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.

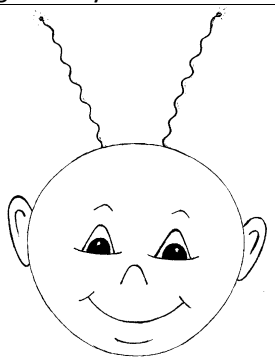
B. Approach to using communication skills

- **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.

[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.

[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*

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.