3 Selected literature: Challenges in skills training for communication and emotional competence

The literature regarding what influences the way health providers communicate and manage emotions is vast and includes knowledge from a number of professional fields and theories[6]. It is beyond the scope of this manual to provide a comprehensive review of relevant literature from all these fields.

We have chosen to focus on literature relevant to some main challenges health providers experience when communicating with patients and colleagues, highlighting the gaps that the iCARE-Haaland model can contribute to filling. We have also described some key authors who have written major works on these topics. To exemplify how the model meets challenges, we have included some reflections from participants.

In this chapter we explore Benefits, challenges and gaps in health communication; Building emotional competence – definition, and challenges; Evidence and reflections on effective skills; the contributions of the iCARE-Haaland model, and some results from using the model in nine countries.

3.1 Benefits, challenges and gaps in health communication

3.1.1 Communication skills are needed for good care

Some of what good communication can contribute:
The positive effects of health professionals using good communication skills have been well documented: improvement in patient-centred care, patient outcome, communication with colleagues and also on the emotional well-being and work satisfaction of the professional[7],[8].

Good communication is essential for patients' learning, their motivation to adhere to treatment, and - e.g. for TB and HIV patients – for their ability and willingness to be open about their disease(s), and to fight stigma. The increasing focus on patient- and person-centred care[9] is putting even more pressure on the health providers to meet patients' needs, often without giving them the necessary skills to provide such care in a sustainable way.

3.1.2 Poor communication can have serious consequences

There is clear and increasing evidence showing the effects of health providers applying (and not applying) effective communication skills in their interactions with patients. An editorial in the BMJ[10] notes that most patient complaints in the US and UK are related to poor communication. Another editorial in the same journal focuses on the need for providers to also be skilled at handling emotions, and states: "…poor communication skills have been shown to be a predictor of

[6] For example: behavioural sciences, social and educational psychology, adult learning theories, experiential and reflective learning theories, medical education.
[7] See e.g. Sandra van Dulmen: Communication in healthcare: What makes a difference? An overview of research on communication skills, presented to the third Geneva conference on Person-centered Medicine, Geneva May 3-5th 2010.
[8] Krasner, M.S. &al (2009): Association of an Educational Program in Mindful Communication with Burnout, Empathy and Attitudes among Primary Care Physicians. JAMA Vol 302 no 12, Sept 23/30
[9] See e.g. the increased focus demonstrated in the third Geneva conference on Person-centered Medicine, Geneva May 3-5th 2010, where 22 organizations participated, up from only 4 organizations in the first conference in 2008.
[10] Clinical and communication skills. Need to be learnt side by side. Editorial, BMJ 2005:330:374-375

medicolegal[11] vulnerability and also of burnout"[12]. These papers reference others that show how poor communication skills and lack of skills to manage emotions influence patient outcome. Communication and interpersonal issues have been found to be a common root cause of patient safety incidents[13]. Poor communication also has a negative effect on collaboration in medical teams.

Challenge: Lack of kindness across cultural barriers

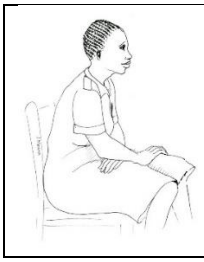
The problem of poor communication and lack of appropriate care from providers exists worldwide and has been documented in many countries. Examples from the UK and Kenya show how expected kindness, care and compassion is replaced by insensitivity, cruelty and punishment:

In the UK, the report of the situation in the Mid-Staffordshire NHS Trust in the English Midlands shocked the country. In the executive summary of the inquiry[14], the abuses are clearly described:

> *"Requests for assistance to use a bedpan or to get to and from the toilet were not responded to. Patients were often left on commodes or in the toilet for far too long. They were also left in sheets soaked with urine and faeces for considerable periods of time, which was especially distressing for those whose incontinence was caused by Clostridium difficile. Considerable suffering and embarrassment were caused to patients as a result.*
> *There were accounts suggesting that the attitude of some nursing staff to these problems left much to be desired. Some families felt obliged or were left to take soiled sheets home to wash or to change beds when this should have been undertaken by the hospital and its staff. Some staff were dismissive of the needs of patients and their families."*

Investigations in other hospitals, following this report, showed that the Mid-Staffordshire hospital was by no means alone in mistreating patients. An analysis concluded that "…a lack of understanding and management of emotions is a major issue (…) and should be given much more attention[15]".
A number of actions have been taken to deal with the problems in UK hospitals: The NHS has e.g. recruited 7800 more nurses to the wards since 2010, and made a number of other changes.[16] However, other reports[17] show that not much has changed, and that the problems remain.

In Kenya, several recent studies and reports have shown that midwives in a number of hospitals slap and verbally abuse women when they give birth. Women respond by giving birth at home – in 2015, only 4 of 10 women gave birth in hospital[18]. The women cited the rough treatment by midwives as a main reason to give birth at home.



Note: It is easy to judge the nurses and midwives for their cruelty. However – there are strong indications that a major reason for the nurses' behaviour in Kenya (and also in the UK) is – fear: Their own fear of not doing a good enough job – if the baby dies. The nurses and midwives have never learnt to recognise and manage emotions – neither their own, nor the fears and pains of a woman in labour.

[11] Medicolegal involves both medical and legal aspects of medicine
[12] Communications and emotions. Skills and effort are key. Editorial, BMJ 2002:325:672
[13] https://www.gponline.com/improving-communication-skills-colleagues/article/1050179
[14] The Mid Staffordshire NHS Foundation Trust Public Inquiry. R. Francis, 2013
[15] Ballatt, J and Campling, P (2011): Intelligent Kindness; reforming the culture of healthcare, 2011
[16] Culture change in the NHS Applying the lessons of the Francis Inquiries. Paper presented to Parliament by the Secretary of State for Health by Command of Her Majesty, February 2015
[17] **Review of maternity services at the former Cwm Taf University Health Board: report, April 30th 2019.**
[18] Abuya, T & al (2015): Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. PLOS ONE DOI:10.1371/journal.pone.0123606 April 17

3.1.3 Challenge: Training contents and methods not meeting students' needs

"Traditional" training contents: Several reviews (e.g Chant[19] (2002), Kruijver[20] (2000), Lane and Rollnick[21] (2007)) conclude that in "traditional" communication skills training curricula and courses for health providers there is a lack of focus on

- The importance of building relationship and trust
- Why and how to relate to patients as persons
- Interaction with awareness and management of emotions
- How to recognize and relate to power, constructively
- Learner-centred methods, and practice of new skills in work context

In brief, the health provider communication skills training lacks a focus on *the relationship between patient and provider* as a basis for practicing patient-centred care, as well as skills to establish and maintain this relationship. Lack of such skills contributes to problems not only for patients but also for the health professionals themselves. Skills to recognise and manage emotions are not mentioned.

Training methods: Reviews of evaluation of nurse communication skills training[22] [23] in Europe and the US show that

- There is a lack of coherent strategy for teaching communication skills;
- Trainers are uncertain about good practice in this area, and
- Training contents and methods often perpetuate hierarchical power structures and strengthen the hidden curriculum.

Training programmes have also been found to be undermined by focusing on mechanistic rather than relational communication, teaching theory rather than practical training relevant to job challenges, and using learning styles that are poorly tailored to students' workplace needs. Courses are often short - from 1-2 days to a week's workshop, with no preparatory work to encourage participants to become aware of their learning needs, and no after class work to help participants integrate new learning into everyday practice. This approach does not lead to improved skills over time. Special attention is needed to transfer skills into practice, another key area which is lacking focus in training[24].

Failure to meet students' needs was a key deficiency, and a lack of a clear theoretical base and segmentation between education and work contributed to making training ineffective.

3.1.4 Challenge: Limited research on training in resource-limited countries

Relatively little research has been conducted to identify problems related to patient-provider communication in resource-limited countries, or to conduct implementation research to demonstrate effects of interventions to deal with problems identified. A recent (2017) BMJ article[25] refers to a study investigating providers' communication skills in seven African countries. The study

[19] Chant, S &al (2002): Review: Communication skills: Some problems in nursing education and practice. Journal of clinical nursing. 11:12-21.

[20] 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

[21] Lane, C and Rollnick, S (2007): The use of simulated patients and role-play in communication skills training: A review of the literature to August 2005. Patient Education and Counseling 67 (1-2), 13-20.

[22] Chant, S &al (2002): Review: Communication skills: Some problems in nursing education and practice. Journal of clinical nursing.11:12-21.

[23] 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

[24] Heaven C; Clegg, J and Maguire, P (2006): Transfer of communication skills training from workshop to workplace: the impact of clinical supervision. Patient Educ Couns. Mar;60(3):313-25. Epub 2005 Oct 19.

[25] Larson, E; Leslie, H.H; Kruk, M.E (2017): The determinants and outcomes of good provider communication: a crossectional study in seven African countries. *BMJ Open* 2017;7:e014888. doi:10.1136/bmjopen-2016-014888

concludes that there are major deficiencies in communication during sick child visits, and that there is a clear need to develop new strategies in communication.

The limited literature that does exist[26] shows similar trends to those found in Europe regarding the definition of the problems: Providers often do not communicate well with their patients, attitudes constitute a main problem, and short-term communication training programmes do not make much difference in providers' use of communication skills.

An article in the Indian Journal of Palliative Care [27] concludes that "Communication skills are as important as vital needs. Health care professionals have to be aware of their own communication practices and need to undergo periodic appraisal of the same. Training programmes in communication skills are unfortunately not part of our academic curriculum."
The article highlights the need for and gives an overview of such training programmes.

A main reason for the limited research available on communication training for providers in resource-poor countries is that very few training programmes have been evaluated and written up in scientific journals. With increased global attention being paid to the importance of communication in health care, and the significant benefits to be gained for patients and providers by improving communication skills, we hope that this manual can contribute to increasing training and research in many countries.

3.1.5 Challenge: Different ways of teaching reflective practice

In a review of the literature on teaching reflective practice across health and social care professions, Norrie et al[28] have illustrated how different professions choose certain types of reflective practice.

In the medical literature, the focus is on "measuring" reflection and finding evidence for the effectiveness of reflective practice in teaching. The researchers shape the production of knowledge by asking specific questions or posing them in a particular way, and the literature produced tend to have more positivist and pragmatic rationales. The same trends can be found in research into physiotherapy.

The research into nursing and midwifery take a different approach and show a greater interest in exploring and understanding teaching processes, using constructivist approaches. Finally, literature from social work tend to draw on wider questions from across the social sciences.

There are however a few researchers from the medical field who "break rank" and venture into the qualitative research fields. The review notes: "It is interesting to note that some of the literature identified is characterised by the intrinsic tension (usually unacknowledged) between discussion of the teaching of reflection which values experiential knowledge versus realist research approaches being used to 'assess' the practice. Close inspection of the literature also illustrates how the teaching of reflection has been taken up and developed differently across the professions to support their

[26] See for example Labhardt &al (2009): Provider-patient interaction in rural Cameroon – How it relates to the patient's understanding of diagnosis and prescribed drugs, the patient's concept of illness, and access to therapy. Patient Education and Counselling p 196-201, Doyle, D. &al (2010): A course for nurses to handle difficult communication situations. Patient education and counselling, January 2010; Kim, Y.M & al (2000): Self-Assessment and Peer Review: Improving Indonesian Service Providers' Communication with clients. International family planning perspectives 26(1): 4-12; Roter, D. & al (1998): The effects of a continuing medical education programme in interpersonal communication skills on doctor practice and patient satisfaction in Trinidad and Tobago. Medical Education 32, 181-189.
[27] Rajashree, KC (2011): Training Programs in Communication Skills for Health Care Professionals and Volunteers. Indian J Palliat Care. 2011 Jan; 17(Suppl): S12–S13. doi: 10.4103/0973-1075.76232
[28] 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

separate legitimisation projects. In the medical context, the focus is on improving professional practice and competence in the light of an increasingly litigious, knowledgeable and demanding public (e.g. Wald et al., 2009). In contrast, in the other professions, reflective practice is approached more as a way of asserting each group's autonomous professional identity. This is particularly obvious in fields of practice which have been traditionally subordinated by medicine. In the nursing and midwifery literature there is an emphasis on valuing, validating and developing nursing knowledge and skills within healthcare."[29]

3.1.6 Challenges within the health system

The health system determines the framework providers operate in and has a major effect on how providers conduct their work and how they experience their workplace. Changes in health systems, especially over the last decade, have increased the pressure on health providers in many countries.

There are large challenges to overcome to reach the goal of providing patient-centred care, communicating well with colleagues, and taking care of the professionals' own health and wellbeing.

Ministries and other institutions of health in a number of countries are increasingly aware of the need to meet patients' demands for improved quality of care and committed to changing their system to make this happen. Decisions are made to strengthen patients' rights and encourage providers to give more humanistic and patient-centred care.

In many hospitals in Kenya for example, announcements of patients' rights are painted on hospital walls for all to read, in line with statements in the constitution supporting the right to the highest attainable standard of health, to equality and non-discrimination in access to health care and in access to information.

However in Kenya as in many settings these rights are often not upheld for a range of complex reasons. These include issues related to the hardware of the system (for example inadequate numbers of staff, and of financial resources and medical supplies) and the software of the system (such as relationships among those working in the health system, and staff motivations and values). For staff, challenges can seem overwhelming, and have structural drivers that are out of their sphere of influence.

The development of training courses to challenge health systems and attitudes that permit and perpetuate provider behaviour which is less than respectful, is lagging behind in many countries. The health systems need to develop training programmes that build providers' skills to engage with and meet patients' expressed needs for PCC. Such programmes would require a focus on relationship building, respect and management of emotions.

This manual does not focus on health system factors that providers cannot influence, but rather on factors that they **can** influence, to be able to function better in the system they work in.

As a manager in a recent (2018) course on the Kenyan coast put it:

> *"I used to just complain about the new political players and how they are messing up our [health management] work but now I have learned that I can use my communication skills to actually talk with them and get some of the things that I need'.*

[29] Ibid

3.2 Building emotional competence: Definition, challenges

3.2.1 What is "Emotional Competence"?

Emotional competence and emotional intelligence (EI) are closely related, and will be used interchangeably in this manual. In practice, both concepts refer to abilities to recognize, interpret, analyse and respond constructively to your own emotions as well as those of other persons. Emotional competence also implies that you are at ease around other people.

There are two sets of skills in emotional competence – the ***intrapersonal*** skills which refer to something inside your self, and the ***interpersonal,*** which refers to relationships and interactions. The intrapersonal skills include developing self-awareness, and observing and reflecting on your own behaviour to build skills to control and regulate your emotions. This is the basis for developing emotional competence: You must be capable of understanding your own emotions before you can understand well the emotions of others, and before you can handle these emotions well.

Emotional competence (and emotional intelligence, or EI) skills can be learnt and built – based on a recognition that these skills are important, and needed. There is much evidence about the usefulness of these skills:

- **In the education field**, it has been shown that good EI helps reduce teachers' stress and burnout, raise teachers' level of engagement and their wellbeing, helps motivate students positively, encourages students to learn/open up, and increases job satisfaction.[30]
- In the business world, leaders with good EI skills facilitate better teamwork and show better results. Developing self-awareness has been shown to be a key to success.[31]

Some examples of emotional competence in practice:

The most important skills participants gained in the training were – to recognise automatic emotional reactions, take a step back to reflect, and then act with awareness and respect (i.e. -practicing emotional intelligence).

"Showing respect for patients' emotions is certainly a good way of interacting with patients. *What I have realized is that most patients/parents with sick children will show a sign of relief the moment they feel you are showing respect to them. They relax and start expressing themselves.*

When this happens I feel good, it sets me in the right mood. Even when I feel overwhelmed with work it brings out some kind of positive energy in me. I feel am in control of a situation in a perfect way. I become confident.

And even if I may have had my own issues affecting me emotionally, the power of being aware, accepting and stepping back from them boosts my morale. I can even forget about my issues for a considerable length of time and when I remember, I am in a better mood to reflect and find solutions or just cope with a situation."

"Before the course I used to be irritated when handling a difficult patient/relative. ***The course has shown me that for every stubborn client, there is a reason behind,*** *and instead of getting irritated, I nowadays probe to get to know the reason behind. The concept of the tip of the ice-berg has made me aware of clients'/patients' needs and has help me advance with care to avoid them exploding on me."*

Both examples: Health Care Providers, Kilifi

[30] Aurora Adina Colomeischi; Teachers Burnout in Relation with Their Emotional Intelligence and Personality Traits, Procedia - Social and Behavioral Sciences 180 (2015) 1067 – 107

[31] https://www.extension.harvard.edu/professional-development/blog/emotional-intelligence-no-soft-skill

Reflection on the impact of emotional competence, on a doctor's work

"This training – first stumbled upon as a trainee and then revisited as a trainer – empowered me to consider, develop and put into practice a skill set that has almost completely changed the way I think about my work; not just in the way I think about my patient interactions, but also in the way I think about my interactions with my colleague and perhaps most importantly with myself. Coming to appreciate the immense value in recognising emotions, developing a greater emotional awareness and understanding how, through using EI, it is possible to grow and develop this across the spectrum of work and teaching I do.

Using experiences, appreciated through the lens of in-action reflection, I realised the profound value of communicating via stories. As our memories are formed of moments so our lives are full stories. I now recognise that the opportunity to share these builds connection in a way that seems both natural and authentic in a way that other communication now seems to lack. Seeing stories and communications of emotional integrity and expressions of vulnerability I now wonder when and why we stopped using such a powerful tool.

More than anything, this realisation, encouraged by the training, took me on a journey. It started from a place that saw vulnerability as something that was an exclusively negative experience and brought me to recognise its power; how fundamental it is to expressions of humanity in creating safe spaces I and those around can feel psychologically safe.

As well as building quite complex conceptual models that I have found practically useful, there is an equal part that recognises the intrinsic value of the simple things that can have immediate impact. For example, recognising the value of a smile beyond being a reflection my own emotional state. The infectious nature of emotions so easily demonstrated through such a simple act."

Dr Thomas Kitchen, Anaesthetist and communication skills trainer, Cardiff

3.2.2 Challenge: Lack of recognition of the need for emotional competence

While the need for communication skills has been recognised, researched and taught in the medical community worldwide for a number of years, the recognition of the need for skills to recognise and manage emotions – both of the patient's and of the health provider - is still in its infancy. One reason for this can be a denial of the emotional dimensions of communication and relationship, and a rejection of the need for emotional competence because of health professionals' fear of exposing their own emotions.

Thus, learning how to recognize and manage emotions has not been a priority in medical education. Yet, research has clearly established that ***emotional care*** impacts patient outcome, and that patients want **humanistic health care professionals** who are medically and technically competent as well as being compassionate and empathetic, and thus help make them feel safe to open up and share their concerns.

After a thorough analysis of the UK health system, John Ballatt and Penelope Campling[32] conclude that a lack of understanding and management of emotions is a major issue, one which demands much more attention. The book demonstrates how the health system changes in recent years have eroded this fundamental practice, contributing to events in which patients have suffered scandalous

[32] Ballatt, J and Campling, P (2011): Intelligent Kindness; reforming the culture of healthcare, 2011

cruelty and neglect. Ballatt and Campling make the case for strengthening the practice of meeting patients with kindness.

Healthcare providers are met with a high number of emotional demands during a workday, demands which may trigger negative emotions and influence a provider's ability to make ethical decisions. This situation can result in emotional labour[33] for the provider, including negative physical and psychological health consequences. Shocking reports[34] [35] of providers treating patients with lack of dignity and respect strengthen the picture of providers lacking important skills to practice emotional intelligence in their work.

Emotional labour has been recognised as a main concern for health professionals. Research clearly documents the profound need for building a bridge between the medical and the emotional aspects of care. In the last few years, awareness has been increasing in medical communities about the need for doctors, nurses and health professional teams to learn to recognise and manage their own and their patients' emotions with competence and compassion.

In a recent article, Campling also notes[36] that "… there has been a failure to create organisations that are fit for purpose and able to facilitate the emotional work that is such an important component of the healthcare task. ***There has been a failure to acknowledge and get to grips with the way overwhelming anxiety - largely unconscious - can unhelpfully drive and undermine the system.***" (our emphasis).

Many of our course participants, from across a variety of cultures, have admitted to insensitive and unkind – and sometimes even cruel - behaviour towards patients. Such behaviour is often due to a lack of ability to manage stressful and challenging situations, most of which involve and evoke strong emotions. Few providers have ever been taught how to manage such emotions[37].

In the UK, this lack of emotional competence among medical professionals costs them dearly in the form of **increased rates of mental ill health, burnout and suicide. Many health professionals also leave their profession.** This is the case in other countries as well; the cost to health providers' wellbeing and job satisfaction of such increasingly stressful and often unsupportive environments is well documented[38]. In resource-poor countries the pressures are even worse, and the cost to medical professionals as well as to patients is very high.

The conclusion: There is a need for a paradigm shift in medical education. Communication skills training for health providers must focus on relationship-centred care, on building competence to recognise and manage emotions with awareness, kindness, intelligence and wisdom.

Many aspects of medicine influence providers' ability and motivation to recognise, respond to and manage their own and their patients' emotional needs. Some of these are discussed below.

[33] **Emotional labor** is the process of managing feelings and expressions to fulfill the **emotional** requirements of a job. More specifically, workers are expected to regulate their **emotions** during interactions with customers, co-workers and superiors.
[34] The Mid Staffordshire NHS Foundation Trust Public Inquiry. R. Francis, 2013
[35] Timothy Abuya1*, Charlotte E. Warren2, Nora Miller3, Rebecca Njuki4, Charity Ndwiga1,Alice Maranga5, Faith Mbehero6, Anne Njeru7, Ben Bellows1: Exploring the Prevalence of Disrespect and Abuse during Childbirth in Kenya. PLOS ONE | OI:10.1371/journal.pone.0123606 April 17, 2015
[36] Editorial Reforming the culture of healthcare: the case for intelligent kindness. Penelope Campling. BJPsych Bulletin (2015), 39, 1-5, doi 10.1192/pb.bp.114.047449
[37] See e.g BMJ article February 2019: Should doctors cry at work? *BMJ* 2019;364:l690 doi: 10.1136/bmj.l690 (Published 26 February 2019)
[38] The Mid Staffordshire NHS Foundation Trust Public Inquiry. R. Francis, 2013

3.2.3 Challenge: Need for training on emotional competence

D. Roter & al[39] suggest that "…the emotional context of care is especially related to nonverbal communication and that emotion-related communication skills, including sending and receiving nonverbal messages and emotional self-awareness, are critical elements of high-quality care." The authors conclude that "The conference devoted to articulating the nature of relationship-centered care (…) suggests that it is **the largely untapped healing power of the emotional connection between patients and physicians that can provide meaning and strength to the therapeutic relationship[40]"** (our emphasis).

The effect of engaging with the patient: In a forthcoming book[41] to be published this year, professor Saul J Weiner, who is a medical doctor and research director at the University of Illinois, US, writes about meeting the patient as a person:

> *"In nearly every patient encounter there is an opportunity to connect within the medical context in a way that acknowledges our shared human experience."*

Weiner describes the attitude with which he meets the patients, and that patients are almost always eager to engage with the clinician, but – "they do not expect it". They expect "medical detachment". Making a human connection with the patient is, according to Weiner, of benefit to the medical encounter, the patient, and the clinician: Seeing himself as a healer and a partner to the patient, the clinician gains more satisfaction from his work, and this affects his wellbeing positively. Weiner's rich description of how engagement with the patient affects both patient and clinician gives an untraditional and much needed perspective on medical work.

Weiner emphasizes that engaging with patients requires that the clinician has boundary clarity – without it, he may invade the patient's boundaries, or neglect his own. This caution is also very important in our model and course (see the core module about handling emotions, Module 3b).

Saul Weiner further notes[42] that in addition to learning to manage emotions, there is also a need for medical professionals to interpret emotions*: "For instance, I've learned that when I start to feel depressed around a patient it's usually a clue that they're depressed. It's a message to myself that I should screen them for depression."*

In Europe, emotional care is considered to be one of three primary aspects of communication that impacts patient outcome when meeting primary care physicians, and which health professionals are expected to master. The other two are "Room to talk", and "Positive communication"[43]. In a review, several studies[44] are quoted and demonstrate the need for providers to deal with patients' emotions, and positive outcomes when they do.

Much of the recent literature[45] confirming the importance of responding to patients' emotions is related to cancer care, or dealing with the terminally ill. One study showed that 65% of patients'

[39] Roter, D & al (2007): The Expression of Emotion Through Nonverbal Behavior in Medical Visits. Mechanisms and Outcomes
[40] Roter, D (ibid)
[41] Weiner, S.J (2019): Title not yet defined
[42] Weiner, S.J, personal communication, February 2019
[43] Sandra van Dulmen, see ref xx.
[44] Fogarty, L.A & al (1999): Can 40 seconds of compassion reduce patient anxiety? J of Clin Oncol 17:371; Zimmerman, C, Del Piccolo, L, Finset, A (2007): Cues and concerns by patients in medical consultations: A literature review. Psychological bulletin 133: 438-463
45 e.g. de Haes, H.C.C.M (2009): Responding to patient emotions: The different reactions to sadness and anger. Patient Education and Counseling, editorial, Vol 76;

emotions are not responded to, with providers having particular difficulties in responding to anger. Another study of emotions and cancer care showed that oncologists were least responsive to patient fear[46].

There is a lack of research into the potential benefits of making emotional connections with patients, on the mental health of the providers. One research study[47] points out the link between burnout and the emotional demands made on nurses. While we will not be reviewing the large literature on burnout here, it is worth noting that implementing the iCARE-Haaland model seems to deal effectively with all three major symptoms of burnout: *Emotional exhaustion* and *depersonalization* are reduced, while there is an improvement in *job satisfaction*.

Why, then, is there so little literature or research available describing processes for developing and strengthening such emotional connections between patients and physicians and other health care personnel? Why are so few training programmes designed to give health professionals such skills, and why have such programmes not been documented? What might help explain this gap?

3.2.4 Challenge: Vulnerability is considered a weakness in medical tradition

Emotions are regarded in medical culture as primarily ***negative,*** as "emotionalism", leading potentially to misconduct or mistakes. To be vulnerable is defined in medicine as *"Capable of being physically or emotionally wounded",* or *"being open to attack or damage"*[48]*.* It is usually seen as a weakness or an embarrassment. The presumption is that medical professionals will always remain in control, as if any acknowledgement of insecurity - that one "does not know" or "does not know what to do" represented exposure of incompetence, of not being good enough, as if one failed to fulfil the role of the perfect, all-knowing medical professional.

As one doctor, a participant in an iCARE training in Wales, wrote as part of her reflection work:

- ***«There was an innate belief within, a feeling that vulnerability must be stamped out and hidden»***

The denial of vulnerability does not, however, help stimulate or develop safety. Emotions that are unacknowledged and thus unaddressed may lead providers to act insensitively or even cruelly, most likely without realizing or intending to. Not only does the literature document this, but many of our course participants across the cultures have courageously provided examples when admitting to having treated some patients cruelly. They felt they could trace their behaviour to their lack of ability to cope with stressful, challenging situations, most of which involved strong emotions, most often related to insecurity. Many providers have never been taught how to cope with these emotions – neither the ones the patients show, nor their own.

Few providers work in environments that allow or encourage the expression or discussion of emotions as a natural part of communicating in situations involving people's health. There are several studies showing that patients forget more than half of what the provider said, shortly after

[46] Kennifer, S & al ( ): Negative emotions in cancer care: Do oncologists' responses depend on severity and type of emotion?
[47] Erickson, R.J, Grove, W, (2010): Why Emotions Matter: Age, Agitation, and Burnout Among Registered Nurses. The online Journal of issues in nursing, April 2010.
[48] Merriam-Webster dictionary: Vulnerable

the consultation. When, in addition, patients' feelings of vulnerability are left unrecognized and unacknowledged their capacity to listen to, understand and ultimately follow medical instructions may well be further compromised.

The cost of ignoring and/or judging emotions or the health of the providers themselves has been described above: a high rate of suicide, mental health problems, conflict and burnout. A young doctor from Wales contributed this reflection:

- *"(…) I was surprised by just how little patience and tolerance I exercised in certain situations. I was surprised at how I was not meeting the very expectations I have of other people. No one likes being spoken to in a rude manner. Furthermore, directing anger or frustration at others is not an appropriate reaction to stress. (…) I recognize that as doctors we are made to feel that showing stress or insecurity is perceived as a sign of weakness or incompetency and so we avoid doing this, to our detriment. (…) it is harder to be open about these feelings with your colleagues, however, this is more likely to sustain strong working relationships and trust amongst teams. Over the last four weeks I have learned to acknowledge when and why I become angry and frustrated in work and I am learning how to manage these feelings in the appropriate way."*

Vulnerability that is controlled by being ignored remains stored in the mind and body as "an unresolved problem". It may surface later as a factor contributing to a variety of physical illnesses (ulcers, heart attack…) and/or problematic mental states or conditions, depression, burnout, reactivity provoking conflict. However, when emotions – including vulnerability – are recognized, acknowledged and managed using emotional intelligence skills, they may shift from being problematic to becoming a resource.

Edvin Schei is a medical doctor and professor at the Department of Global Public Health and Primary Care at the University of Bergen, and is challenging the traditional role of the doctor and the medical culture in his practice, his teaching and his writing. Schei started the Philosophical Policlinic in Bergen in 1998 with a talk named "Fundamentalism in white. About power and submission to authority in medical culture." In a recent book simply named – "Listen"[49], he discusses the role of the doctor and the way the doctor communicates with patients. He guides the readers through practical examples to recognise, question and reflect on their role and their power, and to build relations and really SEE their patients, and to find out and communicate about their real needs.

In a lecture at the Medical and philosophical forum at the University of Oslo on April 9th, 2019, Schei gave a talk called "The philosophical policlinic. An attempt to shake up medical culture"?

Schei emphasized the need for critical reflection among medical professionals, and the need for building "inner authority" to counteract the institutionalized authority which can make it difficult to express emotions and to be the humanistic doctor most professionals wish to be. Schei advocates for doctors to become more aware of and respect their own emotions, as well as recognising and responding to patients' emotions.

[49] Schei, E (2015): Lytt. Legerolle og kommunikasjon. (Listen. The role of the physician, and communication). Fagbokforlaget Vigmostad og Bjørke AS

Schei says many doctors have become an echo of authoritarian attitudes and are stuck in a denial of their own vulnerability. This, says Schei, works against the doctors' own interest and health, as well as against the patients' needs and wishes:

> *"When you meet people with empathy, consciously, you also receive much good energy from the patient. As doctors we need to make emotional competence a strength – and not think that emotions make us weak or unprofessional."*

In the next section, we review how vulnerability may be seen as a resource, and some potential benefits and effects of this on medical professionals.

3.3 Evidence and reflections: Effective skills training

There is solid evidence in the literature for what constitutes effective strategies for communication skills training, and some which shows the need for and benefits of including skills to train for emotional competence. Some of this evidence is reviewed in this chapter.

After reviewing the evidence, we have selected a few key authors whose work have influenced this manual: William T Branch, Donald Schøn, Jonathan Silverman, Susanne Kurz and Mary C Beach. Carl Rogers' foundational work on identifying key aspects of person-centred care and of what makes a trainer relate well to students provides the groundwork: Rogers' work defines the focus on communication in a relationship as the starting point for the work.

3.3.1 Effective training methods – a summary of characteristics

The research base for the work is communication training programmes for providers across Europe and the US. A clinical review in BMJ in 2002[50] gives an overview of key communication skills physicians need to be able to deal well with patients, and also shows how physicians use blocking behaviour to avoid dealing with patients' emotions.

Recent literature[51] [52] shows that the body of knowledge about what works in communication skills training for health professionals is growing, and consistently points to the same: ***Training needs to be conducted over time, integrating contents and skills, using experiential learning methods where participants practice skills and are given feedback and reinforcement throughout, and use critical thinking and reflection.***

The BMJ review adds that evidence of current deficiencies in communication, reasons for them and the consequences for patients and doctors, as well as evidence for the skills needed to overcome these deficiencies, must be the basis for the teaching methods used.
There is limited research assessing the need for communication skills training in countries in the South or evaluating impact of such training but a recent cross-sectional study from seven countries in Africa clearly concludes that there is a need for communication skills training for health providers[53].

[50] Maguire, P; Pitceathly, C (2002): Key communication skills and how to acquire them. BMJ 325:697-700.
[51] van Weel-Baumbarten, E (2010): Best Evidence Teaching Communication Skills. Presentation to the third Geneva conference on Person-centered Medicine, Geneva May 3-5th 2010.
[52] Branch, W. T (2015): Teaching professional and humanistic values: Suggestion for a practical and theoretical model. Patient Education and Counseling 98 (2015) 162–167
[53] Larson, E; Leslie, H.H; Kruk, M.E (2017): The determinants and outcomes of good provider communication: a crossectional study in seven African countries. *BMJ Open* 2017;7:e014888. doi:10.1136/bmjopen-2016-014888

However, our own research and training strongly supports the notion that the principles found in the North are also applicable for training in the South.

The research concludes that ***effective communication training for medical doctors and nurses uses interaction in a relationship as a basis for the learning***. The training methods needed for the training to function optimally are:

- **Longitudinal (over weeks/months),** using reflective and **experience-based or experiential** learning methods
- **Active** small group learning, in a **safe and supportive** learning environment
- **Practicing the skills**, with effective and focused ***feedback:***
- Based on and used in **clinical practice**
- **Using critical reflection** to challenge and transform perspectives
- **Integrating** knowledge and skills
- **Problem-solving,** using active and empowering methods
- **Focus on feelings**, not on thoughts alone: ***Emotional intelligence and competence needed***
- **Using authenticity (being genuine), empathic understanding and appreciation** as key skills

3.3.2 Key approaches influencing iCARE-Haaland model contents and method

The foundation: Carl R Rogers, the "father" of person-centred care

Carl Rogers challenged with his research and action the medical professional view of the patient as a dependant person, and questioned the medical professionals' power over the patient in psychiatry as well as in general medicine. He argued for the view that a client or patient is a responsible person and should be included in the medical consultation as an equal. Needless to say, Rogers' work created a lot of controversy in the medical community in the 1960s and 70s, and the question of the location of power remains a hot one till today.

Rogers demonstrated through a number of research projects and experiences that there are three main skills that make a difference in how a medical professional relates to and connects with the patient: Being authentic or genuine, using empathic understanding, and using appreciation.

This helped the health care provider see the patient as a person, and thus contributed to developing a person-centred (rather than a disease-centred) care. Rogers showed how using these skills also had a powerful effect when used by teachers with their students, and by parents with their children. He shows how being authentic is a prerequisite for personal growth.

He also described the effects of non-judgment and empathy, as contributing to healing:
"When… someone really hears you without passing judgment on you, without trying to take responsibility for you, without trying to mould you, it feels damned good… When I have been listened to and when I have been heard, I am able to reperceive my world in a new way and go on. It is astonishing how elements that seem insoluble become soluble when someone listens. How confusions that seem irremediable turn into relatively clear flowing streams when one is heard."[54]

The medical educator: William T Branch focuses on experiential learning, +3

William T Branch has published widely about medical education the last 30 years. In a position paper from 2015[55] he sums up his experience as a researcher and teacher of medical students and professionals over 30 years and provides an extensive review of the field of medical education.

[54] Rogers, Carl (1978): On Personal Power.
[55] 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 adopting a practical and theoretical model for teaching professional and humanistic values which consists of and combines four main teaching methods that must be in place for effective learning to take place:

- ***Experiential learning of skills,***
- ***critical reflection,***
- ***a supportive group process, and***
- ***a sufficiently longitudinal curriculum.***

He shows how these methods mutually reinforce each other to enhance commitment to core values and to optimize professional identity formation.

A review of Best Evidence teaching on Person-centred basic communication skills[56] supports these findings, and adds some, including the need to use interaction in a relationship as a basis for the learning.

Branch also shows clearly that the "Road to Professionalism" goes through reflective learning in theory and practice, and the use of critical thinking[57].

Reflection In Action: Donald Schøn focuses on learning in the situation

Schøn did his work in the US. A major method he contributed is Reflection In Action, which he describes as "***the ability of professionals to think what they are doing while they are doing it***"[58]. Using this method, Schøn asks students to be aware of their actions while at work, and then uses their observations to discuss and reflect on the situations observed (Reflection On Action).
This method, with our additions, is an important basis for the iCARE-Haaland model.

Learning from experience is a key skill: Systematic review

In a systematic review, Mann et al (2009) describe learning from experience as a key skill in health professions: Critical reflection on experience and practice is essential to identify learning needs; reflection is a key method to develop an active approach to learning, and to develop self-awareness and self-monitoring as professional skills. Despite these clearly documented advantages, Mann 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."*

Communication Skills in Medicine: Silverman, Kurz, Draper

The influential works of the authors on "Teaching and Learning Communication Skills in Medical Education" come with a companion manual, "Skills for communicating with patients", and are seen as "The Classics" for medical education[59], [60]. The manuals provide a comprehensive approach to teaching and learning throughout the three levels of medical education for physicians in family and specialist medicine (undergraduate, residency and continuing medical education). The books have become standard texts in teaching throughout the Northern world, and the methods described are all evidence based.

[56] van Weel-Baumgarten, E.M and Brouwers, M.H (2011): Best Evidence Teaching of Person-centred Basic Communication Skills: a reflection E.M.
[57] Branch, W.T (2010): The road to professionalism: Reflective practice and reflective learning. Patient Education and Counselling 80 (2010) 327–332.
[58] Schøn, D. A (1983): The Reflective Practitioner – how professionals think in action. Basic Books, 1983 ISBN 0465068782
[59] Kurz, S; Silverman, J; Draper, J (2005): Teaching and Learning Communication Skills in Medical Education, second edition. Radcliffe Publishing, Oxfor and San Fransisco.
[60] Silverman, J; Kurz, S; Draper, J (1998): Skills for Communicating with Patients. Radcliffe Medical Press, Oxford

The manual uses the Calgary-Cambridge Observation Guide as a basis for the curriculum and is a goldmine of knowledge and methods for medical teachers. Experiential learning methods are used as the standard for teaching, and the evidence base supports the principles and practice we use in our training.

Patient-centred and Relationship-centred Care: Patients' choice

Research on patient-centred care shows that PCC has a positive impact on patient outcome[61] and is clearly preferred[62] by patients: They want to be treated with respect and to have the medical professional take their perspectives and wishes into account. Patients in the UK, Canada and South Africa have similar wishes for how they want their health professionals to communicate with them, pointing towards a global definition of patient centred care[63].

In her article on Relationship Centred Care: A constructive reframing[64], Mary C Beach writes:
"All illness, care, and healing processes occur in relationship—relationships of an individual with self and with others. Relationship-centered care (RCC) is an important framework for conceptualizing health care, recognizing that the nature and the quality of relationships are central to health care and the broader health care delivery system."

A main difference between PCC and RCC is that RCC includes a stronger focus on emotions, and also acknowledges the moral value of establishing and maintaining genuine relationships.
PCC and RCC are a basic starting point, central to the philosophy and practice of the iCARE-Haaland training model.

3.3.3 Building emotional competence and emotional intelligence

Emotional intelligence: Skills to manage emotions and strengthen resilience

There are a number of different ways of describing "Emotional Intelligence". Daniel Goleman, who has written several books on the subject, 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"*[65].

In a critical review of using EI in medical education[66], Cherry & al describe that "there is increasing research evidence that doctors' EI influences their ability to deliver safe and compassionate health care, a particularly pertinent issue in the current health care climate". The review concludes that *"Emotional intelligence-based education may be able to contribute to the teaching of professionalism and communication skills in medicine, but further research is needed before its wholesale adoption in any curriculum can be recommended."* Other articles conclude similarly – that EI skills are useful, and – that there are many unanswered questions. Some of these questions relate to whether EI can be taught, and to defining more clearly the effects the practice of EI has on the learner's own health.

Patients appreciate EI: An article on EI and the healthcare staff in the US refers to a survey of more than 2.4 million patients receiving medical care which showed that patients place a high priority on

[61] Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, et al. The impact of patient-centered care on outcomes. J Fam Pract. 2000;49:796–804. [PubMed]
[62] Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, et al. Preferences of patients for patient centred approach to consultation in primary care: observational study. BMJ. 2001;322:468–472.
[63] Stewart, M (2001): Towards a global definition of patient centred care. The patient should be the judge of patient centred care. BMJ. Feb 24; 322(7284): 444–445
[64] Beach, M.C (2006): Relationship-Centred Care. A constructive reframing. Journal of General Internal Medicine. Vol. 21 Issue 51, pp53-58
[65] Goleman, D (1995): Emotional Intelligence. Why it can matter more than IQ. Bloomsbury, London
[66] Cherry, M.G & al (2014): Emotional intelligence in medical education: a critical review. Medical Education 2014: 48: 468–478

the degree to which a medical staff meets their emotional needs. The article highlights empathy, self-awareness, self-management and social awareness as key competencies for EI training[67].

In parts of the scientific literature, EI is described as a set of four distinct yet related abilities. In an article on EI and Resilience[68], the abilities are described as:

Article on EI and Resilience: Definition of EI	EI made simple
1. Accurately perceiving emotions	1. Recognize
2. Integrating emotions with cognition	2. Think
3. Understanding emotional causes and consequences, and	3. Analyse
4. Managing emotions for personal adjustment	4. Act

The article concludes that abilities to use emotional intelligence skills facilitates resilience to stress.

These skills are what we have focused on in our training, as they relate closely to skills providers develop in the self-observation and reflection tasks. Please see chapter 6 for a description of how these skills are developed while doing the reflective tasks.

Vulnerability: A source of human connectedness, and empathy

The ability to practice emotional competence (and EI) is to a large extent dependent on skills to recognize, acknowledge, appreciate and manage vulnerability. Vulnerability may be seen as an essential aspect of being human, and the very quality that enables a health professional to establish a connection with a patient, and enables the patient to speak about her deep concerns and fears. A young doctor participating in the training in Wales shared the following reflection of discovering the positive effects of applying emotional competence:

> *"Recently I was working in a pre-op clinic for patients who were due to undergo cancer surgery within the next few weeks (…) assessing their fitness for anaesthesia/make an anaesthetic plan - a rather routine process from my point of view.*
>
> *(As) I introduced myself and my role to the patient and explained what operation they were due to have and why, (…) I recognised that this is where I feel vulnerable……the patient is feeling emotional and faced with a lot of uncertainty…… normally my defences would kick in and I would shy away from the subject and press on with the consultation.*
> *I recognised it was an emotional time for the patient and I decide to verbalise this - saying that this must be an extremely stressful time for the patient and that they must have a lot going on…..tapping in to past experiences from my past/family/friends to empathise with the patients situation. The patient opened up to me and I listened to her….giving her time to talk and reassuring her where I could. I felt like I was able to build a connection where in the past I would have avoided it."*

The connection to empathy: The American sociologist Brene Brown says that vulnerability is "…the birthplace of innovation, creativity, trust and empathy"[69], and shows how there can be no learning without vulnerability. Her extensive scientific research into vulnerability and shame has resulted in an understanding of the role and importance of vulnerability in relationships which is starting to break down the apparent taboo against speaking about the concept. Brown shows how people want to avoid negative feelings of shame, fear, sorrow, grief and disappointment by numbing them, but –

[67]Copperman, K.B (2007): **Emotional intelligence and the healthcare staff:** Maximizing performance and patient satisfaction. Srm-ejournal Vol8 no1
[68] Schneider, T & al (2013): Emotional intelligence and resilience. Personality and Individual Differences 55, 909–914
[69] Brené Brown | Daring Classrooms | SXSWedu 2017

that when they do, they also numb positive feelings of joy, gratitude and happiness: You cannot numb feelings selectively. Brown links the avoidance or numbing of emotions to over-eating, overuse of substances like alcohol and drugs, overuse of medicine, and – to the quest for perfectionism: "Perfectionism is a self destructive and addictive belief system that fuels this primary thought: If I look perfect, and do everything perfectly, I can avoid or minimise the painful feelings of shame, judgment, and blame[70]". Perfectionism does not open one up to feeling or practising empathy.

The need for health professionals to be able to recognize and manage emotions in this "landscape" is increasingly obvious. Brown writes and speaks about emotions with humor and self-irony, and emphasizes the wisdom of being clear: "Being clear is kind, being unclear is unkind". She is an excellent communicator, and has probably done more to make knowledge about vulnerability accessible and understandable than anyone else: Her TedTalk "The Power of Vulnerability" has reached an audience of over almost 40 million viewers (April 2019).

The renowned American professor and writer Saul Weiner, who is a medical doctor and research director at the University of Illinois, US, notes that *"… in my research, I've shown that caring physicians are attentive physicians, and attentive physicians ask questions when there are discrepancies between what the patient says and what is observed, and that those questions in turn lead to information which is critical for care planning, which in turn leads to better outcomes."*[71]

3.3.4 Research into vulnerability as a potential resource

There exists some, though scarce, research on professionals' relationship to vulnerability, and its connection to ethics. Conclusions from these may be summarised as follows:

Recognising and managing vulnerability can be taught as a strength, a resource helping health providers to achieve important goals in their work:

- ***It improves the capacity to connect with and relate to both oneself and to other people***
- ***It provides a basis for experiencing empathy, including for being kind to oneself;***
- ***It helps one learn how to nurture, including oneself;***
- ***Thus, it helps one find and maintain balance in life.***

Some brief examples from the literature:

In her investigation of how doctors use vulnerability, and how it can affect patients, **Kirsti Malterud**, a Norwegian researcher who is also a GP, concluded:

> "*The doctor is expected to be detached and omnipotent, yet compassionate and empathetic. Attention is usually drawn to the negative aspects of doctors' vulnerability and emotionality related to burnout or misconduct. Focusing on the potential benefits of vulnerability in the doctor, we find that it may bring strength, but must be used with caution*.»[72]

Gjengedal[73] investigated the link for health professionals between empathy and vulnerability: She found that a strategy to help them understand the patients or families from ***their*** own perspective "…seems to make vulnerability bearable or even transform it into strength. Being sensitive to the vulnerability of the other may be a key to acting ethically". When the professional attempted to help from ***her*** own personal perspective, her attention remained on herself, and this could impair the ability to help.

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[70] Brené Brown, The Gifts of Imperfection: Let Go of Who You Think You're Supposed to Be and Embrace Who You Are

[71] Saul Weiner, personal communication, January 2019

[72] Malterud, K (2009): When doctors experience their vulnerability as beneficial for the patients. A focus-group study from general practice. Scandinavian Journal of Primary Health Care, 2009; 27: 85_90

[73] Gjengedal, E &al (2013): Vulnerability in health care – reflections on encounters in every day practice. https://doi.org/10.1111/j.1466-769X.2012.00558.x

The authors conclude:

»*However, in order to recognize vulnerability as strength, one needs help to face one's vulnerability in the first place. Then, a gradual growth process leading to flourishing might take place*[74]*.»*

Norwegian theology professor Sturla Stålsett and his colleagues write about the importance of vulnerability and security in the context of international relations:

"Vulnerability was seen purely as a weakness to be overcome. Our main point is that vulnerability is both *the foundation of an ethical and political right to protection* and *a fundamental precondition for ethical human behavior – both between individuals and at the political level. We even dare to speak of human vulnerability as a potential strength."* [75]

They call for a new understanding of fundamental ethical questions to better enable us to protect people facing such crisis as need, abuse, and accidents:

"Vulnerability is the unique capacity for receptivity and empathy which allows human beings to acknowledge and care for their ethical responsibility for each other, for the community and their environment. Against this aspect of vulnerability, we ought not protect ourselves."[76]

Hal and Sidra Stone[77] developed the model and method "Psychology of Selves" enabling people to become more self-aware. They consider an understanding of vulnerability as essential to becoming a balanced person able to offer empathy to others – and oneself. They describe vulnerability as "…*to be without defensive armor, to be authentic and present."* A health provider's capacity to experience and communicate respect for vulnerability may prove crucial to his developing and maintaining reliable connections with his patients.

3.3.5 Vulnerability: Approach, but with educated caution

As described above, these skills are much needed in the medical profession, enabling providers to identify more accurately with their patients, which in turn enhances the possibility for understanding them. When the health professional is able and willing to share – carefully, appropriately and with awareness – from her own life experiences and the vulnerability they evoked – the health professional becomes *a person* to the patient, potentially deepening their mutual empathy. This can influence on the quality of clinical practice. However, training is required to utilise this resource responsibly.

Boundaries needed: The awareness necessary for determining how, when, with whom and to what extent to express vulnerability – or not to do so – demands that the health professional develop well-functioning boundaries. She must ensure that there is a balance between what she takes in and what she gives out. For example, she needs to protect herself, having empathy also for herself and her own vulnerabilities and needs, as well as for those of the patient. If not, she may become emotionally exhausted and prone to burnout. To become skilled at using empathy and vulnerability with awareness, providers need to reflect personally and interactively with others about their own difficult emotional events, sensitive situations and general sensitivities.

Acknowledging imperfection: Health professionals may not be well known for acknowledging mistakes and apologizing to their patients or colleagues. To be able to determine when and how to

[74] Gjengedal, E &al (Ibid)
[75] Vulnerability and security, p.8-9 (2000). Published by the committee for international issues, in the ecumenical (will get right info)
[76] Ibid
[77] Stone, Hal and Winkeman, Sidra (1985): Embracing our Selves. Voice Dialogue Manual.

do so, honourably, appropriately and sincerely, the HP needs to acknowledge her own vulnerability, including in the context of medical legal requirements.

3.3.6 Emotional competence to prevent and reduce burnout

The competence providers learn – often on their own – is to ***control*** emotions, rather than to ***manage*** them. This often contributes to burnout[78, 79,80,81, 82,83].

Some interventions described in the literature show clearly that giving physicians and specialists skills and insights, through awareness, reflection and communication skills training over time, may reduce provider burnout, as well as have positive effects on patient outcomes. See for example literature on Balint groups[84], to deal with challenges in physicians' practice, and an article on training physicians in "mindful communication"[85] which showed short term and sustained improvements in well-being and attitudes associated with patient-centred care. There is a lage literature on these topics, mostly concluding that causes of burnout include emotional exhaustion, depersonalization and lack of job satisfaction. Learning to manage emotions has a positive effect on limiting burnout by reducing emotional exhausition and depersonalization, and increasing job satisfaction.

The public health challenge is an important one – providers burn out or leave the profession at an alarming rate. The problem is even more pronounced in the resource-poor countries - the "care drain" from Africa is depleting scarce resources that are sorely needed to deal with the continent's many health challenges.

3.4 The iCARE-Haaland model fills a gap in training and literature

The iCARE model contributes to filling two gaps in both the literature and its application to training:

1. **A training approach** to strengthen skills on emotional competence for health providers, and
2. **Learning method to build a personal evidence base, and empower participants to change**: A sequence of guided, systematic self-observation and reflection tasks which enables participants to discover how they communicate, what are the effects of their communication (and of their automatic emotional reactions) on the other person(s), and thus develop an inner motivation to learn, and to change.

1. The training approach

Training on emotional competence and EI has become very popular, especially in the business world and for leaders. Few – if any – models take into account that these skills take time and effort to learn if they are to be internalised and work well for the individual: a "quick fix" is not the answer.
The iCARE-Haaland training approach combines communication skills training with skills to manage emotions, using emotional intelligence as a guide. The training has a number of features that distinguishes it (see chapters 2 and 4), and the approach works across different cultures. Having been

[78] Mann, K &al (2009): Reflection and reflective practice in health professions education: a systematic review. Adv in Health Sci Educ (2009) 14:595–621. DOI 10.1007/s10459-007-9090-2
[79] Bagdasasov, Z and Connelly, S (2013): Emotional Labor among Healthcare Professionals: The Effects are Undeniable. Narrative Inquiry in Bioethics • Volume 3 • Number 2
[80] Szczygiel DD, Mikolajczak M (2018): Emotional Intelligence Buffers the Effects of Negative Emotions on Job Burnout in Nursing. Front Psychol. 2018 Dec 21;9:2649. doi: 10.3389/fpsyg.2018.02649. eCollection 2018. DOI: 10.3389/fpsyg.2018.02649
[81] McQueen, A. C (2004): Emotional intelligence in nursing work. J Adv Nurs. 2004 Jul;47(1):101-8.
[82] Smith, K.B et al (2009): Emotional intelligence and nursing: An integrative literature review. International journal of nursing studies 46(12):1624-36. DOI: 10.1016/j.ijnurstu.2009.05.024
[83] Panagiotis E Prezerakos (2018) Nurse Managers' Emotional Intelligence and Effective Leadership: A Review of the Current Evidence. Open Nurs J. 2018; 12: 86–92.
[84] See for example Kjeldmand, D. and Holmstrøm, I. (2008): Balint Groups as a Means to Increase Job Satisfaction and Prevent Burnout Among General Practitioners. Annals of family medicine Vol 6 no. 2
[85] Krasner, M.S. &al (2009): Association of an Educational Program in Mindful Communication with Burnout, Empathy and Attitudes among Primary Care Physicians. JAMA Vol 302 no 12, Sept 23/30

developed "from below", with health practitioners defining the needs and testing out the contents and methods over time, ***the model responds to the actual work situations of the health providers.*** It helps them develop practical ways to handle real challenges.

2. **Learning method to build a personal evidence base, and empower participants to change**

We have not found much guidance in the literature on – how to train health providers to observe and reflect IN Action, systematically and using a pedagogical sequence to build skills over time. We have also not found training programmes that work well to develop insights and skills on recognising and managing emotions for health providers, related to their daily work situations.
We use Donald Schøn's Reflection in action as a base, and have built a model that guides participants to build their learning about communication and emotions in a systematic way. Starting with "simple" skills like listening, participants observe and reflect systematically on one skill at a time, building their own personal evidence base on how they communicate and what are their patterns of communication in different situations. They also observe the effects of their communication on others, i.e. how they react, and then gradually include learning about how emotions influence the communication. They look at how their own emotions affect the communication and behaviour of the person they talk with, and how the other person's emotions can affect how they themselves communicate. This becomes their personal evidence base – a base from which to practice EI.

When building up this knowledge, understanding and insights based on their own experiences over time, the participants gradually build confidence in using their skills with awareness: They see that they can influence the communication, and start taking responsibility for how they communicate. This is a major shift, and is facilitated by the **emotional impact** they experience when accepting that their communication has an effect on others, and by working systematically to understand and learn from this effect. Their personal evidence is supported by evidence from theories, during workshops.

This process is empowering, and it belongs to the participants.
These factors contribute to the changes becoming, for many, a sustainable part of new behaviours.

3.5 Results from using the iCARE-Haaland model in nine countries

The training has been assessed by using a variety of qualitative tools. Self-assessment (baseline, endline) and narratives describing learning and insights from using observation and reflection tasks (Most Significant Change stories, with examples) have been used in all nine countries. In addition, an evaluation was conducted by an independent group in Kilifi, Kenya in 2011, and the training in Wales was evaluated by an independent researcher conducting a focus group discussion with participants after training.

We have included examples from participants' feedback throughout the manual, to illustrate challenges and learning. In this section, we give a summary of some of the feedback.

The trends in the feedback from participants in all training sites are remarkably similar, given the differences in cultures from Lithuania and Russia to Namibia and Kenya, and to Wales.

3.5.1 A summary of main trends from the feedback

Participants have experienced the training as very useful, and the most important skill they gained was – to the surprise of all – learning emotional competence: they see there is a clear link between how they manage emotions, and how they experience their work. Many say that they cope better with the emotional demands from patients when they have learnt to recognize, acknowledge and

manage their own emotional reactions and needs, and at the same time communicate well and meet the needs of the patient. When they give (effective) emotional care and in turn receive emotional nourishment or gratification from the patients, it impacts positively on their job satisfaction.

Changes during first three months of observation and reflection (before the workshop)

In all nine countries, the observation task feedback shows strengthened awareness among participants regarding how they use communication skills such as listening, asking questions and giving feedback, and of the effect of using the skills in different ways.

Some examples:

- *"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." HCW, Kilifi*

- *"When listening to patients before, I always had things to do, and did them while I listened, not thinking about how the other person felt. Then I tried the observation task and listened fully to the patient and saw how it worked: I caught more of what the other person said, I understood deeply, not only the facts. When I listened with full attention, I would understand why this patient has a problem, e.g. why he is without family. When listening like this, I do not judge, I listen to understand deeply, I listen with empathy. I can also communicate my emotions – and tell him "I worry about you, how are you really?" Then the patient will tell. And then we can deal with the problems – together." HCW, Kilifi*

- *"Patients open up if they are talked to nicely, politely and given time to express themselves and their views without fear. I try to put myself in their situations and this helps me to understand them better." HCW Kilifi*

Another key point is – participants strengthened awareness of **the influence of emotions on communication**, especially related to their own insecurity, and their anger:

- *"Anger and fear after an HIV positive husband became aggressive when his wife tested negative and he was saying our machine and the health workers don't know what they are doing and are unskilled, it can't be possible. I withheld my anger and fear and after he had expressed his feelings I asked for his opinion whether he accepts the results or not. He calmed down and cried then later accepted." HCW, Kilifi*

  "I think mainly communication becomes a problem when we don't know how to deal with our self in the 1st place. If I knew how to deal with my own emotions, I would treat others better" HCW group 3, Kilifi

  "*When I'm very busy in the ward, I wear a stone face so that clients don't approach me to tell me anything which will disrupt my days program. So these clients normally look at me on the face and fear so much such that even if they have very burning issues they cannot tell me because I'm unapproachable" HCW Kilifi, group 3*

Many made improvements on their own during the first three months of observations

Most participants have **made improvements in how they communicate** with patients and colleagues, based solely on discoveries they make through observations and reflections during the first three months, or during the first phase of the course process. Below is a selection of such changes, chosen to show major trends in the changes.

Examples of key changes, Lithuania (where the first course was held, in 2006)

Before training process (April)	After observations and reflections (October)
"*It is most important to inform the patient about treatment and hospital routines."*	*"It is most important to listen to the patient"*
"Feelings are not important"	*"Feelings are important"*
"I have to solve all problems by myself"	*"I have to cooperate with others"*
"Seeing the patient as 'just a patient'"	*"Seeing the patient as a whole person"*

Participants discovered what they wanted and needed to learn, in all countries, as a major outcome of working with the observation and reflection tasks*. **In all countries, participants discovered the need for learning about emotions, and to all – this was a surprise.***
Their questions and examples are used in the course, to create role-plays, demonstrations and exercises.

Changes throughout the process

A majority of the participants say that in the course of the learning process, they have strengthened their awareness in all the work they do – and they especially recognise and manage their emotions in a better way by stepping back from automatic emotional reactions. This has led to the participants experiencing improved relationship with patients and colleagues and having a strengthened confidence in their work. Many report that they have fewer conflicts.

Burnout symptoms[86]: Many report changes in all three major symptoms leading to burnout: They have reduced emotional exhaustion, they treat patients as persons (=stop depersonalisation), and they experience an increased job satisfaction.

The extent to which participants have experienced the changes has varied, but all say the focus on strengthening awareness to improve their communication skills have had positive outcomes for themselves and for their work.

More specifically, the assessment shows that participants after the nine months training process have strengthened their skills to -

- ***Give and receive*** respect
- Build ***trust*** with patients
- Treat patients as ***persons***
- Look for ***reasons*** for patients' actions; dialogue with them (rather than judge them)
- Take **responsibility** for improving communication (stop blame)
- ***Stop automatic reactions***; focus on patient
- ***Understand, respect and take care of their own + patients emotions***
- Increased awareness of ***effects of showing respect***, on patients ***emotions,*** and consequently on ***cooperation and care***.

In Kilifi, Health care Managers confirmed participating providers' assessment of change (in interviews in an independent evaluation of the courses after two years (2011).

An essential skill: Stepping back

One specific skill was consistently gained across all countries – learning to recognise emotions, and automatic emotional responses, and control them by taking a step back (in effect – practising EI):

[86] Maslach, C. (1982): Burnout: The Cost of Caring. Englewood Cliffs, NJ: Prentice-Hall

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

HCW, Kilifi, reported to the independent evaluation group

There were clear changes shown in all four aspects of patient-centred care: The providers' relationships with patients, with colleagues, with the community, and – with themselves. In this last dimension of patient-centred care the provider's relationship with herself (or: developing self-awareness) there has been a lack of practical training models and opportunities. In this aspect the iCARE-Haaland training model has had a real impact on the participants across all the cultures.

Changes at home: Many participants note that communication skills learned in this course could also be used at home. They saw for example that using constructive criticism and managing automatic reactions improved relationships at home (e.g. with partner and with children). One provider in Kenya was asked by her church to talk to other members about communication skills, recognising the usefulness of what she had learned, to the service of the community.

Some other examples of the changes experienced in the later stages of the course process:
An example of empowerment:

"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*

From the independent evaluation in Kenya, 2011:

'Some of them used to be very arrogant in talking to patients, they were rude but now they are polite…When a patient has refused a procedure they take time to understand why they have refused, to express their fears…maybe they have not understood the importance.' (23N)

3.5.2 Special note on training of trainee doctors in Wales (2016-17)

This was the first training held for medical doctors, only (the others were for a mixture of medical professionals). The first round of training (2016) indicated that the trainee doctors experienced the same type of challenges as the professionals in the other countries. In addition, three of 11 participants were very dissatisfied with their jobs and considered leaving medicine. At the end of the training – no one did, indicating a link between emotional management and job satisfaction.

"The fuel for resilience" The Wales training courses focused specifically on strengthening resilience, and evaluation showed clear links in this direction. Participants used positive emotions as "the fuel for resilience", and especially changed their perceptions of vulnerability from being a threat to fear and ignore, to appreciating it as a powerful resource to recognize and manage. The examples below illustrate the use of emotional intelligence skills – especially to step back from emotional reactions.	**«Positive feelings are the fuel for resilience»**  ***BUT:** Genuine positive emotions are only possible if you learn to acknowledge and go through negative emotions – by practicing the four EI skills!*

Examples of changes from Wales:

- ***"I saved my own sanity and retained control****: 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 emotional intelligence 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."

- ***"My journey to becoming a more resilient doctor:*** *Over the last six moths I have actively and consciously started listening to the people around me. I have started picking up on subtle clues which I may have been blind to before. Through listening and observing I came across a fellow trainee who was suffering with her confidence and I helped her adopt the resilience model. Another revelation that I have had is that some criticism that I may hear has very little to do with me and a lot of do with person giving it. I now take my time to process information before reacting and tend not to have very emotional reactions but rather measured ones. This portrays a very professional image to the seniors and they usually respect it and find it easy to teach me.*
  It's very easy to say that I am resilient now but sadly I don't think that's the case. It's a journey for me and my emotional intelligence is something I have to work on daily. I do however believe that training is something to be enjoyed and by making certain tweaks I can change my inner critic to practice emotional intelligence."

- ***"I no longer take rudeness so personally****: I now accept that I am good at my job and am open to criticism as an opportunity to learn and develop and become better. I no longer take rudeness so personally, I am able to more effectively manage the emotions provoked in me when people behave in a rude manner and adjust my behaviour accordingly."*

The learning in Cardiff is however less deep and thorough than the learning for the groups who go through the full course. Some main reasons for this are the shortness of the sessions together (three hours per workshop) and the subsequent lack of time to dive into the theories and reflect on them in a substantial way. We have used much time to affirm the learning through using examples from the tasks, and while this has been important – it has also prevented us from going into the theory in any substantial manner. It also prevented the group from establishing the deep, trusting relationships which we saw in the groups who were given the chance to work together over several days. With no follow-up for the groups – except informally – there is thus a question about how much of the learning turned into sustained new behaviour