

Interprofessional learning through simulation

Assertive communication: *making yourself heard in a health care team*



**THIS CLINICAL TRAINING INITIATIVE IS SUPPORTED BY FUNDING FROM
THE AUSTRALIAN GOVERNMENT UNDER THE INCREASED CLINICAL
TRAINING CAPACITY (ICTC) PROGRAM**

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Acknowledgements

This resource was developed by the Interprofessional Ambulatory Care Program (IpAC) at Edith Cowan University (ECU) in collaboration with the ECU Health Simulation Centre with funding provided by the Australian Government under the Increased Clinical Training Capacity (ICTC) Program.

Foreword

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Australia's health workforce is facing unprecedented challenges. Supply won't meet demand, and the safety and quality of care remain key issues. The national health workforce agency, Health Workforce Australia (HWA), an initiative of the Council of Australian Governments (COAG), has been established to address the challenges of providing a workforce that meets the needs of our community – now and in the future.

Accordingly, ECU has set a priority on meeting these challenges, with a focus on the national health workforce reform agenda set out in the 2008 National Partnership Agreement (NPA) on Hospital and Health Workforce Reform.

In June 2010, ECU was awarded \$4.6M from the Australian Government through a nationally competitive process under the ICTC Program, an initiative which aims to develop interprofessional learning and practice capabilities in the Australian health workforce.

The IpAC Program aims to complement traditional clinical placement activities with high quality interprofessional learning competency development and assessment, so that at the earliest point students gain exposure to best work practices within multidisciplinary teams that have the patient's individual needs as the focus.

Additionally, the IpAC Program has developed interprofessional learning resources and interprofessional health simulation challenges in collaboration with the ECU Health

Simulation Centre. The ECU Health Simulation Centre is recognised internationally as a specialist centre in providing human factors based sequential simulation programs using professional actors. Most simulated learning interactions revolve around a single moment, such as a patient's admission to the emergency department. What we provide at the ECU Health Simulation Centre is a sequential simulated learning event that follows the patient and carer's journey through the healthcare system, for example, from the accident site following a motor vehicle accident, to the emergency department, to a hospital ward, to their home and into the community for GP and allied health follow-up.

Human factors in health care are the non-technical factors that impact on patient care, including communication, teamwork and leadership. Awareness of and attention to the negative aspects of clinical human factors improves patient care.

ECU's involvement in national health workforce reform is all about playing a role that enables the health workforce to better respond to the evolving care needs of the Australian community in accordance with the NPA's agenda. The IpAC Program is an example of how we can work across sectors, nationally and internationally, to determine better ways of addressing the pressing issue of how best to prepare students for the workplace and thus assuring that health systems have safe, high quality health services.

Interprofessional Ambulatory Care Program

ECU's IpAC Program was established with support from the Australian Federal Government through funding from the ICTC Program. The IpAC Program aims to deliver a world-class interprofessional learning environment and community clinic that develops collaborative practice among health professionals and optimises chronic disease self-management for clients.

This is achieved through the provision of clinical placements within the multidisciplinary team at the IpAC Unit, a community clinic that develops communication and collaboration among health professionals and optimises chronic disease self-management for clients.

Additionally, a range of clinical placements are offered at existing health facilities, where trained IpAC Program clinical supervisors provide clinical support and ensure the integration of interprofessional learning into each clinical placement.

The IpAC Unit, in collaboration with the ECU Health Simulation Centre, has developed a range of interprofessional learning through simulation resources. These learning resources are packages consisting of an audiovisual resource and a facilitator's manual, and aim to facilitate interprofessional learning and to support the participants in the development of interprofessional skills.

The interprofessional learning through simulation resources developed by the IpAC Program aim to provide health students and health professionals with the opportunity to learn with, from and about one another by engaging them in interactive live simulation events. These simulations encourage students and professionals to challenge themselves and each other in a safe learning environment.

ECU Health Simulation Centre

ECU houses the only fully functioning Health Simulation Centre of its kind in Western Australia, specifically designed and equipped to address the interprofessional learning needs of the health workforce and implementation of both state and national safety and quality frameworks.

The ECU Health Simulation Centre offers health workforce training and development specialising in clinical skills, human factors, and patient safety training for multidisciplinary health teams. Using a variety of educational techniques, including a broad range of simulation mannequins, professional actors and task trainers, ECU specialises in immersive simulation and observational learning. Supporting the ECU Health Simulation Centre are nursing, medical, paramedic and psychology academic and technical staff whose aim is to cultivate the development of competent and confident health professionals centred on enhancing patient safety.

Interprofessional learning

Interprofessional education occurs when two or more professions learn with, from and about each other in order to improve collaboration and quality of care (Centre for the Advancement of Interprofessional Education, 2002).

Interprofessional learning is the learning arising from interaction between students or members of two or more professions. This may be a product of interprofessional education or happen spontaneously in the workplace or in education settings (Freeth, Hammick, Reeves, Barr, & Koppel, 2005). It has been found that interprofessional education can improve collaborative practice, enhance delivery of services and have a positive impact on patient care (Canadian Interprofessional Health Collaborative, 2008).

The World Health Organization (WHO) has recognised the importance of interprofessional education and collaborative practice in developing a health workforce that is able to meet the complex health challenges facing the world and assist in the achievement of the health-related Millennium Development Goals (World Health Organization, 2010). In developing its framework for action, the WHO have recognised that models of interprofessional collaboration are most effective when they consider the regional issues and priority areas (including areas of unmet need) in the local population (World Health Organization, 2010). In doing so, interprofessional education and collaborative practice can best maximise local health resources, reduce service duplication, advance coordinated and integrated patient care, ensure patient safety and increase health professional's job satisfaction (World Health Organization, 2010).

The end goal of interprofessional education is to create a health workforce with improved levels of teamwork, collaboration, knowledge-sharing and problem-solving, eventually leading to better patient and client outcomes in health settings (Braithwaite et al., 2007).

Interprofessional learning through simulation

Simulation in education refers to the re-creation of an event that is as closely linked to reality as possible. Gaba (2004) defined simulation as a technique, rather than a technology, to replace or amplify real life experiences with guided experiences often immersive in nature to evoke or replicate aspects of the real world, in a fully interactive pattern. Simulation provides a safe learning environment for students to practice, where they are free to make mistakes, correct them and improve the processes of care (Kenaszchuk, MacMillan, van Soeren, & Reeves, 2011). Simulation is the bridge between classroom learning and the real life clinical experience, allowing students to put theory into practice.

Interprofessional learning through simulation combines the principles of interprofessional learning and the use of simulation as an educational methodology. Interprofessional learning through simulation provides students with the opportunity to practice working with other health professionals and allows participants to explore collaborative ways of improving communication aspects of clinical care (Kenaszchuk, et al., 2011).

Many of the interdisciplinary team core competencies, such as problem solving, respect, communication, shared knowledge and skills, patient-centred practice, and the ability to work collaboratively (Canadian Interprofessional Health Collaborative, 2010) can all be developed by interprofessional learning through simulation.

Teamwork and interprofessional practice and learning are being recognised as central to improving client care and outcomes and enhancing client safety (Sargent, 2008). Promoting patient safety through team efforts is one of the five core competencies identified by the Institute of Medicine (2003).

In today's healthcare setting, no one health professional can meet all of the client's needs and therefore a healthcare team approach is required. Interprofessional learning through simulation provides learning opportunities to prepare future healthcare professionals for the collaborative models of healthcare being developed internationally (Baker et al., 2008).

How to use this resource package

This interprofessional learning through simulation resource package has been designed to support the facilitation of interprofessional learning among students and practitioners with an interest in developing their skills and knowledge of interprofessional practice.

The package consists of two components: an audiovisual resource and a supporting manual. In order to optimise the learning opportunities from this package it is recommended that participants are firstly introduced to the concepts of interprofessional learning and human factors in health care.

The audiovisual resource depicts the evolution of the receptionist breaking through her communication issues and finding herself able to speak up.

The package has been created in a format to enable flexibility in its application depending of the educational setting. We recommend the following format:

1. Facilitator guided discussion around the concepts of interprofessional learning and human factors in health care.
2. View each segment of the audiovisual resource, followed by facilitator guided discussion around the scenario specific learning competency areas (samples given within manual).
3. After the last segment: facilitator guided discussion, relating assertive communication to personal (future) practice.

Opportunities for further reading and exploration of the scenario are provided in the *Further Information* and *References* sections of this resource manual.

Scenario brief

A receptionist at a medical clinic notices that a client waiting for his appointment with the GP for his chest infection goes to the toilet frequently. She advises the client to tell the GP about this during his consultation, but later finds out that he has not. Due to the traditional hierarchy that exists within health care teams, the receptionist is finding it difficult to voice her concerns to the GP.

List of characters

- Client
- General Practitioner
- Receptionist
- Receptionist's friend
- Receptionist's husband

Key learning competencies

The key learning competencies for this scenario are based on the IpAC Program learning objectives as well as the Canadian Interprofessional Health Collaborative (CIHC) Competency Framework (Canadian Interprofessional Health Collaborative, 2010). The specific competency areas for this scenario are:

- Interprofessional communication
- Perceptions and attitudes influencing practice

Interprofessional communication

The interaction between the health care team demonstrates:

- Communication that is consistently authentic and demonstrates trust
- Active listening to team members
- Communication that ensures a common understanding of care decision making and resultant treatment plan
- The development of trusting relationships with clients /families and other team members

Perceptions and attitudes influencing practice

Reflective practice is crucial in continuous development and re-assessment of skills when working in health care. A reflective practitioner:

- Reflects on feedback and integrates changes into practice.
- Reflects on how own perceptions, attitudes and beliefs impact on practice.
- Identifies knowledge deficits and seeks clarification.

Key discussion points

Segment 1: General practitioner's clinic 1

- What role do non-clinical support staff have in the health care team?

Segment 2: General practitioner's clinic 2

- Why might the secretary be reluctant to raise her concerns for the patient with the doctor?
- What negative consequences could result if she raises her concerns with the doctor?
- What positive consequences could result if she raises her concerns with the doctor?

Segment 3: Learning to speak up

- What further information, if any, is gleaned in this segment as to why she may be reluctant to speak with the doctor?
- What strategies does her friend suggest when communicating assertively?
- Which do you think are most important/most helpful?

Segment 4: Talking with the GP

- How do you think the meeting with the doctor went?
- How do you think the secretary might have been feeling *before* the meeting?
- How do you think the secretary might have been feeling *after* the meeting?
- What aspects of the secretary's communication were assertive?
 - Could anything have been improved?
- What do you think the doctor might be thinking after the meeting?

Putting it into practice

- Can you identify your usual communication style (unassertive, assertive, overassertive). In what environments or circumstances does it differ? Why might this be?
- Identify an area where you would like to improve your assertive communication skills
- In what way would you like to improve your assertiveness in this area/situation?
- What could facilitate improving your assertive communication in this area/situation?
- What is a barrier to improving your assertive communication in this area/situation?
- Write down at least five strategies that you could adopt to improve your assertive communication in this area/situation?
- How could you put these into practice?
- What non-verbal communication skills should you be cognisant of when being assertive in this area/situation?

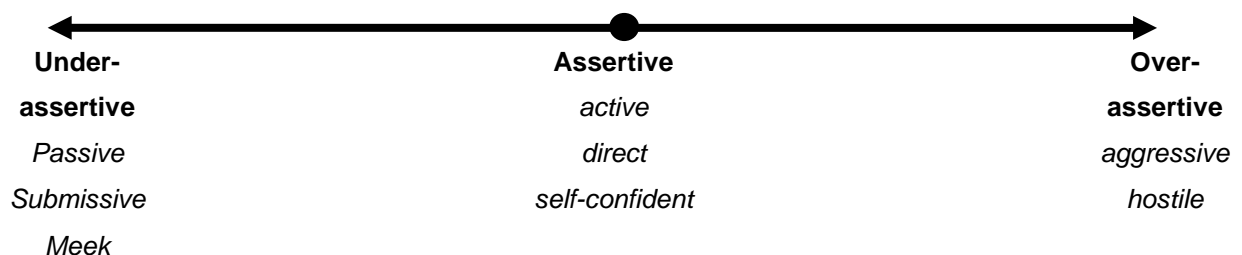
Literature review

Clear, confident, respectful and open communication maximises the effectiveness of health care teams who often operate within an environment that is busy, crowded and with competing priorities (Curtis, Tzannes, & Rudge, 2011). Poor patient outcomes, adverse events and stress have all been associated with poor communication and communication overload in the healthcare setting (Curtis, et al., 2011).

Assertive communicators are able to clearly and openly express their needs, wants, feelings and opinions in a manner which is respectful to themselves and others (Morrissey & Callaghan, 2011). Assertive individuals are able to make requests without belittling, abusing or dominating other people (Bolton, 1986; Dale Carnegie Training, 2009). Learning to be an assertive communicator can be challenging and requires the skills to express one's thoughts and opinions in a self-confident, positive, respectful manner (Kolb & Stevens Griffith, 2009; Sundel & Sundel, 1980).

Assertive behaviour falls within the centre of a spectrum ranging from passivity at one end to aggression at the other (Hasan, 2008). This is conceptualised in Figure 1.

Figure 1: The spectrum of assertive behaviour



Adapted from: (Sundel & Sundel, 1980)

Under-assertive individuals are often described as meek, passive, or easily manipulated and identified from nonverbal indicators such as a lack of eye contact, excessively soft voice and hesitating speech (Bolton, 1986; Sundel & Sundel, 1980). Passive individuals will go to almost any length to avoid conflict, often believing they are inferior to others (Hasan, 2008).

Morrissey and Callaghan (2011) identify the following characteristics in under-assertive individuals:

- Allowing oneself to be treated with little respect, i.e., being a 'doormat';
- Comparing oneself constantly to others;
- Struggling to identify or state needs and wants;
- Finding it difficult to make decisions;
- Fear of upsetting others and apologising excessively;
- Avoiding confrontation, e.g. saying 'yes' when really they want to say 'no';
- Using self put-downs;
- Dismissing self-worth and their value as a person; and
- Using long rambling sentences that lack focus and avoid the use of 'I'

Source: (Morrissey & Callaghan, 2011, p. 110).

Non-assertive behaviour is often encouraged from an early age with children being praised for acts of caring and selflessness and being encouraged to behave 'nicely', that is, being quiet and obedient (Bolton, 1986).

Over-assertive individuals are often perceived as aggressive, hostile, arrogant, coercive, overbearing and intimidating (Sundel & Sundel, 1980). They typically communicate in a loud, abusive or sarcastic manner expressing their own thoughts and feelings at the expense of others (Bolton, 1986). Often, over-assertive individuals are disliked and feared in the workplace (Bolton, 1986; Sundel & Sundel, 1980). Morrissey and Callaghan (2011) outline the following characteristics of over-assertive individuals:

- Find it difficult to acknowledge mistakes and blame others;
- Use verbal attacks or sarcasm, employing threatening tones and body language which may include finger wagging and a raised voice;
- Do not invite others to share their views;
- Take over from others and make decisions with minimal consultation;
- Use put-downs; and
- Give heavy-handed advice

Source: (Morrissey & Callaghan, 2011, p. 111).

Few individuals are assertive all of the time but the skills of assertive behaviour are important to develop so they can be utilised in appropriate situations (Morrissey &

Callaghan, 2011; Sundel & Sundel, 1980). Individuals should reflect upon the risks and benefits of being assertive as there will be times when assertive behaviour may not be the most appropriate course of action, such as in situations that may result in the potential for injury to themselves or others (DeVito, 2011; Morrissey & Callaghan, 2011).

Assertiveness also has a cultural component whereby individualist cultures that value competition, individual success and independence place a higher worth on assertive behaviour than do collectivist cultures that value cooperation, harmony and group achievement (DeVito, 2011; Morrissey & Callaghan, 2011). Therefore perceptions of assertive behaviour will be mediated by an individual's cultural background. As such, it is important for individuals to gain an understanding of the different cultural customs and rules that may impact on individuals' interpretations and understandings of assertive communication and behaviour (Sundel & Sundel, 1980). In addition, assertiveness can be influenced by gender, age, confidence, life experience and education background (Morrissey & Callaghan, 2011).

Assertiveness is a skill that can be developed and involves making changes to one's thoughts and beliefs as well as behaviour (Gray & Moffett, 2011; Morrissey & Callaghan, 2011). It involves developing self-confidence and valuing one's own worth as a human being (Morrissey & Callaghan, 2011). This is a process which takes time and making even small changes can result in benefits (Sudha, 2005). Balzar-Riley (2012) has identified the following advantages from developing assertiveness:

- Being more likely to get what you want by asking for it clearly
- People respect clear, open, honest communication
- Standing up for your own rights and feel self-respect
- You avoid the invitation of aggression when the rights of others are violated
- You are more independent
- You become a decision-maker
- You feel more peaceful and comfortable with yourself

Source: (Balzar-Riley, 2012, p. 9).

Other benefits that have been identified include being more effective in influencing one's environment; improved self-worth and confidence; decreased levels of anxiety and tension and associated health problems (headaches, stomach upsets, skin rashes); increased job

satisfaction and professional opportunities; and making a better impression on others (Bolton, 1986; Morrissey & Callaghan, 2011; Sundel & Sundel, 1980).

Developing assertive communication skills

Assertive individuals are self-assured, direct and sincere communicating their thoughts and feelings in a manner that is not disparaging to themselves or others and are willing to accept differing points of view (Kolb & Stevens Griffith, 2009; Sundel & Sundel, 1980). The following characteristics have been identified in an assertive communicator:

- Appears self-confident and composed
- Maintains eye contact
- Uses clear, concise speech
- Speaks firmly and positively
- Speaks genuinely, without sarcasm
- Is non-apologetic
- Takes the initiative to guide situations
- Gives the same message verbally and nonverbally

Source: (Balzar-Riley, 2012, p. 8).

Assertive communication requires a range of skills and techniques. These include *'initiating and maintaining conversations, encouraging assertiveness in others, responding appropriately to criticism, giving negative feedback respectfully, expressing appreciation or pleasure, being persistent, setting limits or refusing requests, and expressing opinions and feelings appropriately'* (Hasan, 2008, p. 2). Despite the common belief that good communication is an innate skill, individuals can develop their assertive communication skills (DeVito, 2011; Gray & Moffett, 2011). This requires an understanding of some of the basic principles of assertive communication as well as being able to develop goals and a plan for putting the knowledge and skills learnt into practice (Dale Carnegie Training, 2009; Kolb & Stevens Griffith, 2009).

A basic tenet of assertive communication is to be clear, concise and factual (Cornell, 1993). Try and remain calm and avoid blame (Cohen, 2008). The use of 'I' statements is seen as key as it allows speakers to take ownership in expressing their thoughts and feelings rather than making the conversation accusatory and making people defensive (e.g. 'you' make me

...) (Dale Carnegie Training, 2009; Morrissey & Callaghan, 2011; Sudha, 2005). Cornell (1993) believes that 'I' statements are most effective when used as:

1. A statement of feeling, e.g. "I am concerned, upset".
2. A statement of why you feel this way e.g. "I am concerned because I trust whoever is assigned to check the crash cart will do so".
A statement of desired action e.g. "I'd like to discuss this with you, do you have some time this week?"
3. Repeat steps if necessary

Source: (Cornell, 1993, p. 2).

It is also important to be clear in communicating one's message. Cornell (1993) suggests that too often individuals provide unclear or mixed messages, hinting at what they want rather than just coming out and saying it. This should also be communicated in a confident manner with assertive body language (e.g. good eye contact and upright posture) and vocal qualities (e.g. even tone, volume) (Morrissey & Callaghan, 2011; Sudha, 2005; Sundel & Sundel, 1980). Appear confident even if you do not feel it (Sudha, 2005).

In order to effectively communicate your message it is important to determine what outcome you are hoping to achieve (or what you are hoping to avoid) (Cohen, 2008). The likelihood of a successful outcome is increased by taking the time to prepare your thoughts and feelings and determining the desired outcome prior to any interaction (Curtis, et al., 2011). The DESC script (Balzar-Riley, 2012) is a useful framework for structuring thought processes. Steps include:

- **D**escribe the situation
- **E**xpress what you think and feel
- **S**pecify your request
- **C**onsequences

Source:(Balzar-Riley, 2012, p. 7).

In addition, Balzar-Riley (2012) also highlights the importance of considering the timing of communication, the content of your concern, as well as the receptivity of the individual in hearing your words (i.e. are they calm?) in determining when to use an assertive response.

Writing has been recognised as a useful tool for clarifying thoughts and feelings when developing assertiveness skills (Dale Carnegie Training, 2009). It can allow individuals to identify the changes that are required in behaviour, and in what settings and circumstances, as well as recording successful attempts at assertive communication (Dale Carnegie Training, 2009). When a particular situation is identified as one requiring assertive communication, writing a detailed concrete plan can be valuable including '*what happened in the past, what's happening now, and what you'd like to see happen in the future*' (Dale Carnegie Training, 2009, p. 11). Keep the dialogue factual and non-confrontational.

Once a plan has been developed, it can be useful initially to practice the skills and techniques in a supportive environment (Balzar-Riley, 2012; Kolb & Stevens Griffith, 2009). Engaging a spouse, family member or friends to assist you in developing your assertive communication skills can be extremely valuable (Balzar-Riley, 2012). Support people can assist in brainstorming the most effective techniques for a particular situation as well as discussing how to best apply ideas and concepts to real-world situations (Dale Carnegie Training, 2009; Kolb & Stevens Griffith, 2009). Role playing can also be particularly valuable with the support person able to give tangible feedback on content as well as posture, eye contact and tone of voice during practice (Sundel & Sundel, 1980).

Once preparation is complete it is useful to put the developed assertive communication skills into practice. If possible in the first instance, select circumstances that are realistic and achievable. Once confidence has developed in this new style of communicating, more challenging situations can be attempted (Dale Carnegie Training, 2009).

Conclusion

Being assertive means being able to effectively communicate your thoughts and feelings whilst respecting the rights others by not being abusive or denigrating (Sundel & Sundel, 1980). Learning to be assertive takes time, practice and internal motivation (Morrissey & Callaghan, 2011). For an individual who in the past has not been a capable assertive communicator, mistakes may be made and support is necessary to assist in integrating new skills and techniques into everyday practice (Morrissey & Callaghan, 2011).

Once successful, however, the assertive individual is rewarded by:

- Being skilled in a variety of communication strategies for expressing thoughts and feelings;
- Having a positive attitude about communicating directly and honestly;
- Feeling comfortable and in control of anxiety, tenseness, shyness, or fear; and
- Feeling confident that they can conduct themselves in a self-respecting way while still respecting others.

Source: (Balzar-Riley, 2012, p. 8).

Medical glossary and acronyms

Assertive	Being able to express your feelings, stand up for your rights and those of others, and state your opinions without abusing or taking advantage of others (Bolton, 1986).
Body language	A form of non-verbal communication, whereby a person can be “read”, or their emotions or attitudes understood, by observing physical signs such as their facial expressions and gestures.
Communication	The exchange and flow of information between two or more people.
Interdisciplinary teams	A team that is collaboration-oriented. The team meets regularly to discuss and collaboratively set treatment goals and carry out treatment plans. There is a high level of communication and cooperation among team members (Korner, 2008, p. 2)
Multidisciplinary teams	A team that is discipline-oriented. Each professional works in parallel, with clear role definitions, specified asks and hierarchical lines of authority (Korner, 2008, p. 2).
Non-verbal communication	Communication via gestures, touch, facial expression, eye movement and posture.
Verbal communication	The more common and obvious form of communication, whereby people communicate through sound (i.e. speaking).

Further information

Centre for Clinical Interventions, Department of Health Western Australia

http://www.cci.health.wa.gov.au/resources/infopax.cfm?Info_ID=51

CCI offers a clinical service for adults suffering from anxiety, mood and eating disorders. They provide a range of resources and support services including a package on Assertiveness.

Journal of Interprofessional Care

<http://0-informahealthcare.com.library.ecu.edu.au/journal/jic>

The *Journal of Interprofessional Care* is an international journal that aims to disseminate research and new developments in the field of interprofessional education and practice

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