

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

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

1. The holistic approach: Communication in a context

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

2. The humanistic approach: Using Patient centred and Relationship centred care

- as the underlying “philosophy” regarding patient care. See chapter 4.1.3.

3. The process approach: Training over several phases

The training process has distinct phases that build on each other, each with its own aim.

4. Key concepts and contents

The concepts and contents define what we teach participants.

5. Core elements and features that define the training (see chapter 4.2):

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

6. Changing the power practice: from blame to balance (see chapter 4.3)

The further sections in this chapter are related to a main aim for the whole learning process – empowering participants gradually with awareness and skills to enable and motivate them to get a

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

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

4.1 Overview of training approach, contents and process

4.1.1 *The holistic approach: Communication in a context*

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

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

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

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

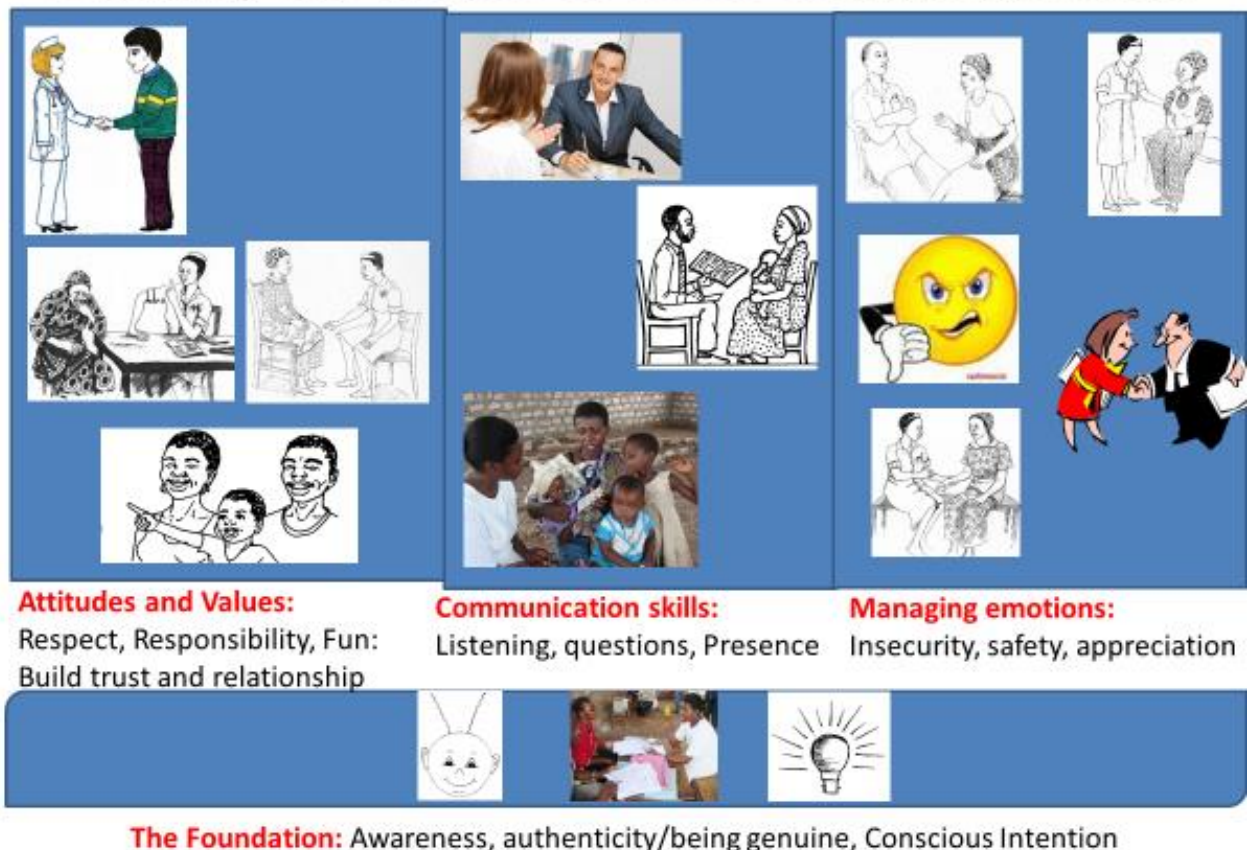
We teach communication skills in relation to work contexts where they have important functions to create safety, build trust, and to establish a professional relationship with the patients to help them to cooperate as partners in care. ***Communication skills are an essential part of almost any***

interaction with patients and colleagues and are best learnt when understood and discussed in these contexts, where every context and challenge requires a different set of skills to be used.

Providers learn to use their own awareness to observe and assess the situation, and to choose which approach is appropriate for each context and situation. Participants learn to practice constructive communication and awareness and management of emotions as a natural set of skills, employed to establish and maintain the relationship with the patient, and to build a basis for providing professional medical care.

4.1.2 Building the House of Good Communication

Building the House of Good Communication



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

The house is built in the following way:

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

- **The First/Left Room** is filled with attitudes and values (*we could call it “the bed room”, as most of our attitudes and values are “just there”, sleeping, but nonetheless influencing our action and communication strongly*): These “set the tone” for what kind of communication is being used. If the mother with the sick baby is poorly dressed, and dirty, your attitude of respect, and your values of seeing the patient as a person will make her feel welcomed and cared for. These attitudes are important for making her feel safe and to build trust, which is essential for building a professional relationship as a basis for constructive communication. The picture of the nurse scolding the patient is the opposite of what we are aiming for – and is included to show the contrast to what is needed. Scolding or disapproving of the patient is common in many cultures, and occurs in all cultures.
- **The Second/Central room** contains the communication skills (*we could call it “the living room”, as this is where a lot of the action takes place*): What you say and how you say it will further influence the interaction between you: When you are present, with the intention to understand her situation, you listen actively to her story and ask good (often open) questions – then you have a good basis for understanding and making good medical choices;
- **The Third/Right room** is filled with emotions (*we could call it “the kitchen”, because emotions are often “messy”, but when recognised and well appreciated, they can turn to “meals” and actions that give much joy*): Using EI to recognise and analyse the emotions before taking action will further enable you to determine the right thing to do: You recognise the mother is worried and insecure (*and maybe you get irritated that she looks dirty, but realise what you feel, and set it aside*). You welcome her warmly and appreciate her for bringing the baby to you, and you make her feel safe by being aware and showing her kindness, care and competence.

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

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

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

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

What is Patient-centred Care?

Being “patient-centred” is in essence to see the patient as a human being, and to take his or her perception and experience of the medical problem as a starting point for a consultation. There are several different definitions of the concept – one of the first was authored by Edith Balint in 1969⁸⁷. She describes patient-centred medicine as “understanding the patient as a unique human being”. Subsequent definitions all focus on seeing the patients’ perspective as a crucial point.

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

Research in a number of countries⁸⁸, mainly in the North, has shown that the majority of patients clearly want PCC. It also shows that there are still misperceptions among medical personnel that patients may not prefer a person-centred approach. There is a strong agreement between UK studies⁸⁹ and reflections on practice by clinicians in South Africa and Canada re how to define PCC, and also – that PCC is best assessed by the patients themselves. Much of the research has been carried out in general practice settings.



Patients in the UK⁹⁰ want Patient-centred care which –

- Explores the patient’s main reasons for the visit, concerns, and need for information;
- Seeks an integrated understanding of the patients’ world – that is – their whole person, emotional needs, and life issues;
- Finds common ground on what the problem is and mutually agrees on management;
- Enhances prevention and health promotion, and
- Enhances the continuing relationship between the patient and the doctor.

The development of the PCC concept is linked to a growing realization of the limitations of the conventional way of doing medicine – often referred to as “the biomedical model”. This model is usually connected to being doctor-centred, disease-centred, hospital-centred and/or technology-centred. Patient-centred medicine differs from this perspective in terms of five key dimensions, according to a conceptual framework and review of the literature⁹¹:

- “The biopsychosocial perspective”,
- “The Patient as a person”,
- “Sharing power and responsibility”,
- “The therapeutic alliance”, and
- “The doctor as person”.

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

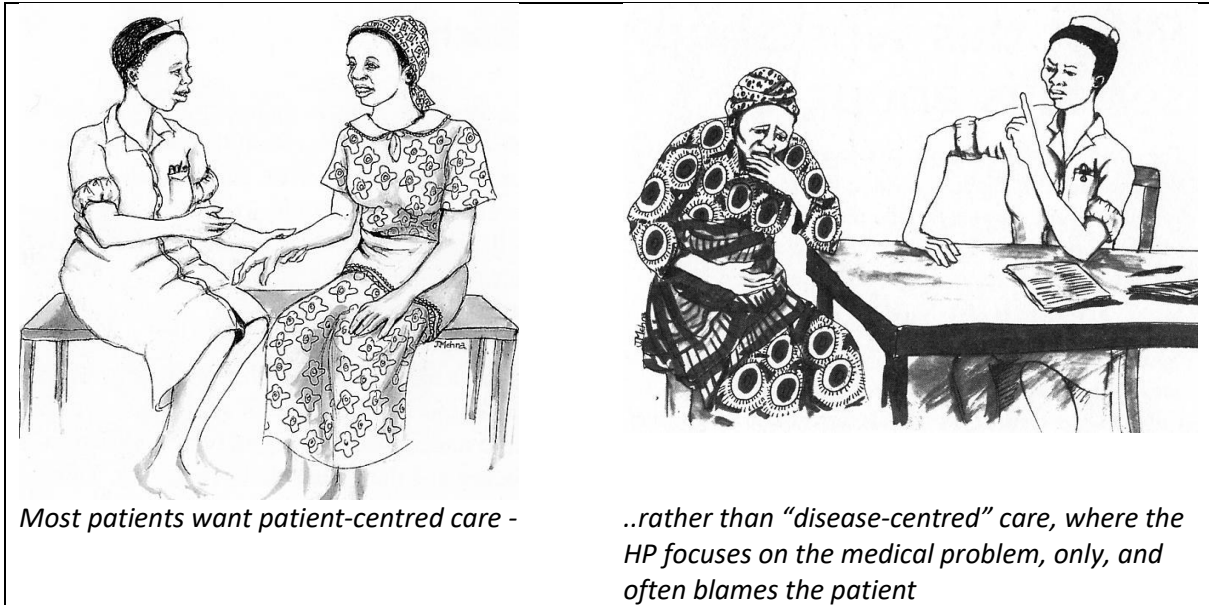
Our training strengthens participants’ awareness and skills related to all these dimensions.

⁸⁸ Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, Ferrier K, Payne S (2001). Preferences of patients for patient centred approach to consultation in primary care: observational study. *BMJ* 2001;322:468-472.

⁸⁹ Stewart M. (2001) Towards a global definition of patient centred care. *BMJ* 2001;322:444-5.

⁹⁰ Little, *ibid*

⁹¹ Mead, N, Bower, P (2000): Patient-centredness: a conceptual framework and review of the empirical literature. *Soc Sci Med*. 2000 Oct;51(7):1087-110.



Focus on the last aspect of PCC: The provider with herself

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

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

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

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

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

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

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

Concept related to PCC: Relationship-centred care

To provide "Relationship-centred care" (RCC) has increasingly been an aim and an ideal for health systems, and is closely related to PCC. M. Beach⁹² states that "*RCC is an important framework for conceptualizing health care, recognizing that the nature and the quality of relationships are central to health care and the broader health care delivery system. RCC can be defined as care in which all participants appreciate the importance of their relationships with one another*".

When providing RCC, the following principles are in focus:

1. Relationships in health care should include the personhood of the participants
2. Affect and emotions are important components of these relationships
3. All health care relationships occur in a context where the people involved influence each other
4. Formation and maintenance of genuine relationships in health care is morally valuable.

(adapted from principles quoted by M. Beach).

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

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

Reflections on patient-centred care

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

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

claimed the father had to give consent, that is the mwenye factor⁹³. Then she said she had other children to take care of at home, so she wanted to go back home to sort out with the father of the boy (patient), then to arrange for the other children on who to remain with them and be able to take care of them at home as she comes back to the hospital for the admission process.

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

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

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

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

HCW, Killifi

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

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

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

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

3	Skills into practice: Informed reflection. Continue self-observation and reflection during daily routine work, using specific tasks to confirm and deepen learning	3 -4 months On the job/ during regular work hours	Practice new skills in their own working environment; discuss with colleagues; become a role model. Strengthen confidence to practice new skills
4	Endline questionnaire	1-2 weeks (one month before f-up workshop)	To assess growth and define further learning needs (identified in phase 3) .
4	Follow-up workshop: Interactive and informed reflection. Further training based on results from observations, to summarize and anchor learning to daily challenges faced by participants	3-4 Days Central place/ full time	Deepen understanding of issues, especially on emotions. Confirm and appreciate learning; strengthen confidence; empowerment

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

Training trainee doctors in Wales: An adjusted approach

In collaboration with professor Debbie Cohen⁹⁴ at the school of Medicine in Cardiff, Wales, the model was adjusted and implemented with two groups of trainee doctors in 2016 and 2017, through the Wales Deanery. The core methods were the same – using self-observation and reflection tasks with intermittent workshops to deepen learning. Experiential learning methods were used, and the young doctors' work challenges and examples were used to develop learning situations. The same theories were used to put the situations and examples into a framework where they could be explored and explained.

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

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

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

4.1.5 Key concepts and contents used in the training

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

a) The concepts underlying the training

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

b) Contents: Communication and learning skills

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

c) Contents: Management of emotions – understanding Emotional Intelligence

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

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

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



Appreciate and explore patients’ concerns, and find reasons behind their actions

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

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

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

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

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



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

4.2 Core elements and features that define the iCARE training

4.2.1 Communicating in professional relationships

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

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

4.2.2 Communication and emotion as natural partners

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

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

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

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

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

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

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

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

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

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

An example:

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

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

4.2.3 Becoming aware of the intention of the communication

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

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

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

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

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

Skills needed when you communicate with Awareness of Intent



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

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

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

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

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

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

a) The Aware (positive) approach –

Focus on Relationship, Common Goal and seeing the Patient as a Person

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

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

b) The Unaware (often negative) approach -

Focus on Self/own needs, seeing the Disease but not the Patient as a Person

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

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

4.2.4 Strengthening self-awareness: Seeing effect of your communication

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

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

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

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

Experiential methods link learning to context and makes it relevant

The self-observation and Reflection In Action method provides the basis for developing awareness and strengthening emotional competence. Participants gain and share experiences that are used for insights and learning during the whole process, and in the workshops. With real situations from their working life as the starting point, the context for the learning is clear and the relevance of the topics is obvious. The methods stimulate the inner motivation to learn.

In the workshops, we use interactive reflections and add theory, to deepen the learning. See Chapter 6 for a thorough description and discussion of these methods.

Focus on attitudes, values and skills of the trainers

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

4.2.5 Seeing the provider as a resource person who cares

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

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

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

A. “Providers are cruel to patients, and they don’t care”

Is this true? Many providers show cruel behaviour, and there is ample evidence of this in reports, literature, and stories of patients’ experiences. In a recent book (2011) describing and discussing the health care system in the UK: “Intelligent Kindness. Reforming the culture of healthcare”, authors John Ballatt and Penelope Campling refer to the report from Mid Staffordshire NHS Trust (UK) where nurses acted cruelly to patients, over time, and nobody took action to stop them (see chapter 1). The literature is also ripe with articles and books showing how health professionals mistreat patients and bully each other. Ballatt and Campling also show how kindness is essential to patients’ satisfaction, wellbeing and to the outcome of their illness, as well as to providers’ own health and well-being, but that being kind also carries an ambivalence.

So yes, it is true that some health providers sometimes act cruelly to patients. But is it true that they don’t care?

B. Why do providers act cruelly and communicate badly?

There are many reasons. Providers in Kilifi identified⁹⁵ the workload and working in context of illness and death as having a major influence. **Lack of training and mentorship** contributed to a culture of poor communication which was seen as self-perpetuating, where new providers acquire poor communication habits from senior colleagues (see Hidden Curriculum, below). This situation, the providers felt, **generates feelings of uncertainty, lack of confidence**, low morale, helplessness, irritation, anger, fear and **exhaustion. The situation leads to high level of stress, and emotional outbursts; continuing patterns of negative interactions** with patients and other staff, and **low ability to practice empathy.**

Below are some further comments on a few of the major reasons.

- **The “Hidden Curriculum”**

When providers start their practice after completing their education, they are usually highly motivated to provide patient-centred care. They are fully informed about the ethical code of conduct spelt out by e.g. the ICN code of ethics⁹⁶ which they are expected to adhere to. But when they start their work in an institution and are met with matrons and leaders who practiced old, power-based communication, their motivation is trampled on, eroded and buried. They are faced with high workloads, and with colleagues and supervisors who criticize and use power, often in cruel or degrading ways, and in front of colleagues. Their new ideas about patient-centred care and open communication often have to be buried. This is “the hidden curriculum” at work - a pattern that is described as “the attitudes and values of older, established professionals who often occupy power positions”. It is a major barrier to change. The structures for supporting and appreciating the young providers and help them grow and gain confidence in their profession – and be effective and respected role-models – are often lacking. The impact on the young providers’ confidence can be devastating, as described by a trainer in Kilifi, commenting on supervision when being an intern:

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

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

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

⁹⁵ LVCT evaluation, 2011

⁹⁶ The ICN code of ethics for **nurses’ professional conduct in Kenya stipulates that:**

- all nurses must treat patients with dignity, respect and compassion,
- regardless of their health condition, economic status, gender, race or personal attributes.
- **Enforces that:**
 - all patients are entitled to the dignity and rights of human beings and so
 - should not be discriminated against for any reason while under a nurse’s care

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

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

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

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

- **Burnout, and moral injury**

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

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

Talbot and Dean⁹⁸ are suggesting that physicians are not suffering from burnout, which they see as something very negative. They suggest physicians suffer from moral injury, and that it is urgent to address this problem through challenging the health system itself: *“We believe that burnout is itself a symptom of something larger: our broken health care system. The increasingly complex web of providers’ highly conflicted allegiances — to patients, to self, and to employers — and its attendant moral injury may be driving the health care ecosystem to a tipping point and causing the collapse of resilience.”*

C. The need and wish for change

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

⁹⁷ **A Crisis in Health Care: A Call to Action on Physician Burnout.** Harvard T.H. Chan School of Public Health, the Harvard Global Health Institute, the Massachusetts Medical Society and Massachusetts Health and Hospital Association has deemed the condition a public health crisis. <http://www.massmed.org/burnoutpaper/?fbclid=IwAR2H3Zm-I-bybzOBsrngnq1qCUgU0FSvakclu7g99PT0Ni0NbQyNckVNUlUw#.XEg3yFVKj3h>

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

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

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

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

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

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

In summary - the underlying premises and assumptions for the iCARE model are:

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

during the observation and reflection period, many get back in contact with this deep inner motivation.

- This awareness will **motivate providers to learn** more effective communication and management of emotions, based on what they see they need to improve: They learn to practice emotional intelligence
- Using examples from their own observations as the basis for teaching theories and skills will make the course contents and methods feel, and actually be, **relevant: It meets their felt needs**, and thus facilitates good learning
- Trainers **role modelling** good communication skills and a non-judgemental attitude during sessions will allow the providers to **experience the power of this approach on their own learning**. They become skilled and motivated to use a similar approach with their patients to facilitate understanding and learning.
- Providers will also be able and motivated to **become role models** for their colleagues, and facilitate further learning (plus gain status themselves)

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

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

4.2.6 Finding the balance: The need for emotional nourishment

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

How the iCARE model addresses the need for emotional nourishment:

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

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

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

“I have not been branded as weak and pathetic, as I feared”

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

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

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

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

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

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

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

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

We suggest that when providers are respecting themselves and learn to recognize, acknowledge and manage their own emotions, respect for the patients is a natural consequence.

Providers in our courses acknowledge the problems they have had regarding treating patients badly, and many tell stories about how they took out their frustrations on patients and "put them in their place". They also noted that this way of treating patients contributed to frustrations, guilt, conflicts and burnout. They knew very well that what they did was not right.

After acquiring knowledge and skills to manage emotions, they no longer take out their frustrations on patients or colleagues:

- *"When angry, I always felt like breaking up into tears, and I would put a grudge on the one who had angered me. After undertaking the communication course, I have learnt how to control my anger and take things positively."* HCW, Kilifi

The approach of this course is to trust in the underlying ideals of the health providers and assume that providers want to care for and communicate with patients, with respect. When emotions cloud this intention, the emotions must be recognised and acknowledged, and then explored – with emotional competence.

- *"There have been changes, I have seen in my case the many people I have interacted with respect they have been able to open up and when I'm also treated with respect, I feel good."* HCW, Kilifi

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

Are problems being ignored in this "Positive outlook"?

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

4.2.8 Summing up: The starting point and the professional base

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

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

The base: Professional clinical care, and respect – with authenticity

The skills are practiced on a “base” of underlying professional clinical care, professional relationships with colleagues, and an attitude of respect. *Exactly how, and which skills are needed, depends on the context and on the challenges facing the provider, in each case.* As each situation and each patient and colleague is unique, there is no simple solution to communicating well: The provider must have her/his “basket of skills” as a resource she/he carries in her heart and head, and in her being – knowing that using these, she will be providing the best care and be the best colleague she can. *Research shows that “the way you are” is more important than “what you say” to patients⁹⁹.* Communicating genuinely, with awareness, is what works best.

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

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

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

4.3 Shifting the power practice: From blame to balance

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

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

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

4.3.1 Taking the fear and boredom out of learning

From being the victims of power (ab)use, to being empowered and inspired to teach, and learn

Trainers and supervisors in medical hierarchies are often accused of displaying and (ab)using power when guiding juniors to learn medical practice. Criticizing juniors harshly in front of colleagues and patients is a common habit, and the consequences can be serious, as expressed by one of the trainers in Kilifi:

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

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

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

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

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

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

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

- *“In this workshop, I cannot sleep! You don’t give me a chance. Usually, such a course should be a real time to rest!”*

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



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

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

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

The training approach: Creating safety and facilitating empowerment

The training approach allows participants to feel safe throughout the process:

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

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

“Making the environment safe by handling my emotions and anger”

“I’m using communication skills and knowledge attained during the intensive learning to make my environment safe through being aware of myself, for example how to handle my own emotion and anger. In so doing it helps to make the environment of my colleagues and patient safe because there will be less conflicts.

Also the knowledge has helped me to appreciate patients and value their belief. Personally I used to feel bad when children wear charms (from traditional practitioners) around their waist, hands and wrist, but nowadays I value them because I understand people are doing whatever they are doing to ensure their relative/children will recover. Before the learning I used to tell them to remove the charms but nowadays I leave them.

Currently I am on a night duty covering the hospital. We have had several cases in maternity whereby expectant mothers are given traditional herbs and also they are massaged at home when they are in labour. I have learnt to step back and avoid to confront them while they are in pain. After delivery and ensuring she is safe and also the baby, I would respectfully advise the mother against such practices. But before I learnt the skills I used to put them off there and then.

HCW, Kilifi

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

4.3.2 Taking responsibility for communication: From blame to empowerment

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

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

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

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

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

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

Some comments from the providers in their endline questionnaires in Siauliai, Lithuania after the course (2007), during the early days of working with the model:

- *“We talk to our patients too little”*
- *“We lack respect to patients as personalities”*
- *“We do not manage to create safe environment”*
- *“Very often we lose patience and judge our patients for their bad behaviour”*

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

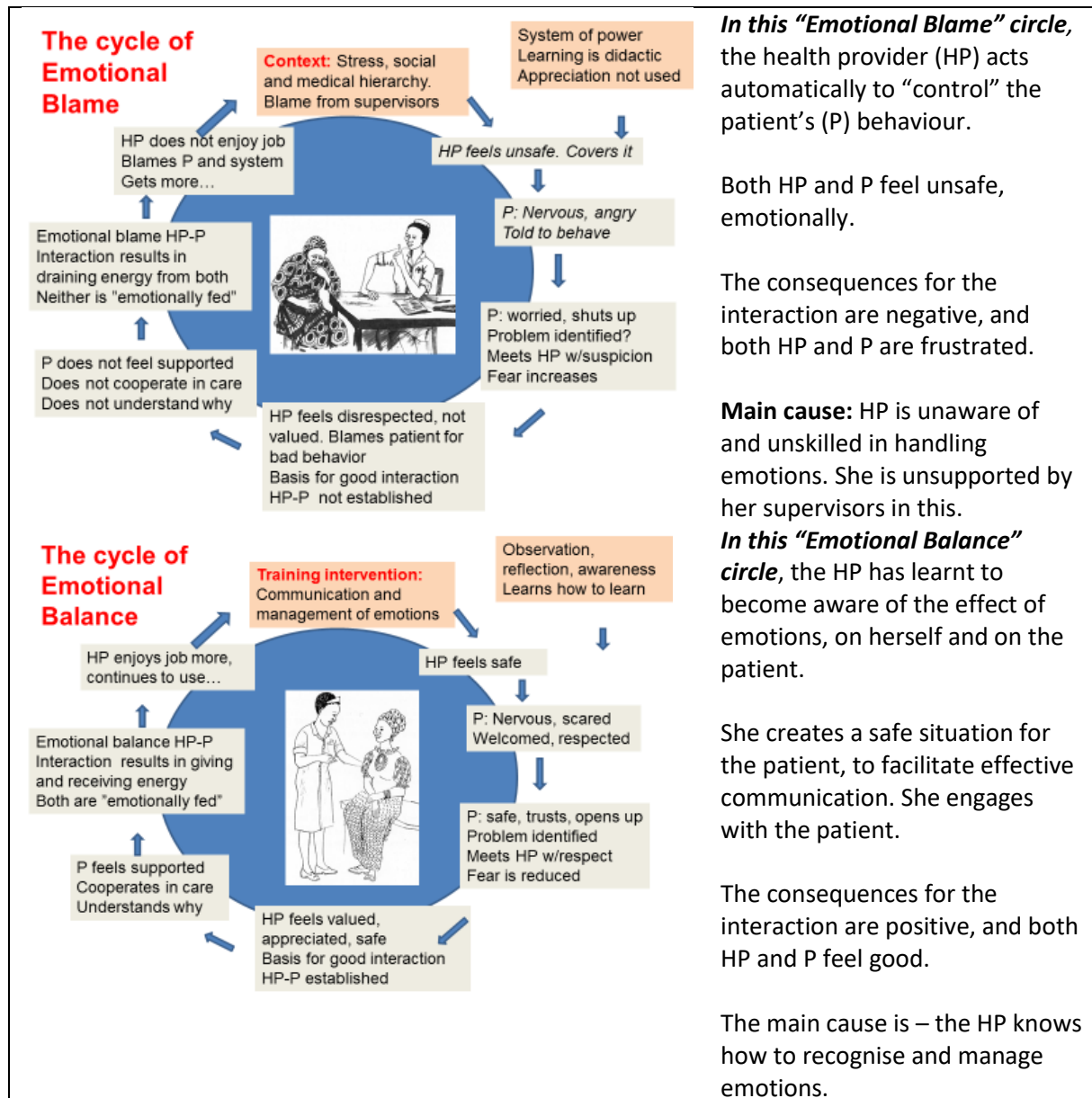
As a nurse in Namibia commented soon after the course process, with a hint of humour – and with professional pride: *“Now we have no more difficult patients!”*

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



The essential change - summarized

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



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

Both HP and P feel unsafe, emotionally.

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

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

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

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

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

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

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

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

HCW, Kilifi

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

1. **Decision to join the course** – and start learning: The course is voluntary, and each participant acknowledges a need to learn about communication. This places the responsibility for learning with her – and sets the basis for the empowerment approach which is the foundation of the course. The provider **takes responsibility to learn**.
2. **Baseline – starting the discovery**: They reflect on a) strengths (*which motivates them*); b) challenges (*which creates curiosity and an interest in meeting them*), c) patients' perspectives, e.g. what makes patients angry (*inviting empathy*). **Responsibility is maintained**: *The participants begin the process of identifying their own learning needs.*
3. **Observation and reflection tasks to discover (months 1-3)**: They look with awareness at their own communication habits when they work, and at the effects of their communication on others. They discover how their own emotions affect others and also affect their own way of communicating: They become aware of their shortcomings. This increases their motivation to learn and gives clarity about what they need to learn. **Responsibility to learn is strengthened.**
4. **Basic workshop (month 4) – theory related to their own examples, and interactive reflection**: The workshop strengthens awareness on a number of topics and relates it to their own experiences and observations. We facilitate learning and practice new skills in a supportive environment, where interactive reflection with colleagues and trainers creates a safe basis for deep learning. **The responsibility for using the skills to change is theirs.** They take on that challenge – when they see their own need, get confidence in the possibility to change, and experience the positive effects of changing.
5. **A second round of observation and reflection tasks, in order to put new skills into practice - Informed reflection (months 5-8)**: “Armed” with new skills and insights, participants practice the new skills with more confidence, and see how they function in relation to patients and colleagues. When they see the skills working well, they know why, and can see the fruits of their efforts – this strengthens motivation to continue. When they have a problem, they know why they have the problem, they can analyse it, possibly using the emotional intelligence framework (alone, or with colleagues), and take steps to solve it. **They have the communication tools to keep learning and have taken the responsibility to continue.**
6. **Endline questionnaire – informed reflection on their own practice, and identification of further learning needs: By month 8**, they “take stock” of where they are in their learning – what functions well, where do they still need to learn. This **“cements” the responsibility for continuing their own learning**, they are in charge of their own progress, and experience that they have the tools to continue to practice the skills well, and to learn further: they have the power of awareness. When they define their further learning needs for the follow-up course, it is from a basis of knowing much more clearly (than before the basic workshop) what they need.
7. **Follow-up workshop (month 9) – sharing best practices, and interactive informed reflection**: The workshop confirms their learning and appreciates and celebrates their growth and change: We contrast the present level of skills with the situation participants identified and described in the baseline and those they discovered in early observation and reflection tasks. This strengthens motivation to continue practicing the skills – by sharing experiences and exchanging useful skills learnt. Workshop sessions deepen their learning, especially on practicing communication skills when dealing with challenging emotional issues (e.g. dealing with anger, stress, conflict, power, burnout and death). **The responsibility to communicate well is now naturally theirs**, and they practice the skills with pride, because they see they get better results in their work. They often

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

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

HCW, Kilifi

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

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

HCW, Kilifi

4.3.3 Challenging cultural norms: Respecting the patient as a person?

The ICN Code for nurses: Commitment to respect

The nurse's code of professional conduct (internationally) stipulates that all nurses must treat patients with dignity, respect and compassion regardless of their health condition, economic status, gender, race or personal attributes. Giving and receiving respect is fundamental to establishing a good professional relationship, and to practicing constructive communication and emotional competence.

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

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

Experiencing disrespect causes equally strong reactions:

- *“I feel rejected, abused, not motivated, embarrassed, discouraged, dishonoured and frustrated”*
- *“Demoralized and wish to avoid interaction with that person”*

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

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

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

Some major factors influencing these behaviours:

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

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

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

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

4.3.4 Kenya example: Changing perceptions of how to practice respect

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

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

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

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

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

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

An overview of group and plenary sessions, in sequence from the workshop:

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

Group session 1: How do you practice respect in your work?

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

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

Group session 2: How do you feel at work – and what are your expectations from patients?

These questions caused much inspired discussion, in the same groups. Participants were ready to talk about their feelings – finally, they could talk about how THEY felt about their work! They recognised many strong feelings in themselves and were relieved to be able to “let off some steam”. They also talked about how these feelings affected the way they communicate (*EI skill 1*). Some comments:

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

Plenary session 1: What happens to the patient, and who is responsible?

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

Group session 3: We asked them to discuss briefly some questions in their groups – to explore possible reasons for the patient’s (or parent/caretaker’s) behaviour:

- “What do you think a patient, or a parent with a very sick child, feels when she comes to the hospital? How may these feelings make her act?
- What are her needs?
- Do you think this patient, or parent, respects you?
- If yes, what could be reasons she does not show it?”

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

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

An awareness about the consequences of this cultural behaviour was dawning, quickly, for the participants. (*EI skill 3*)

Group session 4: Additional reasons you may treat patients with lack of respect?

Participants now were invited to look at their own lack of skills, and at their need to learn. They concluded, after another discussion in the groups, some reasons for their behaviour were (*EI skill 3*):

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

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

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

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

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

They described consequences on **themselves**:

- *“Felt dissatisfied, and often stressed;”*
- *“The negative emotions often spilled over to how we deal with colleagues”*

They also described negative consequences on **patients**:

- *“They closed up, did not give all the relevant information”*
- *“Sometimes they received wrong diagnosis”*
- *“Often, they did not receive patient-centred care.”*

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

Plenary session 3: What do we do now?

Participants’ conclusion was now clear, and unanimous:

- *“We need to change this culture in our hospital”*

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

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

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

Further thoughts: Continuing the work to strengthen awareness on practicing respect

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

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

- ✓ *“Before doing the course I used to expect patients to greet me when they walk into the ward. Nowadays I am the one who greet them and ask them how I can help them. This makes them feel good, accepted, and I also feel good when they open up to me”*
- ✓ *Yes, when people are greeted and recognised it takes no time for them to adjust to the new environment. They don’t fear and are free to express their concerns. They in return appreciate and respect me. “*
- ✓ *«Yes, great changes. If one is respected, they respond with respect. I managed to make a client who was giving up on his care relax, accept that he is of value and that his family needs him most. I showed him respect throughout the counselling session until he opened up and told me there was a communication break down between him and the wife and he was unable to comply with medication due to lack of support from the wife and poor nutrition. He was feeling judged by the wife for being HIV positive when she was negative and so he felt neglected and thought he’d rather be dead than live with the frustration».*
- ✓ *“When I treat patient with respect, they also respect me and it builds their confidence to me hence good working environment.”*

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