HEALTH WORKFORCE TRAINING

PARTICIPANT MANUAL

June 2017

Approval Statement of the Ministry

The Federal Ministry of health of Ethiopia has been working towards standardization and institutionalization of In-Service Trainings (IST) at national level. As part of this initiative the ministry developed a national in-service training directive and implementation guide for the health sector. The directive requires all in-service training materials fulfill the standards set in the implementation Guide to ensure the quality of in-service training materials. Accordingly, the ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST implementation guide.

As part of the national IST quality control process, this national compassionate, respectful and caring health workforces training package has been reviewed based on the standardization checklist and approved by the ministry in June, 2017.

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Abbreviations and Acronyms

ART	Anti-Retroviral Therapy
CEC	Clinical Ethics Consultation
COM	Council of Ministers
CRC	Compassionate, respectful Caring
DNR	Do Not Resuscitate
ED	Ethical Dilemma
EFDRE	Ethiopian Federal Democratic Republic of Ethiopia
FMHACA	Food, Medicine, Health Care Administration and Control Agency
FMOH	Federal Ministry of Health
HIV	Human Immunodeficiency Virus
HSTP	Health Sector Transformation Plan
ICU	Intensive Care Unit
IST	In-service Training
OPD	Outpatient Department
OR	Operating room
PE	Preventive Ethics
STI	Sexual Transmitted Infection
WHO	World Health Organization
WMA	World Medical Association

Foreword

Delivering compassionate and respectful care is essential to high quality healthcare and should be at the heart of our healthcare system. Compassionate and respectful care (CRC) is critical to building a sustainable, equitable and healthy future for all.

A growing body of evidence has demonstrated that delivering CRC improves health outcomes, increases patient satisfaction, improves adherence to treatment and reduces malpractice claims and healthcare expenditures.

While considerable health gains have been achieved in the provision of our healthcare system, there is growing concern about the perceived lack of compassion in its delivery. Addressing the gaps in the provision of compassionate care is a top priority in the Health Sector Transformation Plan II (HSTP II), narrowing its focus a number of initiatives of compassionate care, or dignity in care.

Training our health workforce on CRC is one of the initiatives for the Federal Ministry of Health (FMoH). This initiative began with assessing the training needs of our health service providers to better understand the knowledge, attitude and skill gaps necessary to deliver compassionate and respectful care for their patients. The training needs assessment survey conducted early 2016 in selected hospitals included both health personnel and patients. The survey showed that compassion and respectful care were the principle foundations of quality healthcare. Patients have consistently ranked features of compassion among their greatest healthcare needs in the survey also attested the importance of compassionate, respectful and caring health service delivery.

Thus, this training manual is an important step to address knowledge gaps identified to prepare our service providers with the necessary skills to deliver compassionate and culturally respectful care.

I am grateful to all members of the technical working group and our partners who have collaborated with us to develop this important training manual. Our in-service training centres will be carried out in all regions. It is achievable. Together we can ensure that everyone is treated with compassion, respect and dignity.

Let’s get to work and get it done.

Introduction about this manual

The health sector transformation plan, in line with our country’s second growth and transformation plan (GTPII), has set ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels of the system.
To achieve those listed objective Compassionate and Respectful Care (CRC) is fundamental to the practice of healthcare professionals. A growing body of evidence has demonstrated that compassionate care has been associated with improved health outcomes, increased patient satisfaction, better adherence to treatment recommendations, fewer malpractice claims and reduced healthcare expenditure.

The new national Health Sector Transformation Plan II (HSTP II) created in 2015 has underscored the importance of creating CRC health workforce as a major pillar to improve the quality of health care services. This has led to a renewed focus on how to improve the health workforce performance including responsiveness, timeliness and patient centeredness of healthcare services. The directorate of human resource development and administration developed a national CRC implementation guideline to address this priority in the national agenda. The national CRC implementation guideline created a number of initiatives, including developing a standardized in-service training.

Core Competencies

Following successful completion of the course, qualified healthcare providers are expected to have acquired the following core competencies:

- Improved knowledge and understanding of the principles of compassionate and respectful care
- Developed skills for the effective practice of compassionate and respectful care
- Developed skills for effective provider-patient communication
- Developed skills to collect, analyze and act upon health system data to improve compassionate leadership

Course syllabus

Course Description:

This six days training is designed to equip health professionals and senior management in health facilities to increase core competencies of compassionate, respectful, holistic, scientifically and culturally acceptable care for patients and their families. .

Content of training and its organization:

This training is organized into five chapters to address broad technical areas in compassionate and respectful health care.

This module includes five chapters:	
Chapter 1	Introduction to CRC
Chapter II	Health Care Ethics
Chapter III	Compassionate Care
Chapter IV	Respectful Care
Chapter V	The Compassionate Leader

Course Goals

The goal of this training is to provide paraticipants with the necessary knowledge, skills, attitude and tools to implement

Course Objectives

By the end of this training course, the participant will be able to:

- Describe the components of compassionate care
- Explain the components of respectful care
- Demonstrate different ways of providing compassionate care
- Employ basic concepts of respectful care
- Practice principles of compassionate and respectful care
- Apply basic principles of communication
- Discuss principles of health professional ethics
- Analyze the effects of compassionate leadership in improving the quality of care

Participant Selection Criteria

- Participants for this course should be Healthcare professionals and senior management members of the health facilities (e.g. hospital CEO/ Facility heads, Medical directors, Quality care? officers and Ethics officers) at all levels of Ethiopian public health system.

Duration of the course

This national compassionate, respectful and caring training for healthcare professionals is designed to be delivered in six days for basic training and 8 days for training of trainers (ToT)

Trainers' selection criteria:

Facilitators will be selected from the

- National CRC Technical working group (TWG) or
- Have had Training of Trainers (TOT)
- TOT training must only be organized by the FMOH

The CRC TWG trainer must have experience in using the mastery learning approach to provide the training, which is conducted according to adult learning principles.

For CRC roll out training, facilitators should possess a minimum of a first degree in any health and social science related field with three to five years' experience working in the health sector in mid-to-senior level supervisory roles, particularly in functions related to health service quality, human resource management and development.

In addition, they need to have received ToT on CRC in-service training, including principles of experiential (adult) learning and facilitation skills. During the ToT and facilitation skill training, the potential facilitator should demonstrate his/her knowledge and skill through continuous assessment, participation and contributions to the classes and teach back sessions.

Purpose of Participant's Manual

The purpose of this participant manual is to provide participants of the CRC in-service training course with guidance needed and additional information, tools and resources to expand their knowledge and skill-base in CRC. This will make them better practitioners at different levels of the Ethiopian Health System. The handbook will serve as an informational reference resource during and after the training program. The handbook is organized in five informational chapters, as outlined in the Table of Contents addressing relevant themes that respond to the

CRC gaps identified during the training needs assessment. Each chapter contains short narratives and notes on the topic being covered. At the end of each module, handouts and other resources are provided to reinforce learning and provide additional information on different elements of the topic covered in the chapter.

Learning Method:

- Illustrated lectures
- Case Studies
- Group discussions
- Individual or group exercise/reflection
- Role play
- Video show
- Guided clinical observation
- Video tapes and discussion

Learning materials

- Participants , trainer manual and national CRC guideline
- Flip chart , markers
- Laptop computer and LCD projectors
- CD- ROM
- Projection screen
- Masking tape
- Small prize or candy
- Video of CRC and expert patients
- Standardize Power Points

Method of Evaluation

- **Participant**
  - **Formative**
    - Individual learning plans
    - Checking participants' understanding of principles during presentations and learning activities
    - Role-play demonstrated or played
    - Evaluation of participant developed activities and materials throughout the course

  Summative

    - Knowledge assessment (70%) - Post-course questionnaire
    - Participants' activity and participation throughout the course (30%)- participant activity measured during role play, demonstration and guided clinical practice

- Participants will be certified when they score more than 70% for basic training and 80% for ToT in the assessment.

Course evaluation

- Daily Evaluation
- Daily trainer feedback meeting
- Course evaluation

Suggested Course Composition

- A maximum of 25 health professionals
- Three trainers per course will be needed to facilitate this training
- Venue:IST Center

Schedule for compassionate and respectful care training for health workforce in Ethiopia

Day 1	Time	Activity	Duration
Morning	8:30 – 9:00 am	Registration	30 min
	9:00 – 9:15	Welcoming /Opening remark through CRC Program Coordinator	15 minutes
	9:15 - 9:25	Participants introduce each other and expectation	10 minutes
	9:25 - 9:50	Pre Test	25 minutes
	9:50 - 10:30	Introduction to Compassionate, respectful and caring	30 minutes
	10:30- 10:45	Coffee Break	
	10:45- 11:15	Introduction to Compassionate, respectful and caring	30 minutes
	11:15- 11:35	characteristics of CRC health professionals	20 minutes
	11:35- 12:30	Situation of CRC:- benefits, a transformational agenda, national strategy and approach	1 hour
	12:30- 1:30	Lunch	
Afternoon	1:30- 3:00	Introduction to health professional ethics	1 hour, 30 minutes
	3:00- 3:15	Coffee Break	
	3:15- 4:00	Health care ethics principles in practice	45 Minutes
	4:00- 5:20	Preventive Ethics	1 hour, 20 minutes
	5:20- 5:30	Daily Evaluation	
Day 2	**Time**	**Activity**	**Duration**
Morning	8:30 - 9:00	Recap	30 minutes
	9:00 - 10:45	Preventive ethics cont....	1 hour, 45 minutes
	10:45- 11:00	Coffee Break	
	11:00- 12:30	Ethics and law as enablers for CRC	1 hour 30 minutes
	12:30- 1:30	Lunch	
Afternoon	1:30- 3:00	Compassion in care	1 hour, 30 minutes
	3:00- 3:15	Coffee Break	
	3:15- 4:45	Elements of compassionate care	1 hour, 30 minutes
	4:45- 5:00	Daily Evaluation	
Day 3	**Time**	**Activity**	**Duration**
Morning	8:30 - 9:00	Recap	30 minutes
	9:00 - 10:30	Principles of compassionate care	1 hour, 30 minutes
	10:30- 10:45	Coffee Break	
	10:45- 12:30	Threats of compassionate care	1 hour, 45 minutes
	12:30- 1:30	Lunch	
Afternoon	1:30- 3:00	Definition and Concepts of Respectful and Dignified Care	1 hour, 30 minutes
	3:00- 3:15	Coffee Break	
	3:15- 4:15	Principles of Respectful care	1 hours
	4:15- 5:15	Characteristics of disrespectful care	1 hour
	5:00- 5:20	Daily Evaluation	
Day 4	**Time**	**Activity**	**Duration**

Morning	8:30 - 9:00	Recap	30 minutes
	9:00 - 10:30	Threats to provide respectful care	1 hour, 30minutes
	10:30- 11:00	Coffee Break	
	11:00- 12:30	Enabling factors to provide respectful care	1 hour, 30 minutes
	12:30- 1:30	Lunch	
Afternoon	1:30- 3:00	Demonstration of respectful care	1 hour, 30 minutes
	3:00- 3:30	Coffee Break	
	3:30- 5:00	Demonstration of respectful care continued….	1 hour, 30 minutes
	5:00- 5:20	Daily Evaluation	
Day 5	**Time**	**Activity**	**Duration**
Morning	8:30 - 9:00	Recap	30 minutes
	9:00 - 10:30	Guided clinical practice on respectful and Compassionate care	1 hour, 30 minutes
	10:30- 11:00	Coffee Break	
	11:00- 12:30	Guided clinical practice on respectful and Compassionate care cont.…	1 hour, 30 minutes
	12:30- 1:30	Lunch	
Afternoon	1:30- 3:00	Quality of compassionate leader	1 hour, 30 minutes
	3:00- 3:30	Coffee Break	
	3:30- 5:00	Appraise self-practices against in compassionate leadership mirror	1 hour, 30 minutes
	5:00- 5:10	Daily Evaluation	
Day 6	**Time**	**Activity**	**Duration**
Morning	8:30 - 9:00	Recap	30 minutes
	9:00 - 10:30	Systems think for CRC	1 hour, 30 minutes
	10:30- 11:00	Coffee Break	
	11:00- 12:30	Organizational Culture	1 hour, 30 minutes
	12:30- 1:30	Lunch	
Afternoon	1:30- 2:30	leading CRC health team	1 hours
	2:30- 3:30	Mobilizing and Leading stakeholders for CRC	1 hour
	3:00- 3:15	Coffee Break	
	3:15- 4:30	Post-training assessment and final training evaluation	1 hour, 15 minutes

Chapter One: Introduction to Compassionate, Respectful and Caring Health Work Force

Chapter Description:

The purpose of this chapter is to enhance the participants understanding of the Compassionate, Respectful and Caring (CRC) status from global and national perspectives. It also describes the main benefits of CRC and outlines the National Strategy and approach.

Chapter Objective

By the end of this chapter the participants will be able to:

• Describe Compassionate, Respectful and Caring (CRC)

Enabling Objectives

- Explain Compassionate, respectful and caring(CRC)
- Describe the Characteristics of CRC professionals
- To review the benefits of CRC implementation
- Discuss why CRC is a transformational agenda
- Explain the national strategy and approach of CRC

Session outline

This chapter has the following sessions:

- Introduction to CRC
- Characteristics of CRC health professionals
- CRC a transformation Agenda
- The benefits of CRC
- National strategy and approach of CRC

Session 1.1. Introduction to Compassionate, Respectful and Caring (CRC)

Definition of CRC

Session Objective

By the end of this session the participants will able to:

- Explain Compassionate, respectful and caring

Brainstorming on CRC

- What is Compassionate, Respect and Caring (CRC)?
- Time Allowed 15 minutes

Compassion (ሩህሩህ)

Is a feeling of deep sympathy and sorrow for the suffering of others accompanied by a strong desire to alleviate the suffering? Therefore, we can say it is being sensitive to the pain or suffering of others and a deep desire to alleviate the suffering.

To be optimally effective in clinical medicine, every health professional without exception should be technically excellent and practice with compassionate care. However much technical advances in medicine are beneficial to patients, no person who is ill should have to suffer the indignity of a technically competent but uncaring doctor, nurse, or other staff member. Good medical practice has been perennially captured in the phrase “the art of medicine,” which combines scientific-technical knowledge with humanism, defined as the physician’s interest in and respect for the patient as a person experiencing illness.

Too many patients experience de-humanizing and impersonal treatment, so much so that this is now a crisis within healthcare systems, proving destructive not only for patients, but for professionals, families and the systems themselves

Compassion lies at the intersection of empathy (in this case, understanding patients' concerns) and sympathy (feeling patients' emotions). A health professionals' care without compassion cannot be truly patient-centered. Compassionate care addresses the patient's innate need for connection and relationships and is based on attentive listening and a desire to understand the patient's context and perspective.

Figure 1: Dr. Catherine Hamlin with fistula clients. Hamlin Fistula Ethiopia, Addis Ababa: /www.hamlinfistula.org/

Dr Catherine Hamlin spoke in different interviews that show her compassion for fistula patients.

"This has broken my heart. I feel every time I see woman affected by obstetric fistula "how could they do this to me, how could they do this to this poor woman."

Respectful (ተገልጋይን የሚያከብር)

Is the kind of care, in any setting, which supports and promotes, and does not undermine a person's self-respect, regardless of any differences?

The action meanings of the word respect are:-

- Pay attention to
- Honouring
- Avoiding damage e.g. insulting, injuring
- Not interfering with or interrupting
- Treating with consideration
- Not offending

Caring (ተንከባካቢ)

Caring is an intensification of the affective dimension of empathy in the context of significant suffering. It is coupled with effective interventions to alleviate that suffering.

Compassionate, respectful and caring (CRC) - means serving patients, being ethical, living the professional oath, and being a model for young professionals and students. It's a movement that requires champions who identify with their profession and take pride by helping people.

Historical Background of CRC

Compatin is a Latin word meaning to 'suffer with', and as a word it has been with us a long time. Having said that as a word it is not easy to conceptualize and to say whether it is always good, or whether it is sometimes bad.

The term compassion has long association with most major religions and philosophies and taught to include a number of virtues, such as empathy, sympathy, kindness, respect, and perhaps most importantly, actually taking some kind of 'action'.

Compassionate Care within the healthcare setting has received much attention globally; following concerns that healthcare often fails at a fundamental level. Work is in place at a multi disciplinary level to utilize and integrate this concept. The role and importance of a compassionate approach was brought to the forefront in the UK, with the release of the Francis Report. This report, which gained international attention, was based on an inquiry into devastating events at Mid-Staffordshire Hospital and finding that for many patients the most basic elements of care were neglected.

Looking into the Ethiopian context there are many professionals who are compassionate, respectful and caring with the required skills needed. However, a significant proportion of health professionals see patients as just 'cases' and do not show compassion, lack of respect to patients and their families was the common complaint among the community at large and patients in particular .

The health sector transformation plan, in line with our country's second growth and transformation plan (GTPII), has set ambitious goals to improve equity, coverage and utilization of essential health services, improve quality of health care, and enhance the implementation capacity of the health sector at all levels of the system. A focus in quality and equity requires a shift in the status quo to drive improvement at national scale over the next five years.

The sector has identified transformation agendas for HSTP

1. Transformation in equity and quality of health care
2. Information revolution
3. Woreda transformation
4. The Caring, Respectful and Compassionate health workforce

The National CRC Technical Working Group has developed training packages based on_a Rapid Training Needs Assessment (TNA) which shows the awareness of health care providers on compassionate and respectful care was found to be high; however the results of the assessment also demonstrate the poor translation of this knowledge in to practice. In effect, this discovery has brought to light the need for a tailored training aimed at improving the attitudes and skills of health care providers in relation to CRC.

Characteristics of CRC Health Professionals

Session Objective

At the end of this session participant will be able to:

- Describe the characteristics of CRC Health professionals

Group Discussion on Characteristics of CRC

- What are the Characteristics of CRC? Share your Experience?

CRC health professionals have the following four essential characteristics:

1. Consider patients as human beings with complex psychological, social and economic needs and provide person-centered care with empathy;
2. Effective communication with health care teams, interactions with patients and other health professionals over time and across settings;
3. Respect for and facilitation of patients' and families,' participation in decisions and care
4. Take pride in the health profession they are in and get satisfaction by serving the people and the country.

CRC *a* Transformation *Agenda*

Session Objective

At the end of this session participants will be able to:

- Discuss why CRC is a transformational agenda

Think pair share

- Why CRC is transformational agenda?
- Time Allowed 10 minutes

1.3.1. CRC a Transformational Agenda

Helping health professionals' to become compassionate and respectful practitioners remains a major challenge for the health care. Compassionate and respectful care is not only morally and financially essential, but it is required in many countries through national legislation and/or national health policy.

The notion that health care services must be expanded beyond the prevention of morbidity or mortality is only one aspect of the agenda. It must encompass respect for patients' basic human rights, including respect for patients' autonomy, dignity, feelings, choices, and preferences. It must include choice of companionship wherever possible.

Taken from the United Nations human rights declaration, 'All human beings are born free and equal in dignity and rights.' The Ethiopian constitution of human rights article 25 and 26 states that the rights to equality and privacy.

A survey in USA of 800 recently hospitalized patients and 510 health professionals found broad agreement that compassionate care is "very important" to successful medical treatment. (Beth. et al. 2011).

In the Ethiopian health system, there are many health professionals who have dedicated their entire career to public service and are respected by the public they serve. However, a significant proportion of health professionals see patients as just 'cases' and do not show compassion. Lack of respect to patients and their families is also a common complaint.

A three-year report of the Ethics Committee and relevant documents in Addis Ababa showed that 39 complaints were related to death of the patient and 15 complaints were about disability. The committee verified that 14 of the 60 claims had an ethical breach and/or negligence and other study also indicated that forwarding bad words, shouting on patients, mistreatment, insulting and hitting of clients are some of unethical practices showed by the health professionals.

CRC a Transformation Agenda

Studies showed the need for CRC

- Lack of role models in many health facilities.
- Measuring the worth of a profession by how much it pays.
- Senior physicians cancel their outpatient clinics without informing their patients.
- Elective surgeries get cancelled.
- Admitted patients are by default getting the care they need from relatives.
- Nurses, for various reasons, have limited their role to providing injections and securing IV lines.
- Proper counseling during dispensing of drugs is also becoming a rarity.
- The quality of lab tests and the quality assurance process that lab professionals have to take before issuing results is not practiced as expected.

The transformation agenda builds on the fundamental principle of professional identification and creates a movement and champions that serve as role models to transform health care. It has to be noted further that it is necessary to create caring and supportive health care environments for not only patients and families, but for health care providers as well.

The Benefits of CRC

Session Objective

At the end of this session participants will be able to:

- Review the benefits of CRC

Discussion on the benefits of CRC

Who are the beneficiaries of CRC? And what are their benefits

- Time Allowed 15 minutes

THE BENEFITS OF CRC

Table 1.The benefits and beneficiaries of Compassionate and Respectful Care

Beneficiaries	Who	How
First	**Patients**	• When health professionals are compassionate, patients are less anxious • Adherence to medical advice and treatment plans • Compassionate care correlates positively with both prevention and disease management. Diabetic patients, for example, demonstrate higher self management skills when they self-report positive relationships with their providers • Hostile emotional states in patients delay the healing processes • Quality of health professionals –patient communication with increased physical functioning, emotional health and decreased physical symptoms of pain in patients
Second	**Health Professionals**	• Health care Professionals satisfaction with their relationships with patients can protect against professional stress, burnout, substance abuse and even suicide attempts • Burnout is strongly associated with poorer quality of care, patient dissatisfaction, increased medical errors, lawsuits and decreased expressions of compassion • Participation in a mindful communication associated with short-term and sustained improvement in well-being and attitudes associated with patient care • A major predictor of patient loyalty • When health professionals are compassionate, they achieve earlier and more accurate diagnoses because the patient is better able to reveal information when he or she feels emotionally relaxed and safe • Respect from the client/patients • Health professionals will find their work more meaningful and gratifying
Third	**Students**	• Good role modeling is essential for students • Increased motivation to be CRC health professionals
Fourth	**Health care facilities**	• Patient satisfaction will rise • Quality of health care will be improved • Lower malpractice suits • Staff will be more loyal to their hospital or health care system • Patient adherence to treatment will rise • Resources can be conserved • Greater employee satisfaction and reduced employee turnover.

NATIONAL STRATEGY AND APPROACH OF CRC

Session Objective

At the end of this session participants will be able to:

- Explain the national strategy and approach of CRC

The development of caring, respectful and compassionate health workers requires a multi-pronged approach in order to make CRC as a culture, self-driven inner motive and a legacy that the current generation of practitioners leaves to their successors.

National Strategy and Approach of CRC

NATIONAL STRATEGY AND APPROACHES FOR CRC

- *Reforming the recruitment of students for health science and medicine programs.*
- *Improving the curriculum of the various disciplines.*
- *Ownership and engagement of the leadership at all levels of the system.*
- *Inspirational leadership that aims to create an enabling environment.*
- *National, regional and facility level ambassadors.*
- *An advocacy campaign through mass media will also be launched to project positive images of health professionals.*
- *Patients and the general public will also be engaged in this movement.*
- *An annual health professional recognition event will be organized*
- *Putting in place a favorable legislative framework to reinforce CRC which would include regulation on patients' rights and responsibilities (PRR)*
- *Measurement of health care providers on CRC*
- *Comprehensive projects will be designed.*
- *Conducting national assessment related to CRC.*
- *provision of continuous CRC trainings.*
- *Engagement and ownership of professional associations.*

VARIOUS ACTORS

For various actors, their roles and strategies look in to CRC implementation manual.

NB: CRC implementation manual should be printed and given to each participant.

Chapter Two: Health Care Ethics

Introduction:

Professionalism, attitude, behavior and ethics are among essentially minimal competencies required from health professionals. However, health care ethics has not been given as a separate course till recently in the formal educational curriculum of health workers. As the aim of this training module under this chapter the concept of ethics and its basic principles will be discussed. It also explains confidentiality, informed consent, preventive ethics and the relationship between ethics and law. By the end of this chapter, the trainees will have an understanding of ethical principles regarding decisions and treatment that have potential ethical implications; and act as an effective patient advocate with other members of the healthcare team by practicing compassionate and respectful care (CRC).

Chapter Objective

By the end of this chapter the participants will be able to provide ethically acceptable health care services.

Enabling Objectives

After these sessions participants will be able to:	Apply basic concepts and principles of healthcare ethics - Practice confidentiality in CRC - Practice informed consents in CRC model health care practice. - Identify preventive ethics as a standard practice for the health workforce. - Recognize the relationship of ethics and law to exercise CRC

Sessions outline:
• Principles of health care ethics • Confidentiality and informed consent. • Preventive ethics in the aspect of CRC • Ethics and law as enablers of CRC • Ethics and Law as enablers for CRC

2.1. Definitions and principles of health care ethics

Time: 1 hour and 30 minutes

Session Objective:	
At the end of this session, participants will be able to:	- Define ethics and health care ethics - List principles of health care ethics - Apply principles of health care ethics

2.1. Definitions of ethics and health care ethics

What is ethics?

Ethics:

Ethics is derived from the Greek word *ethos*, meaning custom or character. Ethics is the study of morality, which carefully and systematically analyze and reflect moral decisions and behaviors, whether past, present or future. It is a branch of philosophy dealing with standards of conduct and moral judgment.

Health care ethics:

It is a set of moral principles, beliefs and values that guide us to make choices about healthcare. The field of health and healthcare raises numerous ethical concerns, including issues of health care delivery, professional integrity, data handling, use of human subjects in research and the application of new techniques.

Principles of health care ethics

What are the fundamental principles of healthcare ethics?

Ethical principles are the foundations of ethical analysis because they are the viewpoints that guide a decision. There are four fundamental principles of healthcare ethics.

1. Autonomy
2. Beneficence
3. Non-maleficence
4. Justice

Autonomy

Autonomy is the promotion of independent choice, self-determination and freedom of action. Autonomy implies independence and ability to be self-directed in one's healthcare. It is the basis of self-determination, and entitles the patient to make decisions about what will happen to his or her body.

Case one:

A 49 year old client with diabetic finding came with right foot second finger gangrene to a hospital. The surgeon decided that the finger should be removed immediately. But the patient refused the procedure.

Question: How should the surgeon handle this case?

Beneficence

Beneficence is the ethical principle which morally obliges health workers to do positive and rightful things. It is "doing what is best to the patient". In the context of professional-patient relationship the professionals are obliged to always and without exception, favor the wellbeing and interest of their patients.

Example: Giving the correct and necessary information to patients about their condition is considered as a principle of beneficence. In addition, it will promote the autonomy of patients.

Case two:

Ms. X was admitted to Adult Surgical Ward with severe excruciating right flank pain with presumptive diagnosis of Renal Colic. Nurse Y was the duty nurse working that day. The physician who saw her at OPD did not write any order to alleviate the pain.

Question: What should the attending nurse do for Ms.X?

Non-maleficence:

The principle refers to “avoid doing harm”. Patient can be harmed through omitting or committing interventions. When working with clients, healthcare workers must not cause injury or distress to clients. This principle of non-maleficence encourages the avoidance of causing deliberate harm, risk of harm and harm that occurs during the performance of beneficial acts. Non-maleficence also means avoiding harm as consequence of good. In these cases, the harm caused must be weighed against the expected benefit.

Example: Any medical error (either omission or commission) could be considered as breeching non-maleficence.

If a nurse does not give a patient medication timely and appropriately, it could be considered as violating the principle of non-maleficence.

If a laboratory technologist wrongly reports the investigation result, he or she violates the principles of “do not harm” or non-maleficence.

If a hospital finance manager could not release the necessary finances, especially due to negligence, to procure the drugs, equipment or any supply planned and the patient could not get the care due to the scarcity of the necessary material, he or she may violate the principle of non-maleficence.

Justice

Justice is fair, equitable and appropriate treatment. Justice refers to fair handling and similar standard of care for similar cases; and fair and equitable resource distribution among citizens. It is the basis for treating all clients in an equal and fair way. A just decision is based on client need and fair distribution of resources. It would be unjust to make such decision based on how much he or she likes each client.

Example:

- Resource scarcity is the common issue in healthcare settings. For example, there may be only one or two neurosurgeons and many patients on the waitlist who need the expertise of these neurosurgeons. In this case we need to serve patients while promoting the principle of justice in transparent way. Example, the rule of first come first serve could be an appropriate rule.
- Justice requires the treatment of all patients equally, irrespective of their sex, education, income or other personal backgrounds.

Case study

Miss. D, 36 years old, came to a hospital with chief complaints of right flank pain of one year. Up on evaluation, she was found to have right kidney mass and the surgeon scheduled for surgery.

After informed consent, she goes for procedure and a gall bladder stone was removed successfully. After transferred to surgical ward, ward nurse noticed that the procedure performed was not for kidney mass. She informed to the surgeon that the procedure was not for suspected right kidney mass. The nurse told to Miss. D that her first operation was not successful and she needed another operation; however, she did not tell Miss. D about the mistake. Miss. D again gave her consent and underwent the second surgery and renal tumor was removed. She was discharged after seven days of hospital stay.

Discussion points:

1. **Which ethical principles were considered as breached non maleficent?**
2. **Is the nurse and the surgeon did the right thing?**

2.2. Confidentiality and informed consent

Time: 1hour

Session Objectives

After this session participants will be able to:	- Describe confidentiality and informed consent - Practice confidentiality and informed consent in health care

Confidentiality

Confidentiality in healthcare ethics underlines the importance of respecting the privacy of information revealed by a patient to his or her health care provider, as well the limitation of healthcare providers to disclose information to a third party. The healthcare provider must obtain permission from the patient to make such a disclosure.

The information given confidentially, if disclosed to the third party without the consent of the patient, may harm the patient, violating the principle of non-maleficence. Keeping confidentiality promotes autonomy and benefit of the patient.

The high value that is placed on confidentiality has three sources:

- *Autonomy:* personal information should be confidential, and be revealed after getting a consent from the person
- *Respect for others:* human beings deserve respect; one important way of showing respect is by preserving their privacy.
- *Trust:* confidentiality promotes trust between patients and health workers.

The right of patient to confidentiality

- All identifiable information about a patient's health status, medical condition, diagnosis, prognosis and treatment and all other information of a personal kind, must be kept confidential, even after death. Exceptionally, family may have a right of access to information that would inform them of their health risks.
- Confidential information can only be disclosed if the patient gives explicit consent or if expressly provided for in the law. Information can be disclosed to other healthcare providers only on a strictly "need to know" basis unless the patient has given explicit consent.
- All identifiable patient data must be protected. The protection of the data must be appropriate to the manner of its storage. Human substances from which identifiable data can be derived must also be protected.

Exceptions to the requirement to maintain confidentiality

- Routine breaches of confidentiality occur frequently in many healthcare institutions. Many individuals (physicians, health officers, nurses, laboratory technicians, students, etc) require access to a patient's health records in order to provide adequate care to that person and, for students, to learn how to practice care provision.

- Care providers routinely inform the family members of a deceased person about the cause of death. These breaches of confidentiality are usually justified, but they should be kept

to a minimum and those who gain access to confidential information should be made aware of the need not to spread it any further than is necessary for descendants benefit. Where possible, patients should be informed ahead that such a breach might occur.

- Many countries have laws for the mandatory reporting of patients who suffer from designated diseases, those deemed not fit to drive and those suspected of child abuse. Care providers should be aware of the legal requirements to be able to disclose patient information. However, legal requirements can conflict with the respect for human rights that underlies healthcare ethics. Therefore, care providers should look carefully at the legal requirement to allow such an infringement on a patient's confidentiality and assure that it is justified. If care providers are persuaded to comply with legal requirements to disclose their patients' medical information, it is advisable to discuss this issue with their patients the necessity of any disclosure before it occurs and enlist their co-operation.

Case scenario three

An HIV-positive individual is going to continue to have unprotected sexual intercourse with his spouse or other partners.

Question:

1. **How do you manage such an individual?**
2. **Discuss situations that breach confidentiality.**

Ethiopia Council of ministers' regulation 299/2013, Article 77 Professional Confidentiality

1. A health professional may not disclose, verbally or in writing, information regarding a patient unless the appropriate organ believed that there is a prominent health risk to the public demanding to do so, it is ordered by a court, he gets written consent from the patient or the patient's guardian or it is permitted by law .
2. A health professional may release or transfer information regarding patients for the purpose of conducting scientific research or studies where the information released is in such a manner that it does not identify directly or indirectly any individual patient.
3. A health professional shall encourage a patient with communicable diseases to disclose his status to individuals with potential exposure to the infection.

Informed Consent

Informed consent is legal document whereby a patient signs written information with a complete information about the purpose, benefits, risks and other alternatives before he/she receives the care intended. It is a body of shared decision making process, not just an agreement. Patient must obtain and being empowered with adequate information and ensure that he/she participated in their care process.

For consent to be valid, it must be voluntary and informed, and the person consenting must have the capacity to make the decision. These terms are explained below:

- *Voluntary*: the decision to either consent or not to consent to treatment must be made by the person him or herself, and must not be influenced by pressure from medical staff, friends or family. This is to promote the autonomy of the patient.
- *Informed*: the person must be given all of the information in terms of what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments and the consequences of not doing the treatment. This will help to avoid harm—patients may harm themselves if they decide based on unwarranted and incorrect information.
- *Capacity*: the person must be capable of giving consent, which means they understand the information given to them, and they can use it to make an informed decision.

General principle

You should ensure that informed consent be given by a patient before any medical treatment is carried out. The ethical and legal rationale behind this is to respect the patient's autonomy and their right to control his or her life. The basic idea of personal autonomy is that everyone's actions and decisions are his or her own.

Information for patients

Effective communication is key to achieving informed consent. You should take appropriate steps to find out what patients want to know about their condition and what they ought to know about their condition, its examination and treatment.

Every adult patient is presumed to have the capacity to make decisions about their own healthcare. A care provider or health worker has a duty to assist patients to make informed decisions by giving them information in a clear and comprehensible manner; and ensure that they have appropriate support.

A healthcare worker, should consider patients' individual needs and priorities when providing information. For example, a client's or patients' beliefs, culture, occupation or other factors may have a bearing on the information when making a decision. The health worker should ask a patient whether they have understood the information they have received and if they need more information before making a decision. The care provider must answer any questions the patient might have. Also, the care provider must not withhold any information necessary for the patient to make an informed decision unless disclosure would cause the patient serious harm. In this context 'serious harm' does not imply becoming upset or decide to refuse treatment.

Timing of consent process

Obtaining informed consent cannot be an isolated event. It involves an ongoing process of keeping or in pain and therefore less likely to make a calm and reasoned decision. Where possible, you should explain risks well patients up to date with any changes in their condition and the treatments or investigation proposed. Whenever possible, the health worker should discuss treatment options at a time when the patient is best able to understand and retain the

information. It is not recommended to seek consent when a patient may be stressed, sedated in advance of an intervention.

Health Professionals responsibility for seeking consent

Healthcare providers must have full understanding of the procedure or treatment, how it is carried out and the risks attached to it. If the healthcare provider does not have a full understanding of the procedure, he or she should appoint another colleague knowledgeable of the proposed investigation or treatment and understands the risks involved to inform the patient with sufficient information and time to make an educated decision to consent to the procedure or investigation.

Decision making for incompetent patients

Many patients may be incompetent to make a decision for themselves. Example, include young children, individuals affected by certain psychiatric or neurological conditions which potentially impair their decision making ability, and those who are temporarily unconscious or comatose. These patients require substitute decision-makers. Ethical issues arise in the determination of the appropriate substitute decision-makers and in the choice of criteria for decisions on behalf of incompetent patients.

Refusal of treatment

Every adult with power to decide is entitled to refuse medical treatment. The healthcare provider must respect a patient's decision to refuse treatment, even if he or she disagrees with the patient's decision. In these circumstances, the care provider should clearly explain to the patient the possible consequences of refusing treatment and offer the patient the opportunity to receive a second medical opinion if possible

Ethiopia Council of minister's regulation 299/2013, Article 52. Patient's informed consent

1. Medical service may not be provided without obtaining the patient's informed consent
2. Notwithstanding the provision of sub-article 1 of this article, medical service may be provided to a patient without obtaining his/her consent when:
   - **a.** The patient is unable to give his consent and such consent is given by
     - i. A person authorized by the patient in writing to give consent on his behalf;
     - ii. In the absence of a person authorized to give such consent, the spouse, child, parent, brother, or sister of the patient; or
     - iii. A person authorized to give such consent in accordance with the law or a court order
   - **b.** Failure to treat the patient may result in a serious risk to public health;
   - **c.** The patient has not expressly or in any other way refused to get the medical service and any delay in the provision of medical service could result in irreversible damage on his/her health
3. Any health professional shall make reasonable effort to obtain the patient's informed consent
4. The health professional shall explain to the patient who refused to get medical services, the possible risks of his refusal on his health and shall record same in writing
5. A consent given under this article shall be valid when it is obtained from the patient or any other third party in writing , unless it is permitted by directives to be expressed orally or through conduct with respect to specific types of medical services

1.

Case study 2

A 16 year-old female came to public hospital accompanied by her mother for a complaint of absence of menses since two months. Up on examination she gave a history of forced sex with her uncle before two months, but did not tell to anybody. Up on evaluation, she is found to be pregnant. The physician counseled her on the availability of medical abortion service but he needs written consent. And he also advised her to report the incident of forced sex (i.e. rape) to the nearby legal office. But she decided not to report the incident of forced sex. Also she did not want to reveal her condition to her mother despite her mother insisting to know.

Discuss on:

- **How would you manage this case?**
- **How do you address the confidentiality and consent-related issues?**
- **Do you report this case to the legal office?**

2.3. Preventive ethics in the aspect of CRC

Time: 2:30 Hours

Session Objectives	
After this session participants will be able to:	- Explain preventive ethics and its relevance for CRC Identify ethical dilemmas apply systematic ethical case analysis Identify practical support mechanisms for the implementation of preventive ethics Explain healthcare priority setting and rationing fairly and to handle resource scarcity issues

What is preventive ethics?

Preventive Ethics is a systematic application of ethical principles and values to identify and handle ethical quality gaps, dilemmas, challenges and errors to appropriately and fairly. It could be carried out by an individual or groups in the health care organization to identify, prioritize and systematic address quality gaps at the system level.

Currently, litigation is on the rise and the regulatory ethics is being handled systematically by FMHACA. However, particular focus should be given to strengthen preventive ethics to enable the health workforce predict, identify and handle challenges and dilemmas through fairness and equity in a compassionate, respectful and caring culture. Health professionals' knowledge, attitude and skills need to be built in health care ethics.

Why Preventive ethics important for CRC health workers?

First and foremost, the CRC health workforce, patients, families and the community at large should have a common understanding that the experience of illness and the practice of medicine lead to situations where important values and principles come to conflict and ethical dilemmas and challenges arise everywhere. Moreover, the CRC health worker should always understand the context in which She/he operates (like the services, the clients, the providers, values, norms, principles, culture, religions, socio-economic-geographic…) as the way in which ethical dilemmas are handled vary from case to case and place to place.

Preventive ethics helps the CRC health workforce to predict, identify, analyze, synthesize and manage ethical dilemmas, challenges and errors to make the appropriate and fair decisions. Hence, preventive ethics enhances honesty and transparency between healthcare workers, patients, families and relevant

others to make a deliberated joint decisions. Moreover, it inspires mutual understanding and trust amongst the healthcare provider, recipient and the community at large. A CRC health work force positively influences inclusiveness, thereby, fostering joint Ownership and the Sharing of the Burdens and Benefits in the healthcare. At the end of the day, preventive ethics brings all efforts together productively and leads to the satisfaction of clients, providers and the community even if when the decisions are sometimes painful and outcomes are negative.

Step-by-step analyze and identifies the ethical gap:

1. What is the ethical dilemma and alternative actions/rules?
2. What do we know about the outcome of the alternatives?
3. Are there laws, rules or guidelines regulating decision-making?
4. Who are involved stakeholders?
5. What are the stakeholders' potential burdens and benefits?
6. Who's interests are in conflict?
7. What are the values and principles at stake?

Support mechanisms for preventive ethics

Develop functional tool, documentation, case banks, research, and monitoring and evaluation system and use them all for evidence based preventive ethics, including mitigation of medical errors

Priority setting/rationing in health care

The practice of medicine is resource intensive and there is often a gap between demand and supply. Often healthcare systems are required to set priorities and allocate resources within the constraints of limited funding. Decision-makers may not be well-equipped to make explicit rationing decisions. Resources should be understood broadly to include health personnel, time, equipment, infrastructure, medicines, beds, operating rooms and money.

Priority-setting in healthcare is defined as the ranking of health services and recipients of these services through a decision-making process. Rationing is defined as withholding of health services that could be of benefit on the grounds of resource scarcity. Health workforce at policy and institutional levels make explicit rationing decisions for large patient groups and future patients, while those working at clinical levels also have to make decisions at an individual level. In so doing, health professionals must balance multiple roles when being patient advocates, resource managers of institutions and financial risk protection of the patients. The health workforce should play these roles in a CRC manner.

CRC health workforce should have adequate knowledge and attitudes to conduct ethical and fair practice to set priorities and make rationing decisions at all levels of healthcare delivery.

Levels of priority setting

- *International:* WHO guidelines, donor funding, UHC towards SDGs
- *National Macro*: Policy, strategies and guidelines to align national needs and international commitments
- *Meso:* at the facility/institutions
- *Micro:* clinicians rationing by the bedside

Tough decisions takes place by clinicians in the face of scarcity related dilemmas

- Criteria for priority setting:
- Disease-related criteria: severity; realization of potential; past health loss; rare conditions.
- Criteria related to characteristics of social groups: socioeconomic status; area of living; gender; race, ethnicity, religion and sexual orientation.
- Criteria related to protection against the financial and social effects of ill health: economic productivity; care for others; catastrophic health expenditures.

CRC health workforce with good understanding of the above mentioned issues will strive to participate in the planning and decision-making and play out their roles and responsibilities to their best. Research and Monitoring and Evaluation for evidence-based policies and programs

Educate to build capacities and capabilities in preventive ethics:

Teachings in health care ethics pre and in-service, the development and use tools to prevent and handle ethical dilemmas, challenges and errors through trainings, guidelines, frameworks, checklists, flowcharts, critical pathways, for impartial ethical case analysis and appropriate priority setting and rationing is needed

Research, systematic generation and use of information and documenting cases are important undertakings for policy and program design and improvements in healthcare ethics

Ethics consultation

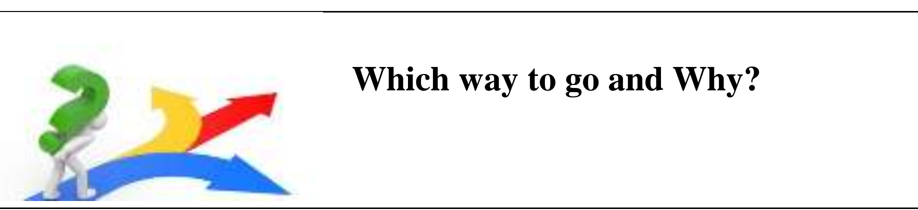
Provide ethics consultations by individual experts, namely through Ethics Consultation Committees and individual ethics experts to healthcare providers

Ethics consultation is a service provided by an individual or group to help patients, families, surrogates, healthcare providers, or other involved parties address uncertainty or conflict regarding value-burdened issues or dilemmas emerging in health care.

Goals of Ethics Consultations:

- To maximize benefit and minimize harm to patients, families, professionals and institutions by fostering fair and inclusive decision-making processes that honors patients' preferences and individual and cultural value differences and dilemmas among all parties
- To facilitate resolution of conflicts in a respectful atmosphere with attention to interests, rights, and responsibilities of those involved
- To inform institutional efforts at policy development, quality improvement, and appropriate utilization of resources by identifying the causes of ethical problems and promoting practices consistent with ethical norms and standards
- To assist individuals in handling current and future ethical problems in a compassionate, respectful, responsible and caring manner by providing education to the health workforce in healthcare ethics

Ethical Dilemmas (ED)



Ethical Dilemmas arise when principles cannot be respected and people disagree on what the best solution is; as legitimate solutions philosophically or practically. The values in conflict must be prioritized as the essence of 'doing ethics' to justify the breaching of the values and principles that are not respected. The choice to be made should be handled systematically, inclusively with due considerations of ethical and practical reasoning and documented in a CRC model health care services.

The following are among common ethical dilemmas encountered in the healthcare:

***Resource Scarcity Related Dilemmas*:**

Health care is resource intensive and there is always gap between demand and supply. This dilemma is a universal phenomenon though particularly severe in low-income countries where there is a large population and high burden of disease. Handling such dilemmas fairly in a companionate, respectful and caring manner should be satisfying to all parties.

1. **Refusal of Treatment:**

   This can happen in many ways including withdrawal from treatment against medical advice for different reasons, because of cultural and/or religious beliefs or personal reasons.

2. Disclosure and Truth Telling Dilemma:

Healthcare providers have the responsibility to tell the truth about the diagnosis, treatment, prognosis and related issues to the patient, parent or legitimate care taker. However, it is quite a common dilemma that relatives of patients come and ask health workers not to tell the truth to the patient with an excuse of protecting the patient from stress. The patient should be allowed to plan his/her life based on firsthand information on his/her health status.

3. End of Life dilemma

Futility is when it is known that all possible efforts would not reverse the patient's condition or patient is brain dead. In such situations, the dilemma of withholding or withdrawal of treatment arises. Health care providers and families get conflicted whether continuing the treatment is actually helping or hurting the patient, prolonging suffering.

1. **Disagreement/conflict:**

   - Amongst colleagues:

     i. The cost of treatment for the patient always matters the CRC health workforce role as financial risk protector for the patient – providing updated information

ii. To save cost for institutions: institutions often want to serve more people with the limited available resources – offering second best treatment, early discharge

iii. A colleague's knowledge and practice is not of acceptable standard and the issue is brought up for possible corrective measures.

- Among patients/professionals and family members:
- Among family members: in case the patient is not able to make decisions (i.e. patient is in coma or has a mental health problem)
    - On consent for procedures…
    - Mostly on treatment cost if it is covered by someone (relatives, friends…) other than the patient
    - withholding and withdrawal of treatment in case of futility

2.4. Ethics and law as enablers of CRC

Time: 1:30 hour

Enabling Objectives	
After these sessions participants will be able to:	• Recognize the relationship between ethics and law • Practice the laws of the land related to health in their daily practice

The relation between Ethics and law

Ethics as discussed in the previous sessions, is considered as a standard of behavior and a concept of right and wrong beyond what the legal consideration is in any given situation.

Law is defined as a rule of conduct or action prescribed or formally recognized as binding or enforced by a controlling authority. Law is composed of a system of rules that govern a society with the intention of maintaining social order, upholding justice and preventing harm to

individuals and property. Law systems are often based on ethical principles and are enforced by the police and criminal justice systems, such as the court system.

Ethics and law support one another to guide individual actions; how to interact with clients and colleagues to work in harmony for optimum outcome; provision of competent and dignified care or benefits of clients/ patients. Ethics serves as fundamental source of law in any legal system; and healthcare ethics is closely related to law. Though ethics and law are similar, they are not identical. Often, ethics prescribes higher standards of behavior than prescribed by law; and sometimes what is legal may not be ethical and health professionals will be hard pressed to choose between the two. Moreover, laws differ significantly from one country to another while ethics is applicable across national boundaries

Health professional code of conduct

The conduct health professionals should practice is clearly put on EFMHAC proclamation 661/2009 and regulation 299/2013. These legal documents explain necessary behaviors the health professionals should adopt. In addition to this regulation, other sources like the penal law, civil law, proclamations and other related regulations are the sources which regulates the health care practice in Ethiopia

The responsibility of health professionals

In healthcare settings, there is often interactions among colleagues and clients. The main responsibility of the health professionals to patients, FMHACA Regulation No. 299/2013, under Article 74, clearly states. Professional responsibilities with respect to patient relationships:

1. Obtain informed consent from a patient, in accordance with the relevant law, before rendering a service.
2. Respect patient confidentiality, privacy, choices and dignity
3. Maintain highest standards of personal conduct and integrity
4. Provide appropriate counselling service to the client
5. Maintain proper and effective communication with his patients and other health professionals
6. Register and keep accurate client records
7. Provide professional service in the working place during assigned duty hours

8. Ensure public participation and acceptance in designing and implementing public health programme
9. Comply with any lawful instructions and procedures of the appropriate

Inter professional communication and teamwork among health workers

Furthermore, healthcare workers support each other for better outcomes, which is supported by ethics (Geneva declaration) and law. The law also indicates the main responsibilities of health professionals (Regulation 299/2013, Article 74, partial) as:

- Provide genuine and adequate information during professional communication with colleagues and clients
- Conduct himself or herself in a professional way in teamwork by respecting the contribution of other health professionals

Duty to report

FMHACA council of minster regulation no -299/2013 under article 95 clearly states that any person who believes that a health professional is unfit to practice or commits unprofessional conduct shall notify the appropriate organ

Case four

Instruction: Read the case below and discuss it under different scenario

Mr. D and Mss. Y are laboratory technologists currently assigned to examine AFB sputum microscopy since the last three months. Mss. Y realized that Mr. D is not following the standard operating procedures examining sputum AFB. Recently the yield of sputum microscopy for AFB has decreased. The laboratory quality control check showed that there is poor quality of AFB slides and some slides which were reported negative actually were positive. The laboratory head called up on them and told the results of quality control check. Miss Y did not report about the observation she made.

Discussion:

a. **What would you do if you were Mss. Y**

Almost all the health workforces practice competently, ethically and legally. Yet, there are very few who do not. Ethics and law is a foundation for providing compassionate care, such care is the aim of treating patients ethically and legally.

Ethical liabilities listed on proclamation 661/2009

- Duty to fully record personal health information generated during each encounter (Art.37)
- Duty to report the existence of professional mal-practice to the appropriate regulatory organ (36).
- Duty to practice in accordance with the standards of healthcare (Art. 34)
- Duty to practice with the scope of professional practice (Art. 34).
- Duty to render emergency medical treatment within the scope of his professional practice (Art. 38).
- If a health professional is not capable of providing the necessary emergency medical treatment, he or she shall immediately refer the patient.
- Duty to perform in accordance with the relevant Code of Ethics (Art. 35).
- No person shall practice as a health professional without having obtained a professional practice license (Art. 33).

Health professional ethics committee

Council of minsters' regulation no 299/2013 Art. 71 establishes the health professional Ethics Committee and its functions. The powers and duties of Ethics Committee include:

- Examine, investigate and propose appropriate administrative measure to the authority (FMHACA) on complaints made with respect to standard health services and incompetent and unethical health professionals
- Where there is sufficient evidence to support the complaint, FMHACA will send summon to the health professional or institution against whom a complaint is made with the notification to respond within 30 days
- Where appropriate, assign an independent researcher in consultation with the authority to investigate the complaint

- May propose suspension of license or certificate of competence to the authority until the appropriate decision is passed on complaint
- Upon identifying the root causes of frequently lodged complaints and grievances, propose policy directions intended to provide sustainable solutions to problems
- Shall perform other duties that may be signed to it by the authority

Process of complaint can begin by presenting to health facilities' complaint and grievance handling committee or directly approaching the health professionals' Ethics Committee.

Unethical acts committed within the health facilities operated by the federal government will be sent to the Federal Health Professional's Ethics Committee. Similarly, those under regional administration will be sent to Regional Ethical Committee.

If Ethics Committee determines validity of the complaint, based on the severity of the act, it might propose one or more administrative measures to be carried out by the authority; including an oral warning or written warning, suspension of the license for a definite period of time, further education to be taken on by health professionals, work to be supervised or withdrawal of his/her license for a limited period of time.

Following the decision of the health professionals' Ethics Committee on matters of professional fault, justice organs will decide whether to proceed with the case for further process. Based on the decision of the health professionals' ethics committee, the courts will make the final decision.

Patient rights and responsibilities

Patient rights

Ethical and legal rationale behind ensuring informed consent is to respect the patient's autonomy and their right to control their own life. The basic idea of personal autonomy is that everyone's actions and decisions are their own. Therefore, the patient has the right to get full information and decide what happens to their own body. Healthcare providers should respect the right of the patient to choose treatment and accept or reject the recommendation provided to him. This is stipulated in Codes of Ethics of different health professions, international documents, as well as in legal documents like regulation 299/2013, directives and standards.

Patient Responsibilities

Every patient shall have the following responsibilities:

- To provide, to the best of the patient's knowledge, accurate and complete information regarding past medical history and issues related to the patient's health, including unexpected changes, to the health professional responsible for the patient's care
- To follow the course of treatment and instructions proposed by the attending clinical practitioner or to accept the consequences if treatment instructions are refused
- To report any changes in his/her condition or anything that appears unsafe to the responsible health professional
- To consider the rights of other patients and to respect their privacy
- To respect patients' caregivers
- To fulfill the financial obligations as promptly as possible
- To keep all appointments and notify health center or the appropriate person when enable to do so
- To observe the health center policies and procedures, including those on smoking, alcohol or drug addiction, cellular phones, noise and visitors
- Be considerate of and not to abuse the health center facilities and equipment
- Not to litter on health center premises
- To sign on "Against Medical Advice Notice" if patient refuses the recommended treatment or intervention

Case scenario

Instruction: Read the case below and discuss it under different scenario

A 31 year old woman, gravida II para I at gestational age of 35 weeks had a regular ANC follow in health center. She requested a midwife to refer her to the nearby hospital. She explained to the midwife she has history of still birth and worried that she would loss this baby too.

Discussion:

a. **If you were that midwife, so you accept her request? If yes why? If no, why?**

Summary:

- Improving the knowledge of ethics is important to boost the ethical behavior in practice.
- To facilitate CRC, ethics and law are tools to exercise CRC.
- Every member of the workforce is expected to work in harmony with a team (i.e. the whole is greater than individual parts).
- Adequate care must be taken so as not to make mistakes. Also, duty to report malpractice is legally mandatory.
- It is important to know and implement patient rights. Hence, obeying the law and ethics will help to be CRC, which in turn will benefit the patient, the health workforce and the facility.

Chapter Three: Principles and Standards of Compassionate Care

Chapter introduction

Humans are living in a very complex World and having more complex life, where many open questions are unanswered even in the 21st century of the scientific World. The World is changing and the phase of medicine is also changing, Neuropsychology: in 2009 experimental study at the Brain and creativity institute showed that compassion for social and physical is activated in the anterior insula, anterior cingulate and hypothalamus this is the same area of the brain associated with pleasure and reward. In almost all religions compassion is considered as the greatest virtues.

The center for compassion and altruism research and education /CCARE/ Stanford University states that “the cultivation of compassion is no longer a luxury, but a necessity, if our species is to survive.

Chapter objective

After completing this chapter the participants will be able to demonstrate the principles and standards of compassionate care

Enabling Objectives

By the end this chapter the participants will be able to:

- Discuss qualities of compassion in care
- Analyze elements of compassionate Care
- Practice principles of compassionate care
- Analyze threats to compassionate care
- Evaluate the status of compassionate care practice at health facilities

Session outline
• *Qualities of* compassionate care • Elements of compassionate care • Principles of compassionate care • Threats to compassionate care • Compassionate care practice

3.1. Quality of Compassionate care

	At the end of this session participants will be able to:
Session objective :	Define compassionate care
	Identify the characteristics and qualities of compassionate care

Compassion can be defined as: 'A sensitivity to the suffering of self and others with a deep wish and commitment to relieve the suffering '

Developing more compassion can be a way to balance emotions to increase the well-being of patients, healthcare professionals and facilitation of healthcare delivery. For patients, compassion can help prevent health problems and speed-up recovery. Compassion can improve staff efficiency by enhancing cooperation between individuals and teams and between patient and healthcare professionals.

Brainstorming Activity:

Can compassion be trained and learned?

Time Allowed: 10 Minutes

Evidence points to the possibility of learning to care by doing!

Evidence:-

A new study by researchers at the Center for Investigating Healthy Minds at the Waisman Center of the University of Wisconsin-Madison shows that adults can be trained to be more compassion.

The study reported that compassion, like physical and academic skills, appears to be something that is not fixed, but can be enhanced with training and practice.

3.1.1. Qualities of Compassionate Care

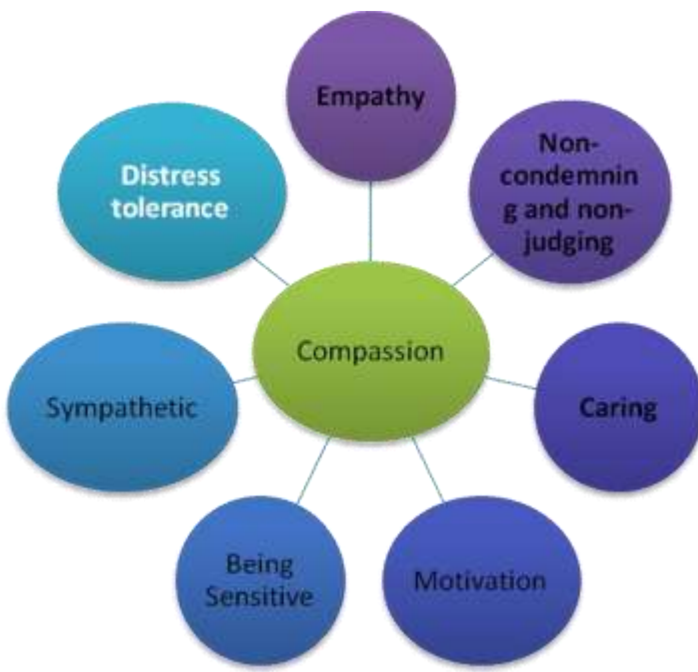


Figure 1: Qualities of compassion

- **Motivation:** Making a decision to be compassionate, and it is the commitment to try to do something about the compassionate care.
- **Being sensitive:** Making an effort to train one's mind to become ***sensitive*** to feelings and thoughts will heighten sensitivity to one's needs. It is difficult to be self-compassionate if one is completely insensitive to feelings of pain, sadness, want or needs. One must learn to notice one's thoughts and feelings as they come about. However, sensitivity does not mean merely react to situations without thought or reflection. To be sensitive means 'openness and ability to recognize and listen in appropriate ways'.
- **Sympathetic:** Compassion requires one to be emotionally open to one's suffering, as well as to the suffering of others. To be sympathetic is to be emotionally affected by suffering of others. Sympathy is an emotional reaction to one's own and other people's emotions and states (e.g. flinching when one sees someone fall. Sympathy can also be expressed by the feeling of joy over the well-being of others.

- **Empathy:** Understanding and how one perceives one's feelings and thoughts is to empathize. To be open and curious helps one to understand how one feels, what one feels and why.

  When we have empathy for others we try to understand the situation from their point of view, what others are thinking and how it may be different. Showing empathy requires work. For example, if client is shouting and complaining on you but you realize that they were under enormous stress and pain and then you don't take it personally and you forgive them: you are showing empathy. Compassion and empathy are closely related but the two terms cannot be used synonymously. Empathy is the ability to sense feelings or concerns of others; this often leads to compassion, which is a feeling of concern for the sufferings or misfortunes of others. Compassion leads to an act of trying to alleviate suffering or misfortune.

- **Distress tolerance:** To be open to feelings, one must accept them. There are a number of different feelings ranging from being sad, angry or anxious and joyful. Some examples of reactions to feelings is sometimes to be critical, to run away from them, to hide or suppress them; but when one is compassionate, it is easier to be open, tolerant, accepting of different types of feelings . Therefore an important aspect of compassion is to learn how to tolerate and come to terms with, become familiar with, and less frightened of, one's feelings. At the same time, however, it is possible to change one's feelings for people, different events or even one's own person.
- **Not to condemn or judge:** The suffering mind, for example, can be filled with condemning and critical thoughts of one's self or others. Letting go of these negative thoughts is linked to becoming kind and mindful; we become more aware of thoughts and feelings from an observational point of view. We should not judge them, nor try to suppress them or push them out of our minds, avoid or run away from them (this means, we have to accept as they are). Rather, one should

learn to reflect more and not react too hastily. These abilities can be developed incrementally. These positive reflections are engaged with the feelings of warmth and a genuine desire to relieve suffering and increase growth and flourishing.

- **Caring:** Promotes compassion. Because the action of caring has the potential to alleviate individual suffering. Care is the "action and activities directed towards assisting, supporting or enabling another individual **or** group with evident or anticipated needs to improve a human condition or life way or to face death".

Role play on <u>Qualities of compassionate care</u>

Duration: 15 min

Learning Objectives

Participants will be able to identify characteristics of compassion

Instructions:

One participant will take the role of a healthcare provider and another participant will take the role of a mother [with limited mobility] of a sick child with a feeding problem. Other participants should observe and note the discussion.

Roles

1. Healthcare provider
2. A mother (with limited mobility) of a sick child:

Situation:

A mother with limited mobility brings her 3-month-old baby girl with cough and fever to the outpatient clinic. The healthcare provider seemed tired. By the time the mother enters the examination room, he was talking with his subordinate about last night's football game. He had already noticed her but did not let her to sit. Her child was crying and she was trying to quiet her.

All of a sudden the healthcare provider shouted loudly at the mother to quiet her child or they would have to leave.

While waiting and calming her child, the mother told the healthcare provider that her child is very sick and needs an urgent care. While facing to his friend, the healthcare provider told the mother that he would see her child in five minutes.

After waiting for 10 minutes, the healthcare provider started to examine the child and felt sad about the condition of the child; apologized to her for having let her wait so long. The healthcare provider evaluated the child gently, gave the child a proper treatment, reassured the mother, and the child went home better.

Discussion Questions

1. Did the health provider demonstrate the characteristics of compassion?
2. If not, what are the areas /conversation that show poor characteristics of compassion?
3. If yes, what are the areas /conversation that show good characteristics of compassion?

Time allowed: 30 minutes

3.2. Elements of compassionate care

	At the end of this session participants will be able to:
Session objective -	Explain elements of compassionate care
	Demonstrate relational communication

According to researches the key elements of compassionate care has seven categories, each contains theme and subthemes.

1. **Virtue**

It is described as ‘‘good or noble qualities embodied in the character of the health care provider. Specifically, patients felt compassion stemmed from virtues of genuineness, love, honesty, openness, care, authenticity, understanding, tolerance, kindness, and acceptance. Compassion is predicated on health care provider virtues, independent of patient behavior, relatedness, or deservedness.

2. **Relational space:**

Relational space is defined as the context and content of a compassionate encounter where the person suffering is aware of and is engaged by, the virtues of the health care provider. The intent and depth of the health care provider-patient relationship was a defining feature of compassion, extending beyond simply acknowledging and understanding the needs of the patient to relating to them as a fellow human being and actively engaging their suffering.

The category of relational space comprised two themes.

- Patient awareness which describes the extent to which patients intuitively knew or initially sensed health care provider capacity for compassion.
- Engaged care giving which refers to tangible indicators of health care provider compassion in the clinical encounter that established and continued to define the health care provider-patient relationship over time.

3. Virtuous Response

It is the “Enactment of a virtue toward a person in suffering,’’ and it is both an individual category and an overarching principle of care that functions as a catalyst to the three core categories of compassionate care giving: ‘‘**seeking to understand, relational communicating, and attending to needs**’’ The category of virtuous response contain three broad themes within it:

- **Knowing the person** refers to the extent to which healthcare providers approached their patients as persons and view their health issues and suffering from this point of view.
- **Seeing the person as priority** involves healthcare providers’ ability to priorities patient needs, setting aside their own assumptions and healthcare system priorities in the process.
- **Beneficence** refers to healthcare providers wanting the best for the patient, informing the three more targeted core categories of compassionate care giving.

4. **Seeking to Understand**

Seeking to understand refers to healthcare providers trying to know the patient as a person and his or her unique needs. Health care providers’ first act is to know and prioritize the patient as a person by pursuing a deeper understanding of the person and his or her unique illness experience to better diagnose the patient. Being seen as a disease, rather than a person living with a disease, is experienced subtlety and infrequently. When patients are seen as mere diseases, however, this has a detrimental effect on the relationship between the caregiver and well-being of the patient. The need to understand a person’s desires and tailor his or her care is identified by most patients as a fundamental feature of compassion.

- Seeking to Understand the Person.
- Seeking to Understand the needs of the Person

5. **Relational Communication**

The category of relational communication is an important element of compassion identified by patients consisting of verbal and nonverbal displays conveyed by the healthcare provider's engagement with the person suffering. There are four specific themes and associated subthemes that convey compassion within clinical communication:

- **Demeanor**(''being''): refers to the disposition of healthcare provider that is conveyed through nonverbal communication, such as body language, eye contact, tone of voice, posturing and expressions. Demeanor is closely related to ''patient awareness'' within the category of ''relational space''. It is more sensory-based and contextual to clinical communication.

- **Affect** (''feeling for''): describes the extent to which healthcare providers actively connects with their patients' emotions; as well as their influence over the process. In relation to compassion, affect is characterized by vulnerability and action, requiring healthcare providers to enter the relational space and position themselves; to be in the ''patient's shoes'' as clinical information is being shared.
- **Behaviors** (''doing for''): associated with relational communication and the use of interpersonal skills in clinical communication, which convey compassion. Compassion- related behaviors vary in expression; behaviors share a commonality that distinguish them from general caring of health care providers to give not only of themselves as a professional but as a person. The primary behaviors associated with relational communication is described by patients as showing respect; physical displays of caring; and listening and supportive words.
- **Engagement** (''being with''): refers to the degree to which patients feel healthcare providers are actively present in the clinical encounter.
    - The first aspect of engagement is attentiveness through nonverbal actions (e.g. sitting versus standing at the patient's bedside) and temporal indicators (e.g. communicating regularly with patients about their needs or communicating potential health issues to other members of the patient's care team).
    - Acknowledgment, the second essential aspect of engagement, involves recognizing the personal impact of suffering, reflecting back to the patient, and integrating this information into subsequent interactions.

- The final aspect of engagement is dialogue, which consists of healthcare providers communicating clinical information accurately and sensitively, including the effective use of silence and allowing patients to participate in the clinical conversation.

- **Attending to Needs**

It refers to ‘‘a timely and receptive desire to actively engage in and address a person’s multi-factorial suffering’’.

Attending to patients’ needs has three interrelated themes:

- **Compassion-Related Needs:** refers to the dimensions of suffering that patient feel compassion: physical, emotional, spiritual, familial and financial. Compassionate healthcare providers are those who, regardless of their scope of practice, is willing to actively attend to a patient’s immediate needs.
- **Timely** refers to addressing suffering in a ‘‘timely’’ manner. It has dual understanding of time, referring to both the desire of healthcare providers to address suffering in a responsive manner and at an opportune moment.
  - The responsive dimension of time is frequently referred to as acute suffering (e.g. a pain crisis)
  - The opportune aspect of time is associated with situations where healthcare providers seek to sensitively address protracted suffering, which includes addressing existential distress or sharing prognostic information at a time when patients are most receptive and supported to receive it (e.g. such as breaking bad news when family is present or discussing prognostic information over time).
- **Action** refers to the initiation and engagement of a dynamic and tangible process aimed at alleviating suffering. Compassion is more action.

- **Patient-Reported Outcomes**

The impact of compassion on patients who are suffering is profound. Patient-reported outcomes refer to the effect of compassion on suffering, patient well-being, and care.

- Although some patients feel that compassion directly improves the health outcomes, compassion primarily enhances patients’ well-being and the quality of their relationship with their healthcare providers.

- These experiences have an equally enduring effect on their well-being and the care-giving relationship, often exacerbating suffering in the process.

Case study: Attending needs

Discuss the following case in your group and answer the follow questions:

A 28-old female patient arrives to tertiary referral health facility after traveling on the road for three days from a rural area with the complaints of recurrent breast ulcer, which was initially diagnosed as an allergy by local and regional health facility s. At the local and regional health facility s, she was given an anti-allergy treatment, which gave her temporarily relief. She was worried if her condition would change to cancer, and consulted her relatives. With the advice of relative, she came to Addis Ababa for care & treatment with referral paper. She expected accurate diagnosis, better treatment to cure her condition, as well as medical advice. She was told to register to private wing service of the health facility to get specialized service from specialist and to address her needs more adequately. To get this service, she went to the health facility early morning and received attention in the afternoon. After she arrived, the physician asked her to show the ulcer; he immediately told her that "This was an allergy and I'm going to give ant-allergy treatment"; and wrote the prescription. She wanted to tell the full story and her expectation. The doctor was not interested; and just gave her the prescription. The patient told him that she had already taken these medications and she wanted another examination. Then, the physician got upset and he reluctantly rechecked her.

Follow up Questions:

- **What was the need of the patient?**
- **Which element of compassionate care is missing?**
- **How should have the treating physician behaved in order to be compassionate in this case?**

Time allowed: 30 minutes

Role Play: Relational communication

Learning Objective: Enable participants to apply relational communication skills.

Time – 30 min

Instruction: Demonstrate the following role-plays of Relational Communication skills. One facilitator should play the role of the client and the other should play the role of the healthcare provider.

Situation: In a busy outpatient department where the healthcare provider is interacting with the patient.

Role: The "Healthcare provider" should say exactly the same words *"Good morning, Addis. How are things going for you today?"*—to the "client" each time, demonstrating first the positive and then the negative aspects of Relational Communication.

Demeanor: Posture, tone of voice, eye contact

Positive: Sit so that your head is level with the other person's. (posture)

- Look at the person and pay attention as he/she speaks (Eye contact)
- Remove the table or computer and talk.
- Make client feel that you have time. Sit down and greet him or her
- do not hurry the intake; then just quietly smile, watching the person and waiting for him/her to answer. (Taking Time)
- Speak humbly and in a Calm tone of voice (Tone of Voice) Negative: Stand with your head higher than the other person.
- Look away at something else or down at your notes.
- Sit behind a table or write notes while you speak.
  - Act hastily. Greet the person quickly, showing impatience and looking at your watch. Speak in angry voice

Engagement: attentiveness, acknowledgment, dialogue (accurately and sensitively)

Positives:

HW: Good morning, (name). I am (name), the health worker. How are you feeling today? Client: *I'm well, but I don't have much appetite.*

HW: Tell me, what have you been eating?

Client: *I've had some porridge this morning. I'm not sure what I will have later on.*

HW: Mmm (nods, smiles)

Client: *Well, I was a bit worried the other day, because I had diarrhea*

3.3. Principles of compassionate care

The universal principles of compassion will help us know one another in a more meaningful way where we discover one another respectfully.
They create the conditions that allow a person who is suffering to experience the healing power of compassion.

Session Objectives

At the end of this session participants will be able to :

- List principles of compassionate care
- Discuss principles of compassionate care
- Apply principles of compassionate care

	What are the principles of compassionate care?

1. **Attention** is the focus of healthcare provider. Being aware will allow the healthcare provider to focus on what is wrong with a patient; or what matters most to the patient.
2. **Acknowledgement** is the principle of what the healthcare professional says. The report of the examination or reflection on the patient's message. Positive messages of acknowledgment are buoyant; they let someone know that you appreciate them as a unique individual.
3. **Affection** is how healthcare providers affect or touch people. Human contact has the ability to touch someone's life. It is the quality of your connection, mainly through warmth, comfort, kindness and humor. Affection brings joy and healing.

4. **Acceptance**- is the principle of being with mystery – how you stand at the edge of your understanding or at the beginning of a new experience, and regard what is beyond with equanimity. It is the quality of your presence in the face of the unknown, in the silence. Like the sun in the north at midnight, acceptance welcomes the mysteries of life and is at peace with whom we are and where we are, right now. It is the spirit of Shalom.
    - The principle of acceptance is: being at peace with the way things are allows them to change.

3.4. Threats of Compassion

What factors threaten the provision of compassionate care?

Time: 90 min

Session **Introduction**

There are factors preventing compassion and compassionate behavior for individual members of staff, teams and units and health facility. Most research discusses compassion at the individual level. In general, the most common threats for compassionate care are:

- Compassionate fatigue
- Unbalanced focus between biomedical model (clinical training) and person
- Stress, depression and burnout
- Overall health facility context

After this session participants will be able to describe compassionate fatigue

Role play: On Principles of Compassionate care

Learning Objectives: participants will be able to:

Demonstrate principles of compassionate care

Instructions: One participant will take the role of a healthcare provider and another participant will take the role of an adult patient with a chronic irritability. Other participant should observe and note incorrect practices of principles of compassionate care.

Role players

1. Healthcare provider
2. Adult patient Situation:

A chronically ill adult patient is admitted to the medical ward. The healthcare provider was following him for the last few days and gave him an advice on nutritional management. Now the healthcare provider will ask some questions about how the person is adhering with his advice.

Healthcare provider: How are you feeling today?

Patient: Not better. I have not been sleeping well and have cough.

Healthcare provider: Are you taking your medication as prescribed?

Patient Yes, I am taking my medication as prescribed

Time: 15 min

3.4.1. Compassion Fatigue

- Physical, emotional and spiritual fatigue or exhaustion resulting from caregiving that causes and a decline in the caregivers' ability to experience joy or feel and care for others.

- A form of burnout, a kind of "secondary victimization" what is transmitted by clients or patients to care givers through empathetic listening.

3.4.2. *Unbalanced Focus in Biomedical Model in Clinical Training*

Medical training and practice for healthcare professionals are usually based on biomedical model with little emphasis on developing characteristics of compassion. The biomedical model explains and focuses on disease in scientific, pathological and physiological terms.

Effective clinical care is clearly fundamentally important, but human aspects of medicine and care must also be valued in training and in terms of how to be a good healthcare professional. Without emphasis on also the human aspect of medicine, there is a risk that professionals detach themselves from the patient's distress and personal circumstances and ultimately mistreats the patients

3.4.3. *Stress, depression and burnout*

- **Self-reported stress** of health service staff is reported greater than that of the general working population. Evidence suggests that depression and high stress affect the performance of staff in a variety of ways, including problems in memory, decision-making, concentration, as well as potentially leading to abuse of alcohol and other drugs, and decreases the ability to perform compassion.

- **Burnout** (or **occupation burnout)** is a psychological term referring to general exhaustion and lack of interest or motivation to work.

Activity on Sign and symptom of compassion fatigue and burnout

What are the signs and symptoms of compassion fatigue and burnout?

Situation: You are a head nurse working in a busy ward. It is been one year since you became a leader in the ward. This week you have started to notice that one particular hard working, punctual and motivated nurse came to work later, just after morning medication administration time. For the next two days the nurse arrives late, looking depressed, tired and irritable, as well as dressing inappropriate. The next day, the nurse complained about headache and requests anti-pain medication. You are growing concerned and wondering what would be the cause.

- What will be the other signs and symptoms of compassion fatigue and burnout?
- Have you ever experienced any compassion fatigue?
- Please share what you have felt and write the signs and symptoms of compassion fatigue and burnout on a paper and explain to fellow participants.
- How did you handle the situation?

Duration: 20 minutes

3.4.4. *Wider health facility Context*

Attention by senior managers and health facility boards to achieve financial balance that affects priorities and behaviors of staff in health facility. If finance and other internal stakeholders are not perceived as being primarily important, it can have a negative effects on the whole achievement of the health facility and hampers the value of compassion.

3.4.5. *Addressing Threats of compassion*

	Group activity: on addressing the threats of compassion Think-pair-share: How can we overcome the barriers of implementing compassion? Write down your answers on a piece of paper and discuss with your fellow participants next to you. Duration: 15 minutes

Overcoming compassion fatigue: Compassion focused exercises and imagery is designed to try and create feelings to stimulate a particular kind of imagery. We can try to stimulate more compassionate responses in a number of ways. For example,

Developing an inner compassionate self: Focusing on creating a sense of a compassionate self, just like actors do if they are trying to carry out a specific role.

Compassion to yourself: This is linked to developing feelings, thoughts and experiences focusing on self-compassion. Life is often very difficult and learning how to generate self- compassion can be helpful during these times, particularly to help understand emotions.

Mind full: self-compassion breathing exercise:

5 Easy steps for deep breathing exercise:

- Lie down in a comfortable, quiet place. Allow yourself to be free from distractions for at least 5-10 minutes.
- Give yourself a moment to start relaxing your muscles. Seek out places that are holding tension and release it.
- Breathe in and out through your nose, inhale deeply, filling your lungs with air. Bring the air into your abdomen, not just your chest. Count slowly to five as you inhale. It may

help to place a hand on your belly to feel it fill with air. Each breath should extend all the way down to your pubic bone.

- Exhale deeply, emptying your lungs completely. Again, count slowly to five as you exhale. As you exhale, release tension from your muscles.
- Continue to inhale and exhale deeply for several minutes, counting slowly to five each time. Concentrate on your breathing and counting. Let your mind take a break from distractions.

Teaching compassion to professionals through, training and education

Healthcare professionals' role is to increase compassion in healthcare. Training of health professionals should focus on aspects of care that are important in establishing a good relationship with patients.

Dealing with staff stress and burnout

Ways to address staff stress may include providing preventive strategies, including creating regular support groups or stress management workshops for health professionals or suggesting taking time outs. These preventive interventions can run parallel to secondary strategies including counseling and occupational health services. These strategies will also help to improve patient care.

Dealing with wider health facility context: As health facility s cope with increasing patient demand and higher levels of patient need, it becomes even more important to address issues of humanity within the process, dealing compassionately with staff so that health facility staff can do the same for patients.

Case study on Stress, burn out and coping mechanism

Instruction: Read the following case study and answer the questions in groups.

Choose one person in your group to share your answers with the larger group.

Betty is a team leader in an inpatient ward at Amanuel Psychiatric Health facility. Because of recent staff shortages, she has been required to work double shifts with high patient-to-staff ratios. She previously felt good about her job and confident that, even though her patients were severely impaired, she was making a difference in their lives. Lately, however, she has been emotionally and physically exhausted and cannot seem to relax. She has been having nervous, headaches, stomach pains, mood swings, explosions of rage and bursting into tears

To cope with the stress, Betty has become distant and detached from her team members and patients. She does not actively engage with her co-workers during her shift and has insufficient time to meet all of the needs of the patients. She has expressed her frustration and anger during nursing handing over when discussing cases, verbally accusing her co-workers of leaving work unfinished.

Because of her reactions, Betty's co-workers have complained to their supervisor about her attitude. Betty knows she is not managing the situation well, but the stress of the job and lack of support from her supervisor are exhausting. She feels angry, trapped, insecure, inadequate overworked, underappreciated, as well as fearful she will lose her job. **Discussion questions**

1. **What is the consequence of burn out and stress?**
2. **What are the signs and symptoms of stress and burn out?**
   What would you do differently if you were Betty?

Time allowed: 30 minutes

Checklist for Compassionate care

Put √ under yes column if the procedure is correctly performed and Put √ under No column if the procedure not performed

S/No	Task or activity	Yes	No	Remark
1	Does the healthcare provider properly introduce himself/herself and status?			
2	Does the healthcare provider introduced her/his name to the client			
3	Does the healthcare provider called the client by name?			
4	Does the healthcare provider actively listening what the client is saying?			
5	Does the healthcare provider showed love and tolerance?			
6	Does the healthcare provider try to understand the clients' need?			
7	Does the healthcare provider actively understand patients' emotions?			
8	Does the healthcare provider show relational communication?			
9	Does the healthcare provider use supportive words?			
10	Does the healthcare provider respond promptly and Professionally when the client asks questions?			
11	Does the healthcare provider try to address the various need of the client (i.e. psychological, social, spiritual, physical…..)?			
12	Does the healthcare provider involve the client in treatment options?			
13	Does the healthcare provider check the client frequently?			
14	Does the healthcare provider frequently communicate and collaborate with the healthcare team regarding the client treatment?			
15	Does the health care provider breaks the bad news when family was present or titrating prognostic information over time?			

Chapter Four: Respectful Care

Session time: 60 minuets

Chapter Introduction

This chapter is divided in to five major sessions. The first defines dignity and respect concepts as it applies to health care settings. The second session describes the seven core principles of respectful care so as to guide actions and responsibility of care providers in ensuring dignified care for their service users. The third session describes the commonest forms of disrespect and abusive care in health care setting. The fourth session will enable participants to understand the key factors that affect the provision of respectful care. The fifth session enables participants to demonstrate different components of respectful care

Chapter Objective

By the end of this chapter the participants will be able to demonstrate the principles of respectful care

Enabling Objectives	
After this sessions the participants will be able to:	- Define respect and dignity - Discuss principles of respectful care - Differentiate respectful and non-respectful care - Demonstrate principles of respectful care - Analyse the challenges and threats to provide respectful care - Analyse the enabling factors to provide respectful care - Reflect on their experience during clinical guided practice with regard to respectful care

Session outline

- Definition of Concepts of Respectful and Dignified Care
- Principles of Respectful Care
- Characteristics of Disrespectful Care
- Factors affecting Respectful Care Provision
- Demonstration of Respectful Care

Session introduction:

People are seeking health care services when they are most vulnerable; when they are feeling weak , when they have to expose personal parts of themselves (their bodies and minds) to inspection and handling by health care providers. Because people are to the loss of their dignity, it is important that it's recognized and protected. This session will define dignity and respect concepts as it applies to health care settings.

Session objective

After this session the participants will able to:

- discuss the concepts of dignity and respect
- describe types of dignity

"People must learn to hate and if they can learn to hate, they can be taught to love"

Nelson Mandela

1. Can you share us your experience with regard to respect and dignity in the health care setting?
2. What does respectful care mean to you?

Case scenario on dignified and respectful care

W/t Z, a lady in her 26th week of pregnancy, went to a district hospital and asked a physician to perform an abortion since the pregnancy happened because of rape. The physician performed the abortion in the hospital based on the existing law. However, a fetus was delivered because of the above mentioned abortion was alive. Even though the estimated weight of the premature infant was less than 950 grams, there was a possibility that the infant could continue to develop. Unfortunately, the hospital lacked facilities and equipment required to provide medical care for premature infants, for example incubators; however, the physician could try certain life saving measures to the best of his ability. Nevertheless, he left the infant unattended and provided no measures necessary for the infant to survive and didn't attempt a referral to the nearby specialized hospital which is 200 km far with accessible transportation. As a result, the infant died 48 hours after birth.

Questions for discussion

1. **How do you see this case in terms of dignified and respectful care?**
2. **Should the physician have acted differently? If yes how? If no, why?**

Definition of Dignity (ልእልና)

The word dignity originates from two Latin words: 'dignitus' which means merit and 'dignus' meaning worth. It is defined from two perspectives:

- Dignity is a quality of the way we treat others.
- Dignity is a quality of a person's inner self.

Types of Dignity

There are four types of dignity: dignity of human being, personal identity, merit and moral status.

1. Dignity of human being

This type of dignity is based on the principle of humanity and the universal worth of human beings their inalienable rights-which can never be taken away.

2. Dignity of personal identity

This form of dignity is related to personal feelings of self-respect and personal identity, which also provides the basis for relationships with other people.

3. Dignity of merit

This is related to a person's status in a society.

4. Dignity of moral status

This is a variation of dignity of merit, where some people have a personal status because of the way they perceived and respected by others.

N.B. Refer to Hand-out 3.1 for details.

Attributes of Dignity

There are four attributes of dignity:

1. **Respect:** self-respect, respect for others, respect for people, confidentiality, self-belief and believe in others
2. **Autonomy:** having choice, giving choice, making decisions, competence, rights, needs, and independence
3. **Empowerment**: Feeling of being important and valuable, self-esteem, self-worth, modesty and pride

4. **Communication (may be verbal or non-verbal):** explaining and understanding information, feeling comfort, and giving time to the patients / families

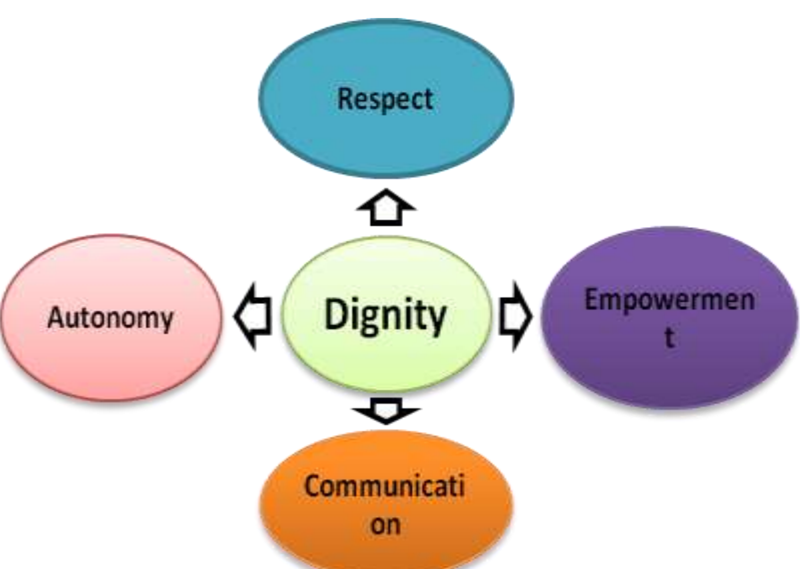


Figure 4.2. Attributes of dignity

Definition of Respect (አክብሮት)

- It is a term which is intimately related to dignity
- It is probably the most important action verb used to describe how dignity works in practice.

- **The action meanings of the word respect are:**
  - **Pay attention to**
  - **Honouring**
  - **Avoiding damage e.g. insulting, injuring**
  - **Not interfering with or interrupting**
  - **Treating with consideration**

Therefore, dignity is brought to life by respecting people:

- Rights and freedoms
- Capabilities and limits
- Personal space
- Privacy and modesty
- Culture
- Individuals believes of self-worth
- Personal merits
- Reputation
- Habits and values

People can vary by their skills, educational background, gender, age, ethnicity, and experiences. But, as human being, all are entitled to get dignified and respectful care. Every human being must respect others and get respect from others.

Figure 4.3. Rank by achievement and Dignity

Dignity and respect in the health care setting

Treating clients with dignity implies treating them with courtesy and kindness, but it also means:

- Respecting their rights
- Giving them freedom of choice
- Listening and taking into consideration what they say and
- Respecting their wishes and decisions, even if one disagrees.

Treating clients with dignity implies being sensitive to clients' needs and doing one's best for them, but it also means:

- Involving them in decision making
- Respecting their individuality
- Allowing them to do what they can for themselves and
- Giving them privacy and their own personal space

Session summary

- In all health care settings, clients must be treated equally irrespective of their social, economic, political, racial, or any other background and without any discrimination.
- Dignity of human being is the basis for healthcare delivery
- Clients should be treated as human being not as cases
- Clients must be called by their name and it is also important to ask their preference. However, they shouldn't be called by their cases.

4.2. Principles of Respectful Care

Time: 45 minutes

Session Introduction

The principles of respectful care guide actions and responsibility of care providers in ensuring dignified care for their service users. This session will describe the seven core principles of respectful care

Think of a person who gave you the most respectful care/service.

- Describe the situation?
- What are the qualities of that person?
- What did you value most?

Session Objectives

At the end of this session participants will be able to :	- Explain the principles of Respectful Care - Explain the current client care habit

The principles of respectful care guide actions and responsibility of care providers in ensuring dignified care for their service users. Dignified care has seven core principles.

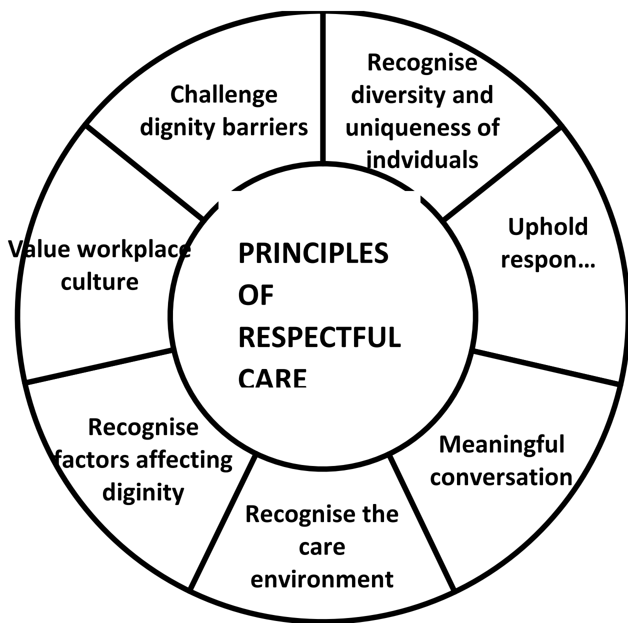


Figure 4.4. Principles of respectful care

Core Principle 1: Recognize Diversity and the Uniqueness of Individual

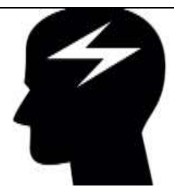
Respect and dignity may have different meaning to different people based on their culture, background, values and beliefs. Diversity of clients/ patients / in terms of ethnicity, religion, belief, culture, language, age, gender, disability , mental status , and social conditions shall be taken into account when we assess , examine ,diagnosing , plan and manage any health condition.

Health care providers must fully appreciate the need to ensure that services are provided in a way that respects individuality as well as the ways in which personality impacts on user's perceptions of the services that are provided. Health care providers themselves shall understand the impact of their own personal values beliefs could impact the practice of care.

	Group work: (5minutes) **In your group discuss the implications of health care provider personal values on provision of abortion care** ***Each group will be asked to share their major discussion points in plenary***

Core principle 2: Uphold the responsibility to shape care and support services around each individual

Health care providers must play a key role in translating the understanding and knowledge regarding diversity and uniqueness of patients in to clear practices of care planning and provision. When providing care and treatment, health care providers should understand the implications of the individual's mental capacity, knowledge, and experience, their involvement and level of participation in care planning and treatment.

	***Brainstorming question:*** **Discuss what to counsel for individual patients/clients before urinary catheterization for different age groups?**

Core principle 3: Communicating with individuals in ways that are meaningful to them

Communication plays a key role in understanding individual needs and preferences. This is fundamental to care provision to ensure dignity and respect. Verbal, non-verbal and body language are important elements of communication and these are affected by individual's culture, disability and language. Maintaining confidentiality and transparency is also fundamental for good communication. It is essential that care providers understand these factors and provide opportunities for the service user to express their wishes and concerns to their care providers.

Meaningful communication

- Avoid Using Medical Jargons
- Avoid mixing foreign language with local language
- Use culturally appropriate eye contact
- Use body language that encourage clients to express their view without fear
- Provide tailored information appropriate to the client's needs
- Allow sufficient time to actively listing and reflect on what was being said

Core principle 4: Recognize and respect how an individual's dignity may be affected When supported with their personal care

While every care provider aims to provide dignified care there are many occasions which Unintentional compromises to dignity can happen due to lack of awareness and understanding. It is vital that all professionals providing care understand and support the need for an individual to receive personal care in a sensitive manner and protect their privacy at all times.

When treating or talking to patients remember their need of, and right to, privacy. Often a hallway or curtained bed space just isn't private enough. If a patients' bedside curtain or door is closed, please ask the patient or staff attending the patient if it is OK to enter. In general, in ensuring dignified care it is important that individuals are enabled to be independent and not made uncomfortable when receiving intimate personal care.

Core principle 5: Recognize that an individual's surroundings and environments are Important to their sense of respect

Ensuring a friendly and supportive environment is a key enabler for individuals to feel respected and maintaining their dignity. A welcoming atmosphere, respect for personal space and privacy and the right environment for effective communications are all integral to caring with dignity. A simple welcome to a patient can do a lot to make them feel comfortable and relaxed.

Core principle 6: Value workplace cultures that actively promote the Respect for everybody

In addition to providing the right environment for an individual it is also important to ensure a positive workplace environment for health care providers which would enable them to provide dignified care.

A respectful workplace A place where everyone can do his or her best, and where health care providers are free to report workplace concerns without fear of retaliation or reprisal. A health care setting/ facility that reflects and values the best in everyone, where professionals treat each other respectfully and professionally, and where individual differences are valued.

Core principle 7: Recognize the need to challenge care that may reduce the dignity of the individual

Respect is everyone's responsibility and this should be integral to all practices in a care setting. staff health care providers needs to have the opportunity to discuss things that make them feel uncomfortable but are not necessarily issues that meet safeguarding thresholds. If health facilities develop cultures that are open and reflective of practice that is undertaken during service delivery then this will be addressed.

Opportunities to learn from mistakes and improving performance are a strong lever for improving the quality of care. A culture of maintaining integrity and following professional conduct enables health care providers to speak up when they come across substandard quality of care. The facility managers and leaders at all levels have a significant role to play in ensuring this. Encouraging everyone including staff, patient/client, and their families can provide ample learning opportunities and scope for improving practice.

Group work: Application of principles of respectful care

In your group discuss How to translate the core principles in to professional practice?

Time: 15 min

Session summary

The seven core principles of respectful care delivery includes Recognition of the Diversity and the Uniqueness of Individual, upholding the responsibility to shape care around patient needs, communicating to patients in a way that is meaningful to them , recognize factors affecting dignity , value workplace culture and recognize the need to challenge care that may reduce the dignity of individuals.

4.3. Characteristics of Disrespectful Care

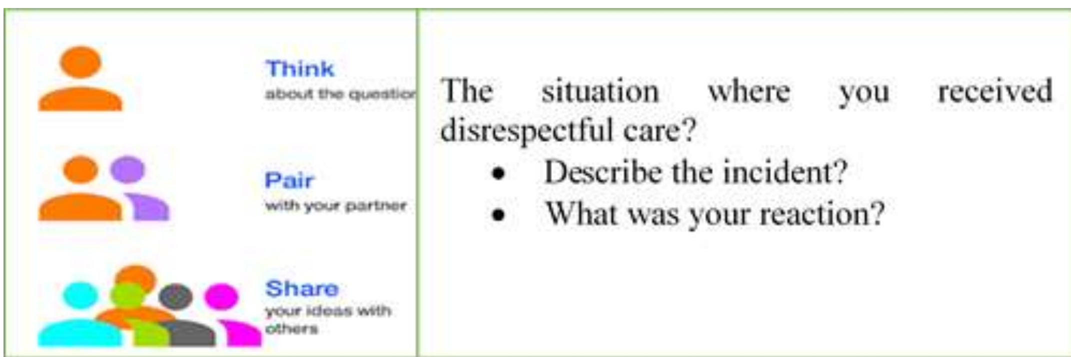
Session time: 60 minutes

Session Introduction:

Disrespectful and abusive treatment in health facilities has many forms. This session will describe the commonest forms of disrespect and abusive care in health care setting.

Session objective:

- Identify the categories of disrespectful care



Case Scenario Disrespectful care 1

Mrs K was primi gravida having labour pain and brought to Health Centre D after long hours of travel. The midwife in Charge told Mrs K and her family to stay on the bench outside the delivery room as the delivery coach is full. . The midwife just took history while the women is on the bench and went back to the delivery room. Mrs K family called the nurse who is walking by the corridor as Mrs K was in sever labour pain and shouting . the nurse told them that she is not able to assist them as she is not working on the labour unit. After 3 hours of waiting on the bench the midwife allowed the labouring mother to get into the delivery room. She also told the family to stay outside since the room is small and it is not allowed relatives to stay with labouring mother since their role is over once the mother reached in the facility

In between the midwife colleague came from emergency OPD and they started to talk, and laugh while Mrs K was in sever labour pain and crying.. Mrs K asked one of the relative to be with her and to give her some drinks, the midwife told her to keep quiet and food and drinks are not allowed this time.Three hours later Mrs K was at 3rd stage of labour and making a lot of noise. The midwife came and hit the mother with her fist on her thighs. The women was shocked by the midwives act kept silent. Finaly Mrs K gave birth a baby girl; the midwife informed the family about the outcome and told them to bring her some hot drink and food to eat. The midwife transferred Mrs K to postnatal ward for follow up and subsequent cares. The next day Mrs K is discharged after the baby having BCG and polo 0 vaccinations. However Mrs has not informed by the midwife when to come to the next postnatal follow up and when will be the next vaccination for the baby. The relatives thanked the staffs and the midwife for their support and left the facility

Discussion question

1. In which occasion(s) do the health care providers breached respectful care?
2. If you were in the providers place what would have you done differently

Case scenario Experience of Hospital KK 3

Hospital KK is specialized hospital has multi-disciplinary doctors, every working days of the week the doctors in the hospital conduct a morning meeting from 8:30 to 10:30 AM, they are debating a lot of scientific practices. Some of the health care providers are very proud of about the doctors' morning meeting since they thought doctors are discussing to help their patients but the patients who are waiting the doctors complaining. They raised concerns like their day to day activities at home and their workplace have been disorganized by Doctors 'lengthy meeting.. One of the nurses told the patients to be tolerant since the meeting by the doctors is important to them.

1. **What is your thought about the routine morning meeting in Hospital KK?**
2. **Do you think is it helpful for the patients in what way?**
3. **What other ways you suggest the morning meeting to be held?**

The Seven categories of Disrespect and abuse

Category	Example
Physical Abuse	Slapping , pinching, kicking, slapping, pushing, beating,
Non-consented care	Absence of informed consent or patient communication , forced procedures
Non-confidential care	Lack of privacy(e.g. Laboring in public or disclosure of patient information
Non-dignified care	Intentional humiliation , rough treatment shouting , blaming, treating to withhold services laughed at patients, provider did not introduce themselves , patients not called by their names throughout the interaction.
Discrimination based on specific patient attributes	Discrimination based on ethnicity , age , language , economic status , education level, etc
Abandonment of care	Women left alone during labor and birth Failure of providers to monitor patients and intervene when needed
Detention in facilities	Detention of patients/family in facility after delivery , usually due to failure to pay

Case scenario on Disrespectful care 2

Mr. X is a daily labourer. He felt abdominal pain and had one episode of vomiting while at work. He couldn't continue his work and went to his home to get some rest. Overnight the pain worsened and early in the morning went to the local district hospital with his wife Mrs.Y. the g hospital Guard told them to Waite outside the gate until the hospital staffs arrived.. Fortunately the duty nurse saw them and told assisted them to get into the hospital. She went to the record room to get him registered. However, the people in the card room told them to go directly to the emergency OPD.

The nurse at the emergency OPD assisted Mr. X who is in a severe pain. She supported him and took him to the examination room. She made him rest on the examination bed. She immediately called the surgeon. The surgeon came very late and He then took history , did physical examination after getting permission from Mr. X. He told Mr. X and Mrs.Y that his condition is acute appendicitis. He explained to them what it means, the management options and that he needs to have surgery. The patient agreed and signed the consent form.

He was operated and was transferred to the ward. He was feeling severe pain at the surgical site and wanted to get analgesics. But the nurses were not around as they have gone out for lunch.

Mr X was ready for discharge on the third day. But the ward head nurse told him that he cannot go to his home because he hasn't paid the entire required fee. He was detained in the hospital for two more days till Mrs.Y borrowed money and paid the rest of the fee. However, Mrs Y brought the money on Friday at 5 PM the surgeon was not around to write his discharge summary, the nurse insisted Mr X has to stay in the facility the weekend until the surgeon to confirm his discharge.

Discussion questions

1. **How was the reception at the record office?**
2. **How did the different providers ensure or breach respectful care?**
3. **If you were in the ward nurse's place what would have done differently?**

Session summary

Disrespectful and abusive treatment in health facilities includes physical abuse, Non-consented, care Non-confidential, care Non-dignified care, Discrimination based on specific patient attributes abandonment of care and Detention in facilities.

4.4. Factors Affecting Provision of Respectful Care

Time: 105 minutes

Session Introduction

This session will enable participants to understand the key factors that affect the provision of respectful care. There are a wide range of factors that contribute to the maintenance of dignity / respect in health care settings. Likewise there are also factors which hinder the provision of respectful care. This session will enable participants to understand the key enabling factors that facilitate the provision of respectful care and highlights factors that hinders/threats the provision of respectful care

Session Objectives	
By the end of this session participants will be able to :	- Explain enabling factors for provision of respectful care - Explain threaten factors the provision of respectful care

Case scenario 1 on threats to provide respectful care

Mr. N was suddenly presented with a strangulated intestinal obstruction. He was scheduled for a Laparotomy, an operation which started at midday and was expected to last for three hours.

Mr. N's wife and daughter remained alone in the waiting room for five hours. They were searching for a place to sit but they couldn't find even a single chair. Adjacent to the waiting room there was a single toilet intended to serve both male and female. Remaining frustrated with increasing anxiety, Mr. N's wife and daughter were finding someone to give them information. They eventually found a health professional, who reported that the surgery had gone 'reasonably well and all things considered', and that as far as he was aware, Mr. N was in the recovery room. Sadly, 20 minutes after admission to recovery, Mr. N's condition deteriorated significantly. He was returned to the theatre for repeat laparotomy. However, all of the operation tables (four in number) were occupied at that time so that the second surgery had been delayed for 30 minutes. After 30 minutes the surgery had been started and; unfortunately, in the middle of the procedure he suffered from cardiac arrest.

Meanwhile his wife and his daughter waited nearby for news, wandering the corridors looking for someone to tell them what was happening. Mr J, a member of the OR team, spoke to the patient's wife and daughter that he couldn't tell them the situation right now and furiously warned them not to ask again. Another health professional was overhearing when Mr J was warning the patient's wife but said nothing. All of a sudden the family was informed by the senior surgeon that Mr N had been pronounced dead. Discussion questions

What did you observe from this case with regard to respectful care?

What should the health professionals do to address the problems you have identified?

1. **If you were in the ward nurse's place what would have done differently?**

Case scenario 2: Enabling factors for respectful care

W/ro C multi gravid mother started to have labour pain after midnight (1:00 AM) and was taken to the local hospital accompanied by her husband and mother in law. On arrival the provider welcomed and examined her and told to her and the family she is in the early phase of labour; the hospital was very busy and there were five mothers on labour ward and three mothers were on delivery bed to give birth.

There was no place to admit Mrs C .unfortunately the hospital ambulance was down to refer her to the next facility and the relatives and Mrs C insisted to stay in the facility despite an advice from the midwife to look other possibilities. In the meantime one of the midwives brought a mattress from store and rested the mother to stay on the floor until admission bed is available. The midwife told the relatives only one of the relatives to stay and the remaining family members to stay outside since there is no space to accommodate all of them.

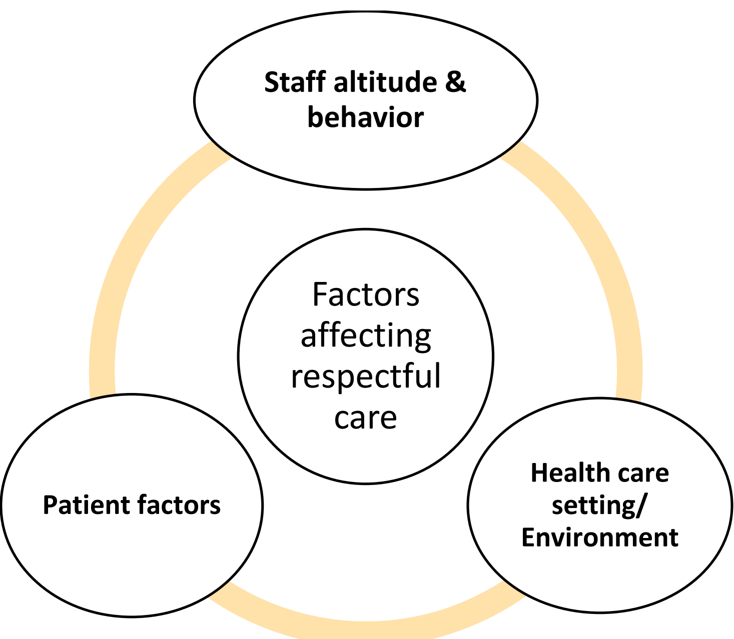
At 9 am W/orC gave birth a female baby, the midwife and her colleagues brought porridge and hot drinks to the mother. The relatives were very surprised with the service of the facility and thanked the midwife and her colleagues for their kind and respected care. The next day Mrs.C is discharged after the baby having vaccination and mothers received all the health education related to her and her baby.

Discussion questions

1. **Which factor revealed in this case scenario?**
2. **If you were in the providers place, what you would have done differently?**

1. **What do you think hinders you from providing respectful care in your health facility?**
2. **What are the factors that facilitates provision of respectful care in your health facilities?**

Different Factors have a significant impact on hindering or facilitating the provision of respectful care service. These factors can be broadly classified in to three major groups.



4.4.1. Health Care Environment

Positive attributes of the physical environment which helped health professional to provide dignified care are related to aspects maintaining physical and informational privacy and dignity, aesthetically pleasing surroundings and single sex accommodation, toilet and washing facilities. Aspect of the environment that maintain physical and informational privacy are listed below

- **Environmental privacy** (for example curtains, doors, screens and adequate separate rooms for intimate procedures or confidential discussions (auditory privacy).
- **Privacy of the body**: covering body, minimizing time exposed, privacy during undressing and clothing are some of the enabling factors to ensure bodily privacy done by health professionals.
- **Aesthetic aspects** of the physical environment (for example space, colour, , furnishing, décor, managing smells); and the provision of accommodation, toilet and washing facilities

- **Managing peoples in the environment:** such as other patients, family and ward visitors/public contribute positively to maintain dignity in the health
- **Adequate mix and proficient Staffing**: adequately staffed with appropriate number and skill mix, as high workload affects staff interactions, and have strong leaders who are committed to patient dignity.

Physical environment which hinders health professional form providing respectful care are related to the overall health care system, lack of privacy, restricted access to facility /service and lack of resources. Aspect of the environment that hinders the provision of respectful care are listed below,

- **The healthcare System:** Shortage of staff, unrealistic expectations, poorly educated staff, 'quick fix' attitude ,low wage, pay 'lip service' to dignity, low motivation, lack of respect among professionals ,normalization/tolerance of disrespectful care, lack of role model ,management bureaucracy and unbalanced staff patient ratio and skill mix.
- **Lack of privacy:** Lack of available single rooms, bath rooms and toilets without non-functional locks, use of single rooms only for infectious cases and lack of curtains or screens
- **Restricted access to facility/service:** Badly designed rooms, inadequate facilities (e.g. toilets, bath rooms), Cupboards with drawers that does not open, toilet and bath rooms shared between male and females.
- **Lack of resource:** Run out of hospital ,gowns and pyjamas ,Lack of medical equipments and supplies

4.4.2. The attitude and behaviors of health care providers

While environment and resources are important factors, all staff working in practice should take individual responsibility for promoting patients' respect and dignity as just one individual's behavior in a team can lead to a distressing experience for patients the core values of healthcare (respect and kindness) are easy to overlook in the busy, high patient load facilities he. Yet it's the humanity of healthcare that gives meaning for the work we do as health care professionals and helps to achieve the best possible health outcome and creates a lasting memory for the public we serve.

The A, B, C, of respectful health care, is a tool designed to consider the attitudes and behaviors of health care providers as follows:

Table 3:1 The ABC of staff attitude and behavior

A –Attitude

Ask yourself:

- How would I be feeling if I was this person?
- Why do I think and feel this way?
-
- Are my attitudes affecting the care I provide and, if so, how?
- Are my personal beliefs, values, and life experiences influencing my attitude?

Action to be taken

- Reflect on these questions as part of your everyday practice.
- Discuss provider attitudes and assumptions and how they can influence the care of patients with the care team.
- Challenge and question your attitudes and assumptions as they might affect patient care
- Help to create a culture that questions if and

B- Behavior

- Introduce yourself. Take time to put the patient at ease and appreciate their circumstances.
- Be completely present. Always include respect and kindness.

C- Communication

- Communication revolving around the patient's needs.
- Patient centered communication with defined boundaries
- Objectivity is an important attribute when assessing the clients' needs

Case scenario 2. on therapeutic communication

Read the following case scenario and discuss how the nurse established provider-patient relationship/ bond: what did she do?

Case Study: Therapeutic Communication

MR X is a 62 years-old man having very small tumor on his feet, he came several times for minor surgery but the doctor cancelled the surgery three times. On his next appointment he came early in the morning into the inpatient surgery unit for minor surgery He sits in the waiting room with his wife and is obviously nervous staring at the wall, taping his feet and wringing a tissue in his hand thinking and worried of the surgery might be cancelled. The nurse approaches MR X to introduce himself and bring him into the operation theatre to prepare him for surgery.

Nurse: I am Nurse Y and I will be the nurse working with you today. What do you like to be called?

Patient : hello call me X : that's what everyone else calls me. This is my wife, Z

Nurse: (she shakes hands with the patients and his wife) it's nice to meet both of you. Y I would like to explain what's going to happen today, get a little more information from you, and answer any questions that you may have about the surgery

Patients: oh thank you. I am so scared. I don't know how I am going to get through this

Nurse: it's common to feel nervous about surgery .my goal is to help you trough today. I will explain everything as we go along and answer any questions you and your wife may have.

Patients: I am glad that you will be there. May my wife z will come with me

Nurse: Of course

Illustrative Example:2 therapeutic communication

Instruction: Read the following case scenario and discuss how the nurse established provider- patient relationship/ bond: what did she do

Patient: *I have some bad news. After our last appointment, I started smoking again I tried really tried but everyone at home was smoking.*

Nurse*: I am glad that you tried to quit. It's tough. Isn't it. Often people try to quit many times before succeeding. The more attempts you make to stop smoking, the more likely you will* succeed. Let's talk about other strategies where your family smoke that is away from you can.

Case scenario 3 therapeutic communication

Instruction: Read the following case scenario and discuss how the senior physician interacts With Co-worker

Case study

Dr H. is a senior physician in outpatient internal medicine practice who has seen working with a young women. Mrs T. for the last five years he has cared for Mrs T. during many stressful episodes of angina and has also been involved in her life during the recent loss of her husband. One day Dr H. observes Mrs T. being advice by another Physician in the hospital with which he does not agree. Rather than Waite for private moment to discuss the issue with the coworker he interrupts the conversation , corrects the other physician in front of a patient and gives the patient what he feels is better advice.

Staff behaviour: the behaviour of staffs while providing care to the patients can hinder the provision of respectful care. Behaviors such as harshness, poor use of language, Authoritarianism, Prejudice and discrimination, breaching privacy, impede the provider patient communication which ultimately leads to poor patient satisfaction.

Exercise on use of language

W/ro X is 80 years old, has diabetes, weighs 90kg, has depression, uses a wheel-chair, has verbally and physically attacked staff and other clients.

Question

If you were given the following words to call W/ro X, which words might be appropriate and which words would you try to avoid? Why?

Patient and family factors

Many patients actively promote their own dignity. The patients identified that their attitude towards potentially undignifying situations helped either to promote their dignity or to accept a loss of dignity, thus, feeling more comfortable.

- **Rationalization**- Patients rationalized that bodily exposure to staff, and intimate procedures were necessary in hospital it's just part of the health professional job.
- **Adaptation**-having a urethral catheter was a loss of dignity. The patient thus adopted an attitude of acceptance which seemed to make them feel more comfortable
- **Take initiative to build relationship**: In addition developing good relationships with staff to promote their dignity and patients were often observed taking the initiative to build relationships.

  Some patient factor might affect the provision of respectful care. This includes, loss of function, psychological impact of diagnosis, diagnosis associated intimate procedures.

Ten Mechanisms to mitigate threats to respectful care -

1. **Support clients with same respect you would want for yourself or a member of your family**
2. **Have a zero tolerance of all forms of disrespect**
3. **Respect clients' right to privacy**
4. **Maintain the maximum possible level of independence, choice, and control**
5. **Treat each client as an individual by offering personalized care**
6. **Assist clients to maintain confidence and a positive self esteem**
7. **Act to alleviate clients' loneliness and isolation**
8. **Listen and support clients to express their needs and wants**
9. **Ensure client feel able to complain without fear of retribution**
10. **Engage with family members and care givers as care partners?**

Session summary

- Factors which affect the provision of respectful care are classified into three major categories: health facility environment. Staff behaviour and patient and family factors.
- Engaging patients and/or families in the decision of care plan and zero tolerance in all forms of disrespect are among the mechanisms to mitigate threats to respectful care.

4.5. Demonstration of Respectful Care

Session introduction: In this session participants expected demonstrate different components of respectful care in a simulated environment
Objective: Demonstrate components of respectful care

Check list for demonstrating respectful care

S. No	Task or activity	Yes	No	Remark
	Getting ready			
1.	The provider greets the client respectfully			
2.	The provider introduces him/herself to the client			
3.	The provider properly address patients considering their social status and age			
	Care during practice			
4.	The provider actively listen to patients			
5.	The provider allocate adequate time to the client to talk			
6.	The provider respects patient's view on treatment and care			
7.	The provider obtain consent before examination and procedures			
8.	The provider ensures confidentiality of patient information			
9.	The provider maintains privacy in providing clinical care			
10	The providers have good communication and collaboration within the team			
11	The provider treat patients equally without discrimination			
12	The provider responds promptly and professionally when patients ask for help			
	Post procedure communication			
13	The provider gives adequate information regarding patient treatment and care			
14	The provider confirms her understanding with respect			
15	The provider provides when to return with at most respect			
16	If necessary he/she provides contact address			

Role Play on Respectful Care (Laboring mother)

The purpose of this role play is to provide an opportunity to the participants to appreciate the importance of respectful care practice and interpersonal communication when providing care for an emergency patient.

Participant's role

Provider – A health provider working at the local health centre

Patient – Ms XX is 16 years old girl got pregnant with her first baby after being raped by a relative

Patient's mother

Situation 1

Ms XX started to have labour in the middle of the night and was taken to the local hospital by her mother. The provider was very tired because he had a busy night. The provider wanted to evaluate Ms XX quickly and then to get some rest. The provider asked her to lie supine and get ready for a pelvic examination. Ms XX has never had a pelvic examination and she also felt uncomfortable because other patients could see her. She refused the examination. However the provider got angry and shouted at her saying that she shouldn't have got pregnant at this age. The provider said she is wasting time and started to perform the pelvic examination forcefully.

Situation 2

Mrs C started to have labour after midnight (1AM) and was taken to the local hospital accompanied by her husband and mother in law. On arrival the provider welcomed and examined her and told to her and the family she is in the early phase of labour; the hospital was very busy and there were five mothers on labour ward and three mothers were on delivery bed to give birth. There was no place to admit Mrs C .unfortunately the hospital ambulance was down to refer her to the next facility and the relatives and Mrs C insisted to stay in the facility despite an advice from the midwife to look other possibilities. On mean time one of the midwives brought a mattress from store and rested the mother to stay on the floor until admission bed is available. The midwife told the relatives only one of the relatives to stay and the remaining to stay outside since there is no space to accommodate all of them.

At 9 am Mrs C gave birth a female baby, the midwife and her colleagues brought porridge and hot drinks to the mother. The relatives were very surprised with the service of the facility and thanked the midwife and her colleagues for their kind and respected care. The next day Mrs.C is discharged after the baby having vaccination and mothers received all the health education related to her and her baby.

Discussion questions for both Scenarios

1. Which elements of respectful care are properly followed?
2. Which elements of respectful care are breached?
3. If you were in the provider's place what would have done differently?
4. What enabling factors hindered the providers to give respectful care?

Role Play on Respectful Care (A patient with urinary retention)

The purpose of this role play is to provide an opportunity to the participants to appreciate the importance of respectful care practice and keeping patient privacy when providing care for an emergency patient.

Participant's role

(1) A nurse
(2) A patient
(3) A doctor

Scenario

A staff nurse was inserting a urinary catheter on a 75 years old patient who has developed retention of urine. Just as the nurse was about to insert the catheter a doctor popped her head around the curtains. "Oh, sorry" said the doctor and proceeded to ask the nurse a question, to which she responded.

Discussion Questions:

(1) Which component of respectful care is violated in this situation?
(2) If you are in place of these health providers, what would you do insure respectful care?

4.6. Guided clinical practice

Clinical practice is the major leaning step to transfer knowledge into practice and to understand the real situations at the ground. Therefore, this session supports to put into practice how they evaluate or assess the status of respectful care provision in the facilities. Moreover, it enhances the knowledge and skill of the participants in analysing, interpreting and how to use the findings for further intervention.

4.5.1. Checklist for assessment of respectful care practice in health care facilities

Objectives

- To assess respectful care provision by facility and providers
- To identify strengths and gaps in respectful care provision

Instruction: Rate the performance of providers during care provision using the following checklist

S.No	Task or activity	Yes	No	Remark
1	The provider greets the client respectfully			
2	The provider introduces him/herself to the client			
3	The provider properly address patients considering their social status and age			
4	The provider actively listen to patients			
5	The provider allocate adequate time to the client to talk			
6	The provider respects patient’s view on treatment and care			
7	The provider obtain consent before examination and procedures			
8	The provider ensures confidentiality of patient information			
9	The provider maintains privacy in providing clinical care			
10	The provider verbally abuse patients			
11	The provider treat patients equally without discrimination			
12	The provider responds promptly and professionally when patients ask for help			
13	The provider gives adequate information regarding patient treatment and care			
14	The provider physically abuse clients (slapping, pinching, inappropriate restraint, etc…)			
15	The provider abandon patient without care for a long time			
16	The providers have good communication and collaboration within the team			
17.	The guards receive patient and families with respect			
18.	The record officers treat patient and families with respect			
19.	The record officers facilitate patient registration in a timely manner			
20.	The facility detain patients without their will			
21.	The facility ensures safe and clean care environment for patients			

Chapter Five: The Compassionate Leader

Chapter Introduction:

Compassionate leadership begins with the intention to see and feel what other see and feel around a certain issue. By practicing genuine empathy, leaders are better positioned to cultivate mindfulness in others, enabling them to both fulfill their own potential and to unleash it in those around them for a greater good. Compassionate health care is universally valued as a social and moral good to be upheld and sustained. Leadership is considered pivotal for enabling the development and preservation of compassionate health care system. Culture and leadership are interdependent and synergistic; their development needs to be grounded in a sophisticated, scientifically based account of human nature. Developing leadership for compassionate care requires acknowledging and making provision for the difficulties and challenges of working in a complex health care setting. This chapter will explore the basic concepts and principles of compassion for leaders. It will focus on understanding, implementing, analyzing and disseminating CRC best practices using variety of methodologies. The module will contribute to creating an organizational culture where members have flexibility to express distress and to provide compassion in contextual and localized ways. Finally, it will encourage participants to identify roles of team members and relevant stakeholders for successful CRC implementation.

Chapter Objective

By the end of this chapter the participants will be able to implement compassionate and respectful leadership

Enabling Objectives -

- Distinguish the quality of compassionate leadership
- Exercise systems thinking to facilitate CRC
- Designate organizational cultures in line with CRC
- Manage roles of health teams in CRC
- Identify relevant stakeholders for CRC implementation

Chapter outline

- Quality of Compassionate Leadership
- Systems Thinking for CRC
- Organizational culture
- Leading CRC Health Teams
- Mobilizing and Aligning Stakeholders for CRC

5.1. Quality of Compassionate Leaders

Group exercise
Quality of Leadership
Duration: 20 minutes
Discuss in your small group
What does it mean for you to lead, and manage?
Can you give an example of a leader whom you know in your professional or personal life? What makes him or her good leader for you?
Do you know of any individuals in high positions or authority who demonstrate compassionate, respectful and caring practices when they deal with their staff and clients?
Be a group of 4-5 and share your experience to the larger group

Session Introduction

The session introduces transactional, transformational, and servant leadership theories. It will also provide a better understanding of qualities of CRC leaders, which will enable participants to provide better service and increase awareness of CRC leadership.

Brief description of leadership theories

Transformational leaders lead employees by aligning employee goals with their goals. Thus, employees working for transformational leaders start focusing on the company's well-being rather than on what is best for them as individual employees.

Transactional leaders ensure that employees demonstrate the right behaviors because the leader

provides resources in exchange.

Servant Leadership defines the leader's role as serving the needs of others. According to this approach, the primary mission of the leader is to develop employees and help them reach their goals. Servant leaders put their employees first, understand their personal needs and desires empower them and help them develop their careers.

Table 1. Characteristics of Transactional, Transformational and Servant Leadership styles

Transactional leadership	Transformational leadership	Servant Leadership
Contingent Reward • Clearly formulates expectations • Shows satisfaction if expectations were realized • As a counter-move for achievement offers support	Charisma/ Idealized Influence attributed • Mediates pride, respect and trust • Places own interests above those of the group	Service to Others • Desire to help others • Encourage greatness in others
	Charisma/ Idealized influence behavior • Has ethical and moral principles • Demands and promotes high engagement • Communicates convincing values and goals	Holistic Approach to Work • Challenge organizations to rethink relationship with stakeholders • Encourage people to be who they are

Transactional leadership	Transformational leadership	Servant Leadership
Management by exception active • Prioritizes breaking of rules and deviation of set standards • Draws attention to mistakes • Consistently persecutes mistakes	Inspirational motivation • Sees the future optimistically • Radiates enthusiasm • Offers attractive visions for the future • Mediates trust and confidence that the goals can be reached	Promoting a Sense of community • Encourage individuals and groups to provide good service • Engage followers for organizational success
Management by exception passive • Only intervenes when problems have arisen • Only reacts to problems if it is absolutely necessary	Intellectual stimulation • Promotes an intelligent, rational and carefully thought through resolution of problems • Questions constantly • Makes innovative suggestions	
	Individual consideration • Takes his or her time for each colleague • Promotes individual development • Treats every colleague as an individual • Acts a coach and directs	

Case study5.1. Compassionate leadership

Duration: 20 minutes

A hospital CEO made a surprise visit to the health facility and reviewed the work of nurses in a particular unit. The CEO discovered that the nurses were not providing the necessary care for patients. Upon observing some activities, the CEO did not discuss the possible causes of the problem, or listen to the nurses but merely criticized the nurses for the poor performance. The CEO then gave possible solutions.

a. **How do you see the approach of the CEO in the context of compassionate leadership?**
b. **Do you think the performance of health professionals be improved after the solutions provided?**
c. **Do you think this situation will affect the motivation of the health workers?**
d. **If you were a CEO, what approach would you have used?**

Characteristics of compassionate leaders

Compassionate leadership

Compassionate leadership is more than just being a compassionate, respectful and caring individual. A compassionate leader encourages employees to discuss their problems and tries to provide support. Compassionate leadership is about a) being a compassionate person and b) trying to create a culture where people seek or provide help to alleviate a sufferer's pain.

Characteristics of compassionate leaders

- **'In-tune' feeling**: Their actions abide by their words – and they always have the time to engage with others.
- **Manage their moods:** They know feelings affect others and they use positive emotions to inspire, not infect others with negative feelings.
- **Put people before procedures:** They are willing to set aside or change rules and regulations for the greater good.
- **Show sincere, heartfelt consideration**: They genuinely care for the well-being of others and have a humane side that puts other people's needs before theirs.
- **Are mindful:** They are aware of their own feelings and their impact on others. They are also attentive and sympathetic to the needs of others.

- **Are hopeful**: They move others passionately and purposefully with a shared vision that focuses on positive feeling of hope..
- **Courage to say what they feel**: They communicate their feelings, fears, even doubts which builds trust with their employees.
- **Engage others in frank, open dialogue**: They speak honestly with humility, respect and conviction, and make it safe for others to do the same.
- **Connective and receptive**: They seem to know what other people are thinking and feeling.
- **Take positive and affirming action**: They carry out compassion. They do not just talk about it; they make a promise, act on it and keep it.

What does compassionate leadership do for the organization?

- Positively affects sufferers, clients, employees
- Increases people's capacity for empathy and compassion
- Promotes positive relationships
- Decreases the prevalence of toxic viral negative emotions and behavior
- Increases optimism and hope
- Builds resilience and energy levels
- Counteracts the negative effects of judgment and bias

Self-evaluation of compassionate behavior

Good leaders can evaluate their own behavior using different methodologies. For example, one can conduct a Self-assessment Questionnaire (Appendix 1). The data should be analyzed and based on the required level of behaviors and practice.

The self-assessment of compassionate leaders should be conducted every six months.

Enhance Self-compassion through mindfulness

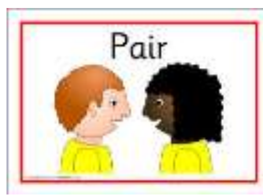
This innovative program will help health leaders create compassionate cultures and develop mindful practice. Evidence suggests that mindful practice, i.e. paying attention, in the present moment, without judgment, to things as they are, can have a significant impact on key leadership qualities. Mindfulness and meditation have demonstrable effects on the brain, including increasing immunity, reducing stress and improving relationships. An individual engaging in

mindfulness and meditation suffers less stress and experiences better health.

Mindfulness begins with self-awareness: knowing yourself enables you to make choices about how you respond to people and situations. Deeper knowledge about yourself enables you to be consistent, to present yourself authentically. You will learn and practice different ways to develop mindfulness and explore how it can contribute to developing compassionate leadership practices through:

- Enhancing attention and concentration
- Increasing creativity and flexibility
- Working efficiently in complex systems and uncertain environments
- Creating meaning and purpose
- Making effective and balanced decisions
- Responding effectively to difference and conflict
- Acting with compassion and kindness
- Enhancing relationships and partnerships
- Enabling genuine and courageous action
- Working ethically and wisely
- Developing cultural intelligence

5.2. Systems Thinking for CRC



Activity 5.2. Systems thinking in healthcare Duration: 20 minutes

Discuss in pair

- Concepts of Health System and how it relates with your Health Facility /Hospital and Health Center/ functions.

Group work

- Take your Health Facility/Hospital and Health Center/ and list the various department/core processes/support processes.

	- Using a systems thinking approach, discuss how they interact with each other? Take in to account the CRC concepts and identify gaps you may have experienced in your facilities? - How do you address the identified gaps in your own context? List your consensus points and share with the plenary session using flip chart

Session introduction

This session explores the key characteristics of a health structure using systems thinking approach. This will help participants know better their own health systems. After applying systems thinking, participants will be encouraged to discuss relevant approaches that help them integrate health systems to build up CRC health workforce as a new initiative.

Systems thinking in health care

System: A system is a set of interacting or interdependent components forming an integrated whole.

Health System: A health system consists of all the organizations, institutions, resources and people whose primary purpose is to improve health. Strengthening health systems means addressing key constraints related to health worker staffing, infrastructure, health commodities (such as equipment and medicines), logistics, tracking progress and effective financing.

Fully functional health system*:* A point which various management systems and subsystems are connected and integrated to provide the best possible health services to all the intended beneficiaries of those services.

Management systems: The various components of the overall health system that managers use to plan, organize and keep track of resources. In well-developed management systems, routine transactions are systematic, replicable, consistent, and complete. Critical information is well

documented, so that the system does not rely on the knowledge of individuals. Effective management systems are continuously maintained, updated, and improved to serve changing organizational needs and resources.

Management systems are run by people living in different contexts

Healthcare managers and providers in facilities, ministries, and nongovernmental and civil society organizations have to operate and sustain management systems and service delivery after the technical experts leave.

Health System Building blocks as defined by the WHO include (WHO 2007);

1. **Service delivery:** packages, delivery models, infrastructure, management, safety and quality and demand for care
2. **Health workforce:** national workforce policies and investment plans, advocacy, norms, standards and data
3. **Information:** facility and population based information and surveillance systems, global standards and tools
4. **Medical products, vaccines & technologies:** norms, standards, policies; reliable procurement; equitable access; and quality
5. **Financing:** national health financing policies; tools and data on health expenditures; and costing
6. **Leadership and governance:** health sector policies; harmonization and alignment; and oversight and regulation

Integration of CRC into existing system

Activity 5.3. Integration of CRC into existing system

Duration: 10 mins

Instruction: Write responses from group discussion and share it with other teams

- Discuss potential steps to integrate new initiatives into existing structure
- Identify and discuss anticipated external and internal challenges during the implementation of CRC
- How do you address the discussed challenges in your own context?

Integrate CRC into Existing System

Integration of new initiatives into existing system has paramount importance in expediting the process of implementation and ensuring sustainability of CRC in a health system. Integration can be done using "AIDED" model.

Assess: Understand the capacity of the unit structure, especially in regards to the availability of resources, as well as human resource; also to assess the level of human capability when integrating and sustaining the CRC by determining the level of support the unit requires before or after carrying out CRC.

Innovate: Design and package the CRC to fit with the existing quality of unit structure and their environmental context to spread the CRC throughout the hospital departments.

Develop: Build upon existing knowledge of main stakeholders and opinion leaders by encouraging hospital policies, organizational culture, and infrastructure to support the implementation of principles of CRC

Engage: Use existing roles and resources within the hospital units to introduce, translate, and integrate CRC principles into each employee's routine practices

Devolve: Capitalize on existing organizational network of index user groups to release and spread the innovation to new user groups

5.3. Organizational Culture

Group discussion

Activity 5.4. Description of organizational culture

Duration: 15 minutes

Discuss within your teams how you understand the hospital culture from an organizational context? Do hospitals and health centers have peculiar cultures? If so, list the important cultural components that relates with improving patient care?

- How do you ensure quality of care for clients by influencing hospital/health center culture? Write your responses on a flip chart and share with the plenary

Session introduction

The goal of this session is to provide participants with an overview of concepts and description related to organizational culture, and educate participants how to empower to enable them to practically empower the CRC health teams.

Description of organizational culture

Organizational culture consists of the values and assumptions shared within an organization. Organizational culture directs everyone in the organization toward the "right way" to do things. It frames and shapes the decisions and actions of managers and other employees. As this definition points out, organizational culture consists of two main components: shared values and assumptions.

Shared Values are conscious perceptions about what is good or bad, right or wrong. Values tell us what we "ought" to do. They serve as a moral guidance that directs our motivation and potentially our decisions and actions.

Assumptions are unconscious perceptions or beliefs that have worked so well in the past that

they are considered the correct way to think and act toward problems and opportunities.

A hospital's culture reflects the beliefs, attitudes, and priorities of the staff, including clinicians throughout the organization. It influences the effectiveness of the hospital's performance, including its ability to promote the goals of high-quality, safe care, financial sustainability, community service and ethical behavior.

Five key systems influence the hospital's effective performance with respect to improving the safety and quality of patient care, as well as sustaining these improvements. The systems are:

- Using data
- Planning
- Communicating
- Changing performance
- Staffing

Leaders create and maintain a culture of safety and quality throughout the hospital. Rationale

- CRC thrives in an environment that supports teamwork and respect for other people, regardless of their position in the organization
- Leaders demonstrate their commitment to CRC and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis.
- Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care.
- Leaders must address disruptive behavior of individuals working at all levels of the organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Table 2. Myths and Realities of Organizational Culture

Myths	Realities
What works as culture in one organization will work in another	Organizational culture cannot be replicated. Organizational culture is constructed locally, socially and historically.
Organizational culture is the responsibility of top management.	Top management team/members cannot dictate all aspects of an organization's culture. No one person or team can control the communication activity of all organizational members.
Organizational culture is the key to success.	Not necessarily. An successful organizational culture may fail; it is important to contextualize
Talking about changes to the culture will change the culture.	Espoused values cannot create a culture; only enacted values can.
Everyone needs to see the culture similarly for a sense of unity to exist	Differences and dissension among organizational members can exist. Acknowledgment of those differences can bring together groups to work together.
It is easy to see all aspects of an organization's culture.	No one person can see all aspects of the culture. From any one person's perspective, some aspects of the culture are unknown or unimportant, and thus, out of their awareness

Creating an Organizational culture of empowering employees for CRC

Having empowered employees is the aim of many leaders. Literature has reported that creating an organizational culture will empower employees to increase customer satisfaction levels, as well as to improve employee morale and productivity (references?).

What does empowerment really mean?

Empowerment is about giving employees the permission to give customers priority and to use their creative talents to find solutions when issues arise, without having to ask management for permission. Empowerment will enable lower management greater power over operational decisions, as well as employees will more likely make decisions that align with organizational goals and values because they have embraced them as their own.

Employee empowerment encourages communication, participation in shared decision-making and enabling physicians and staff to reach their full potential by creating and optimal healing environment. There are many different ways to build employee empowerment and engagement, but all share six fundamental actions to promote CRC on the part of leadership:

I. **Share information and communication:** Sharing information with employees is important because it not only helps to build trust; it gives employees important information to allow them to make the best possible decisions in critical situations when providing CRC services. The leader might have clear direction and more experience, but the leader should still get feedback and ideas from front-line workers. It is important to give employees regular opportunities to formulate their thoughts, feelings and observations to allow employees understand that their input is valued even if the leader does not take their advice. The leader must acknowledge employees for sharing, as well as reward valuable input that helps implement the CRC.

II. **Create clear goals and objectives:** Inspire employees to embrace the mission or changes of the organization by appealing to their innate desire to help patients and provide an efficient CRC service. Great leaders share important information in a structured and consistent manner. Hence, an employee who clearly understands the core values, purpose and direction of the CRC can easily make consistent decisions and take appropriate action. It is important that the leader impart the vision of his or her health facility.

III. **Teach, accept and encourage:** If you empower employees to make decisions that will help keep customers happy, then you have to be willing to allow them to make mistakes and learn from those mistakes. Create an environment where employees can make and learn from mistakes. A leader will encourage employees to take positive action. CRC by its nature requires individual healthcare professionals to promote creativity to satisfy different customers with a variety of healthcare needs. As a result, give employees the opportunity to try new ideas that do not put the clients/patients or health facility in danger.

IV. **Reward Self-Improvement:** Create an environment that celebrates both successes and failures. A good leader celebrates successes; and employees who take risks for the benefits of patients/client; also, a good leader will assist employees to develop a plan for growth and reward them as they advance. This environment will help empower employees to apply their newly-learned skills to new leadership opportunities.

V. **Support a learning environment:** Listen to the voice of physicians, nurses and other staff to understand key barriers, issues, and opportunities to allow them to have a voice in crafting solutions for CRC challenges. This is an ongoing process where working groups discuss how they might handle things differently in the future to achieve better results.

VI. **Create a clear role of autonomy:** Enable frontline workers to execute change by supplying resources (education, funding, access to other skill sets within the health facility, etc.) and removing obstacles themselves. This requires a lot of support from their teams as they move from depending on a leader for every decision to making more independent decisions. Boundaries also need to be explicit as there still needs to be accountability for instances of failure.

Specific roles and responsibilities with employees must be established so employees are clear of their roles and be able to work together.

5.4. Leading CRC Health Team

Activity 5.5. Applying moral and ethical practice

Duration: 10 mins

Discuss in your teams:

What principles do you think of when implementing CRC?

Do you think there are differences between your current "leading" style and leading based on CRC? If yes, list the differences. Please share your thoughts to others

1. How will you address the differences?
2. Write your responses on a flip chart and share with the plenary session

Session introduction

This session will explore ethical leadership related to how one leads and manages health teams at health facility level. It also encourages participants to practice problem-solving skills. This session will have some practical exercises on how to document and replicate better practices for health services. It will also educate leaders how to design strategies, evaluate and ensure effective implementation of CRC practices.

Apply moral and ethical practice

Leaders play a critical role in creating, sustaining, and changing their organization's culture through their own behavior and through the programs and activities they support, praise, neglect and criticize. All leaders must undertake behaviors that foster an environment conducive to ethical practices by effectively integrate ethics into the overall organizational culture.

Health facility leaders have intersecting roles as public servants, providers of health care, and managers of both healthcare professionals and other staff.

- **As public servants**, health facility leaders are specifically responsible for maintaining the public trust, placing duty above self-interest and managing resources responsibly
- **As healthcare providers,** health facility leaders have a fiduciary obligation to meet the healthcare needs of individual patients in the context of an equitable, safe, effective, accessible and compassionate health care delivery system.
- **As managers,** leaders are responsible for creating a workplace culture based on integrity, accountability, fairness and respect.

Ethical healthcare leaders apply at least the following six specific behavioral traits:

1. **Ethically conscious:** Have an appreciation for the ethical dimensions and implications of one's daily actions and decisions or, as described by author John Worthily, the "ethics of the ordinary" (reference?).
2. **Ethically committed:** Be completely devoted to doing the right thing.
3. **Ethically competent:** Demonstrate what Rush worth M. Kidder, president and founder of the Institute for Global Ethics, calls "ethical fitness," or having the knowledge and understanding required to make ethically sound decisions (reference).
4. **Ethically courageous:** Act upon these competencies even when the action may not be accepted with enthusiasm or endorsement.
5. **Ethically consistent:** Establish and maintain a high ethical standard without making or

rationalizing inconvenient exceptions. This means being able to resist pressures to accommodate and justify change inaction or a decision that is ethically flawed.

6. **Ethically candid:** Be open and forthright about the complexity of reconciling conflicting values; be willing to ask uncomfortable questions and be an active, not a passive, advocate of ethical analysis and ethical conduct.

Nurturing problem solving skills of the health team

Activity 5.6. Problem-Solving in Healthcare

Duration: 15 mins

Instruction: Write responses from group discussion and share it with other teams

- What is problem-solving?
- What are some examples of problem-solving methodologies? How do you think you would robust staff problem solving skills
- Write your responses on a flip chart/paper/ sticky notes and share with the plenary

Problem-solving in healthcare

Problem-Solving

Problem-solving skills are no longer a responsibility for people in leadership positions. As hospital services and patient flow are increasing and becoming more complicated, health workers in hospitals have to assume more problem-solving roles.

Contemporary leadership prioritizes creating an atmosphere of empowerment for employees to meet customer and professional expectations through problem-solving skills. Nurturing employees' problem solving skills has numerous benefits. Solving a problem on the spot instead of over time reduces the overall hospital time of patients and clients.

Steps of Scientific Problem Solving Skills

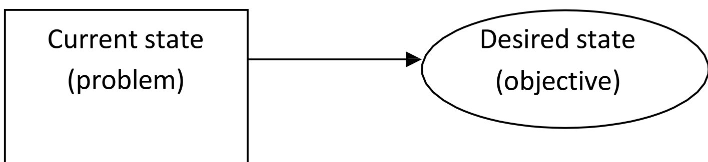
1. Define the problem
2. Set the overall objective
3. Conduct a root cause analysis
4. Generate alternative interventions
5. Perform comparative analysis of alternatives
6. Select the best intervention
7. Develop implementation plan and implement plan
8. Develop evaluation plan and evaluate

Step 1. Define the problem

- A problem statement is a concise description of the issues that need to be addressed
- Good problem statement should:
  1. Focus on a single problem
  2. Not state the cause or the solution
  3. Be concise
  4. Address problems that are feasibly solved
  5. Ensure the problem is shared widely by key constituents and stakeholders

Step 2: Set the Objective

Start with the desired outcome in mind! What do you want to achieve?



What is a good objective?

- One that addresses the problem statement.

Strep 3. Root Cause Analysis

- To find out the actual cause of the problem
- A difficult but crucial step

How to do root cause analysis?

1. Reflect on possible root causes

   First, reflect on possible root causes and opinions by brainstorming, interviewing, through focus groups.

   - Discuss with involved staff
   - Ask them about the causes of the problem
   - Allow them to provide staff to express their opinions
   - Record the "suggested" root causes using "Fishbone"
2. Verify
   - Collect evidence to verify each "suggested" root cause
3. Identify the real root cause
   - Use the data and evidence collected to prove or disprove the "suggested" root causes
   - Identify the real root cause(s)

Potential tools for root cause analysis of CRC

- Prieto Diagram
- Flow Chart
- Questionnaire

Step 4. Develop Different Interventions

- To list all the possible solutions you might use to address the root cause(s)

Characteristics of good interventions:

- Clearly described
- Effective to address the root cause
- Feasible
- Distinct
- Specific
- Agreed by stakeholders

Step 5. Set criteria for Comparison

- To compare interventions using different criteria

Characteristics of good criteria

- Effectiveness (impact): How much will it improve the problem?
- Time to see the consequences: How long will it take to work?
- Feasibility: Is there capacity/stakeholder support/will in the organizational culture to accept it?

- Annual Cost: How expensive is it to carry out?

Step 6. Select the Best Intervention

- Select the best intervention(s) that could address the root cause

Step 7. Develop Implementation Plan

Steps to develop implementation plan

- Create a detailed list of tasks/activities
- Estimate the time required for each task
- Sequence the tasks/activities
- Identify a person(s) responsible
- Use Gantt chart format for the project plan

Step 8. Evaluate implementation of intervention

- Measure process
- Measure outcomes

Best Practice Identification, Documentation and Replication

Feasibility: Is there capacity/stakeholder support/will in the organizational culture to accept it?

Activity 5.7.Best Practice

Duration: 10 mins

In your career, do you remember any of your actions, your colleague's actions which was considered as act of innovation or proven to achieve results? What was it? How did you identify the action or practice?

- Was it replicated? If yes, indicate how it was replicated?
- Write your responses on a flip chart/paper/ sticky notes and share in the plenary

Best Practice

Knowledge about what works in specific situations and contexts, without using unwarranted resources to achieve the desired results, can be adapted and used in similar health facility challenges.

In other words, the term “Best Practice” is not about “perfection”, the “gold standard” or only elements that have been shown to work. Results can be partial and may be related to only one or more components of the practice being considered. Indeed, documenting and applying lessons learned on what does not work and why it does not work is an integral part of “Best Practice” so that the same types of mistakes can be avoided during implementation of CRC.

Criteria to select best practices

- **New/Novel idea-** not much practiced in other hospitals in Ethiopia
- **Effectiveness:** has brought empirical change to the implementation of CRC specifically to patient satisfaction and quality of service provision. The practice must work and achieve results that are measurable.
- **Relevant/impact:** improved CRC and quality of patient experience (Explain the relevance of the innovation using a clear baseline and current performance of CRC)
- **Diffusible:** implemented at low cost in other facilities or implemented innovation in other hospitals.
- **Sustainable:** Innovation is easy to understand, easy to communicate and works for long time.
- **Political commitment:** The proposed practice must have support from the relevant national or local authorities.
- **Ethical soundness:** The practice must respect the current rules of ethics for dealing with human populations.

By definition, “Best Practices” should be “new/novel”, “effectiveness” and “relevance”.

Documentation of Best Practices

To ensure readability and a clear presentation of what makes a practice innovative, interesting, and informative and a "Best Practice", the following format should be used:

I. Title of the "Best Practice". This should be concise and reflect the practice being documented.

II. Introduction. This should provide the context and justification for the practice and address the following:
   - What is the problem being addressed?
   - Which population is being affected?
   - How is the problem impacting on the population?
   - What were the objectives being achieved?

III. Implementation of the Practice - what are the main activities carried out?
   - When and where were the activities carried out?
   - Who were the key implementers and collaborators?
   - What were the resource implications?

IV. Results of the Practice - Outputs and Outcomes
   - What were the concrete results achieved in terms of outputs and outcomes?
   - Was an assessment of the practice carried out? If yes, what were the results?

V. Lessons Learnt - what worked really well
   - What facilitated this?
   - What did not work – why did it not work?

VI. Conclusion
   - How have the results benefited the population?
   - Why the intervention is considered a "Best Practice"?
   - Recommendations for those intending to adopt the documented "Best Practice" or how it can help people working on the same issue(s).

VII. Further Reading
   - Provide a list of references that give additional information on the "Best Practice"

for those interested on how the results have benefited the population.

Methods of Sharing

Different methods of dissemination/replication can be used, especially

I. During regional and national review meetings, supervision and experience sharing events. This can be done by giving a brief introduction, presentation of the best practice and providing documents for further reading.

II. Through the national Ethiopian Hospital Alliance for Quality initiative where hospitals create a cohesive cluster to share their practices for better implementation of initiatives.

III. Distributing CDs and printed materials that contain the best practice details

Monitoring and Evaluation of CRC Health Team

Activity 5.8. Monitoring and Evaluation

Duration: 10 min.

- Based on your experiences what do you think of the process of monitoring and evaluation? Is it helpful? Why?
- Share your thoughts on how you applied M&E processes?

Write your responses on a flip chart/paper/ sticky notes and share it with the plenary session.

Monitor and Evaluate (M&E) CRC Performance

Leaders design strategies to evaluate and ensure effective implementation of CRC practices. The traditional practice of sitting down once or twice a year to discuss how employees implement CRC have not been effective. Hence, conducting regular M&E sessions are important to evaluate how employees are implementing CRC practices.

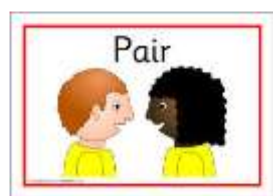
Patients and families should also be involved in designing and evaluating care delivery and organizational policies at all levels. Healthcare, consumer and advocacy organizations can play a key role in educating patients and family members about the elements and importance of compassionate care, their right to ask for it when it is absent, and to take action when its absence impacts their health or wellbeing.

After each review and evaluation, leaders are expected to provide feedback in writing and/or orally to discuss CRC evaluation tools to their employees individually or in groups.

Potential focus areas where leaders focus to evaluate their CRC staff

- **Quality of work**: Provide accuracy and thorough CRC service
- **Communication and interpersonal skills**: listening, persuasion and empathy to clients/patients and teamwork and cooperation in implementing CRC
- **Planning, administration and organization**: setting objectives, and prioritizing CRC practice
- **CRC knowledge**: knowledge-base training, mentoring, modeling and coaching
- **Attitude**: dedication, loyalty, reliability, flexibility, initiative, and energy towards implementing CRC
- **Ethics**: diversity, sustainability, honesty, integrity, fairness and professionalism
- **Creative thinking**: innovation, receptiveness, problem solving and originality
- **Self-development and growth**: learning, education, advancement, skill-building and career planning
- Sample CRC health professionals evaluation questionnaire is attached in Appendix 2.

5.5. Mobilizing and Aligning Stakeholders for CRC



Activity 5.9. Stakeholder identification and analysis
Pair and share to the larger group
Duration: 10 minutes
While any person or organization with an interest in your organization is a stakeholder, leaders are most concerned with those who have the most influence on, or will be most influenced by, the organization.

Session introduction

This goal of this session is to enable participants to identify relevant stakeholders, engage stakeholders for implementation of CRC and manage stakeholder roles in the CRC.

Distinguish relevant stakeholders

What is Stakeholder?

Is a person or group of persons having an interest or share in something, primarily something to gain or lose through the outcomes of a planning process, program or project. For health facilities, stakeholders are internal employees and customers, which includes patients, community and partners.

There are two types of Stakeholders

Internal stakeholders: Those within the health facility who carry out the day-to-day activities and have a key interest in the health facilities' decisions e.g. nurses, janitors, guards and cardroom workers. This excludes employees who are outsourced for services.

External stakeholders: Those external to the organization. Health facilities are key external stakeholders, including customers, suppliers, communities and charities/partners.

Differentiation of stakeholders

The first step in the process of stakeholder engagement is to identify the health facility stakeholders. This, however, can be challenging because it may not be sufficient to focus merely only on groups that are actually impacted by the health facility's CRC practices, but also those who perceive that they are adversely impacted or consider themselves the representatives of impacted people.

Mapping of stakeholders is very important to identify the target groups and gather information about them.

The following questions are designed to expose stakeholders, as well as to help to identify the right people to involve in CRC implementation.

- Who is or will be affected, positively or negatively, by the implementation of CRC?
- Who holds official positions relevant to CRC?
- Who runs organizations with relevant interests in CRC?
- Who has been involved in CRC or any similar situations in the past?
- Whose names come up regularly when you are discussing CRC?

Engage stakeholders

Activity 11: Stakeholder engagement Duration: 10 min.

Instruction: Write responses from group discussion and share it with other teams

What is stakeholder engagement from your experience?

How do you engage your stakeholders?

Stakeholder Engagement is the process of effectively eliciting stakeholders' views on their relationship with the health facility CRC practices.

Steps of stakeholder engagement

Inform → Consult → Involve → Collaborate → Empower

Engagement Type	Description & Examples
Inform	Primarily one-way communication from the health facility to stakeholders about practices or new developments
Consult	Health facility asks for stakeholder perspective and may consider it in the decision-making process. Primarily a one-way flow of information from the stakeholders to the health facility. In this way, health facilities show that they value stakeholders' advice and feedback.
Involve	A two-way or multi-party conversation in which stakeholders play a more important role in decision-making. Decisions are often carried out by the health facility or the patients.
Collaborate	Collaboration between two or more parties on an area of mutual interest. The health facility and stakeholders achieve synergies and reduce risks by combining resources and areas of expertise. This anchors stakeholder relationships around a common purpose and can increase learning between the two groups.

	A negotiated outcome also allows both companies and stakeholders to come to a mutually agreed-upon decision and may be appropriate in certain situations where agreements are necessary to continue operations.
Empower	Stakeholders are given responsibility or legal recourse to influence health facility governance or operational decision-making.

Stakeholder management

Activity 12. stakeholders Management Duration: 10 min.
Instruction: Write responses from group discussion and share it with other teams
What is stakeholder management?
Do you have any experience and how did you manage it?

What is Stakeholder Management?

Stakeholder management is essentially administering or controlling a stakeholder relationship, as the focus is the relationship and not the actual stakeholder groups.

List of principles those summaries the key features of stakeholder management:

Principle 1	Managers should acknowledge and actively monitor the concerns of all legitimate stakeholders, and should take their interests into account when making decisions
Principle 2	Managers should listen and openly communicate with stakeholders about their respective concerns and contributions, as well as the risks that they assume because of their involvement with the corporation.
Principle 3	Managers should adopt processes and modes of behavior that are sensitive to the concerns and capabilities of each stakeholder constituency.
Principle 4	Managers should recognize the interdependence of efforts and rewards among stakeholders, and should attempt to achieve a fair distribution of the benefits and burdens of corporate activity among them, taking into account their respective risks and vulnerabilities.
Principle 5	Managers should work cooperatively with other entities, both public and private, to ensure that risks and harms arising from corporate activities are minimized and, where they cannot be avoided, appropriately compensated.
Principle 6	Managers should avoid activities that might jeopardize inalienable human rights (e.g. the right to life) or give rise to risks which would be unacceptable to relevant

Principle 7	Managers should acknowledge the potential conflicts between (a) their own role as corporate stakeholders, and (b) their legal and moral responsibilities in the interests of stakeholders, and should address such conflicts through open communication, appropriate reporting and incentive systems and, where necessary, third party review.

Chapter Summary

- In this chapter covers important issues about compassionate leadership that can enhance the implementation of CRC at all level within the health sector.
- Leaders strongly influence the ethical environment and culture of health care organizations, which, in turn, influence employee behavior.
- The Ethical leadership skills are important to foster an ethical environment and culture that will make it easier for employees to do the right thing.
- Integration of new initiatives into existing system has paramount importance in expediting the process of implementation and ensuring sustainability of CRC in a health system.
- Organizational culture consists of the values and assumptions shared within an organization. Organizational culture directs everyone in the organization toward the "right way" to do things. Contemporary leadership prioritizes creating an atmosphere of empowerment for employees to meet customer and professional expectations through problem-solving skills.
- Monitoring and evaluation that help participants ensure effective implementation of CRC practices. Stakeholder engagement to improve the performances your facilities in light of CRC.

Annex:

HAND OUT 1. INTRODUCTION TO CRC HEALTH WORK FORCE

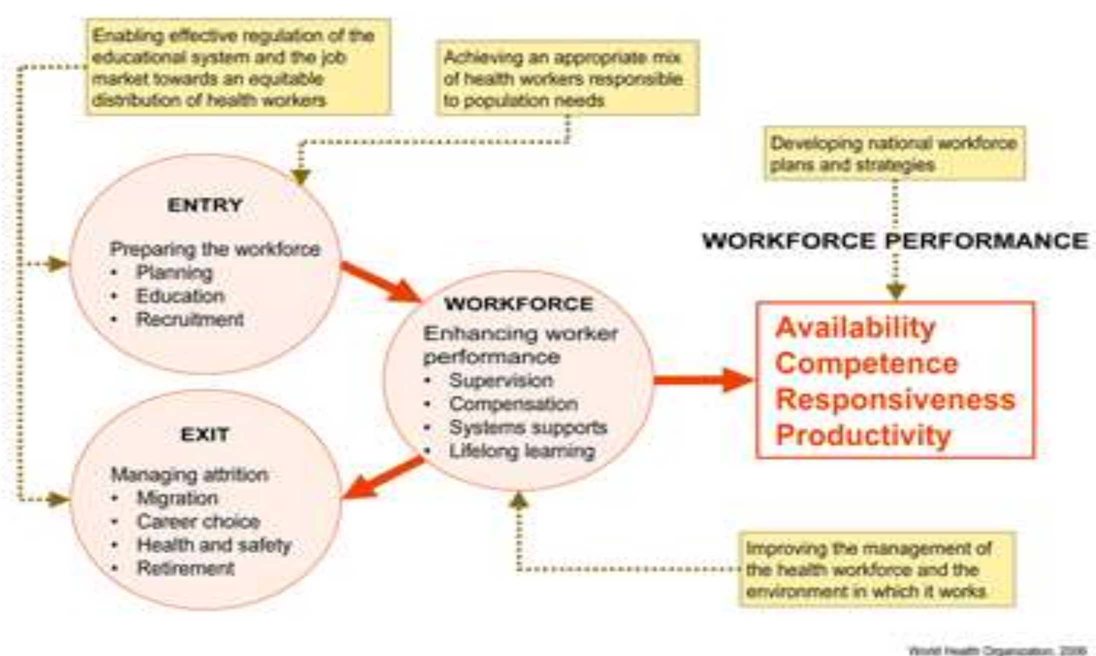
CRC a Transformational Agenda

Culturally competent compassion is not something we are born with rather imaginative teaching methods, good textbooks, good role models and opportunities to practice what one learns under supervision is required to activate our capacity for compassion and nurture compassion in order to re-establish itself as the essence of health professionals.

Intercultural education provides learners with cultural knowledge, skills and attitudes to enable them to respond to others with respect, compassion, and understanding. Such education assists in the transformation of the individual and the institution and also operates

as a mechanism for the transformation of society.

National strategy for implementation of CRC



Stakeholders and roles in CRC

Stakeholders' roles and participation for national mobilization of CRC

For successful implementation of CRC agenda actors in health care and leaders have key role. Through identifying the gaps the facilities should have detail plan in place for implementation. So stakeholders and health sector mangers have to maintain ownership and enhance mobilization effort for beneficial of the successors.

List of Stakeholders for mobilization

1. Prime Minister Office
2. Public and Political Leaders
3. Ministry of Health
4. Ministry of Education
5. Ministry of Health Agencies
6. Regulatory Bodies
7. Judiciary bodies
8. Regional government and city administration
9. Public Service and Human Resource Development Ministry
10. Human rights Institutions
11. Religious Leaders and renowned
12. individuals
13. Universities and Health Science Colleges
14. Nongovernmental Organizations
15. Public and Private Health Facilities.
16. Health Professionals Ethics Committee
17. Health Professionals Associations
18. Community
19. Medical and Health Science Students
20. Media
21. Health Services Clients/customers
22. Patients Associations

STAKEHOLDERS AND THEIR ROLES

FMOH/RHBs

- Lead national Mobilization Initiates
- Resource Allocation for the national mobilization
- Advocacy on stakeholders
- Monitoring mobilization of implementation

Health Facilities /public and private

- Providing CRC capacity building

- Monitoring and Evaluation of Mobilization effort
- Promote CRC agendas through local media
- Nominate one delegate to be a permanent member of the health facility
- Implement CRC plan of action as per the implementation guideline and measure CRC achievement based on indicators
- Align CRC plan with the facility annual operational plan and follow up the implementation process.
- Choose CRC Champions and engage them in various promotional activities.

Universities and health science colleges

- Incorporate CRC concepts in to the pre service education curriculums
- Provide CRC in-service trainings to health professionals educators and support staffs
- Support the establishment of health students CRC circle
- Lay down CRC monitoring and evaluation system that enables to capture improvements
- choose CRC Champions and engage them in various promotional activities
- Nominate CRC ambassadors and ensure their active engagement in CRC promotional activities
- Participate in the annual health professionals day /week, recognize and reward CRC Champions and model educators
- Health Professionals
- Practicing compassionate presence—i.e., being fully present and attentive to their patients and being supportive to them
- Listening to patients' fears, hopes and pain
- Obtaining spiritual history
- Being attentive to all dimensions of patients and their families: body, mind, and spirit
- effective communication with health care teams, interactions with patients and other health professionals over time and across settings;
- Respect for and facilitation of patients' and families' participation in decisions and care
- Strive to be a champion as members of the interdisciplinary health care team.

Health Professionals Associations

- Initiate health professionals to implement CRC
- Coordinate their members for the implementation compassionate and respectful care
- Subsequent provision of service on caring respectful and compassionate manner
- Advocate compassionate and respectful care in general assembly
- Provide support as technical assistance
- Commence & incorporate compassionate respectful care in continuous professional development training
- Initiate and support members research presentation
- Advocate concepts and needs of CRC in media and web site

- Association are expected to choose CRC candidates (ambassador)
- Follow for the provision of compassionate respectful care for service user

Handout: 2 : health care ethics

Definition:

Ethics is derived from the Greek word ethos, meaning custom or character. Ethics is the study of morality – careful and systematic reflection on and analysis of moral decisions and behavior, whether past, present or future.

Morality is the value dimension of human decision-making and behavior. The language of morality includes nouns such as ‘rights’, ‘responsibilities’ and ‘virtues’ and adjectives such as ‘good’ and ‘bad’ (or ‘evil’), ‘right’ and ‘wrong’, ‘just’ and ‘unjust’.

Ethics could also be defined as the branch of philosophy dealing with standards of conduct and moral judgment.

The most common ethical theories are:

1. **Deontology (Duty or rule-Based theory)**
2. This theory proposes that the rightness or wrongness of an action depends on the nature of the act rather than its consequences. This theory holds that you are acting rightly when you act according to duties and rights. The theory denotes that duties and rights are the correct measuring tools for evaluating action. E.g Code of Professional Ethics **Teleology ((utilitarian or end based theory)**

   This theory looks to the consequences of an action to judge whether that action is right or wrong. According to the utilitarian school of thought, a right action has greatest utility or usefulness. Utilitarian holds that no action in itself is good or bad, but only outcomes or results of actions.

   3. Ethical Relativism-
   This theory holds that morality is relative to the norms of one's culture. The theory states that before decisions are made, the context of the decision must be examined. The doctrine states that there are no absolute truths in ethics and that what is morally right or wrong varies from person to person or from society to society. The theory believes that variances in culture and society influence whether an act is moral. Unlike deontology, this theory believes that what is right for one group may not be right for another; this theory believes there is no “universal truth.” Those opposed to this theory feel that there are some issues (e.g. incest or torture) that are not open to debate.

The Role of Ethical principles in Health Care

Ethical principles are the foundations of ethical analysis because they are the viewpoints that guide a decision.

1. Autonomy

   The autonomous person must

   - ❖ Be respected
   - ❖ Decide own personal goals. The goals may be explicit or less defined
   - ❖ Have capacity to decide on a plan of action
   - ❖ Have the freedom to act upon the choices

Example2: Mr Y, 20 years old, is referred to a nurse counselor for HIV Screening because he has history of sexually transmitted infections (STI). The nurse adequately offered HIV counseling and recommended to get HIV test. He refused despite the HIV counseling. A nurse counselor should respect his autonomy.

The counselor's duty is to provide the necessary information and benefit of HIV-testing. The decision to be tested, however, is up to the patient, provided that he or she received the necessary information.

Health Care Ethics principles in Practice

Consent

A person's capacity to give consent can be affected by illness (emotional, mental or physical). People who are considered not to have the capacity to give their consent are still entitled to the same respect for their human dignity and personal integrity as any person with full capacity.

If a patient is unable to understand, retain, use or deliberate information they have been given, or if they are unable to communicate their decision, they might be seen as lacking the capacity to give consent to the proposed investigation or treatment. A judgment that a patient lacks the capacity to make a particular decision does not imply that they are unable to make other decisions or will be unable to make this or other decisions in the future.

Information for patients

Information for patients prior to giving consent

Information patients want or should know before deciding whether to consent to treatment or an investigation might include:

- ✓ Details of the diagnosis, and prognosis and the likely prognosis if the condition is left untreated
- ✓ Uncertainties about the diagnosis, including options for further investigation before treatment
- ✓ Options for treatment or management of the condition, including the option not to treat
- ✓ Purpose of a proposed investigation or treatment
- ✓ Details of the procedures or therapies involved, including methods of pain relief
- ✓ Preparation for the procedure and what the patient might experience during or after the procedure, including common and serious side effects
- ✓ Explanations of the likely benefits and the probabilities of success and discussion of any serious or frequently occurring risks and any lifestyle changes which may be caused or required by the treatment (of all options)
- ✓ Advice about whether a proposed treatment is experimental
- ✓ Information about how and when the patient's condition and any side effects will be monitored or re-assessed
- ✓ Name of the doctor who will have overall responsibility for the treatment and, where appropriate, names of the senior members of their team
- ✓ Involvement of doctors in training
- ✓ Involvement of students in the investigation or treatment;
- ✓ Reminder that patients can change their minds about a decision at any time
- ✓ Reminder that patients have a right to seek a second opinion
- ✓ Details of costs or charges to be paid by the patient

Healthcare provider giving information should consider patients' individual needs and priorities. For example, patients' beliefs, culture, occupation or other factors may have a bearing on the information they need to reach a decision. The health worker should ask the patient whether they have understood the information they have received and if they would like more information before making a decision.

The care provider must answer any questions the patient wishes. You must not withhold any information from a patient necessary for decision-making unless disclosure would cause the patient serious harm. In this context, serious harm does not mean the patient would become upset or decide to refuse treatment.

Advance healthcare planning

Sometimes patients might want to plan for their medical treatment in the event they become incapacitated in the future. This might include an advance refusal of medical treatment and/or a request for a specific procedure. Advance treatment plan has the same ethical status as a decision by a patient at the actual time of an illness.

If it is unclear that an advance treatment plan exists, the state of the patient's capacity at the time of developing the treatment plan or whether it still applies in the present circumstances, healthcare professionals should make treatment decisions based on the patient's best interests. In making such a decision, healthcare workers should consult with a legal authority to make decisions on behalf of the patient and patient's family.

Children

Children and young people should be involved as much as possible in discussions about their health care

When you are talking to a child or young person, it is important to give them information in an age appropriate manner, listen to their views and treat them with respect

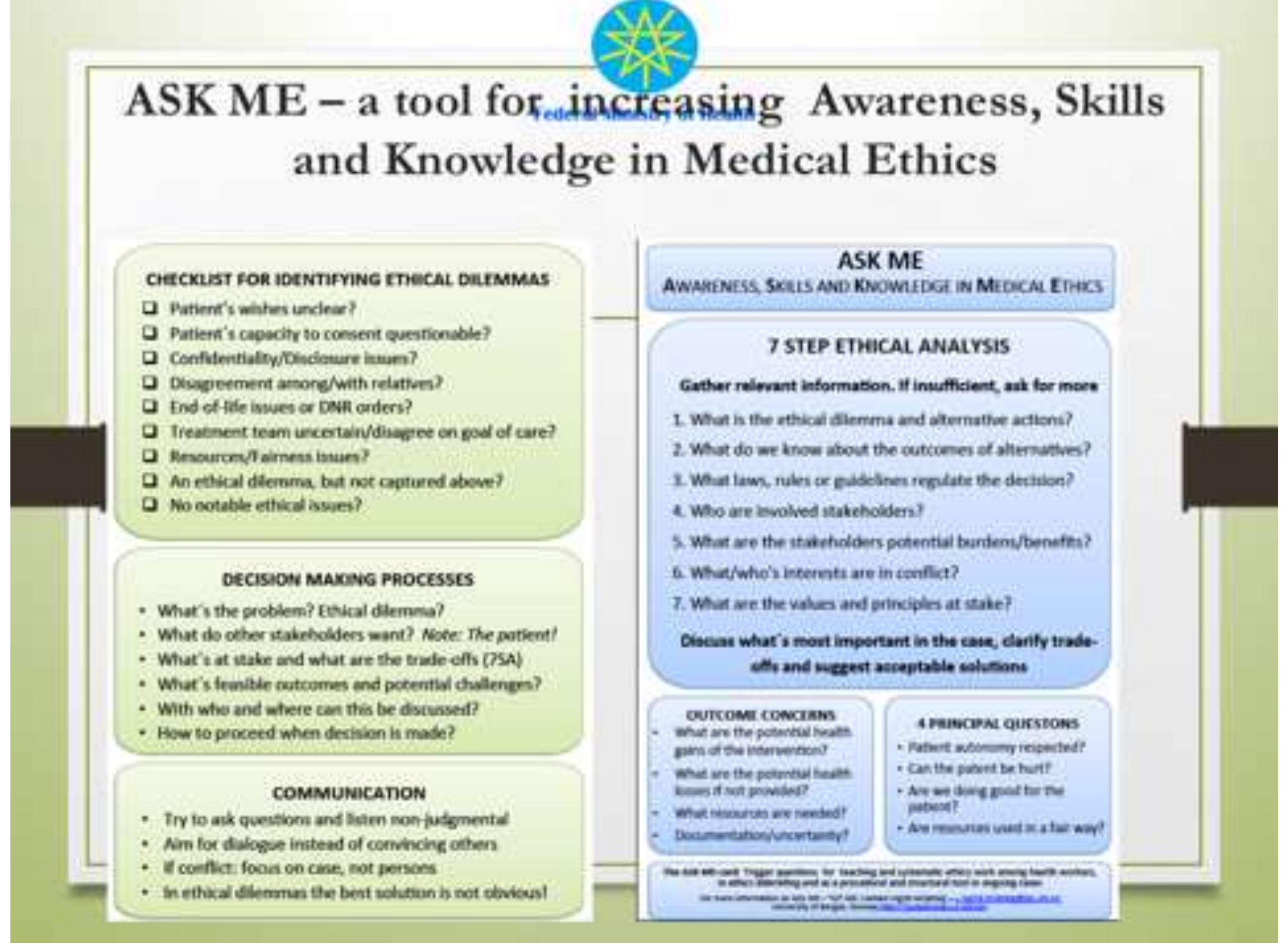
2.3 Preventive Ethics

Tools for systematic impartial ethical case analysis:

2.3.1. Impartial Ethical Case Analysis

1. What is the ethical dilemma and alternative actions/rules?
2. What do we know about the outcome of the alternatives?
3. Are there laws, rules or guidelines regulating the decision?
4. Who are involved stakeholders?
5. What are the stakeholders' potential burdens and benefits?

6. What/who's interests are in conflict?
7. What are the values and principles at stake?



Decision making processes

Federal Ministry of Health

PROCESS

- What do I/we want, given this situation?
- What do other stakeholders want? Note: The patient!
- What is possible to achieve?
- With who and where can we discuss this?
- What challenges can come?
- How to proceed when decision is made?

TIPS

- Create dialog instead of convincing the others
- Ask questions
- Non-judgmental listening
- Postpone own judgments
- If conflict, focus on case not persons

TIPS FOR COMMUNICATION CHALLENGES	
RESPONDING AND ACCEPTING PATIENT EMOTIONS:	**EXAMPLE**
N - Naming - Name the patient's emotion	"It sounds like you are worried that the cancer is back"
U - Understanding (clarify own understanding of patient's concern)	"My understanding is that you worry about how your wife will respond"
R - Respecting (show the patient verbally)	"It impresses me how you've been able to take care of your family"
S - Supporting (let the patient know that s/he will not be abandoned)	"No matter what happens, I'll be with you throughout this illness"
E - Exploring (any concerns that the patient may have)	"Can you tell me about you worries about the treatment?"
COMMUNICATION STEPS WHEN BRINGING BAD NEWS	**SPESIFICATION**
S - Set up of the interview	Ensure privacy and adequate time
P - Perseption of the his/her problem	Assess patient understanding and perseption of her/his problem
I - Invitation for you to disclose the details of his/her illness	Desire for full information or not?
K - Knowledge and information to the patient	Small amounts, avoid medical jargon, check frequently if understood
E - Emotions should be explored and acknowledged	Empathize and explore patient's expressed emotions
S - Summarize and plan for future care/treatment	Close with a clear verbal contract: "I'll do_"; "We'll re-evaluate__"
Ref: Smith RC. Patient-centered interviewing: anevidence-based method. 2002. Baile WF Buckman R et al. The Oncologist 2000	

2.3.2. Ethical guidelines:

a. Help health workforce to make better choices for the patient in accordance with agreed norms and values in society
b. Support health workforce and patient to make difficult decisions
c. Reduce disagreements: patients, relatives and health professionals, among the health workforce
d. Function as an arena for debate in the medical community and society
e. Make ethical choices more transparent, accountable and legitimate
f. Be used in teaching, in basic education, through specialization and on the job

2.3.3Ethics Consultations:

Definition: Ethics consultation is a service provided by an individual or group to help patients, families, surrogates, healthcare providers, or other involved parties address uncertainty or conflict regarding value-burdened issues emerging in health care

Goals of Ethics Consultations:

a. To maximize benefit and MINIMIZE HARM to patients, families, professionals and institutions by fostering fair and inclusive decision-making processes that honors patients' preferences and individual and cultural value differences and dilemmas among all parties

b. To facilitate resolution of conflicts in a RESPECTFUL atmosphere with attention to interests, rights, and responsibilities of those involved

c. To inform institutional efforts at POLICY development, quality improvement, and appropriate utilization of resources by identifying the causes of ethical problems and promoting practices consistent with ethical norms and standards

d. To assist individuals in handling current and future ethical problems in a compassionate, respectful, responsible and caring manner by providing EDUCATION to the health workforce in healthcare ethics

Highlights on the ethics of priority setting/rationing in health care

The practice of medicine is resource intensive and there is often a gap between demand and supply. Often healthcare systems are required to set priorities and allocate resources within the constratints of limited funding. Decision-makers may not be well-equipped to make explicit rationing decisions. Resources should be understood broadly to include health personnel, time, equipment, infrastructure, medicines, beds, operating rooms and money.

Priority-setting in healthcare is defined as the ranking of health services and recipients of these services through a decision-making process. Health workforce at policy and institutional levels make explicit rationing decisions for large patient groups and future patients, those working at clinical levels also have to make decisions at an individual level. In so doing, health professionals must balance multiple roles when being patient advocates, resource managers of institutions and financial risk protector for patients. The health workforce should play these roles in a CRC manner.

Selected articles from civil code:

Art. 2031. - Professional fault.

(1) A person practising a profession or a specific activity shall observe the rules governing that practice.

(2) A person shall be liable where he or she is negligent or ignorant of his or her duties, or accepted rules of his or her professional practice

Art. 2032. - Intent to injure

(1) A person commits an offence where he or she acts with intent to injure another

(2) A person commits an offence where, with full knowledge of the acts, he or she causes substantial damage to another to seek personal gain

Art. 2034 - Purpose of rights.

Subject to the provisions of the preceding Articles, the manner in which a right is used may not be challenged on the ground that it is contrary to the economic or social purpose of that right.

Art. 2035 - Infringement of a law.

(1) A person commits an offence where he or she violates any specific and explicit provision of a law, decree or administrative regulation.

(2) Ignorance of the law is no excuse.

Selected Articles from Criminal Code:

Article 81 - Mistake of Law and Ignorance of Law.

(1) Ignorance or mistake of law is no defence

(2) The Court shall, without restriction, reduce the punishment (Art. 180) applicable to a person who in good faith believed he had a right to act and had definite and adequate reasons for holding this erroneous belief.

The Court shall determine the penalty taking into account the circumstances of the case and, in particular, the circumstances that led to the error.

(3) In exceptional cases of absolute and justifiable ignorance and good faith and where criminal intent is not apparent, the Court may impose no punishment.

Article 744- Mistake.

(1) A person who committed a petty offence may not plead as justification ignorance of the law or a mistake as to right (Art. 81).

(2) If a person acted under a proven mistake of fact which excluded knowledge or intention to commit an offence he or she shall not be liable to punishment (Art. 80).

Hand out 3; on Respectful Care

- **Dignity of the Human Being**. This type of dignity is based on the principle of ***humanity*** and the ***universal worth*** of human beings and their ***inalienable rights*** – which can never be taken away. This is a ***moral approach***, which considers that we all have a moral obligation to treat other human beings with dignity because of the belief that all human beings have ***nobility*** and ***worth*** and people need to be treated with dignity as part of fulfilling their human lives. Various international conventions and legal instruments define this in terms of human rights and how all human beings ought to be treated. This brings with it other ideas such as ***equality***, where, for example, it is expected that all people merit treatment as human beings on an equal basis, whoever they are, whatever their age, whatever their background, how they are behaving or whatever they may be suffering from.
- **Dignity of Personal Identity**. This form of dignity is related to personal feelings of self-respect and personal identity, which also provides the basis for relationships with other people. Most people have a self-image and wish to be treated by others in the manner they believe they deserve. Most people have a very finely tuned sense of being treated in a dignified or an undignified manner. It is relatively easy to damage a person's perception of their self-esteem and self-worth with a few harsh words or with physical mistreatment. On the other hand, many people are quite robust and manage to keep their personal self-esteem, whatever bad happens to them.
- **Dignity of Merit.** This form of dignity is related to an older person's status. Many older people are proud to have held positions in society, been awarded honors and had significant achievements in their lifetime. Uniforms, awards, badges and titles all bring to the owner a level of respect and dignity in society. People have a reasonable expectation of continued recognition for their achievements as they become older and can be very disappointed when this does not happen.

- **Dignity of Moral Status**. This is a variation of dignity of merit, where some people have a *personal status* because of the way they are perceived and respected by others. This type of dignity is difficult to appreciate because the meaning and value of a person's moral status will vary from situation to situation and time to time. Unlike permanent awards or honors based on merit, an individual's *moral status* is not something everyone recognizes. For example, an unelected *community leader* may well have a moral stature and be treated with considerable dignity by members of that community. Yet to others, this unelected individual may be seen as having no legitimate right to represent anyone and just be ignored. In this sense *dignity of moral status* will be very much in the *eye of the beholder*. This is a complex aspect of delivering care with dignity. Older people will also have an expectation of continued recognition of their previous moral status no matter how volatile that was.
- The Dignity and Older Europeans (DOE) Project Study (2004) (*Note 1)* produced a succinct and perceptive classification of four **types of dignity**[1]:

  HASCAS © JW Burgess, HASCAS, 2010, page 7 – 8

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