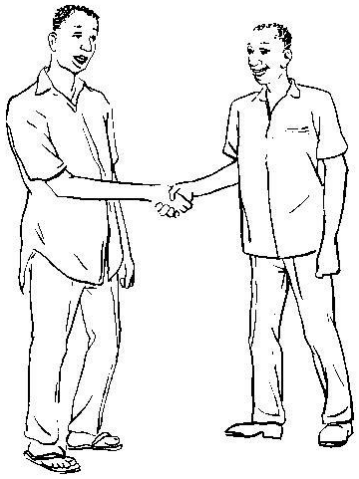
Module 1 in iCARE-Haaland model:

Communicating with awareness and emotional competence with patients and colleagues

Introducing concepts and contents, and introducing participants

Ane Haaland, with Mwanamvua Boga

Background for trainer



The purpose of this module is to make participants feel welcome, and that they have come to "the right place": To demonstrate that the workshop will be relevant to them. Furthermore, it is to acknowledge them for the important work they have done and show them where they are in the learning process *(whether you use 9 months, or shorter).*
This module takes the participants through an overview of core concepts that guide our communication and emotional competence work. We use examples from their baselines and self-observation tasks to demonstrate how these concepts are linked to their work. Finally, the participants will get experience with and insights into the effects of ***using appreciation to introduce each other*** to the group, and – thus set the "tone" for the learning during the course:
Appreciative, generous, non-judgmental, humorous and – using curiosity and evidence-based methods to achieve good learning.

The values and ideas in the course and in the workshop are based on principles for Patient Centred Care, where respect for the patient and seeing the patient as a person is the core. The main concept is ***awareness***: ***When providers decide to invest time and effort into becoming aware of their own communication behavior, and of the effect this behavior 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 her- or himself – it is not something that is imposed from the outside. The discovery that the provider's own emotional state (irritated? Angry? Indifferent?) can affect the patient is shocking to many participants: the patient can become insecure, scared or put off, and it is then difficult to communicate well to develop trust and make the patient feel safe. This can prevent the provider from finding out what the real problem is, and thus s/he may not be able to give good quality care. 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 competently – to develop trust and establish a professional relationship with the patient. The self-observations and reflections participants have engaged in the last 3-4 months, to discover problems (and some solutions) – will now be deepened by reflecting interactively with colleagues in the workshop.

In our course, communication and emotional competence skills are taught in work contexts where they have important functions to help providers build trust and make the patient feel safe, and to establish a professional relationship with the patients to cooperate as partners in care. Such 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 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 the appropriate set of skills for each context and situation. Learning how communication and emotional competence skills work together enables participants to practice constructive communication 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.

All the concepts introduced in this module will support this process and these aims.

There are five sections in this first module. An overview:

1. **Setting the climate and establishing relevance** – welcoming and appreciating participants (slide 1)
2. Establishing **where we are in the learning process**, linking this to course history and international research (slides 2-6);
3. Looking at **aims for the course**, what we are going to learn, and course approach (slides 7-10)
4. Understanding **core concepts underlying the course**, linked to examples from participants' observation tasks (slides 11-33)
5. **Introducing participants and trainers** through appreciation and expectations (slides 34-35)

Further background about purpose and contents of the sections

1. Setting the climate – establishing relevance

Welcome participants to the workshop and appreciate them sincerely for all the work they have done through the last 3-4 months: Acknowledge their learning through the self-observation and reflection tasks and thank them for the many good examples they have contributed. Acknowledge that you and the other trainer(s) have read their examples, learnt a lot about their situations and challenges from these, and that you have built their examples into the workshop contents. Tell them that you are impressed with the good work that they have done, and that this is the basis for the work we will be doing together during the course – by continuing to reflect together on challenges they have experienced.
This will establish the relevance – from your side.

To ***confirm the relevance from participants' side***, you need to ask an open question related to the self-observation and reflection tasks, e.g. – *How was it to do the observations? Would anyone like to share what they learnt?* A couple of contributions here will make them connect to their learning and make them feel that their work has been worthwhile, and important. Acknowledge and appreciate their contributions – but ***do not comment or go into long discussions here***. If they are reluctant to speak up at this point – have one of their (brief) examples with you and read this out. This may inspire others to contribute.

2. Establishing where we are

Participants need to see where they are in the learning process – to acknowledge that they have now concluded Phase 1 (*baseline, self-observation and reflection – the first self-learning phase*) and are now starting Phase 2 – the intensive basic skills-training workshop. Reminding them where we are now helps them get settled and be present for the workshop.

The history of the project is special (*see also the introductory chapter in the manual, to inform yourself*) – and the purpose of introducing this here is to make participants see that the course has been developed and refined with health professionals like themselves in several countries, over many years. This will help them feel that they are part of a "larger task", that they are not the only

ones having trouble with using communication and emotional competence skills well with patients and colleagues.

The brief reference to literature and to research on effective communication skills training builds this understanding further: Participants will see that their challenges are felt by providers in many countries, and – that our course is built on an understanding of this, and on the best evidence for which contents and methods we have chosen for the course. *See also a brief summary of evaluations of communication skills training for nurses, at the end of this module, and further evidence in the manual*.
Our "Meta-message": You are in safe hands, we know what we are doing, it is based on evidence. This is also the time to build trust with participants and make them feel safe in the workshop.

3. The Aims and contents of the course

This section makes it clear what we are aiming to achieve in the course, and the contents we will cover throughout the workshop period. Explaining the course approach, you can re-emphasize the focus on making the course relevant to their needs and situations, and that the course will be interactive, with a lot of practice of the new skills. The literature is very clear on this point: ***Practice with feedback is key to learning communication and emotional competence skills.*** This may be new to many – who have been taught communication skills mainly through lectures and theory (*which is what many basic training schools, as well as Continuing Medical Education courses, still use)*. Most of your participants may not have been taught anything about how to recognize and manage their emotions – these are topics not often taught in medical (or other) education. Inform them that of the 350 providers trained with the iCARE-Haaland model in 9 countries (2006-20), most of them said that ***the emotional competence skills were the most important ones they gained***, and – they did not know that they needed these skills.
Meta-message: Prepare to pay attention to the emotional competence skills already now!

4. Understanding core concepts underlying the course

This is the main part of the presentation: To explain and exemplify the concepts we are using to guide our training, and - show how we use them as a basis for communicating with patients with emotional competence, when practicing patient centred care. Thus, the way the training is conceptualized and conducted is closely interwoven with good clinical practice and care.

The sequence of the concepts is carefully constructed – to make them build on each other.
The idea here is to introduce the concepts briefly and use these 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 work context and reality.

Critical thinking is one of the core concepts and is an important skill to be cultivated throughout the course. It is therefore introduced specifically, see below for more info.

We have suggested in the slides to ask brief questions throughout to ask for confirmation of the issues observed – recognizing that not everybody's observations have been quoted. Asking questions will enable trainer to ensure relevance and maintain the contact with the group.
Research has shown that when training is made relevant to participants' everyday work life and challenges, motivation to learn is strengthened.

5. Why do we introduce participants so late?

It is common in training courses to introduce participants and trainers before starting to teach. There are several reasons why we do this at the end of this module:

- **Firstly,** at the beginning, everyone is a bit nervous and unsettled, and if doing a classical introduction where people say their names and where they are from, most will not listen to what the others are saying, but rather think about how they will introduce themselves.
- **Secondly**, we have a clear aim with the introduction – we want them to practice a new skill and discover the effect of appreciation on themselves and their colleagues. Participants will only be ready for this after they have settled – which usually happens during the first hour, when they hear their examples from the observations being used to illustrate the concepts for the course. They then get a sense that their learning and contributions have been received, and valued. They experience that the contents will be very relevant to them, and – they connect with their motivation to learn: *they are then ready to participate in the first exercise, and to really get to know their fellow participants. And also – to maybe enjoy the surprise, joy and occasional embarrassment when colleagues appreciate them openly for their good personal and professional skills.*

Notes on one of the special concepts: Critical thinking

Critical thinking is an essential part of the course, as an underlying concept or approach used throughout the four phases of our training process. 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."

We further quote from "The Foundation for Critical Thinking" the following on description of the problem, definitions of Critical Thinking, Analysis, Assessment and Results:

"Why Critical Thinking? The Problem

Everyone thinks. It is our nature to do so. But much of our thinking, left to itself, is biased, distorted, partial, uninformed, or downright prejudiced. Yet, the quality of our life and that of what we produce, make, or build depends precisely on the quality of our thought. Shoddy thinking is costly, both in money and in quality of life. Excellence in thought, however, must be systematically cultivated.

A Definition

Critical thinking is that mode of thinking — about any subject, content, or problem — in which the thinker improves the quality of his or her thinking by skillfully analyzing, assessing, and reconstructing it. Critical thinking is self-directed, self-disciplined, self-monitored, and self-corrective thinking. It presupposes assent to rigorous standards of excellence and mindful command of their use. It entails effective communication and problem-solving abilities, as well as a commitment to overcome our native egocentrism and sociocentrism.

To Analyze Thinking

Identify its purpose, and question at issue, as well as its information, inferences(s), assumptions, implications, main concept(s), and point of view.

To Assess Thinking

Check it for clarity, accuracy, precision, relevance, depth, breadth, significance, logic, and fairness.

The Result

A well-cultivated critical thinker:

- Raises vital questions and problems, formulating them clearly and precisely
- Gathers and assesses relevant information, using abstract ideas to interpret it effectively
- Comes to well-reasoned conclusions and solutions, testing them against relevant criteria and standards
- Thinks openmindedly within alternative systems of thought, recognizing and assessing, as needs be, their assumptions, implications, and practical consequences
- Communicates effectively with others in figuring out solutions to complex problems

Wikipedia (*the free encyclopedia*) defines **Critical thinking as "**The art of analyzing and evaluating thinking with a view to improving it." The following quote on research relates to our course:

"Research in efficiency of critical thinking instruction

A meta-analysis of the literature on teaching effectiveness in higher education has been undertaken.[25] The study noted concerns from higher education, politicians and business people that higher education was failing to meet society's requirements for well-educated citizens. The study concluded that although faculty may aspire to develop students' thinking skills, in practice they tend to aim at facts and concepts in the disciplines, at the lowest cognitive levels, rather than development of intellect or values."

Relevance of critical thinking for our course

In our course, we aim at giving participants tools to reflect and learn on higher cognitive levels – which makes the learning more useful, and sustainable. The construction of the course process and the choice of learning methods is made to reach this aim. Participants are continuously challenged to self-observe, think and reflect alone (observe "In Action", to discover, and reflect "On Action", to learn), and together in smaller and bigger groups (interactive reflection). Each time they are strengthening the vital skill of critical thinking. Participants have already made a very good start at this learning, when practicing the self-observation and reflection tasks.

Further reading on critical thinking: See at the end of this module, and on the websites.

Time needed: 2 hours.

Time management: The first part – introducing the course and the concepts – should take no more than an hour. The introduction part takes 45 - 60 minutes. It is usually not necessary to take a break – as sitting in groups to learn to know each other is experienced as a break.

Handouts: Programme, and presentation (6 slides per page, double-sided = 6 pages)

Materials needed: Flipchart, marker pens, tape to put up flipcharts on the wall

Facilitator/co-facilitator roles: This presentation is best done by the main trainer responsible for the course. Other trainers can function as assistants, rather than "co-facilitators" (*see definition in the introductory chapter to the manual*).
Assistants should distribute handouts, show or role-model how to introduce each other, and write expectations on flipchart. NB – *Choose a trainer who writes clearly for this exercise!*

Two trainers should prepare to start the introduction exercise, to "set the standard" for what kind of appreciation we encourage, and – for it being brief. Participants may have a wish to say a lot, especially those who know each other – and if this is allowed in the first presentations, others will follow this lead – and it will take too much time.

An example of what the trainers could say: "*This is my colleague Sarah (who is asked to stand up while being introduced). She is a nurse, and I really appreciate working with her because she is very observant and encouraging: If I am struggling with a task, she is quick to help and support*."
Choose any feature of the colleague you want to comment on – but make it brief and related to the work situation. Participants will pick up from this example. If participants go on and speak about several things they appreciate, gently interrupt, appreciate with humor (e.*g. – "It is great to hear there at so many things you want to appreciate with M – for now, let us stick to just one, and I am sure we will experience the other good sides during the course"…. Or something of that kind*).
If you are alone as a trainer – choose a participant you know, and role-model the first intro with him/her, as above.

Note on the comments to the slides, below: The comments are suggestions for what to say and to focus on, based on trial and error to find out what works well in our courses. Please make your own, depending on your situation.

It is however essential to ask questions of participants, consistently, to keep them involved – and to make sure the teaching is experienced as relevant and is being understood.
When you manage to do this – participants will be motivated, and will learn well.

Presentation slides: Comments, questions, main points to bring out

<table>
<tr>
<td>

Communicating with awareness and emotional competence with patients and colleagues

Communication and emotions in theory and practice

Kilifi 2010-2020
Ane Haaland, Mwanamvua Boga,
All trainers and participants

Communicating about clinical care and research with patients and colleagues

Communication and emotions in theory and practice

Kilifi 2010-2020
Ane Haaland, Mwanamvua Boga,
All trainers and participants

</td>
<td>

Introduce the course in your own words – see background. *If research is a part of your course – use alternative slide, below.*

Ask e.g. We gave you observation tasks to look at how you communicate and how you deal with emotions. *How was it to do these observations?* Give them a minute to talk to their neighbour, then ask in plenary.

Main points:
To link the work participants have been doing (through self-observation and reflection) to the learning we will be doing during this workshop;
To bring out emotions as an important part of the course, and emphasize that communication always has an emotional aspect to it, and in this course we are learning how they work together, and how to manage them;
To make them see that challenges they are experiencing in their profession are the same as challenges for health providers in other countries, and that

The approach to learning in our course is built on ***evidence*** from research, and – on their needs

</td>
</tr>
<tr>
<td>

Objectives

To create awareness about
- Where we are in the learning process
- The history of developing the training model
- The aims and contents of the course
- The gaps in communication skills training for providers, from the research literature
- Our approach building on research evidence, and – on their needs for learning
- The concepts underlying the course

To strengthen skills in
- Using appreciation as a communication method, and
- Reflecting on the effects of using this method, on participants' emotions

</td>
<td>

Read out the objectives
Explain – we will introduce each other at the end of this presentation of the main concepts we use in the workshop. Then, we will also ask you about your expectations for learning this week.

</td>
</tr>
<tr>
<td>

Overview: Our learning process

Participants – (add – how many are in the course, where/institution they come from)
Preparation (Phase 1)
- Baseline questionaire
- O&R tasks: Pack 1 – communication skills
- Pack 2 - emotions
- Pack 3 – research/anxiety, medical terms, PCC

Now: Workshop 1: 5 days Intensive course (Phase 2)
Next phase (3): Putting skills into practice
(Time/dates: 3 months, 3 packs of observation tasks)
Endline questionaire (date)
Final phase (4): Follow up workshop, 3-4 days (date)

</td>
<td>

Fill in your own dates to give an overview of what you have done, where you are now, and where you are going.

Main points: Participants should get a sense of where they are in the process, see "the whole picture";
Get a sense of accomplishment by linking to the preparatory phase they have been through;
See that the process continues after the workshop.
This will help to "ground them" in where they are, here and now.

</td>
</tr>
</table>

History of the training project

- Process training approach, contents, methods and tools developed with users/ providers by Ane Haaland with Norwegian NGO 2006 -08
- Implemented and refined in Lithuania, Tanzania, Nambia, Zambia, Latvia, Russia and UK/Wales
- Two Kenyan nurses (J. Chakaya and M. Boga) participated in Zambia 2008
- Took initiative to adapt +implement process in Kilifi from 2009, and added research aspect.
- AH lead process and training. M. Boga took over as lead trainer and coordinator in Kilifi in 2012
- Course now run independently in Kilifi
- M Boga took course to Gambia, 2015-17
- Course run for trainee doctors, Wales UK, 2016-17

Participants and trainer, Lithuania 2006

Trainers w/ AH, Kilifi 2012

Explain and acknowledge the history and origin of this iCARE-Haaland model.

Main message: The model is developed by an experienced communication trainer and social scientist, in close collaboration with doctors and nurses in TB hospitals and in regular district hospitals and institutions – based on their felt needs.

The model has been tried out and further refined in nine different countries, proving to work well in all these different cultures.

Literature reviews: Problems in communication training for providers*

Contents, methods and approach:

- ***Focus on:***
  - ***Mechanistic – not relational communication***
  - ***Theory, not practice***
  - ***Cognitive learning, not including emotions***
  - ***Patients' needs, not including providers' needs***
  - ***Short term interventions, few implemented over time***
- ***Teaching not adapted to learning styles of students***
- ***Contents not based on providers' daily challenges***
- ***Lack of focus on patient-centred approach***

Outcome

- ***Training does not lead to improved communication practice***
- ***No effect on behavior change, or patient outcome***

* *Reviews on evaluation of training for nurses, Europe and the US*

Explain: The problems we are experiencing here are common across many countries.

Refer main points from this article by Chant et al (*read the article before you teach*), add other ref from literature if you wish. The picture very similar.
The last ten years, there have been initiatives to train providers in health communication in several countries. This is not yet "mainstream" and needs much attention: The training gap is big, especially in low resource countries.
Ask them to think about communication skills training courses they have attended before, in nursing or medical school, and reflect on this gap.
Discuss their experiences.

Useful resources and links on emotions and EI

- Link to Emotional Intelligence article
- http://m.huffpost.com/us/entry/us_5952b6b8e4b0c85b96c65d4e

- Interesting Ted Talks:
- https://www.ted.com/talks/brene_brown_on_vulnerability?language=nb and https://www.ted.com/talks/brene_brown_listening_to_shame?language=nb
- https://www.youtube.com/watch?v=ISbsGGK8vvI Susan David
- http://heartsinhealthcare.com/doctors-dont-cry/

Use this to encourage self study.
You can also use some of these resources in the presentation.
It may be useful to view together the Ted Talk on Vulnerability, and discuss this in the group.

Developing/strengthening emotional competence is a key aim in the course process.

Research: Effective communication skills training characterized by:

- Longitudinal, using reflection
- Safe learning environment
- Experiential learning methods
- Active small group learning
- Use in clinical practice
- Critical reflection
- Focus on emotions, not on thoughts alone

Aim:

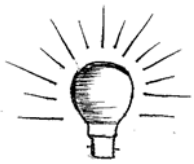
- ***Develop professional identity***
- ***Core human values***

Van Weel-Baumbarten, E (2010): Best Evidence Teaching Communication Skills. Presentation to the third Geneva conference on Person-centered Medicine, Geneva May 35th 2010.
Branch, W: Teaching professional and humanistic values: Suggestion for a practical and theoretical model PCC 2015

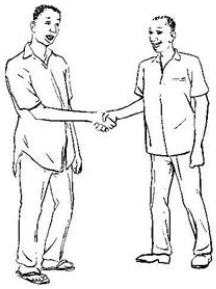
Link the training approach to international literature, using your own words. Explain how this research has informed contents and methods of our course.

Main point: Effective communication skills training is characterized by being conducted over long term. It uses experience based learning methods, is practice based + focus on cognition AND emotion.
Meta-message: We know what we are doing, they are in safe professional hands – even if it may feel strange, sometimes!
Affirm that the training we offer is evidence-based. Link our training to the evidence (*e.g. by ref to the long term aspect, and the reflection tasks*).
All we do has a reason, to be found in research evidence.

Overall training aim: **Strengthen knowledge, skills and self-awareness to communicate with emotional competence**  *Discover why you may blame patients - and why and how communicating with awareness and respect for emotions, works better* 	**Explain the overall aim:** To teach providers knowledge, strategies, skills and self-awareness – so they have a "toolbox" and can choose the right strategy for each situation they meet. **Communication is complex**, and there is no "common solution" to all situations: Providers need to identify and assess the needs in each situation they meet. ***The course will give them tools to do so. We will give them tools, slowly, to fill into their tool basket. At the end of the course, we will revisit the tool basket, and review the uses for the tools.***
Aims of the training process • **General:** To strengthen providers ' **awareness** of *what facilitates and what hinders good communication with patients and colleagues* • **Personal**: Strengthen awareness of *how you communicate with others*, and of the ***effects*** of your own communication habits, on the other person • **General:** To strengthen providers **skills** to communicate **professionally with respect** • **Personal:** Strengthen **skills** to recognize and manage your own and patients' emotions with awareness and respect • To strengthen providers **skills** to communicate about research .  	**Explain**: These are the specific aims for the training process. **We are aiming** to strengthen their awareness of how and why to communicate with respect and emotional competence, to establish trust and form a professional relationship with the patient – and train them in skills to do so. Furthermore, to use the same skills when communicating with colleagues and supervisors. ***Note:*** *If research is not part of your agenda, drop the last point on this slide.*
Overview – contents workshop 1 • When and how do ***adults learn best*** • Basic communication ***theory and skills***, related to clinical care+ research • The effect of ***emotions*** on communication – and how to build emotional competence • Why do ***conflicts*** occur, how to handle them • How to ***step back*** to see a situation clearly • The effect of ***blaming and judging*** patients, on learning and adherence • Understanding and handling ***anger, fear*** and ***insecurity*** • How do people ***change attitudes*** and behavior • Communication ***strategies***	**Explain:** These are the topics we will deal with in this workshop. When reading out the topics, give example(s) /refer briefly to situation(s) from their everyday work-life – to link the contents firmly in their reality. *If research is not on your agenda – delete this point*
Course approach: **Supportive process learning** • Theory founded course • Participants' observations and reflections = basis for adapting course contents • *By using your situations, learning will be relevant* • Practice with feedback bridges knowledge and skills  	**Explain:** The course is founded on theories from a number of disciplines, for ex adult learning theory. **Main points:** Participants' own descriptions of challenges at work are used to exemplify and explain theories, to make the learning relevant – and effective **We use a lot of practice,** to apply and link learning firmly to everyday work (*These points are linked to effective communication skills training, from literature)*

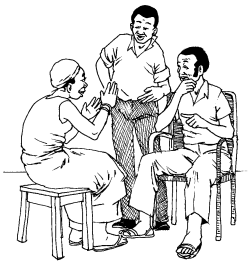
Key concepts in learning and practicing good communication with patients, colleagues and supervisors – aiming for *Patient Centred Care:* **1. Awareness** 	**Explain:** A number of key concepts are underlying the teaching throughout the week **Patient centred care** is the clinical foundation we use as a guide. The first concept is **awareness.** **Ask:** What is awareness? **Main point:** Awareness means to pay attention to what you are doing and saying, and how you are doing/saying it, and to the effect of this, on the other person. This is what you worked on when doing the **observation and reflection tasks.** (*Make the link)*
Examples from participants *"I found that listening to my clients without interfering as they talk to me was good as it gave them time to explain all their complaints and gave me time to think about their problems".* *"Have realized that I am a poor listener and I don't pay attention to instructions. Sometimes I interrupt when one is talking with my own opinion. I have been harsh, rude and most people told me that I am always serious and thus fear me."*	**Ask** co-trainer or participant to read out examples. **Ask** if others have seen and experienced similar things? (*just get confirmation of relevance/link to their observations – not discuss here – you'll run out of time*). And don't comment – just ask if the second example is related to emotional competence? And get a confirmation… and say we will work with this.
Key concepts: 2 **Critical thinking; Reflection, insights**  	**Explain in your own way:** **Critical thinking is closely linked to awareness**: You become aware, you reflect and think about what you have seen or realized; then use critical thinking to decide what to believe, or what to do. **Critical thinking and reflection**, based on observations, knowledge and experience, will lead you towards skillful judgment of the situation. (*ex: – the way I listen is a problem because of a, b and c)* You will then know what is the best action to take. **Insights** will guide you to assess the outcome and continue to learn. These are the "AHAAA!"-moments, when you realize something is working well, or not well – based on what you have seen. **In hierarchical societies**, critical thinking is often not encouraged: *It is seen to challenge authority*
Example – Insights *"I never knew "listening know how is communicating know how". I learnt that when I am involved in a conversation, I have to bear in mind that the person I am talking to is much more interested in himself, his needs and his problems'.* *"Medicine is strange to non-medics so we need to engage patients, clients and their relatives in management and to succeed in this we have to communicate effectively."*	**Ask** co-trainer or participant to read out examples. (*NB Do not comment/evaluate by saying e.g. "This is good"; "I very much agree with this", or similar – then you make it a personal comment.* *Rather ask – "Do you recognize this?" "Is this the case?" "This is a powerful example". Then you comment in a non-personal way)*
Example – Reflections *"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 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"*	*This example shows the need to build emotional competence, to recognize and handle anger.* **Link these examples** to their own observations by asking leading questions for confirmation – thus ***maintaining the contact with the group***. This is all about THEIR examples – we have "just" sorted them to illustrate the course concepts.

Key concepts: 3 **Respect** 	**Ask them to buzz:** What is respect? Get feedback/suggestions. **Add your own words and conclude: Respect** is the main attitude and skill which help you build trust and establish a professional relationship with patients. Respect shapes the quality of the interaction between you + the patient, colleague or supervisor. A person who is feeling vulnerable (e.g. sick) is especially sensitive and needs to be shown respect. **The ability to show respect** is in all of us. ***Respect is usually linked to positive emotions, and often linked to practicing emotional competence.*** **The willingness to practice it is** based on awareness about its importance (*see next slide*), and the perception you have about how respect should be shown in your culture. "***Culture***" here can be national, or professional/medical. This perception is often ***subconscious*** – you have not thought and reflected about it. ***Lack of awareness leads to automatic reactions.***
Examples **How do you feel when treated with respect?** ➢ *"I feel good and appreciate it, I also ensure I give that person twice the respect they gave me"* ➢ *"I feel great, am motivated to do better and even respect the other person"* **When treated without respect?** ➢ "*When I sense disrespect from someone geared towards me I feel bad, angry and if I decide to react then I can tell what I think about that person*" ➢ *I feel offended feel demoralized and my moral goes down"*	**Read the examples/get someone to read.** **Ask:** Can you recognize these kinds of reactions in yourself? (*Not to discuss – just for confirmation of relevance)* **Ask them to reflect:** If this is how you felt as a healthy person – take a moment to reflect on how a mother with a sick baby feels after she has - *struggled to come; *come late; *borrowed money for transport and medicines – ***How will she feel when met with disrespect?*** What could be consequences for her + the baby? Ask them to buzz briefly; get feedback.
Key concepts: 4 **Empathy** 	**Ask them to buzz:** What do you understand by empathy? What is it? **Get feedback. Add on empathy** in your own words. **Main points:** Empathy is to step into the shoes of the other person, with awareness, and 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 and emotional competence*** ***NOTE:*** *This concept is central in the course. Participants have experiences, link to these.*
Example *"I carry so much of the patients burden (sickness) and really feel for the patient and most of the time I put myself in the patient's shoes"*	**Read** the example/get someone to read. **Ask (e.g) –** did you experience using empathy when doing your observation tasks? (*just asking Yes/No question – to keep group involved/active, and link concepts to own situation*)

Key concepts: 5 **Humanistic medicine**  • Interdisciplinary • From ***Disease-centred*** to ***Patient-centred*** care • **Aims:** – Open communication – Mutual respect – Emotional connection between HP + patient	**Ask them to buzz:** What do you understand by patient centred care (PCC)? **Get feedback, discuss. Add briefly on** Humanistic Medicine in your own words (see article). **Emotional competence** is very often a part of PCC. **Main points:** Patient-centred care is accepted (through research evidence) as meeting patients' needs, beliefs, ideas and opinions better than the "pure" medical disease-centered model which is dominating medical training. ***Our training focuses on patient-centred care*** – assuming that the (technical) medical needs of the patient are taken well care of.
Example *"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 and taken care of very well."*	**Read** the example/get someone to read. **Ask** e.g – has any of you experienced patient-centred care, as a patient yourselves? How did you feel/what effect did it have on you? (get one example, briefly)
Key concepts: 6 **Appreciation** 	**Ask:** How does it ***feel*** when someone appreciates you? (*get short answers – "good", "inspiring", etc*) **Ask: When** did you last appreciate a patient, or a colleague? **Get** brief feedback **Main points:** We 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".*** **Explain**: In this course, we will use appreciation, and discuss the effects it has on us.
Example ➢ *"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.*	**Read** the example/get someone to read.

Key concepts: 7 **Responsibility**  You cannot change others. You can take responsibility for own change	**Explain** in your own words: **As providers**, we often want people to change behavior. A common method is to ***tell them what to do*** and expect change. We take the ***responsibility*** for determining their change. We see that ***very often, people don't change*** Often, we ***blame them*** for "not knowing what is best for them" (*implying that YOU know this*) 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. We need to acknowledge that ***the responsibility for making changes, lies with the person practicing the behavior***. It does NOT lie with us!
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!"* *'I think I need to put more words into my explanations because sometimes I use very few words/ statements hence somebody can't understand"*	**Read out** the examples
Key concepts: 8 **Motivation** 	**Explain** in your own words: **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.
Example ➢ *"When I am treated with respect, I feel happy, absolutely honoured, my levels of motivation are usually high and naturally take to my heart the whole situation"* 	**Read** the example/get someone to read.

Key concepts: 9 **Empowerment** 	**Ask them to buzz:** What does "empowerment" mean? **Add/Explain** in your own words: **Empowerment** means to ***give or delegate power*** to someone, to enable that person to take the power and decide how to act on his/her own. (Or – something that has been added on to you – to strengthen someone's ***ability to act.)*** **As providers, we are used to having power** over patients. If we want them 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. **Conclude**: We will work on practical empowerment.
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 not 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"*	**Read** the example/get someone to read. **Ask:** Can this be done? Why is it difficult to do this? **Discuss** briefly.
Key concepts in the course: **10. Handling conflicts through conscious communication**  From Persuasion……To Dialogue	**Explain** in your own words: ***Our second last concept is – dealing with conflict by communicating with awareness.*** It means that we learn ***why conflict occurs***, what makes people (ourselves, and patients/colleagues) ***react***, and how to ***stop our own automatic reactions.*** We will learn ***practical ways*** to handle conflict constructively. This means to practice emotional competence.
Example *"I confront **at the right time** especially when the person I have had a conflict with, I keep the communication open so that we can resolve the issue between us. I acknowledge the problem and if am on the wrong I never hesitate to apologise"* *"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 angered but it's good to have self-control, otherwise the end could be destructive."*	**Read** the example/get someone to read.

Key concepts in the course: **11. Have fun – why?**  *Research shows:* When participants enjoy learning, they learn better	**Ask:** Why is fun important for our learning? **Get feedback; Discuss/add** your own words: Having a good atmosphere in a workshop is important for good learning. This includes having fun, laughing at ourselves and laughing with each other. *This is seriously established by research!* So you do not need to worry – if we are also having a good time, we are not "wasting your time" – we are learning well.
Communicating about research **Challenges:** • *"Fear of explaining complications/ risks/assuring patients of their safety to participate in research"* • *"Not able to listen, asking questions/exploring patients feelings about research"* • ***Concepts we use to communicate clinical care are applicable to research***	**Use this slide if your institution** is also dealing with research, and your participants are involved in obtaining consent for research and for taking research samples (e.g. blood) from patients. **Main points:** When participants learn to communicate well with patients in clinical care, they use these skills to also communicate well about research.
Our Expectations ***We expect that during the course, you will:*** • find contents relevant to your situation and needs • work hard • take with you: – New insights, ideas, skills and questions; – A motivation to use the new learning to take action in your work • tell us when something is not clear, or does not feel right • participate to the best of your ability	**Explain** in your own words: **As trainers**, these are our expectations from you. **Ask:** Are these fair expectations? **Get** feedback.
Introductions: Our resources • Sit in groups of 3, with colleagues you know • Tell colleagues what you appreciate about them – how they are a resource • Let other colleagues add • Be generous, and honest • Discuss your expectations for this week • Each group presents their members, and expectations 	**Explain:** Now, it is time to hear from you – who you are, and what you expect from this course. We will do this in a way that may be new to you?? **Divide participants** in groups, give instructions. When getting feedback, start with the trainers – to show an example of how to do it (*see instructions*) Get appreciations from the group (of 3) first, then ask for expectations (from the group). Ask co-trainer to write expectations on a flipchart, hang on wall, ***leave it there for the week***. After introductions – ask – ***how did it feel to be appreciated like this?*** **Main point:** Some feel shy, all feel good: It is a powerful tool that lifts the mood, and motivates.

Slides with literature references – in the presentation.

Exercise, additional examples, and selected literature

Exercise 1: Our resources

Purpose: To strengthen awareness of how to use the method of appreciation with patients and colleagues, and of the effects of using appreciation on self and colleagues. Furthermore, to strengthen motivation and skills to use appreciation consciously with others in their own work.

Procedure: Discussion in groups

- **Let the participants form their own groups** of 3, with someone they know. If some groups want to be 4, let them (the main thing is – they should feel at ease with each other in the group). If a group is 5, let them divide into two groups of 3+2 (it takes shorter time for the group work).
- **Give them 7-10 minutes** to talk together about the questions on the slide – on what they appreciate about each other, and what they expect from the course.
- **Explain** that they will afterwards introduce each other, by saying name of the colleague, what s/he works as/what her profession is, and one thing the person appreciates about her.
- Trainers should also do this exercise – by talking to each other about what they appreciate with each other.
- ***This is an important exercise, the first one in the course, and should not be rushed.***

Procedure: Feedback on appreciation, and expectations:

- **Trainers start the feedback** by showing an example of how to do it. For example, a trainer pair would say: "*This is my colleague Hiza, I appreciate her because she is always wanting to learn – she is asking many questions, and she helps me see things in new ways. Hiza is a CO, and works for KEMRI"* Hiza responds: "*And this is my colleague Baya, I appreciate him for his great energizers, he is always able to make the group wake up and be able to learn again! Baya is an occupational therapist, and works for* …." (there is usually laughter….)
- **Then, ask** for a volunteer group to start, and point out that even though we assume they told many good things about each person to each other when they exchanged, we want them to tell us ***only one thing about each person now***, in the interest of time.
- **NOTE:** *If you don't have your trainers demonstrate how to do this, you may end up with very loooong feedback reports, stating e.g. "This is Phelomena, she is a mother of three beautiful boys, and ….." When one participant is allowed to talk about family issues, you can be sure that all will start with this, and focus on this… and you will spend a lot of time, and – miss out on the main purpose of the exercise: To appreciate someone for something they are good at,* ***at work****.*
- **Feedback on expectations:** After each group of three has introduced each other, ask the group for their expectations, and have your co-trainer write this on a flipchart, and then proceed to next group – to appreciate each other.
- **As the groups continue** to give their expectations – ask them to report only additional points that have not been mentioned before, to avoid repetition.
- **Ask for effect of being appreciated:** Ask the group what they felt about being appreciated in the group. At this stage, they are not used to talking about their feelings, so if nothing comes out, ask them to talk in their groups for a minute, and then ask again.
- You can also ask your trainer(s) to comment first, if the group is hesitant.

Main points to be brought out

- Points that will usually come out about **how they felt** are - "It felt very good", "It made me feel motivated to work more", "It made me feel shy", "I wanted to cry", etc. (Trainer should

just acknowledge each contribution with a "Thank you", and ask for other contributions – he/she ***should not comment on or evaluate*** each contribution.

- The trainer should comment when several have contributed, e.g. saying –
- (*choosing one or two participants – asking*:) What your colleague told you now – have you heard this before? *(making the point that – many of us might think positive things about people around us, but not say them – why?)*

At the end of the appreciations, trainer can comment e.g.

- "It sounds like this was a very good experience for you? Can we use this method in our work?" (*just asking for confirmation – not going into a discussion: At this point, you just need to conclude the exercise and the session. Make the point – e.g. You have seen the effect of appreciation – it makes you feel good. When you feel good about what someone – a colleague or a patient – has done, let them know, by appreciating them/what they have done. When you appreciate consciously, this usually has a positive effect on the other. It is important for job satisfaction, and can prevent conflicts at work.)*

Expectations

- **At the very end,** comment on their expectations: If there are some that you know you will not meet – say so, and ***explain why you cannot meet them*** in this course. Ask your co-trainer to hang the flipchart(s) on the wall, and tell the group you will check throughout the course that you are meeting the expectations.

NOTE: Do not rush this exercise – it is an important one which sets the mood for the whole week.

NOTE 2: It is a good idea to have one of the trainers make notes of what each participant is being appreciated for. This could e.g. be used on the certificate of the training course.

Additional examples from participants' observations

Awareness

"I found out that I spend lots of time not listening to what is being said but forming a reply. I realized that am only interested in my own ideas and pay little attention to the words of others"
"I didn't know that lack of eye contact when someone is speaking to someone convey disinterest, distrust and a lack of caring "

Critical thinking; Reflection, insights

*"*I *never knew "listening know-how is communication know-how". I learnt that when am involved in a conversation, I have to bear in mind that the person I am talking to is much more interested in himself, his needs and his problems".*

"I think I should be more patient, listen more and avoid being judgemental and giving conclusions before I have given myself time to listen to them".

Respect

How do you feel when treated with respect?

- *"I feel valued and appreciated as person"*
- *"I feel good and honoured and greatly motivated"*

When treated without respect?

- ***"****I feel someone has degraded me, despised me and feel really bad".*
- *"I get worked up and irritated, Feel like revenging back."*

Empathy

"*There was this woman who came frequently with recurrent asthmatic attacks used to give her medication without listening to her complains and when examining her God knows I branded her "**mama wa asthma**".*
She would respond well to medication only to see her the next day. After attending these training sessions I decided to give her an ear. She really poured her heart out. She has been undergoing cascades of marital problems which were the core cause of her attacks."

"*Have found out that if I narrate or give my story to colleagues or patients on issues or something that happened to me, the person am talking to gets the courage to tell me their part without making faces or commenting, wins my partners confidence to say their side of story / opinion"*

"By self-disclosure, a times I disclose what I have gone through in my life and I have won most of the clients cooperation and confidence which sees them give their ideas"

NOTE: Telling about your own situation is often NOT experienced by the other as empathy!! Sometimes it is – but this method has to be used carefully. Providers are encouraged not to disclose intimate or sensitive issues which could make the patient feel embarrassed. **It is often easier for the patient to relate to the disclosure if you "assign" it to a colleague – i.e. the provider pretends that the experience "belongs" or happened to a colleague. The patient is then more free to look at the issue – and not feel forced to "accept" it for herself – if it is not right for her/him.**	

Humanistic medicine and patient-centered care

"*A patient might come with one problem but when you interact and dig up might have more issues which might have contributed to defined problem so holistic approach to all patient as an individual can really help the patient wholly"*

"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 and taken care of very well."

"Have realized that patients are human beings just like us and already bitter because of their illness. A little smile on your face gives them hope, a warm welcome gives then trust and a gentle touch relieves pain. I wish I knew this before."

Reflection: *"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"*

Appreciation

"I feel happy when patient have faith in me and appreciate the service I render. This in turn gives me courage to practise the same to the rest of patients, hence job satisfaction".

"A patient saw how much I had been walking round and round the workplace without complaining and giving services. when I was about to hand over, he came to me and exposed his neck where he

was covering a burst abscess pouring pus soiling himself and requested me "I know and I can see you are already tired but I request you to put a new dressing here."
I felt very sorry for him and dressed the wound site. He appreciated and thanks were being rained on me. I went home satisfied for my work".

Responsibility

"*I have learnt that people are different; that I cannot change anybody. If anything I am the only one who can change to what I want to be. I have learnt to be more tolerant to other people"*

"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"

"*By reflection I have realized what makes me react easily and I realize that am capable of changing but still needs a lot of self awareness. But still you have to be aware of challenges you will undergo. Change is possible where there is a will there is a way"*

Empowerment

"There was a mother who was frequently admitted to the paediatric ward with her little daughter where she is observed and given treatment and later discharged home with treatment; but after a short time the child is being readmitted in the ward with the same condition.
I went to the mother and politely asked what happens to the child after discharge. I asked if she was giving the child the drugs she was given during discharge at home. She told me that, due to the nature of her work she was sometimes not able to fully comply with the treatment.
I understood that the child was not getting the treatment as she should have been and that was the reason of the recurrence of her condition and readmission to the ward.
I explained to her the importance of treatment compliance and she promised she would set her phone alarm to remind her the treatment time, even if it is in the middle of the night, for her daughter to take her treatment.
Before I started these classes I would have called her, told her the responsibilities and asked to do nothing less but to follow the laid down responsibilities.
Thanks to the communication skills training, I am a better communicator now."

Handling conflicts through conscious communication

*"I confront **at the right time** especially when I am with the person I have had a conflict with. I keep the communication open so that we can resolve the issue between us. I acknowledge the problem and if am on the wrong I never hesitate to apologize"*

"When I am faced with a conflict, I usually remain calm without making any communication. Take time and think on how to solve the conflict."

"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 angered but it's good to have self control otherwise the end could be destructive."

Further background and points from literature:

Reviews of evaluation of communication skills training courses for providers show a number of problems and shortcomings

A summary from articles by Chant, and Kruivjer – see literature list.

Lack of communication skills in healthcare

- Lack of clarity in defining theoretical base for curriculum planning and delivery. No coherent strategy for teaching communication skills.

Focus on mechanistic – not relational communication

- Emphasis is on learning concrete, discrete behavioural actions, and learning "lists of skills". Needed: on natural capacity for connection and relationship formation:
- …caring and communication are inseparably linked. You cannot hope to communicate effectively if you do not care about the person on the receiving end.

Poor evaluation of course outcomes

- Uncertainty amongst educators about what is good practice in communication skills teaching.
- Lack of research, and lack of evidence concerning effectiveness of different educational interventions.
- Rating student satisfaction, rather than patient satisfaction.

Teaching not adapted to learning styles of students

- Failure to adjust to individual needs or abilities of students – they have different learning styles which influence the impact of training.
- Failure to meet needs of students was a key deficiency

Gap between theory and practice

- Segmentation between education and work is a major barrier to effective and appropriate communication skills teaching.

Barriers to using communication skills in practice

- … nurses not only need good skills, they also have to have an environment open to good communication.
- Relationship: Occupational stress, burnout and social support.
- Lack of support structures for patients to enable them to cope with emotional distress, which hinders ability to communicate effectively.

Workplace policies and practice; hierarchy

- Traditional organization of nursing work, and fear of dealing with emotional distress, are barriers to empathy and communication skill implementation
- Modification in workload can lead to increased level of therapeutic listening by staff, and improved patient satisfaction
- Hierarchical structure of healthcare deters students and nurses from attempting to implement communication skills knowledge in practice.
- If communication skills are to be applied, more egalitarian and cooperative relationships between different professionals, regardless of perceived status, authority or power, is essential.

Lack of focus on patient-centered approach

- Very few studies have investigated patients' experiences and perceptions of how nurses communicate.
- Nurses can communicate well when they use a patient-centred approach. However, health care organizations do not appear to value or recognize the importance of nurses using such approach when communicating with patients to ensure delivery of quality patient care.

NOTE: Almost all of these points are addressed in the course process presented in this manual.

Further background on Critical Thinking

The Etymology & Dictionary Definition of "Critical Thinking"

The concept of critical thinking we adhere to reflects a concept embedded not only in a core body of research over the last 30 to 50 years but also derived from roots in ancient Greek. The word ''critical'' derives etymologically from two Greek roots: "kriticos" (meaning discerning judgment) and "kriterion" (meaning standards). Etymologically, then, the word implies the development of "discerning judgment based on standards."

In Webster's New World Dictionary, the relevant entry reads "characterized by careful analysis and judgment" and is followed by the gloss, "critical — in its strictest sense — implies an attempt at objective judgment so as to determine both merits and faults." Applied to thinking, then, we might provisionally define critical thinking as thinking that explicitly aims at well-founded judgment and hence utilizes appropriate evaluative standards in the attempt to determine the true worth, merit, or value of something.
The tradition of research into critical thinking reflects the common perception that human thinking left to itself often gravitates toward prejudice, over-generalization, common fallacies, self-deception, rigidity, and narrowness.
The critical thinking tradition seeks ways of understanding the mind and then training the intellect so that such "errors", "blunders", and "distortions" of thought are minimized. It assumes that the capacity of humans for good reasoning can be nurtured and developed by an educational process aimed directly at that end.

The history of critical thinking documents the development of this insight in a variety of subject matter domains and in a variety of social situations. Each major dimension of critical thinking has been carved out in intellectual debate and dispute through 2400 years of intellectual history.
That history allows us to distinguish two contradictory intellectual tendencies: a tendency on the part of the large majority to uncritically accept whatever was presently believed as more or less eternal truth and a conflicting tendency on the part of a small minority — those who thought critically — to systematically question what was commonly accepted and seek, as a result, to establish sounder, more reflective criteria and standards for judging what it does and does not make sense to accept as true. (…..)"

A quote on the website:

Critical thinking is self-guided, self-disciplined thinking which attempts to reason at the highest level of quality in a fair-minded way. People who think critically consistently attempt to live rationally, reasonably, empathically. They are keenly aware of the inherently flawed nature of human thinking when left unchecked. They strive to diminish the power of their egocentric and sociocentric tendencies. They use the intellectual tools that critical thinking offers – concepts and principles that enable them to analyze, assess, and improve thinking. They work diligently to develop the intellectual virtues of intellectual integrity, intellectual humility, intellectual civility, intellectual empathy, intellectual sense of justice and confidence in reason.

They realize that no matter how skilled they are as thinkers, they can always improve their reasoning abilities and they will always at times fall prey to mistakes in reasoning, human irrationality, prejudices, biases, distortions, uncritically accepted social rules and taboos, self-interest, and vested interest. They strive to improve the world in whatever ways they can and contribute to a more rational, civilized society. At the same time, they recognize the complexities often inherent in doing so.

They strive never to think simplistically about complicated issues and always consider the rights and needs of relevant others. They recognize the complexities in developing as thinkers, and commit themselves to life-long practice toward self-improvement. They embody the Socratic principle: The unexamined life is not worth living, because they realize that many unexamined lives together result in an uncritical, unjust, dangerous world.

~ Linda Elder, September 2007

For further background and details, please consult the website.