# 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

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# 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 participants' 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

# Overview: Our learning process

**Participants** – (add – how many are in the course, where/institution they come from)

**Preparation (Phase 1)**

- Baseline questionaire
- Observation and reflection tasks - Pack 1 – communication skills
- Pack 2 - emotions
- Pack 3 – research/anxiety, medical terms, PCC

**Now: Workshop 1: 5 days Intensive course (Phase 2)**

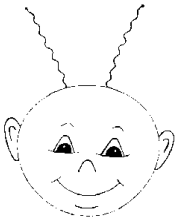
**Next phase (3):** Putting skills into practice (Time/dates: 3 months, 3 packs of observation tasks)

Endline questionaire (date)

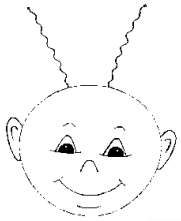
**Final phase (4):** Follow up workshop, 3-4 days (date)

# Reflective learning process – 9 months:
# Changing habits takes time

- **Phase 1: Self-observation and reflection (3-4 months' independent on the job learning)**
  - ***Awareness building:*** Weekly tasks – to **discover.** Narratives.



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



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

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

# 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*

# 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***

- ***Lack of focus on***
  - Importance of building relationship and trust
  - Why and how to relate to patients as persons
  - **Awareness and management of emotions; building self-awareness**
  - ***Contents not based on providers' daily challenges in clinical practice***
  - Learner-centered methods, and practice of new skills in work context

**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***

# 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/

# **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 3-5th 2010.*

*Branch, W: Teaching professional and humanistic values: Suggestion for a practical and theoretical model. PCC 2015

***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*

# Aims of the training process

**General: To strengthen providers' -**

- **Awareness** of *what facilitates and what hinders good communication with patients and colleagues*
- **Skills** to communicate **professionally with respect**

**Personal: To strengthen your**

- **Awareness** of *how you communicate with others,* and of the ***effects*** of your own communication habits, on the other person
- **Skills** to recognize and manage your own and patients' emotions with awareness and respect

**Research: To strengthen providers'**

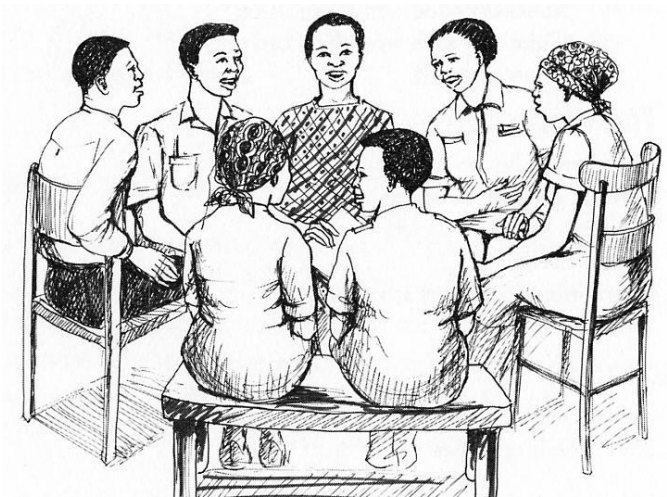
- **Skills** to communicate about research, with emotional competence.

# 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***

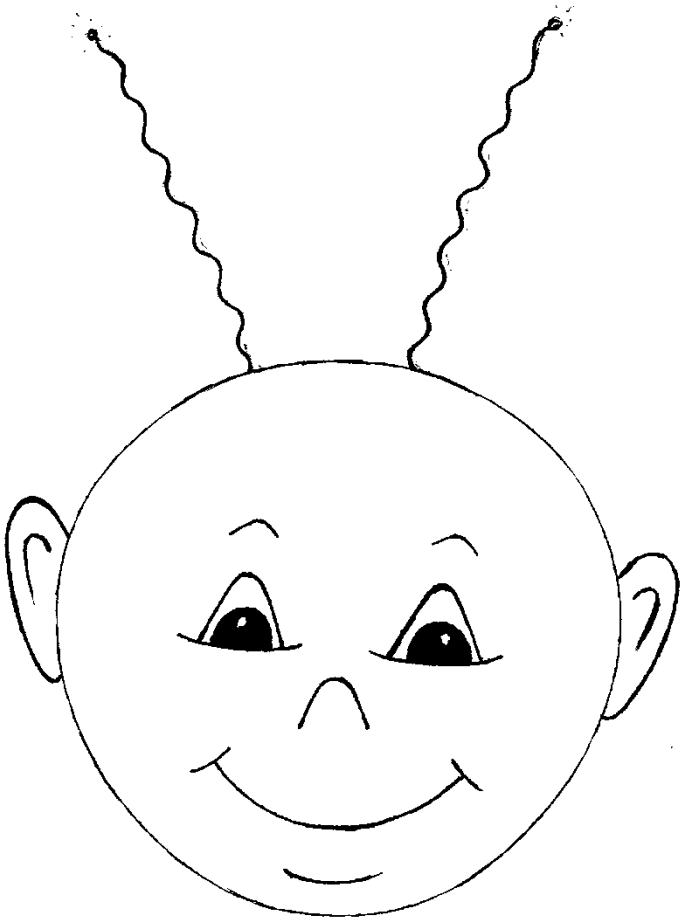
# Course approach: Supportive process learning

- Theory founded course
- Participants' observations and reflections = basis for adapting course contents
- *By using your own situations, learning will be relevant*
- Practice with feedback bridges knowledge and skills



**Key concepts in learning and practising good communication with patients, colleagues and supervisors - aiming for *Patient centred care***

# 1. Awareness



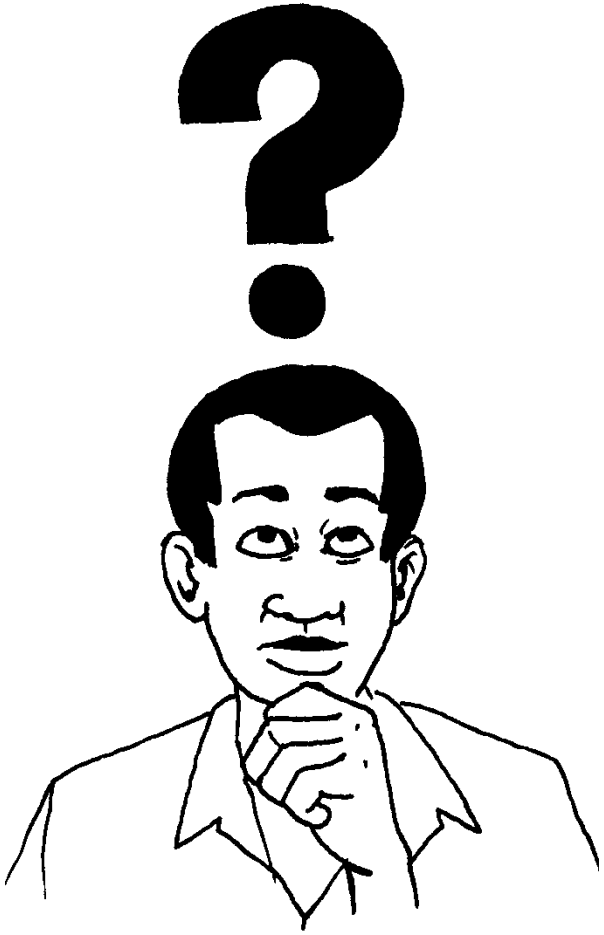
# Example from participants

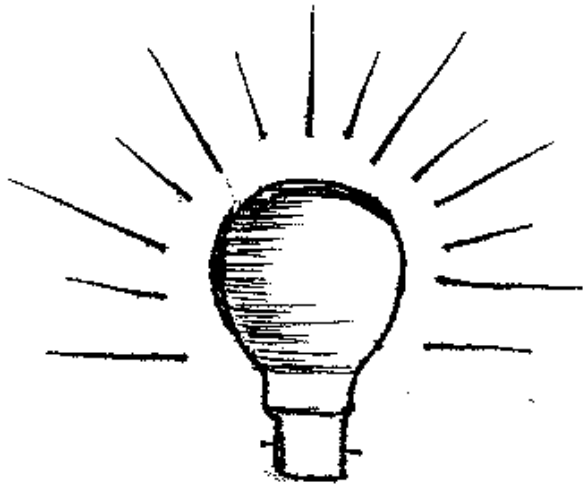
- *“I found that listening to my clients without interfering as they talk to me was good as it gave them time to explain all their complaints and gave me time to think about their problems”.*

- *“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.”*

## *Key concepts: 2*

# Critical thinking; Reflection, insights





# Example - insights

- *“I never knew “listening know-how is communicating 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’*

- *“Medicine is strange to non medics, so we need to engage patients clients and their relative in management and to succeed in this we have to communicate effectively.”*

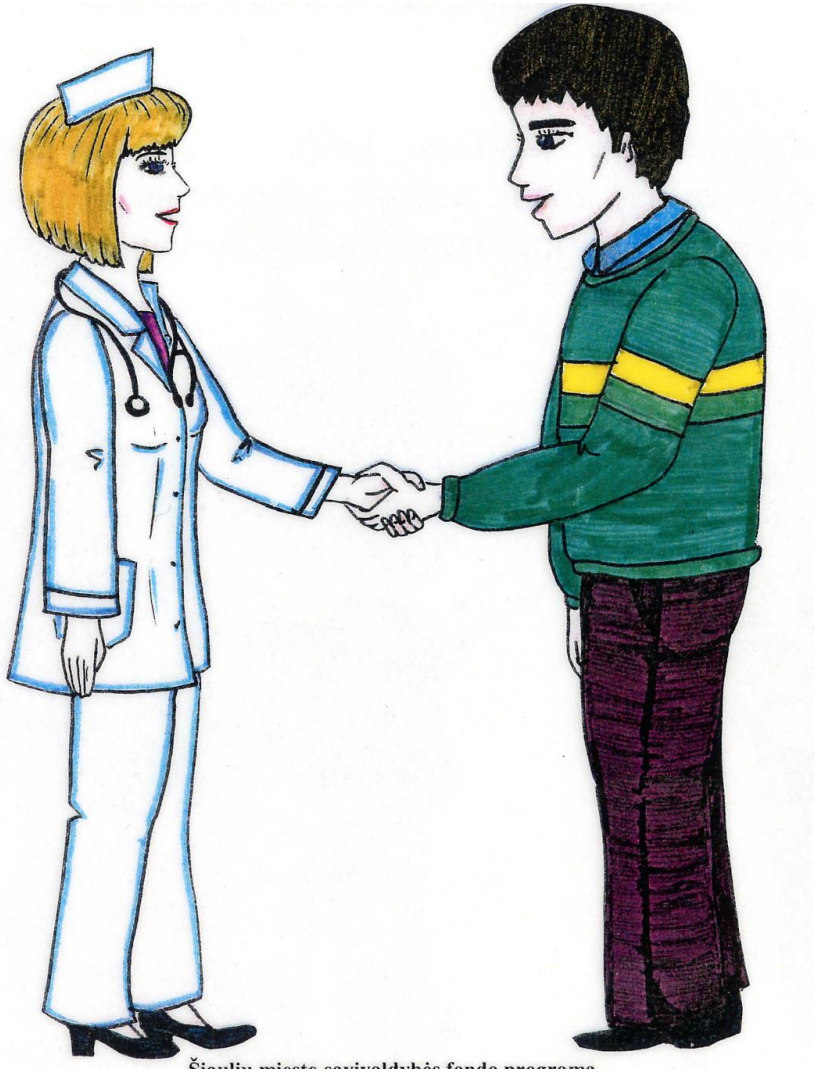
# Example- Reflections

- *“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”*

## *Key concepts: 3*

# Respect



# Examples from participants

**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 it I decide to react then I can tell what I think about that person*"
- *I feel offended feel demoralized and my moral goes down"*

## *Key concepts: 4*

# Empathy

# Example

- *“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”*

*Key concepts: 5*

# Humanistic medicine

- Interdisciplinary
- From ***Disease-centred*** to ***Patient-centred*** care

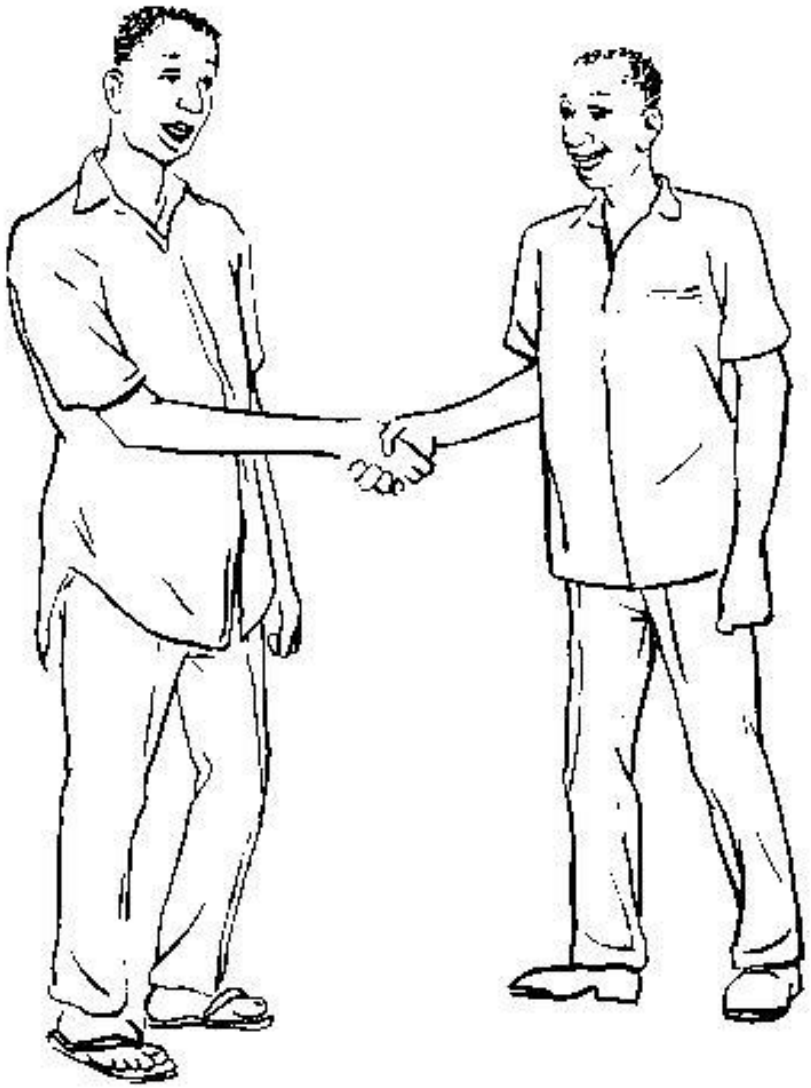
- **Aims:**
  - Open communication
  - Mutual respect
  - Emotional connection between HP + patient

# Examples

- *“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.”*

*Key concepts: 6*

# Appreciation



# 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. “*

*Key concepts: 7*

# Responsibility

You cannot change others. You can take responsibility for own change

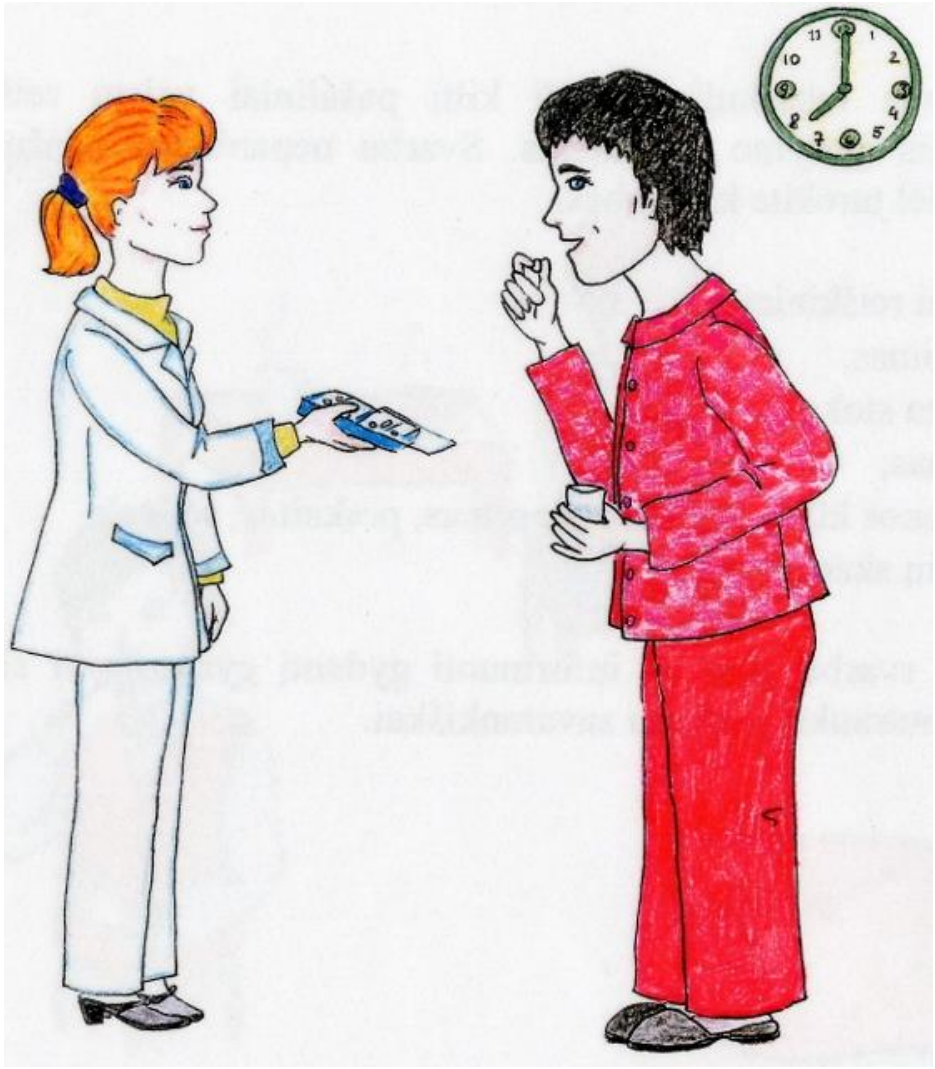
# Examples

- “*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*”

*Key concepts: 8*

# Motivation



# 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”*

## *Key concepts: 9*

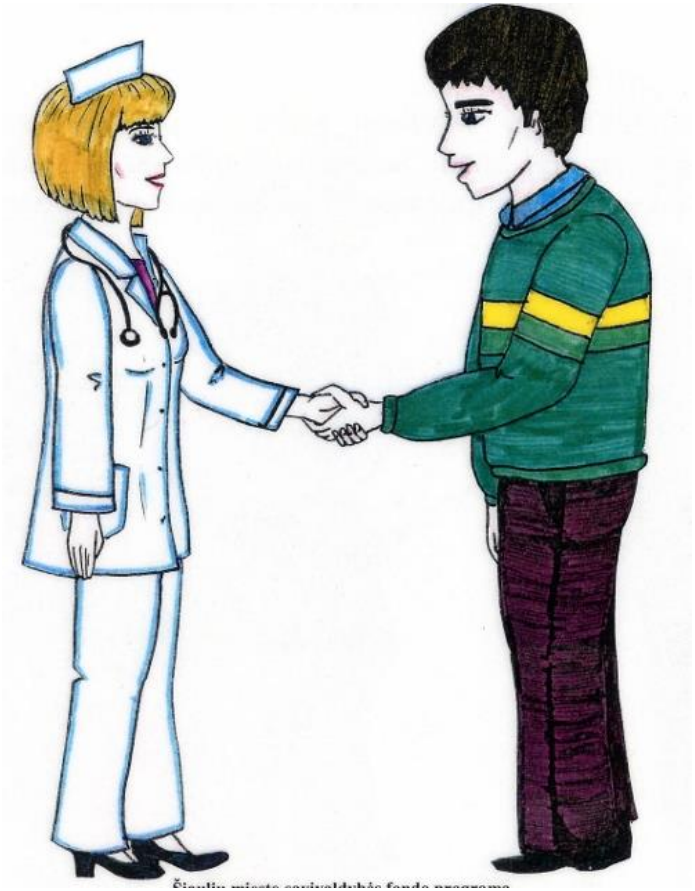
# Empowerment

# Example

- *“I have adopted a pattern of seeking to know what my clients already know from what subject we are discussing .I encourage then 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”*

*Key concepts: 10*

# Handling conflicts through conscious communication



**From Persuasion……..To Dialogue**

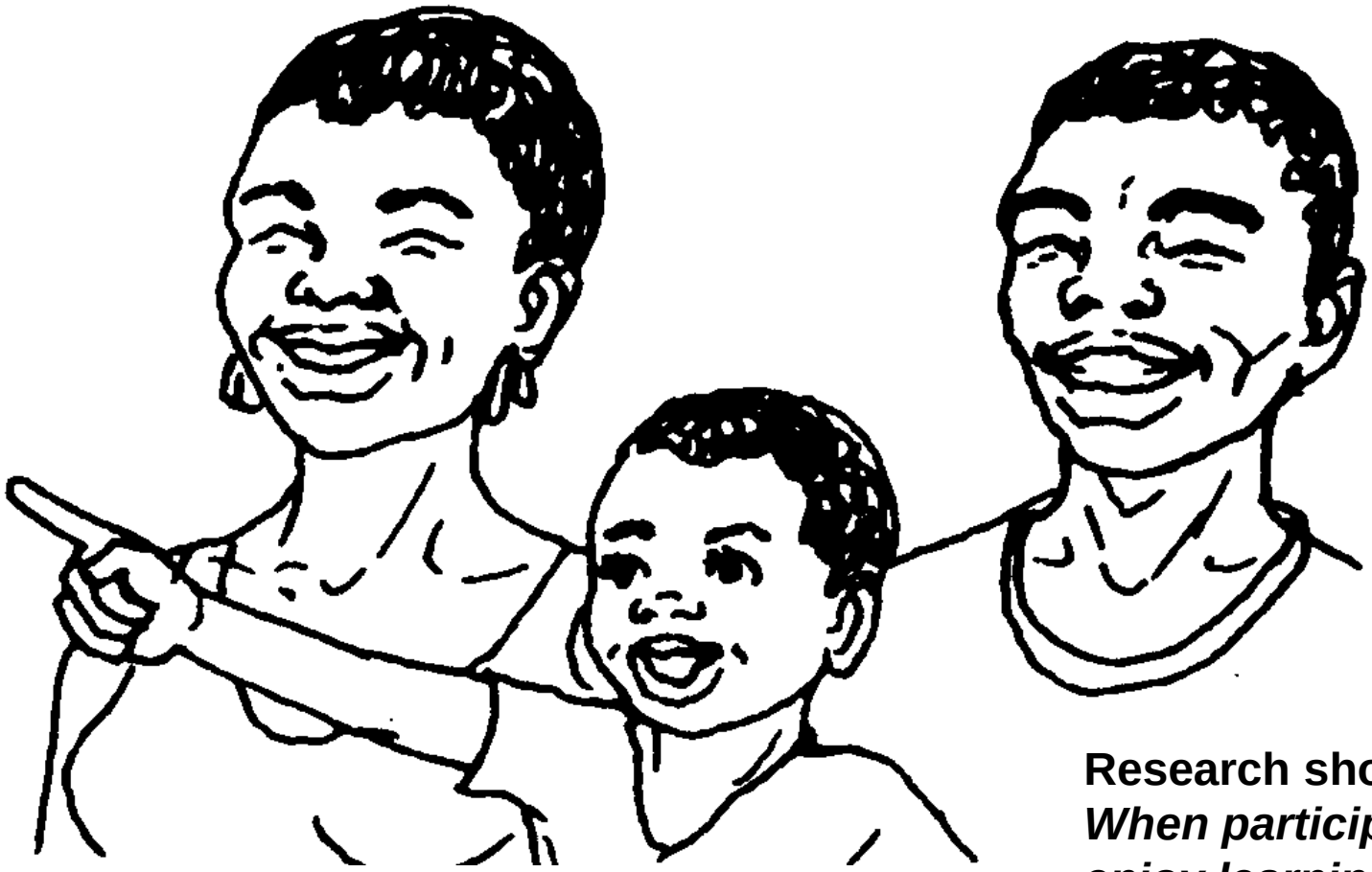
# Examples

- *“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.”*

*Key concepts: 11*

# Have fun – why?



**Research shows:**
***When participants enjoy learning, they learn better***

# Communicating about Research

**Challenges in communicating about research.**

- *"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"*
- ***Concept we use to communicate clinical care applicable to research***

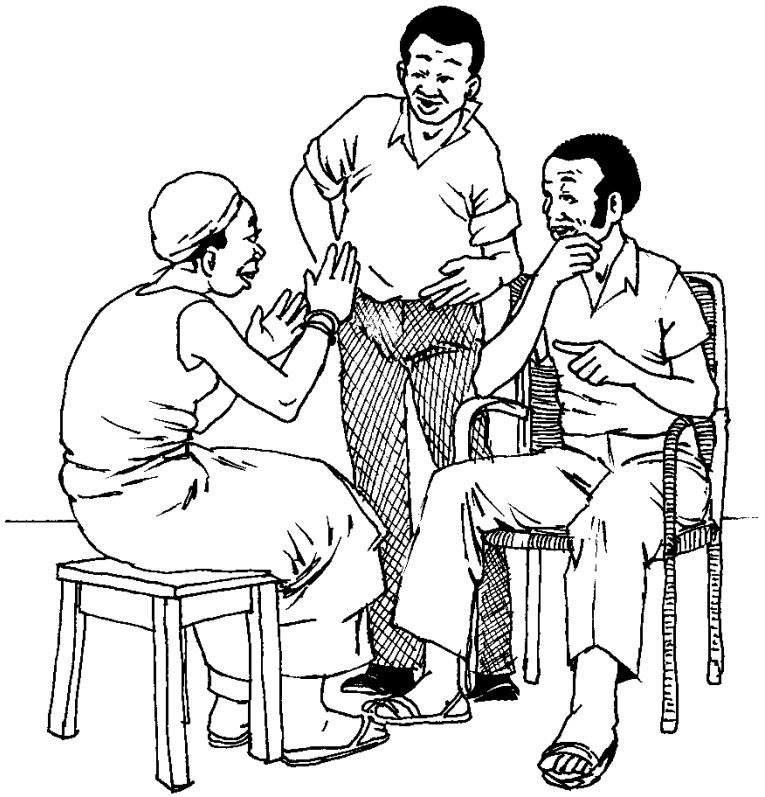
# Our expectations

***We expect that during the course, you will:***

- Find the 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
- You will tell us when something is not clear, or does not feel right
- You will participate to the best of your ability

# 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



# Literature: Problems in communication training for providers

***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 behavioral 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

# Literature, cont.

***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.