

# Evaluation of a Multidisciplinary Professional Development Activity to Enhance Communication Skills Based on Calgary Cambridge Model

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## Abstract

Communication skills are essential for all categories of health care workers. The Calgary Cambridge Model of communication is accepted as a doctor patient communication model in Europe and Canada. It has world-wide recognition and is now used as a model for teaching communication in disciplines like nursing and veterinary science. Since the value of an interdisciplinary approach in continuous professional development has been recognised and all categories of health care professionals face similar challenges with regards to communication with patients an educational activity was developed to facilitate the learning of communication skills as a multidisciplinary team. Feedback on this program was accessed by means of observations, questionnaire and focus group discussions. Results revealed that there was positive feedback on this approach as a means of communications skills training.

## Introduction

Communication is a trainable skill that is mandatory for all health care professionals. Good quality communication is known to enhance patient satisfaction, treatment adherence, and efficacy and cost effectiveness while promoting professional satisfaction and minimising vicarious trauma [1,2].

All the health care workers face increasingly complex and diverse challenges in the delivery of health care. Dealing with a diverse group of patients in terms of personality, problems encountered and expectations requires an interdisciplinary approach [3,4]. A majority of health care professionals in developing countries with inadequate opportunities for training adopt their own styles of communication by watching others perform and by personal experiences [5]. It has been documented that the style of communication in the absence of professional training is influenced by socio-cultural background [5]. Furthermore developing favourable communication skills require feedback and experience per se is inadequate [2]. Therefore teaching communication skills based on a recognized model of communication will make teaching more efficient while making it amicable for research and further development [6]

The Calgary-Cambridge Model of communication was developed by Silverman J and Krutz S [1,2]. While the model was initially meant for doctor patient communication it has now been adopted in the training of nurses, medical laboratory technicians and veterinary surgeons [6]. The model is gaining popularity and is used for teaching

communication in many parts of the world at undergraduate, post graduate and continuous professional development levels [6].

Teaching communication skills is a challenge. Most learners are adults. They possess ideas and concepts, developed within a background of race, religion and culture [5,7] They have own beliefs and established practices. The culture and the Buddhism heavily influence communication behaviours and styles of the Sri Lanka society. Several principles of Buddhism could be adopted in doctor patient conversation; listening to yourself, using silence as a part of speech, listening to others, speaking slowly, clearly, and concisely [8]. In Buddhism three stages of the process of a conversation are recognized; the beginning, middle and the end [8]. This communication teaching session promoted the exploration of good behaviours during the beginning, middle and end of a conversation before relating it to the approach used in the Calgary Cambridge Model.

Inter and intra professional collaboration and multidisciplinary approaches in delivery of health care is becoming mandatory. Interdisciplinary education is a valuable approach to building teams and facing ever expanding changes [5]. However work related conflicts are commonly observed resulting in loss of collaborative relationships. The possibilities of enhancing relationships among different groups of professionals by bringing them together in a communication workshop were explored in this activity.

## Objective

To evaluate participants satisfaction of a multi-disciplinary communication workshop

## Method

A one-day multi-disciplinary workshop on communication skills was developed and conducted for a group of health care professionals. Participant satisfaction was evaluated by real time observations, questionnaire and by a focus group discussion.

The content and teaching methods were developed after a consultative workshop with administrators, subject experts and a group of stakeholders that included 2 doctors, 2 nurse, 2 midwives and 2 patients.

Once the content was developed the workshop was conducted by a resource team consisting of senior teachers with some experience in teaching communication skills, experienced simulated patients and regular health educators. Their participation was voluntary and they were involved from developing course objectives and teaching material to the assessments.

Participants for the workshop were selected to represent 6 health care institutions with 2 doctors, 3 nurses and 2 other categories of health care workers from each institute.

The one-day workshop was initiated by an introductory interactive lecture (duration -1½-hours, medium- Sinhala language) followed by the role playing of a scenario involving all the categories of health care professionals in one large group (duration-one hour). Trained simulated patients and senior resource person demonstrated what is expected during the role-play. Participants were guided to observe the good qualities using an observation guide developed based on the Calgary Cambridge Model of communication. After the initial demonstration volunteers from among the participants were invited to role play with the simulated patient adopting their role in actual work. The entire process generated valuable teaching opportunities and generated valuable interactions.

Subsequently role-playing was done in small groups developed according to working categories. In this session nurses, doctors, midwives and other categories were separated in to small groups and role-playing was done as a parallel activity. Facilitators for this session were predetermined and their role was defined and tasks of addressing specific challenges were discussed at the facilitator training stage.

Finally participants were regrouped according to the institution that they represent. In this session role-playing was induced in small mixed groups developed according to the institutions. A scenario involving all the working categories was practiced. The facilitator role modelled and promoted providing non-critical observation based suggestions as feedback using the guide developed based on Calgary Cambridge Model.

The administrative officer while keeping descriptive records observed behaviour of the participants. At the end of the workshop participant's perceptions were evaluated by a pretested questionnaire completed anonymously and brief focus group discussion conducted in four separate small groups of doctors, nurses, midwives and other categories. The Focus group discussion was based on the usefulness of each component of the study. The members of the resource team recorded qualitative data.

## Results

Six participating hospitals contributed with 8 doctors, 20 nurses, 8 Public health midwives and 12 supporting staff. Resource team include one senior teacher, 4 doctors and 2 trained simulated patients.

1. Interactive lecture –Observers commented that “the lecture created high level of enthusiasm” and that “contributions in discussion by all the categories especially by the supporting staff were very high”. While analysis of the questionnaire revealed that all participants found the lecture as very interesting and useful the focus group revealed the following observations; “We are grateful for doing this workshop in Sinhala that we understand properly” “we realize how good we are” “We realise the strengths of the members of other categories”

2. Role-playing with the large group–Participant generated exchange of knowledge; perceptions, feelings and values were observed. Observer commented about the high level of engagement and cross communication within the group. A comment by a nurse indicated readiness for a change ‘I don't know why we are not doing the same during the work’.

3. Role-playing in work category specific small groups –Observed engagement and enthusiasm was rated as high. Facilitators as well as the observer reported this part of the workshop as an essential component to retain in future teaching programs as it created opportunities to discuss issues related inter professional communication. One of the comments is noteworthy. “we should understand the difficulties of doctors when they deal with patients” “we have to support” “Earlier I was not sure whether we should get involve in talking to patients”

4. Role playing in a small mixed group– Role-playing was observed to have generated a similar level of enthusiasm and opportunities for practice. Unique observation of the session was that some groups were in serious discussion on how to practice what they learn when they return to their own institutions. Some participants expressed concerns “I don't know whether our colleagues are going to take us as a joke” “first of all we have to develop our OPD facilities” Some responded differently “But we can try and see”

5. Focus group discussion for program evaluation –The quality of the program, its usefulness and clarity of teaching were rated very high by all participants. Responses of the participants were reported along with each part of the teaching program above. Overall impression about the teaching program was very high. Participants commented on this, as a “great opportunity” must do for everybody “I want to do it again”. The response to specific questions such as “are you happy to learn together with other categories?” Identified some concerns. The responses were as follows “after participating in a workshop like this, we may face difficulties in controlling our subordinates” “They may start teaching us” “We should teach each category separately”. However majority had a different view “it is very useful to learn together”, “we should know what others do”, “it helps to understand our own problems”.

## Discussion

Advances of available therapeutic options and emerging complexities in the epidemiological pattern of disease can leads to segregation of professionals [4]. Carefully designed multidisciplinary teaching could enhance collaborative working as well as learning. However attention to the sociocultural milieu in which such activity is conducted need to be taken in to account [4].

In developing this communication workshop adult learning principles and a multi-disciplinary approach were adopted. Examples relating to culture and religion were utilized in teaching while teaching scenarios were developed to mimic realistic issues in clinical practice. Special attention was paid to avoid the stress of working with deferent categories of workers.

Judging by the perception of the participants and direct observations the workshop was a success. Starting from this basic evaluation at bottom of the Kirkpatrick pyramid, evaluation of learning outcomes, performances that includes change of the participant's behaviour and impact of such change on society would be useful future tasks [9,10].

Planning based on adult learning principles and adopting experiential learning were the reasons for the success of the workshop.

Needs of the adult learners were taken in to consideration in developing the workshop. Respect towards learners and their existing belief and knowledge was entertained from the stage of developing, conducting and evaluation of the course. At the onset of the workshop information generated by the group was utilized successfully to establish the usefulness of learning communication skills. The group was facilitated to share their experiences and promoted to develop learning requirements by the group adherent to learner centred concepts [11].

Experiential learning facilitates learning cognitive, affective, and psychomotor domains that involve in communication. Building relationship was highlighted as a part of affective domain related to communication and building rapport. Trained simulated patients depicted a near real scenario for doctors, nurses and other health care workers to practice skills of communication. Facilitators could stop and restart the conversation allowing opportunities for participants to practice skills [12,13].

Giving feedback facilitated learning. Furthermore, proper feedback is essential to avoid possible conflicts [12]. However poorly constructed feedback can cause stress and may not facilitate learning. Various methods of giving feedback in medical education have evolved [14,15]. Therefore methods of providing feedback was planned with care. The process for experiential learning introduced by Silverman; Agenda Led out Come Based Analysis (ALOPA) was adopted for teaching. Accordingly learners were engaged in developing an agenda and learning outcomes were discussed before starting the experiential learning session and feedback was based on analysis of outcomes. ALOBA promotes providing non-threatening observation based feedback by SET-GO which is a mnemonic that explain the process of proving feedback based on observation of behaviours (I saw) and impact of the observed behaviour (what else happened) and what the observer think (I think) followed by reference to the goals of the learning sessions (goal) and suggestion for improvements (offers). Resource persons adopted SET-GO approach of the ALOBA to provide feedback and participants were also promoted to use the same approach. This approach helped to eliminate stress and possible subtle conflicts cropping up during the workshop [1,2,6].

The program evolved gradually providing an opportunity to everybody to practice at least some aspects of the skill. Mixing of participants allowed a range of free discussions. Willingness to collaborate with other categories was expressed by several participants.

Our main focus in this educational activity was to avoid possible conflicts that we have experienced in our country and reported in

literature [4]. This study evaluated perceptions of participants on an interdisciplinary activity. Even though the benefits of interdisciplinary teaching are evident in the literature, findings of this study will be of particular interest to systems, which have a hierarchical system with fairly rigid boundaries between disciplines. This study while identifying positive attitudes towards 'Role blurring' in such a system proposes a mechanism to do so.

## Conclusion

This multidisciplinary educational workshop involving all the categories of health care workers demonstrated that participant satisfaction was high. Collaborative learning was successful. However, further evaluation of future programs by observation of behaviours of participants, benefits to the society, patient's satisfaction and/or therapeutic efficacy would be of great value.

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