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

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

The iCARE-Haaland Model uses several different training methods that we combine to facilitate discoveries and insights, leading to a motivation to learn actively and to change practice. The main methods are:

- **Experiential learning** as the core training method;
- **Self-observation and reflection in action** on-the-job to discover their present communication habits and the effects of these habits on the person you talk with. As they work with this, they identify their learning needs;
- **Reflective and interactive learning methods in workshops** to link topics directly to work-based challenges;
- **Short lectures** to link work-related examples to theory and provide a theoretical foundation.

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

The link to emotional intelligence and emotional competence

The sequence of learning builds EI over time by strengthening four main skills needed to practice this very useful combination of awareness, reflections, analyses and skills:

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

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

6.1 The learning elements build on each other

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

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

The key elements in the learning sequence are:

Phase 1: Discovery, and creating active learners

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

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

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

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

Phase 2: Theory and practice, and reflective interaction: The first workshop

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

Note 2: An *next to a topic or title refers to a module where the theme is discussed.

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

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

- **How to discuss and learn from mistakes**: The aim in the workshop (and throughout the training) is to explore and understand – not to judge each other. Participants are encouraged to share mistakes and to discuss and find reasons why they happened. Everyone knows when they have made a mistake, and many feel guilty and shameful.
  Acknowledging and discussing mistakes does not mean accepting the mistake as "right", but to acknowledge that we all make mistakes and that we can learn from them, together. Understanding the (usually emotional) reasons for making mistakes can enable the participants to recognise the emotion next time and choose a different action. This approach can enable participants to put the mistakes behind them and go on – making aware choices.
- **Acknowledge and systematize participants' learning:** Examples from participants' learning and insights during the three months of discovery (baselines, and observation and reflection tasks/MSC stories) are presented in themes, to acknowledge the learning of the group: ***Feedback from observing how you communicate.*** Participants usually experience this as very motivating and reflect interactively on their learning process.
- **Linking learning to theory**: Participants are invited to share experiences and **reflect interactively**, and examples from their work situations are analysed and linked to theory throughout the workshop. When they understand the theory, they gain new knowledge that can enable them to understand their experiences in a new way. This enables them to explore the crucial question of WHY they react the way they do, and to see that such reactions are "normal" or common – and that many others react the same way. They build a system of understanding issues or phenomena, which enables them to recognize the same issue when it reoccurs, and – prevent an automatic reaction to it: They become able to step back, reflect, and then react with awareness – using emotional competence.

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

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

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

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

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

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

- **Further informed reflection: Skills into practice:** In this phase, participants apply their new skills with more confidence – they now know **what** they need to do, and **why** – to meet the needs of the patients, and themselves, in various situations. They also know **how** to do it, using EI as a tool: When they reflect on their successes, they reflect from a basis of knowledge about why what they do, works well. They know they can continue to use and refine these strategies – and this builds confidence. When they reflect on what goes wrong and where they still have challenges, they also reflect with awareness on the basis of knowledge – they can analyse what went wrong, and **why**, and decide to handle such a situation better next time, using their emotional competence.
- **Participants are given new weekly observation and reflection tasks. They keep notes on their further discoveries and also note persistent behaviours they still need to work on. They send in their MSC insights and examples to trainers once a month.**
- **The Skills into practice phase programme is built to empower:** The relatively fragile mastering of skills and the confidence participants have built can be bruised and damaged by colleagues and supervisors who may be jealous, fearful, or angry with "the new communicators". To meet this challenge, participants are made aware during the course about natural resistance to change in hierarchical systems, and that they are likely to encounter such resistance. They are encouraged to build themselves up as role-models who practice good communication skills with awareness and recognize and step back from sarcasm and criticism from colleagues. *We discuss how the reasons behind such behaviour is usually fear, which should be met with awareness and knowledge rather than anger.* Such aware responses can facilitate a better work environment.
- The new series of tasks aims to strengthen EI by practicing these skills. It starts with observing and reflecting on ***situations they handle well*** – to strengthen empowerment. They are asked to look at ***natural ways they use the skills well***, to strengthen awareness of how they already have acquired new skills and have also made important changes in their work. They also ***identify barriers to practicing new skills*** and reflect – often together with colleagues from the course – on how to overcome these. They start noting further learning needs.
- **Handling colleagues with awareness:** To strengthen their image as "aware communicators", participants are given suggestions for how to share information from the course with colleagues, in a structured and non-threatening way. These strategies are intended to create a positive attitude to constructive communication in the work station, and to start (or strengthen) the role of the trained provider as a role-model. Participants also have a task to give constructive feedback to a colleague, with awareness – which is usually a positive experience for them both. Such action can help turning possible negative attitudes from colleagues, to positive ones. Dealing with sarcasm is another skill they practice in this set of observations – where the EI skills come in handy. (*Sarcasm is an aggressive emotional reaction which often causes an automatic response. By using EI, participants can recognise*

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

- **Handling supervisors with awareness:** The relationship to those in power is often based on deeply held fears, often related to cultural experiences of power and hierarchy in families and/or at work. After becoming aware of how they relate to colleagues who (mis)use power, and building confidence to handle these situations well, participants start mapping the patterns of how they relate to supervisors. Through the mapping tasks, they become aware of what they react to, and how they react – and they then apply some of the tools (e.g. EI) to reflect on why they react like this. These reflections and examples become important parts of the follow-up course, where dealing with power with awareness is a central theme.
- **Handling patients with (more) awareness:** The last set of tasks brings all the learning together to looking at central elements of Patient-Centred Care. Participants observe how they relate to patients feeling safe and being respected, and the effects on how they communicate. Safety and respect are key elements in PCC - they affect both patient and provider and create a basis for building trust and relationship. Participants are asked to focus on these elements – as they affect patients, and themselves, in the last set of observation and reflection tasks.
- **Collecting Best Practice Examples:** Throughout the Skills into Practice period, participants are encouraged to collect and note "Best Practice"-examples, where they feel they really use the communication skills well. These examples will be role-played and discussed in front of the class in the follow-up course, where the sessions have several important functions: They show how participants have integrated the skills into their daily practice and are using them with pride – this has a strong empowerment effect. These participants are then seen as resources or role-models on the skills or topics being shown, and other participants can continue to learn from them. Trainers can pick out the skills they use, and add further comments and theories to these. They can also use them to reflect with the group of participants on what makes a provider able to use these skills well. The examples can be further analysed, using the EI framework, and can help to make the EI skills more visible.

- **Endline questionnaire** consists of the same questions as the baseline, with some questions added to ask participants to identify and reflect on changes they have made during the course process, and on the effect of these on themselves and on patients and colleagues. This exercise makes participants reflect on their learning over the last eight months and acknowledge changes they have implemented in their practice – using **informed reflection**. The reflections throughout phase 3 build professional pride. They also help participants reflect on and point out where they still have learning challenges, which should be dealt with in the follow-up workshop. Finally, the answers to the endline questionnaires are a tool for planners and trainers to analyse the perceived learning since baseline.
- **Trainers read, analyse, and detect recognised and hidden learning needs from observation tasks/MSC stories, and endline:** The process is the same as the one before the first workshop: Trainers read all the feedback from the observations and reflections, and the endline, to get a sense of what participants have learnt, and pick out examples to illustrate the different points in the modules. Participants are now more used to, and skilled in, identifying their learning needs, and – these are included in the programme to further strengthen the relevance of the training to participants' needs. However, there are still "black spots", or hidden learning needs – issues and skills trainers know the participants need to learn about to be able to communicate better, but which participants do not see on their own. Trainers identify these, and make sure they are covered in the programme. Most of these are related to emotions.

Phase 4: Handling challenging emotions, with awareness

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

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

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

Summary of key elements in four phases

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

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

6.2 The baseline and endline questionnaires

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

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

Examples from two baseline questions:

1. **a) What are you good at when communicating? Please give an example and describe a situation when you were communicating well with a patient or parent.**

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

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

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

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

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

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

Some examples from the endline:

1.a) What are you good at when communicating? Please give an example and describe a situation when you were communicating well with a patient or parent

- *"I am good at listening to my clients. I'm no longer judgmental and I give due respect. I learnt how to go about asking open ended questions to gather more information from my patients. Example: In my ward we have a mother who admitted with a malnourished child and some of our staff had labelled her a difficult mother who was not caring about her child because the child was not gaining weight. I took time to talk to her and I realised she was undergoing a lot of stress. She was abandoned by a husband and left with a two year old son with no relative in Mombasa. I reassured her and she came into reality that life has to continue. She relaxed, took time to feed her child, the child gained weight and they were discharged through the social work follow–up."*

- *"I am good at active listening and use of open ended questions. This makes me able to make a closed patient open up and disclose her problem, and later involvement of both me and the patient in making a plan of care."*

- *"Listening actively to patients and giving them a chance to talk or ask questions"*

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

- *"Patience"*
- *"Dealing with disclosure of death/bad news to relatives – taking care of emotions."*
- *"I still feel there is the old self on anger management once in a while."*

The baseline and endline questionnaires can be found in Parts B and D. The tools used with trainee doctors in Wales, UK, to assess their changes are slightly different from the original ones, and are also found in the parts B and D.

6.3 Developing evidence-based personal learning: The O&R tasks

Introduction to systematic self-observation and reflection tasks, and to reflective learning

Reflective learning is increasingly used as a method in the health professions. It is a powerful method that enables participants to develop or strengthen awareness and critical thinking skills, and link this to action. They learn to learn independently, and the learning often results in sustainable behaviour change. The most commonly used method is **reflection ON action**, i.e. **"thinking back"** on what happened some time ago, and reflecting on this alone, or in a group.

In our training, self-observation and **reflection IN action,** i.e. **"thinking when"** is the very heart of the model. We show a way of using self-observation and reflection which is ***so far not described in the literature***: We are bringing in the crucial link to touching and engaging participants' emotions when they are observing, and in doing so – engaging empathy and stimulating an inner motivation to care, and to change: they are learning emotional competence. **The main addition to literature and to reflective health practice is our focus on *systematically guiding participants to learn in-depth about one skill at a time* and reflect on the effects of using this skill (well, or badly), on the other person.** The reaction of the other person will affect the participant's emotions.

The sequence of learning the skills is carefully built up, so participants are guided to progress from "simple" skills (such as listening) to more complex skills (such as recognising and handling anger), thus providing a cumulative effect. In each task they will observe and reflect on how their way of communicating will affect, and be affected by, the emotions in the interaction.

While learning to identify the patterns guiding their communication and emotions, participants will also discover their **learning needs**: These are communicated to the trainers through the examples and reflections participants send in at the end of each month. Trainers will use some of these examples in the workshops - to illustrate theories and emphasize learning points, and to introduce main issues for discussion.

A participant contributed this reflection after having observed her reactions to what irritated her, and how this irritation affected her communication, for several weeks (Pack 2):

"I always wondered…"
Thanks this has been the hardest exercise from the time we started this course. I have not met with colleagues to discuss this but I truly want to share my own personal experience and feelings as of now.

I have discovered that I am part of the conflicts which arise from the way I react to questions and comments which come my way. Also to how people behave towards me. My judge is too quick at bringing out from my mind the negative side of the situation or statements.

I always wondered why people react badly towards me and have now got the answer. I am too cautious with the statements. I now need to digest the message, read the inner meaning, then think of the answer and the repercussions of what I want to say and do before I deliver my actions or statements. I have to train myself to go slow until I am used to picking the message the right way. It's going to be a tough task as for years I have behaved this way.

The same patience I tried to instill to clients and patients is what I need to practice as I view my colleagues and family member differently. I am on a journey to maybe discover why I view them differently and at times negatively. But help is also to be sorted out to be able to approach the person I wish to express my feelings to whom I feel is unapproachable. Thanks, thanks, if I have not brought out the feelings yet, know there is still confusion in my mind that will be sorted out slowly as I apply the skills laid down. *HCW, Kilifi*

This reflection can be used to illustrate how participants discover the effects of their emotions on how they communicate, and then take responsibility for changing the way they communicate.

The process, and the reasons for constructing it this way, is described in this chapter.

We call the method "Evidence-based personal learning".

In a review of the literature on teaching reflective practice across health and social care professions, Norrie et al[102] have illustrated how different professions choose certain types of reflective practice. Please see chapter 2 for a brief discussion of how the different professions work with reflection to "measure" it (medical literature) or use it to explore and understand teaching processes (nursing and midwifery).

The literature identifies key problems in communication training for providers as not meeting their learning needs, and not using methods that are conducive to learning practical skills. Our way of integrating providers' discoveries from their observations into the training ensures that the training is

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

relevant and meet participants' needs. Experiential learning methods, with examples from observation and reflection tasks as a basis for developing demonstration, role-plays and exercises, ensure that the learning is practical and results in developing useful skills.

Several authors have described reflective practice as a useful practice for health professionals, starting with John Dewey in the early 1920s who explored the connection between experience, interaction and reflection. Kurt Lewin and Jean Piaget soon after developed relevant theories of human learning and development. Donald Schøn (1983) was the first author to define and describe "Reflection-in-action" (RiA) as "the ability of professionals to think what they are doing while they are doing it"[103]. Schøn showed how Reflection In Action could be a key method to teach health professionals to improve their work performance. Central to all the theories on reflective practice was the acknowledgment of the need to integrate theory with practice: The learning is a cyclic pattern of experience and the conscious application of lessons learnt from experience.

The special contribution of our work: What Schøn and his predecessors did NOT describe was how RiA connects to the learner's ***emotions***, and that in this connection lies an important part of the key to the deep learning and insights providers experience when using this method. Our method is to guide participants to observe and reflect systematically over time, using a sequence of tasks that build on each other. The aim is for the participants to carefully develop confidence in the learning, and to become used to recognising the influence of emotions on their communication. They start to recognize the effect of their own communication, on the other person's emotions. The discovery makes them reflect and ignites the inner motivation to change. ***The interaction of the emotions is the key element here.***

Several other authors have later acknowledged the need to strengthen reflective learning. In a systematic review of reflection and reflective practice in health professions education, Mann et al (2009) note that "Reflection and reflective practice are frequently noted in the general education literature and are increasingly described as essential attributes of competent health professionals who are prepared to address these challenges". The review describes learning from experience as a key skill in health professions. They show how critical reflection on experience and practice is essential to identify learning needs, and reflection as being a key method to develop an active approach to learning, and to develop self-awareness and self-monitoring as professional skills. Yet, despite these clearly documented advantages of reflective learning, the review concludes:

"Yet, despite reflection's currency as a topic of educational importance, and the presence of several helpful models, there is surprisingly little to guide educators in their work to understand and develop reflective ability in their learners."
Mann & al (2009)

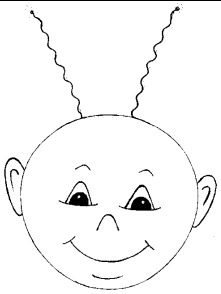
This manual, and especially this chapter, aims to fill parts of this hole, and to be a practical guide for educators.

[103] Schøn, D (1983): The Reflective Practitioner: How professionals think in action. New York, Basic Books, ISBN 978-0465068746. OCLC 8709452.

The following main elements of the training are described in this chapter:

What is self-observation and reflection, and reflective learning?
A method to systematically observe how you communicate with others, and how your communication affects others, and reflect on what you see and feel. The aim: To develop self-awareness.

How do you do it?
By looking at one aspect of communication at a time, e.g. listening. You observe how you listen in different contexts, every day for a week, and remind yourself briefly to pay attention before each time you meet a person, or you are in a meeting. You take brief notes after each encounter with another person about what you did well and where you did not listen well, or make notes at the end of the day, based on memory. The closer to the actual event you write down your notes, the more accurate will be your memory, and the more useful your observations. At the end of the week, you discover a pattern for how you listen.



The "mascot" uses «antennae» to become aware

Why is it important?
When you experience and understand how your communication affects others, you start to reflect: Is she hurt by you interrupting her, and shuts off? Is she delighted/relieved about you really listening to her with awareness and interest, and opens up to you, giving you essential (or sensitive) information? Your experience is both cognitive and emotional, and you develop an inner motivation to change. You take responsibility for making the communication function well, because you are motivated to do so, and you experience that you can actually make a difference by changing how you communicate. This is using EI, in action.

How does it work?
Observation IN action (which they do when using the weekly tasks) enables participants to discover effects of their "bad" communication habits, on others:

- *"When I shouted at the parent because of not following instructions, the parent feared me so much that she could not share with me anything, not even something to do with the patient. Hence I could not give quality of care because I did not know more about the patient."*

It also makes them discover the effects of "good" habits:

- *"It was amazing that I could give her a lot of time just listening to her without interrupting (..). It was amazing to me how just listening could work magic".*
- *"Lesson learnt: When you listen with open ears and heart, the other person will be keen on what you too have to say"*

Both discoveries are important stimulants for learning, and both are linked to emotions:

- **In the first example**, the provider discovers the effect of her own anger: strong fear, and the patient closing up. This resulted in her not being able to do her job well - which made her feel bad and made her reflect. She sees herself as a "good health provider", and to maintain this image, she sees that she has to change her behaviour. She has become aware of the conflict between her behaviour, and the image she wants to have of herself as a professional who cares about her patients.
- **In the second set of examples**, providers saw that using good listening skills, they could establish a good relationship, and create a basis for good cooperation. This made them feel good, made them feel like good providers, and made them want to continue, and to strengthen their use of active listening skills.

The method enables participants to recognise their own emotions as well as those of their patients and colleagues, and to analyse the consequences of these emotions. They **start developing Emotional Intelligence**, which is a key skill to be able to prevent and handle stressful situations at work, and to develop resilience. Four skills comprising EI will be highlighted throughout this chapter, linked to the aspects of the reflective learning where the development of each of the skills is primarily located.

6.3.1 What is self-observation and reflection, and reflective learning?

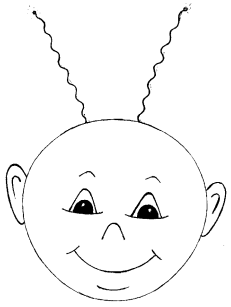
Self-observation in our model is to systematically observe how you communicate, while you are doing it, and how your communication affects others, and then reflect on what you see and feel ("**think WHEN**"). This is what we refer to as ***Observation and Reflection IN Action (O&RiA)***. A key aspect of O&RiA is that the emotional reactions are included, and these make your discoveries very powerful. The purpose of the work is to observe systematically to discover how you communicate with others and how the other(s) react to your communication. Over time, you will recognize what your own patterns are, and then reflect and find out how you can change them to be able to communicate better. You will also discover what your learning needs are, and communicate these to the trainers. In the workshop, you will learn why and how to change how you communicate, and the theory behind.

The contrast: Reflection ON action is to "**think BACK**" to what you did some time ago and reflect on what you can learn from your successes, or mistakes. This is also useful and is used in combination with O&RiA. **A key difference is that reflection ON action usually lacks the fresh and often powerful experience of the emotional aspects.**

This method is the heart of the training model and is the "secret" behind participants developing an inner motivation to change. The method helps participants transfer the learning into sustainable new behaviour.

In practice, the method motivates and enables providers to practice several EI skills. They -

- ***become aware*** of their communication habits/how they communicate with others in different situations;
- ***become aware*** of the ***effect*** of their communication on the other person, and get insights on how it might feel;
- ***discover the patterns*** of how they communicate (when observing the same skill over time, and reflecting on how they use it), and
- ***take action to and responsibility for change*** – and for learning to improve their skills. They stop "blaming others" automatically for bad communication, and rather look at what they can (or could) do to make the communication more constructive.



Awareness is a key skill to improve PCC

The process can be summarized as "Reflective learning". The most important aspect is that it gives you a basis for how to make links between theory and practice and make theoretical "sense" out of what you experience in practice: Participants observe and reflect on their habits and experiences in phase 1, and link these to theory during the first workshop.

The integration between self-observation and reflection on the job, and interactive reflection around theory inputs during the first workshop, provides **deep learning**. It makes the participants able to comprehend cognitively and experientially and make a bridge between theory and practice. They become aware of, and gradually understand, the **causes and consequences** of acting on their emotions (*e.g. how they communicate when they are irritated, and that this can cause the client/patient to pull back, and not give full information*). When the learning is further followed up

with informed reflection tasks *("Skills into Practice")* after the workshop, the value of the learning is further confirmed, and moves the use of new skills into behaviour and practice that can become sustainable:

- *"We see and feel it works better than the old methods – so we adopt it. Why go back to old behaviour that gives us grief?"* *HCW, Kilifi*

The observation and reflection tasks are characterised by the following:

- ✓ ***Focus.*** Each task is simple, focussing on one thing (e.g. how you ask questions)
- ✓ ***Repetitive.*** Each task is repeated several times during a week to discover personal patterns
- ✓ ***Reflective.*** Reflection *in action*, and *on action*. Analysing, writing what you see, thinking
- ✓ ***Purposeful.*** The aim is to learn, based on own insights, and then define learning needs
- ✓ ***Systematic, sequential.*** Each set of tasks built up carefully to fit conceptually and practically
- ✓ ***Time limited.*** One or two weeks is the normal time for a task
- ✓ ***Skills strengthen:*** Skills to carry out the tasks strengthen over time
- ✓ ***Self-directed***. You yourself decide how much time and effort to put in
- ✓ ***Safe*****:** You are the one in charge of the situation you want to observe
- ✓ ***Personal.*** Belongs to the person who is reflecting, he/she owns the results
- ✓ ***Empowering***. The learning can be powerful, and the power to learn, stays
- ✓ ***Improves practice***. Enables you to take action to change, on your own
- ✓ ***See consequences***. When you change, the effects on your work and yourself can be powerful

6.3.2 How do you carry out the observation and reflection tasks?

In Phase 1, "The Discovery phase", we guide participants systematically through a three month's process, using weekly tasks that ask them to observe how they communicate with others. They observe while at work, doing their regular work tasks.

Practically, they learn to keep a small part of their attention on how they practice a particular skill ("***observation IN action***") during an interaction. As soon as possible afterwards, they spend anything from a few seconds to a few minutes to reflect: *"How did I listen this time? What happened to the other person when I listened this way?"* ("***Reflection ON action***"). The participants repeat this observation and reflection on interactions several times each day during the week. They make some notes, at the end of the work day, and sometimes right after the interaction. At the end of the week, they start to see the pattern, and can reflect further on implications of what they have discovered.

- "*I used to think that listening is a passive activity, but I was wrong because it is **active and it means participating and caring** by me for the listener. I learnt that I am responsible of attempting to grasp **emotions often veiled behind the spoken word.** In active listening, I have learnt that I simply **lay aside my personal feelings** in order to understand/assist the client in her conversation."* *HCW, Kilifi*

The tasks are specific and limited and focus on one aspect of communication at a time.

An example: the first task given to participants during a meeting with a trainer

The idea of observing themselves is new to most people – they are used to being observed by others and being told what they need to change (and – if they are lucky, they may also be told what they do that functions well). It takes a change of mind-set to observe oneself, and resistance is common.

Over time and with encouragement, the resistance is overcome, and replaced by excitement and satisfaction that they are able to learn well, alone. (See Part B for a handout of a more extensive *Introduction on how to carry out the tasks).*

Brief introduction to Observation, and The Listening task

Communication and Dialogue: Learning about our own communication habits is a necessary step to understand how to communicate better with our patients and colleagues. It is also an important aspect when planning how to develop and implement effective health communication strategies, and how to manage change in our organization. Becoming aware of what we do, and understanding the effect of our actions on others, is a first essential step for improved communication skills and for insights on how to teach others.

Thus, you are invited to **observe** your own communication practices in the weeks before the intensive skills training workshop in … (Place, dates). This pack contains four observation and reflection tasks – each to be done during 1 week. You will receive a new pack of observation tasks after 1 month.

Please use one task per week. An important key to making effective observations is ***focus:***
If you look for one or a few things, you will be able to discover **the pattern** in what you are doing and become aware of what you need to learn more about – and what you do well and can help others learn from. If you look at too much at the same time, you will not discover the patterns. You can use a small notebook we recommend you get to note observations, and always carry it with you. Some people make notes on their phones.

Looking at not only ***what*** you are saying or doing, but also on ***how*** you say and do it, is crucial. The ***effect*** on others of what you say and do is the other crucial part. Start looking at this, and at the feelings you have – and at what reactions and emotions you bring out in the other person. Recognising and understanding the effect of ***emotions*** on communication ***outcome*** is key in this learning and is the first essential step in developing emotional intelligence.

NB: Research and experience has showed that learning about communication is more effective when it is done over time and builds on a period of self-observation.

Observation Week 1: How well do you listen to others? (e.g April 1-7th)

When discussing with another person, how well do you listen? Do you

- Listen "with open ears, eyes and heart" until the person has finished?
- Listen "with your mouth full of words", impatient to explain your own view/idea?
- Give your answer or your next question as the person is talking because you believe you know what he/she will say (i.e. you interrupt and "take over");
- Listen with the intention to really understand the other person's point of view; ask questions to find out more, appreciate his/her point of view (without necessarily agreeing), and only then offer your own ideas?
- Do some of each, depending on the situation and your mood; etc

In other words: Do you try to ***really*** listen to find out what ***their*** ideas are, or are you more concerned about getting the other person to listen to ***your*** opinion and ideas? Or do you do a bit of both? Do you decide when to do what, or does it happen automatically?

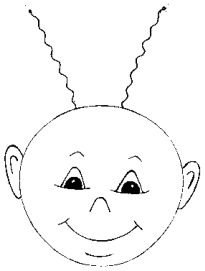
Observe ***when*** you use the different methods, and what are the ***results*** or outcome. Observe especially what emotions your different listening methods seem to bring out in the other.

Have fun! And please make notes on your observations. (***Add address/email to send reports to***)

As a part of the first task, or in the introduction meeting for the course, participants are given written instructions for how to carry out the tasks, practically. A full version is found in Part B:

How do you do these observations, practically?
Some suggested practical methods are:

- **Carry these instructions** in your notebook, or in your smartphone.
- When you **plan your day**, **plot in** one or two times or situations when you know you will be interacting with others
- **Before the meeting**/other event/patient interaction, read the instructions again to remind yourself what you are looking for.
- **Try to be aware** during the meeting or conversation how you behave regarding the habit you are observing:
- ***Imagine you have "antennae"*** *on your head (see our Kilifi mascot, right), or – a little invisible observer sitting on your shoulder, or anything that helps you develop a "friend" who helps you learn about yourself.*
- **After the meeting**/event, reflect (as soon as possible) on what you have observed in your own behaviour, and make **a few notes.**



If you do this once or twice per day, you will start to see a pattern.
Discussion with your colleagues about how they do their observation, and may be what they have found out, is a good way to get over a (natural) resistance to this task!

Self-observation will be a new practice for most of you, and it may take some time before you get used to it. But – it is simply a matter of practice, and once you see how useful it is, you will (most probably!) want to continue to learn this way.

What is required of the participant to self-observe and reflect effectively?

Linking the learning to Emotional Intelligence

The attitude one approaches this learning with will determine how the individual will learn, and how the learning will affect her actions and emotions. To get the best out of the method, the learner requires:

1. **Commitment**
   You must be committed to observe yourself ***"in action"***, while communicating and having feelings. You must learn to recognize what you see, and experience, in yourself as well as in the other person.
   ➔ *This is related to skill 1 in EI: Recognizing the emotions*
2. **Honesty**
   You must decide to be honest with yourself about what you see and experience yourself do, say and feel, and try to understand it. (*If you experience guilt, shame or other difficult emotions or reactions, these are yours – to keep quiet about, or to share. But you must notice they are there.)*
   ➔ *This is related to skill 2 in EI: Integrating emotion with cognition.*
3. **Curiosity**
   You need to find out **why** you feel and act and react as you do, and why it has the effect it has, on the other person(s). What is behind your outburst of anger, for example?

➔ *This is related to skill 3 in EI: Finding out the causes and consequences of the emotions*

4. **Action**
   Reflecting on your (new) understanding of the situation, take action to communicate with awareness and respect for the emotions (your own, and those of the other person).
   ➔ *This is related to skills 4 in EI: Taking action to adjust your behaviour, based on your understanding*.

6.3.3 Guiding and managing the reflective process

Participants need to be supported, especially in the first part of phase 1, to learn how to carry out the tasks and to discover the usefulness of this method: Most of them will not be familiar with self-observation as a learning method. The trainer needs to take account of this and create awareness about how they can develop the skills, and why it is essential for their learning.

The process is managed in the following way, each meeting with the trainer lasting about 1 hour:
Phase 1:

- **Meeting 1:** Introduction to the training aims and process. Distribution of baseline, and of introduction guide for self-observation and reflection tasks (see short version above, + longer version in appendix). This meeting lasts 1 ½ -2 hours.
- **Meeting 2** (1-2 weeks later): Collect baselines; Distribute pack 1. Discuss how to carry out the observation and reflection tasks; answer questions.
- **Meeting 3** (1 month later): Collect reflections/MSC stories from pack 1, let them share experiences of how to carry out the observations, discuss, and answer questions. Distribute pack 2.
- **Meeting 4** (6 weeks later): Collect reflections/MSC stories from pack 2, let them share experiences, discuss. Distribute pack 3.

The first workshop is conducted about 4 months after the initial meeting. The trainers need time to read and analyse the feedback from the baselines and from the observation and reflection tasks and put these into the various presentations for the course.

Phase 3: We repeat the same pattern of meeting after each pack to share experiences, ask and discuss questions, and handing out the next pack. See Chapter 8 (Planning), and Parts B and D.

Taking notes is essential: In the first meeting, the facilitator emphasizes the need to take notes on what they observe, and hands out a small notebook to everybody – the ***observation-notebook***.
In Wales, the trainee doctors preferred to make notes on their mobile phones, and this functioned well. Participants are encouraged to make a few notes every day, and to note examples of interactions where they have used the skill – well, or badly – and reflect on learning. At the end of the first month, participants write a story – the Most Significant Change (MSC) story, which describes an important part of their learning, with an example. The handing in of the MSC story is compulsory. For each of the other packs, participants are asked to submit further MSC stories or **written reflections** to the facilitator. The stories and/or reflections should describe what they have learnt, based on an example, and are handed in anonymously, using a participant number they have been assigned. These examples and reflections are read and discussed by the trainers before making the program for the workshop.

> *"Reflecting on the time I have worked as a doctor I can most certainly see that I have changed a great deal; I have seen a great change in myself with regards to giving and receiving criticism. Throughout my time at school and university I was a perfectionist and can*

remember dealing with criticism poorly. I quite often became defensive and refused to accept advice that was given to me. My 'inner critic' has always been very harsh and I have beaten myself up emotionally for long periods in the past over trivial things.

I have realized and accepted, especially over the last couple of months, that I am not perfect and a constant strive for perfectionism is not necessarily healthy. I have enough confidence in my own ability and I want to learn in order to be a better doctor for my patients. I feel that I have started to channel my inner critic in a more positive way and this has had a great impact on my general well-being. This reasoning has allowed me to more gracefully accept criticism, to take it more 'on the chin' and be kinder to myself at the same time. I felt my interaction with the registrar was a good example of giving criticism in a positive way and this is something I plan to emulate in the future." *Trainee doctor, Wales*

Be prepared that it will take time for the participants to become familiar with practicing self-observation and reflection in action as a routine task on the job. It is a new and unfamiliar practice, but once they discover the sense and the usefulness of the method, they will usually continue with much motivation. The meetings are an important arena for the participants to learn from each other, and to receive encouragement and information from the trainer as well as from each other.

Note – Meeting in person is important: If participants are able to send in the MSC stories electronically (rather than hand-written), this simplifies the process – but it is still advisable to meet, to keep the motivation up. When calling the meeting, it should be emphasized that even if a participant has not been able to complete the assignment, they are welcome to join the meeting: it is often insecurity about how the tasks should be written which prevents participants from sending in their tasks. A common assumption is that there is a "right" and a "wrong" answer to the tasks, and many are scared of doing something wrong, and be criticized: This is what they have often experienced in their education. When they learn and trust that "what they observe and describe is simply OK", and that there is no right or wrong answer, they carry out the observations with much more confidence. With interactions and discussions in the meeting, they often get the answers needed to complete their tasks.

Suggested contents and main points to emphasize in each meeting, plus powerpoint presentations, are found in chapter 8 and in Parts B and D.

Some common question participants ask in the meetings:

- "*How can we observe ourselves? Is it not better to have our colleagues observe us, and comment on what they see*?"
- *"Am I not likely to report just the good things about myself, and not report the bad ones?"*

It is important to give time to discuss these and other questions participants bring up. Some points:

- ***When you learn to observe yourselves, you will always have "your observer" with you*** – as an invisible friend sitting on your shoulder and helping you to notice – and learn. You can continue learning every day. Observing yourself also means you do not have to be afraid of failing or doing something less than perfect – you will notice it yourself, and usually take action to improve. Thus, you can learn actively, without being humiliated by someone who may criticize you is un-kind ways. HOWEVER – there is also no guarantee that you are kinder to yourself than a colleague would be – many providers are extremely self-critical and set themselves too high goals of being "perfect". Reflections on this are also needed!

- ***Until participants feel safer with each other and with the trainer***, some may choose to report only the good things about themselves. However – this is also useful – as there is a lot to be learnt from how providers carry out tasks in good ways, and in the course – these examples are as useful as the ones describing the problems. After some time, most participants see that by sharing their challenges openly (but anonymously), they do get a unique opportunity to learn – in a supportive learning environment, by having other participants reflect on their situations. This gradual increase in confidence and willingness to learn is a very important reason why O&RiA tasks function so well.

Carrying out the O&R tasks and writing what they really experience , what is right ***to them***, is an important method for participants to get to know better their authentic, genuine sef: The more comfortable they are with being "themselves", the more free and honest the communication will feel to the other person.

NOTE: It is important that the trainer uses the opportunity in these meetings to establish relationships and build trust with the participants. The trainer should encourage participants to start sharing experiences openly, without fear – and emphasize and demonstrate a non-judgmental attitude to what participants bring out for the group. When participants experience that they can share experiences without fear of being judged, they can start feeling free to describe mistakes and ask questions. The sooner the group can start functioning as a real learning community, the more effectively and deeply the participants will learn.

We discuss further details on management of the training process in chapter 8.

6.3.4 Overview of the observation tasks in phases 1 and 3

The self-observation and reflection work is carried out in two phases, before and after the first workshop.

Phase 1: The Discovery Phase, to discover problems, habits and what they do well when communicating with others. It is a period of 3-4 months where participants receive one pack of four separate tasks each month, after having completed the initial baseline questionnaire. The topics of the first pack of tasks are listening, asking questions, and habits that inspire or hinder good communication. Packs 2 and 3 are also given in this phase (see overview of topics, next pages).

The link to emotional intelligence: The discovery phase is aimed at developing EI skills 1 (recognizing emotions in themselves, and in the other person) and 2 (thinking about them), and start working on skill 3 (analysing, to understand causes and consequences of the emotions). Some are also starting to practice taking different action than they have done before (EI skill 4), e.g. on listening with more awareness and attention.

6.3.4.1 An overview of the topics in each task

Phase 1: Discovering communication habits and learning needs

Pack 1 consists of 4 tasks with easy topics, central to everyday communication:

- **Task 1:** How well do you listen to others?
- **Task 2:** How do you discuss, and ask questions?
- **Task 3:** What do you do to inspire good communication, and what do you do to hinder good communication?
- **Task 4:** Write a story of the Most Significant Change[104] that has happened as a result of your observations and reflections. Send this story to the trainer.

[104] MSC is a method developed based on work by the anthropologist Gregory Bateson

These tasks build competence in EI skills 1, 2 and 3.

Example of an insight from this phase:

- *"I have a challenge in asking questions to find out more what the other one is saying. Most of my questions are close ended requiring yes/no answer. When I let my feelings take control over me, I end up becoming impatient and ask close ended questions, hence not listen to what the person is saying".* *HCW, Kilifi*

Pack 2 contains a set of tasks to observe what makes the providers irritated and angry, how they deal with anger and irritation, and what are effects of their (automatic) reactions to various emotional challenges, on the other person(s).

- **Task 5:** My personal irritation and anger map: WHAT do I react to?
- **Task 6:** My (automatic?) response to irritation and anger: *HOW* do I react? What are my feelings behind the reactions?
- **Task 7**: Effect of your irritation and anger on others: How do THEY react, and what are (possibly) their feelings behind the reactions?
- **Task 8:** Writing your reflections on learning – a new story of change about these emotions.

This pack also contains additional ideas on how to discuss the work on the observation tasks with your colleagues, to help each other master the method of self-observation.
These tasks also build competence in EI skills 1, 2 and 3, and sometimes skill 4.

Example of an insight from this phase:

"I can truthfully say my undertaking the communication course has helped me better my good points and improved on my bad. I have always believed myself to be a good listener but my joining the course has helped me to be better. Am also good in discussion, I love them but I had a way of trying to dominate them, so my undertaking the course has made me learn that I do this through personal observation and reflection. I am temperamental but in some way undertaking the course has made me master my temper and be able to control it.

Discussing with friends and collegues has made it easier for me because I have learnt that when I am stressed about something be it personal or professional, when I talk it out with another it seems small and lighter!" *HCW, Kilifi*

Pack 3 contains tasks on patient-centred care, communicating anxiety, and on dealing with research participants:

- **Task 9:** Linking *Patient-centred Care* to practice in your daily care
- **Task 10:** Stepping into the shoes of a patient, or caregiver: How does PCC feel?
- **Task 11:** Your methods to take care of fear and anxiety in patients and parents
- **Task 11b**: Special task for providers working with research projects
- **Task 12:** Hand in *one example* from this set of tasks, which *reflects your learning* during these weeks – something you do, which has changed in an important way, or something which has made you realize why your present practice is effective/ achieves the goal. Please also tell why these changes are important to you.
  Also, please define your learning needs (for the workshop).

The tasks and the sequence are carefully developed and structured to strengthen awareness and skills that build on each other. Towards the end of phase 1, participants are starting to be very much aware of their learning needs and communicate these to the trainer(s). See Chapter 8 and Part B for

how to analyse baseline and observation tasks, identify learning needs, and include these in the course programme.
These tasks build competence in EI skills 1, 2 and 3, and now more often – skill 4.

Example of an insight from this phase:

> *"On realizing this I became angry but my antennae's were up and my fear was the quality of data this colleague could produce at the end of the study. Someone could not read it from my face that I was angry but indeed I was boiling up. I went further for my lunch and when I went back to my desk I found her alone in the office. Calmly, I talked to her about the quality of work she is doing and that she is suppose to adhere to the protocol as stipulated, giving reasons as to why its necessary in a positive way"* *Research participant, Kilifi*

Phase 3: "Skills into Action"

After the basic workshop (phase 2), participants enter **"Skills into Action".** They receive further weekly tasks for three more months to guide them to reflect on how they use their new skills, how well they work with the new skills, and to identify where they still need to strengthen skills. Participants continue to explore and confirm learning and strengthen confidence in using the new skills. The emotional competence is strengthened throughout this phase, and participants become more familiar with recognising emotions, stepping back, analysing the causes of the emotions, and taking new action based on a good understanding of the situation.

The observation and reflection packs include the following themes:

Pack 4 contains tasks to strengthen communication with colleagues, including how to share information and skills from the course with them:

- **Task 13:** Natural ways to use your skills, and barriers to using them;
- **Task 14:** Sharing information from the course with colleagues and supervisors;
- **Task 15:** Observing the reactions of your colleague;
- **Task 16:** Giving constructive feedback to a colleague, and – sending in an MSC story.

Example of an insight from this phase:

> *"I have noticed that after a series of self examination and awareness when problem arise at home or with my colleagues at work, I don't confront anymore and my blame habit has reduced. Although, it's a challenge and this has made my colleagues ask questions and others being judgmental that with time I will go back to the old ways. But calming down has helped solve problems and also avoided conflicts with colleagues"* *HCW, Kilifi*

Pack 5 continues to focus on natural ways of using the tasks, communicating with supervisors, and then focus on taking care of safety, and of emotions:

- **Task 17:** continued from pack 4: Natural ways to use your skills, and barriers to using them (continued from pack 4 – this task to be carried out throughout the period);
- **Task 18:** Patterns of communicating with your supervisor – to find out what you react to, and how;
- **Task 19:** Taking care of safety (making patients feel safe), and effects of this on communication;
- **Task 20:** Taking care of emotions: Showing respect for patients' emotions, and effects of this on you; Taking care of your own emotions. And – sending in an MSC story.

Example of insights from this phase:

> *"My emotions, oh my! I have learnt to keep emotions to myself.* ***I have stopped pouring my emotions to others.*** *I have realised talking to myself before handling any difficult situation*

really helps. It has brought peace in my life. This part of the training has done wonders in my life. It came at the right time"

"This course has really changed me from who I was to who I am and I am very grateful. It amazes me how I can now take care of my emotions regardless of my moods and what has happened. It has changed both my personal and social communication at work and at home. This is not to say that I don't get hurt, discouraged or disappointed but am able to use my skills selectively to make me move on at times it's challenging but I have come to know that a ***good routine turns into a good habit****."* *Both: HCW, Kilifi*

Pack 6 asks participants to "sum up" their learning by sharing further reflections on how they now handle challenges related to patients' emotions; to "show and share" best practices, and to share questions and insights on research:

- **Task 21:** Dealing with patients' emotions – and the effect of this on you: Further reflections on changing the interaction with the patient.
- **Task 22:** Best Practice example – to demonstrate to the group;
- **Task 23**: Special task: Insight on and questions about research;

These tasks build competence in all four EI skills – participants are now more routinely using skills 1-3 (recognize emotions, think, analyse the situation) and take reflected action based on their understanding and analysis.

Please also refer to chapter 6.1, where you find a description of how the tasks build on each other and work together to create the aimed-for results.

The tasks used in the whole course can be found in Parts B and D. In part B and in Chapter 8, Planning and Management, there is a section to guide trainers on how to analyse the observation tasks, and how to pick good examples for presentations, demonstrations and exercises.

Managers and researchers: The tasks used in courses with researchers and with managers in Kenya will be added as part of further updates to this manual, with the revised presentations and the adjusted approach used for these different groups.

6.3.5 The process and the observation tasks used in Wales

When training trainee doctors in Wales, we had a half day workshop after each set (or pack) of observation and reflection tasks, i.e. one workshop every 5th or 6th week. The exception was a 10 weeks' gap between workshops 3 and 4 because of summer holidays.

The tasks we used followed the same structure as in the original training process but had slightly different topics, based on the emerging needs from this group: Especially in the second course (2017), we developed several tasks focusing more directly on how to become aware of and deal with their vulnerability, and how this is linked to doctors' perfectionism. Other tasks around this theme focused on becoming more aware of what causes positive emotions, and how these can affect the way they work, and feel about the work. A further set of tasks looked at giving and receiving criticism, and finally a task on the interaction between professional cultures. All tasks can be found in Part B.
In 2016, the training period ran for six months with four workshops, and in 2017, eight months with six workshops.

The tasks were:

- **Pack 1, tasks 1-4:** The first two were as original (Listening, asking questions), including a task to reflect on their power role as medical doctors. Task 3: Personal communication to build relationship and trust, and Task 4: How do you do inspire or hinder good communication. An Msc story was the last task in this pack.
- **Pack 2, tasks 5-8:** Observation tasks dealing with anger and irritation that can result in conflict. These tasks also followed the original ones but related some observations to the relationship with patients.
- **Pack 3, tasks 9-11:** These tasks differ from the original ones, and focus on identifying positive feelings:
- **Task 9:** Positive emotions, and their effects on you and people around you
- **Task 10:** Becoming familiar with your vulnerability followed by an MSC story to reflect on the link between vulnerability and using emotional intelligence.
- **Task 11**: Being kind to yourself, with awareness: How well do you treat yourself?
- **Pack 4, tasks 12-14**: Criticizing and being criticized, with awareness
- **Task 12**: Recognizing your Inner Critic and how he operates
- **Task 13:** Receiving criticism/feedback – do you acknowledge, or defend, or a mix?
- **Task 14**: Criticizing others: When, Why and How do you criticize, and how do they react?
- **Pack 5, tasks 15-16:** Tasks on professional cultures
- **Task 15:** Becoming aware of the influence of (other) professional cultures on your emotions, communication and behaviour
- **Task 16:** Examples of confrontation and conflict – automatic reactions, and reasons behind

An example of a reflection after pack 4

"I have grown in emotional intelligence and resilience over the duration of this course.
I always felt competent in the first three EI Skills but struggled with the 4th.
Today I worked with a consultant with whom I have previously argued and cried as a result (very non-resilient!!)

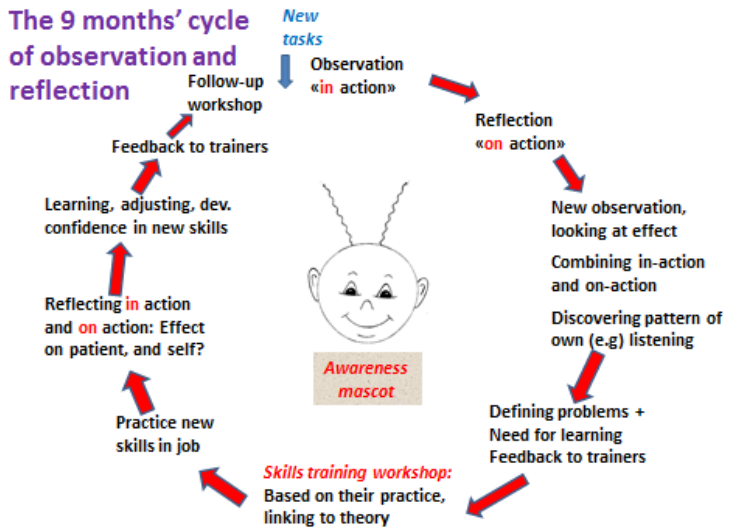
I was dreading today but thought it a good opportunity to practice my EI especially in how I respond to people and being kind to myself.
This consultant can be argumentative and belligerent. I suppose it helped that I knew this before we even started. However, when the consultant argued against things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

With regards to accepting criticism and being kind to myself, I failed the arterial line on the first occasion but reminded myself that there is not an issue with my competence (which I would have previously) and actually it was probably due to my anxiety of working with that consultant. Hopefully this will improve with further practice at EI. By realising that every attempt to give advice is not a criticism I was able to take advice on improving my skills with the video laryngoscope.

Overall, I am pleased with the way I handled this experience and have practiced my EI skills. This is possibly the first time I have successfully managed to reflect in action, completed the 4th EI skill and responded in a way that I am proud of."

Trainee doctor, Cardiff 2017

6.3.6 Summary of the 9 months' cycle with observation and reflection tasks



The cycle summarizes the process of working with and learning from the observation and reflection tasks.

A key feature is – the participants first observe themselves ***in action***, i.e. they pay attention to an actual skill, while carrying out their normal job. For example, they look at how they listen to a patient, while assessing her medical problem.
After they have finished the work task, they reflect ***on action***, and assess how well they listened, and how it affected the patient.
They take notes. Then observe again.

This method enables them to get an immediate and real assessment of their behaviour, and the impact of it: Participants carry out the same observation several times during a week, and reflect on it after every interaction *(or at least several times a day*). By doing this, they will start to see the pattern of what they do. They will decide what they need to learn, and what they want to change – without any influence from the outside (except when they choose to discuss with a colleague). Participants are firmly the boss of their own behaviour and communication and decide on their own ambitions. The process is empowering, and stimulates inner motivation to learn, and to build confidence.

Examples of insights from health care workers in Kilifi:

- "*When communicating I am good at listening. There was a patient whom colleagues termed as very uncooperative and she does not answer questions when asked. But when I sat and talked with her and listened what was bothering her, she opened up and gave information"*

- **Listening/empathy:** *"During delivery I listen very carefully to mother's problems and complaints and empathize with them and this helps to achieve good delivery. The mother was able to follow my instructions well and this made the delivery process very fruitful."*

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

The insights during the first phase are especially powerful. Participants discover that -

a) ***Their skills may not be as good as they thought*** *("I am a good listener – or so I thought….."*);
b) ***The effect of their lack of skills is serious, and affects their ability to perform their work well***

"I am not good at listening to long stories especially during admission. I get irritated so fast so I will only take what is important";
"When I shouted at the parent because of not following instructions, the parent feared me so much that she could not share with me anything, not even something to do with the patient. Hence I could not give quality of care because I did not know more about the patient", and

c) ***They can do something about this themselves and take action on their discovery:*** *"When angry – I step back. Most of the times I avoid communicating at this time. I give time for the situation to cool down. With this I have noticed that most conflicts are avoided."*

Note: Situation c is a good example of use of all the four EI skills – and the participant taking conscious action to avoid that her emotions contributes to causing a conflict.

The process is empowering, and helps them get new ideas about how they can learn in an active way, and be in charge of their own learning:

- *"The exercise on observation tasks has been an eye opener on the importance of paying conscious attention to how I communicate. It helps in becoming a good communicator."*
  HCW, Kilifi

6.4 Why are self-observation tasks so central to the model; the links to EI

There are several reasons why the self-observation and reflection tasks are at the "heart" of the training model – they teach providers to become aware, teach them how to learn, and result in them taking responsibility for their own learning, and their own change. They also help participants and trainers identify learning needs that are being addressed in the workshops. These are all factors that are central to the success of this training, and to the learning being sustainable.

The reflective learning process seems to strengthen or lead to developing emotional intelligence (EI) – the links to EI are referred to under separate points. The process they go through naturally enables the participants to build EI as they progress, without the training process originally having stated "developing EI" as a pronounced goal. However, once the connection became clear to us (as trainers and planners), we have decided to add this very useful EI framework and set of skills to our model. ***NB for those who do not find the links to EI useful, it is perfectly possible to simply ignore these – and the process will also make sense without these links. The key process is about building emotional competence, which is a slightly broader concept.***

Daniel Goleman, who wrote the original book on Emotional Intelligence (1995), describes EI as "*the capacity for recognizing our own feelings and those of others, for motivating ourselves, for managing emotions well in ourselves and in our relationships".* This is an important part of what the training model is about.

The main reasons why baseline questionnaire and observation and reflection tasks are so central to the model, and how they link to EI, are described in some detail below. There is much overlap and connection between the factors, and I have chosen to rather leave it like this, despite some repetition – to underline the complexity and inter-connectivity between the factors and the skills and abilities. The sequence the factors are presented in is also chosen to illustrate the natural evolvement of the skills and abilities. The **sequence of the tasks** in most cases closely follows the development of the different skills that build EI.

What do the tasks lead to, and why are they so central?
The points are further elaborated, below is an overview

Becoming aware: The discovery process

a) Participants reflect on what they do well, and start developing awareness
b) Participants become aware of how they hurt others. This is not what they want to do
c) They feel the patient's pain: they empathize, connect emotionally, and see the Person
d) They discover the effect of emotions on communication, and feel a need to change
e) The discoveries and reflections lead to an inner motivation to change

Exercising empowerment – taking new action, and understanding why

f) They take responsibility for the communication in the relationship, rather than blame the other for "bad communication"
g) They consciously look for and find the reasons behind the problems
h) They change from passive to active learners
i) They learn to recognise and then stop automatic reactions, step back, and communicate with respect
j) They feel guilty for mistakes, but are not being shamed for who they are
k) They may decide to change of attitudes and behaviour

6.4.1 Becoming aware: The discovery process

a) Participants reflect on what they do well, and start developing awareness

The process of strengthening awareness and skills on how they communicate starts with volunteering for the course: Participants are motivated and ready to take a close look at how they communicate, with a critical eye.

When working on the baseline, providers identify and reflect on what they do well, as well as on what are their challenges in communicating with patients and colleagues. The baseline exercise, which they conduct individually over a period of one week, starts building their awareness about how they communicate and how it works on others. It prompts them to start looking consciously at their communication behaviour, and often makes them curious to learn more.

The question in the baseline to look at what they do well is purposively chosen (*and is followed up in the tasks and in training by also focusing on strengths*), with the intention to gradually build professional pride, and to motivate and empower the participants to learn well. In many learning traditions, the focus is mainly on detecting problems, and solving these – which is often not experienced as empowering (*although problem-solving is of course an important skill to possess).* We also emphasize ***problem-solving*** in our training – often by ***looking at what they do well and exploring if and how these strategies can be an entry point to solving other problems.***

When observing in action how they listen, they start recognising both how they practice this skill (*e.g do they interrupt others often?),* their own emotions when they use the skill in various ways (e.g. *when they are irritated they may tend to interrupt, automatically*), and the effect on the person they listen to (e.g. *the other person becomes insecure when she is interrupted*).

Perceiving or recognising emotions accurately is an important (initial) part of the emotional intelligence skills (skill 1): Participants are guided to become aware of how they practice the "regular" aspects of communication (e.g. how do they listen or ask questions), as well as the emotional reactions that happen or are triggered by how they communicate.

b) Participants become aware of how they hurt others. This is not what they want to do

Something important happens to the providers when they start looking at the effects of how they communicate, on the other person. They discover that they often hurt the other person, or that they confuse, or cause other unpleasant reactions - and that they have to take the responsibility for this. Once this awareness is awakened, it cannot be "un-done", there is no "way back": They have to live with, and reflect on, the consequences of how they communicate. A typical reaction is – *"I started to see how the patient withdrew when I used a harsh tone, and my antennae came up and made me ask – do I want this to happen?"* The answer is – of course not! The providers ***do not have the intention to hurt***, or to cause problems.

A typical comment or insight:

- *"It was like it was another person behaving like that with the patient – it could not have been me! I was shocked!"* *HCW, Kilifi*

The problems are caused by of lack of awareness, by automatic reactions to emotional challenges, and by lack of skills to observe and reflect on their way of communicating: They have habits that are formed by their background and personality, and influenced by the culture and environment they live in and work in and by attitudes and habits of colleagues they work with. The function and power (ab)use of hierarchical systems has a particularly strong influence: This is the hidden curriculum at work.

- *"There are times they don't want to listen, especially the supervisor, they have the tendency that a junior cannot tell them anything".* *HCW, Kilifi*

The ability to perceive or recognise emotions accurately is being strengthened as they get used to observing and reflecting on their actions. The first parts of emotional intelligence is being built.

c) They feel the patient's pain: they empathize, connect emotionally, and see the Person

The process of observing and reflecting makes the providers able to put themselves in the shoes of the person they communicate with and feel her pain – or her joy and gratitude – as a result of what they say and do. It almost "forces" them to see the other person as just that – a person, rather than e.g. "the diarrhoea case", or "the stubborn patient". It enables them to connect with the other person's emotions, to empathize, to build a professional relationship, and experience how this affects their ability to develop trust and to provide patient-centred care. It is also a useful set of skills to enable them to communicate and relate well with colleagues.

When connecting with the patient as a person, e.g "Mama Mary with her one year old daughter who is coughing strongly and can almost not breathe", the respect comes naturally, and the automatic reaction to judge the patient/parent (e.g. for coming late) can be replaced with compassion, kindness and care.

- *"The mother who appeared anxious initially now looked calm and opened up to me and we communicated freely concerning her child"*
- *"I am amazed on a daily basis how important communication is in our lives. I have discovered I have been doing things/communicating badly hence hindering information to be relayed or hurt the other party in ways unimaginable, not realizing. Self-realization is hard to find if you do not put yourself in the other person's shoes."* *both quotes: HCWs, Kilifi*

Through these processes (a, b and c), participants get the opportunity to reflect on what they do well and develop awareness about how their actions can hurt others. They become aware of and

can connect with the pain patients go through when treated badly, by acknowledging, respecting and empathizing with the patient. Participants develop skills that enable them to appreciate the importance and effect of their actions towards patients and strengthen their ability to recognise their own and their patients' emotions more accurately, thus building their emotional intelligence (EI skills 1 and 2).

d) They discover the effect of emotions on communication, and feel a need to change

As they go on learning how to observe and reflect, they will discover more deeply, and start to see not only THAT they have to change, but also HOW they can change. During the second month of observations they look at how emotions affect communication, and this is when many really "wake up" to some surprises. The quote below shows how a participant has built on the understanding of the first set of tasks (*one of which is to look at how they ask questions, and if questions they ask are open or closed*). She has added an observation from the second set – where she has looked at how her feelings influence how she communicates:

- *"I have a challenge in asking questions to find out more what the other one is saying, Most of my questions are close ended requiring yes/no answer. When I let my feelings take control over me, I end up becoming impatient and ask close ended questions, hence not listen to what the person is saying".* *HCW, Kilifi*

Other participants reflect on how emotions affect their communication:

- "*On my own observation, when I'm overwhelmed I find myself I do not have patience and I don't want to hear stories, which affect my clients seeing that I don't listen to her/him. This is bad."*
- *"Lack of effective communication skills, mostly emotional awareness. Unless I understand my emotions well, I cannot think and feel what a patient/parent goes through at that particular moment."* *Both quotes: HCWs, Kilifi*

Many participants take responsibility for the consequences of their actions when they look at how emotions affect communication. The habit of judging others for having different opinions (colleagues) or culture and tradition (patients) is common. They become aware of the negative consequences of these habits, and continue to reflect:

- *"I become judgmental because of the traditional charms[105] on the child's waist whereby I told the mother to cut it before I could attend to her."* *HCW, Kilifi*

They discover that the effect of their own emotions is often an automatic reaction, like blaming the mother for having been to the traditional healer. The provider acts from her own anger (*covering her fear of the spirits and of traditional healing, behind it?*) – thus often preventing her from giving appropriate patient-centred care. They reflect. They continue to observe the effects of emotions, and many become very surprised at the strong effects they see, every day, of their own automatic emotional responses to various challenges. They start to become aware and recognize **the need** to learn to step back from their own automatic emotional reactions, but not yet practicing this skill.

Emotional awareness and intelligence at the first three levels are described in this section – from recognising emotions (1) to seeing the link between emotions and thinking/understanding (2) to understanding the causes and consequences of emotions (3). The next and last step - managing emotions based on their learning, by adjusting personal behaviour, is "right around the corner",

[105] Charms are usually black pieces of cloth put on the sick person by the traditional healer, to ward off evil spirits.

but is the most difficult skill to learn: This is about changing behaviour which might have been practiced for decades.

e) The discoveries and reflections lead to an inner motivation to change

A main challenge is to motivate providers to change behaviour and make the change sustainable. Planners, researchers, decision makers, patients – all may agree that providers need to change their attitudes, and change behaviour, to be able to provide patient-centred care and to communicate well with colleagues. However, when the decision or "push" for change comes from "the outside", rather than from the providers themselves ***experiencing a need*** for change, the "motivation" will be ***external,*** and often causes resentment: "*Someone else (or: Our bosses?) has determined that we need to change. They don't understand our situation, and our problems*." Skills training courses in such situations usually do not result in sustainable attitude and behaviour change.

When using observation and reflection as a method, planners understand and acknowledge that the decision to change behaviour needs to come from the providers themselves. The motivation to change must be internal *("I have seen that I need to change, and I will*") rather than external *("YOU need to change"):*

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

When the providers observe their own habits and discover a problem (with their behaviour) and see what the consequences of their actions are on the other person, ***the problem is theirs***, and it affects their perception of themselves as a good, kind, caring health professional. ***The solution is also theirs***: They own it. There is no fixed, simple technique which will solve the problem – they need to engage, and to find the solution. They do, and often become empowered. This strengthens the ***inner motivation*** to continue the work to change – as they experience the effect as useful to themselves and to the patient.

Examples of insights that prompt behaviour change

The decision to look for a solution is a very important step – and is connected to the point above, about taking responsibility for the change. It starts with an almost deceivingly simple task – **to listen**: Pay attention to how you listen, and to the effect on the other person. You discover for example:

- *"I feel most of my patients do not have time to explain more on what their problems are because I don't give them time to do so." HCW, Kilifi*

With this discovery, the provider has become aware that she is to "blame" for not getting the "full story" behind the patients' problems, AND – that she can take action to change this, on her own. This understanding often leads the provider to start experimenting with different ways of listening to the patients and becoming aware of the effects.

- "*I used to think that listening is a passive activity, but I was wrong because it is active and it means participating and caring by me for the listener. I learnt that I am responsible of attempting to grasp emotions often veiled behind the spoken word. In active listening, I have learnt that I simply lay aside my personal feelings in order to understand/assist the client in her conversation." HCW, Kilifi*

By experiencing the effects of listening better, on the other person as well as on themselves, the provider reflects, and concludes that she/he can of course use better listening skills to achieve such

good results. It feels good: They experience the joy of learning, the moments of "Wow! This works!" When this is based on their own efforts, it is very satisfying.

The connection between the cognitive understanding of the effect of the listening, and the emotional experience (*either negative, when they don't listen well, or positive, when they do listen well*), contributes to stimulating the inner motivation to change, and/or to sustain the new behaviour. Another example describes this process:

- ***Feeling the need to change:*** *"After a series of self-reflections as per the observation tasks I started feeling I needed to change. In meetings for instance, I would just hear myself talk and explain things while the rest keep quiet and rarely contribute. I felt like I am sort of judgmental and conclusive. I thought to myself that this is not right. I have also learnt that in allowing people to share or give their opinion, they own it."* *HCW, Kilifi*

The ability to take action to adjust your behaviour based on your understanding of the "emotional landscape" is the 4th skill in developing emotional intelligence. In the examples above, the participants in fact combine all four factors: They perceive the emotions, they understand what is going on, they understand the causes and consequences of the emotions, and – they manage the emotions and change their own behaviour. They practice all the four EI skills.

6.4.2 Exercising empowerment – taking new action, and understanding why

f) They take responsibility for the communication in the relationship, rather than blame the other for "bad communication"

The realization of the impact of what they do makes them gradually start to take responsibility for the communication in the relationship, and for the change process. They change from being a **"victim"** *("She was such a difficult patient, there was nothing I could do"*) to becoming an **"aware communicator"** *("She was feeling very scared, so I could see I needed to listen and to empathize with her; I did, and we cooperated well")* who takes responsibility for making the communication process work well.

- *"I later realized that I had been harsh to others, quick to blame other people for any mistake that happens, not realizing that I could have also contributed to the outcome of the incidence."* *HCW, Kilifi*

The tendency to ***blame others*** for problems is well known and is probably one of the most important barriers to constructive communication. It is often caused by insecurity and fear – fear of what will happen if the provider acknowledges that she caused the problem: she may be criticized by supervisors, maybe colleagues, maybe the patient; there may be punishment of various sorts; she will feel like a failure, etc. The automatic reaction to blame others is natural, to protect herself and avoid the many negative consequences of taking responsibility for causing a problem. When asked about the effect of insecurity, on their own communication, a provider expressed:

- *"I result to blame game. I will result to point fingers at the other members of the team as being the cause."* *HCW, Kilifi*

The tendency to blame others is very common in hierarchical systems and is also a consequence of lack of emotional competence.

Taking different action:

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

When the provider becomes aware that

a) she probably caused the problem (*e.g. by communicating unclearly, or not listening/ understanding, or by not paying attention to the emotions*), and
b) she has the skills to solve the problem (*e.g. by apologizing, or asking more questions, or empathizing/responding to the emotions*),

the fear is reduced, or gone: She can take action, solve the problem, and make both herself and the patient feel well. This awareness and the possession of these skills give self-confidence, and over time – job-satisfaction. The stress caused by the insecurity and the guilt feelings from blaming someone else for a problem you know (or suspect) you have caused, is also reduced, or gone.

The provider has developed the ability to discover the effects of her actions on the patients, and to understand how emotions influence the actions and communication of both herself, and the patient. The provider integrates emotions with cognition, i.e. she starts to understand how she uses emotions. This is the second key skill in developing emotional intelligence.
(NB in the last part of this example, the "full EI", with all four skills, is referred to.)

g) They consciously look for and find the reasons behind the problems

Participants have not been used to exploring problems from the perspective of the other person, e.g. the patient: When a parent e.g. brings in a child with charms (often black pieces of cloth tied around wrists or ankles), showing the child has been treated by a traditional healer, a common reaction has been to judge and blame the parent for their action (*of taking the child to a traditional healer, rather than coming straight to the hospital – thus delaying seeking "real help", in the mind of most providers)*. The consequence is often that the parent feels judged and may not feel free to give information, and the child may not be diagnosed or treated in the most effective way.

With their new skills to recognise and step back from the automatic reaction (to judge and blame), the providers can explore the reasons behind the parent's actions and find central information that is important to treat the child in an optimal way.

- *"My journey to self-discovery has been interesting. It's amazing how much people can tell when given a listening ear. I discovered that giving others an opportunity to express themselves leads them to confide more than what they had anticipated, rather than interrupting and judging them as I used to. For me....my new Motto is "patience pays".*
  HCW, Kilifi

The skill (and attitude) to find the reason(s) behind a problem is central to deciding on appropriate action, and to establishing good cooperation with the patient:

- *"I was very busy with my work and it was about lunch time. There came in a parent with a study child and I just felt pissed off - why at this time? So I just started telling the mum the importance of coming early, reasons why she has to be there early, without even giving her time or asking her why she was late… So she just opened her mouth, innocently telling me, "Doctor, I am sorry for being late, but you are just throwing so many words at me, you could just have asked me why I came late!''*

- *Waaw! I felt bad. I had to apologize there and then. I gave her a seat and asked her why she was late and her answer made me feel I am a bad person. I just judge a person without knowledge. She said she had to use three motorcycles to reach the hospital. The first one got a tire bust, and she had to walk for at least one hour. Luckily she got the second one, and after a little distance it went out of fuel. She had to walk again for at least 45 minutes to get another one. All those motorcycles - she had to pay them. And here I am complaining she came late, not knowing the effort she made to reach here. All she asked me was - what if she gave up and went back home, what could I have done? I felt bad, it really made me realize how to appreciate all study participants (taking part in a research project) because I don't know how they struggle to reach the facility."* *HCWs, Kilifi*

The skill to look for and understand causes and consequences of the emotional reactions (one's own, as well as those of the patient/the other person) is central in developing emotional intelligence. This is the third skill (of four) in the sequence of developing EI.

h) They change from passive to active learners

Some colleagues may already have made changes, and this inspires others to try new methods as well. Furthermore, sharing experiences and reflections in the meetings during the discovery phase opens up for sharing with colleagues and mentors also during the individual observation periods: Participants are encouraged to do so, to share challenges and reflections, and strengthen awareness and skills over time. They gradually accept that they have responsibility for managing their own learning: after initial hesitance about why and how to use the observation and reflection, they see ***the purpose and the results***, and continue with increasing motivation.

The process can be described as "**active learning**", and this is new to many providers working in a hierarchical system, where they are used to being told what to think and do and told what they have to learn. The system of passive learning is still the predominant style in many education systems, where lecturing and knowledge reproduction is the norm, rather than facilitating and encouraging individual learning, critical thinking and empowerment. But the systems are gradually changing, following research which clearly shows that active learning and critical thinking produces better professionals who have more job satisfaction, treats patients better and have better collaboration with colleagues.

Active learning[106]: Openness		**Passive learning: Fear**	
Characterized by	***Leads to***	***Characterized by***	***Leads to***
Open structure Humanistic and democratic approach Tearcher is facilitator of learning Taking initiative Curious to learn Feeling safe – not judged as poor communicators Taking responsibility for own learning Encouragement Group work	Changes Positive attitude to learning Problem solving Empowerment Learns how to learn Democratic attitudes? Student trusting teacher Analysis of reasons behind behaviours Motivation to take new action Reflection	(Strict) Hierarchy Top-down authoritarian approach where teacher has all answers Knowledge reproduction/ memorization of facts Lecturing Obedience; Punishment Individual work, for exam Learner does not question, or make suggestions Describing Right and wrong	No change Learning is a duty Learning often boring Students often quiet: Fear of asking, and of making mistakes Students protecting themselves against criticism Keeping things as they are

[106] Some points taken from Werner, D and Bower, B (1982): Helping Health Workers Learn. Hesperian Foundation, Berkeley, California

Collaboration Reflective learning Critical thinking Learner questions the trainers – questions are welcomed Supervision=supportive and constructive	Openness	Rules and regulations Learning not necessarily relevant or practical Large classes Competition Supervision=fault-finding, and destructive	Slower students drop out Gossiping and backbiting Denial Bullying No trust

The learning through the process with the tasks also to some extent **counteracts the fear of taking initiative:** In a hierarchical system, it is safest not to "stick your neck out" and take initiatives, because when you don't, you cannot be criticized for initiating something wrong. When conducting the tasks, and discovering a problem, the providers are the only ones who can take initiative to solve it. They are the only ones knowing they have a problem (even though it might have also been observed by their colleagues), and they have to take an initiative to understand it, acknowledge it, reflect on it, write about it to the trainers (or keep it to themselves), and then – do something to change. All this requires initiative, and all is contributing to developing active learners – who learn how to learn. In most cases they will continue to learn after the course process is finished. They have become empowered and are free to use these learning methods any time they want to. Experience has shown that they do – because they find the process useful and gain better results at work.

The ability and decision to change your own way of recognising and acting on emotions, based on understanding the effects of your old ways and deciding consciously to adopt new behaviour, is an expression of "full emotional intelligence", and corresponds to the fourth EI skill (which assumes the mastery (or at least the use) of the first three). These are very powerful skills that are increasingly acknowledged as central also for good management and leadership.

i) They learn to recognise and then stop automatic reactions, step back, and communicate with respect

Automatic reactions to emotional challenges is very common. In the health professions such reactions can have very negative consequences for the patient's health – and for the provider's own feeling of managing well on the job and for her emotional wellbeing. Automatic reactions can also affect collaboration in the professional team.

The discovery of how their automatic reaction patterns can lead to a series of negative consequences comes from the series of observations on emotions (see factor d). The providers become aware of the need to **recognise and step back** from these reactions, to be able to communicate with empathy and respect. Many providers say this skill makes a very important change in how they relate to emotions, and how they are able to function in their job. An example:

- *"One day as we were attending ANC clients, one of the booklets for a client was misplaced and she was left to stay in the queue for long. Mothers who came behind her were served and left. The mother then stepped in the room. She was so angry, using abusing words, I and everybody was like "who this mother is and what was wrong with her?" She created a scene and we were the centre of interest to other clients and patients who were around. We tried to calm her down and she was so emotional. I almost went into same emotions myself, but I had put my antennae up. I stepped back, calmed down and composed myself.*
  I requested her to just enter the room calmly; I asked her what was the problem and how I could help her. She also calmed down saying she has stayed for so long without being attended to. I apologized and tracked down her book which had been misplaced, served her, and she went home.

My stepping back made her cool down, which enhanced the conversation. Taking care of my emotions solved the problems without worsening them." *HCW, Kilifi*

Learning the skill to recognise and step back from an emotional reaction is a key focus in the first workshop, and the motivation to learn is very high: Everybody has experienced that emotions affect them and their patients and colleagues much more than they had realized, during the first three months of doing observation and reflection tasks. The insight that this is something they need to learn much more about, is universal in the group. They have developed a strong inner motivation to learn.

- *"I used to feel stressed, get angry very fast when a person comes at a time when I'm so tired and almost time to come out of work for either lunch or evening. I'm now able to step back – listen first then give answer. Stepping back when I am angry has really helped me."* *HCW, Kilifi*

Feedback from the providers shows that for a majority, learning to manage emotions (*and in particular to stop automatic reactions and step back*) is the skill which enables them to make the biggest change in their work and lives. It brings them work peace and satisfaction and makes them give better and more patient-centred care. However, some struggle with their "old self popping up" and fall back to old habits. The difference is that they now have the awareness and the perspective, and see what they do, and how it works on others. Most thus try to practice the new skills.

The ability to step back is a "consequence" of having mastered the first three EI skills, and of now bringing this understanding together to take action, based on her understanding and reflection: The provider is able to manage his/her emotions wisely, and to communicate constructively – thus practicing emotional competence (using all four EI skills).

j) They feel guilty for mistakes, but are not being shamed for who they are

Making another person feel shame or guilt is a power strategy frequently used, especially in hierarchical cultures (*like the medical one*). Being shamed is a very strong negative experience, one that especially young providers who are insecure (and older ones who feel insecure for different reasons), will react strongly to. For example, it has been common practice for some supervisors to shame a colleague under him/her in the hierarchy by criticizing her in front of others, commenting on her as a person: "*You are completely useless*". The effect of such criticism is severe:

- *"Being criticized in front of my colleagues makes me irritated and outraged. I feel like I have been undressed in the open for everyone to laugh at me. I feel so vulnerable and so much alone. The need to protect myself just automatically sets in."* *HCW, Kilifi*

The need to protect oneself is automatic – but exactly HOW one does it, depends on the level of awareness – and on the emotional intelligence the person has developed. Below is an example of a provider who "hits back", apparently without awareness or emotional competence:

- *"A fellow clinician talked to me badly in the presence of patients. Oh I talked to him very badly too on the spot and ensured that they all heard what I was telling him, and I was very pleased with myself."* *HCW, Kilifi*

The person who is shamed may hit back, as above, and contribute to causing conflict and bad working relationships in the team. In other cases, the provider who is criticized in front of others may feel so bad that he or she does not learn from the incident. The power behaviour of the colleague can create fear and resentment in the person who was shamed and set a bad example for her

colleagues. Many take out their frustrations and anger over such incidents, on those who are below them in the hierarchy – the patients. The lack of skills to recognise and manage emotions competently very often has consequences on PCC and patient safety.

The difference between shame and guilt

Shame: "I am a bad person"

Shame results from negative evaluations (real, or imagined) of who one IS, by others. It is a violation of cultural or social values.
It is a negative, painful social emotion, making the person feel small, embarrassed, scared or humiliated.

Guilt: "What I did, was wrong"

Guilt feelings arise from violations of one's internal values, from one's negative evaluation of oneself – of what one DID.
You can also be ashamed of a thought or behaviour no one knows about.

When learning through observation and reflection, providers become aware of the effect of their communication, and many are surprised, and shocked, at what reactions they cause (*usually without consciously intending to hurt the other person*). BUT – ***and this is important*** – they are not shamed or made to feel guilty by an external person: The discovery is their own, and therefore – the decision to share it, or keep it to themselves, is also their own. The decision whether to change is also their own – there is no one pressuring them, but themselves. When they don't like what they cause – when it is not in line with an image they would like to have of themselves as a kind and caring provider – they may feel guilty. They are free to take action to remove the guilt, and to change - without pressure. Some people may also feel ashamed of themselves.
A common reaction is to develop an inner motivation to change.

The decision to change is also influenced by colleagues and trainers. In the first observation phase (the "discovery phase"), they meet briefly every month to share experiences from the observations, and to receive the new tasks. During these meetings, they hear that colleagues are struggling with the same issues as them, and this causes relief: They are not alone with their problems, and with their guilty feelings for what they have done. They are not "especially bad", or worse than others. The problems they experience are "normal" or common, and the problems have causes that can be discussed. By becoming aware of and understanding the reasons behind their own behaviour, e.g. covering up their own fear or insecurity by anger and judgment, they can make a conscious decision to act differently.

Trainers can trigger guilt feelings: Many trainers also use power strategies in their teaching – authoritarian didactic teaching methods (*where the teacher has all the "right" answers*) can create resentment and guilt feelings, rather than an inspiration to learn. Such methods are much used, and do not contribute to honestly questioning one's own attitudes and behaviour, nor to look for the effects of what you do, on others. Providers often (*automatically*) adopt the methods their teachers used, to their own teaching of patients (*e.g. on how to manage their disease, or how to take medicines*), often with the effect that the patient does not learn. The awareness of the negative effects of such teaching methods on learning is increasing, and experiential methods are gaining ground.

The provider who becomes aware that her actions are hurting the patient, and feels guilty/bad, is practicing the first three skills of EI. When she takes action to step back, apologize and act consciously, (e.g. to build trust and to empathize with the patient), she is practicing the 4th EI skill. When the provider is left to discover and reflect through using this model, she may develop the EI skills naturally. If shamed by a teacher, supervisor or mentor, this natural EI development is disturbed – and maybe stopped: Being shamed is so uncomfortable, psychologically, that the person will do her best to protect herself. She may blame and judge her teacher for being cruel, and will not reflect or and learn consciously from experiencing the problem.

Shaming stops reflective and natural learning.
It turns the learning opportunity into a judgment game, with no winners.

k) The tasks can lead to change of attitudes and behaviour

The key to change behaviour is our own inner motivation to do so – because we have ***experienced*** a need, because we know it is possible, and because the decision to change is our own. The factors above have all described various parts of this "puzzle" that leads to a sustainable behaviour change, and how the observation and reflection tasks facilitate this learning – supplemented by healthy doses of critical thinking.

The following can function as a brief review of the steps leading to behaviour change, and are related to the model of attitude and behaviour change which is described in Module 3c. Understanding this model, and how we ourselves change, has been one of the most important insights for participants: They have seen why telling people what to do, does not change their behaviour. They have stopped blaming people who do not change because they are told to do so – because they have experienced and understood how they themselves change behaviour. See module 3C.

The observation and reflection tasks provide the important **ground work** for understanding how we change behaviour.

Our way of teaching how (individual) attitudes and behaviour changes is different from what is commonly practiced in training courses. When using e.g. motivational lectures, the lecturer may aim to convince the listeners that they need to change and give them good reasons to do so. The listeners might agree and develop an ***intention*** to change. Research shows that most of the listeners will not follow their intention to change their habit(s) only based on such inspiration: The idea to change and the reasons for doing so belong to the (motivational) lecturer, NOT to the listener. This is an ***external*** motivation, not an intrinsic or inner one.

In hierarchical systems, workers are used to being told what to do, and also often – to a large extent – what to think. This may "work" in the moment but will not help to change habits over time. Critical thinking is not encouraged, and passive learning is often the norm. Changing this "culture" is a real challenge for educators.
Note: Some of the didactic information is of course necessary, to ascertain that essential rules are followed and medical work is organised in functional ways.

The difference in our training course lies in the discovery or in the slow development of **a need and a wish to change** – through observing and reflecting on our own experiences, over time. You see how you listen today, and become aware of and interested in changing. These are the first two steps in the attitude and behaviour change model, see Module 3c:

- *OOOps, I interrupted the patient again. Ooops, I could not get her to talk. Hmmm. The same happened yesterday, and I am not sure my assessment of her problem right. Hmmm. This does not feel good, I cannot do my work well if I don't get the patient to talk freely. How can I learn to tame my impatience?*

Maybe you decide to try to listen without interrupting tomorrow, which means – your experience(s) lead you to change behaviour, or to try another way of listening. Then, you experience that when you listen without interrupting, patients open up, and you get to the "bottom" of their problem, quite fast, without wasting time and effort. You reflect. This works better, and it is your own solution, which you have learnt from – and are applying on – your own work situation. Maybe you discuss it with a colleague, and explore what she has discovered, and done, and find out you have similar experiences. You are on the way to having changed your behaviour, based on experiencing a need to do so, and on trying out a different action.

You also reflect on what you have heard, and learnt, earlier:
Maybe the lecturer in that course some time ago, who said listening well is the key to good patient-centred care, was right. This may strengthen your decision to keep attention on your listening habits and continue to change.

The awareness leads to a decision to get involved in looking at yourself and your listening habits, and the subsequent awareness made you decide that you *really* needed to change:

- *You were a bit shocked when you recently experienced how a mother with her very sick baby reacted when you interrupted her brusquely and told her to get to the point about the baby's illness. She started crying and shut up. Awareness entered the scene: It dawned on you that you had really hurt her by acting on your impatience, while she was in a very vulnerable situation. You took a deep breath, apologized sincerely, and asked her to please tell you her story. She looked at you – surprised. But she heard your honest and genuine intention and told you how and when the baby got sick.*
- *You learnt your lesson, and decided that listening well, and kindly, was a better method than your old one. You started to really change your habit. (Rewritten from participants' example)*

Reformulating the learning, using emotional intelligence (EI skills used, in parenthesis):

The provider is irritated and unaware, handling the mother with the very sick baby by brusquely interrupting her. But then –

- The mother cries, and awareness and recognition of emotions sets in, with the provider: She recognises the mother feels hurt, maybe sad, maybe scared, and the provider herself is irritated (1);
- The provider knows there is a connection between thinking and emotion (2)
- She analyses quickly that her own action of being harsh and interrupting is a main cause of the mother's reaction, and that the mother is very vulnerable because of her severely ill child (3);
- She steps back from her irritation and apologizes to the mother (4). The mother accepts, and they work well together to care for the child.
- The provider reflects on this experience, and it contributes to her changing behaviour (4).

Change of habits and behaviour has to start from an inner motivation, a conviction that change is needed (*often triggered by an emotional event, like in the example above*). This is what the observation and reflection stimulate providers to do. Discussions with colleagues affirm and deepen their understanding and build confidence in using the new skills.

Summary of why the tasks are so central to the model

The tasks are central to the model, because the process of observing your actions and reflecting on what you see (and feel), and how the other person responds, makes the provider aware of the power of his communication and of the effect it has on others. You can facilitate a good relationship, or make the other person feel insecure and close down. When they experience this, repeatedly, and reflect on it – most of them decide to change.

6.4.3 Additional important aspects of observation and reflection

With each step, inner validation of and confidence in the method is strengthened

The validation happens at five levels, each of which strengthens participant's own inner validation:

- By trainers, in monthly meetings;
- By trainers, in basic workshop: They have quoted participants' examples in presentations
- By colleagues, who share similar observations on themes in groups
- By linking to theory
- By seeing that new skills "work", during Skills into Action phase.

The sequence of tasks is created to systematically build providers' trust in their own learning and ability to use the skills consciously and independently. Participants **validate** the learning steps, **internally** (*and in many cases – probably subconsciously*), and gradually build their confidence – both in the value of carrying out this work, and in trusting what they learn:

In the first phase, participants reflect **individually** – first, to assess their own strengths and challenges when filling in the baseline. They then start the systematic weekly guided observations and reflections, with monthly meetings to briefly share experiences, give feedback, clear questions, and give new tasks. During these meetings, **their learning is appreciated and validated by the trainer(s),** and by other colleagues who have made similar discoveries. The participants start building confidence in the importance of their learning, that it has value. As they discover more and get new insights, the confidence is strengthened.

The individual reflections are further validated externally, by trainers – who select and build examples from the reflections into **presentations in the first workshop**. The reflections are shared in groups, linked to discussion of specific aspects of communication and emotions. **The group discussions function as a third level of validation** from their colleagues: They also struggle with the same problems. They also make mistakes. Through interactive reflection, they learn from each other.

Fourthly, the reflections are linked to theory, and this external validation makes participants see that what they have experienced, is "true" – it is part of a natural phenomenon which can be explained by theory. Their guilt feelings are natural, to be expected, and can now be placed behind them. They learn and practice new skills, based on insights from the reflections, and on theories.

During phase 3, participants take **"Skills into Action"** in further observation and reflection tasks, and **new practice is validated by providers seeing the results in their work**: They see that what they have observed, shared, learnt about in theory and translated into practice is "true" – and experience the powerful effects of their new practices, on patient collaboration. They also experience that they now work better with colleagues, with more awareness and less conflict. Many report that the new skills also reduce burnout. Their confidence in using the new skills is gradually strengthened, and many report that they are much happier in their jobs:

- *"I used to feel stressed, get angry very fast when a person comes at a time when I'm so tired and almost time to come out of work for either lunch or evening. I'm now able to step back – listen first then give answer. By stepping back when am angry has really helped me."*
  HCW, Kilifi

The final validation happens in the last workshop, when participants present "Best practice" examples from how they use the skills and get feedback from the group and the trainers – usually with a lot of appreciation and affirmation of their learning. This helps to cement the learning and reinforces the value and usefulness of observation and reflection to learn systematically how to communicate better. The new skills are firmly and systematically validated and have become new behaviour that they use and show with professional pride. The chances of the new skills turning into sustainable new behaviour, are high.

- *"I have realized that most of our patients had been misdiagnosed due to poor communication. I find it very enjoyable listening to my patients and also learn from them and in the long run we are both very happy. Even in the evening when I go back home I feel at ease as I left my workplace happy."* *HCW, Kilifi*

6.4.4 Limitations of using self-observation and reflection

In many cultures, the idea of observing oneself is uncommon – the power to define one's good and bad sides is commonly placed with the teacher/trainer/authority.
It takes time to learn the method of self-assessment and learn to trust one's own judgement. The main influencing factors helping them to learn well are –

- **The provider's own motivation to learn**, and to follow instructions;
- **The trainers' ability to encourage and explain**, and to be a mentor and role-model for the participants during the first phase;
- **The meeting with the trainer**, when she collects the baselines and distributes the first tasks: Her ability to explain and discuss the purpose and practice of the observation tasks, and to appreciate their learning and their questions so far;
- **The second meeting with the trainer**, to discuss the participants' first observations. The trainer explores how they have observed, appreciates their discoveries, gives feedback and answers questions;
- **Participants' own discoveries**: When they start seeing their own patterns of e.g. listening, they "see the point" of the observation and reflection tasks: They learn, get insights, and become motivated to continue exploring and learning.

Without encouragement or feedback during this first period, many participants may lose motivation. This places an important responsibility on the trainer, who needs to make sure all participants are contacted during this time, if they do not show up for the common meeting.

Author's reflection:

"The response and motivation is the best I have ever had in a training course."

"I started using observation tasks as preparation for a communication training course for field workers (whose task was to collect research data for scientists, by interviewing community members) in Kilifi in 1993, in collaboration with Sassy Molyneux and Vicki Marsh. We broke down the field worker interview into small bits and asked them to observe each bit for a week, starting with how they did their greetings of the respondent/family. We asked them to look at what worked well, and what didn't. After a week they all met to share their observations, facilitated by Sas or Vicki. They started to learn from each other – they shared good methods and debated those that did not work.
Motivation to learn more, and to learn from each other, developed quickly.

In the training course I conducted for them, there was a lot better participation than I had had before in such fora: The participants had a lot to share, and they had learnt the "magic" of how to learn systematically by themselves. They had also defined many of their learning needs, they had invested in their learning, and they were eager to learn more – about how to tackle problems THEY had described, using the observation tasks. Evaluations showed a clear improvement in their communication skills, and the learning made a big difference to the quality of the information the field workers brought back to the researchers.

The change in my training practice has become permanent – I hardly ever conduct a training course without using the observation tasks to create awareness, stimulate reflection and identify training needs among participants. I use the method at the University of Oslo and at Atlantic Medical High School, as well as in professional courses internationally. The engagement of the students is always positively influenced by them having invested in the topic and in their learning before they show up for the course. When I read their feedback I am always inspired and amazed at what these "simple" tasks can lead to in terms of awareness, insights and motivation to change. Research clearly shows that what motivates people to do something they don't earn money from, or that money is not the driving force, is enjoyment[107]: The participants using the observation tasks enjoy the learning." *Ane Haaland*

6.5 Teaching method: Experiential learning, based on theories

Reflective practice (see chapter 6) and experiential learning is now largely seen as the "gold standard" for teaching medical professionals to practice their skills with insight and confidence. We use this base, and add in Paolo Freire's[108] principles for adult learning, as well as evidence from reviews on effective (participatory) training methods and strategies, to craft our workshop training approach. We also build on Carl R Rogers principles of developing relations with patients. Further adjustments are made based on experience and feedback from participants and trainers during training courses in several countries.

In many countries, didactic and lecture-based teaching methods are still being extensively used to teach communication skills to nurses and medical doctors. Reviews[109] show that these methods fail to meet students' needs for learning, and that the methods are not conducive to learning practical skills – the training is too theoretically focussed. Such training has been shown to have no or limited effect on nurses' skills, their behaviour change in practice, or on patient outcomes.

[107] Pink, D.H (2009): Drive. The surprising truth about what motivates us. Canongate Books, London
[108] Freire, P (1968): Pedagogy of the Oppressed. Published in English 1970. ISBN 9780826412768
[109] Chant, S &al (2002): Review: Communication skills: Some problems in nursing education and practice. Journal of clinical nursing. 11:12-21. Kruijver, I.P.M. & al (2000): Evaluation of communication training programmes in nursing care: a review of the literature. Patient Education and Counseling vol 39, 129-145

The purpose of referring to some of the literature in this section is to provide evidence for the appropriateness of using experiential learning methods to teach providers effective communication skills. **The aim** is that the evidence, together with the pragmatic description of experiential learning, might encourage managers and trainers to take steps in the direction of using these methods to adjust (or transform) the teaching style for medical providers. The shift is very much needed, and the knowledge base is there to draw from. However, the shift will require commitment from leaders with visions, and with a willingness to challenge training models that neither inspire nor stimulate health professionals to choose effective communication and management of emotions.

The main difference between the didactic teaching style and experiential learning is the role of the learner: When the didactic style is used, the learner is a passive receiver of knowledge. In experiential learning, the learner is active – using her own experience as a starting point and taking active part in the learning of theoretical knowledge and practical skills. She learns through studying and reflecting on what she does.

This chapter gives an overview of the background for our chosen learning methods, and of how the methods are used in the workshops. It is beyond the scope of this manual to provide a detailed description of methods used in experiential learning, for trainers not familiar with these methods. A companion manual for trainers is planned, to share the rich material used to train trainers (all coming from a didactic teaching background) in concepts and practice of these methods. The modules do provide detailed descriptions of how to teach, but – trainers would be more successful with their participants if they do have some experience in using experiential learning methods, or at the very least – using participatory techniques as part of their training tools.

6.5.1 Background on theories: Branch, Kolb, Rogers and Freire

William T Branch has been teaching professional and humanistic values to medical providers for decades. In an article which also includes an overview of the evidence of what works and does not work in medical training[110] he suggests a practical and theoretical model for this training. The evidence for his suggestion is based on two studies of the effectiveness of the combined model, his own extensive practice as a teacher (and having used the elements in the model since the 1980s), plus a thorough review of the literature. The model consists of four main components: ***Experiential learning of skills, critical reflection on one's experiences, a supportive and validating small group environment, and a sufficiently longitudinal cohesive program to allow moulding of the whole.***

The importance of the supportive group process is emphasized: When students/participants trust each other in a group, they will be able to reflect deeply and disclose challenging experiences and give each other honest feedback in a climate of understanding, validation and acceptance from other group members and the facilitator.

Branch has dubbed this positive dynamic **"the counter to the hidden curriculum"**, where participants will be developing an informal "curriculum" together, which strengthens their commitment to compassion, empathy and respect. The group thus becomes a learning community. The facilitator, by constantly modelling care and respect, becomes a powerful role model for humanistic teaching.

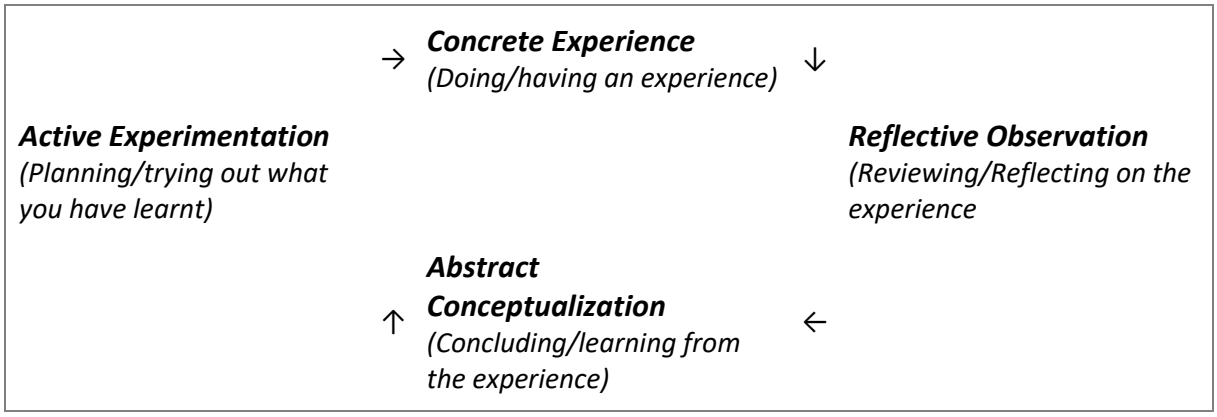
Workshop session, Riga, Latvia

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

Branch suggests that when such core professional values are practiced by a critical mass of students and trainers, they may positively influence the culture of an institution. NOTE: We saw this happening in the Tuberculosis hospital in Siauliai where the model was first used: We trained two groups of doctors and nurses, altogether 40 of 65 professional medical staff. This was enough to positively influence the way staff communicated with patients and with each other in the hospital. We had trained a critical mass: Those who had not participated in the courses were also influenced by the new ways of communicating with patients, and each other.

David Kolb developed his model of experiential learning[111] to explain the meaning-making process of an individual's direct experience. His work popularizes original ideas from as far back as Aristotle, in year 350 BCE *("for the things we have to learn before we can do them, we learn by doing them"),* and draws on the work of John Dewey, Kurt Lewin and Jean Piaget to develop the modern theory of experiential learning, in the 1970s.

Kolb's Experiential Learning Model (ELM) is one of the theoretical foundations for our training model, both for the learning during the observation and reflection phase, where participants make first-hand discoveries and experiment with knowledge and new skills), and for some of the workshop learning:



In our training model, the observation and reflection tasks take participants through Kolb's four stages:

- Building on **concrete experiences** with a patient (e.g. listening poorly during history taking),
- the participant **observes and reflects** (e.g. the patient does not give full information),
- slowly makes meaning out of his experience/**conceptualizes the incident abstractly** (e.g. he does not get to understand the patient's problem well and connects this to his own poor listening style/habit), and then
- decides to **actively experiment** with listening better to patients.

Similar processes happen throughout the workshop as well, when participants are e.g. working with demonstrations and role-plays and experience the good (or bad) effects of their "normal" behaviours (e.g. a demonstration of a provider blaming a patient for coming late, and the patient closing up). They reflect together (interactive reflection) to analyse why such behaviour happens, and then actively experiment with patient-centred behaviours in a role-play. They get the background for the provider behaving in an irritated way and get the choice to practice emotional intelligence – to show how to recognise the emotions and step back, and act with compassion and empathy. When this

[111]Kolb, D. A., & Fry, R. E. (1974). *Toward an applied theory of experiential learning*. MIT Alfred P. Sloan School of Management.

process happens repeatedly, also building on the process in the preparatory reflection phase, the process becomes a natural way of learning.

Kolb states that the following abilities are required in order to gain genuine knowledge from an experience:

- The learner must be willing to be actively involved in the experience;
- The learner must be able to reflect on the experience;
- The learner must possess and use analytical skills to conceptualize the experience; and
- The learner must possess decision making and problem-solving skills in order to use the new ideas gained from the experience.

Participants in our training gradually build these skills during the initial observation and reflection period (phase 1). The skills are mainly self-taught, with support from the monthly meetings with the trainer, where they ask and discuss questions related to carrying out the observation and reflection tasks. Trainers and colleagues in the institution who have gone through the course earlier are important mentors and role-models during this period. Participants who actively seek out the role-models to discuss questions and experiences tend to learn at a deeper level than those who don't.

The skills are further deepened in the workshop, through interactive reflections on experiences, and constant attention to individual and common meaning-making.

Experiential learning is mainly concerned with concrete issues related to the learner and the learning context. It is concerned with the relationship between teacher and student, and with broader issues of educational structure and objectives.

The American psychologist and psychiatrist Carl Rogers was the pioneer of "the person-centred approach" in health care[112], and devoted decades of his professional life and research to understand "the characteristics of helping relationships".

Rogers showed in his ground-breaking research in humanistic psychology how three main skills influenced the relationship between the health provider and the patient, the teacher and the learner and the parent and the child: ***Being authentic, using empathic understanding and using appreciation.*** We are teaching these skills consistently in the training, also by trainers role-modelling these skills.

The key methods to become aware of how these skills function are the observation and reflection tasks, and it is especially in the "Skills into Action" period participants learn to strengthen these skills.

The Brazilian adult educator Paolo Freire has contributed essential principles[113] to our training model. Freire was so effective in his teaching adults to read, write and demand their social and economic rights that he was jailed and later exiled from his country by the dictators running it in the 70s, and spent many years in Chile. But – his methods were so powerful that they were picked up by educators all over the world and have been used extensively in adult education – with very good results. The methods are very useful for teaching humanistic medicine, and for strengthening awareness of values and behaviour.

[112] Rogers, C. R. (1986). Carl Rogers on the development of the person-centered approach. *Person-Centered Review, 1*(3), 257-259. Regers, C. R (1967): On becoming a person. Constable and Company Ltd, London.
[113] Freire, P (1968): Pedagogy of the Oppressed. Published in English 1970. ISBN 9780826412768

Some of his main principles and methods of effective adult learning are:

- ✓ **Dialogue.** The teaching method is to be based on dialogue, which is a horizontal relationship between teacher and learner. Communication and empathy are the main methods in the dialogue.
- ✓ **The educator is a partner**: Freire's view of a good educator emphasizes the need for a flatter structure in the learning hierarchy, and for an exchange between teacher and learner: *"The mark of a successful educator is not skill in persuasion - which is but an insidious form of propaganda - but the ability to dialogue with the educatees in a mode of reciprocity."* (Freire, Education for Critical Consciousness, 1973)
- ✓ **The learner is the subject**. The learning should be based on an understanding of his or her situation and should lead the learner to see himself as a subject in the world, a subject who can be a maker of the world of culture. Through this, his attitude of being an object, a victim of circumstances, and thus passive with no power, will gradually change. He will become a transforming agent of his own social reality.
- ✓ **Critical thinking and analysis**. The learner describes and analyses his situation, and reflects critically on it: He questions the definition of "reality", and gain the skills to redefine this reality. Through this, he is stimulated to begin solving problems. In Freire's own words: *"We needed, then, an education which would lead men to take a new stance toward their problems - that of intimacy with those problems, one oriented toward research instead of repeating irrelevant principles. An education of "I wonder", instead of merely "I do"*. (Freire, Education as The practice of freedom, 1967)
- ✓ **Problem-posing as a pedagogical method**. Freire's central message is that one can know only to the extent that one "problematizes" the natural, cultural and historical reality in which s/he is immersed. Problematizing is the antithesis of the technocrat's "problem-solving" stance. In the latter approach, an expert takes some distance from reality, analyses it into component parts, devises means for resolving difficulties in the most efficient way, and then dictates a strategy or policy. Such problem-solving, according to Freire, distorts the totality of human experience by reducing it to those dimensions which are amenable to treatment as mere difficulties to be solved. He recognizes participants as thinking, creative people with the capacity for action: *"Problem-posing education is prophetic, and as such is hopeful, corresponding to the historical nature of human beings. It affirms people as beings who move forward and look ahead,...for whom looking at the past must only be a means of understanding more clearly what and who they are, so that they can more wisely build the future."* (Freire: Education as The practice of freedom, 1967)

These methods and principles provide a good basis for a different approach to training groups used to being taught with didactic methods.

The power and practice of experiential learning

Experiential activities are characterized as being among the most powerful teaching and learning tools available. Important characteristics of experiential learning is that ***it requires self-initiative and intention to learn, and an active phase of learning.*** The learning is most effective when it involves 1) a reflective learning phase, 2) a phase of learning resulting from the actions inherent to experiential learning, and 3) a further phase of learning from feedback. This process of learning can result in changes in judgment, feeling or skills for the individual and can provide direction for the making of judgments as a guide to choice and action.

Most educators understand the important role experience plays in the learning process. The role of emotion and feelings in learning from experience has been recognised as an important part of

experiential learning. While those factors may improve the likelihood of experiential learning occurring, it can occur without them. Rather, what is vital in experiential learning is that the individual is encouraged to directly involve themselves in the experience, and then to reflect on their experiences using analytic skills, in order that they gain a better understanding of the new knowledge and retain the information for a longer time.

Facilitators who are not very experienced in using experiential learning with their students might use the practical "5 questions" model to promote critical reflection:

- ***Did you notice...?***
- ***Why did that happen?***
- ***Does that happen in life?***
- ***Why does that happen?***
- ***How can you use that?***

These questions are asked after an experience, one by one, and can gradually lead the group to reflect critically on their experience and gain an understanding of how they can apply the learning to their own life. These simple questions allow the facilitator to use the theories behind experiential learning in practice.

6.5.2 A brief selected literature review of the effects of training strategies

In an overview of systematic reviews of how training methods work to teach physicians and nurses about communication skills[114], the authors conclude that a combination of learner-centred strategies, with a focus on practicing skills in small groups, with feedback, has the best effect. The best strategies included role-play, feedback and small group discussion. Other reviews conclude similarly, with role-modelling, personal reflection and critical thinking as main strategies showing good results.

The following conclusions were drawn from extensive evidence referenced in the Berkhof review:

- The best results are achieved with longer duration, learner-centred training, and combining didactic component with practical rehearsal and feedback. To maintain skills in practice and to handle emotional situations effectively, positive attitudes and beliefs are needed.
- There is reasonable evidence that brief training is not effective. Duration should be at least three days;
- Outcomes were better in programmes that included skills practice than in purely didactic programmes
- No significant differences were found between using simulated patients and role-play

The review assessed the evidence for effectiveness of the strategies, and concluded:

No evidence for effectiveness:

- Giving oral presentations, e.g. lectures
- Written information about communication skills in handouts, or manuals, in combination with lectures.

Evidence for possible effectiveness:

- Feedback (effects most pronounced when feedback was given in response to practical rehearsal in for example role-play).
- Discussion, in small groups

Evidence for effectiveness:

- Role-play (because of the active way of learning).

[114] Berkhof M[1], van Rijssen HJ, Schellart AJ, Anema JR, van der Beek AJ.(2011): Effective training strategies for teaching communication skills to physicians: an overview of systematic reviews. Patient Educ Couns. 2011 Aug;84(2):152-62. doi: 10.1016/j.pec.2010.06.010.

The experiences from our training sessions confirm these patterns of effective strategies: We use role-plays and demonstrations, with small group discussions and skills practice with feedback, as the main methods throughout the workshops.

6.6 Workshops: Active, supportive experiential learning

Note: We use "trainer" and "facilitator" as equal terms – they lead and guide the learning.

6.6.1 Overview of basic features

See Chapter 5 for a description and discussion of training methods and concepts central to the model.

A main basis for our workshop sessions is **creating a safe environment** where it is allowed to share success without being envied, ridiculed or ironized over: It is allowed to share mistakes and failures without being judged or shamed, and to learn at each participant's own pace. William Branch calls this **"safe insecurity"** – an environment where acknowledging vulnerability is seen as a natural – and necessary – part of reflection and learning. On this basis, developing (or strengthening) **relationships with trainers and colleagues** also becomes a natural part of the process, and becomes a working tool in the further learning.

The other main basis is the starting point – **Relevance**. Participants in our workshops come to the sessions with the bags full of experiences, challenges and questions from the last 3 months' observations and reflections from their daily work situations. The teaching uses this "base" of experiences and information as the most important contents input in the workshop. This "base" keeps the contents and context relevant and recognizable for the learners and keeps their motivation and involvement high.

We add some **basic theories** to the experiential learning practice, to give participants some theoretical "hooks" to "hang" their experiences on: When they get to understand WHY they behaved in a certain way, using experience AND theory, the learning goes even deeper. They learn about the "principle" and the "phenomenon" behind their experience and will therefore easier be able to recognise and remember a similar situation or challenge when it occurs again, and then be able to pull out the right response from their "basket of skills".

Throughout the course, our approach is to first make participants realize how a principle works on themselves – thus linking their cognitive and emotional understanding of the issue. Then, they will be able to transfer this understanding to the patient (or the colleague) and see the parallels. This will help the provider continue to see the patient as a person (as opposed to categorizing and judging "difficult patients" as a group).

The role of the facilitator or trainer is crucial in the workshop. The trainer adds structure and further challenges to the independent learning the participants have gone through during their first three months when they discovered how they **really** communicated. The facilitator will ask open questions, and guide the participants to reflect before, during and/or after an experience. This interactive reflection in groups can help open them up to new thinking, learning and insights.

Some basic features of the workshop

- ✓ *Safe learning environment*
- ✓ *Relevance: Situations and challenges are from their own practice*
- ✓ *Experiential learning and basic theories*
- ✓ *Interactive reflection and exploration of their own and patients' behaviour*
- ✓ *Understand how it works on them – then apply principle/action to others*
- ✓ *Appreciation and empathic understanding*
- ✓ *Encouraging participants to be genuine*
- ✓ *Make learning enjoyable, creative, and – real*
- ✓ *Explore reasons why, rather than judge*
- ✓ *Role-model kindness and compassion*
- ✓ ***See Module 1: Concepts used in training***

Role play, Kilifi, Kenya

During the work on the present model, more than 30 trainers in 9 countries have been trained to train practitioners by using experiential methods – all of them health professionals coming from a practice of being taught with lecture-based didactic methods in hierarchical systems. The large majority of them are nurses or medical doctors working in hospitals or out-patient clinics.

Methods and tools used to train these providers are planned to be presented in a companion manual to the present one. The trainers' manual will cover facilitation skills, with a rich base of examples of what has gone right and what has gone wrong in developing and refining the iCARE-Haaland model described in this manual and methods for trainers to learn these skills (i.e. a TOT manual). Trainers have reflected on these experiences, and on what and how they have learnt to become the trainers they are today.

The following is a detailed account of the methods and strategies used, the concepts that are at the base of the teaching, the practice of skills in the workshops, the sequence of the skills and knowledge taught, and the effects of the training, on participants. In the next section, central skills trainers need to be able to manage this process, are spelt out.

6.6.2 Training methods and strategies

Key training methods are based mainly on participatory principles and experiential learning, and on the research conducted to identify best evidence for teaching communication skills to health providers. We use examples or short lectures to introduce topics, then demonstrations, role-plays, small group work, buzzing, mutual problem solving, practice in groups with feedback, and facilitation in the large group (of 20-30 participants). In the modules, there are detailed instructions for how to use each of these methods to the best effect, with examples and exercises.

Lectures are used sparingly and are short. Research[115] has established that participants' attention span is radically reduced after 10-15 minutes, if they are not involved or encouraged to relate the contents to their own practice. This is particularly the case for practitioners who are not full-time students. We thus typically stop a lecture after some minutes and ask participants to talk with the person beside them about what they just heard and come up with questions if anything is unclear, or give an example from their work. Then, the trainer can lecture for some more time. After the lecture

[115] Mellis, C.M (2008): Optimizing training: what clinicians have to offer. and how to deliver it. PAEDIATRIC RESPIRATORY REVIEWS 9, 105–113

(or sometimes introducing it, or in the middle), there are always exercises to practice the ideas or skills introduced.

Whenever possible, we follow the "rule":

- ✓ ***Show, don't tell!***
- ✓ *"I loved the role plays – both by facilitators and the participants – they have a way of nailing the point home. I think this was a job very well done. I think as learning methods, they are great as they are practical and we are more likely to remember what we learnt compared to only lectures".* *Research staff, Kilifi*

Feedback from participants, often years after the course, show that what they still remember are:

- **The demonstrations** - e.g. of "bad practice", where they could recognize and laugh at themselves and each other; and "good practice", the "gold standard" that becomes a friendly companion and reminder to them in their work, and
- **The role plays**, where they have either tried to practice a new skill and failed to get it right – discovered through their own budding awareness, or through feedback from colleagues; or – they have managed to practice a new skill well and experienced the satisfaction of "success", with appreciative feedback.

NB: Research shows that this is how our brains function: We do remember examples, events and situations that also trigger our emotions, but we do forget facts. Thus, a training that focuses on showing good as well as bad practice in vivid demonstrations and role plays is much more likely to be remembered, and have an impact, on participants' practice.

The examples from the participants' own observations and reflections are used to illustrate theories of behaviour change, social and educational psychology, communication and information, and adult education. We focus on what they do well – as an entry point to solve problems. We discuss problems and let participants who have good ways of solving these problems describe their methods to others. This also creates empowerment, and role models – and as everyone usually is good at something – the method creates a mutual learning environment where participants use each other as resources. Using participants' own descriptions of situations from clinical practice is essential in making the course relevant to their learning needs. These examples change with each country, but the topics and issues are amazingly similar.

> *"My friend was happy to learn the active listening skill and probed where I got the skill. She was interested to join my communications skills training so that she can communicate better with clients and help them. Nowadays she tells me that I have really changed, and she wants to be like me".* *HCW Kilifi*

The approach: Learning why, rather than judging: Participants also learn *what causes their reactions*, and see that reactions to a variety of actions and emotions are "natural" or common. We don't judge what they say or do or feel – we use critical thinking and probing to look for the **reasons behind the actions or feelings**. Thus we take the guilt feelings out of the reactions. This makes it easier for participants to learn – and we then help them to transfer this insight - i.e. that they learn well when they are appreciated and understood - to their treatment of the patients, and of their colleagues.

The effect is that participants learn the theory – based on their own experience – and are taught to recognize the same type of problems when they occur in another setting. They also learn to recognize that patients react the same way as they themselves do, and thus if they treat patients

with respect and understanding, they will have a better relationship with the patient and be able to practice better patient-centred care.

"Translating" the steps in the learning methods to how Emotional Intelligence works:

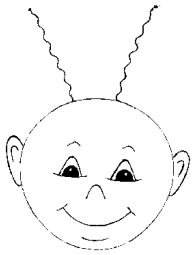
- **Demonstration:** When they see a colleague showing a "typical" bad practice situation, they **recognise** the emotions in patients/colleagues, and also in themselves (skill 1)
- **Discussion:** This is what happens – we acknowledge and **think** about the situation (skill 2)
- **Analyse reasons why,** on both sides: Find out what can be the causes which can prompt the provider to feel and act the way she does, and also reasons for the patient/colleague's emotions and reactions (skill 3)
- **Role-play, to choose a different action** ("good practice"), based on having understood the reasons why "bad practice" was used, and knowing what good practice should look like (skill 4).
- **Discuss insights from the role-play**, to anchor learning and make meaning out of what happened. Use appreciative feedback to confirm good practice, and reasons for it, and emotional reactions to practicing well: Good energy and job satisfaction. (Skill 4/summary).

6.6.3 Core concepts underlying the workshop modules

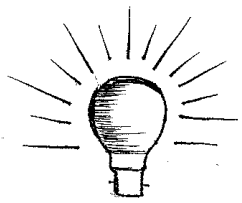
The values and ideas in the course and in the workshops are based on principles for Patient-Centred Care, where respect for the patient and seeing the patient as a person is the core in the first PCC dimension (Provider – Patient). The second dimension (Provider – Provider) is equally important – communicating well in the team is crucial for the providers being able to practice good PCC, and the third dimension (Provider – Community) focuses on the relationship to the local community.

The fourth dimension – Provider – Self – is an important focus in our training.

The main and first core concept is ***awareness***: When providers decide to invest in becoming aware of their own communication behaviour, and the effect this behaviour has on the other person (patient, or colleague) – she or he becomes motivated to learn, and to change with the learning and insights. The motivation evolves from within the person herself/himself – it is not something that is imposed from the outside.



Becoming aware….



And gaining insights

The experience of becoming aware e.g. that the provider's own irritation and anger scares the patient and may prevent the provider from finding out what the real problem is, and thus not be able to give good care – is shocking to many participants. Reflecting on this and on many other similar discoveries motivates them to learn, and – makes them see they can make many changes by themselves, there and then. This process is empowering.

The concepts in the course are all designed to support this process of learning to communicate with awareness, with respect for and skills to handle emotions – to develop trust and establish a professional relationship with the patient. The observations and reflections they have made the last 3-4 months, to discover problems (and some solutions) and reflect individually – will now be deepened by reflecting interactively with colleagues in the workshop.

The sequence of the concepts is carefully constructed – to make them build on each other.
The idea is to introduce the concepts briefly in the introductory session, to give an overview of the thinking behind the course, and to show what are the values and directions we will follow.
The examples from the participants' observations link the concepts to their reality.

The other core concepts are:

- **2. Critical thinking, reflection, insights**

Critical thinking is an essential part of the course, as an underlying concept or approach used throughout the four phases of our training process. It is a key skill when learning emotional intelligence. The Foundation for Critical Thinking (http://www.criticalthinking.org//) is an organization dedicated to teach the skill of critical thinking to students and professionals in a number of areas, including health. The following quote is a description of their concept – which is very much in line with how we look at the aim for the observation and reflection tasks to build awareness:

- *"Our basic concept of critical thinking is, at root, simple. We could define it as the art of taking charge of your own mind. Its value is also at root simple: if we can take charge of our own minds, we can take charge of our lives; we can improve them, bringing them under our self-command and direction. Of course, this requires that we learn self-discipline and the art of self-examination. This involves becoming interested in how our minds work, how we can monitor, fine tune, and modify their operations for the better. It involves getting into the habit of reflectively examining our impulsive and accustomed ways of thinking and acting in every dimension of our lives."*

An example of an insight from one of the participants:

- *"I left the place while full of anger and I could not control it. I went straight to my bed without taking anything. I tried to meditate on the story, "How has it started? The way I am tired? How should I handle this case?" After settling the issue I took time to go through myself over the whole situation. I visualized how it started, how I contributed and what I went through in the process".* *Health Care Worker, Kiifi*

- **3. Respect**

Respect is the main attitude and skill which help providers build trust and establish a professional relationship with patients. Respect shapes the quality of the interaction between the provider and the patient, colleague or supervisor. When respecting the other person is a natural starting point, it becomes natural to check the emotional "landscape" in the interaction, and take the necessary steps to manage this competently, using the emotional intelligence skills. **The ability to show respect** is in all of us, and respect is often "contagious", as expressed by a provider in Kilifi who was asked how she felt when met with respect:

- *"I feel good and appreciate it, I also ensure I give that person twice the respect they gave me"*

A person who is feeling vulnerable (e.g. sick) is especially sensitive and needs to be shown respect. **The willingness to practice respect** is based on awareness about its importance, and the perception participants have about how respect should be shown in their culture. "***Culture***" here can be national, or professional/medical. This perception is often ***subconscious*** and automatic – many have not thought and reflected about it. See section on challenging the cultural traditions for how respect is seen and practiced, chapter 4.3.3 and 4.3.4.

- **4. Empathy**

Empathy is to step into the shoes of the other person, with awareness, and step out again, with the ability to act. **When using empathy**, they see the patient as a person, and as partner in care:
Establishing relationship, based on communicating with respect.
This concept is central in the course.

- *"I carry so much of the patient's burden (sickness) and really feel for the patient and most of the time I put myself in the patient's shoes".* *Health Care Worker, Kilifi*

- **5. Humanistic medicine**

Humanistic medicine shifts the focus from disease-centred to patient-centred care. It is interdisciplinary, and aims for open communication, mutual respect, and assumes an emotional connection between the health provider and the patient.

An example from a participant, on patient-centred care (PCC).

- *"I can now have ample time with a client and get to know his/her other needs apart from what has brought him like the physical needs which is the sickness, because if you don't meet all her needs she will be there physically and be disturbed emotionally and she won't really take good care of the sick child.*
- *PCC is a very good element and if well applied we will have such a good world to live in where patients will never be mismanaged but will be taken care of very well."*

Health Care Worker, Kilifi

- **6. Appreciation**

Many of us don't use appreciation very often. It is a simple skill that can be used more – **BUT** – you have to ***mean it***. False/non-genuine appreciation used to obtain an effect – ***"stinks",*** *and the other person feels the falseness immediately, and reacts negatively.* Honest appreciation is a very effective communication method that makes people feel seen and motivates to communication and action.

Examples:

- *"If a person is appreciated for what he/she is, and her/his opinion is respected, there is always positive attitude in them that motivates them to give more input."*

Effect of appreciation:

- *"I feel safe when patients show and explain their faith in you and in what you are doing to help. Also when they explain their gratitude to you after getting better."*
  Both: Health Care Workers, Kilifi

- **7. Responsibility**

Providers often want people to change behaviour. A common method is to ***tell them what to do***, and expect change. Providers take the ***responsibility*** for determining their change.
However, we see that ***often, people don't change.*** Often, we ***blame them*** for "not knowing what is best for them" (*implying that YOU know what is best, THEY don't, i.e. they are ignorant, and we judge them for not taking "rational" action – i.e. rational, from our perspective*).

In this course, we will learn ***how people change***, and how we can work to ***encourage and empower*** people to make their own decisions to change. This includes to take responsibility for the communication, based on their understanding of why people change, and why they don't.

Example:

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

HCW, Kilifi

- **8. Motivation**

Motivation to act is a powerful partner in our work: We should work with patients in a way that motivates – and enables - them to collaborate with us to care for them: ***Partners in care.***

This will make it more likely that they continue to take care of themselves/their disease when they go home. We are finding ways to stimulate their inner motivation to change – for their own reasons. Communication with awareness and EI is a powerful skill to help this happen.

Example:

- *"When I am treated with respect, I feel happy, absolutely honoured, my levels of motivation are usually high, and I naturally take to my heart the whole situation." HCW, Kilifi*

- **9. Empowerment**

Empowerment means to ***give or delegate power*** to someone, to enable that person to take the power and decide how to act on her own, based on her own perception of what she needs and wants. (Or – something that has been added on to you – to strengthen someone's ***ability to act.)***
Providers are used to having power over patients. If we want patients to be able to take action on their own at home (*e.g. to continue to give medicines in the right way, identify danger signs in their child, etc*) – they will do this better if you ***"share the power"*** with them: Show that you believe in them and respect them. To be able to do this, participants need the EI skills – to recognize the emotional need to "keep the power", decide consciously to step back from it because they want the patient (or colleague) to be empowered to act independently – and then act on this understanding.

Example:

- "I *have adopted a pattern of seeking to know what my clients already know from what subject we are discussing. I encourage them to tell me everything so that I only add to what they may have forgotten or omitted. When I respond in my own opinion, the client feels left out of a decision, unlike when I make the client an active participant, I realize that he owns the decision made and if it requires change, he becomes a forerunner for the change expected".* *HCW, Kilifi*

Empowerment is an important aim of the entire training model. The approach is to facilitate and stimulate self-awareness, to encourage the person to learn actively, to take initiative to change when she sees there is a good reason to do so. And then – to enjoy and own the pride when she experiences success from using the new methods – which she has decided on using, herself. When she feels empowered, she will more naturally inspire patients and colleagues to be empowered, too.

- **10. Handling conflict through conscious communication**

Dealing with conflict by communicating with awareness is a key skill. Participants explore reasons ***why conflict occurs***, what makes people (ourselves, and patients/colleagues) ***react***, and how to ***recognise*** and ***stop our own automatic reactions.*** The course teaches practical ways to handle conflict constructively, through using emotional competence: Conflict is fuelled by emotions, from both sides, and learning to recognise and deal with these constructively can reduce the level of conflict in the work place.

Example:

- *"It doesn't matter how hurt we are. Approaching the other person in a calm manner and with respect can help solve a problem. We should stop thinking of the person who irritates us and focus on way forward to solving the problem. We always need change immediately when (we are) angered but it's good to have self-control otherwise the end could be destructive."* *HCW, Kilifi*

- **11. Having Fun**

Having a good atmosphere in a workshop is important for good learning. This includes having fun, laughing at ourselves and laughing with each other. Participants do not need to worry – also having a good time does not mean "wasting time" – it simply means they are learning well. This fact is seriously proven by research!

6.6.4 Practicing skills in the workshops

Practicing new skills is central to the training. Communication skills are learnt through practice, with constructive feedback, and practice is a part of all exercises. Participants have a good basis for new practice, as many of them have already changed how they communicate from having discovered e.g. how ineffectively they listen, and have thus experimented with new practice. What they need now is clarity about "the gold standard" – what good practice for each skill "looks like" and feels like, and what effect it has on the patient. Then, they work to further adjust their skills as well as they can, within their personal style.

The skills training often starts with **sharing of experiences** in a group, to identify challenges related to the particular skill (*e.g. asking open questions, and what makes it easy – or difficult – to practice this skill*). Participants or trainers then **demonstrate or show the skill** and asks the group to relate it to their own work in the clinic. Participants practice the skill through an exercise, or role-play, and then reflect together (using constructive feedback) about how well they did, and what they still have to improve. Reflections on insights from doing the exercise, and on the way forward, closes the session. All exercises are directly related to participants' own context and practice.

An important part is then **to link the practice to theory**. For example, the research which is the basis for constructing the Meta Model is explained: The research showed that people who communicate well use open descriptive questions, and ask many more questions than those who do not communicate well. See module 2c for a full explanation of the model.

6.6.5 The modules in the workshops: An overview of the sequence

The sequence of learning is carefully built up as a natural progression. It starts with building the foundation for understanding all the modules (see Chapter 4 – Building the House of Good Communication), and then goes deeper into each of the main challenges. The parts marked with * refer to the modules.

The Basic workshop

***The introductory module** in the basic workshop explains and discusses the **key concepts** underlying the course (**Module 1**). It then applies some of the concepts to introduce the participants to each other – through using appreciation with awareness and discussing appreciation as an important communication and motivation concept to be used in patient-centred care (and with colleagues).

Having put the participants into the right "frame of mind" to learn, the topic is ***HOW do adults learn (Module 2a**). They realize this through an analysis of methods used by good teachers who inspired them to learn, and by linking this to adult learning theory and principles. They use their experience of what is "effective learning" for themselves to analyse how this applies to their work with patients. Their first session of experiential learning has brought important insights, and decisions: Concluding that patients ALSO learn best - e.g how and when to take the medicines, and why, or how to deal with their chronic condition - when these principles of effective adult learning are adhered to, participants can decide to apply them in their work.

The presentation with ***Feedback on observing how you communicate** from their baselines and observation tasks (**Module 2b**) acknowledges participants' hard work during phase 1, as well as their challenges and insights. This overview signals to the participants that trainers have thoroughly read and analysed their work in preparation for the workshop, and that their examples and work situations are an important basis for the workshop. The presentation of challenges AND accomplishments further motivates participants to learn.

The CORE modules: The next two modules provide the other part of the core basis for the workshop and for the whole course: ***Gold standard communication theories, skills and strategies in practice (Module 2c**), and ***Communicating with awareness and emotional competence** (**Module 3b**). A brief overview of ***Feedback on use (and misuse!) of emotions** (**Module 3a**) from the observation and reflection tasks introduces participants to the group's present perceptions of the topics on emotions, and of their many struggles to get to grips with their automatic reactions. Through practicing the different communication techniques in situations with familiar context, participants strengthen awareness and skills to communicate with confidence, and include recognition and management of emotions in the process.

The emotions module explores and draws the emotional "landscape" of clinical consultations, negotiations and treatments, and provides a basis for how to recognise, understand, interpret and handle common day to day challenges at work. Emotional intelligence skills are gradually built up. Demonstrations and exercises show the (potentially) devastating effects of automatic use of power (*like putting patients "in their place" or showing anger or irritation at them not following "orders", or withdrawing to show disapproval*), and the good effect of acting with awareness to recognize and handle emotions with respect. Participants link this to their discoveries during the observation and reflection period and build the skills that most of them say have made the biggest difference to their professional (and often also personal) life: ***Recognition and management of emotions, by stepping back from automatic reactions and handling emotions in themselves and in patients with respect, as a natural part of their work.***

- ***In all the nine countries where the model has been used, participants conclude the same: Learning to recognise and manage emotions was the most important aspect of the course, and – they were not aware that they needed these skills.***

The core modules are followed by an introduction to ***What makes people change attitude and behaviour** (**Module 3c**), where the theoretical model is explained through participants' own experiences of change. Important insights include that behaviour change takes time (often months, or years), and is most often influenced by someone who is close to the person changing and/or is respected by her. The other main influence that inspires change is an emotional event. Sometimes, the two go together.

"Armed" with a basket of conceptual and practical tools and skills, participants are now ready to tackle challenges related to stress: ***Recognising, managing and preventing stress with communication and emotional competence (Module 3d)**, and conflict ***Managing conflict with awareness and emotional competence to maintain dignity and respect** (**Module 3e**), which are important parts of their everyday life. Again, emotional competence is essential and help them get into the habit of recognising emotions that can lead to stress or conflict and taking steps to manage

them before they get out of hand. Challenging situations described in their observation period are "translated" into exercises and role-plays, and participants practice handling these situations, with awareness and new EI skills. The interactive reflections enable them to start integrating the skills into their practice.

The next module (**Module 4**) applies the skills learnt to ***Communicating about research with awareness and emotional competence,** in the hospital. Participants are involved in recruiting and treating research respondents among their patients, and skills are used to strengthen awareness of how to recognise and practice ethical aspects of this work.

The last two modules "bring it all together": ***Using communication skills and emotional competence to educate patients (Module 5a**), and ***Strategies to communicate with awareness and emotional competence** (**Module 5b**). In these two modules, participants use what they have learnt to practice their skills in various challenging situations, and reflect on the outcome, and on further learning they need to focus on. These sessions also help to cement relationships among the participants and make plans for how to continue to work together to support each other when they are back in their wards: *The continued contact between participants, with support from trainers and other role-models, is important to provide a solid alternative to values and attitudes communicated through the "hidden curriculum". The three months' period of "Skills into Action" is crucial for the skills to gradually become a sustained pattern of behaviour among the participants. With their awareness about how ingrained practice and "accepted" rules are often setting the standard for how fellow professionals work, they can now consciously challenge the **"hidden curriculum"** with their new skills: They can inspire colleagues to (consider) change through acting constructively, not judging, and being role models who practice good patient-centred care, communicate well with colleagues, and take good care of their own health.*

The follow-up workshop

This workshop follows a similar pattern of logic as the basic one: **The introduction (Module 6a): *Introduction and review: Gold standard communication strategies with patients and colleagues** reviews the main elements from the basic workshop and puts them together to a "Gold Standard" interaction between a patient and a provider. This interaction is thoroughly analysed for its parts - how it works, what are the elements, and why does it work well - and becomes the common reference point for the further work throughout the workshop.

Module 6b is titled ***"The Big Changes – Confirmation of growth, and challenges participants still have"** and outlines the analysis of the changes participants have made between the baseline (before the course) and the endline (at month 8, a set of the same questions, with added questions to reflect on and describe own changes). The module also includes insights from the observation and reflection tasks during the "Skills into Action" period. This provides an empowering moment, when participants share real pride - and some astonishment! - at the changes they as a group have made in their practice since they started working on their communication skills. The mutual acknowledgment and appreciation of these accomplishments is a strong and empowering moment in the training process, and further motivates them to learn with an open mind in the next three days.

A number of "heavy" modules follow. These modules deal with emotional challenges providers face in their work, and using constructive communication skills and strategies to approach them, with awareness. The modules are: ***The many faces of anger: Recognize, acknowledge and handle with respect (Module 7a), Managing conflict with emotional competence: From confronting – to stepping back, and dialogue (7b); *Using power with awareness and emotional competence (7c) and *Recognizing bullies in the medical profession: Using emotional competence to confront and prevent bullying (7d).**

In these modules we address the issue of power and status in the relationship, and look at the effects of using power, on the outcome. Participants learn to look at what they want to achieve in the meeting with the patient or colleague and choose their communication strategy (including how they deal with their power role) accordingly.

The "heavy" modules continue with ***We can't always Cure, but we can always Care: Managing death and dying with emotional competence (7e); *Professional closeness or professional distance? Conscious use of personal and impersonal language (7f) and *Using emotional competence to recognize, manage and prevent burnout (7e).** The many exercises and practices with feedback in each of the modules help participants to strengthen confidence in the use of these skills. Their interactive reflections confirm that they see the skills work well to practice patient-centred care and to communicate constructively with colleagues, using emotional awareness. In the module on death and dying (7e), the concept of vulnerability and how to relate to it is especially discussed.

The last two modules on ***Working with emotional competence in a research environment: Understanding and communicating about the difference between research and treatment (8a) and Strategies for effective information and communication: Communicating with awareness and emotional competence (8b)** complete the course. In these modules, participants again use their basket of skills to apply to situations from their practice and reflect on how they now work.

The sequence has been adjusted as the course has taken its final shape, especially in Kilifi.

NOTE: Shortened versions of the full course have been conducted for researchers in Kilifi and Nairobi, and for managers and leaders in Kilifi. These courses will be outlined in further manuals. The experience and results from these courses are very similar to the courses run for health providers: All participants appreciate the learning and see the need for learning to communicate and manage emotions as central skills for their professions. They recommend further learning of these themes for colleagues.

6.6.6 The contents and sequence of learning the iCARE model in Wales

In the second year of training trainee doctors in Wales we ran six workshops over a period of seven months. Each workshop ran for three hours, with one running for five hours. The first and last workshops included filling in baseline and endline assessment tools. The last workshop also included a focus group discussion by independent researchers to assess outcome of the training, and thus the actual facilitation session with participants was only 1 ½ hours.

In between the workshops, participants worked on self-observation and reflection tasks, see an overview of topics in chapter 6.

The modules had the following main themes:

1. Strengthening emotional intelligence and resilience: An introduction to the model and the methods.
2. The foundation for good communication: Listening, being present and practicing Emotional Intelligence
3. Emotions affect communication: *How, why, and what to do?*
   Vulnerability: a positive force to build Resilience
4. Communicating with awareness and emotional intelligence: Enough to build resilience?
   Summing up, Linking learning to resilience + burnout. Focus on positive action
5. Criticism and Conflict: Finding reasons behind, and Managing with Emotional Intelligence
6. Demonstrating awareness and EI competence: Sharing insights and strategies. Impact on confidence and resilience?