test: The providers also felt fear when faced with an angry patient, and covered it up with using their own anger, and power.
The "picture" of two scared "children" shouting at each other brought home the idea of how seemingly impossible it is to communicate well in such situations. The emotions take up all the space.

I taught them the basic skills in emotional intelligence: To recognise and acknowledge the patient's as well as their own emotions, to analyse what happened, and to take action based on this understanding. Thus, the providers learnt:
- To recognise and acknowledge their own fear when they met with and angry patient;
- To use their knowledge to analyse the situation – that behind the patient's anger was also fear (of possible death, related to being possibly HIV positive);
- To take a step back from their automatic reaction (often anger), and then
- To meet patients' fear with respect, kindness, sincere listening and compassion.

The health providers used guided observation and reflection tasks to continue developing awareness of how they communicated with patients. The providers responded well to the new skills and reported – 6 months later – that they now had hardly any problems with their patients: Almost all the TB patients (more than 80%, according to providers' own estimates) now agreed to take the HIV test, compared to almost no one (about 20%, same estimates) before they did this training. The providers wanted to learn more – they had discovered the importance of recognising and managing emotions.

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[122] TB and HIV: *There was 70% co-infection in many African countries in 2006 – if you have TB, you are 70% likely to also be HIV positive, so there is a need for TB patients to be tested for HIV. At this time in Tanzania, most TB patients (80%) refused to be tested for HIV.*

Full course taking shape in Lithuania: We (my colleague from LHL and myself) then went to the TB hospital in Siauliai, Lithuania, at the invitation of the director, a progressive medical doctor who wanted her staff to learn to communicate better with patients. Twenty members of her staff (medical doctors and nurses) had responded to a needs assessment survey I created, and a small group of them participated in formulating the first programme.

The director, who had been trained in the Russian authoritarian style, participated in the sessions, and frequently used her customary power to speak in the plenary sessions without asking permission. Stopping her respectfully and asking her to follow rules we had agreed, that everyone asks before speaking, caused everybody to hold their breath for a moment – until she laughed and said – "of course"! She was also there to challenge old ways of communicating, she said. Participants then relaxed and appreciated her.

On day 2, a conflict between the director and a line manager came to the surface – the line manager had taken the "licence to speak her mind" literally, and the two giants made the room boil with tension as they described their views, laced with heavy judgments and blame, standing up in full force in opposite parts of the room. I let it boil for a while, then stopped them respectfully, and asked if we could explore what was behind the conflict, and use the situation for everybody to learn from. I had everybody's full attention, and complete silence.
The two "combatants" agreed, after some consideration.

The explorations brought out a number of emotions on both sides, emotions that had been allowed to build up because they had not been acknowledged, respected and dealt with in a constructive way. We worked to listen to the reasons behind the strong feelings, on both sides, inviting empathy, compassion and understanding for how the two leaders saw the situation. Although some sore feelings surely remained on both sides after the session, the "air" in the training group had cleared, and the open and respectful way of dealing with the conflict had been an eye-opener.

We continued to use the lessons from this event to explore other issues, and to communicate with awareness. I revised the plan for the next day's lesson every evening, based on what had happened in the group: The curriculum was being formed, and a core element in all sessions was – recognizing, acknowledging, understanding and handling emotions – with respect.

The response to learning to recognize, understand and manage emotions was similar in all countries where we later implemented the model: This was knowledge they needed, and they did not know they needed it until they received it. Initial reluctance to deal with emotions was soon replaced by experiences and insights that showed them the power of awareness, and the strong positive effect of being able to manage their own emotions – and to recognize, respect and respond well to the patients' emotions as well: Inviting empathy with patients' fear and frustrations rather than judging them for "being emotional and difficult".

Scepticism from managers and leaders was and is there, but much of it turned into acceptance and appreciation when they saw the results of the changes – on the providers themselves, and on the patients. Several managers also participated in the courses and became strong advocates for the communication approach – in addition to radically changing their own supervision style.

Health professionals: Lack of training in management of emotions leaves a "black hole"
During my participation in the conference on person-centred medicine in Geneva (May 2010), I asked some of the many good professionals gathered there about reasons for the apparent "black hole" in the literature about training providers to deal with their own as well as patients' emotions. All acknowledged that the "hole" exists, and reasons suggested were mainly that a majority of the

medical professionals thought themselves intuitively capable of communicating well and dealing with patients' emotions and coping with their own, despite increasing evidence to the contrary. An editorial in the BMJ on "Communications and emotions" confirms this view. All of the participants I talked with acknowledged a need for more research and attention to the field of training providers to recognize and deal better with their own emotions, as well as those of their patients. As I have continued to present results from our work in national and international conferences, the response has been the same: *There is a need for research and training on providers' recognition, understanding and management of emotions, and there is a lack of training materials in this field.*

In the last couple of years, there has been increasing attention to the effects of emotional labour and to the need for emotional competence among health professionals. Furthermore, the perception of vulnerability as weakness has been strongly challenged, first and foremost by the American scientist Brene Brown – see chapter 2. The professional world is slowly getting ready to learn more about emotional competence.

So – what is so special about this learning?

The iCARE-Haaland model is complex, but the main elements are quite straightforward – starting with the need for the provider to decide that she wants to learn to communicate better. Then, the key elements are:

- Guiding users to *discover* their learning needs, through self-observation and reflection over time;
- *Meeting these felt needs* in the training workshops;
- *Providing a realistic time frame* - giving space for self-determined change;
- Providing a *safe learning environment*, where failing is common, expected, and – is seen as creating situations to learn from;
- Using a methodology that *respects the learners* and starts where they are – in their practical day to day work, with their present skills and behaviours;
- *Seeing emotions as a natural and positive part of life* to be expected and managed, both in relation to providers' own emotions, and those they meet in patients and colleagues;
- Acknowledging, valuing and building on their experiences, and *empowering* them to take *responsibility for their own learning;*
- Guiding them to become aware of and further develop their *own authentic communication style* – which feels natural, and will therefore be sustainable;
- *Encouraging interactive reflection* with colleagues who experience the same kinds of challenges, thus creating *common goals* within the training group: strengthening self-awareness, improving collaboration with colleagues, and improving patient-centred care;
- *Having trainers who role-model respect, kindness, compassion and care,* with curiosity and skills to explore reasons for present problems – without judging the person in action.

As both trainers and participants are emotionally present with each other, are non-judgmental, and share a common goal, a remarkable *give-and-receive exchange of energy* builds during the sessions. As a result, neither group becomes exhausted. Later, after having applied the methods described in this model with patients, participants report that this practice helps increase the satisfaction and enjoyment they find in their work while also lowering their risk of becoming burnt out.

The challenge is to apply all of this to the **relationships** that are central to good health care – the relationships providers have with patients, with colleagues, with communities, and – with themselves. With awareness and practice, this becomes easier, and the good results encourage the providers to continue using the skills.

The personal contribution of the author: A professional mix of skills and experience

I am not a health provider myself, and therefore had no fixed idea about what the training should look like (*although having run many training courses for health providers in a number of countries, I had experience to draw from*). I could be open to ideas without being bound to any single training models. I could simply look for what works, for what was relevant to them and which methods would inspire them to learn – in close collaboration with nurses and doctors who lived with the problems every day. Providers are busy practical people and would only change if they saw the new skills as working better than the old ones. We had the same clear goal: ***Strengthen skills to communicate and collaborate with colleagues and patients, and build skills to recognize and respect emotions – their own, as well as those of colleagues and patients.***

My first profession as a journalist had stimulated my curiosity and critical thinking and gave me techniques to explore these issues. **My second career** as a social scientist and international development worker added knowledge about cultures, context and challenges in health systems and with health personnel, as well as about research. I have worked internationally since 1975, for UN organizations, NGOs, universities and other groups, as a trainer, researcher, project developer, analyst, photographer and writer. I have worked in some of the poorest and toughest parts of the world, but also in modern well-functioning hospitals in Europe. When I started work as a UN volunteer with UNICEF in Nepal in 1975, 70% of the children in certain parts of the country died before they were 5 years old. I hit a steep learning curve then, with a clear focus on finding out which efforts worked, and why. There was no time for inessential nonsense.

I had a boss and mentor - Hallvard Kuløy, who was UNICEF Representative in Nepal and hired me for the job there - with a philosophy he expressed clearly to the staff: "*I will not criticize you for trying new things or methods, and failing – but if you don't try, you will have trouble with me!*"
We tried a lot, failed a lot and learnt a lot, in a working environment Kuløy described as "creative anarchy". I learnt the language, and started learning from my Nepali colleagues, who taught me many lessons during the eight years I worked in this beautiful country. I also did my first piece of systematic research then – to find out how people with low literacy skills interpreted drawings and pictures. We used the results to develop effective educational materials and developed a manual to share these methods with others[123].

During my years of professional work in health communication in Asia, Africa, Latin America and Europe, I have trained a number of different groups in the use of communication skills. The training often did not respond to the needs of the users, but rather to the needs of their bosses: **They** defined the need as "lack of communication skills among providers," to which the "obvious" solution was: skills training to learn better communication. To ask what the health providers felt they needed, and what the reasons were for their treating patients in rather "rough" ways, was not deemed necessary. It was not even mentioned as a valid concern: health workers were by "design" obligated to care and expected not to ask for anything but salary in return. The prerequisites for the providers to be motivated to give good care were not addressed, and the managers did not pay attention to emerging research on the subject. Now, several decades later, the knowledge about "what works" in communication skills training is readily available to any planner with a will to investigate the issue. Still, much communication training is carried out "the old way", expecting medical and nursing students to learn to communicate better by being told, through lectures and discussions, *what* they have to do, but very little about *how* to do it. Results are often as could be expected: no, or limited, improvement in communication skills. When travelling to countries across the globe, most of the

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[123] Fussell, D and Haaland, A (1976): Communicating with Pictures in Nepal. UNICEF and National Development Service and Haaland, A (1983): Pretesting Communication Materials. UNICEF, Burma

providers I have met have complained about lack of communication skills: The awareness about the need for good training, and for training to manage emotions, continues to increase.

Joining hands with doctors and nurses: Action research to develop the model
The work took a new turn when I started working directly **with** the providers, rather than responding to managers' requests to conduct courses **for** them. By listening to what they felt were the problems they faced, and exploring and analysing the problems together, the training became a collaborative project that transformed the work – and the results. The providers defined the situations they struggled with, through observation and Reflection-IN-Action (RiA), the powerful method that also included the (often raw) emotions and reactions involved. We could deal with "the real thing", and the authenticity, sincerity and down to earth quality this gave the work, was precious.

There was no bullshit. No possibility to discount the training. It was about their work.
To this, I added my knowledge about communication, and gradually about emotions – I am no psychologist, but have worked extensively in the psychology field, both professionally and personally.

In 2008, Mwanamvua Boga joined a workshop in Zambia together with her colleague Jackson Chakaya, both nurses from the District Hospital in Kilifi. From an initial scepticism to the work, Mwana slowly embraced the methods and gradually made them her own: When we ran the first training course in Kilifi in 2009, Mwana and Jackson started their education as trainers. We ran one course per year in Kilifi, and Mwana gradually took charge of the training, and brought in her own experience and ideas. With Mwana on the team, we collaborated to shape the modules to their present form. Mwana has gradually introduced the work into a number of different fora, at her own initiative and/or in collaboration with her colleagues in Kilifi. I have remained a mentor to the process, and the collaboration with Mwana has an important impact on the work.

In 2015, I started collaborating with Debbie Cohen, an occupational therapy professor who invited me to develop a project with her to train their trainee doctors, using my method. We ran two courses, in 2016 and 2017, with very good results.

During the years of working with this manual, some of the aspects of our training have been gaining momentum in the research and literature in the communication field: In patient-centred care, the dimension of provider – self-relationship has been acknowledged as a very under-researched and under-focused area which is of crucial importance to the provider practicing good PCC. Our model offers a strong training focus on this aspect. The focus on emotional labour is a similar case – it has just recently been acknowledged as having crucial importance for nurses especially, and – there are few resources available to train them to handle the emotional challenges of their work. Emotional Intelligence (EI) has furthermore gained attention as a set of skills that especially leaders need, and leaders with good EI skills have been shown to get better results for their businesses. In health care, EI is gaining increasing attention and recognition. Although the concept of EI was only included in the model from about 2015, I have added it in: What we have been teaching for years is essentially EI skills – just under a different heading. I have thus included the concept where it is natural.

Serious illness in my close family from 2012-2016, and the subsequent process to cope with my husband's death has slowed the work to complete this manual. It has also given me an opportunity to experience how a number of different providers in the Norwegian health system handle difficult emotions related to terminal illness. We have met providers with empathy and presence who made us feel seen and appreciated as fragile human beings, providers who accept tears and impossible

questions with compassion, kindness and patience. These doctors and nurses have enabled us to cope better with the situation, and we are very grateful to them. We have also met providers who give bad news by showing us the X-ray of the growing tumours on the computer without even asking my husband how he is when coming in to get the results of a brain scan, with no empathy and no time for dealing with the shock. Others have "hidden" behind statistical facts about a bleak chance for survival beyond X years, the news being delivered with a smile. We have been shocked and angered. The range of methods used to deal with emotions, and the lack of skills to do so, may be as large in the Norwegian medical system as it is in the UK, Eastern European countries, and in Africa.

Finally, my work during the last couple of years has had an increasing focus on vulnerability as a central concept which health providers need to improve their skills on – also fuelled by the experiences of being closely involved with terminal illness. In the model up until then we have worked with the concept of insecurity, and on skills to recognize and handle these emotions. I discovered during the three years I accompanied my husband through his illness that the medical approach to vulnerability was largely ignoring it as an issue affecting the providers, and seeing it as a weakness.

We included vulnerability as a topic with the trainee doctors in Wales, and from an initial surprise and reluctance to discussing it, the two groups of young doctors learnt the positive gains from recognizing and integrating the management of their own vulnerability as an important part of their practice.

- *«I feel a heightened sense of awareness of my own emotions. I recognize emotions like anxiety and vulnerability and try to find the triggers and manage them. It is a life long learning as different situations can challenge me in different ways but this journey of discovery is an exciting one.»*   *Participant, Cardiff*

I have challenged the medical views on vulnerability and shared the positive results of our training in Wales, in professional conferences in Australia, Singapore and London in 2018, and the awareness and interest in vulnerability as a central concept for medical professionals, is increasing. Much inspired by the work of the American scientist Brene Brown, this work will be a continued focus for me in the years to come.

The development of the iCARE-Haaland training model has been an exciting journey of discovery, in collaboration with good colleagues. It has been fuelled by curiosity and by the determination to get to the core of the problem and then deal with it, in collaboration with those who experience it. The model is a product of 45 years' professional work in 30 countries and is the most important work I have engaged in during my long career. Everybody who was involved in the development of the model felt somehow "right" about the structure and contents of the learning process, although many have questioned the complexity and length. As the writing has progressed, other work has been published which has supported the findings from working with the model.

Throughout the years of working with the model, as I have experienced providers struggling with making sense of death, cruelty, difficult working conditions, unrealistic or unkind managers, babies who die and patients who have lost hope – my respect for them has increased steadily. Thus, this manual is primarily dedicated to them all, with the hope that the methods here will be made available to many and help make their lives a bit easier.

10.2 Acknowledgments and Dedications

I have never before dealt with such motivated learners as those I have met when working with this model in its current form: At the time of the first workshop, they knew what they wanted to know, and how they would use the new skills in their work. There was no resistance to learning, but rather

an impatience to learn - which makes the teaching a joy. The learning process somehow gave them energy, and also energized me as the trainer. During the first workshop at the TB hospital in Siauliai, Lithuania in 2006, one of the participants drove me back to the hotel after the day's sessions, and reflected, surprised –

"I am going home to do some more reading and work on these topics. It is strange, after a long day's learning, I am not tired. Usually, after workshops I am quite exhausted."

Dedications to leaders and trainers: Manuals evolve through cooperation

Some of the best work I have done has been where I spent many years working on a communication method until it was ready to be published in a manual. ***My main learning has been: Quality work takes time, and – the close involvement of and cooperation with the users is the key element.***
I have been lucky to work with leaders who understood this and let me use the time needed to write the manuals (see ref list).

This manual is thus also dedicated to the progressive leaders and researchers who believed in the communication training model and supported me to develop it further:

- **Mette Klouman**, the leader of the international section in the Norwegian NGO (LHL), asked me in 2006 to help them develop communication interventions to support TB patient empowerment. She was open to the suggestion that we needed to work with the health providers' communication skills and attitudes, if we were to make a real impact on the patients' knowledge and skills to deal better with their TB and HIV infections. I worked with the LHL team and their partners in 6 countries for three years; (*In addition, we developed educational materials with the TB patients, to meet their need for information, see ref list*).
- **Dr Vita Globyte**, the director of the TB hospital in Siauliai, Lithuania, wanted all her staff to learn better communication skills, and used her creativity to become the first institution to run this training, as well as to support 5 of her staff to become trainers;
- **Several other leaders** welcomed the training of their staff and contributed to the development of the model: **Dr Vaira Leimane** in Latvia, **Dr Nina Nizovskaya** in Arkhangelsk, Russia, **Dr Neema Kapalata** in Temeke, Dar-es-Salaam, Tanzania, **Sister Nerumbo,** the regional TB coordinator in Windhoek, Namibia, and **Alick Nyirenda** of CHEP, Zambia. These training courses were all supported by LHL.
- In 2009, **Dr Vicki Marsh** in KEMRI-Wellcome Trust Research Programme in Kilifi, Kenya, applied for and received a grant from the Wellcome Trust to implement the training in Kilifi District Hospital, with her as the PI. Two of the hospital nurses, Mwanamvua Boga and Jackson Chakaya, had participated in the training course I conducted in Zambia, and decided to bring the training to Kenya. A number of research projects are implemented in the Kilifi hospital, and "Communicating about research" was added to the model in collaboration with Vicki and **Dr Sassy Molyneux,** and with course trainers. The model has been further developed and found its present form during the first six years (2009-2015) it was implemented in Kilifi. Vicki has been the "Godmother" of the model and supported the development throughout these years.
- **Sassy Molyneux** has collaborated with me on developing communication strategies and materials in Kilifi since 1993, when we created the concept for the first communication training approach for the fieldworkers. The manual describing this approach[124] took eight years to develop, and the present manual also builds on the work done during this period. Sassy has taken the initiative to support the completion of the manual, and get it published.

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[124] Haaland, Ane and Molyneux, Sassy (2006): **Quality Information in Field research. Training manual on practical communication skills for research field workers**. WHO/TDR

- **Vicki Marsh and Sassy Molyneux** took initiative to have the training course evaluated by independent external evaluators in 2011. The report from the evaluation is referred to in several places throughout the manual, and essentially confirmed the conclusions drawn from participants' self-reported materials.
- **Dr Debbie Cohen** invited me in 2015 to come to Cardiff, Wales to implement the model with trainee doctors, based on a presentation of the work in Kenya and other countries at a medical conference in Greece.

Five trainers have been especially important in shaping the contents of this work, see the Prologue.

It has been a privilege to carry out this work, and I want to thank everybody who has been involved and made it possible – especially Mwana, who has burnt endless litres of "midnight oil" to dive deeper, question herself and others – including me – with respect, and having joy in working with these skills and see the fruits of the work when participants, as they emerged to communicate with awareness and to enjoy their work more – and become better colleagues.

11   Practical advice from trainers

A group of trainers in Kilifi brainstormed and identified a methods they use when preparing for or running exercises, to be shared with readers of the manual. The exercises are described at the end of each of the modules.

1) **Choosing volunteers from the group to do a demo**
   Things to consider:
   - Participants should speak clearly with a good voice and not be shy
   - Avoid domineering participants/who talk too much, sometimes they can make a demo too complex as they have a lot to share.
   - Participants should be in the role they are familiar with (e.g it may be challenging to ask e.g. a pharmacist to play the role of a nurse/a doctor in a demo). Preferably, choose a nurse or doctor to play the role.

2) **Running an exercise where participants (in groups) will write points on flip chart**
   - Give flip chart with different colour maker pens to the groups
   - Introduce the exercise, let the participants know how much time they will take to do the exercise
   - Ask them to write on the flip chart using different colours on different points
   - After the exercise, ask them to hang the charts on the wall
   - Ask participants to stand up and move close to the flip charts on the wall
   - Ask them to read each other's responses
   - The facilitator should then ask specific questions to guide the discussion
     e.g What strikes you on the responses on point A?
        What can you say about the feelings illustrated by the groups?
   - The facilitator should avoid reading one point after the other from all what the groups have written as this can make the discussion boring - too long and not focused.

3) **"Golden rules" when writing on flip chart**
   - Write clearly (others should read!)
   - Use different colours to illustrate different points
   - Write date on the chart
   - Do not write using capital letters

4) **Facilitating a role play**
- Ask participants to sit in groups of three
- Ask each of them to pick a role to play i.e health provider, patient and observer
- Explain the roles of each actor to the class
   - ➢ Health provider – will act as the provider according to the script that will be given
   - ➢ Patient - will play the role of the patient/relative as per the script
   - ➢ Observer – will observe the interaction between the provider and patient, and lead the feedback session in their group at the end.
- Distribute the script to the groups; ask them to read only their own script (observer gets all three scripts)
- Let them know how much time the role play will take. Before the play, ask the groups if they need anything to be clarified and ask the trainers to sit in the groups to observe. They should only offer guidance if really needed.

NB/ If a patient is to show anger in the role, it may be advisable to call all patients actors into a group and let them know/show them exactly how they are supposed to act, to allow the HP to put the skills into practice "with some sweat".

- After the role play - ask the provider to appraise his/her performance constructively, starting with what he did well and the areas to improve
- Then let the patient say how he/she felt she was handled, starting with areas the provider did well and then areas to improve
- Lastly, let the observer give the provider constructive feedback as per his observation and the script instructions.
- The facilitator then calls the discussion together in plenary and ask the following questions:
  - How was it doing the role play? Let them share their experiences
  - What did you learn from doing this role play?
- Put the learning points on a flip chart and use them as a summary of the discussion

5. How to recap the previous day learning
Things to consider:
- It is important for the facilitator doing recap tomorrow to sit through the day's learning
- It important for them to know at the end of the day's events that they will be doing the recap tomorrow
- Let him prepare summary points of what was learnt, to use as a guide when doing the recap
- There two things to consider when asking questions
  - **Asking for learning points, and**
  - **asking for cognitive knowledge**

When asking for learning points- the facilitator can ask open questions like:
  - ✓ What did you learn yesterday that was important to you as a person/provider? Or
  - ✓ What did you learn yesterday that was significant to you as a provider?
- When asking for cognitive knowledge (i.e. to recall the points from the sessions), the facilitator should ask specific questions e.g
  - Yesterday we learnt about active listening. What did we say active listening is? Why is it important to listen actively to our patients? What disturbs active listening?
  - The questions here are very specific, and asks them to remember.
- As a facilitator you can use the two methods interchangeably, you can start by asking for learning points then follow it up with specific knowledge questions.

6. Running an Exercise
Facilitating an activity to bring out learning on a topic
Why important?
- Can be used as an energizer to break the monotony of trainer talking about it. Brings in energy to participants hence still facilitating their learning.
- It enhances participants' involvement in the learning. They become responsible for their own learning; they feel empowered.
- It gives a chance for all participants to take part in the session especially those who feel "shy" to contribute in the larger group.

When do you do it?
- Mainly pre-planned (when preparing presentation)
- When energy in the room is low, you can run an impromptu exercise e.g. asking them to discuss a specific point.

- When a point is not clear; ask them to discuss and come up with questions and reflections.
- When you want participants to practice a skill.

How do you do it?
- First and foremost, prepare objectives for the exercise. What is the purpose of it?
- Decide on how to achieve these objectives e.g.
  - ➢ Discussions
  - ➢ Ask them to share experiences
  - ➢ Role play
- Formulate questions to draw learning points, analytical ones
- Come up with a list of what you expect to bring out from the exercise.
- Decide how long exercise will take
- Summarize important points at the end
- Be very clear on what you expect them to do
- If intending to put instructions on exercise on a flipchart, do it before the time you intend to begin exercise to avoid delays.
- Insights: To get insights, participants need to share real experiences through role play or sharing their own experiences they encounter or through showing a demo.
- An exercise needs to be simple i.e. minimize number of questions. Questions need to be straightforward.
- Besides objectives, be open to any important points that may come up from the exercise that you had not captured.

How does it affect me as a trainer?
- It allows me to assess progress of my presentation and make adjustments when need arises
- When I do it well, I draw out learning from participants' point of view. Learning becomes relevant to them because they come up with what they feel is important.
- It helps me to be present when I run it because when getting feedback from the exercise I have to be there, engaged with participants in order to bring out learning from their contributions.
- Exercises, when well facilitated bring learning on the "ground" as opposed to lecturing which leaves participants at descriptive/cognitive level.
- The ability to get insights requires one to formulate analytical questions and linking them to participants' experience. This engages their emotions hence facilitate learning.

Example 1(Chea)
I ran an exercise on advising a mother how to give resomal. I didn't explain that participants must discuss then practice how to give advice.
When it came to getting insights from this exercise, they did not have any insights. Reasons being, I did not make it clear that they needed to practice so they only discussed (talked about it). This means they did not share a common experience hence impossible to get insights.

Learning points;
- ➢ To get insights, participants need to share experiences e.g. show a demo, reflect on a past experience and share, or have a role play so that they have an experience to relate to.
- ➢ It is important to give clear instructions on an exercise for participants to do exactly what facilitator expects them to do.

Example 2(Hiza)
I ran an exercise on effects of lying on emotions and communication. I asked participants to share an experience where they felt patient lied to them and how they handled. And the strategies they used to handle patient well.

Learning points;
➢ Writing on flipcharts was not done before the exercise so it took a long time to run it. Writing on flip charts should have been done earlier before time for starting the exercise.
➢ I need to wrap up main points by summarizing at the end of the feedback session.
➢ I can also ask them if they have ever lied to patients….this makes participants laugh at themselves but also reflect on what they do.
➢ The strategies they came up with from their experiences I could link directly to the theory
➢ It was easy for them to come up with insights since they reflected deeply hence learning from themselves.

The power of using open questions

"For me when using open ended questions it's like a weapon that can be used to disarm any person who is angry, who has tension, who has fear if you use open ended questions you actually can see the effect on the spot. And in my experience I was involved recently in a study following people who refused to participant in studies and these people who have at times been very violent to the staff who are visiting them. When I got the assignment I was filed with fear because I was like how am I gonna follow these people who have already refused to participate in these studies some of them have actually chased away the staff because they say they do not want to be involved in research activities. So the only "weapon" that we used are the open ended questions.

The only weapon that we carried with us to follow up these people who had refused were the open ended questions so I could visit the home, and introduce myself and right from the beginning used open ended questions to try to understand what happened and these guys would just confront you like, "I told your people never to visit this home again why are you here?" So but now the use of open ended questions… you would see these people immediately coming down from being very high tall looking very angry, wanting almost to confront you head on but then you try to understand, "Okay I'm here to try to understand more about what experiences you have, what exactly happened". And based on those questions you actually feel them, you see them relaxing down and open up and share a lot of information and eventually majority of them actually could say, "I wish all the people who were coming here were like you, they were patient enough they were inquisitive enough to know what we are experiencing". So the open ended questions is a very powerful weapon that's what I can say.

Francis Kombe, Kilifi