WHAT HELPS AND HINDERS FAMILY PRACTICE RESIDENTS LEARN COMMUNICATION COMPETENCIES IN A BEHAVIOURAL MEDICINE PROGRAM

by

JULIA C. WONG

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ABSTRACT

Research regarding adverse effects produced from poor communication between physicians and their patients has increased Behavioural Medicine Programs in medical curricula. Efficient and cost-effective instruction is sought for the programs. This study's purpose was to develop a set of categories describing what helps and what hinders family practice residents in a hospital's Family Practice Behavioural Medicine Program (the BMP) learn communication competencies targeted by the BMP. The participants were residents in the BMP who volunteered for an in-depth interview required by the study's qualitative methodology: the critical incident technique. From the specific factors, behaviours, and events reported in the incidents, 9 helpful categories and 5 hindering categories were formed. The four main theories supporting the categories are self-efficacy theory, experiential teaching method, self-determination theory, and group process theory. All the categories have theoretical support and are of value for future development of the BMP.

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CHAPTER 1

Introduction

Background

A substantial set of clinical skills forms the knowledge basis for physicians. In addition to these skills, family practice physicians who communicate effectively with their patients possess significant communication competencies. The term communication competencies covers a wide variety of skills ranging from interviewing skills, empathy, listening skills to the ability to tackle difficult subjects and interactions such as delivering bad news or discussing suicide. Effective communication is valuable to the physician-patient interaction because most of the information required for diagnosis, treatment, and prevention is extracted during the interview, to the extent of exceeding the data yielded from the physical examination and investigations (Smith, Lyles, Stoffelmayr, Van Egeren, Marshall, Gardiner, Maduschke, Stanley, Osborn, Shebroe, and Greenbaum, 1998).

There is a multitude of other ways communication competencies contribute to a physician's practice. A physician's communication competencies affect patient care (Stewart, 1995) and more specifically attitudes towards patients (Briggs and Replogle, 1991; Jenkins and Fallowfield, 2002), patient compliance (Aspergen, 1999; DiMatteo, Hays, and Prince, 1986; Jenkins and Fallowfield; Millis, Jain, Eyles, Tulsky, Nadler, Foye, Elovic, and DeLisa, 2002; Jewett, MacDonald, Templeton, Greenberg, Gluck, and Lipnick, 1983; Oh, Segal, Gordon, Boal, and Jotkowitz, 2001) and satisfaction (Cegala and Lenzmeier Broz, 2002; DiMatteo et al.; Smith, Lyles, Mettler, Marshall, Van Egeren, Stoffelmayr, Osborn, and Shebroe, 1995; Kahn, Cohen, and Jason, 1979; Jenkins and

Fallowfield; Jewett et al.; Millis et al.; Oh et al., 2001;), treatment selection and therapeutic outcome (Cegala and Lenzmeier Broz; Kahn, et al., 1979; Jewett et al.; Smith et al., 1995; Smith, Mettler, Stoffelmayr, Lyles, Marshall, van Egeren, Osborn, and Shebroe, 1995a; Srinivasan, 1999; Stewart), the physician's own well-being (DiMatteo et al.; Mankin Sherer and Johnson, 1980) and their interactions with other health care colleagues (Kahn, Cohen, and Jason, 1979a; Longhurst, 1988), the efficiency and effectiveness of their practice (Aspergen, 1999; Hojat, M., Gonnella, J. S., Mangione, S., Nasca, T. J. Veloski, J. J., Erdmann, J. B., Callahan, C. A., and Magee, M., 2002; Jewett et al., 1983), their vulnerability to malpractice claims (Hojat et al., 2002; Kahn et al., 1979; Levinson, Roter, Mulloly, Dull, and Frankel, 1997; Smith et al., 1995; Smith et al., 1995a), and the general reputation of physicians (Stewart). Indirect financial consequences for the Health Care System may exist dependent on the effectiveness of physicians' communication competencies since physician's health and the efficiency and effectiveness of their interactions with their patients contribute to the monies they cost the health care system. Should a physician's health deteriorate, the health care system as a whole is affected both by the physician becoming a patient and by the loss of a provider of Health Care. Improving the physicians' well-being and enhancing their communication and empathy skills benefits the individual physician, their patients, the Health Care System, and the tax payers whose funds maintain the System. Physicians have a heightened vulnerability to developing depersonalization, burnout, and emotional exhaustion that are associated with a range of serious mental health issues such as generalized anxiety disorder, major depressive illness, and alcohol/drug abuse (Maguire,

2000). The quality of the delivery of care, specifically the patient-physician interaction, is also of concern since it has been shown to affect patients' health (Stewart).

Hall, Horgan, Stein, and Roter (2002) found that physicians perceived that they lacked sufficient training or competence in essential communication skills leading them to be less effective in interacting with their patients than they should be. Helping physicians to improve their communication skills and their self-efficacy in those skills would improve their delivery and quality of care and decrease their stress, thus enhancing their well-being (Smith et al., 1995a). That medical students and residents would benefit from being taught communication competencies seems logical.

The discussion regarding the relevance of communication competencies to the practice of medicine and the current abilities held by physicians and medical students were a major focus initially in the literature. Research on the feasibility as well as the most effective ways of teaching such skills was also pursued. Studies that evaluate the effect of communication competencies training, how well the competencies are learned, and the sustainability of learned skills over time are plentiful (Aspergen, 1999). Fewer studies exist that examine how the participants' learn the skills. How best to teach the participants has been the focus of a variety of studies examining different areas such as who should teach the skills and how to train the teachers. The differential success produced by specific teaching methods was the focus of other studies that concluded on the superiority of the experiential teaching method (Aspergen). Gender differences in learning communication competencies also emerged from some studies with males learning at a slower rate to females (Hojat et al., 2002; Hojat, Gonella, Nasca, Mangione, Vaergare, and Magee, 2002a).

Recommendations for future research topics are also present in the literature. Buyck and Lang's (2002) study that examined the teaching of medical communication skills called for future research to focus on faculty effectiveness. Research on how to better teach communication competencies to medical students is also recommended in Aspergen's (1999) comprehensive review and synthesis due to the advantages of such skills for medical practice and to discover the most efficient and cost-effective way to teach communication competencies.

Communication competencies are important for all primary care physicians but are especially compelling for family practitioners (Kahn et al., 1979a). Kahn and colleagues note that the extent of the physician-patient interaction requires a range of communication skills and abilities to adequately relate to the variety of patients in a physician's practice. They also acknowledge the extensive interactions family practitioners have with other health care professionals and workers that are facilitated by possessing effective communication competencies.

Family practice physicians trained in BC generally complete a minimum of three years of undergraduate study, four years of medical school, and end with two years in residency prior to setting up practice. While considerable time is spent developing their clinical knowledge, little of their education is spent learning communication competencies such as active listening skills or empathy (Cassata and Kirkman, 1981; Maguire and Rutter, 1976; Ockene, Ockene, Kabat-Zinn, Greene, and Frid, 1990; Patterson, Ferguson, Lane, Farrell, Martlew, and Wells, 2000; Swanson, 1994; Vanderford, Stein, Sheeler, and Skochelak, 2001; Voineskos, Greben, Lowy, Smith, and Steinhauer, 1981).

Following some studies supporting the view that students and residents become increasingly cynical and less compassionate throughout their training (Feudtner, Christakis, and Christakis, 1994; Self, Schrader, Baldwin, and Wolinsky, 1993), the Association of American Medical Colleges (1999 in Buyck and Lang, 2002) was sufficiently concerned about the level of communication skills held by students and residents to recommend the teaching and assessment of such skills throughout medical school and residency. Recommendations for the development of Behavioural Medicine Programs (hereafter referred to as BMPs) was followed by increasing numbers of articles describing and/or evaluating existing BMPs in various medical schools in North America and Great Britain. The general consensus seems to be that BMPs are necessary and beneficial and the discussion now centres on how best to develop and teach the programs. In recognition of this need the Department of Family Practice (Faculty of Medicine) at one of the University of British Columbia's hospital sites and the Counselling Psychology Program (Faculty of Education) at the University of British Columbia (UBC) have developed a BMP for Family Practice Residents at the aforementioned UBC hospital site's Family Practice Residency program. The focus of this study is what helps and what hinders the family practice residents' learning of the communication competencies in this BMP.

Definition of Terms

The literature tends to use communication skills, counselling skills, and communication competencies interchangeably. Each term may refer to interviewing skills, empathy, listening skills, various counselling skills including suicide assessment, doctor-patient interactions, cross-cultural communication, and the delivery of bad news.

For the purpose of consistency and because the Behavioral Medicine Program being studied uses the term in its title (Family Practitioner-Patient Communication Competencies component of the Behavioral Medicine Program of the [UBC hospital site name] Family Practice Behavioural Medicine Program), this paper will use Communication Competencies to describe all of the above.

The residency program receiving the Behavioural Medicine Program is affiliated with the University of British Columbia rather than the hospital itself. The university has a number of residency sites at different hospitals. The program in this study contains the name of the hospital at one of the sites affiliated with the university: Family Practitioner-Patient Communication Competencies component of the Behavioral Medicine Program of the [UBC hospital site name] Family Practice Behavioural Medicine Program. For the purpose of convenience, the Behavioural Medicine Program in this study is referred to as the BMP. Other Behavioural Medicine Programs have been shortened to BMPs. The Family Practice Residents are referred to as the Residents. The term communication competencies have been shortened to CCs. The University of British Columbia is referred to as UBC.

One of the sessions in the Behavioural Medicine Program presents the topic of discussing a patient's preference for code status with the patient and/or their family. Code status refers to the treatment measures the patient will receive should they go into cardiac arrest; if their heart stops, does the patient wish to be resuscitated. If yes, the patient and/or their family may delineate limitations they wish to place on the efforts of the medical staff to revive the patient. If the patient does not wish to be resuscitated, the

desire is identified as a Do Not Resuscitate (DNR) order. This session will be discussed in chapters 4 and 5.

Chapter 3 discusses how the categories were formed. The incidents within each category are referred to as subthemes within chapters 4 and 5. The subthemes in each category contain the same category factor but are different in how the factor or event occurred. Very similar incidents are classified under the same subtheme.

Rationale for the Study

Aspergen (1999) called for future research on how medical students and doctors learn communication competencies (CCs) most effectively for several reasons: CCs are valuable to the practice of medicine and are therefore worth learning; training is time-consuming so minimizing the amount of time needed to learn is worthwhile; and training is expensive making studies that determine cost-efficient methods of teaching useful. Evaluating what helps and hinders the residents' learning in the [UBC hospital site name] Family Practice Residency Program's BMP (the BMP) is therefore valuable to determine how to refine the program to improve the effectiveness and the most efficient way of learning.

This study is also important because the BMP has the potential to affect many people. Those that are invested in the program as well as those that will benefit from the program both directly and indirectly include: the family practice residents, their patients, their colleagues, the facilitators [Medical (3) and Counselling Psychology (5)], [UBC's site] Family Practice Residency Program Director, Faculty of Medicine Postgraduate Dean's Office, University of British Columbia's (UBC) Department of Family Practice (and therefore the Faculty of Medicine), UBC Counselling Psychology Department (and

therefore the Faculty of Education), current and future residents, Preceptors (Community, Hospital, and Research), Patients, Nurses and other Healthcare colleagues, Patients' families, UBC College of Health Disciplines, Ministry of Health (2 ministries), Ministry of Advanced Education, the British Columbia (BC) Health Care System, and BC Tax payers. The future expansion of the communication-competencies program to other medical schools in Canada and even requests from other countries for implementation enhances the importance of evaluating the BMP.

This study responds to the recommendations in the literature in what is hopefully a unique way by asking the participants' to report what helps and what hinders their learning of the CCs, thus attempting to provide information for the faculty on which actions they perform are facilitating learning, and which are not. It was anticipated that included in what helps and hinders would likely be which teaching interventions were the most effective thus contributing to the research on: (1) the best ways to teach the skills and helping to identify how to improve the efficiency of teaching; and (2) ways in which resources may be used most effectively.

Kahn and colleagues (1979a) recommended future efforts be directed towards sharing resources, faculty development, and cooperative research. Anderson and Sharpe's (1991) synthesis and review notes that BMPs would benefit from interdisciplinary collaboration with professionals such as psychologists. Voineskos and colleagues (1981), and Quirk and Letendre (1986) also recommend interdisciplinary collaboration in developing and teaching BMPs. Since the BMP was jointly developed with the University of British Columbia's (UBC) Department of Family Practice (Faculty of Medicine) and the Counselling Psychology Program (Department of Counselling

Psychology, and Special Education; Faculty of Education), this study will also contribute to the literature on interdisciplinary collaborations.

Assumptions

The underlying assumptions of this study are: a) [UBC hospital site name] Family Practice Residency Program's Behavioural Medicine Program (the BMP) is worthwhile and worthy of continuation; and b) the communication competencies, the content of the BMP, can be taught.

The literature generally supports the assumption BMPs are worthwhile and the competencies can be taught (Anderson and Sharpe, 1991; Aspergen, 1999; Betchart, Anderson, Thompson, and Mumford, 1984; Briggs and Replogle, 1991; Cassata and Kirkman-Liff, 1981; Cegala and Lenzmeier Broz, 2002; Ockene et al., 1990; Oh et al., 2001; Patterson et al., 2000; Rudner, Bestvater, and Bader, 1990; Shapiro, Lenahan, and Masters, 1993; Swanson, 1994; Vanderford et al., 2001; Voineskos et al., 1981). The program's facilitators firmly believed the program to be worthy of continuation (personal communication with Dr. Knell, September , 2003) and this is also strongly supported by the call in the literature for the development of BMPs (Cassata and Kirkman-Liff; Cegala and Lenzmeier Broz Voineskos et al., 1981; Ockene et al., 1990; Patterson et al.; Rudner et al., 1990; Shapiro et al., 1993; Srinivasan, 1999; Swanson; Vanderford et al.) and the strong positive evaluations given by the residents that participated in the BMP over the past four years (personal communication with Dr. Knell, September , 2003).

The use of the experiential teaching method by the BMP is supported by the literature (Aspergen, 1999). Support for the content of the BMP is also found in the expertise of the creators of the program, the faculty and doctoral students from the

University of British Columbia's Counselling Psychology Program in conjunction with the physicians from associated with the UBC hospital site's Department of Family Practice (Faculty of Medicine).

Purpose of the Study

The purpose of this study was to develop a set of categories that described what helped, and what hindered the family practice residents (the Residents) in Family Practice Behavioural Medicine Program (BMP) learn the communication competencies taught in the program. The hope was the resulting information would identify how to improve the program and fine tune the curriculum in order to strengthen the BMP. The study will contribute to counselling psychology by: a) providing insight into how medical students learn counselling skills, specifically what helps and what hinders their learning; b) providing the literature with the students' perspectives on effective and counter productive contributions to their learning; and c) providing information that may help the development or improvement of BMPs or counselling programs. This information is worth knowing because it allows for the modification of the program to enhance learning, provides justification for the program's existence and funding, contributes to the long-term improvement of quality of Health Care, and facilitates the correction of problems before implementing expansion programs. The focus on the students provides an alternative view point to previous studies that focus on the instructor's point of view, the content of what is taught, or the facilitators' performance.

CHAPTER 2

Review of the Literature

Introduction

The literature on teaching communication competencies in the medical context is vast. A selection of the relevant topics from the literature will be outlined. To justify the existence of the [UBC hospital site's name] Behavioural Medicine Program (the BMP), the research supporting the value of communication competencies (CCs) to the practice of medicine will be discussed. To provide a background from which to interpret the results of this study, to support the way the BMP is taught, and to anticipate possible areas the residents might identify as helpful or hindering in their learning process several areas of research are reviewed: studies examining which teaching methods are the most effective, which type of teachers produce the desired results, and how to train teachers for Behavioural Medicine Programs (BMPs). An outline of self-efficacy theory and the principles of group process will be presented to provide a rationale for the experiential techniques used in the BMP. The purpose of the study is also revisited prior to the section providing support in the form of a methodological review for the study's chosen methodology, a qualitative method named the Critical Incident Technique.

Value of Communication Competencies in the Medical Context

A physician's communication competencies (CCs) are important to the practice of medicine because their skills affect many facets of health care. Patient care (Stewart, 1995), patient compliance (Aspergen, 1999; DiMatteo et al., 1986; Jenkins and Fallowfield, 2002) and satisfaction (Cegala and Lenzmeier Broz, 2002; DiMatteo et al.; Jenkins and Fallowfield), treatment selection and outcome (Srinivasan, 1999),

physicians' attitudes towards their patients (Briggs and Replogle, 1991; Smith, Marshall, and Cohen-Cole, 1994), and physicians' knowledge, skills, and self-awareness (Smith, et al., 1994) are positively affected by physicians receiving training in CCs. Physicians' own well-being (DiMatteo et al.) and their interactions with other health care colleagues also benefit from such training. Improving physicians' CCs also improves the efficiency and effectiveness (Aspergen; Hojat et al., 2002) of their practice, and the general reputation of physicians (Stewart).

The many ways CCs contribute to the practice of medicine have been documented in a variety of studies. For example, training physicians in CCs was found to improve patient compliance with treatment and satisfaction (Smith et al., 1995; Stewart, 1995). Another study found that a major communication competency, empathy, is related to the academic performance and clinical competence of medical students (Hojat, M. et al., 2002). The value of CCs training for medical practitioners received further support in Frymoyer and Frymoyer's (2002) statement that effective communication is associated with improvement in the areas of patient and physician satisfaction, patient compliance, health outcomes, informed medical decisions, and a decrease in the areas of malpractice suits, and costs of care. Markakis, Beckman, Suchman, and Frankel (2000) noted that meeting the psychological needs of the students during their training in CCs led the students to be more supportive of their patients' psychological needs.

A variety of studies found the medical practitioner's own health was improved by CCs training because their stress level was decreased through improved doctor-patient interactions (Jenkins and Fallowfield, 2002; Smith et al., 1994). CCs training has also been shown to improve family physicians' attitudes towards mental health counselling

and towards providing such interventions (Probst, Rainwater, and Michels, 1999; Shapiro et al., 1993), to increase empathy for patients and improve patient care attitude (Seaberg, Godwin, and Perry, 2000), and to improve physicians' coping ability and competence in breaking bad news to patients (Ungar, Alperin, Amiel, Beharier, and Reis, 2002). Evidently CCs are valuable skills to possess for medical practitioners.

Most Effective Teaching Method for the Medical Context

Another topic in the literature focuses on the most effective ways to teach CCs. The two main types of methods used in the medical context to teach CCs have been instructional and experiential. In medicine, the instructional (also known as the traditional) method of learning involves presenting how to do the skill, either by lecture or by demonstration, with the assumption that the student will practice the skill but will not receive feedback. Experiential training starts with the student performing the skill and then receiving feedback, often but not necessarily involving video-taping or audio-taping of the student and the teacher providing feedback while or after watching or listening to the tape. Research has determined that experiential methods should be used since "it has been shown conclusively that instructional methods do not give the desired results." (Aspergen, 1999, pp. 563).

The journey to reach the conclusion on the superiority of the experiential method began in 1976 when a series of randomized studies were performed by a group of medical teachers from Manchester, England. The first study examined interview skills training for students in a clinical course in psychiatry using either the traditional teaching or experiential teaching. The latter method used a videotaped interview with a patient followed by individual feedback by a teacher. The experiential group was significantly

more effective in interviewing than the traditional group after only one week of training (Rutter and Maguire, 1976).

Building on those results, Maguire, Clarke, and Jolly, (1978) began a study in 1977 that randomly placed first year residents in three groups that received different teaching formats: (1) traditional teaching (control group); (2) primer reading material followed by traditional teaching followed by group discussion; and (3) primer material, student-generated questions, demonstration, followed by discussion. The study found that both groups (2) and (3) performed significantly better than group (1).

The research was continued further in 1978 to determine what type of feedback was most effective. Four groups were formed: (1) a control group; (2) a written feedback on a video-taped interview group; (3) an immediate individual feedback on an audiotaped interview group; and (4) an immediate individual feedback on a videotaped interview group. The three groups that received some form of feedback all performed better than the control group and the interpersonal skills of groups (3) and (4) were rated by blind independent observers to be significantly better than groups (1) and (2) (Maguire et al., 1978).

Quirk and Babineau's (1982) randomized study, rated as high-quality by Aspergen's (1999) review, found only the experiential method produced an improvement in the students' performance. Four more high quality studies, as reported by Aspergen, also supported the conclusion that experiential method should be the instruction of choice (Evans, Coman, and Goss, 1996; Evans, Stanley, Burrows, and Sweet, 1989; Evans, Stanley, Mestrovic, and Rose, 1991; Marteau et al., 1991) as did the results of a rigorous review of the literature and guidelines for teaching by Smith and colleagues (1994).

Essentially, the literature seems to have concluded that what helps students learn is most likely to be a part of an experiential method of teaching.

Smith and colleagues (1995a) elaborated on the experiential teaching method further to provide the following guidelines for teaching residents communication competencies effectively: "modelling, successful performance, persuasion and support by teachers, a relaxed atmosphere, cognitive understanding, learner self-direction, training in specific strategies, explicit performance related feedback, [short-term goal-setting], attributing learner success to work rather than innate ability, and tying rewards to specific accomplishments." (pp. 315-6).

Behavioural Medicine Program Teachers

The teachers or facilitators in [UBC's hospital site's name] Family Practice Residency Program's Behavioural Medicine Program (the BMP) are physicians from the UBC's hospital site's Department of Family Practice and PhD students from the Counselling Psychology Program at the University of British Columbia (UBC). The studies relevant to this program are therefore those that evaluate family practice physicians or social scientists as teachers.

Quirk and Letendre (1986) found that social scientists received significantly higher scores for their teaching than the doctors when rated by the students in a small-group CCs training module. Family practice physicians were rated higher than psychiatrists in a similar study by Madan, Caruso, Lopes, and Graceley (1998). The impact of the teacher's performance was put in perspective by a study by Van Dalen, Van Hout, Scherpbier, Van Der Vleuten, and Wolfhagen (1999) who found through regression analysis that students' perception of the different components of learning during a CCs

course was affected more by the content of the program, rather than the teacher's performance. The medical coordinator for the program disagrees with this conclusion and feels that for the BMP, it is more the attention to group process and safety of the learner that greatly enhances the residents' learning (personal communication with Dr. Knell, Sept. 11, 2003).

The key to effective teachers seems to be more in the training than their profession (Aspergen, 1999). Teachers who receive experiential training produce better results in their students than those who receive instructional training (Gask, Goldberg, Boardman, Craig, Goddard, Jones, Kiseley, McGrath, and Millar, 1991; Naji, Maguire, Fairbairn, Goldberg, and Faragher, 1986). Essentially, the most effective training has the teachers receiving the same training as the students (Gask et al.). Markakis and colleagues (2000) found that when the three basic psychological needs (autonomy, competence, and relatedness) from self-determination theory were met during training, the students' learning was more successful. The teacher's level of experience does not seem to affect the students' overall learning (Fairbairn, Maguire, Chambers, and Sanson-Fisher, 1983).

The studies that found that social scientists were rated as more effective teachers than the physicians may be due to the greater similarity between the social scientists' professional training and the BMP training for students than that which the physicians receive (Aspergen, 1999). With regards to the facilitators of the BMP, the PhD students teaching the program were taught the CCs in their profession in the way that is essentially the same as the way that they are instructing the students. The family practice physician who is also the medical faculty member responsible for the program and who co-

facilitates the group also received training similar to the program that the students received by taking counselling psychology courses at UBC. All of the facilitators should therefore be effective in teaching the CCs to the residents.

Theoretical Rationale

Self-Efficacy Theory

The success that is associated with the experiential method finds theoretical support in Bandura's self-efficacy theory. The belief of an individual in their own ability to perform a given task or skill, their self-efficacy, is linked to their performance of that specific task or skill (Bandura, 1982). Strengthening a person's self-efficacy should therefore improve their performance. On the strength of self-efficacy theory, one would expect effective execution of communication competencies (CCs) to be closely related to the practitioner's belief in their ability, their self-efficacy. A major focus in teaching CCs is therefore developing the students' confidence in their own ability involving the CCs. Many of the guidelines advocated for the use of the experiential method by Smith and colleagues (1995a) and used in the BMP find their roots in Bandura's Self-Efficacy theory: Modelling, successful performance, learner self-direction, explicit performance related feedback, short-term goal-setting, attributing learner success to work rather than innate ability, and tying rewards to specific accomplishments are components of the experiential method and are tools that help improve the individual's self-efficacy (Bandura, 1977). Furthermore, the BMP draws on the principles used for conducting group therapy to facilitate the group of residents' learning by creating an environment conducive to learning and enhancing self-efficacy.

Group Processes

Learning communication competencies (CCs) for the residents can be compared to learning social skills and communication skills for a psychoeducational group because they both involving learning tasks. It follows that the principles for running a psychoeducational group may be applied to provide a positive learning environment for a group learning CCs in a behavioural medicine program.

Group therapy principles advocate creating an atmosphere of safety and trust to facilitate learning and interactions between members. The importance of the personal characteristics of the group leaders, their empathy, authenticity, as well as training them to maintain the personal power of the group members and to model appropriate behavior for them (Corey, 2000), are also emphasized to enhance learning. Since the way in which CCs are taught contribute to the learning process and eventual performance of the skills, the creators of [UBC's hospital site's name] Family Practice Behavioural Medicine Program (the BMP) drew from group counselling principles to provide an environment conducive to the family practice residents' (the Residents') learning of the CCs. Specifically, the creators used the forces of group processes to guide the teaching of the BMP and thus the learning of the Residents (personal communication with Dr. Knell, September 11, 2003).

Group processes facilitate the completion of the group tasks that, in the case of the BMP, are learning the CCs. By fostering certain types of communication, group norms, decision-making, problem confrontations, problem-solving, and conflict management, the learning of each group member is enhanced (Borgen, Pollard, Amundson, and Westwood, 1989). The rationale for how the group processes influence

group members lies in understanding the member needs. By accommodating the needs of the members, the leader provides a safe environment where the individuals are able to focus on the task rather than unmet needs. Member needs outlined by Amundson and colleagues are: "Belonging to the group; mutual support and encouragement; mutual communication of feelings of enthusiasm and success between members; comparison of situation with that of others; contribution to helping others (feeling valuable); ventilating feelings; developing a positive outlook; and a supportive leader." (p.12). Aspects of self-esteem such as belonging to a group, feeling successful, and feeling at least equally competent compared to others are part of the member needs. Self-efficacy and self-esteem are linked in that the belief that one is competent and can master a situation has a positive affect on one's self-concept (Bandura, 1982). Attending to the residents' member needs allows the BMP to provide an environment that facilitates the improvement of the residents' self-efficacy and thus their ability to perform the CCs. The influence of the leaders, in the BMP's case the facilitators, in fulfilling the member needs highlights the importance of the teaching method used, the interventions employed, and the training the facilitators receive.

History of the Development of the Program

The advent of this Behavioural Medicine Program (BMP) arose from the Family Practice Department's recognition of the growing literature about the adverse effects produced from how family practice physicians communicate. Dr. Knell (personal communication with Dr. Knell, Sept. 11, 2003) stated that the program was driven by the developers' recognition that family practice physicians' poor communication skills can negatively affect their patients, their relationships with friends and colleagues, and likely

contribute to the development of burnout. The desire to provide the family practice residents at this particular site with the skills that would hopefully minimize the development of iatrogenic (physician-induced) suffering and to improve the sustainability of those family practice physicians in the health care system, with the recognition that we would want to expand this program should it be successful, to other health care professionals as well. "We recognize that physicians unfortunately don't always do the "how to do" well although the "what to do" is hopefully there and that this causes problems and that we're taking steps to change that so that they will hopefully have more rewarding relationships with their doctors and will have better health care." (Sept. 11, 2003)

In developing the BMP, the physicians recognized the value other professions such as Counselling Psychology and Nursing could bring to the program. One of the physicians involved in the BMP development had worked with a counselling psychologist that synthesized medicine and counselling psychology. Together they could see the contributions of social competencies training for physicians. Working closely with members from both of those areas of expertise, the physicians selected the BMP topics but the sessions didn't get the expected response. A needs assessment was completed to consult the residents regarding their preferences to refine the topics of the sessions. The structure and the templates used to teach the topics were derived from research and work developed by renowned counselling psychologist and UBC professor, Dr. Marv Westwood. The templates for the program originated from work with nurses done by Dr. Westwood, Hilary Pearson, and Diane Westwood that was published with UBC counselling psychology professor Dr. Ishiyama as a social cultural competencies

training program. Cognitive Behavioural Theory provides the basis for the templates meaning the templates include a map of the target behaviour accompanied by statements and descriptions of how to verbally and non-verbally complete the behaviour. The templates for that program were then used for the BMP.

In personal communication with Dr. Westwood (personal communication with Dr. Westwood, May 31, 2004), he explained the theory driving the BMP and the why behind how the content is presented. The theoretical model was Social Learning Theory. The theorist that comes closest to the model is Bandura with his self-efficacy model discussed in the literature review. The design of the BMP is based on the notion that people can't provide effective skills with only using a cognition based model.

Dr. Westwood described how the medical teaching model often follows a 'see-one-do-one' form of instruction (May 31, 2004). In contrast, the BMP involves a microskills model that breaks the skills down and allows opportunity to practice and gain competency and confidence. The microskills model uses the experiential teaching method and the self-efficacy yielding a product that is supported by research described in the literature review. Dr. Westwood explains that "We cover what we cover because knowledge alone is incomplete, practice alone without a cognitive schema is incomplete, but the knowledge with the identified skills and practice and feedback and together provide a competency, efficiency, and efficacy with the skill." (May 31, 2004)

Ultimately, the following Program Mandates were developed for the BMP:

1) To increase the residents' level of self-awareness such that that quality can inform most of their clinical practice.

2) To learn Communication Competencies such that those skills can inform the residents' clinical practice.

The Research

The literature reviewed previously supports the value of communication competencies (CCs) to the practice of medicine and thus the value of [UBC's hospital site's name] Family Practice Residency Program Behavioral Medicine Program (the BMP). The studies present in the literature evaluate the effect of CCs training, how well they are learned, and the sustainability of the competencies. Fewer studies examine how the participants' learn the skills. The studies on this topic focused on how best to teach the skills, mainly using faculty and content evaluations by the students. Extensive investigation from the medical students' perspective appears to be absent. Therefore the research for this thesis attempts to fill the gap in the literature regarding the learning process of family practice residents from their perspective.

The research question for this study was what facilitates and what hinders the Residents' learning of the communication competencies taught within the BMP. The program is the Family Practitioner-Patient Communication Competencies component of the Behavioral Medicine Program of the [UBC's hospital site's name] Family Practice Behavioural Medicine Program. This program is an interdisciplinary collaboration between [UBC's hospital site name's] Family Practice Residency Program and UBC's Counselling Psychology Program. The purpose of the BMP is to teach specific, focused skills that are required for optimal medical practice to the Family Practice Residents (the Residents). The sessions are designed to enhance existing skills and model new strategies. The skills are practiced during the sessions so that the Residents can quickly

apply them in clinical practice. The program uses the experiential method of teaching and builds upon the residents' own experiences and personal qualities. There are fourteen 2 ½ hour sessions that are distributed throughout the two-year Family Practice Residency. Appendix A contains the Program Overview, including the program's purpose, how it is taught, an overview of a typical session, the topics covered, the program templates, the coaching provided by the team, and future plans for the development of the program.

Methodological Review

Qualitative research methodology was selected because its style is appropriate for the type of information being solicited, namely the participants' opinion of what facilitated and what hindered their learning of the communication competencies in the BMP. This study's need to understand individuals' experiences and the need to provide insight into the processes of both internal and external experiences was well suited to the qualitative style (Weiss, 1994). Weiss also notes that qualitative methodology affords a unique insider perspective that allows the reader to relate more closely to the participant from that individual's viewpoint thus permitting an understanding from a personal level.

The participants' perspectives were central to this study since the process of their learning is what is missing in the literature. The qualitative methodology is therefore suitable for helping this study to fulfill its goals of understanding the participants' experience of what helped and what hindered their learning of the communication competencies in the BMP and contributing to the gap in the literature regarding how communication competencies are learned from the participants' perspectives.

Maxwell (1996) notes that qualitative methodology is especially suited to a number of particular research purposes. Outlining four of these particular purposes permits elucidation of how each purpose uniquely fits this study:

1. Understanding, from the participants' perspectives (in this case the Residents), the meaning of the incidents they experience, and the accounts they consequently recount which, for this study, is the learning experience in the BMP.

2. Understanding the particular context occupied by the participants, specifically how the context affects their actions. For this study, the context is the participants' learning environment and the conditions that affect their practice of the communication competencies.

3. Identifying unanticipated phenomena and influences. Qualitative methodology is appropriate for this study is because the researchers in this study are hoping to identify unanticipated factors that help or that hinder the participants' learning in the BMP.

4. Understanding the process by which events and actions take place (apt because understanding the process of the participants' learning is a goal of this study).

Maxwell (1996) also notes that qualitative research is particularly appropriate when conducting formative evaluations where the focus is more on improving existing practice rather than a simple program evaluation. Qualitative methodology was therefore appropriate for this study's goal of helping the facilitators to identify the factors that facilitate and hinder the participants' learning in the existing BMP in order to make future adjustments.

The type of qualitative methodology selected for this study was the Critical Incident Technique (CIT). CIT consists of modifying or adapting a flexible set of principles to suit the specific situation being examined (Flanagan, 1954). Applying CIT to the targeted situation enables researchers to obtain first-hand reports, or reports from objective records, regarding the satisfactory or unsatisfactory execution of an assigned task or skill set that is not significantly present in the literature (Flanagan). More specifically, CIT involves asking eyewitness observers to give accounts of incidents, events or observations of events (also known as behaviours), that significantly contribute to a specified outcome (Woolsey, 1986). These experiences or observations of events are considered to be critical incidents if the participant deems the event to have been particularly helpful or detrimental to the outcome (Flanagan).

Flanagan (1954) first employed CIT to assess the performance of pilots during World War II. Since then, research has applied the technique to industry, personnel psychology, job analysis, leadership, quality of life, and psychopathology. More recently, CIT has also been applied effectively to the social sciences (Baum, 2000; Bruce, 1999; Humphery, 2001; Koehn, 1996; McCormick, 1997; Ross, 1998). The following four studies used CIT in a similar way to the proposed use of the technique in this study. More precisely, these studies illustrate the use of semi-structured interviews of participants to investigate the participants' observations of others' or their own behaviour regarding helpful and hindering behaviours relevant to each topic and the subsequent categorization of their responses: a study of unemployment (Borgen and Amundson, 1984); a study of the factors that help and hinder the unemployed in group employment counselling by Amundson and Borgen (1988); an evaluation of what helped and hindered the experience

of the clinical practicum for nurses (Dachelet, Wemett, Garling, Craig-Kuhn, Kent, and Kitzman, 1981); and a study examining female sexual abuse survivors' perceptions of which counselling behaviors are helpful and which are hindering (Koehn). Patterson and colleagues (2000) applied CIT, interviewing patients and general practice physicians, to develop a competency model for general practice and noted that, "...CIT has been strongly recommended for use in medical settings." (p. 188).

The wide variety of applications of CIT made the methodology particularly applicable to this study. CIT allows for the identification of specific tools and events that help or hinder the family practice residents learn the communication competencies. The methodology also permits the program facilitators to identify areas needing adjustment and thus contributes to improving the program. Woolsey's (1986) article on the CIT states, "...the critical incident technique is an exploratory qualitative method of research that has been shown both reliable and valid in generating a comprehensive and detailed description of a content domain." (p. 242).

Andersson and Nilsson's (1964) evaluation of CIT's reliability and validity also found the method to have satisfactory methodological rigor, finding that the material's structure was not significantly influenced by the method of data collection or by the interviewers. Ninety-five percent of the subcategories were present when two-thirds of the incidents were classified providing evidence of saturation and comprehensiveness. Repeatability and between-rater stability existed among the categories. The issue of validity of the results from the CIT, specifically whether or not all the important aspects of the content domain were found, was determined by analyzing the contents of previously published literature and by developing a rating form that was used by four

separate groups of raters to analyze the subcategories. Both results supported the validity of the findings yielded by CIT.

Research Interview Questions

As previously discussed, the study used the Critical Incident Technique. The research interview questions were designed to elicit information on what helped the students' learning of the Communication Competencies (CCs), what hindered the students' learning of the CCs, and in the case of the latter question, what the students' would have preferred to experience and how it would have improved their learning. The questions regarding helpful incidents that began the interview and were:

1. How would you describe your experience in the Behavioural Medicine Program so far? Are there are any extenuating circumstances unrelated to the actual Program that affected your experience?
2. Over the time you have participated in the Behavioural Medicine Program session, is there a specific event that helped you learn the skills?
3. What led up to the incident? Please tell me what was happening at the time.
4. What happened and what was your experience of the incident?
5. What happened after the incident? What was the outcome?
6. How do you know that it was helpful?

The next questions that focus on hindering incidents were:

7. Over the time you have participated in the Behavioural Medicine Program session, is there a specific event that did not help you to learn the skills?
8. What led up to the incident? Please tell me what was happening at the time.
9. What happened and what was your experience of the incident?

10. What happened after the incident? What was the outcome?

11. How do you know that it was not helpful?

12. What would have helped your learning that didn't happen?

13. How would you have known that these helped?

The concluding questions that allow the students to comment on what actions, if any, could have been taken to improve their learning were:

14. Is there any specific occurrence that would have helped your learning in the Behavioural Medicine Program that didn't happen?

15. How would you have know that it helped your learning?

CHAPTER 3

Methodology

Approach

The critical incident technique, a qualitative approach, was employed in this study to determine what facilitates and what hinders the students' learning of communication competencies. This method was chosen because it is appropriate for answering this study's research question and contributes to the literature.

Design

The Critical Incident Technique (CIT), a qualitative approach, was employed in this study to determine what facilitates and what hinders the residents' learning of communication competencies, as well as what the students' would have preferred to have occurred, framed in the research interview questions previously outlined in Chapter 2. Critical Incident Technique (CIT) is a set of principles developed to obtain first-hand reports, or reports from objective records, regarding the satisfactory or unsatisfactory execution of an assigned task or skill set that is not significantly present in the literature (Flanagan, 1954). Flanagan also described the procedure as being designed to be flexible, modifiable, and adaptable to the targeted situation. Incidents are experiences or observations of events and are considered critical if the participant deems the event to have been particularly helpful or detrimental to the outcome. Data from the incidents was be classified and sorted to form categories.

Participants

Volunteers from the 14 Family Practice Residents completing their second year in the BMP were the participants in this study. The inclusion criteria were:

1. voluntary participation
2. active participation in the program
3. able and willing to provide informed consent
4. able and willing to conduct interviews in English

The exclusion criteria excluded participants who didn't meet the inclusion criteria listed above or who were not able to clearly describe their learning experiences regarding the communication competencies.

Participant Interviews

The study was conducted by the researcher who is a graduate student in the UBC Counselling Psychology Master's Program with a Bachelor of Science in Psychology. The researcher was responsible for contacting, interviewing, and following up with participants and analyzed the data, wrote up the results, and wrote the thesis under the supervision of Dr. Bill Borgen, professor, UBC Counselling Psychology Program, Faculty of Education.

Residents received a hand-out explaining the needs of the study and received a further explanation by the researcher during one of their BMP sessions at their hospital residency site. Participants enrolled in the study by contacting the researcher by phone or email.

After the participants contacted the researcher, a phone interview or an email determined which participants met the inclusion criteria and maintained the confidentiality of the residents. One to two hour interviews were conducted by the researcher with the participants in a private, pre-arranged location at UBC or at a private residence.

The interviews began by establishing rapport with the participant, clarifying the study and answering any of the residents' questions; discussing expectations, confidentiality, and the consent form (see Appendix B) including the participant's rights regarding withdrawing from the study at any time; and the optional audio taping of the interview. Optional demographic questions (age, gender, first language, country of origin, culture/ethnicity, religion, and previous work experience) were asked (see Appendix C). The next questions pertained to the context of the resident, the specific critical incidents, and the details of each incident such as what led up to it, the experience of each incident, and the outcome of the event. The initial questions consisted of: "How would you describe your experience in the Behavioural Medicine Program so far? Are there any extenuating circumstances unrelated to the actual Program that affected your experience?" The proceeding questions elicited information on the events that helped the Residents' learn followed by questions related to hindering incidents. Other questions were asked (See Appendix C) that elicited more complete information about the helpful and the hindering events, and that solicited information on what could have been done to improve their learning. The questioning continued until no further incidents were recalled.

Once the interview concluded, a follow-up email or phone call in accordance with the participant's preference, was arranged to allow the resident to assess the categories and rankings in terms of importance to them personally. For both the participant's and the researcher's convenience and benefit, phone calls or emails rather than meetings were chosen. The estimated total time that participants contributed to the study is estimated to be approximately two to three hours in total with 15 minutes being allocated to the initial

contact phone call, one to two hours for the interview, and a 30 minute follow-up phone call or an email.

At the time of the interview, the participants had several sessions remaining. The interviews contained incidents that encompassed their experience to date. At the time of the interviews, all the residents had been participating in the BMP sessions for a year and a half and all but one were several months away from finishing their residency. The residents participated in several Behavioural Medicine sessions after the interviews.

Interview Analysis

The audiotapes from the interviews were transcribed and analyzed for categories using the Critical Incident Technique (CIT). The incidents were checked to ensure that the participant's account was complete, that the event or factor was clearly identified, and that the outcome was related to the study's purpose. If the incidents met the requirements, they were recorded and divided into source (context of the incident), action taken (what happened), and outcome (effect that follows the event). The clearest incidents were categorized first to serve as prototypes. The content of the interviews were categorized until no new categories were formed. See analysis section for validity and reliability checks performed on the categories.

Analysis of the Data

In order to provide a complete, detailed, and valid description of the resident's learning factors, a three step inductive reasoning process was used: a) extracting the incidents from the transcribed audiotapes and recording the incidents on index cards; b) forming the categories based on information recorded on the index cards; and c) utilizing validation procedures to check the categories that had been developed. Descriptive,

interpretive, and theoretical validity was addressed using the following procedures: 1) Participant cross-checking; 2) theoretical agreement; 3) expert rater agreement; 4) independent rater agreement; 5) exhaustiveness; and 6) participation rate.

Extraction of the incidents

The following criteria determined what incidents were extracted from the interview transcripts: a) a complete account that provides a source for the event, more specifically a context of the who, what, when, and how surrounding the incident; b) clear identification of the event or factor, essentially the action that occurred that helped or hindered the resident's learning; and c) an obvious relationship between the outcome of the incident and the purpose of the study. Initially if incidents did not meet the criteria, they were set aside to be clarified with the participant in the follow-up phone call or email. If the account, once clarified by the participant, met the criteria, the incident was then included in the analysis. Each incident was recorded on index cards under the following headings: 1) Context, 2) Factor, and 3) Outcome. The categories to which the incident was assigned was not recorded on the card to permit independent raters to complete a blind check for validation purposes.

Forming the Categories

The majority of the index cards (90%) were sorted into categories based on the similarity of the incidents perceived by the researcher until the categories were found to be exhaustive for this sample. The remaining 10% of the incidents were then sorted to verify the exhaustiveness of the category system. There were three incidents that did not fit into any of the categories and were therefore assigned to a miscellaneous category. However, the remaining 10% of incidents did fit into the previously established

categories thus fulfilling the criteria for exhaustiveness. The focus was initially on the factor or event recorded so that the specific action that helped or hindered the resident's learning of the communication competency was the defining characteristic of the categories. Once categories have been formed, the cards were sorted further to delineate between the helping and the hindering incidents. The clearest incidents were categorized first and used as prototypes. Ambiguous incidents were cross-checked with the participant who selected which category to include their incident in should their event be eligible to fit into more than one category or to create a new category should that be more appropriate.

Validation Methods

Clarifying and checking with the participants during the interview along with the audiotaping and subsequent transcribing of the interviews followed by the phone interviews with participants to cross-check the categorization of their incidents or to clarify the ambiguous incidents provided descriptive validity and account for accuracy checks. Re-categorization, changes to the wording of the categories, or creation of new categories occured at any point during the formation of the categories or during the follow-up phone interviews with the residents. Attempts were made to use the language and concepts of the participants in order to conserve the meaning intended by the participants and to maintain the anonymity of the parties involved in the incidents. The interpretive validity was addressed during the follow-up phone interview. The categories were compared to previous findings on what was most effective for teaching communication competencies to determine theoretical validity. However, because there is a gap in the literature on what helps and hinders learning from the participants' point of

view, the comparisons used research on what techniques have been found to be effective in teaching the competencies.

Expert raters who were solicited from the UBC's Counselling Psychology Program and UBC's Department of Family Practice, Faculty of Medicine, to ascertain the content validity of the categories. Two independent raters from the Master's degree program in the same program familiar with the categories (through discussion with the researcher) placed 15% of randomly selected incidents into the formed categories. Percentages express the agreement level between the researcher and the rater regarding the categorization, using a cutoff of 75-85% agreement for validity as set by Andersson and Nilsson (1964). The 10% of the incidents that were set aside to be sorted after the formation of the categories determined if the categorization is exhaustive. The participation rate, that is the number of participants to have an incident in a category to include the category, was 25%. This rate is considered generally considered to be adequate to verify the validity of the categories (Borgen and Amundson, 1984).

Confidentiality

Access to the data was given to Dr. Bill Borgen, UBC Counselling Psychology professor and principal investigator and Julia Wong, graduate student in the Counselling Psychology Masters Program and researcher. The validity and reliability checks on the initially formed categories performed by the two independent raters were randomly selected anonymous segments of transcribed data on index cards.

Each participant's consent form was assigned a code number that will be the sole means of identifying them throughout the study thus maintaining their confidentiality. The index cards containing the participants' identification codes and names were kept in

a locked filing cabinet. Only the researcher knew the identity of the participants. The transcribed data, audiotapes, and diskettes will be kept and stored in a locked file cabinet for five years after publication and then destroyed by shredding the paper, erasing the tapes through demagnetization, and erasing the diskettes. No persons other than Dr. Borgen and Ms. Wong or agencies outside the University will have access to data that identifies the participants.

One potential risk to confidentiality was that the relationship between facilitators (including head of family practice) and resident could have been affected by participation if their participation was revealed. To prevent this possibility, the thesis will not be released until after the participants have graduated and by employing the confidentiality precautions. The interview process may have generated more reflection about the communication competencies and increased the participants' self-awareness that may benefit their abilities to practice the communication competencies. It was not anticipated that participation in the study would generate any discomfort or incapacity although referral for psychological counselling was available. The majority of participants commented that they found the interviews cathartic and appreciated the opportunity to discuss at length their reactions to the program. The best interests of the participants took precedence. There was no monetary compensation for participants but refreshments were provided at the interviews.

A further attempt to protect the anonymity of the participants involved the follow-up phone call with each participant. During the phone call, each person was asked if the categorizations their incidents fall under were phrased in such a way as to protect the individuals involved in the incident. Attempts were made to word the categories in such a

way that it is not easy to identify who is involved in the incident. A significant challenge existed regarding the inclusion of participant quotes that are real and meaningful but that maintain the safety of anonymity.

CHAPTER 4

Results

A total of 116 critical incidents were identified from interviews with eight participants concerning what facilitates and what hinders family practice residents learning of communication competencies. Of the 116 critical incidents, 113 were formed into 14 categories: nine helping and five hindering. The remaining three incidents stood on their own and are presented separately. During the category extraction, a miscellaneous category was presented as an option for the expert raters to classify any incidents not fitting into the identified categories. Sixty-five (56%) of the 116 incidents were classified as helpful and 51 (44%) were assigned to unhelpful categories.

The themes that emerged from answers to the question, "What would have helped your learning that didn't happen?" are summarized following the presentation of the categories. The validation procedures are described in Part II of the chapter.

Part I Description of the Categories

The 14 categories are separated and presented according to their helpful or hindering outcome in order of higher participation first. Categories with the same participation rate are presented with precedence to the category with the higher number of incidents. The sub-themes (refer to the definition of terms in chapter 1) of critical incidents within each category are provided as well as examples of incidents. Appendix D contains the descriptive criteria used to define each of the helpful categories and the hindering categories. Table 1 lists the nine helping categories, the five hindering categories, their participation rates, and their frequencies.

TABLE 1: Category Frequencies and Participation Rates

Helping Category	Frequency	Participation Rate
1. Facilitator(s) Actions (other than Feedback)/ Attitudes /Characteristics	11	7 (88%)
2. Other Resident(s) Actions/Attitudes/Characteristics	9	5 (63%)
3. Content of Sessions	8	5 (63%)
4. Role Play Activity	7	5 (63%)
5. Facilitator(s) Feedback	6	4 (50%)
6. Code Status Session	5	4 (50%)
7. External factors to the Behavioural Medicine Program	9	3 (37%)
8. Environment	5	3 (37%)
9. Resident(s) Personal Actions/Attitudes/Characteristics	4	2 (25%)
Hindering Category		
1. Facilitator(s) Actions/Attitudes/Characteristics	15	5 (63%)
2. Resident's Personal Actions/Attitudes/Characteristics	9	4 (50%)
3. Group Rules/Norms	6	4 (50%)
4. Behavioural Medicine Program Sessions/Content	12	3 (37%)
5. Other Resident(s) Actions/Attitudes	5	3 (37%)

Attitudes and characteristics, although presented together in the categories, may be elucidated as follows: attitudes refer to opinions regarding any aspect of the Behavioural Medicine Program (BMP), including the content, the personnel (both residents and facilitators), and the importance of the BMP and its content; and characteristics are the factors related to personality and competencies.

Helpful Categories

The nine helpful categories are presented comprising a total of 64 incidents. One helpful incident did not fit into any of the categories and is presented separately after the other categories (for a total of 65 incidents). All nine of the participants contributed helpful incidents and are contributors to the examples presented in the categories.

Helpful Category 1: Facilitator(s) Actions (other than feedback)/Attitudes/Characteristics (11 incidents – 88% participation rate)

This category included: 1) Facilitator actions (other than feedback); and 2) Facilitator attitudes or characteristics. Feedback was not included because the frequency with which it occurred was sufficient to form its own category. Apart from feedback, the actions included are: demonstrating or modelling role plays; demonstrating communication skills; providing support, listening, and helping residents to process difficult experiences; body language; use of language; and the presentation of topics in what is perceived by resident to be a humane treatment.

Helpful facilitator attitudes or characteristics include: teaching expertise; expertise that residents' respect; genuine interest in Behavioural Medicine Program (BMP) topics (conveyed to residents); an evident desire to teach and help; and facilitator authenticity.

The various outcomes produced are: seeing new and/or different ways of interacting, reacting, and coping; being able to select optimal way of communicating; perception of a safe learning environment; increased motivation to attend sessions, learn the skills presented, and increase personal expertise in communication competencies (CCs); increased feelings of support; and increased openness to CCs.

EXAMPLE 1

Usually we watch the preceptors interact and show us how it should be done and I think that generally is helpful. I would watch the preceptors interact on a difficult topic, to teach us, and would see something new or see different ways of dealing with things that I wouldn't have thought of before, and then hopefully take that away.

EXAMPLE 2

The teachers were very supportive, you could feel them engaging with us which is also unusual for us cause often we're taught carelessly or we're taught coldly with no human interaction.

They're willing to listen to the whole story of my experience with this particular patient which is unusual again. Often you describe exceedingly difficult cases, then the patients, then our treatment, then our feelings, but in an incredibly condensed period of time so really normally you only get a sentence and hardly anyone's listening. Here I got to explain my sense of difficulty with the patient, the social interaction. So they listened, they listened well, offered options, gave me a chance to work at, to actually replay the situation and try and find another ending and/or to try to define the experience, and solidify in my own mind as to what was actually occurring.

EXAMPLE 3

The outcome on a more general basis was that I learned, if you're able to put in a context that's comfortable for you and the patient primarily, it's going to sound more sincere, it's going to be more sincere if you're choosing your own words with an eye to what the patient will understand, if you're choosing your words rather than employing the words that you've been told to use, that you're going to more effective in communication.

EXAMPLE 4

I don't know how to say it properly, I think, but B cuts through the psych speak, the psychobabble. B doesn't need to use catch phrases or clichés and that's what I find disturbing about C and some degree, occasionally, the psychologists can be that way. But there's an emphasis with B on put it in the patient's words. Say, if you've got a street person/drug user, they're going to respond to different words that an 80 year old from the Old Country and Europe, or, it's just going to sound a little different and B understands that and B puts it in a way that's comfortable and complete and still respectful. And there's the emphasis on don't just approach the person with pancreatic cancer as the same, you know, the next time you go to someone with pancreatic cancer. Don't say all the same things, you have to address this person as a whole and don't say the contrived and don't say that I hear you're expressing this fear and I hear that you're expressing this and I hear that you're feeling bad. Just say it in a natural way, say what comes out naturally. Express it, use the tools that were being taught in the Behavioural Med session, but you don't need to necessarily phrase it like it is on the sheet, you need to just put it in the way that it comes out more naturally for and for the patient.

EXAMPLE 5

I'd say that the most positive person in the program is D. D is fantastic, D has a style that is easy to learn from. D has a manner that connects with people. D explains the quote unquote flaky or hokey subjects in a way that don't seem flaky or hokey; D makes it seem genuine instead of rehearsed. D is fantastic at that.

I'd say D is the one factor why I've enjoyed the sessions that D's been in.

The outcome made me want to be in small groups with D.

Helpful Category 2: Other Residents' Actions/Attitudes/Characteristics (9 incidents – 63% participation rate)

Other residents helped the participant learn in two ways: 1) through their actions; and 2) by their attitudes and/or characteristics. The examples of actions are listening and interacting with the participant in a respectful manner, asking helpful questions, providing alternative view points, presenting different cultural perspectives, and demonstrating communication skills for the participant. Attitudes and characteristics such as being supportive, being committed, being open to the Behavioural Medicine Program (BMP) and its topics, being authentic, and being committed to the BMP process also helped the participant's learning. Outcomes were: perception of a safe learning environment and supportive colleagues; acknowledging and processing of emotions; clarification of their personal experience and thoughts thus increasing the validation of the process; opening up new perspectives for the resident so that when interacting with patients, resident will be aware of the different perspectives brought to bear on the issue; increasing opening up and being emotionally vulnerable; increasing self-awareness; increasing receptivity to the BMP skills presented; increased processing of unresolved

residual emotions; and allowed participant to select how they wanted to communicate/what would make their communication optimal.

EXAMPLE 1

First I got to describe it and how puzzling it was. [The other residents] listened respectfully. I couldn't have done it without a few people asking me questions, helping me analyze it, and externalizing it. And of course making my feelings conscious.
I also felt reassured that my peer group could deal with my emotional reactions to patients or scenarios. I knew it was helpful because I was more at ease with my patients, because I trusted my colleagues more and I became excited about the challenge of my patients rather than confronted or even scared of those difficult patients.

EXAMPLE 2

I had actually a caring peer group, you know, it turned out to be a caring peer group. I felt accepted, I was glad to be here. I was proud of my peer group again for being sophisticated emotionally which I hadn't expected. It set a standard for me to, for me and my peer group, to continue to try and sharpen our behaviours and support our patients and each other in a meaningful way.

EXAMPLE 3

I find the opinion of others also helped me, like, the last session we had on suicide. Another person talked about the way [their] culture looks at suicide and it was something that I had never considered before. And I found like it was, these people must be kind of a little bit more free than, like the way they looked at death is different than for example the way I do and makes them be probably not, not indifferent, but somehow they see

death as a natural thing. It's part of the cycle and nothing else, so we all go there and that's the way it is.

EXAMPLE 4

I felt like it was possible that my colleagues actually cared about me as a person. I felt like there was some sophisticated learning going on rather than me being a simple empty vessel to be filled. I felt like I had a chance to experience, or sorry, I had a chance to express my thoughts and feelings. I felt valued as a person, not just for my knowledge which you know, when you're a young doctor your knowledge base is at its worst, and I felt, I felt like there was a place for me here, so it was very helpful.

Helpful Category 3: Content of Sessions (8 incidents – 63% participation rate)

This category encompasses the content of the sessions, apart from role plays, that helped the residents learn the communication competencies (CCs). Role play was reported with significant frequency and is therefore a separate category. The helpful content consists of: specific topics such as Bad News Delivery, professional resiliency, and difficult patient sessions; the templates; session discussions; the inclusion of the Behavioural Medicine Program (BMP) and its CCs as part of the residency curriculum; and the experience of the BMP process. The various outcomes included: viewing new or different ways of dealing with situations; increased comfort with similar issues in a realistic context; increased knowledge about topics; acquisition of skills; guidance regarding how to begin to practice skills; implementation of template tools; increased confidence of acquiring appropriate methods of communication; participants' increased self-awareness regarding their own capabilities, limits and where to draw the line; increased courage to assert fulfillment of the participants' own needs; a stronger

conviction on the validity of CCs to the practice of medicine; heightened interest in and learning CCs; using self-awareness to inform practice; increased motivation to learn BMP content; and a safer learning environment.

EXAMPLE 1

The fact that these sessions that are incorporated into residency program sort of affirms the value of them, so my residency program feels that I should be able to communicate properly within the realm of let's say, end of life care or suicide issues, things that are not formerly or explicitly trained or taught in either school or in your internship otherwise. Like your general surgeon, for example, won't take you aside and say, like, you know, Mrs. So and So is dying because you know, of her cancer. We're going to go and talk to about, you know, how she feels, how she feels about that. They're going to consult palliative care about that.

I would say accelerated, it, it's, it deepened, it put it on a higher level in terms of skills that I wanted to take with me. So being, let's say, an official part of a curriculum makes it more, validating. Credibility, I guess, yeah. As something that should be a part of being a doctor.

EXAMPLE 2

You know, it's not everyday that you have to put the kind of topics that we cover into practice so I think, overall, you probably don't realize it. But I think they do sort of, I'd say it's more of a desensitization process in a way. Like the more you see something or the more you're exposed to something and the more it sort of creeps into the back of your head, it becomes less elusive in the end. So I don't think it will be me sitting in an office

or in a hospital and being triggered to an exact moment during a session, it will be more like something happened along the way.

In reference to the BMP bringing some issues to conscious awareness: Yeah, like it's an awareness, it's being able to bring something that's maybe in the back of your head that you've never talked about out in the open, yeah, yeah.

Because the way that the medical culture, it traditionally doesn't put as much value on what the sessions are about so it, not sure how to describe it but, there is tremendous value in the issues that we talk about, because they've been ignored for a long.

EXAMPLE 3

It [the content of the BMP] reaffirms the fact that what you were feeling all along about all these things are probably real and true and that you don't have to sort of hide behind, you know, the title of doctor, that you're also a real person too, you're not just a doctor.

EXAMPLE 4

I remember the professional resilience [session]. That was useful. I thought it was a good session to have this because it isn't anywhere else in the curriculum.

Some of the people who were leading it talked about sort of what happens when you sort of don't allow yourself to process things and let go of them or how you are at risk of losing some of yourself or getting burnt out or however you want to look at it but, it was useful just to hear that, and you know, have a chance to reflect on how we might do that ourselves you know.

I think it's [self-care] something that I know but you have to be reminded of it. And it was useful to see people that you respect reflecting on their own experiences.

I know that if we didn't have that type of thing in the curriculum then, because the majority of the residency program is performance and very long hours that are expected, you know you're not really expected to need like an hour's sleep in the middle of the night when you're working 24 hours, so to acknowledge the humanness I think is really important because it gives you some...some, I'm trying to think of what the word is but, to know that yes that is, (It validated) valid yeah, it's valid to say, "you know what, I just need an hour." And sometimes I do that, instead of just being, and I know that I'm much more likely to make a mistake, you know, and usually the nurses can give you an hour, you know. Like they'll just save things up and give you an hour, to have a nap. If there's emergencies and that doesn't happen then that's okay but I think that it was useful because the context of residency in general is still, you should be able to be superhuman or something.

Helpful Category 4: Role Play Activity (7 incidents – 63% participation rate)

This category catalogs the frequency with which participating in a role play activity was cited as helpful by the residents. The specific session topics in which the role play was most helpful were listed as the difficult patient session and the breaking bad news session. Being allowed to role play actual experiences and playing the role of a patient were also described as helpful aspects of the role play. The various outcomes of the role plays included: increasing the resident's comfort and confidence when working with difficult patients and in anticipation of future encounters; gaining skills to create a better experience for both resident and the patient; increasing the resident's self-awareness regarding their own reactions and behaviours in similar situations; learning through observation and practice; increased receptivity to the Behavioural Medicine Program and

learning communication competencies; feeling respected both as a person and a physician by having the opportunity to practice the skills in a scenario that felt authentic and genuine; and feeling respected by efficient use of time and presentation of appropriate topics.

EXAMPLE 1

I remember the previous one that was about dealing with difficult patients and I think I did the role of a patient that, there was a very difficult situation where the patient had yelled at me and she was really upset in the sense that she had been given a medication that was, that had some side effects and she had gone through the side effects and she was really upset and she yelled at me. And she couldn't, she was so angry that she couldn't behave I guess but I felt at the time that she was yelling, and she was so mad so I learned that in doing the thing again it felt, I was just about to get up and the staff person just said no, no it's not time to get up. You ask her what is it that really bothers her and just go over the situation don't run away because it's not your preceptor, because I was in my preceptor's office when that happened, and she said, no, no, no, no ,no no. You talk, you're the doctor you have to deal with the situation so she intervened. So I, what I found really useful was that I was repeating the same thing that I had done and by doing it a second time, I was able to to learn what was the next step. It was really unacceptable that I go out of the clinic and look for help because in this interaction I am the doctor and I have to deal with the problem.

EXAMPLE 2

The main thing that I found really helpful to me was to practice, to rehearse the things, the play role [the role playing] what they do. I find it very, very helpful.

EXAMPLE 3

Being able to set up a scenario where you can be honest and forthright, where you can explore a situation or a story or an event in a safe way where you feel better after having looked at it then rather than feeling worse, to be able to do that is an art. I had never been given permission as a physician before then to be a feeling person who has experiences.

Helpful Category 5: Facilitator(s) Feedback (6 incidents – 50% participation rate)

This category is formulated from incidents where facilitator feedback was perceived as helpful by the resident. The range of ways feedback was helpful included the type of feedback (good and efficient rather than extensive and directive), the topic of the feedback (how to deliver bad news), and the situations in which the feedback occurred (during role plays, during specific sessions). The various outcomes of the feedback reported by the residents included: a rise in the resident's comfort level with breaking bad news; heightened conviction in the effectiveness and validity of communication competencies (CCs); greater knowledge regarding how to implement the CCs in a medically relevant way; increased acceptance and receptivity regarding feedback and learning the skills; a stronger sense of being respected; awareness of optimal modes of communication through demonstration; more motivation to learn CCs; greater confidence in their ability to cope with difficult situations; and increased comfort with using the skills in real situations.

EXAMPLE 1

It worked when they weren't pressing me to do anything particular. It worked best when they saw, when they watched what I was doing and gave specific feedback on that but not directive feedback. Things like, "That seemed to work well." And, "This is what it

sounded like when you know, you told me this." The things like, "Maybe you should try this," or "let's do this," and "try this," weren't helpful. I guess it was more when they usually worked with me rather than try to make me do what they would do.

EXAMPLE 2

Well, I found that the feedback was more clear and more applicable and I found that the whole experience was a lot shorter because they kind of said, "this might be helpful, this might not be helpful. I'm just putting, you know, I'm just saying, this is what I say and you know this is what I would do." They didn't say, "let's do this again," but they did kind of talk about my experience, talked about what they saw as the whole experience and let it go with that.

EXAMPLE3

Well we all worked through a, I think we all worked through a scenario but what H did was [H'd] stop you part way and just sort of say, "you're going real well, what if you asked this, where would that take you," and sort of let you pause and think about it for a moment and say, "Oh yeah, that would actually nicely transition from one topic to the next" and you could see where H was going. H, almost encouraging you to empathize and be connected with your patient and yet stay in your mind thinking, "how am I going to draw out."

Helpful Category 6: Code Status Session (5 incidents – 50% participation rate)

As outlined in the definition of terms in Chapter 1, code status refers to the patient's and/or their family's preference for the order regarding resuscitation measures. This category refers to the frequency with which the participants reported the Code Status session as being helpful to their learning. The aspects of the Code Status Session the

participants found helpful included discussions related to the topic of code status, how to bring up the topic with patients and their families, and validation of the resident as a physician and person through the discussions. The inclusion of a code status session in the BMP allowed a variety of experiences to occur for the residents with a range of outcomes: increased awareness of the factors that need to be considered regarding code status and subsequent communication with a patient and their family; greater comfort and motivation regarding discussing code status with the patient and their family; an opportunity for the residents to reflect and practice how they would like to communicate with patients about code status; and increased the residents' knowledge about the realm of their responsibility regarding code status decisions thus relieving some of the self-imposed pressure and improving their self-care.

EXAMPLE 1

Like we had a session about it [code status] at some point and then part of the rules I guess you can say, or part of the, part of proper patient care let's say on the family medicine ward is to make sure you know the code status of a patient or make it known to the nurses and the doctors and everyone else so that's clear, so I would say that that session helped me to take and approach to how we do this with all patients.

I would say the session's quite helpful because, it just, it's something that you know you have to ask, but you don't know exactly, besides how to ask it, but what are the issues surrounding the whole decision-making process. It's not just going to a person and asking them, you have to sort of be wary of all the other things going on so, the session was useful because we don't, we didn't just teach us how to ask a patient, they were like, what are we really talking about here. So that was useful.

EXAMPLE 2

Well, I mean, I think the outcome was positive in terms of my practice because I feel more comfortable just having spent that amount of time talking about, that your comfort level increases and you know, I asked everyone about it. So prior to that I certainly wouldn't have felt comfortable asking someone I just met about code status but now I sort of see it as part of a job and that people want to be asked and seem to think so as well. That's been the outcome.

EXAMPLE 3

I think it is emphasized in the session that I shouldn't carry with this situation, that I, that although I have sort of responsibility for my patients I am also a person and I have to, I have so many incidents to deal with that I can't bring everything into me but, so that part is, I think helps me but somehow dealing with I guess all the youth in my training and before when I was in Y, I know that I can't help, like every single person into my own, it would get really impossible that I deal with everybody's things.

Helpful Category 7: External factors to the Behavioural Medicine Program (BMP) (9 incidents – 37% participation rate)

This category included incidents that occurred outside of the residency BMP that helped the residents' learning: participating in a medical school BMP; participating in an outside project involving communication competencies (CCs); encounters with patients before, during, and after the BMP; observation of preceptors outside of the BMP; specific instructors outside of the BMP respected by participant; the realistic context and structure of the activities in a medical school BMP; a seminar attended by the participant; and observing a variety of people outside of the BMP. The outcomes from these experiences

included: learning the CCs outside of the BMP; increased motivation to attend sessions and learn CCs; affirmed the validity of the content of the BMP; heightened conviction of the relevance of the CCs to medical practice; new ways of resolving communication issues; being exposed to previously unknown CCs; greater interest in learning CCs prior to the start of BMP; and an opportunity to observe both poor and effective communication from which to select the desired mode of communication.

EXAMPLE 1

I learned it in medical school. I went to X, we had a really, really good instructor and great sessions on how to give bad news, how to get a DNR [Do Not Resuscitate order], how to deal with a bad patient, all that kind of stuff, and so I came from a very good PBL base learning school where I'd done a lot of that. I got a lot of my skills there.

EXAMPLE 2

Yeah, just seeing a lot of different kinds of patients and the occasional one that you know there's issues with let's say suicide or end of life care, the more like, the heavier issues of life and death. Yeah, and they sort of stick in your mind and either if it's after or before these sessions, there's, somewhere you make a little bit of a connection between them.

EXAMPLE 3

I was enrolled in a seminar which was very positive experience for me which involved looking at everything that medicine is not in a sense, like looking at whole integrated picture of how a person becomes ill, besides from what we'd learned in med school so in the seminars which was, like, what, twice a week for three weeks, something like that, not every one was a positive figure, or a couple actually, that you develop respect for, you've already had respect for them.

Helpful Category 8: Environment (5 incidents – 37% participation rate)

The participants reported several ways in which the environment of the Behavioural Medicine Program (BMP) was helpful to their learning: perceiving the environment as safe, welcoming, an optimal learning environment; and providing a contrast to other environments such that the BMP was a more safe learning environment. Such perceptions produced the following results: decreased anxiety; increased focus on the content of the BMP; a supportive learning environment; and increased self-awareness and sharing with the group.

EXAMPLE 1

It's not just a safe environment it's almost like a learning environment that I would have hoped for.

Well, the environment of let's say the sessions themselves. I thought it was kind of neat at the beginning, we were, you were told to, you know, it was at, let's say at the beginning when we were just getting to know each other, it was a bit more personal, created a somewhat more nice environment to share experiences and emotions with.

EXAMPLE 2

For me the quality that I think I really enjoyed about the program was the sense of safety, I thought, or acceptance in that environment. I think so often in medicine we're sort of, we're being evaluated and there's a sense of there's a right way and a wrong way to do things and so in this environment there's no such thing as a right way or wrong way, it's all just the validity of each person's individual experience and so, to me that environment itself, is more relaxed. And I just really enjoyed the manner and the, and just the vibe

from all the people, most of the people I guess who facilitated such that it felt like a welcoming environment, a very non-threatening environment.

Helpful Category 9: Resident's Personal Actions/Attitudes/Characteristics (4 incidents – 25% participation rate)

This category consists of the actions, attitudes, and/or characteristics of the participant that helped their learning of communication competencies (CCs). Actions that helped learning included opening up and sharing feelings with the group. Attitudes and characteristics of the resident also helped learning such as allowing oneself to be emotionally vulnerable during the activities, personal beliefs regarding the value of CCs and the Behavioural Medicine Program (BMP), the resident's appreciation for the intent of the BMP and the difficulty of learning and teaching CCs. Outcomes that occurred included: heightened self-awareness; learning of CCs; trust in those involved in the BMP; stronger belief in the value of CCs and therefore greater motivation to attend sessions; increased commitment to and patience with the learning process; and more open and real participation in the activities in the BMP.

EXAMPLE 1

I might say the process of opening up and the process of allowing myself to be emotionally vulnerable would be something that helped me learn the skills.

EXAMPLE 2

I mean I appreciated the intent of the Behavioural Medicine Program, and could appreciate that it was an important aspect of medical education so I was sort of more committed to the idea of participating, and then appreciated also that the skills that they

were trying to teach us were so much more complicated than what we could learn in that context.

One incident did not fit into any of the categories (and was classified as miscellaneous by both the researcher and the expert raters): the resident reported that the scheduling of the BMP sessions over the two years allowed them time to process different experiences throughout the two years and explore questions that came up over the time.

> I'm glad it's spread out over the two years and not condensed down to a week or something, because I look forward to the Behavioural Medicine component. It's reassuring to come back to it with a little more experience and a few more questions that can be explored.

Some of the helpful categories provide guidance to the BMP developers regarding what factors or experiences are helpful to the residents' learning and should be retained, increased, or enhanced. Others provided information regarding the content of the sessions. Chapter 5 explores the theoretical support for the helpful categories and the implications for both practice and research.

In addition to the facilitative incidents described previously, the residents described critical incidents that hindered their learning of the CCs. These were grouped into the five categories that are elaborated upon next.

Hindering Categories

This section presents the five categories that did not help the participants' learning. Forty-nine incidents form the categories. The two incidents that did not fit into any of the categories are presented following the five categories. The examples presented

in the categories represent seven of the participants. One participant did not contribute to the hindering incidents.

Hindering Category 1: Facilitator(s) Actions/Attitudes/Characteristics (15 incidents – 63% participation rate)

Facilitator's actions, attitudes or characteristics were frequently cited as unhelpful to the participants' learning. The incidents included: perception of facilitator as incompetent; facilitator's insistent suggestions and pressuring participant to use them; directive feedback; directive instruction during role play; pressuring participant to share feelings; having feedback expressing dissatisfaction about the Behavioural Medicine Program (BMP) disregarded by facilitators; being singled out in group discussion by facilitator; and poor modelling of communication competencies (CCs) by facilitator. The outcome of the unhelpful incidents consist of: decreased receptivity to the facilitator's instruction; less commitment to the BMP; cultivated negative attitude towards BMP and instructors; diminished belief in the value of CCs; fostering belief that the BMP was a waste of time; decreased belief in group norms; a reduced willingness to participate in the BMP; decreased openness to the BMP content; increased frustration; and feeling disrespected and unheard.

EXAMPLE 1

This person, both in these sessions, and even when J would be talking to us as a group seemed uncomfortable and would use these really irritating catch phrases that are okay if you use them once but when you use them repeatedly, it starts to become meaningless and it starts to sound like you're just spewing you know, buzz words that don't mean

anything to you, so it came across as very ingenuine if that's a word and you know I think that, so that, seeing that is like okay, we're expecting you to do this.

EXAMPLE 2

And then you have someone model it that way and you think, (exhale) "sorry, I'm not going to do that, I'm not going to interact with people that way," because it comes across as completely insincere and patronizing in some ways and just sort of a stereotype of all the things you imagine to be the worst things about psychology.

EXAMPLE 3

What happened is repetition of what I perceived to be insincerity professing to be sincere. I found it to be very hypocritical, I found it to be very off-putting to the point where I would speak to colleagues about it after and just say, K's infuriating me and some of that was echoed but it got to the point where I'd actually discussed with colleagues and I said, I can't take K anymore, I just can't stand K.

I think that with a hundred percent honesty I form a block to what K brings to the sessions. I think K makes my skin crawl so I sort of say, "I can't take this, I don't want to listen." So even if K was to bring forth a more applicable, more important point than I'd seen yet, I'd probably be adverse to hearing it, I'd probably just have my back up. I don't know, I don't know what K'd do to reverse that but, yeah.

EXAMPLE 4

As I mentioned before, just the fact that often times the facilitators would be very directive in what they wanted us to say and do and basically who they wanted us to be in a role play so to me that wasn't helpful because I found quite often that the role play that they had given us on a sheet wasn't anything similar to what I would have said or done in

the situation. I would have had the same end point, I would have gotten the job done but I wouldn't use the same words or wouldn't have done what I felt to be, you know, I wouldn't have had a conversation that I felt to be patronizing which I thought a lot of those role plays seem to be.

EXAMPLE 5

I found quite often that I wouldn't give an opinion because I didn't like something but they [the facilitators] would, you know, even though they said not everyone has to give an opinion, if I didn't give an opinion they would point at me and say do you want to give an opinion, and single somebody out in other words and so, you know, you can't blame them entirely cause they just wanted to make sure that everyone was included but it just wasn't consistent.

Hindering Category 2: Resident's Personal Actions/Attitudes/Characteristics (9 incidents – 50% participation rate)

Participants reported that their own actions, attitudes, and characteristics hindered their learning at times. The incidents included having different priorities to that of the Behavioural Medicine Program (BMP), having little faith in BMP content and process, not respecting facilitators, seeing no value in the activities, not feeling able to openly disagree with others, feeling disrespected as an adult learner, and feeling closed off. These hindering incidents led to the following outcomes: frustration with the time allocated to and spent in the BMP; decreased motivation to learn CCs; anxiety regarding the BMP; resentment about attending the BMP; decreased commitment to the BMP; diminished belief in the BMP; poor attitude regarding the BMP; reduced receptiveness to the BMP content and activities; and unwillingness to participate.

EXAMPLE 1

In reference to the resident's priorities being different to the BMP: There's so many things that you don't know about the medicine part of things that the thought of having to concentrate on how to give bad news and all of that is overwhelming because you're thinking well, I don't even know what type of insulin this person should be on let alone that they're dying from the diabetes, you know, so there's kind of a, we have a hierarchy in our head in that, in order to prevent this person from dying I should know how to treat them, and I don't know how to treat them.

EXAMPLE 2

And I honestly don't know if you can teach people who have so much to know, I don't know if you can teach them to be good behavioural medicinists or whatever, like they either have it or they don't and hopefully because they've gotten into medicine, they've gotten into family medicine and that they've gotten into this program, people choosing them have enough information to say this person is the type of person you want because of how they interact, how they are with people in general. We need to trust that, they're going to be able to deal with some of these situations then, that they don't need to spend three hours on the one situation.

EXAMPLE 3

I think a lot of the reasons so far that I didn't learn things was because I had so little faith in the actual process of things after that that you know, I did try but I really didn't put much faith into what the result was going to be and, I don't know. I was uncomfortable usually when we were doing things. I didn't feel the set-up was comfortable and I don't know we just, they, there's a lot of pressure to think up situations that fit what they were

trying to teach because they put it onto us to come up with our own past experiences and that was sometimes the barrier.

Hindering Category 3: Group Rules/Norms (6 incidents – 50% participation rate)

This category pertains to the group rules or norms that the participants listed as unhelpful: mandatory attendance; mandatory participation in role plays; proscribed tools for role plays; imposition of facilitator generated group rules and norms; and inconsistency between stated rules and the treatment in the groups. Outcomes of the incidents included: decreased receptivity to learning communication competencies; increased anxiety; difficult group atmosphere; feelings of disrespect and not being heard; reluctance to attend the Behavioural Medicine Program (BMP); decreased commitment to the BMP; unwilling attitude; diminished perception of safety in the environment.

EXAMPLE 1

I think that sometimes it might have been useful to not require everyone to do the role playing but rather to do the demonstrations and then ask for volunteers and that some people would just observe because that's where their comfort level was and that they might have learned more from it rather than the anxiety of, because I actually like performing and drama and stuff but there certainly was a bit of you know stage kind of pressure.

EXAMPLE 2

I think it's very important that the, I don't know how to say this. The residents have to be there I know. I know it's mandatory for the residents to be there. However a resident who's there against their wishes is not a resident who's able to create a safe environment for the rest of us to work in, they detract from our experience.

Hindering Category 4: Behavioural Medicine Program (BMP) Sessions/Content (12 incidents – 37% participation rate)

Participants reported a number of different aspects of the sessions they perceived as unhelpful to their learning of the communication competencies (CCs). The range of content and activities in the sessions that were listed as unhelpful included: skills unnecessary to a medical education; the check-in activity; the discussion on Do Not Resuscitate orders; rehashing topics; the whole opening session; psychosocial and group process activities; inappropriately used or inauthentic catch phrases and tools; unrealistic role play, scenario, and/or template; the content and experience of the Behavioural Medicine Program (BMP) being very different to the experience and clinical aspects of residency; and the participant's belief that they already possessed the CCs having learned them in a medical school BMP. The various outcomes were: decreased belief in the value of the CCs for the medical profession; perceiving sessions as a waste of time; reduced commitment to activities in the BMP; a negative attitude towards the sessions and content; increased anxiety; decreased willingness to practice or use tools or attend sessions; belief that skills lead to inauthenticity; and feeling that the time spent in the residency BMP was wasted for that resident because skills already acquired.

EXAMPLE 1

We did this little thing called check-in where you had to leave, you've heard about this, we leave things behind. Completely useless, like there's no point to that at all, it's just really ridiculous. I've nothing to leave behind so it was a waste of time for me and was it a barrier to things, not really, just kind of, you know, it led to again a kind of lack of

integrity of the whole thing because there was just no, there was nothing there that was useful or that was interesting and, you know.

EXAMPLE 2

I also don't like what they call the templates. I'm never going to use the templates, I'm just not. I don't think anybody else is going to either so I think taking those out altogether and just discussing would be better.

EXAMPLE 3

A lot of it wasn't helpful. For example when talking about the DNR [Do Not Resuscitate], their aim was to discuss how you'd bring it up with a family and how you'd be sensitive and different steps to go around that which is fine, but we're all sitting there saying well, what are the options for a DNR, what are the actual, you know, number 1 you don't do anything, number 2 you don't go to CCU/ICU [Critical Care Unit/Intensive Care Unit], number 3 you don't get intubated, like, we didn't know the facts about what do we actually have to offer them, so the whole conversation about how to present a DNR was useless because we didn't actually know what our options were to present, so that was a really useless.

EXAMPLE 4

So, the airy fairy stuff is the different language, or the checking in, or the always going back over things so, "What I've heard you say is," or "Now if I could use a different word," or things that personally I feel would make people feel belittled and that I would never use because I don't want to hear that stuff coming out of my own mouth with my patients.

So that's the airy fairy stuff, obviously how people feel that's why we're in the profession, we need to know what's going on in the mind and how it's affecting the body and what have you but the way they go about it is not how I would ever treat my patients.

Hindering Category 5: Other Resident(s)' Actions/Attitudes (5 incidents – 37% participation rate)

The participants described a number of incidents involving the actions or attitudes of other residents as unhelpful to their learning. The incidents included other residents not committed to the Behavioural Medicine Program (BMP) sessions, comments from other residents indicating dissatisfaction with the BMP, insincere group members during the BMP sessions, perceiving that other residents had difficulty adjusting to the difference between the residency and the BMP program, and observing a disinterested resident participate in a role play. The incidents resulted in reducing the safety and support in the BMP environment, decreased the connection the participant felt to the group and the activities, and feeling that their own participation as well as the welfare of the patient was devalued.

EXAMPLE 1

Speaking on why other residents were less committed and therefore created a less supportive environment:

Asking residents to suddenly share their feelings when there's been, asking residents to express their or indulge their feelings when for eight years we've been trying to learn not to is different for them. I think many of them are emotionally tired or not emotionally sophisticated. I think some are less patient or less committal about the, what's the word, just the human side of our interactions, more comfortable with the hard diagnostic

treatment-oriented flow charts. They are less committed to say delivering bad news. What I mean by commitment is, they are going to give themselves over to a scenario requiring an intellectual prowess but when it come to, I have to make this patient feel better, less committed or they don't know how to commit to, you know, finding a good ending to that.

EXAMPLE 2

I saw a resident in a role play who was uninterested in committing to the role. For instance, discussion with the patient was vague, was dishonest, it was, it had little effort to it. Afterwards I heard [them] speaking at lunch, at snacks, saying, I don't like this stuff, it kind of pisses me off. I was surprised because it's done in the spirit of helping our patients, helping us help ourselves, a chance for us to practice one rather than just go do one and, and it's fun. It can be fun if you think it's fun. Of course it's subjective, it leaves room for subjectivity and this person's decided, or was not encouraged to be open to these experiences.

I knew it wasn't helpful because I felt that that resident was not learning, was not participating in the exercises and thus did not have a good outcome. I felt like my experience was devalued. I also felt like the patient's desire to feel good about the interaction had been lessened on the list of, in the hierarchy of things you want to accomplish in patient interaction.

Two incidents did not fit into any of the categories (and were put under miscellaneous when sorting the categories): finding the large size of the group as hindering learning because it was perceived as a threatening environment in which to

open up; and a group atmosphere that is "not completely safe" and thus hinders learning because participation and opening up during the course was inhibited.

The hindering categories may inform those running the program on modifications to reduce factors or experiences that hinder the residents' learning. Other incidents, however, are more difficult to predict or to control. Hindering incidents that occurred due to personality factors regarding the residents and/or the facilitators are most likely unavoidable. Time factors and group size may also be difficult to control due to time or economic constraints. However, awareness of the hindering incidents allows for preparing steps that may be taken to mitigate uncontrollable or unavoidable factors should they happen. Using the categories to increase awareness of hindering factors may also allow early identification of problems that may provide both learning and action opportunities to benefit both facilitators and residents.

What Would Have Helped

The nine helpful and the five hindering incidents categories were elicited from questions regarding what happened. Table 2 presents the twelve themes noted from answers to the question, "What would have helped your learning that didn't happen?" by the eight participants and the frequency the categories were named. All of the eight participants in the study contributed to this section. Summaries of the comments by the participants are presented under the relevant themes.

Theme 1: Discussions

Four residents proposed increased use of discussions in the Behavioural Medicine Program sessions. The format of the discussions suggested included psychologist-led roundtable discussions, Balint groups, using less mandated ways of exploring self-

Table 2: What Would Have Helped - Themes and Participation Rate

Theme	Participation Rate
1. Discussions	4
2. Program Purpose	3
3. Real Scenarios	3
4. Background Facts	2
5. Group Work	2
6. Environment	2
7. Evaluation and Supervision	2
8. Personality Conflicts	2
9. Preparation	2
10. Voluntary Participation in Role Plays	2
11. Skill development	1
12. Timing of Behavioural Medicine Program	1

awareness, replacing templates with discussions, broadening the discussions to more practical things, and more one-to-one discussions with someone with clinical experience who's willing to share their experience with you and to help you work through maybe some of the, what you perceived flaws in your experiences would help, because "putting things into a cookie cutter is not the way to teach people to be authentic."

Theme 2: Program Purpose

Regarding the program purpose, participants suggested that more focus and efficiency as well as demonstrated relevance of the program to the residents' perception of "real life" be attended to. The following suggestions were given: present physician anecdotes where a poor patient interaction led to a law suit or having the patient transfer their care; testimonials from previous Behavioural Medicine Program participants reporting, for example, this course taught me this skill that I use often. One participant reports that, "something to draw out how this applies to our real practice and applies to our real life would have made a little more, a little bit better enhanced learning experience." Essentially, anything that persuades or convinces residents that they need this program and that it will benefit them would be helpful. Another participant thought that, "Learning more about the importance of the patients' subjective experience with the physician as being high on the list of things to accomplish" would be helpful. From the participant's perspective, "Doctors often have their own agenda around diagnosis and treatment. The patient is not rating us on that but on our kindness, our ability to interact in an intimate way with them so that medical students and residents need to be taught that value."

Theme 3: Real Scenarios

More real patient scenarios were suggested as well as specific difficult patient scenarios that pertain to the hospital to which the residency program was attached. To elicit the realistic examples, participants suggested email solicitation prior to sessions, video analysis of genuine encounters, incorporation of sessions into palliative care rotation or family medicine ward, or videotapes of interactions that aren't too contrived. Deceitful patient or drug seeking patient scenarios were examples described that would be especially useful for the participants' residency site.

Theme 4: Background Facts

Provide more background facts about issues and information, for example, a Do Not Resuscitate session, before starting the communication competencies development segment of the session because residents are often fearful of their lack of knowledge and believe that searching for information demonstrates ignorance. Residents often want to know "more hard core kind of clinical information: such as how often does resuscitation work, specifically what are the success and failure rates or more in depth information such how do you do an in depth suicide

Theme 5: Group work

Minimize group work or decrease size of group. This was requested because resident reasoned an increase in numbers, raises likelihood of suppressing somebody's opinion. assessment and what things can you not miss and what are the most important factors and how do you contract.

Theme 6: Environment

Two changes to the environment were requested: no observer and a more relaxed environment so that the participants would feel less embarrassed if they became emotional.

Theme 7: Evaluation and Supervision

The desire to incorporate practicing the skills into their clinical work after the sessions or an analysis of their skills in the form of mock interviews or being videotaped on the family practice ward was present in the participants. An evaluation was thought to demonstrate a direct correlation between the skills and how they would be used by the residents in the future. The relevance of the communication competencies (CCs) to medical practice would also be demonstrated by having faculty preceptors supervising the residents encouraging the practice of the CCs learned in the Behavioural Medicine Program and including the context of the Behavioural Medicine sessions in the ongoing patient interaction experiences and discussions.

Theme 8: Personality conflicts

Monitor relationships between facilitators and residents to permit specific pairings, avoidance of specific pairings due to personality differences, or use potential conflicts as a group learning opportunity.

Theme 9: Preparation

Participants had two suggestions regarding how to prepare residents for the experience of the Behavioural Medicine Program (BMP). Due to the intimacy involved in participation in the BMP, starting the year with a social like a wine and cheese before the courses start so that instructors and students can become acquainted without any type of pressure was

one idea. Explaining in advance about the emotionally sensitive matters that are covered in the BMP was another idea. In the resident's words: "maybe I would explain in advance that these are very, that we know that these are very sensitive matters but try not to be personally involved in the things, it is just a learning experience. And the things that we have done in the past, and those that we are playing, we will go through the experience in a way that we will feel this is my personal situation. I have felt the things [the role plays] that I have done."

Theme 10: Voluntary participation in role plays

Voluntary participation in the role plays was also recommended with the expected outcomes of validating the residents as adult learners and the likelihood that residents would participate as their comfort and safety in the sessions grew.

Theme 11: Skill Development

One participant desired a more tangible kind of skill development. For example, how to talk to patients in an informed way about code status.

Theme 12: Timing of Behavioural Medicine Program (BMP)

Conduct the BMP, teach communication competencies, in medical school, later in residency, or schedule the majority of the sessions in the second year. Changing the timing of the BMP would allow residents to feel less overwhelmed at the start of residency by already bringing a competency in communication skills to the program or would allow the resident time to accumulate experiences that the BMP would help process.

Part II Validation Procedure Results

Exhaustiveness

The purpose of this validation check was to ensure saturation and comprehensiveness. Following the recommendation by Andersson and Nilsson (1964), 10% of the incidents were left unclassified until all the categories had been formed. All of these incidents but one fit within the formed categories. Therefore although the categorization system was considered comprehensive, exhaustiveness may not have been achieved.

Participation Rate

The rate of participation was determined by counting the number of participants that contributed incidents in each category and then calculating the percentage out of the total number of participants interviewed. Participation rate of 25% or higher is recommended as sufficient to demonstrate the validity of the categories (Borgen & Amundson, 1984). The participation rates ranged from a low of 25% (Helpful Category 9: Resident's Personal Actions/Attitudes/Characteristics) to a high of 88% [Helpful Category 1: Facilitator Actions (other than feedback)/Attitudes/Characteristics]. As noted by Flanagan (1954), categories are increasingly valid with the increase in the participation rate. The participation rates and frequency rates for the 14 categories are presented in Table 1 in the results section in chapter 4.

Participant Cross-Checking

This procedure was performed to address descriptive and interpretive validity and took place during the follow-up emails. The respondents reported no unclear categories and confirmed the categories were meaningful to them and accurate.

Independent Rater Agreement

Anderson and Nilsson (1964) indicated that the acceptable level of agreement between raters on the categorization is 75%-85%. Two independent raters participated in a one-to-one training session with the researcher explaining the names of the categories and the subcategories. One of the raters was a doctoral student in the Measurement, Evaluation, and Research Methodology program in UBC's Faculty of Education. The other rater was a doctoral student in the Counselling Psychology PhD Program at UBC. In each sorting, the researcher read the 14 categories to the rater and clarified the definitions when asked. All the incidents had been written on index cards. One independent rater sorted all the cards. For the other independent rater, the researcher had randomly chosen 35 (approx 30%) critical incidents (three or four for each category). The original plan was to use only 17 (15%) critical incidents but this would have required only one to two incidents be sorted per category because there are 14 categories, and this was deemed insufficient for assessment of agreement. The independent raters sorted 116 and 35 index cards respectively into the 14 categories. For the first rater's sorting, 92% agreement was achieved; 81% agreement was obtained by the second rater's categorization. The majority of the disagreement was attributed to terminology confusion such as the difference between medical school and residency. Several incidents were classified differently because the incident was misread. Both sorters fulfilled the criteria for what is considered an acceptable level of validation.

Expert Agreement

The researcher asked two physicians and one psychologist with behavioural medicine interests to judge the relevance and usefulness of the categories to the

Behavioural Medicine Program Evaluation and Development. Two physicians responded. The first physician indicated all the categories would be particularly helpful either in retrospect or the future because they allow the facilitators to have a better understanding of what they have done and to guide them for planning for what they will do in the future. The physician said the categories would be used to inform the developers on the following issues:

1) What the residents brought to the Behavioural Medicine Program (BMP)
2) The impact of other residents and/or facilitators on the individual participant
3) How the facilitators are perceived
4) The effect of the facilitators direct actions
5) Specifics of the content of any of the sessions
6) The role play component of the BMP experience

The physician was especially interested in examining the categories from the perspective of what, as program planners and instructors, they are able to influence. This study's categories will be compared to the various sources of feedback and evaluation received from the BMP throughout the two years in the form of evaluation forms post-sessions, feedback to the site director, various physicians, and various committees. The physician was eager to note how the feedback obtained from the confidential structure and methodological rigor of this study compares to the feedback solicited previously. Categories were explained and questions were clarified resulting in the physician's concluding the categories will be useful to the development of the BMP.

The second physician concurred with the first and reported the results of the study would be examined seriously to aid in the development and future evaluation of the program.

Theoretical Agreement

Four major theories provided the basis for the theoretical agreement: Self-efficacy theory (Bandura, 1977; 1982), theory on group processes (Borgen et al., 1989; Corey, 2000)), theory on the experiential teaching style (Smith et al., 1995a), and self-determination theory (Markakis et al., 2000). The importance of the participants' perception regarding their own abilities, the safety of their learning environment, and the satisfaction of their psychological and group member needs is discussed in detail in the section in the review of the literature in chapter 2.

Specific discussion regarding the theories and studies that agree with each category's subthemes (the individual events comprising each category as discussed in chapter 1 in the definition of terms) is presented in chapter 5. The following chapter also presents briefly the agreement of the literature with the outcomes of the incidents. The support for the outcomes bolsters the findings for the categories.

The next section, regarding helpful incidents, provides an outline of the four theories and their relevance to the helpful categories. The following sections will name the theories and explain their relationship to the unhelpful incidents categories and to what would have helped but didn't happen.

Helpful Incidents Categories

Anything that affected the participants' self-efficacy in the communication competencies (CCs) or topic areas (such as bad news delivery), their perception of the

safety of their learning environment, the three basic psychological needs in self-determination theory, and group member needs has support in the literature.

Bandura's (1982) social learning theory provides theoretical support for how self-efficacy, the belief an individual has in their own ability to perform a given task or skill, affects their performance of that specific task or skill. Therefore, any category whose contents list as an outcome an aspect of improved self-efficacy such as increased confidence or comfort in executing a particular skill or belief in the value of the skill finds support in Bandura's theory. Additionally, category content that includes as a factor tools described by Bandura (1977) as helping improve self-efficacy is also supported. Such tools include: modelling, successful performance, learner self-direction, explicit performance related feedback, short-term goal setting, attributing learner success to work rather than innate ability, and tying rewards to specific accomplishments.

Many of Bandura's tools are listed by Smith and colleagues (1995a) guidelines for the experiential teaching method. As discussed in chapter 2, the guidelines are:

> ...modelling, successful performance, persuasion and support by teachers, a relaxed atmosphere, cognitive understanding, learner self-direction, training in specific strategies, explicit performance related feedback, [short-term goal-setting], attributing learner success to work rather than innate ability, and tying rewards to specific accomplishments. (pp. 315-6).

Categories including any of these factors find support in the theory on experiential teaching method.

Self-determination theory and subsequent studies have shown satisfaction of three basic psychological needs, autonomy, competence, and relatedness, facilitates

participants' learning (Markakis et al., 2000). Any category having as its outcome satisfaction of the psychological needs is considered helpful to the participants' learning.

Theory covering group processes also provide considerable theoretical agreement for the categories generated. Group therapy principles advocate creating an atmosphere of safety and trust to facilitate learning and interactions between members. To achieve a safe environment attention to the importance of the personal characteristics, including empathy and authenticity, of the group leaders in addition to training them to maintain the personal power of the group members and to model appropriate behaviour for them is crucial (Corey, 2000). Borgen and colleagues (1989) outlined member needs requiring accommodation by group leaders to provide a safe environment where the task rather than the unmet needs are the focus:

> Belonging to the group; mutual support and encouragement; mutual communication of feelings of enthusiasm and success between members; comparison of situation with that of others; contribution to helping others (feeling valuable); ventilating feelings; developing a positive outlook; and a supportive leader. (p.12)

Theoretical agreement is provided when one or more of the above factors are reported by participants as being helpful to their learning.

Unhelpful Incidents Categories

Many of the categories did not help the participants' learning because they resulted in incidents and outcomes counter to the group therapy principles (Borgen et al., 1989; Corey, 2000), social learning theory (Bandura, 1977), experiential teaching method (Smith et al., 1995a), and the basic psychological needs required for learning outlined by

self-determination theory (Markakis et al., 2000). The specifics of the theories are discussed in the previous section.

What Would Have Helped

The calls for changes to the Behavioural Medicine Program often have their roots in what the participants believe will address their unmet needs. Self-efficacy theory (Bandura, 1977; 1982), self-determination theory (Markakis et al., 2000), theory on the experiential teaching method (Smith et al., 1995a), and group process theory (Borgen et al., 1989; Corey, 2000), explained previously, provide explanation for the answers participants gave to the question, "What would have helped your learning that didn't happen?" The theoretical agreement for each category is presented in chapter 5.

CHAPTER 5

Discussion

The purpose of this qualitative study was to generate categories describing what facilitates and what hinders family practice residents learn communication competencies (CCs) taught by a Behavioural Medicine Program (BMP). The participants shared their experiences and were considered to be the experts on the topic. Fourteen valid and exhaustive categories emerged from 116 critical incidents described by eight participants; nine categories of what helped the participants learn CCs and five categories regarding what hindered their learning were elicited. All 14 categories found substantial support in the literature and were deemed by the expert raters to be of value to the evaluation and development of the Behavioural Medicine Program.

The four theories providing the support for the categories are discussed in detail in the review of the literature (chapter 2) and the theoretical agreement section (chapter 4). How they specifically support each category is presented in this section. Theoretical agreement for the helpful categories are is presented separately to the theoretical agreement for the unhelpful categories. The theoretical agreement for the recommendations regarding "What would have helped" is also provided.

Helpful Incidents Categories

Nine categories were formed from 64 helpful incidents. All the participants contributed incidents to the helpful categories. Literature support was found for all the categories. The Helpful Categories contained the categories with both the maximum and the minimum participation rates (Category 1 and Category 9).

Helpful Category 1: Facilitator(s) Actions (other than feedback)/Attitudes/Characteristics

This category is supported by the literature in a variety of ways. As discussed in the literature review, there is a wealth of studies presenting the experiential teaching style used by the facilitators in the Behavioural Medicine Program as the most effective. The actions and characteristics of the experiential style as listed by Smith and colleagues (1995a) include modelling, persuasion and support by teachers, a relaxed atmosphere, and training in specific strategies and are relevant to the some of the category's subthemes: demonstrating or modelling role plays; demonstrating communication skills; providing support, listening, and helping residents to process difficult experiences; body language; use of language; and the presentation of topics in what is perceived by resident to be a humane treatment. Other subthemes such as body language, the use of language, and how topics are presented are supported by the literature on the importance of the personal characteristics and attitudes of group leaders outlined by Corey (2000) such as authenticity, empathy, and demonstrating or modelling appropriate behaviour.

Helpful Category 2: Other Resident(s) Actions/Attitudes/Characteristics

This category contains factors that relate to the participant's perception regarding the safety of their learning environment. Borgen and colleagues (1989) note that when group members feel safe in their environment, they are then free to focus on specific tasks rather than their unmet needs. Requirements to create the environmental safety include: belonging to the group; mutual support and encouragement; mutual communication of feelings of enthusiasm and success between members; comparison of situation with that of others; contribution to helping others (feeling valuable); ventilating feelings; developing a positive outlook; and a supportive leader.

The category's subthemes concur with the requirements listed by Borgen and colleagues (1989) as needing to be fulfilled for members to feel safe. The helpful actions, attitudes, or characteristics of the other residents (presented in chapter 4) resulted in the participants' perception of a safe learning environment and supportive colleagues thus allowing them to focus on the Behavioural Medicine Program mandates and tasks.

Helpful Category 3: Content of Sessions

There is a dearth of literature demonstrating residents' desire to develop their competence in the delivery of bad news (Eggly, Afonso, Rojas, Baker, Cardozo, Robertson, 1997; Gordon and Tolle, 1991; Greenberg, Ochsenschlager, O'Donnell, Mastruserio, and Cohen, 1999; Ungar, Alperin, Amiel, Beharier, and Reis, 2002). It is not surprising Bad News Delivery was a subtheme for this category.

The professional resilience session addresses the issues surrounding physician burnout and self-care. These topics have recently been a popular topic in medical journals (Martini, Arfken, Churchill, and Balon, 2004).

The other subthemes in this category were helpful to the participants because: 1) they contributed to developing participant self-efficacy (Bandura, 1977; 1982) for different communication competencies in various subject areas, and 2) they helped to fulfill the BMP mandates of increasing self-reflection and using that to inform their practice. One of the outcomes of the inclusion of the BMP and the CCs in the residency curriculum was perception of a safer environment that spoke to the theory on group member needs (Borgen et al., 1989) and the studies emphasizing the development of physician self-care (DiMatteo et al., 1996; Ungar et al., 2002).

Helpful Category 4: Role Play Activity

Using role play to improve targeted communication skills is supported in the literature (Henwood and Altmaier, 1996). The theoretical support for this category is found in Bandura's (1977; 1982) social learning theory and Smith and colleagues (1995a) work on the experiential learning style. The role play activity allows the participants to observe demonstrations, practice, and execute successful performances, all of which are named by the theorists as important to learning (Bandura; Borgen et al.1989; Corey, 2000; and Smith et al.). The activity provides opportunity for a key component to another category tied to self-efficacy: explicit performance related feedback in the facilitator feedback category. All of these experiences improve the participants' belief in their own ability to perform a similar scenario outside the Behavioural Medicine Program (BMP), their self-efficacy. The outcome of the role play, increased self-awareness (fulfillment of the first BMP mandate), and the flexibility surrounding the role play scenarios satisfies self-determination theory's recommendation for the learner to experience a sense of competence and autonomy (Markakis et al., 2000).

Helpful Category 5: Facilitator(s) feedback

Bandura (1977; 1982) and Smith and colleagues (1995a) highlight explicit performance-related feedback as an important learning tool. The way the feedback was delivered, a subtheme of the category, finds theoretical agreement under the experiential teaching style that notes the importance of persuasion and support by teachers (Smith et al, 1995a). The topic of the feedback such as how to deliver bad news and the situations in which the feedback occurred find theoretical support in the literature. Specific support is found in studies examining topics rated as important by the residents such as bad news

delivery (Dosanjh et al., 2001; Eggly et al., 1997; Gordon and Tolle, 1991; Greenberg et al., 1999; Ungar et al., 2002) and situations that improve their self-efficacy for various skills (Bandura 1982).

Helpful Category 6: Code Status Session

This category refers to the specific exploration of the code status topic in the Behavioural Medicine Program. Inclusion of code status as a session provides an opportunity for residents to improve their self-efficacy in the skills required for the issues around this topic. The code status session may be considered a corollary of the breaking bad news session. Although delivering bad news is usually thought of in terms of diagnoses, discussing code status with patients and their families involves decisions regarding worse case scenarios. The literature extolling the residents' desires and need for skills to deliver bad news (presented in the Content of Sessions category) may therefore be applied to discussing code status with a patient and/or their families.

Helpful Category 7: External Factors to the Behavioural Medicine Program (BMP)

Some of the subthemes of this category consist of learning communication competencies (CCs) or developing their interest in CCs in a different venue. The other subthemes would have been classified under the other categories had they occurred in the BMP context such as actions of a medical school facilitator would have been classified under the category regarding Facilitator Actions (other than feedback), Attitudes, and/or Characteristics. The theoretical agreement presented under the other categories applies to the subthemes in this category.

Helpful Category 8: Environment

Finding a safe learning environment helpful is supported by the principles of group therapy (Borgen et al., 1989; Corey, 2000) and experiential learning (Smith et al., 1995a).

Helpful Category 9: Resident's Personal Actions/Attitudes/Characteristics

There is a variety of theoretical support for this category. The action subthemes of opening up and sharing feelings with the group find theoretical agreement in the member need for ventilating feelings (Borgen et al., 1989) and the psychological need for relatedness that helps learning (Markakis et al., 2000). The subthemes regarding attitudes and characteristics are also supported by the principles of group therapy. Being emotionally vulnerable during the Behavioural Medicine Program (BMP) activities allows the participant to satisfy the following member needs: to experience support and encouragement; to convey their feelings to the rest of the group; and to compare their situation to the other participants (Borgen et al.). The subthemes of believing in the value of the communication competencies (CCs) and the BMP, appreciating the intent of the BMP, and understanding the difficulty involved in teaching and learning CCs correspond with the member needs for mutual support and encouragement, mutual communication of enthusiasm, and developing a positive outlook (Borgen et al.).

Hindering Categories

Five hindering categories were formed from 50 incidents. All the unhelpful categories' participation rates were in between the lowest rate and the highest rate of the helpful categories. All the categories found support in the literature.

Hindering Category 1: Facilitator(s) Actions/Attitudes/Characteristics

The incidents in this category were not helpful because they did not fulfill group development principles (Corey, 2000) and therefore group member needs (Borgen et al., 1989), they negatively affected the participant's self-efficacy (Bandura, 1977; 1982), they were not congruent with the experiential teaching method (Smith et al., 1995a), or they interfered with the self-determination theory's three basic psychological needs of competence, relatedness, and autonomy (Markakis et al., 2000).

Specifically, the perception of the facilitator as incompetent means the participant does not feel there is a strong leader, a member need (Borgen et al., 1989), and speaks to the importance of the personal characteristics of the group leaders highlighted by Corey (2000). Unhelpful facilitator modelling, feedback, or instruction subthemes contradict Corey's group therapy principles of maintaining the personal power of the group members and modelling appropriate behaviour for group members, and highlights the influential role the personal characteristics of the leaders, including their empathy and authenticity, play in affecting the group members' learning. The need for autonomy (Marakakis et al., 2000) is thwarted by the participant's perception of having their feedback disregarded by the facilitators. A safe learning environment where the focus is on the task and not the participants member needs (Borgen et al.) is not achieved by the subthemes of feeling pressured to share experiences with the group and being singled out in discussions by facilitators.

Hindering Category 2: Resident's Personal Actions/Attitudes/Characteristics

This category most strongly aligns with theory on group member needs (Borgen et al., 1989). The subthemes containing anger towards the Behavioural Medicine Progrma

(BMP), the facilitators, and other residents have roots in their unmet needs. The member needs outlined by Borgen and colleagues not met in these incidents are: developing a positive outlook, ventilating feelings, a supportive leader, mutual support and encouragement, and belonging to the group. In accordance with the theories, these unmet needs became the focus for the participants rather than the tasks and at times, caused active resistance to engaging with any of the BMP activities.

Hindering Category 3: Group Rules/Norms

Self-determination theory (Markakis et al., 2000) provides the main theoretical agreement for this category. According to the self-determination theory, when three basic psychological needs (autonomy, competence, and relatedness) are fulfilled during training, learning is more successful (Markakis et al.). The subthemes mandatory attendance and participation, proscribed tools for role plays, and imposition of facilitator generated rules and norms counter the need for autonomy. The subtheme exception was the inconsistency between stated rules and the implementation of the norms. The participants felt the stated rules met their member needs (Borgen et al., 1989) but failure to apply them created an unsafe learning environment and contributed to the perception of a lack of a supportive leader thus hindering their learning. The desire for a supportive leader has theoretical agreement in experiential teaching method (Smith et al., 1995a) and theories on group process (Borgen et al.; Corey, 2000).

Hindering Category 4: Behavioural Medicine Program (BMP) Sessions/Content

This category includes incidents involving the BMP sessions and content participants' perceived as unhelpful. For many of the subthemes, the delivery of the material rather than the actual content itself is likely what is unhelpful. The subthemes

include skills unnecessary to a medical education; the check-in activity; the discussion on Do Not Resuscitate orders; rehashing topics; the whole opening session; psychosocial and group process activities; inappropriately used or inauthentic catch phrases and tools; unrealistic role play, scenario, and/or template; the content and experience of the BMP being very different to the experience and clinical aspects of residency; and the participant's belief that they already possessed the CCs having learned them in a medical school BMP.

The importance of the delivery of the content to the group is theoretically supported by the principles of group therapy including the role group leader characteristics play in group members reception to group activities (Corey, 2000) and by the modelling guideline for the experiential teaching method (Smith et al., 1995a).

Another source of the hindering nature of the incidents is the lack of congruence between the content to the residents' experiences outside of the BMP. The incongruence between the residents' perception of medical practice and the BMP activities is not unusual and supported by previous research (Benbassat and Baumal, 2001; Reuben, McCue, and Gerbert, 1988). Benbassat and Baumal observed:

> Students' difficulties were related to the inconsistency between the patient-centered approach that was emphasized in the preclinical teaching programs and the disease-centered (biomedical) approach that was practiced on the wards. Others were confused by ambiguous vocabulary and by the multiplicity of rules they had to remember. Still others appeared to resent attempts to teach them what they thought was elementary courtesy, to reject counterintuitive interviewing rules, and to be bored by the repetitive nature of the practice sessions. (p. 349)

The outcomes of the incidents indicate applying group therapy principles (Corey, 2000) and member needs theory (Borgen et al., 1989) to the subthemes provides insight into the source of the hindering nature of the content. The residents' experience the content as unhelpful because they focusing on their anxieties and unmet needs rather than learning the tasks. In these incidents, the residents do not perceive an atmosphere of safety and trust.

Hindering Category 5: Other Resident(s) Actions/Attitudes

The subthemes in this category find support in the theory on what occurs when member needs are not met (Borgen et al., 1989). The incidents describe events involving other residents when the needs for mutual support and encouragement, mutual communication of feelings of enthusiasm and success between members, and developing a positive outlook are not met.

What Would Have Helped

This section presents the theoretical agreement for the subthemes formed from answers to the question: "What would have helped but didn't happen?"

Theme 1: Discussions

The recommendation for more discussions focuses on the group members' perception of the facilitators' characteristics who are leading the discussions. The desire for authentic and competent discussion facilitators drove this request and is supported by group therapy principles where the group leaders' characteristics are paramount (Corey, 2000).

The Balint group suggestion has support in the literature by previously successful Balint groups currently in practice around the world (Brock and Stock, 1990).

Theme 2: Program purpose

Receiving more information and achieving greater clarity about the Behavioural Medicine Program's purpose utilizes the experiential teaching method guideline for facilitating cognitive understanding (Smith et al., 1995a), self-determination theory's psychological need for relatedness (both to the program and to the disseminators of the information) (Markakis et al., 2000), and the group member need to develop a positive outlook (Borgen et al., 1989).

Theme 3: Real scenarios

The desire to contribute to selecting scenarios for discussion and role plays finds theoretical agreement in experiential teaching method's guideline for learner self-direction (Smith et al., 1995a) and self-determination theory's psychological need for autonomy (Markakis et al., 2000). The desire for more realistic scenarios has roots in self-efficacy theory. Self-efficacy is more likely developed when the skill rehearsal is as similar to a real-life performance of the skill as possible (Bandura, 1977; 1982).

Theme 4: Background Facts

Self-determination theory's basic psychological needs for competence and relatedness (Markakis et al., 2000) provide explanation for participants' desire for more background facts. Markakis and colleagues found that satisfying those three needs facilitates learning. The desire to have more background facts speaks to the participants' psychological need for competence. The need for relatedness, to feel more connection to the Behavioural Medicine Program (BMP) and the facilitators, may be increased by receiving more background facts because greater understanding may occur. It is a reasonable assumption on the part of the residents that more background information will

lead to greater knowledge and connection to the program and facilitators, and correspondingly raise their sense of competence. Theory and the participants' recommendation predict higher levels of competence and relatedness leading to more successful learning.

Receiving more background facts also has support in group process theory (Borgen et al., 1989; Corey, 2000). Providing more information helps maintain the personal power of the group members (Corey), may help develop a positive outlook on the BMP, and allow residents to value how their communication competencies contribute to their medical practice, both of which are member needs outlined by Borgen and colleagues.

Theme 5: Group Work

The impetus for the participants' recommendation for smaller groups lies in the residents' need for an atmosphere of safety and trust so that a safe learning environment is achieved. Smaller groups are perceived as safer groups by the participants. Group processes theory provides agreement for the need of a safe environment to facilitate learning (Borgen et al., 1989; Corey, 2000).

Theme 6: Environment

A more relaxed environment and participating in the role plays without an observer speaks to the participants' desire for a safe environment and is theoretically supported by experiential teaching method (Smith et al., 1995a), group member needs (Borgen et al., 1989), and the need for autonomy put forth by self-determination theory (Markakis et al., 2000).

Theme 7: Evaluation and Supervision

Participants' request for ongoing supervision and evaluation in realistic contexts is supported by self-efficacy theory (Bandura, 1977; 1982). The desire for explicit performance feedback and tying rewards to specific accomplishments, synonymous with successful skill performance, corresponds with developing self-efficacy (Bandura). Evaluation and supervision would also increase the participants' competence, one of self-determination theory's basic psychological needs (Markakis et al., 2000).

Theme 8: Personality Conflicts

Insight into the request to monitor for personality conflicts is provided by the theories on the experiential teaching method (Smith et al., 1995a), self-determination (Markakis et al., 2000), and group member needs (Borgen et al., 1989). A relaxed atmosphere, and persuasion and support by teachers are recommended guidelines for the experiential teaching method and more likely to occur if personality conflicts are minimized (Smith et al.). Autonomy regarding selecting one's leader or facilitator and relatedness increased by working with a facilitator one feels more connected would lead to more successful learning from the perspective of self-determination theory (Markakis et al.). When personality conflicts are present between the resident(s) and the facilitator(s), the group members' needs affected are the need for a supportive leader and the development of a positive outlook (Borgen et al., 1989).

Theme 9: Preparation

Participants recommended preparing the residents for the experience of the Behavioural Medicine Program (BMP) because anything that increased the participants' psychological need for relatedness to the program and those involved in the BMP, the

sense of belonging to the group, and their trust and perception of safety in the program would help their learning. Respectively, the theoretical agreement lies in self-determination theory (Markakis et al., 2000) and group process theory (Borgen et al., 1989; Corey, 2000).

Theme 10: Voluntary Participation in Role Plays

Permitting voluntary participation fulfills the experiential teaching method's guideline (Smith et al., 1995a) and self-efficacy theory's recommendation for learner self-direction (Bandura, 1977), and for self-determination theory's psychological need for autonomy (Markakis et al., 2000).

Theme 11: Skill development

The desire for more tangible skill development finds theoretical agreement in self-efficacy theory (Bandura, 1977; 1982) and the experiential teaching method (Smith et al., 1995a). The participant's request is essentially for the development of their self-efficacy in specific skills or situations. The recommendation is also in accordance with the experiential teaching method guideline (Smith et al.) to provide training in specific strategies.

Theme 12: Timing of the Behavioural Medicine Program (BMP)

The participants' rationale for timing the BMP later in the residency or prior to the residency is to provide an environment that is more relaxed. The participants' desire to have the BMP during a time when residents are more likely to be willing to attend and participate finds support in the theory of the experiential teaching method (Smith et al., 1995a). A relaxed atmosphere is recommended to facilitate learning. Scheduling the BMP when residents are more willing to attend also increases their psychological need

for autonomy and, if scheduled later in the residency, may attend to their need for competence since the residents will have more experience further on in their training (Markakis et al., 2000). For all the above reasons, if the BMP is scheduled later residents may also perceive a safer environment, a member need outlined by Borgen and colleagues (1989).

Outcomes

As discussed previously, the categories found support in four major theories: self-efficacy theory (Bandura, 1977; 1982), experiential teaching method (Smith et al., 1995a), self-determination theory (Markakis et al., 2000), group processes (Borgen et al., 1989; Corey, 2000). The outcomes further augment the findings by their relationship to those same theories. For the helpful incidents, the outcomes fulfilled the theories predictions regarding what would facilitate successful learning. The outcomes for the unhelpful incidents supported the theories because hindered learning was produced when the theories recommendations were either not performed or events occurred contradicting the theories' guidelines. Specifics are discussed under each section.

Outcomes of Helpful Categories

Many of the helpful categories' outcomes related to the four above mentioned theories. The overlap between the four theories means one outcome may find support in more than one or even all of the theories. The themes emerging from the outcomes of the incidents reported by the participants: 1) improved self-efficacy in communication categories (CCs); 2) changes to attitudes and beliefs increasing motivation and commitment such as increased receptivity to the Behavioural Medicine Program (BMP) and CCs; 3) increased safety; 4) fulfillment of the BMP mandates: increased self-

awareness and learning the CCs such that that quality and those skills can inform most of their clinical practice; and 5) fulfillment of psychological needs such as autonomy, competence, and relatedness.

The relationship of the outcomes to the theories is demonstrated in numerous ways. For example, the outcome observing new and/or different ways of interacting, reacting, and coping is made possible by modelling, a tool suggested by Bandura (1982) to improve self-efficacy and as a guideline given for the experiential teaching method (Smith et al.,1995a) as a means to facilitate successful learning. Theory on group processes also highlights modelling to demonstrate appropriate behaviour for group members (Corey, 2000). Other outcomes directly demonstrate relevance to one theory such as the participants' reported increased self-efficacy in the communication competencies (CCs) as a result of the events or factors forming the categories. That attitudes and beliefs may be affected by training in CCs is supported by Jenkins and Fallowfield (2002).

Outcomes of Hindering Categories

The hindering categories' outcomes were often a result counter to the intention of the Behavioural Medicine Program (BMP). For example, the BMP designers' attention to group processes (Borgen et al., 1989; Corey, 2000) was intended to create an atmosphere of group safety where many of the group member's needs were fulfilled to allow focus on the tasks. When the outcome of an event was increased anxiety rather than feeling safe in the group atmosphere, participants focused on their anxiety rather than the tasks. Unmet needs were also a frequent outcome reported as not facilitating learning. The outcomes of the hindering categories are often what the theories are targeting to improve and change.

Self-determination theory's recommendation to fulfill a learner's psychological need for autonomy, relatedness, and competence is supported by the participants' reports that when the outcome of an event involved loss of one of the three psychological needs, learning was hindered (Markakis, et al., 2000). Hindered learning was also the outcome reported when guidelines from the experiential learning theory such as learner self-direction or support from teachers (Smith et al., 1995a) were not fulfilled. Decreased belief in the communication competencies and increasingly negative attitudes towards the program were outcomes often reported and are supported by Jenkins and Fallowfield (2002).

Limitations

The timing of the study was a drawback because not all the BMP sessions had been completed before the interviews were conducted. Therefore the categories formed from the incidents did not contain any of the content or events from those sessions. Thus the categories formed may not illuminate the content of any of the sessions occurring after the interviews. However exhaustiveness was most likely reached for the categories formed from the participants' experience to that point.

The methodology used by this study contains a number of limitations. Weiss (1994) reports qualitative interviews are limited by a variety of possibilities: recall imperfections caused by memory gaps; reporters' tendency to withhold negative information perceived as possibly self-implicating or conflict creating; and succumbing consciously or unconsciously to the temptation to present a more positive image common when discussing values, beliefs, attitudes, opinions, and evaluations. Some of the memory concerns may have been addressed by the opportunity to report or amend

information was offered by the follow-up email. While acknowledging the desire for a positive image, the researcher presumed the reports were honest. The motivation to withhold information was minimized by precautions to assure confidentiality and anonymity but may have been present for other reasons such as concern for the facilitators or the desire to encourage the continuation of the Behavioural Medicine Program (BMP).

A source of bias may have been the interview. Leading questions and the researcher's unintentional either positive or negative reaction to responses may have influenced the results. Attempts to address this issue included: establishing a clear description of the participants' and the researcher's roles; defining for the participant the clarity, detail and concreteness of incidents required, and how they would be categorized; and conducting the interviews using the wording in the interview schedule. The participant pool may have contained volunteers with extreme reactions to the BMP, providing another source of bias. The interview questions eliciting both helpful and hindering incidents are an attempt to identify this possibility. Only one of the eight participants was unable to report both helpful and hindering incidents. Demographic concerns were addressed by the self-selected cross-section of participants obtained (for gender, culture, and age). The individual context of the residents was not reported as a relevant factor by any of the participants.

The analysis of the results contained the hazard of interpreting incidents supporting the investigator's bias resulting in more effective arguments for preferred positions. Self-discipline on the part of the researcher and consultation with the faculty advisor were used to include everything during the analysis and reporting process.

Another difficulty with qualitative research is the generalizability of the results. Qualitative results are not intended to be generalizable but rather to illuminate. The content of this study's BMP may provide insight into other BMPs containing similar topics. Using the results to inform regarding the BMP in different years brings the caution that different personalities from year to year greatly affect the delivery and the experience of the program. The teaching principles and group processes used in this program may also guide the development or implementation of other BMPs because the categories and their strong theoretical agreement provide insight into what affects the participants' learning. The caution for qualitative research is the inability to imply causation, measure correlation, or evaluate the efficacy of the study that is present with quantitative research. Ross and Altmaier (1990) also warn critical incident technique focuses on discrete aspects and the results may not provide a holistic understanding of the process.

Flanagan (1954) found recalled data was reliable when the participants were motivated and when the incidents reported were relatively recent. The session schedule, five summer sessions and four sessions in both the first and the second year of residency, may therefore have affected the reporting of the incidents. Incidents occurring at the start of the residency may not have been recalled as completely or at all compared to later events. Some participants mentioned the difficulty recalling the BMP sessions presented earlier in the residency. Since participants only relate incidents of which they are aware, and can remember or can articulate, incomplete categories may have been obtained. The follow-up email attempted to address the latter point. Four participants out of the eight participants replied to the follow-up email. The absence of feedback from the other four

participants was considered disappointing but since not one of the four respondents reported faults or additions to the categories or incidents, the completeness and accuracy of the categories was considered likely.

With regards to the frequency of incidents per category, the frequencies' meaning is uncertain (Dachelet, 1981) but has been used in this study to decide the precedence of categories presented in the event of a tie in the rate of participation. The negligible difference overall between the frequencies of helpful to hindering incidents and the uncertainty regarding the meaning of frequencies prevents significant interpretation.

The rate of participation determined the presentation order of the categories with the frequency of the incident used to break ties in participation rates. An alternative to this method for other studies to consider is a suggestion by Alfonso (1997) where participants are invited to rank the categories in order of importance during the follow-up. The difficulty assigning the degree of importance to each category is a limitation of this study. The importance of each category is difficult to interpret.

Implications for Practice

The results of this study may inform those individuals developing and evaluating this study's Behavioural Medicine Program (BMP), fulfilling one of the purposes of this study regarding how to improve the program and fine tune the curriculum in order to strengthen the BMP. The study may also provide justification for the existence of the BMP. The developers of BMPs in other locations and those teaching communication competencies (CCs) may also find the results pertinent to planning their programs. The categories formed suggest it is feasible to positively affect participants' learning.

The categories are supported by four theories discussed in great detail in the previous chapters: self-efficacy theory (Bandura, 1977;1982), experiential teaching method (Smith et al., 1995a), self-determination theory (Markakis et al., 2000), and group processes (Borgen et al., 1989; Corey, 2000). The categories' correspondingly support the four theories by providing concrete examples of how theory affects practice. The participants directly reported incidents containing elements outlined by the theories. For example, participants' described how perception of a safe learning environment facilitated their learning, an element outlined by group processes and experiential teaching method. Many other examples are discussed in Chapter 4 and earlier in Chapter 5. The importance of the role of the facilitator, group processes, and spending time informing the residents on the value of CCs and the BMP to their medical practice is highlighted by this study.

Group processes are significantly affected by facilitators and were a focus of the BMP designers (personal communication with Dr. Knell, Sept. 11, 2003). The categories involving both facilitators and group processes yielded both validation for the effectiveness of the designers' efforts and a source of inquiry for the future modification of the program. Group leader characteristics relate back to the discussion on the facilitator's role and the environment is often created significantly by the facilitator yielding information for developers to focus on. The member needs are also affected by the facilitators who may create an environment favourable or unfavourable for meeting their needs.

The regression analysis study by Van Dalen and colleagues (1999) determined the content of the program had more effect on the students' learning than the teacher's

performance. The program's medical coordinator, Dr. Knell (personal communication, Sept. 11, 2003) asserts the attention to group process and safety of the learner are what enhances the residents' learning. The categories generated from the interviews with the participants support both Van Dalen and colleagues, and Dr. Knell. The content of the sessions was a helpful and a hindering category but the terminology used by Van Dalen and colleagues was used more broadly and therefore may refer to other categories such as the code status session, environment, role play activity, and group rules and norms. These results support Van Dalen and colleagues' findings. The incidents reported by the participants forming the helpful and hindering categories involving actions, attitudes, and characteristics of the facilitators or residents support the assertion of the program's medical coordinator, Dr. Knell (personal communication, Sept. 11, 2003): the attention to group process and safety of the learner are what enhances the residents' learning.

The BMP developers' intentional focus on the importance of the facilitators' role to teaching the CCs (personal communication with Dr. Knell, Sept 11, 2003) is validated by the results of this study. Incidents involving the facilitators were dominant in both the helpful and the unhelpful categories. Facilitators were so influential they were involved in two separate categories for helpful incidents: Facilitator actions (other than feedback), attitudes, and characteristics; and Facilitator feedback. Although many of the incidents involving facilitators led to helpful outcomes, they also significantly affected the learning process negatively. The helpful incidents provide positive reinforcement and validation for many of the facilitators' efforts and the unhelpful incidents identify areas to investigate and modify. Another aspect of facilitator behaviour the BMP may note is the need for consistency in the application of group rules or norms. The profession of the

facilitators, counselling psychology or medicine, does not seem to be a factor in affecting the participants' learning in this study. The study by Quirk and Letendre (1986), discussed in the review of the literature in chapter 2, found social scientists received significantly higher scores for their teaching than doctors. The results of this behavioural medicine study did not support this finding: the participants did not report one profession as more helpful to their learning than another. Aspergen's (1999) attributes Quirk and Letendre's finding to the similarity between the training received by students and that received by social scientists. Developers of the program may find the results of this study and Aspergen's explanation useful for future training of program facilitators.

What emerged from the question "What would have helped but didn't happen?" especially when examined with the unhelpful incidents, was the importance of participants' perception of the value of the BMP and CCs to their medical practice. Authenticity, of themselves and everyone else involved (facilitators, preceptors, and colleagues), was extremely important to the participants. Facilitator authenticity is recommended by experiential teaching method and group processes, aids in creating scenarios where self-efficacy is developed, and facilitates relatedness. Personal authenticity was also evident as a crucial factor for the motivation to participate in and the openness to the content of the BMP. Helping participants understand not only the feasibility of improving their CCs but also how they may perform CCs authentically would be beneficial. Participants' emphasis on maintaining their personal style provides insight into the importance of convincing participants' the CCs training may augment their personal style. The difficulty teaching such a personal topic and skill set is illuminated by the participants' concerns. There is a strong contrast between performing

concrete medical procedures and CCs. The protocol for how to perform the medical procedures correctly contrasts greatly with the variety of methods possible to execute CCs. Acclimatizing residents to the lack of structure and certainty involved in learning and developing CCs at the onset of the BMP may facilitate the following sessions. Demonstrating how the training will augment their personal style and may be integrated to eventually flow seamlessly with their personality will also facilitate the residents' openness to the BMP.

The expert rater's discussion on the usefulness of the categories contains some implications for practice. The comparison of this study's results to the BMPs' own evaluation data will provide insight into the success of their current feedback methods and possibly suggest changes for the future.

Implications for Research

Future research may wish to examine the relationship between the participants' perception of their learning and an objective measure of changes in their competencies. Examples of ways to measure competencies include preceptor checklists or the use of patients as evaluators. Pre-training and post-training measures have also been used. The results of this study were supported by theory and correspond with the aspects of results from different but relevant studies. More research regarding training facilitators to successfully implement the experiential teaching method and maximize group process principles may also yield useful information.

This study contributes to counselling psychology by providing corroboration for theories regarding how to conduct groups (Corey, 2000), how to address group member needs (Borgen et al., 1989; Markakis et al.), and the relevance of social learning theory

(Bandura, 1977; 1982) and the experiential teaching method (Smith et al., 1995a). The study's results provide insight into how these residents' learn the communication competencies (CCs) and their perspectives on effective and counter productive contributions to their learning (specifically what helps and what hinders their learning). The literature breadth is expanded with the addition of this study to previous research focusing on the instructor's point of view, the content of what is taught, and the facilitators' performance.

The literature recommending interdisciplinary collaboration between physicians and psychologists (Anderson and Sharpe, 1991; Kahn et al., 1979a; Quirk and Letendre, 1986; and Voineskos et al., 1981) and cooperative research (Kahn et al., 1979a) between disciplines is fulfilled by this study.

Conclusions

The main purpose of this investigation was to provide a set of categories summarizing what facilitates and what hinders family practice residents' learn communication competencies identified by a Behavioural Medicine Program from the perspective of the family practice residents. Examining how medical students and doctors learn communication competencies (CCs) was considered worthy of research for several reasons: the value of CCs to the practice of medicine, time-efficiency issues, and cost-efficiency concerns (Aspergen, 1999). The emergence and subsequent validation of 14 categories, nine helping and five hindering categories, fulfills the study's purpose. The results may be used to modify the current program, develop future programs, evaluate future learning experiences, and inform those planning training programs for facilitators

or conducting groups. The study's goals to contribute to the literature by identifying efficient and effective ways to teach the skills and use the resources were achieved.

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Appendix A

[UBC's Hospital site's name] Family Practice Residency Program

Behavioural Medicine Program:

Teaching Communication Skills

by Family Medicine and Counseling Psychology Faculty

Program Overview

Developing Critical Competencies for Effective Medical Practice

The effective physician understands illness from the patient's perspective. Active listening and empathy, the processes by which the physician demonstrates to the patient that both the emotional and the content components of their message have been heard and understood, are critical clinical skills needed to achieve this understanding.[1]

We have good evidence that acquiring these communication competencies benefits patients and physicians. Interviews yield most of the data required

for diagnosis, treatment, and prevention, far beyond the contributions of physical examination and investigations.[ii] There is also strong evidence of correlation between effective communication and improved health outcomes for patients.[iii] Physicians with specific communication strategies, such as soliciting opinions and checking understanding, are less likely to have malpractice claims than those who do not employ these skills.[iv] The medical interview that attends to the patient's experience of illness is the fundamental skill of medicine.

In order to be able to use communication skills to their greatest advantage within the doctor-patient relationship, the doctor needs to be able to understand how his or her own life experiences result in strengths and challenges that can affect the professional relationship.[v] Unrecognized issues can impair effective physician-patient communication.[vi] Personal awareness ultimately contributes to improved clinical care, to the healing process, and to the growth and satisfaction of the physician.[vii]

Purpose of our program

The purpose of our Behavioural medicine program is to teach specific, focused skills required for optimal medical practice. These sessions enhance existing skills and model new strategies. The skills are practiced during the session so that the residents can quickly apply these in clinical practice. The program builds upon their own experiences and personal qualities. The residents then are observed applying these skills in clinical settings including the Family Practice Ward at [UBC's hospital site's name] hospital as well as in the community practices

How the program is taught

An interdisciplinary team from Family Medicine and Counseling Psychology conduct each of the now fourteen 2 ½ hour sessions. The sessions are distributed throughout the two-year Family Practice Residency.

The learning environment is interactive and attention is paid to creating a well-functioning, safe group. The topic of the day is clarified and relevant evidence provided. The skill is modeled by the instructors and then practiced by the residents with coaching and feedback from the faculty to ensure proficiency.

Overview of a typical 2 ½ Hour Session

- Check – in/Group building
- Sensitization exercise re topic of the day
- Group discussion of exercise
- Demonstration of scenario by faculty
- Introduction of a guiding template
- Practice of scenario by residents using the template
- Group debrief
- Closing

What topics do we cover?

- Active Listening and Basic Empathy- verbal and non-verbal skills
- Discussing Code Status
- Breaking Bad News

- Dealing with the Difficult Doctor - Patient Interaction

  Session 1: developing awareness of impending difficulty

  Session 2: a template for managing a difficult interaction

- Expressed Empathy in the history and physical exam
- Counseling: What's a Family Doc to do- the Rogerian approach
- Suicide Assessment
- Professional Resilience
- Effective Closure of the Doctor - Patient Relationship- planning for the future
- Future topics: include Cross-cultural Communication (to be developed with the UBC Division of Aboriginal Peoples' Health), the Family Conference, Basic Group Skills

Templates

The team has developed guiding templates for each of the topics. Each template has four parts - labeled A, B, C, D, to assist residents in

remembering the stages of the template. This is based on the model developed by Westwood et al[viii]

- "A"ttend
- "B"ridge
- "C"omment
- "D"evelop Contract

An example of such a template is that developed to encourage a patient suffering from somatic symptoms to attend a psychologist:

"A"ttend

- Self: What am I experiencing?
- Patient: What is the patient experiencing?

"B"ridge (Between physician and patient/counselor and client/medicine and counseling psychologist)

- "There may be something else going on..."

"C"omment

- "I think it may be helpful if..." or
- "I want you to consider seeing someone else because this has gone on too long..." or
- "I would strongly recommend that you ... (e.g. "break this cycle of abuse")

"D"evelop Contract

- Acknowledging patient's emotion(s) including possible fear, shame, anger
- Link to ongoing relationship

These templates provide a starting place for the residents and, over time and with practice, they will develop language more congruent to their own style.

Microskills coaching provided by the team

- During the session the Residents practice the templates with microskills coaching by the medical and counseling psychology facilitators.

- We aim to help them get through the scenario with a new skill, not to help alleviate their discomfort directly.
- With this point in mind:
    - Practice is the point...not performance.
    - We acknowledge what we noticed them doing effectively.

- as though we were cameras reporting only what they have displayed not our assessment of what they have done right or wrong.

    - "The next snippet!!"

      We choose one behavior to add as they continue to practice the template. "When you do it this time I'd like you to do/say is ----------".

Development and Planning for the Future

The program is now in its fourth year and has been very highly evaluated by the residents. We have presented the program at national meetings of both the Family Practice and Counseling Psychology professions where it has also been very well received. In addition, we have presented Faculty Development

sessions about the program to our community preceptors at the [UBC's hospital site's name] Family Practice Program. Much interest about the program has been expressed by other groups within the UBC Family Practice Residency Program as well as nationally.

The sessions for both the residents and the faculty can in fact be adapted for undergraduate training, other postgraduate residency training sites and programs, as well as CME. Using a $22,500 interdisciplinary curriculum development grant, we have developed a series of four sessions for [the UBC's hospital site name]-based PGY1 specialty residents to be delivered in January and February 2003. We are also evaluating the financial and "human resource" requirements for effectively, efficiently and ally delivering this type of ethic interprofessional small group experiential learning at other sites. Our work will allow the UBC Family Practice Residency Program to develop plans for recruitment and faculty development of teachers. To date, we have had preliminary discussions with the City and Prince George Sites of the UBC Family Practice Residency Program and there are repeated requests from other universities.

07 January, 2003

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Appendix C

Learning Communication Competencies during Residency:
What Helops and What Hinders

OPTIONAL DEMOGRAPHIC QUESTIONS

1. Age:
2. Gender:
3. First Language:
4. Country of Origin:
5. Culture/Ethnicity:
6. Religion:
7. Previous Work Experience:

INTERVIEW QUESTIONS

1. How would you describe your experience in the Behavioural Medicine Program so far? Are there any extenuating circumstances unrelated to the actual Program that affected your experience?
2. Over the time you have participated in the Behavioural Medicine Program session, is there a specific event that helped you learn the skills?
3. What led up to the incident? Please tell me what was happening at the time.
4. What happened and what was your experience of the incident?
5. What happened after the incident? What was the outcome?
6. How do you know that it was helpful?
7. Over the time you have participated in the Behavioural Medicine Program session, is there a specific event that did not help you to learn the skills?
8. What led up to the incident? Please tell me what was happening at the time.
9. What happened and what was your experience of the incident?
10. What happened after the incident? What was the outcome?
11. How do you know that it was not helpful?
12. What would have helped your learning that didn't happen?
13. How would you have known that these helped?
14. Is there any specific occurrence that would have helped your learning in the Behavioural Medicine Program that didn't happen?
15. How would you have known that it helped your learning?

Appendix D

Criteria for Categories

Helpful Incidents

1. **Resident's Personal Actions/Attitudes/Characteristics**
   - Any incident described that names an action taken by the resident as a main component of the incident
   - Any incident described that names the resident's attitude as a main factor in the incident
   - Any incident dependent on the personal characteristics of the resident narrating the incident
2. **Other Residents' Actions/Attitudes/Characteristics**
   - Any incident described that names an action(s) taken by a resident(s) other than the narrator as a main component of the incident
   - Any incident described that names the other residents' attitudes as a main factor in the incident
   - Any incident dependent on the personal characteristics of a resident(s) other than the narrator
3. **Facilitator(s) Actions other than Feedback/Attitudes/Characteristics**
   - Any incident that names the attitude(s) held by a facilitator(s) as a main component of the incident
   - Any incident that names the facilitator(s) characteristics as a main factor in the incident
4. **Facilitator(s) Feedback**

- Any incident that names facilitator feedback as a main component of the incident

5. **Role Play Activity**
   - Any incident where the role play activity in any session is named as a main factor in the incident
6. **Code Status Session**
   - Any incident where the main factor involves the content of the code status session including any activity except role play (content: topics or tools/template; activity: group discussion, check-in, etc...)
7. **Content of Sessions**
   - Any incident that names the content or a portion of the content of a session other than the code status session as a main component of the incident (content: topics or tools/template; activity: group discussion, check-in, etc...)
8. **Environment**
   - Any incident where the experience of the session is dependent upon the atmosphere perceived by the resident(s)
9. **External factors to the Behavioural Medicine Program (BMP)**
   - Any incident that involves an event, experience, or factor that occurred outside of the BMP, either preceding, concurrent, or following the BMP.

Unhelpful Incidents

1. **Behavioural Medicine Program (BMP) Sessions/Content**
   - Any incident where the main factor involves content of a session(s) of the BMP or an aspect of the content of the BMP (content: topics or tools/template; activity: group discussion, check-in, etc…)
2. **Group Rules/Norms**
   - Any incident that is dependent upon a BMP rule or norm set for the groups
3. **Facilitator(s) Actions/Attitudes/Characteristics**
   - Any incident that is dependent upon the action(s) of the facilitator(s)
   - Any incident that depends on the attitude(s) held by a facilitator(s)
   - Any incident that is dependent upon the facilitator(s) characteristics
4. **Resident's Personal Actions/Attitudes/Characteristics**
   - - Any incident described that depends on an action taken by the resident relating the incident
   - Any incident described that depends on the attitude held by the resident relating the incident
   - Any incident dependent on the personal characteristics of the resident narrating the incident
5. **Other Resident(s)' Actions/Attitudes**
   - Any incident described that depends on an action(s) taken by a resident(s) other than the narrator
   - Any incident described that is dependent upon the attitude of a resident(s) other than the narrator

- Any incident dependent on the personal characteristics of a resident(s) other than the narrator

6. Environment

- Any incident where the experience of the session is dependent upon the atmosphere perceived by the resident(s)