Communicating better between different specialists involved in Response to an influenza event: The "Johari windows"

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Communication exercise developed by a working group created by WHO Epidemic and Pandemic Alert and Response Department, in collaboration with the Master of Applied Epidemiology (MAE) - Field Epidemiology Training Programme (FETP) from the National Institute of Epidemiology (NIE), Indian Council of Medical Research (ICMR), Chennai, Tamil Nadu, India. Adapted by the working group for generic influenza training.

Learning objectives

At the end of the exercise, the participants will be able to:
(1) Map out the kind of problems and misunderstanding that may arise between different specialists working on a response to an influenza event;
(2) identify the determinants of these problems and misunderstandings;
(3) propose solutions to improve the collaboration between the two groups.

Going through this exercise

Ideally, this exercise would be best done in a group that includes different specialists. If it is not possible, it can also be run exclusively between epidemiologists or exclusively between laboratory specialists (other specialties will have to added): tools in the appendix will help you do as if the other group was there. You may want to run this exercise with the assistance of an independent moderator who has good communication skills and a basic understanding of the misunderstandings that specialists might have. You could also have several moderators, including the different specialties that you will address. It is important to have the exercise between two specialties that seem to have the biggest problem in working together.

Have fun, play fairly and listen to each other!

Part 1. Identifying problems that may arise in the collaboration between specialists

Like any professional group, different specialists have their culture, their way of thinking, their habits and their behaviors. When they talk among themselves, more often than not, they can understand each other because they speak the same language. However, when different specialties work with each other, they may not realize the cultural and communication differences that are there. In some cases, this may lead to a number of misunderstanding and problems. These can become obstacles to effective collaboration and should be overcome. This exercise proposes help to work together better.

The objectives of this exercise are to:
(1) Map out the kind of problems and misunderstanding that may arise specialists;
(2) identify the determinants of these problems and misunderstandings;
(3) propose solutions to improve the collaboration between the two groups.

This exercise is made of three sections, each of which addresses one of these three objectives. An open, constructive attitude will help making the exercise a harmonious and useful experience.

To achieve this objective, we will be using an approach known as the “Johari Windows” in the second step. The “Johari windows” session helps establishing what we know and feel about each other, helps understanding how others see us and helps providing an opportunity to give feedback. On the basis of this disclosure, the next step is making decisions and pledging specific improvements so that we can act as one team. The “Johari Window” is an excellent model to understand the role of self-disclosure and feedback in developing a more open behaviour. It is proposed to use the model to discuss the strengths and weaknesses of the relationship between laboratory specialists and epidemiologists in an open and yet non-threatening way.

We will get back to the “Johari windows” – the second step - later, but for now, here is how the first step will work:

- Specialists will be divided in two (or more) separate groups (depending on the overall groups composition it will be important to identify the different groups which might have the "biggest problem" collaborating. E.g. laboratory specialist and epidemiologists, veterinarians and epidemiologists, clinicians and laboratory specialist etc. If there are several different specialist in the audience each specialist group would have to have a "opponent" specialist group to think and comment about.
- The specialists will make an inventory of the kind of difficulties that may come up when working together with the "opponent" specialist group;
- The specialists will work individually with Table 2 below (The type of specialty will have to be added in the table accordingly).
- When the individual work is completed, each professional group will get together to make a combined list for (a) specialists.

As [specialist of (put here the specific speciality)], you may have worked with [specialist of (but here the specific speciality)]. You may also have experienced difficulties. Could you describe what these were in the box below? Start making a list on your own, sorting out these difficulties by categories. Then, compare it with your specialits colleagues and come up with a consolidated list to share with the "opponent" specialists later. You may want to do this in a way that remains general and does not point directly at specific institutions and / or individuals. The first line of the table is an example.

Table 1: Practical difficulties identified by [specialist of (put here the specific speciality)] thinking of collaborating with [specialist of (put here the specific speciality)]

Organizational / structural difficulties	Technical difficulties	Communication difficulties
Example of epidemiologist thinking of working with a laboratory specialist		
We are not supplied with transport media at the district level	*There has been errors in the results reported by the laboratory*	*The laboratory is not clear in the guidance they give us for sample collection*
Example of laboratory specialist thinking of working with an epidemiologist		
Samples reach the laboratory too late	*The samples we received are of poor quality*	*We received rectal swabs one day without knowing that there was a suspicion of cholera during a large outbreak.*

Table 2: Practical difficulties identified by [specialist of (put here the specific speciality)] thinking of a [specialist of (put here the specific speciality)]

Organizational / structural difficulties	Technical difficulties	Communication difficulties

Part 2. Trying to understand the causes of the difficulties in the collaboration between specialists

Thank you for filling Table 2. Please sit down between the "opponent" specialists to share and exchange these results. You can briefly comment them together before going to the next stage: the “Johari windows” exercise. If you did not have a group from the other side participating, you can review the production that came from similar exercise in the Table 6 and Table 7 in the Appendix 1.

Filling the “Johari windows”

There are four “Johari windows”. Horizontally, we first have the rows of "things known to others" (above) and then the row of "things not known to others" (below). These are broken down in two columns of the "Things known to us" (left) and the "things not known to us" (right). “The others” in this case means the "opponent specialist" (and vice versa for the meaning of “us”).

The four windows are:

Window 1
Area of free activity i.e. those issues that you know and that the others also know. For example: “We epidemiologists think that laboratory specialists can help us confirm a diagnosis and help us identify things that are unknown.”

Window 2
Blind area, i.e. those issues or beliefs that we believe "others" hold about us. For example: “Laboratory specialists believe that we, epidemiologists, only focus on numbers.”

Window 3
Avoided or hidden area, i.e., your thoughts about the "others" that you find it difficult to say openly. For example: “Laboratory specialists underestimate the importance of epidemiological evidence”.

Window 4
Area of unknown activity: questions that we have about which possibly neither the epidemiologists nor the laboratory specialists know the answers. For example: “Maybe we could work together better if we learned each other’s tricks.”

Please start filling the four “Johari windows” on your own. Then, compare it with your colleagues and come up with a consolidated list to share with the other group later.

Table 3: The "Johari windows"

	Known to [define the speciality here]	**Not known to** [define the speciality here]
Known to ["opponent specialist"]	**Window 1.** (AREA OF FREE ACTIVITY) As [define the speciality here], we share these views about ["opponent specialist"] and we are open about it.	**Window 2.** (BLIND AREA) We believe ["opponent specialist"] hold these views and opinions about us but that they have a hard time saying it.
Not known to ["opponent specialist"]	**Window 3.** (AVOIDED OR HIDDEN AREA) This is what we really think of ["opponent specialist"] (but find it difficult to say!)	**Window 4.** (AREA OF UNKNOWN ACTIVITY) Questions that we have?

Table 4: Content of the "Johari windows"

I am a [define the speciality here]:

And this is how I fill my "Johari windows":

Window 1 (Free activity) As [define the speciality here]_____, we share these views about ["opponent specialist"]_____ and we are open about it:
Window 2 (The blind spot) We believe ["opponent specialist"]_____ hold these views and opinions about us but they have a hard time saying it:
Window 3 (The hidden) This is what we really think of ["opponent specialist"]_____ (but find it difficult to say!):
Window 4 (The unknown) There are questions we have about the way we relate with ["opponent specialist"]_____

Part 3. Using the better understanding we have of each other to facilitate collaboration

Getting to understand each other through increasing the size of the first window (the free activity)

We will now go through a process by which each group will share their window 1 and 4 and disclose to the other the windows 2 and 3. Through this process, the window 1 – what we all share-will get bigger and may help in addressing some of the problems identified in the Table 2. To proceed:

- In your specialist group, prepare a summary of your four windows (either on a flip board chart or on a PowerPoint);
- Report your summary back to the plenary session. (If you did not have ["opponent specialist"] the larger group, or if you want to generate more ideas, you can review what some ["opponent specialist"] have produced in similar exercises (Appendix 2 and Appendix 3)
- Combine all the answers in a large chart – or in a Power Point presentation.

Don't forget to praise the positive content of window 1: It is what is already acquired. An interesting game is to look for matches between the window 2 of one group and the window 3 of the other (and vice versa): You may see that in some cases, one group may be already somewhat conscious of what the other group think. But that is not always true and rarely expressed.

Using the better understanding to propose better practices

Now, it is proposed that ["opponent specialist"] work together as a group to get back to the problems identified in the Table 2 so that solutions can be found. You can use the framework proposed in Table 5. In the first column, you can put back together all the practical problems identified. In the second, write the cause of these problems that you identified in light of the "Johari windows" exercise. In the third, propose recommendations so that this problem is fixed. Once you have reviewed the results of you own working group, you can check out a template framework (Appendix 4).

Table 5: Framework to propose recommendations to improve the collaboration between epidemiologists and laboratory specialists.

Type of difficulty	**Causes identified through the "Johari windows" exercise**	**Proposed recommendations**
Organizational / structural difficulties - -		
Technical difficulties - -		
Communication difficulties - -		

Conclusion

The “Johari windows” exercise can help various groups increase their first window and be more open about problems. This translates into more trust and better collaboration if a plan of action is put in place after the exercise. In addition, and beyond the mere issue of effectiveness, certain attitudes of mutual respect and understanding will always gain from efforts so that the collaboration can become a more pleasant experience. That is the challenge for each of us when we go back to work after this game.

Appendix 1: Practical difficulties experienced by epidemiologists and laboratory specialists

Table 6: Practical difficulties identified by epidemiologists

Organizational / structural difficulties
▪ *Delays in reporting results*
Technical difficulties
▪ *Samples are never good enough*
Communication difficulties
▪ *Difficulties in interpreting tests results*
▪ *Difficulties in obtaining straight answers*

Table 7: Practical difficulties identified by laboratory specialists

Organizational / structural difficulties
▪ *Samples sent with insufficient information on the patients*
Technical difficulties
▪ *Samples not packed safely*
▪ *Bad quality samples*
Communication difficulties
▪ *Delayed laboratory involvement*
▪ *Collaboration sought without full engagement of the laboratory*
▪ *Pressure for unrealistic black or white answer*
▪ *Lack of engagement of the laboratory to interpret results*
▪ *Final report not sent once the investigation is over*

Appendix 2: The "Johari windows" of the epidemiologists thinking of working with laboratory specialists

The free activity (window 1)

- Laboratory specialists can help us confirm a diagnosis and help us identify things that are unknown .
- Laboratory specialists can provide us the last bit of evidence.
- Getting a good collaboration between laboratory specialists and epidemiologists require early partnership, efforts, mutual understanding and communication in the professional and personal aspects.
- Laboratory specialists and epidemiologists are professionals in their own fields and have complementary skills.

The blind spot (window 2)

Laboratory specialists think of epidemiologists:

- We focus on numbers.
- We overestimate our understanding of laboratory issues.
- We are bad at keeping them informed
- We can't engage them early enough.
- We use them and we don't fully engage them in investigations.
- We care more about statistics than about the patient.
- It is easy to be an epidemiologist.
- We can't generate credible evidence.
- We can't understand the details of their investigations.
- We are unable to collect a good sample (while in fact, it is difficult).
- We are too academic and not enough practical.
- We can't understand infectious diseases because we don't work with the pathogens.

The hidden / avoided (window 3)

Epidemiologists think really of Laboratory specialists but never express:

- Underestimate the importance of epidemiological evidence.
- Have a hard time seeing the case-patient behind the sample.
- Get lost in details, miss the big picture and can't think in terms of populations.
- Think in terms of research and don't think in terms of public health.
- Like theirs tests but are not always aware of their sensitivity and specificity.
- Have a hard time giving a straight, easy answer and communicating their work in a simple way.
- Produce results that should be discarded if they don't fit with the epidemiological evidence.

The unknown (window 4)

- Maybe we could work together better if we learned each other's tricks.

Appendix 3: The "Johari windows" of the laboratory specialists thinking of working with epidemiologists

The free activity (window 1)

- Outbreak investigations require laboratory confirmation.
- Laboratory specialists have fewer opportunities to go to the field.
- Laboratory specialists and epidemiologists can learn from each other.
- Epidemiologists are skilled.
- Epidemiologists are good to have a big picture and to define global strategies as they deal with figures.
- Laboratory specialists have a technical role on individual analyses.
- Laboratory specialists do strange things we don't always understand.

The blind spot (window 2)

Laboratory specialist think that Epidemiologists think :

- Microbiology is not essential to generate evidence.
- We can't understand surveillance and epidemiology.
- We don't care about public health.
- We can't talk in terms of statistical significance.
- We are incompetent if we can't give a simple answer.
- We lack global vision
- We can be given a secondary role.
- We are technical and not skilled for complex analyses.
- We are here to confirm their results
- We have no role in the interpretation of the data to yield conclusions.
- We cannot be trusted.

The hidden / avoided (window 3)

Laboratory specialist think of Epidemiologists but don't express:

- Rely too much on their methods and don't think laboratory confirmation is really needed.
- Are not good at communicating with us.
- Feel they are superior because they deal with humans while we deal with tubes.
- Use us as tools, and that does not lead us to be open about the results.
- Involve the laboratory only for outbreaks and too late.
- Get frustrated with delays.
- Lack critical judgment on laboratory issues because they don't understand quality criteria (e.g., sensitivity, specificity),
- Don't understand the complexity and the subjectivity of what we do and want black or white answers.
- Don't appreciate our constraints (e.g., time, equipment), our difficulties and our realities.
- Travel with computers to fill time-consuming databases.
- Want to manage everything without any knowledge of laboratory issues.
- Ask basic microbiology questions about things they should know.
- Are not scientific enough.
- Talk, elaborate, assume, estimate, discuss and interpret but don't deal with real data the way we do.
- Are often arrogant MDs who underestimate laboratory specialists who are often not MDs.
- Don't keep us informed.

The unknown (window 4)

- We could do better surveillance if epidemiologists were to explain surveillance to us.

Appendix 4: Framework to identify problems, review causes and propose recommendations in the collaboration between epidemiologists and laboratory specialists

	Type of difficulty	Causes identified through the "Johari windows" exercise	Proposed recommendations
Organizational / structural difficulties	▪ Samples sent with insufficient information on the patient	▪ Epidemiologists don't understand how patient information helps guiding laboratory testing ▪ Laboratory specialists may not communicate how patient information guide their testing.	▪ Epidemiologists must learn how patient information helps guiding laboratory testing. ▪ Laboratory specialists must communicate how patient information guides their testing.
	▪ Delays in reporting results	▪ Epidemiologists may be unaware of the complexity of some analyses. ▪ Epidemiologists may be unaware of the time it takes to obtain certain results.	▪ Epidemiologists must become familiar with laboratory procedures. ▪ Epidemiologists must enquire about the time needed to obtain results.
Technical difficulties	▪ Bad quality samples	▪ Epidemiologists may be unaware of sampling procedures. ▪ Laboratory specialists may not communicate the sampling procedure.	▪ Disseminate guidance to collect appropriate samples to epidemiologists.
	▪ Samples not packed safely	▪ Epidemiologists may be unaware of packaging and transport procedures. ▪ Laboratory specialists may not communicate the packaging and transport procedure.	▪ Disseminate guidance for the packaging and transport of samples to epidemiologists.
Communication difficulties	▪ Difficulties in interpreting tests results ▪ Difficulties in obtaining straight answer ▪ Pressure for unrealistic black or white answer	▪ Epidemiologists may be unaware of the complexity and limitations of the tests used. ▪ Laboratory specialists may not communicate clearly the complexity and limitations of the test used.	▪ Epidemiologists must become familiar with testing procedures, their complexity and their limitations. ▪ Laboratory specialists must communicate clearly and simply the test procedures, their complexity and their limitations.
	▪ Delayed laboratory involvement ▪ Collaboration sought without full engagement of the laboratory ▪ Lack of engagement of the laboratory to interpret results	▪ Epidemiologists just use the laboratory to confirm a hypothesis. ▪ Epidemiologists do not realize the benefit of high quality collaboration with the laboratory.	▪ Epidemiologists must learn from examples to understand the benefit of high quality collaboration with the laboratory.
	▪ Final report not sent once the investigation is over	▪ Epidemiologists don't take laboratory specialists as full fledge partners in an investigation.	▪ Build trust through engaging in full collaboration with regular communication.