Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma
MEM-TP

ADDITIONAL MODULE 1.

TARGET GROUPS

Unit 4. VULNERABLE GROUPS

Guidelines

Prepared by:
Olga Leralta and Bibiana Navarro
Andalusian School of Public Health

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Migrants & Ethnic Minorities Training Packages

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Unit 2: Interpersonal skill development

1. Objectives and Methods

1.1. Objectives

Objectives of the Presentation:

- To identify barriers and facilitators to communication according to the literature
- To identify aspects of conflict management and negotiation processes.
- To analyse the relevance of breaking bad news techniques.

Objectives of the Activities:

- To practice the negotiation and collaboration skills of the participants
- To contribute with examples of good practices in the interpersonal communication.
- To think over the application of the negotiation process to the trainees' context.
- To think over the behaviours involved in conflict management.

1.2. Methods

The estimated time required for Module 3 is 5 hours, approx. 2 hours 30 minutes for each Unit. The training materials of each Unit are composed of presentations, activities, videos and recommended lectures.

We suggest focusing on activities as the contents of this Module require an experiential pedagogical approach. Each Unit includes various activities prepared to address different professional skills. The activities selected are to be adapted according to the level of skills' development of the trainees. Some activities are "core activities" (marked C.A.) and other ones are complementary.

Contents of this Unit go into detail about some issues raised in Unit 1. They address the interpersonal elements associated with health professional-patient interaction in culturally diverse contexts.

Time	Objectives	Contents	Activity	Sources
5 min.	Present objectives and methodology of the Unit	Objectives of the Didactic Unit	Presentation **Slides 2, 3**	Projector, laptop, screen M3_U2 Presentation
15 min.	Emphasise different dimensions of communication	Group work on voice inflections	Activity 1 "Oh" **Slide 4**	M3_U2_A1 Activity Template

Time	Objectives	Contents	Activity	Sources
5 min.	Identify key elements on communication	Definition	Presentation **Slide 5**	Projector, laptop, screen M3_U2 Presentation
20 min.	- Reflect previous knowledge on this issue - Practice the negotiation and collaboration skills of the participants	Work in small groups and group discussion	Activity 2 "Key elements on communication" (C.A.) **Slide 5**	Paper and pen
15 min.	- Recognise the role of perceived meaning of a verbal message - Recognise the role of feed-back to guarantee correct understanding	Group work on different meanings of verbal messages	Activity 3: Rephrasing Exercise **Slide 6**	M3_U2_A3 Activity Template
10 min.	Identify the barriers to effective communication that participant's face in their daily practise.	Brain storming	Activity 4. Barriers to Communication (C.A.) **Slide 7**	Paper and pen
10 min.	Identify barriers and facilitators to communication according to the literature	Presentation Wrap up on Barriers	Presentation **Slides 8-10**	Projector, laptop, screen M3_U2 Presentation
30 min.	-Think over the application of inclusive communication' principles to their context - Contribute with examples of good practices	Work in small groups and group discussion on the inclusive communication' principles	Activity 5. Good practices in inclusive communication **Slide 11**	Paper and pen M3_U2_A5 Activity Template
5 min.	Identify barriers and facilitators to communication according to the literature	Presentation Wrap up on Facilitators	Presentation **Slide 12-16**	Projector, laptop, screen M3_U2 Presentation

Time	Objectives	Contents	Activity	Sources
15 min.	Identify aspects of conflict management and negotiation processes	Presentation Wrap up on the main issues regarding conflict management and negotiation	Presentation **Slides 17-19**	Projector, laptop, screen M3_U2 Presentation
20 min.	Think over the application of the negotiation process to their context	Individual and group work on the negotiation process	Activity 6: Negotiation (C.A.) **Slide 20**	M3_U2_A7 Activity Template
30 min.	Re-think over the behaviours that lead to conflict management	Individual work and group discussion about managing described problems	Activity 7: Conflict management (C.A.) **Slide 21**	M3_U2_A8 Activity Template
10 min.	Analyse the relevance of breaking bad news techniques	Presentation Braking bad news	Presentation **Slides 22-23**	Projector, laptop, screen M3_U2 Presentation
30 min.	Acquire knowledge about strategy to breaking bad news	Role playing and group discussion on the strategy presented	Activity 8: Role playing on breaking bad news **Slide 24**	M3_U2_A9 Activity Template

Presentation

Slide 1: Title

Slide 2: Outline of contents

Slide 3: Objectives

Slide 4: Activity 1: "Oh" [1]
Description: The same word is to be pronounced using different voice inflections each time, changing its meaning. This activity will emphasize how important voice inflections are to the meaning of words.
Time: 15 minutes

This activity has five steps:

[1] Adapted from Garber PR, Amherst MA (2008) 50 Communications Activities, Icebreakers, and Exercises. HRD Press.

1. Introduce the activity by emphasizing just how important the way we say things is to the meaning that is communicated to others.
2. Distribute or present the indications to the participants.
3. Ask for volunteers to take turns saying the word *oh* with each of the meanings described. For example, the first person should say the word *oh* as if he or she was greatly shocked.
4. Continue until all of the suggested meanings have been communicated by participants.
5. Group Discussion: It becomes obvious that *what* we say is not nearly as important as *how* we say it. However, we do not typically focus on this dimension of communication, as much as we should. However, paying closer attention to *how* people communicate can provide extremely valuable information about how they really feel.

Presentation

Slide 5: According to literature "*the "root cause" of malpractice claims is a breakdown in communication between physician and patient. Previous research that examined plaintiff depositions found that 71% of the malpractice claims were initiated as a result of a physician-patient relationship problem. Closer inspection found that most litigious patients perceived their physician as uncaring. The same researchers found that one out of four plaintiffs in malpractice cases reported poor delivery of medical information, with 13% citing poor listening on the part of the physician."*[2]

Activity 2: Key elements in communication

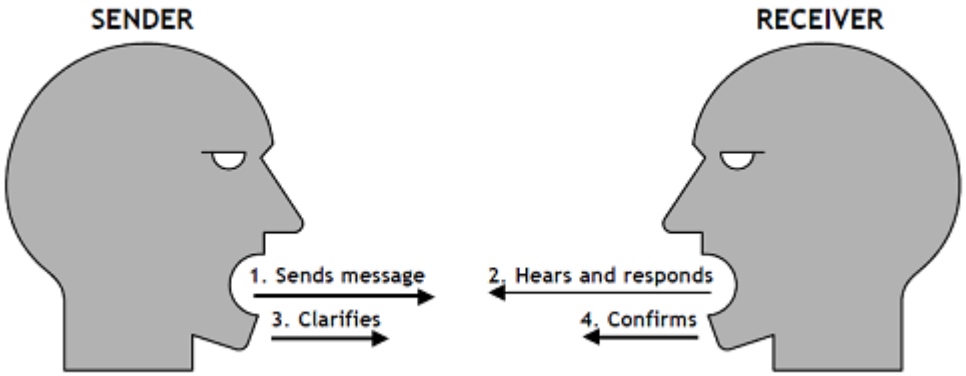
Description: This activity aims both to discuss the key elements of communication and train the participants in negotiation and collaboration skills.
Time: 20 minutes

This activity has four parts:

1. Show the image to the participants.
2. Ask them to work in small groups (max. 10 min.) to answer the following questions:
   - *What elements can you identify? List them.*
   - *How important do you consider each of them? Reach an agreement on the relevance of each element and put them in order using the template.*
3. Group discussion on the relevance of the elements listed by the participants. Make sure to address these key elements:
   Individuals/Context/Setting/Channel/Code/Feed-back.
4. Ask the participant to explain how each group decided on the relevance of the different elements. Stress the role of collaborative work and negotiation to reach agreements.

[2] IHC (2011). Impact of Communication in Healthcare. Available at http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/ (retrieved: July, 19 2015).

Image:



Reproduced from 50 Communications Activities, Icebreakers, and Exercises, by Peter R. Garber. Amherst, MA, HRD Press, 2008

Slide 6: Activity 3: Rephrasing Exercise
Description: Participants will consider how important voice inflections are concerning the perceived meaning of a verbal message, and the essential role of the feedback to avoid ambiguity and wrong interpretations.
Time: 15 minutes

1 Distribute Template 1 to each participant.
2 Explain that this is going to be a listening test. Participants are to carefully listen to how one sentence will be read six different ways, each time with a different intent based on voice inflections.
3 Ask participants what meaning they think each statement has, as you read each one.
4 Look at Template 2 to see how to read the statement each time. The first time you read it, you should read it to mean: *We are not going to take a blood test today*. This will correspond to the second statement, meaning that there will not be any blood test today.
5 Continue reading the statement, emphasizing the highlighted words, according to the boldface numbers provided in Template 2.
6 Read or show the answers to them.
7 Discuss how the very same statement can take on so many different meanings, and how to manage this barrier to communication.

Slide 7: Activity 4. Barriers to communication
Description: Brain storming about the barriers to effective communication that participants face in their daily practise.
Time: 10 minutes

The activity consists of two parts:

1. List on the board participants' contributions regarding the obstacles experienced in their interaction with migrant and ethnic minorities.
2. Discussion in group. Link the issues raised with the contents of the Presentation.

Presentation

Slide 8: BARRIERS TO COMMUNICATION

According to the literature[3], noise, interruptions, lack of intimacy, etc. all affect the communication process. When interruptions occur, the patient may perceive that what they are saying is not important. This leads to patients being reticent to offer additional information. Patient satisfaction decreases, when members of the healthcare team do not take a patient's health problems seriously, neither explain information clearly, nor try to understand the patient's experience and provided viable options.

Time spent is relevant as most accurate diagnoses can be made by taking of careful case histories. Therefore, caregivers should be allotted more time to develop trusting relationships with their patients and the vulnerable populations that they serve. Health outcomes can be improved if health professionals spend time to engage with patients "*making relationships meaningful enough to limit the damaging effects of suffering. Mutual understanding provides a foundation for affective caring, but time and space should be provided for such new forms of clinical care to emerge and take root."*[4]

The barriers listed below are barriers to communication in various contexts. In the healthcare settings they can lead to patients not understanding what they are suppose to do. They may find the instructions too difficult to follow, or feel that the treatment was against their personal beliefs.[5] This can influence adherence (defined as the extent to which a patient's behaviour corresponds with agreed upon recommendations from a healthcare provider) and patient satisfaction with health care.

- Ambiguity
- Lack of feedback
- Lack of attention
- Divergence between verbal message and nonverbal cues
- Faulty channel (whether verbal, nonverbal or printed)
- Rumours
- Personal interpretation (linked to stereotypes and prejudices)
- Inappropriate setting

Slide 9: FACILITATORS TO COMMUNICATION

According to literature, to bridge the *cultural distance* between healthcare services and migrant and ethnic minority patients the focus should be on **health professionals' knowledge, attitudes, and emerging skills**. The strategies raised below are main facilitators to address this concern.

- **Inclusive communication**[6]

[3] IHC (2011). Op cit.

[4] The lancet Commission Culture and Health (2014) *Lancet* 2014; 384: 1607–39 available at http://dx.doi.org/10.1016/S0140-6736(14)61603-2 (retrieved December 19, 2015)

[5] Davis, K., Schoenbaum, S. C., Collins, K. S., Tenney, K., Hughes, D. L. and Audet, A. M. (2002). Room for improvement: Patients report on the quality of their health care. New York: Commonwealth Fund

[6] This content is based on Scottish Government (2011) Principles of Inclusive Communication: An information and self-assessment tool for public authorities; available at http://www.scotland.gov.uk/Publications/2011/09/14082209/0 (retrieved January 11, 2015)

Inclusive communication **means** sharing information in a way that everybody can understand**. Patients have communication support needs, if they need support with understanding, expressing themselves or interacting with others.** *This concept is used in the reference to improve communication with disabled people, and has been adapted in this Unit to migrants and ethnic minority patients in the health services.*

For health professionals, inclusive communication means making sure to recognise that people understand and express themselves in different ways**.** For patients, it means getting information and expressing themselves in ways that meet their needs. Inclusive communication makes services more accessible for everyone. This helps to achieve successful outcomes for individuals and the wider community.

You have to be flexible in how you communicate and the methods that you use in order to meet migrant and ethnic minority patients' needs, for example by having written information in their own language. You will also need to give people the chance to express themselves in a way that suits them, for example by using pictures, instead of speaking. Differences in communicative support needs show that taking communities or groups for granted means constructing "stereotypes".

Slide 10:

Principles of inclusive communication
1. Communication accessibility and physical accessibility are equally important
To make health services fully accessible means considering communication accessibility as well as physical accessibility in the traditional sense.
2. Every community or group will include people with different communication support needs
You should presume that every group you are working with, or expect to work with, includes people with communication support needs. In this training context, support needs also refer to interpretation and mediation services. Inclusive communication should be considered at all times, whether providing information or planning an event, meeting or activity.
3. Communication is a two-way process of understanding others and expressing yourself
Everyone communicates differently regardless of their cultural identity. When somebody has communication support needs, it may take more effort and time to ensure that health professionals and patients or communities using the service understand each other.
4. Be flexible in the way your healthcare service is provided
In order to match the way you communicate to the needs of all the patients and communities who use health services avoid the "one size fits all" approach. Think about how accessible your health service will be, what methods are best and be flexible in your approach.
5. Effective user involvement will include the participation of people with different communication support needs
Identify the full implications of health service access for all members of the community, involving patients. Services delivered around the needs of the people who use them will be more cost effective, user friendly and fit for purpose.
6. Keep trying
Small, simple changes to the way you communicate will make a big difference to the healthcare service delivery.

Slide 11: Activity 5. Good practices in inclusive communication
Description: This activity focuses on the applicability of the six principles of inclusive communication to the interaction of health professionals with migrant and ethnic minority patients and communities.
Time: 30 minutes

This activity consists on small group work and a final group discussion.

1. Facilitator creates 6 groups and gives a reading to each, covering one of the six principles of inclusive communication. Participants are asked to contribute examples of good practices, considering their daily experience.
2. Wrap up and discussion in plenary. The rapporteur of each small group provides a summary of the results in three sentences. Group discussion.

Presentation

Slide 12: *The contents below are other main facilitators to communication:*

- **Self-Awareness:**

Health professionals are encouraged to recognize that, as cultural beings, they **may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions** with individuals, who are different from themselves in terms of age, ethnicity, culture, religion, gender, sexual orientation, disability, and socioeconomic status. Health professionals have **specific knowledge about their own background,** and how it personally and professionally affects **their definitions and biases** of normality-abnormality and the process of healing[7]. Awareness of **medicine's own cultural practices** includes its prejudices, assumptions, and institutional norms, values, practices, and prestige hierarchies[8]. *Cultural mediation programmes will be discussed more in depth in Module 4.*

- **Empathic processes:**

As we have seen in Unit 1, empathic processes affect how the health professional thinks and feels (**intrapersonal outcomes**), and behaves (**interpersonal outcomes**) with the patient. **Interpersonal outcomes** are **related to the behavioural aspect of empathy**, including helping behaviours, aggression and social behaviours. By understanding a patient's situation, empathic processes and the intrapersonal outcomes involved increase helping behaviour and reduce aggressive behaviour. They encourage conflict avoidance, improve conflict management, and promote good communication and a considerate social style. Empathy is useful to address both patients' and carers' explanatory models and perceptions of illness and wellbeing.

To understand patients' explanatory mode, *The Lancet Commission* recommended introducing the following questions:

1. *What do you call this problem?*
2. *What do you believe is the cause of this problem?*

[7] T-SHaRE Project team TRANSCULTURAL SKILLS FOR HEALTH AND CARE. Standards and Guidelines for Practice and Training (2012) available at: http://tshare.eu/drupal/sites/default/files/confidencial/WP11_co/MIOLO_TSHARE_216paginas.pdf (retrieved January 11, 2015)
[8] The Lancet Commission Culture and Health (2014). *Op cit.*

3. *What course do you expect this problem to take? How serious is it?*
4. *What do you think this problem does inside your body?*
5. *How does this problem affect your body and your mind?*
6. *What do you most fear about this problem?*
7. *What do you most fear about the treatment?*

- **Knowledge:**

Following the conclusions from Report *Review of existing training materials* of MEM-TP Project[9] and recommendations from the mentioned The Lancet Commission on Culture and Health, **this training programme aims to avoid reducing individual behaviours to broad stereotypical formulas and applying specific behaviours to categories of people**. Despite generalisations may be based on broad truths, these should be accepted cautiously, as **individual responses to norms vary widely**. Health professionals should deconstruct the idea of culture as synonymous with ethnicity, nationality and language, as if health care to migrant or ethnic minority patients could be satisfied using a checklist (*do this, not that*).

Moreover, health professionals need to be aware of **misattributing cultural reasons to patient issues**, rather than recognise that patient difficulties can be equally economic, logistic, circumstantial, or related to social inequality. The same way health professionals need to **know and understand** how immigration issues, poverty, oppression, powerlessness, racism, sexism, discrimination, and stereotyping influenced and influence the lives of the people with whom they work with.

Knowledge also concerns **being sensitive to the norms and values** of those who use care services. This is *"essential if professionals are to improve adherence. Health-care providers cannot usefully present information to patients if patients do not understand the merits of adherence to treatment within their existing values and concerns."*[10]

- **Language barriers**

In order to get over the language barrier, health professionals may ask to interpret another family member, a friend, a neighbour or a staff member who speaks a foreign language. Other times they may use dictionaries. However, these strategies are unsuitable for many reasons: the interpreter's involvement with the user (especially if the situation covers problems of violence or abuse of authority), the accuracy and faithfulness of the information (no additions or omissions), the person's impartiality, and the confidentiality and neutrality of the interpreting. To correctly address language barriers in communicating with migrant and ethnic minority patients, there are of various specialists with specific roles[11] whose name has variations among countries. This issue will be addressed in more detail in Module 4, Unit 2.

[9] Chiarenza A, Horvat L, Ciannameo A, Vaccaro G, Lanting K, Bodewes A, Suurmond J. (2015). Final Report Review of existing training materials. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Reggio Emillia, Amsterdam: Andalusian School of Public Health, AYSL of Reggio Emilia, University of Amsterdam.

[10] The Lancet Commission Culture and Health (2014). *Op cit.*

[11] Definitions and roles have been get from *Constructing an inclusive institutional culture (*the source is INTERPRET, a Swiss training and certification association for community interpreting and cultural mediation: www.inter-pret.ch, accessed 6 June 2011) and T-SHaRE Project team TRANSCULTURAL SKILLS FOR HEALTH AND CARE. Standards and Guidelines for Practice and Training (2012) available at http://tshare.eu/drupal/sites/default/files/confidencial/WP11_co/MIOLO_TSHARE_216paginas.pdf (retrieved January 11, 2015)

1. **Translators** are language specialists who translate written texts out of a source language into one or more target languages, usually their mother tongue(s).

2. **Interpreters** are language specialists with a perfect command of their mother tongue and one or more foreign languages. They have mastered interpreting techniques for rendering a message orally from the source language to the target language. Interpreting requires close concentration and considerable responsiveness, mastery of terminology in several fields, in-depth knowledge of these fields and the ability to assimilate knowledge in other sectors.

   When using an interpreter, health professionals should **address the "comfort needs" of the patient** with regard to factors such as age, gender, ethnic background, and other potential areas of discomfort. When the issue arises, these potential areas of discomfort for the patient should be discussed with the patient and addressed appropriately.

3. **Community interpreters** specialise in interpreting in three-way situations to facilitate mutual understanding between speakers of different languages. When interpreting they take into account the speakers' social and cultural backgrounds. They have a basic knowledge of intercultural communication. They are familiar with the misunderstandings and conflicts that may occur in this context and are able to react to such situations appropriately.

4. **Cultural mediators.** *Cultural mediation programmes will be discussed more in depth in Module 4.* Definitions of **cultural mediation** are embedded in broader definitions of social mediation as a relational approach. It **seeks to enhance, maintain or re-establish communication between two parties in one given social environment**. Its function is to **bridge between** two worlds, **two sets of representations**. Culture is understood to be located on both ends of the communication, not simply on the immigrants' or the ethnic minority members' side, including religion, tradition and experience.

   Cultural mediators enable the confrontation of **cultural "explanatory models"** on both ends of the communication. They do so by explaining and relating the values and norms associated with such models. The **ultimate goal is** for interlocutors **to be able to identify with one another's model by way of understanding it** and possibly **reformulate the meaning of stories, experiences and symptoms** in a new productive form.

Slide 13: A **dialogue approach** may be used in **situations of potential conflict** to define a problem jointly, seek mutually satisfactory solutions, reach a mutual understanding, negotiate the formulation or application of a shared norm. The principles of dialogue may be summed up as follows:

- Being able to listen with respect and openness,
- Considering the situation from the other person's point of view,
- Allowing the other person to explain how he or she sees things,
- Recognising similarities and differences,
- Looking for common ground,
- Being open to balanced and reasonable compromises in order to find satisfactory solutions and reach agreement.

Slide 14: Promoting a cooperative approach and a culture of dialogue:

- Encourage mutual respect, reciprocity and equality between parties

- Encourage an attitude of openness and reflective listening
- Acknowledge cultural filters in dialogue
- Take account of room for manoeuvre and institutional resources
- Avoid criticising or judging (value judgments) beliefs or convictions
- Be careful to separate the problem from the person

Slide 15: Intercultural dialogue is understood as a process that comprises an open and respectful exchange of views between individuals and groups with different ethnic, cultural, religious and linguistic backgrounds and heritage, on the basis of mutual understanding and respect. It requires the freedom and ability to express oneself, as well as the willingness and capacity to listen to the views of others. Intercultural dialogue contributes to political, social, cultural and economic integration and the cohesion on of culturally diverse societies.

Slide 16: Team-working

Communication plays an important role in the process of collaboration. Role misunderstanding between the different health professionals can lead to a divergence in care, resulting in different approaches to achieving the same goals for patients. Intrapersonal skills contribute to promoting team-working. **Respect for other team members** and **awareness of roles,** supported by **good communication,** are essential attributes in pursuit of effective collaborative practice[12]. Moreover, health and culture deserve attention not only from the point of view of patients and health-care professionals, but also in relation to increasingly diverse **non-medical staff** such as social workers, receptionists, telephone and internet respondents, care administrators who function as *service gatekeepers*. These professionals are also affected by their own diverse cultures. Therefore "*responsibility for advancement of cultural awareness in health-care practice should not be borne solely by those who deliver direct care, nor should responsibility only be seen as a community issue, and therefore non-clinical"*[13].

Slide 17: CONFLICT REGULATION AND NEGOTIATION PROCESS [14]

Conflicts are inevitable in human interaction and may be concealed or open tensions with different levels of social complexity. **Interpersonal conflicts may relate to differences concerning expectations, interests, needs or values**. Some particular expectations or types of behaviour may lead to conflicts between patients and organisational ways of working in health services.

According to the literature[15], the notion that each ethnic group or country of origin is associated with a stable and homogeneous culture has come under fire in recent decades. Moreover, lifestyles are not practised in a vacuum: healthy eating, for example, is not just a personal choice but also depends on the availability and affordability of the right foodstuffs, as well as having the time and facilities to prepare them. Advertising and social pressures are also powerful determinants of behaviour.

[12] Howarth Michelle M (2006) Education needed to support integrated care: a literature review. Journal of advanced nursing , 2006, 56 (2): 144-56

[13] The Lancet Commission Culture and Health (2014). *Op cit.*

[14] This content is adapted from Council of Europe (2011) *Constructing an inclusive institutional culture*. Council of Europe Publishing

[15] Mock-Muñoz de Luna C, Graval E, Ingleby D. (2015). Appendix I, Synthesis Repport. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen.

Some cultural beliefs may be misunderstood as resistance to care.[16] For example, Sudanese women in Canada were found to perceive pregnancy and delivery as natural processes that do not necessarily call for intensified contact with health services. Another study explored the impact of cultural factors on the interactions between health professionals and Somali women in Finland.[17] Physicians, nurses and midwives described situations where cultural norms on both sides hampered, delayed or prevented the delivery of adequate care in a timely manner. Most Somali women were reported to request female gynaecologists, for example. Other examples included different communication styles, the taboo of hand-shaking and other forms of physical contact with male physicians, as well as religious beliefs related to childbirth.

However, as the composition of migrant and ethnic minority populations varies from country to country, as does the degree of integration among groups and individuals, as well as their adherence to traditional or cultural practices, health professionals should **avoid relying on cultural stereotypes** and instead approach those they come into contact with in a **patient-centered way, remaining alert to different forms of diversity**.

Conflicts often have their roots in **differing perceptions**, e.g. nurses may feel stressed by the "invasion" of large family groups, while some patients may regard strict visiting hours as an unnecessary limitation. Other examples of patient's requests are:

- Access to a service in a person's mother tongue
- Menu diversification or dietary restrictions for moral or religious reasons
- Request for a woman/man caregiver
- Wearing a religious symbol or exemption from dress code
- Taking into account cultural practices and values
- Respect for privacy

There is **not always consensus on the principles of fairness** or the "reasonable" nature of a request. Although institutions have a responsibility to provide clear guidelines as a basis for any action taken by workers, it is important for staff to be familiar with the **principles of negotiation and communication in an intercultural context**. Badly managed or unresolved conflict may have repercussions for individuals, the work climate and quality of service. On the other hand, when resolved constructively conflicts can help to strengthen intercultural relation.

Slide 19: The **negotiation process** depends on the professional's capacity for dialogue and the patient's willingness to negotiate. If the protagonists hold to their conflicting interests, it is pointless and risky to embark on a discussion of their mutual values or positions. Main steps in the negotiation process are summarised below:

- **Ask the patient how they perceive** the problem/situation (what is the problem? When does it arise? What's wrong?)
- **Ask the patient to define it** (what does the problem mean to him / her?) Record the expectations of the parts in conflict.

[16] Higginbottom, G.M. et al (2013). "I have to do what I believe": Sudanese women's beliefs and resistance to hegemonic practices at home and during experiences of maternity care in Canada. BMC Pregnancy Childbirth. 13:51.

[17] Degni, F. et al (2012). Communication and Cultural Issues in Providing Reproductive Health Care to Immigrant Women: Health Care Providers' Experiences in Meeting Somali Women Living in Finland. *Journal of Immigrant and Minority Health.* Volume 14, Issue 2. Pg. 330-343.

- **Reaching the same understanding** of the problem **agreeing on the facts** (take note of the objective facts and describe the request on the basis of these facts rather than impressions)
- **Stress the agreement points first** and the discrepancies later.
- **Work together** to find solutions considering: time needed to study the situation, provision for consulting other people, ruling out unrealistic, unfair or unreasonable solutions. For each suggestion it is helpful to ask what would change if the idea were followed up. **Describe the advantages** of the solution once an agreement is reached.
- **Implement** the solution **and verify** that it is effective and satisfactory; make provision for adjustment and evaluation.

It's strongly recommended **to look for creative solutions**, although this often means throwing off old habits of thinking in order to overhaul one's practical skills. To do this, it is not enough to dip into a catalogue of ready-made good practices but **to open one's mind to new ideas and other's contributions.**

Slide 20: Activity 6. Negotiation process
Description: Guided discussion about the experience of participants in negotiation and collaboration processes to solve conflicts in their daily practise.
Time: 15 minutes

The activity consists of three parts:
1. Ask the participants to individually think of a situation they have experienced. They can fill-in the template (check-list of the steps to negotiate).
2. List on the board participants' contributions regarding their experience in negotiation and collaboration to solve problems in the interaction between health services and migrants and ethnic minorities.
3. Discussion in group supported by the presentation contents.

Slide 21: Activity 7: Conflict management
Time: 30 minutes

This activity has two parts:

Part 1: Individual work: Ask the participants to reconsider the difficult situation described in the template of Module 3, Unit 1 Activity 5 "Confronting difficult situations and emotions". Ask them to fill-in the new columns of the table on the template *M3_U2_A8 Activity Template*.
Part 2: Group discussion on the behaviour changes that may solve the problem/conflict described.

Slide 22: BREAKING BAD NEWS[18]
Why should health professionals be concerned about this issue?
- It is a frequent practice for health professionals.
- Training on this issue is lacking.

[18] Information for this issue was obtained from Robert A. Buckman (2005) protocol referred as recommended reading.

- Not being good at breaking bad news can generate unnecessary suffering to the patient or their relatives. Moreover, it can damage the relationship between a health professional and a patient.
- Knowing how to break bad news can decrease the emotional impact at the moment. It can contribute to the patient's acceptance of the situation, and thereby consolidate the health professional-patient relationship.
- It decreases the anxiety level of health professionals.

Bad news can be defined as information that negatively affects the person's expectations, either because the person is directly affected by the illness, or because of the impact on somebody from their environment.

Slide 23: Strategies and skills

- It is important to find the right setting, e.g. avoiding corridors and shared rooms. If possible, inform personally and avoid phone calls to face the reactions.
- Guarantee the patient is not alone, when providing the information, e.g. wait until a relative arrives. Avoid breaking bad news at night.
- Increase the length of the healthcare visit to properly respond to any emotional breakdown.
- Silence is a relevant communication and therapy tool. Through an empathic silence, looking at the patient's face and being aware of their needs can contribute to strengthening the health professional-patient relationship.
- Reflective listening, as seen in Unit 1, is a recommended technique.
- Assertiveness to show the patient that health professionals "know what to do" and are respectful of their opinions.

According to the S.P.I.K.E.S Strategy developed by Buckham, the following steps have to be taken for properly breaking bad news:

- **S**etting. Preparing environment
- **P**erception. What does he/she know?
- **I**nvitation. What does he/she want to know?
- **K**nowledge. Sharing information
- **E**mpathy. Responding to the patient's feelings.
- **S**trategy and summary. Care plan.

Slide 24: Activity 8: Role playing on breaking bad news

Description: Implementing the 6 steps of Buckman's strategy in small groups and discussion in plenary.

Time: 30 minutes

This activity has two parts:

Part 1: In small groups, implement the 6 steps with the support of *M3_U2_A9 Activity Template*. Possible situations to describe are: the diagnosis of a chronic illness, e.g. diabetes; a progressively incapacitating illness, such as degenerative illness; or a de-structuring psychopathic illness, e.g. Alzheimers.

Part 2: Group discussion after the scenes have been represented. *Not all groups need to be involved in the representation in plenary.*

Slide 26: Thank you and questions

Slide 27: References.

Reading

Recommended reading:

- Council of Europe. (2011). Constructing an inclusive institutional culture. Council of Europe Publishing. (Part F Conflict resolution, negotiation and dialogue for mutual understanding, pp. 102-116). Available at: http://cdn.basw.co.uk/upload/basw_100713-4.pdf (retrieved July 19, 2015)
- Scottish Government (2011) Principles of Inclusive Communication: An information and self-assessment tool for public authorities. Available at http://www.scotland.gov.uk/Publications/2011/09/14082209/0 (retrieved January 11, 2015)
- The lancet Commission Culture and Health (2014) *Lancet* 2014; 384: 1607–39 available at http://dx.doi.org/10.1016/S0140-6736(14)61603-2 (retrieved December 19, 2015)
- T-SHaRE Project team TRANSCULTURAL SKILLS FOR HEALTH AND CARE. Standards and Guidelines for Practice and Training (2012) available at: http://tshare.eu/drupal/sites/default/files/confidencial/WP11_co/MIOLO_TSHARE_216paginas.pdf (retrieved January 11, 2015)
- Buckman RA. (2005) Breaking bad news: the S-P-I-K-E-S strategy. Community Oncology 2005;2(2) Available at: http://www.acssurgerynews.com/co/journal/articles/0202138.pdf (retrieved July 19, 2015)

Complementary reading:

- IHC (2011). Impact of Communication in Healthcare. Available at http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/ (retrieved: July, 19 2015).
- Davis, K., Schoenbaum, S. C., Collins, K. S., Tenney, K., Hughes, D. L., & Audet, A. M. (2002). *Room for improvement: Patients report on the quality of their health care*. New York: Commonwealth Fund
- Howarth Michelle M (2006) Education needed to support integrated care: a literature review. Journal of advanced nursing , 2006, 56 (2): 144-56