CURRICULUM DEVELOPMENT USING VR TECHNOLOGY TO ENHANCE EMPATHETIC COMMUNICATION SKILLS IN FUTURE HEALTH CARE PROFESSIONALS

INTELLECTUAL OUTPUT [7]: TUTOR GUIDE FOR HEALTH CARE PROFESSIONALS (HE)-QF WORK AREA 1

ACTIVITY IO7A2: DEVELOPMENT OF THE TUTOR GUIDE

Co-funded by the Erasmus+ Programme of the European Union

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PROJECT MAIN DETAILS

Programme:	Erasmus+
Key Action:	Cooperation for innovation and the exchange of good practices
Project title:	Curriculum Development using VR technology to enhance empathetic communication skills in future health care professionals
Project Acronym:	EmpathyInHealth
Project Agreement Number:	2019-1-CY01-KA203-058432
Start Date:	01/09/2019
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PROJECT PARTNERS

MMC Mediterranean Management Centre

VUB VRIJE UNIVERSITEIT BRUSSEL

CYPRUS CERTIFICATION COMPANY

OMEGA TECHNOLOGY

UNIVERSITY of NICOSIA | MEDICAL SCHOOL

CHARITÉ UNIVERSITÄTSMEDIZIN BERLIN

UNIVERSITY OF THESSALY

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1. DETAILED TOPIC LIST

Work Area ID	**1**
Work Area	**General Overview of Empathy**
Unit	**1.1 Understanding empathy and qualities/competencies necessary for empathy**
Learning outcomes correspond to EQF	**Level 7**

Learning outcomes		
Knowledge	**Skills**	**Competences**
He/she is able to	*He/she is able to*	*He/she is able to*
1. List three different types of empathy (Affective, Cognitive, Prosocial) 2. Describe the different psychological approaches when researching empathy 3. Outline relevant research findings in relation to empathy in different health care settings (e.g. medicine, midwifery, physiotherapy) 4. List the qualities/ competencies necessary for empathy according to published consensus statements (The Kalamazoo Consensus Statement *Acad. Med.* 2001;76:390–393, UK consensus statement Medical Education 2008: 42: 1100–1107 and Calgary/Cambridge model Silverman et al 2013)	6. Self-reflect and self-assess his/her level or lack of empathy in daily life Use evidence-based techniques as listed below to develop empathy during initiating a session with patients and gathering information: 7. Demonstrate genuine interest and respect for the other party 8. Demonstrate active listening 9. Use verbal and non-verbal cues in a way that facilitates/reinforces empathy 10. Use appropriate questioning techniques 11. Use clarifying techniques 12. Demonstrate sign-posting 13. Use summarizing techniques	18. Evaluate the feedback from colleagues and simulated patients on his/her level of empathy and ways of improving. 19. Adapt his/her empathetic behaviour to the patient's and other health carer's needs.

5. Define the qualities/competencies necessary for empathy according to published consensus statements (The Kalamazoo Consensus Statement *Acad. Med.* 2001;76:390–393 and UK consensus statement Medical Education 2008: 42: 1100–1107)	14. Elicit patient's Ideas, Concerns, Expectations (ICE) 15. Recognise, Acknowledge and validate patient's concerns, feelings (RAV) 16. Provide Support demonstrating empathy while doing so by expressing concern, understanding, willingness to help; acknowledging coping efforts and appropriate self-care; 17. Deal sensitively with delicate issues	

2. TRAINING METHODS

☐ Classroom Teaching

☒ Asynchronous electronic learning

☒ Directed Self Learning

3. TRAINING TECHNIQUES

☒ Student Centred Lecture

☒ Role Play

☒ VR Video

☒ Educational Videos

☐ Case Study

☐ Other: ……

4. WORK AREA 1 AT A GLANCE

Activity	Time in minutes	Work Area	Unit	LOBS
Directed Self-Learning				
Students to be directed to the online resource to prepare themselves before the session.	**180**	**1**	**1.1**	
Face to Face Training				
Welcome and Introductions	**30**	**1**	**1.1**	
Ground rules	**30**	**1**	**1.1**	
Plan of the day (s)	**15**	**1**	**1.1**	
Brainstorming activity: what is your understanding of empathy?	**40**	**1**	**1.1**	**1**
BREAK				
General overview of empathy and qualities necessary for empathy Use the Calgary/Cambridge model and refer to USA consensus statement ***This part will be a face-to-face PowerPoint presentation with interactive exercises*** **Self-directed learning activity: Email students the C/C guide and ask them to familiarize themselves with the skills**	**90**	**1**	**1.1**	**1-6**
Question and answer session	**10**	**1**	**1.1**	**1-6**
BREAK				
Introduce Calgary/Cambridge guide on how to analyse video consultations	**15**	**1**	**1.1**	**6-17**
Watch Educational Video 1 and ask students to tick the skills they observe on the Calgary/Cambridge guide **Seek students' feedback on video and discuss** ***(Each partner to choose the most appropriate scenario for the LOBs)***	**60**	**1**	**1.1**	**6-19**
Introduce ALOBA for Role-Plays	**15**	**1**	**1.1**	**6-19**
Role Play 1 with student feedback **Self-directed learning activity: Send students the student task related to the scenario and the related literature in order to prepare for the role-play**	**60**			
BREAK				
Closure and evaluation of the day	**60**			
	425 min=7.083 hours			

5. TRAINING MATERIALS

5.1. DIRECTED SELF-LEARNING

Students to be directed to the online resource to prepare themselves before the session.

Students need to read the papers by:

- Batt-Rawden, Samantha A. MBChB; Chisolm, Margaret S. MD; Anton, Blair; Flickinger, Tabor E. MD, MPH Teaching Empathy to Medical Students, Academic Medicine: August 2013 - Volume 88 - Issue 8 - p 1171-1177 doi: 10.1097/ACM.0b013e318299f3e3
- Decety, Jean, et al. "A social neuroscience perspective on clinical empathy." *World Psychiatry* 13.3 (2014): 233
- Zaki J, Ochsner KN. The neuroscience of empathy: progress, pitfalls and promise. Nature neuroscience. 2012 May;15(5):675.

Students need to read and familiarize themselves with the Calgary Cambridge guides found (Handout 2: Calgary Cambridge Guide-The Skills)

5.2. POWER POINT PRESENTATION: WORK AREA 1

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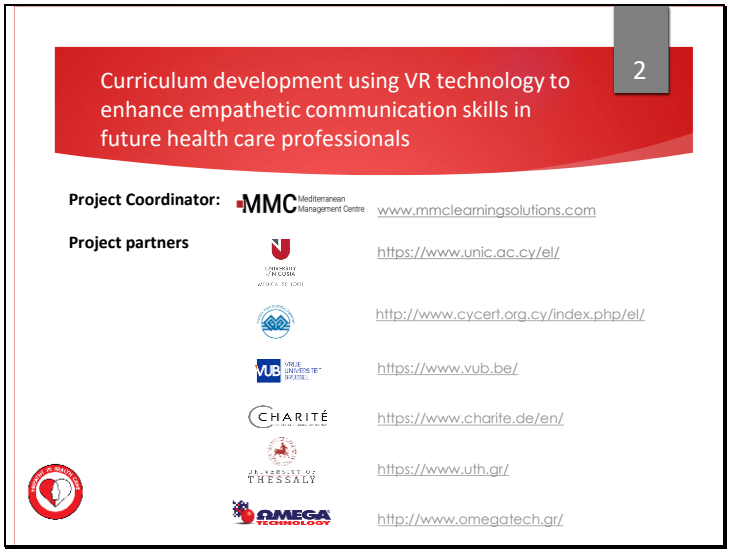
Slide 2



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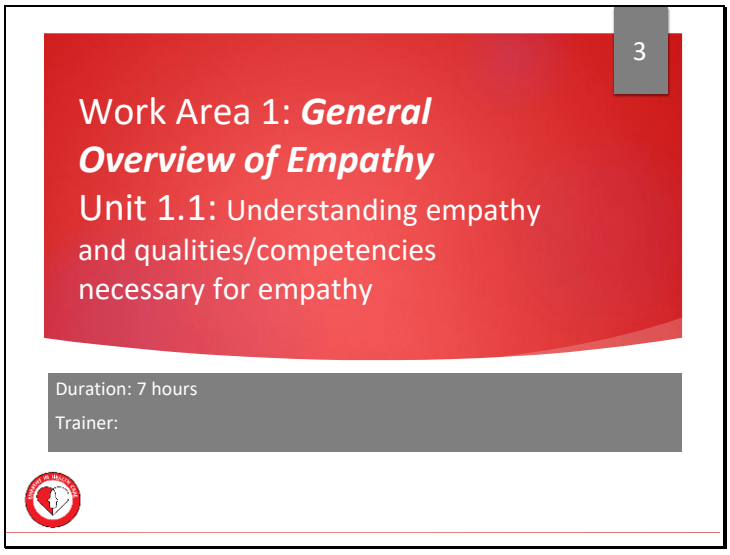

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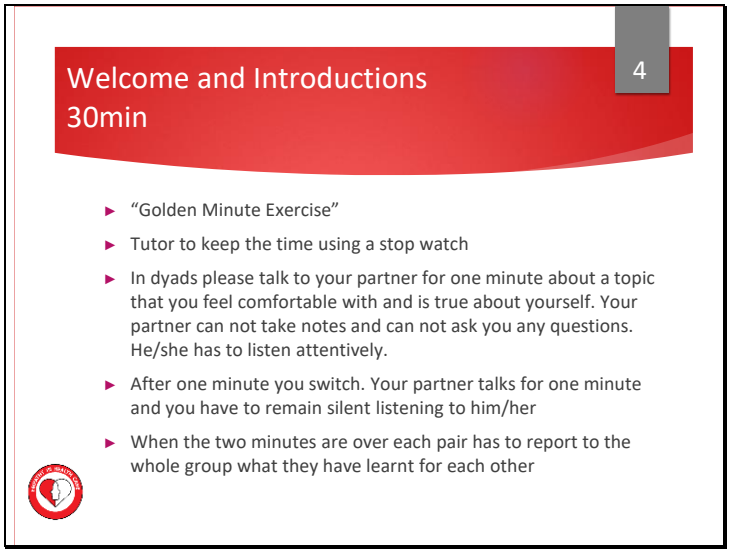

This exercise facilitates attentive/active listening. Research has shown that doctors interrupt patients 18 seconds after they start explaining their problem. Patients who were allowed to complete their opening statement without interruption mostly took less than 60 seconds and none took longer than 150 seconds even when encouraged to continue. Silverman et al 2005 (2nd Ed). Page 46.

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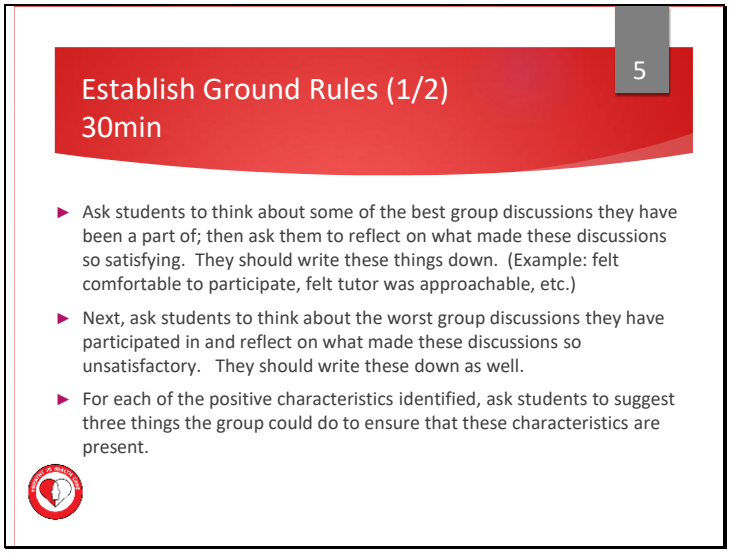

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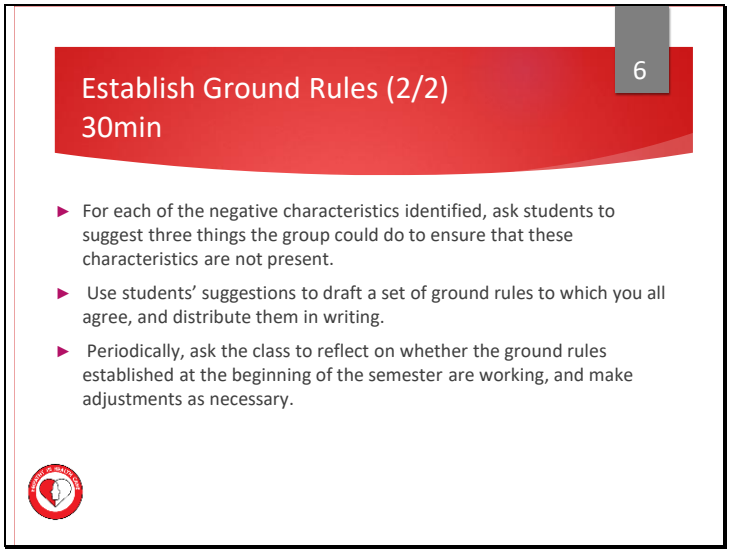

Some ground rules that each group should have ….

- Be on time
- Mobiles off
- Do not interrupt others
- Equal participation by all members
- Feel free to ask questions
- Do not put down or make fun of others
- You have the right to disagree but do so respectively
- Always offer positive feedback first and then feedback on things that can be improved on, in a constructive manner
- Every person in the group and not just the tutor has the responsibility to confront a student if they disrupt the group's function by ignoring the group rules
- If you are offended by something/someone bring it up immediately
- Consequences

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Feel Free to Change

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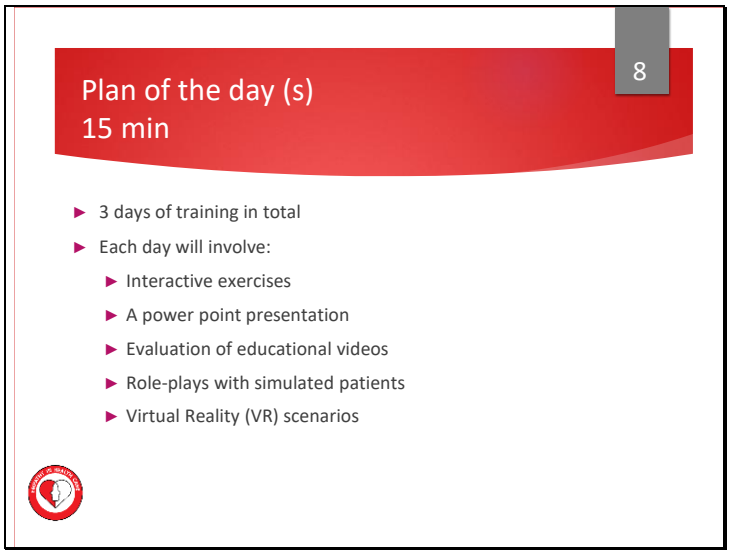

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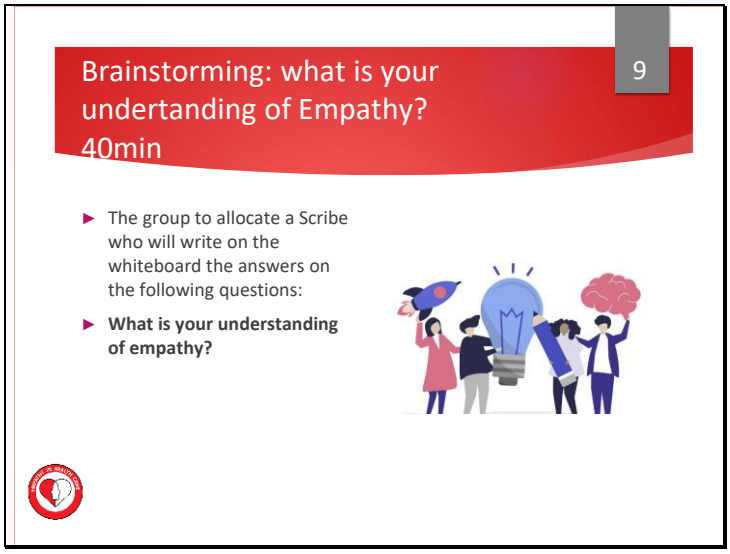

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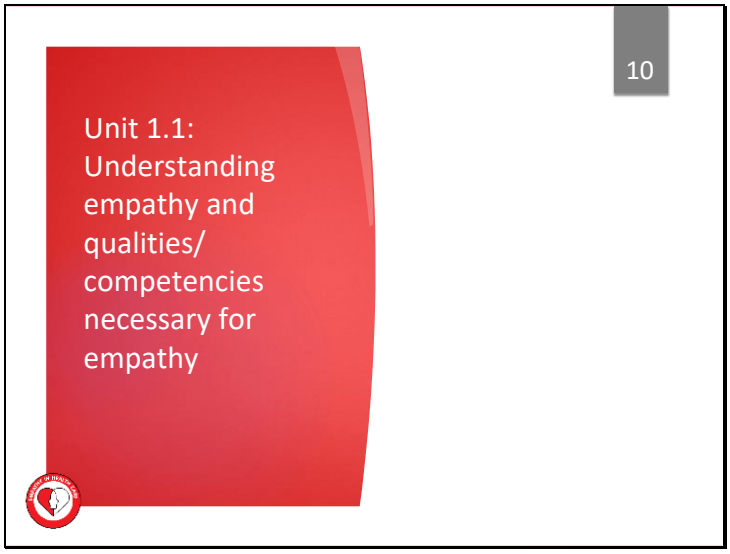

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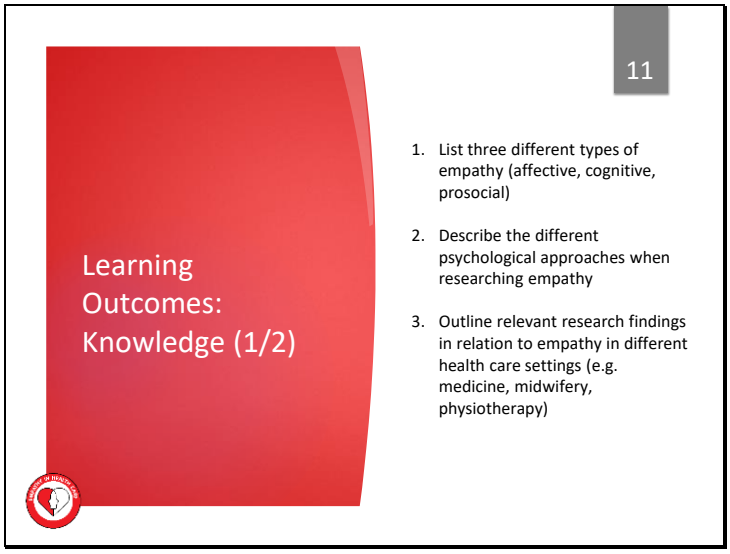

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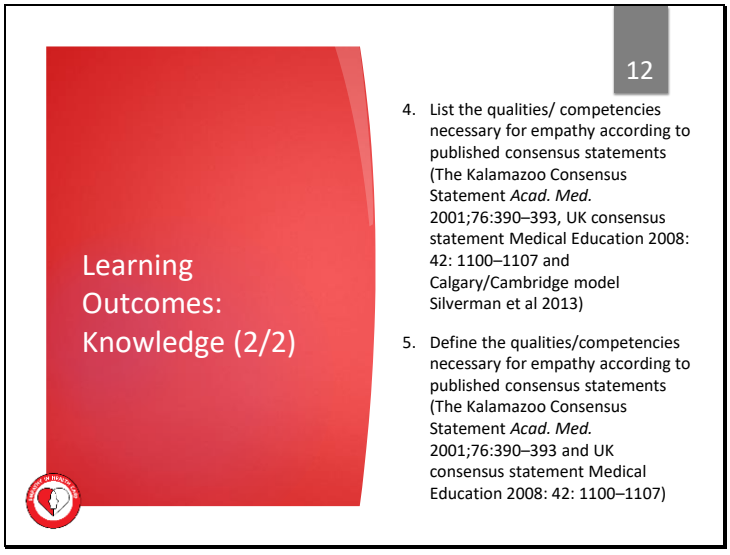

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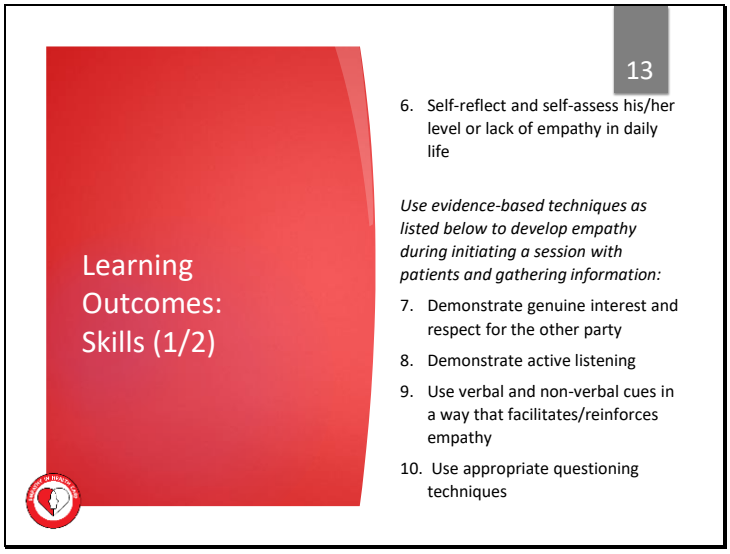

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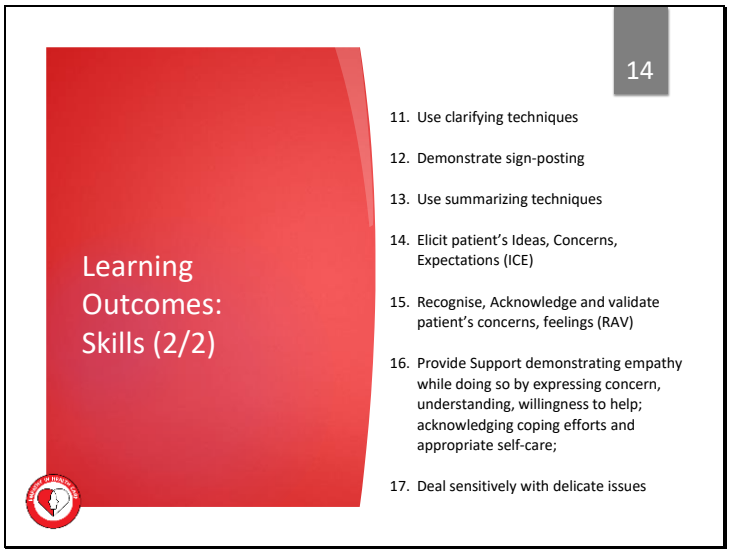

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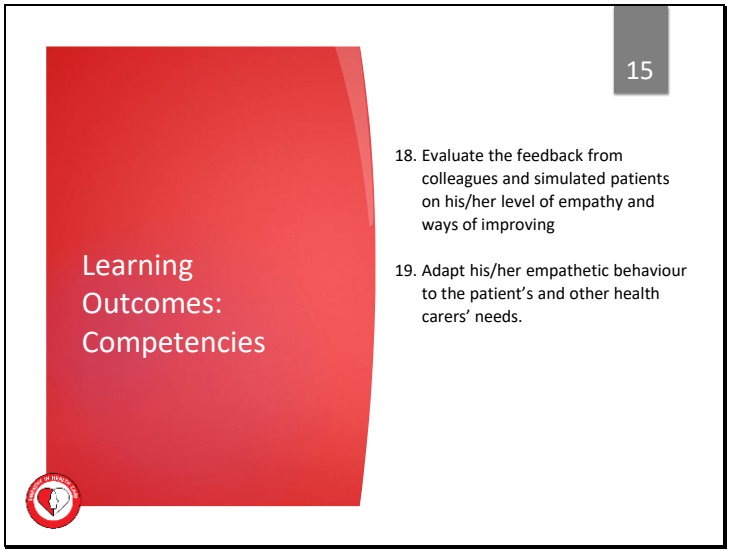

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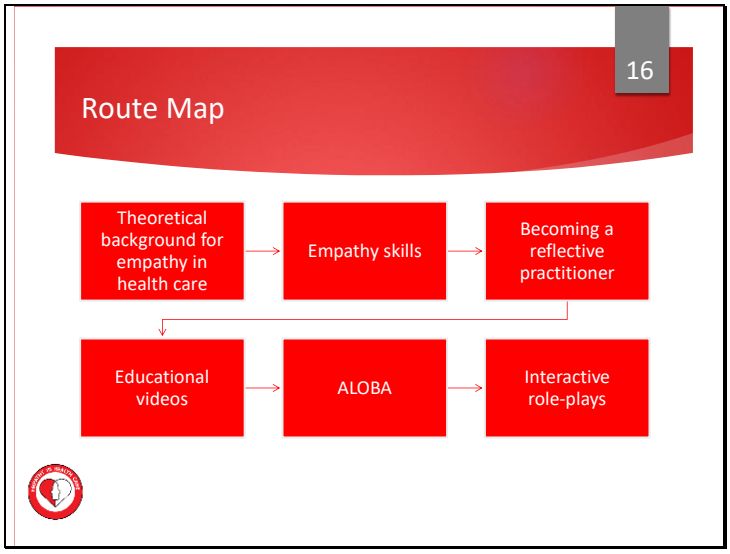

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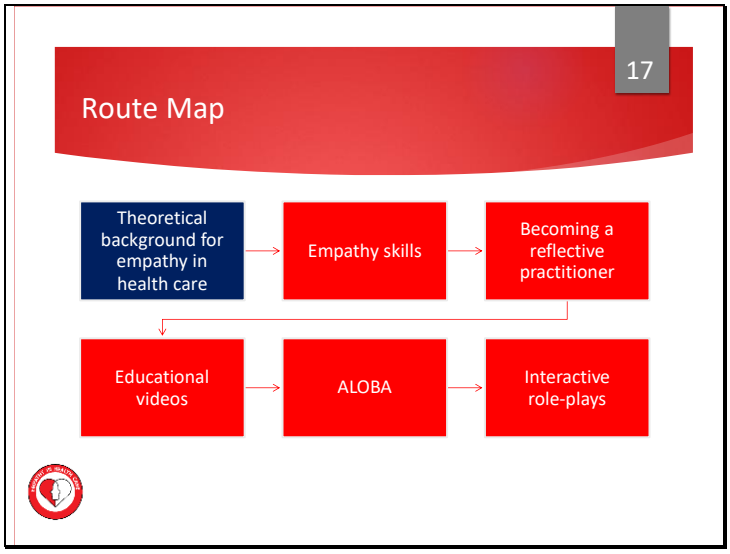

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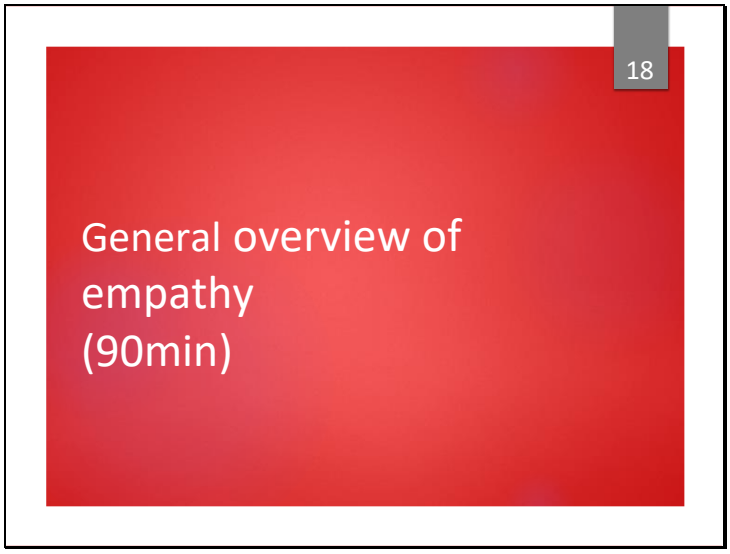

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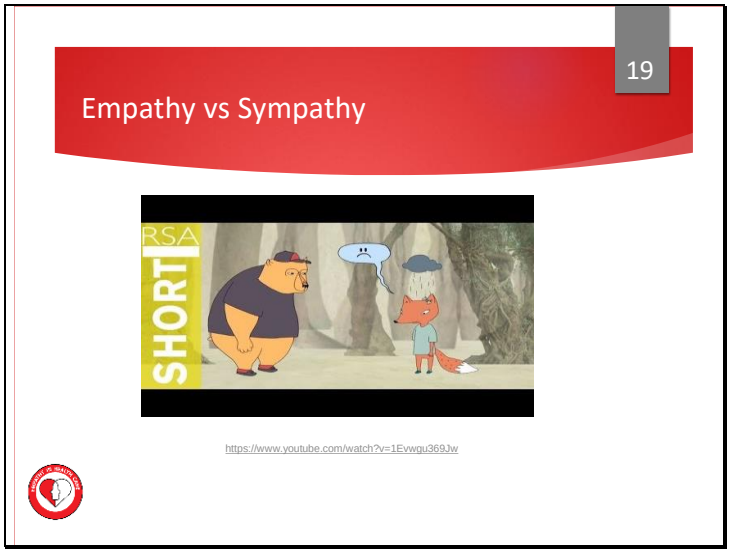

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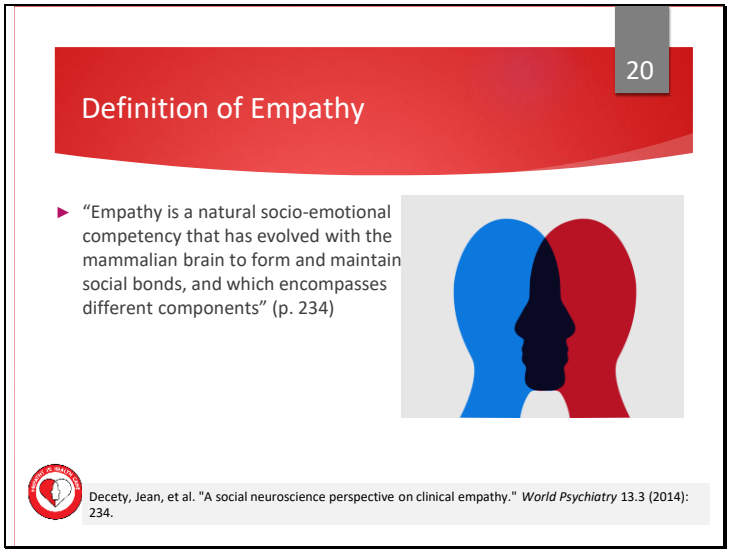

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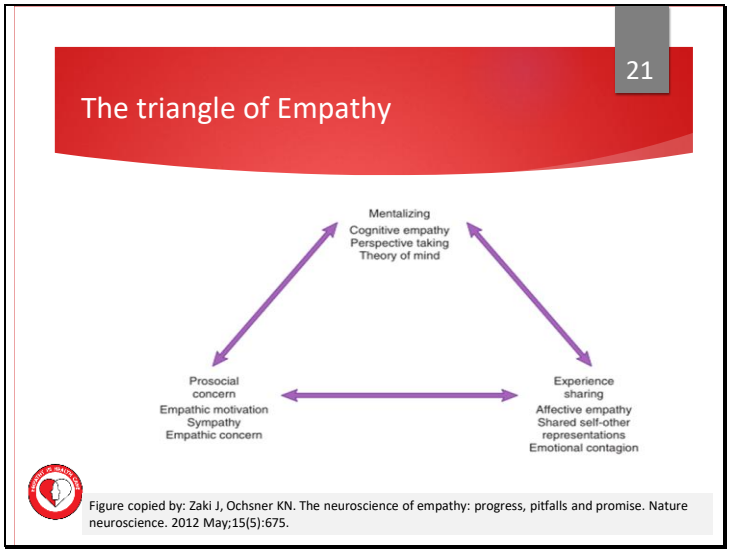

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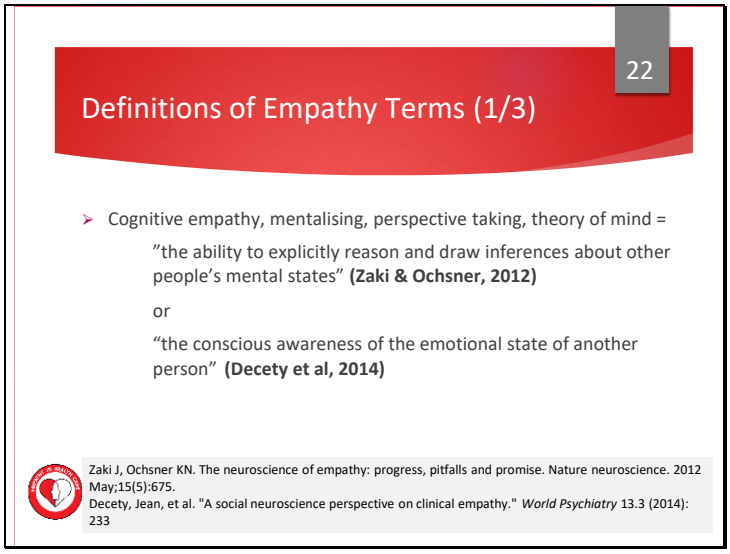

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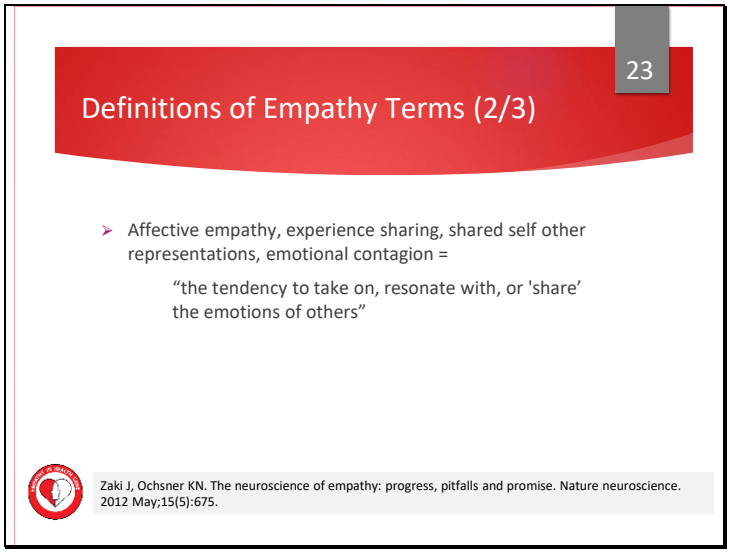

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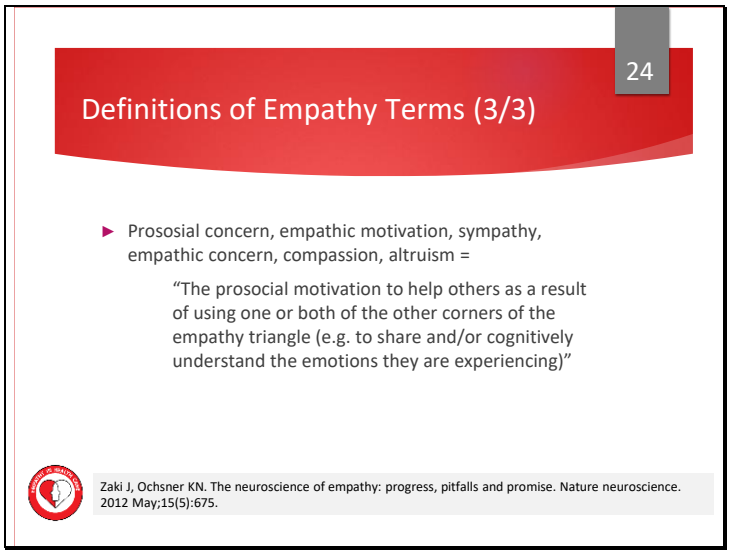

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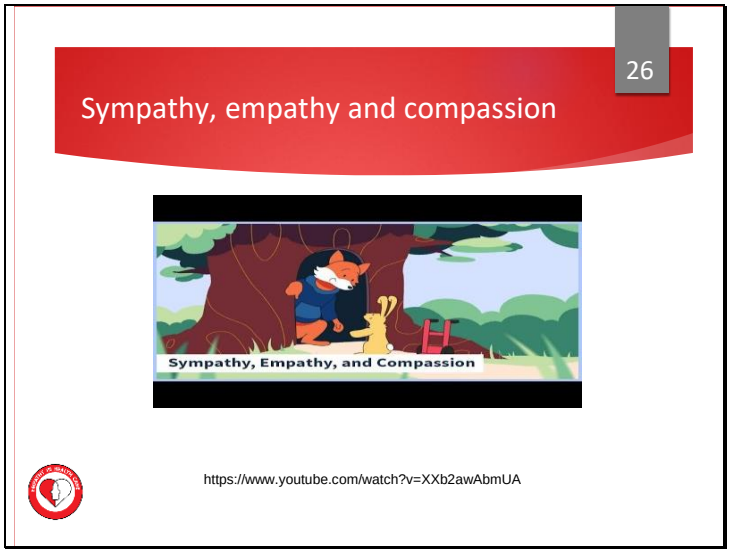

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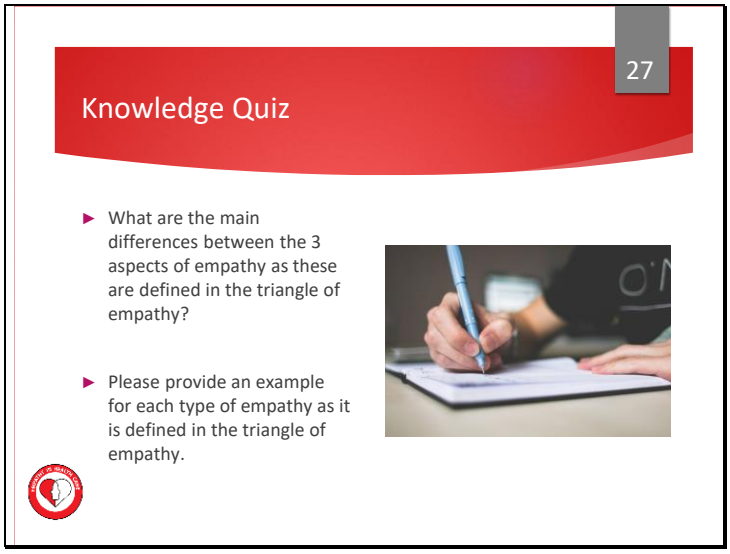

Answer: Cognitive empathy, mentalising, perspective taking, theory of mind is about understanding what another person feels without us necessarily sharing the same feeling which is what Affective empathy, experience sharing, shared self-other representations, emotional contagion are mainly about.

Prosocial concern, empathic motivation, sympathy, empathic concern, compassion, altruism refers to how motivated we feel to perform an altruistic behaviour based on our cognitive and/or affective empathy.

Examples:

Cognitive empathy: “I can see you are delighted with the results of your final year exam.”

Affective empathy: “I feel glad too that your results are so good.”

Prosocial concern: “Let’s go out and celebrate your success.”

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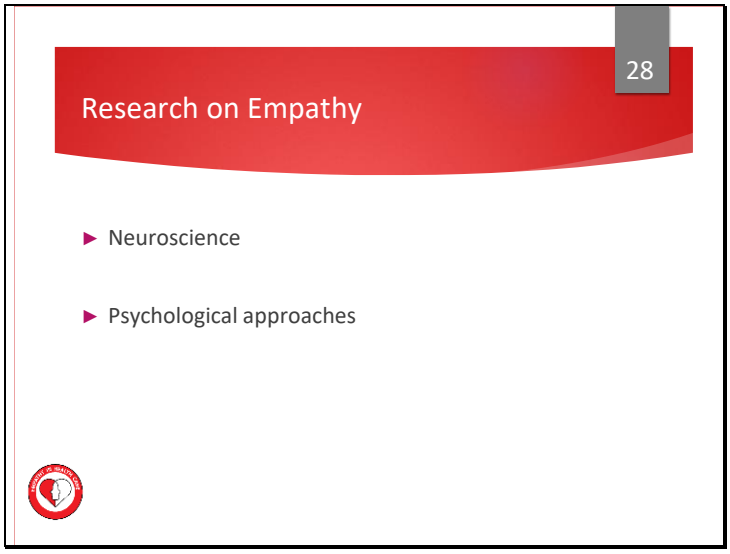

We will first take a look at Neuroscience:

(Zaki et al 2012 p.676)

“The first decade of cognitive neuroscience research on empathy homed in on how perceivers process isolated ‘pieces’ of social information, but left unclear how perceivers put those pieces together when cues combine, as they often do in everyday social interactions.”

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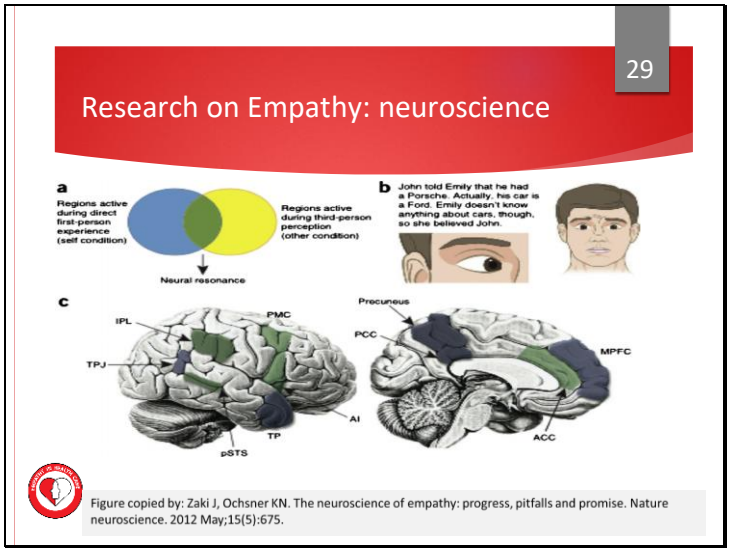

Figure 2 Neuroscientific approaches **to studying experience sharing and mentalizing, and the brain regions that are associated with each.**

- The experimental logic underlying studies of experience sharing. The blue circle represents brain regions engaged by direct, first-person experience of an affective response, motor intention or other internal state. The yellow circle represents regions engaged by third-person observation of someone else experiencing the same kind of internal state. To the extent that a region demonstrates neural resonance—common engagement by first- and third-person experience (green overlap)—it is described as supporting a perceiver's vicarious experience of a target's state (regions demonstrating such properties are highlighted in green in c).
- Studies of mentalizing typically ask participants to make judgments about targets' beliefs, thoughts, intentions and/or feelings, as depicted in highly stylized social cues, including vignettes (top left), posed facial expressions (right), or even more isolated nonverbal cues, such as target eye gaze (bottom left). Regions engaged by such tasks (blue in c) are described as contributing to perceivers' ability to mentalize.
- Brain regions associated with experience sharing and mentalizing. IPL, inferior parietal lobule; TPJ, temporoparietal junction; pSTS, posterior superior temporal sulcus; TP, temporal ole; AI, anterior insula; PMC, premotor cortex; PCC, posterior cingulate cortex; ACC, anterior cingulate cortex; MPFC, medial prefrontal cortex

By contrast, until the last few years, neuroimaging studies of empathy focused much less on behavioral outcomes and more on relationships between stimuli and brain activity. For example, perceivers might be scanned while observing targets in pain or judging targets' intentions; related brain activity was then interpreted as relevant to the empathic subprocess this task putatively engages. In almost all cases, these experiments did not relate brain activity to behavior, either because they required no responses from perceivers (as in many passive experience-sharing tasks) or used very simple social inference tasks that produce near perfect accuracy (and thus not enough variance in performance to relate to brain activity)24.

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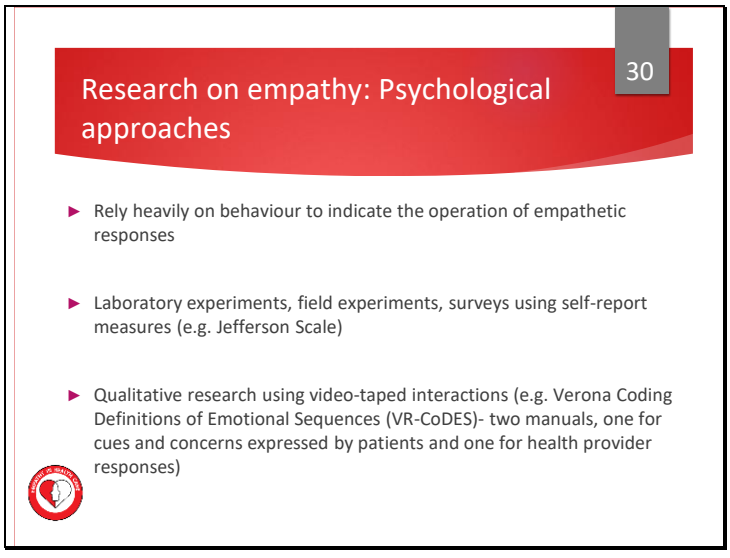

"In other words, the first decade of cognitive neuroscience research on empathy homed in on how perceivers process isolated 'pieces' of social information, but left unclear how perceivers put those pieces together when cues combine, as they often do in everyday social interactions 24 ." Zaki et al 2012 p.676

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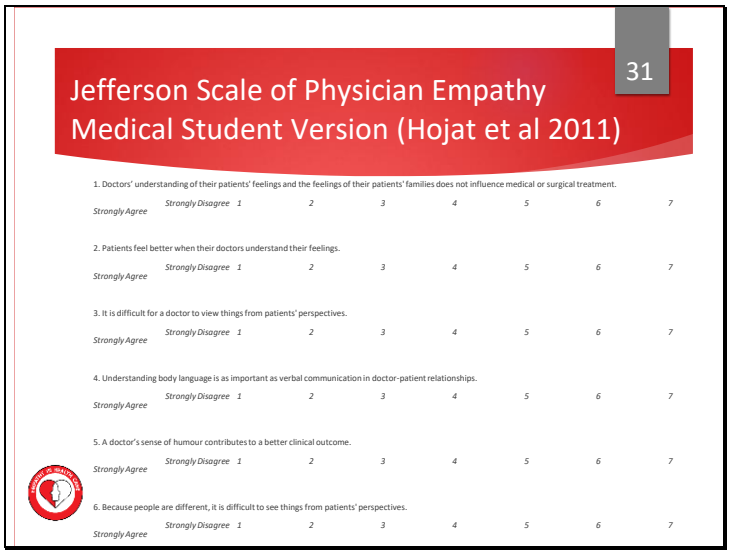

This is an example of one of the most used survey instruments the Jefferson Scale of Physician Empathy-Medical Student Version.

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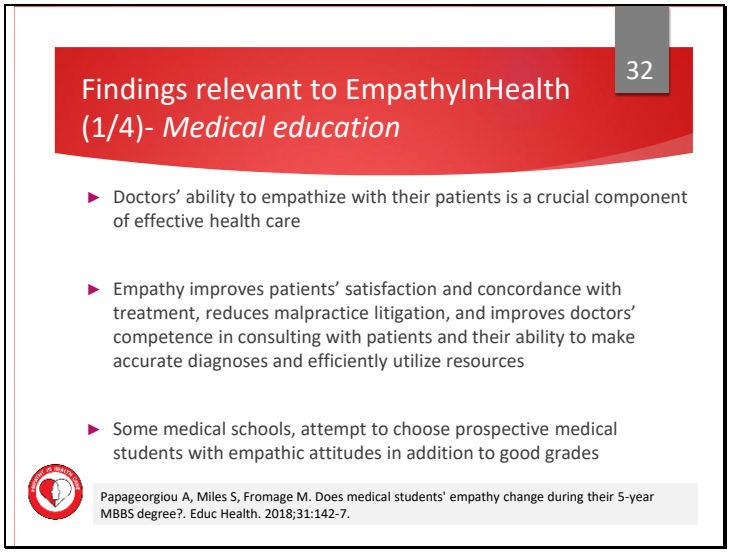

Let's look at the research evidence on empathy in medical care. Studies have shown that:

- Doctors' ability to empathize with their patients is a crucial component of effective health care
- Empathy improves patients' satisfaction and concordance with treatment, reduces malpractice litigation, and improves doctors' competence in consulting with patients and their ability to make accurate diagnoses and efficiently utilize resources
- Empathy is so important in medical care that some medical schools attempt to choose prospective medical students with empathetic attitudes in addition to good grades.

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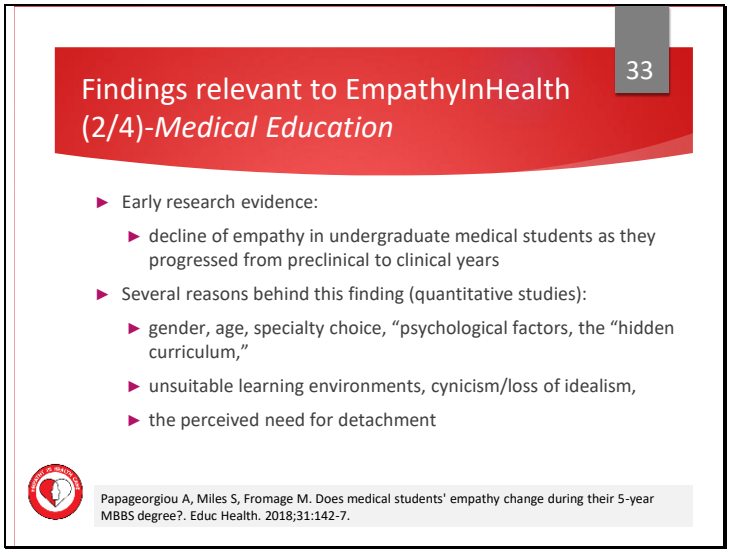

- Early research evidence in undergraduate medical education showed:
  - decline of empathy in undergraduate medical students as they progressed from preclinical to clinical years

There are several reasons behind this finding (quantitative studies):

- gender, age, specialty choice, "psychological factors, the "hidden curriculum,"
- unsuitable learning environments, cynicism/loss of idealism,
- the perceived need for detachment

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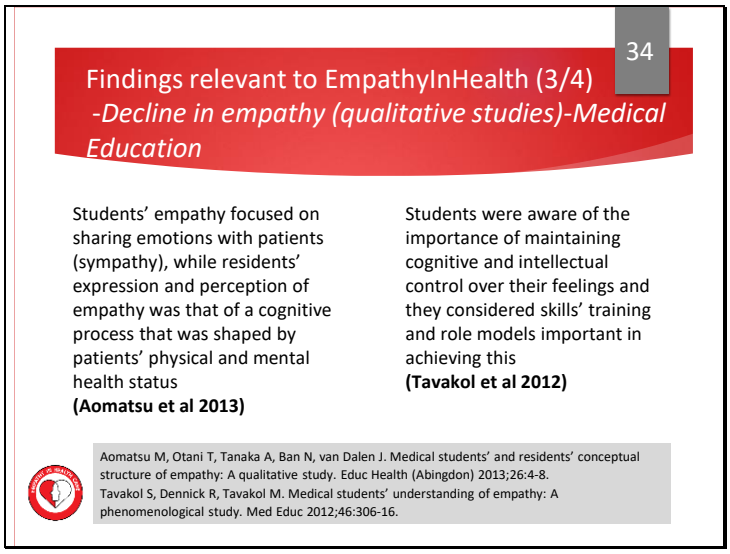

Qualitative studies shed some light into the findings regarding the decline in empathy. **Aomatsu et al 2013,** suggested that undergraduate medical students' empathy focused on sharing emotions with patients (sympathy), while residents' expression and perception of empathy was that of a cognitive process that was shaped by patients' physical and mental health status. In other words, cognitive empathy protected residents against losing their empathy and this is what medical students need in order to maintain their empathy.

The latter is confirmed by **Tavakol et al 2012** who showed that Students were aware of the importance of maintaining cognitive and intellectual control over their feelings and they considered skills' training and role models important in achieving this.

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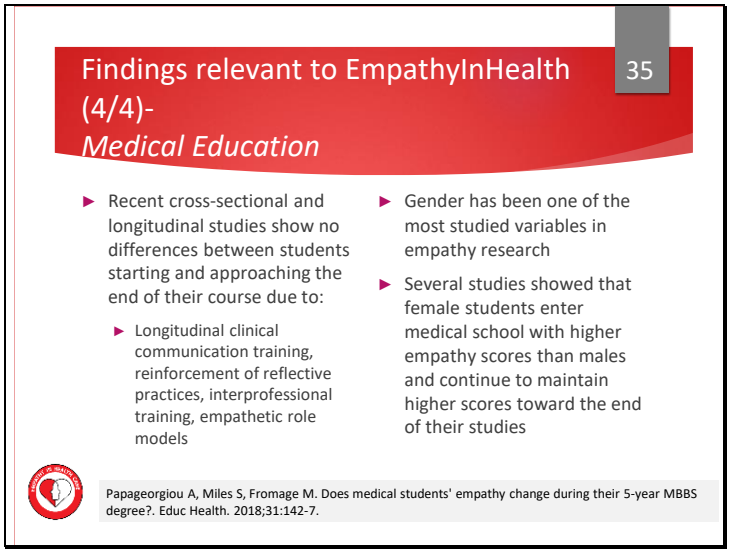

More recent cross-sectional and longitudinal studies in undergraduate medical education show no differences between students starting and approaching the end of their course. This is mainly because modern curricula include:

- Longitudinal clinical communication training, reinforcement of reflective practices, interprofessional training, empathetic role models

One more important variable that is worth mentioning when studying empathy is **gender.**

- Several studies showed that female students enter medical school with higher empathy scores than males and continue to maintain higher scores toward the end of their studies

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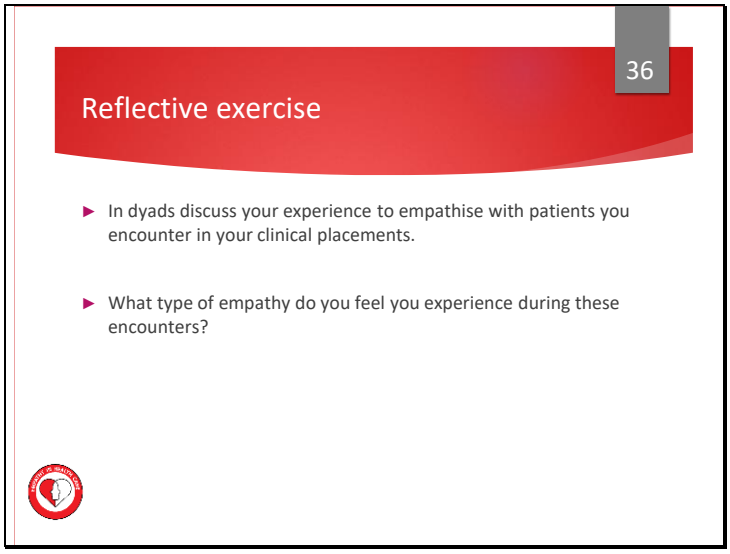

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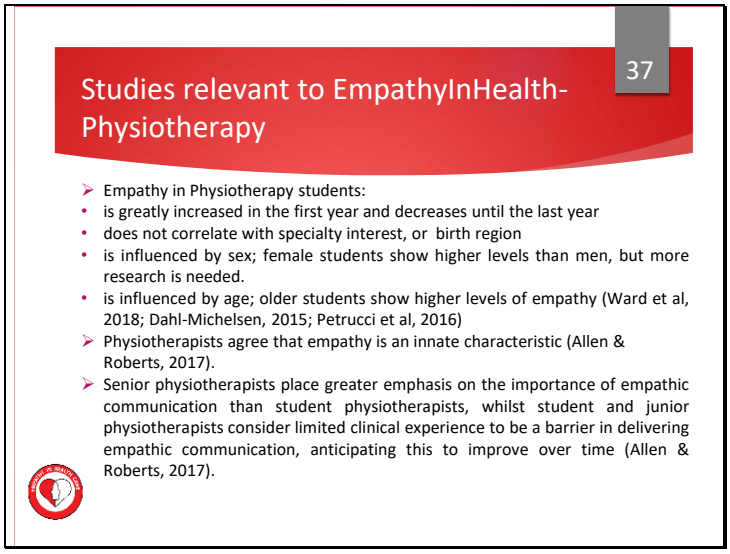

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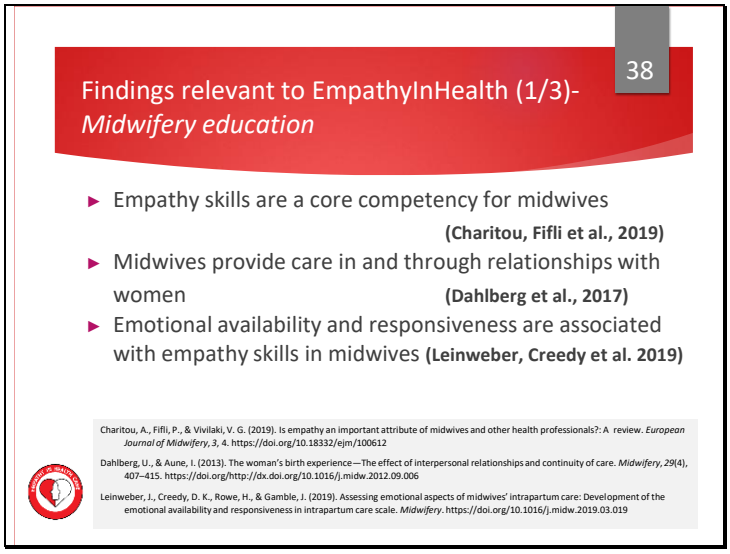

Let's look at the research evidence on empathy in midwifery. Studies have shown that:

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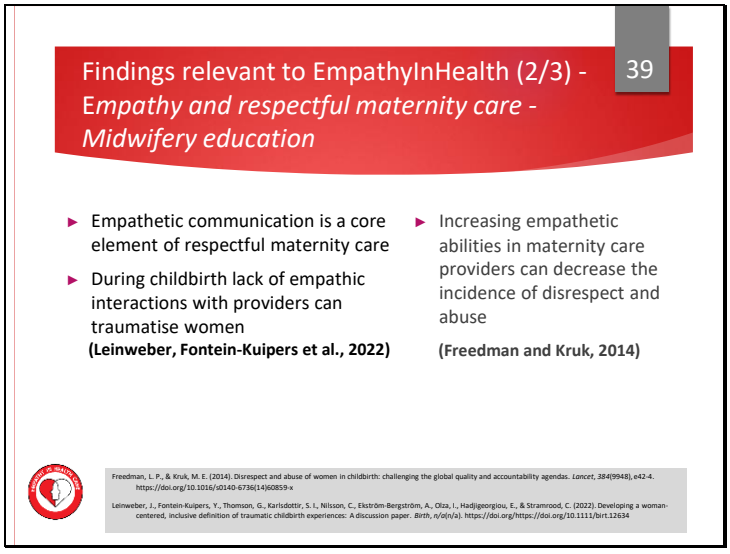

Slide 40

Findings relevant to EmpathyInHealth (3/3)-*Midwifery Education*

40

- Evidence from exploratory study with 52 BSc Midwifery students
  - studying midwifery has an overall positive effect on students' empathy
  - However: low results in participants' attitudes towards patients presenting with substance abuse

(McKenna et al., 2011)

McKenna, L., Boyle, M., Brown, T., Williams, B., Molloy, A., Lewis, B., & Molloy, L. (2011). Levels of empathy in undergraduate midwifery students: an Australian cross-sectional study. *Women Birth*, *24*(2), 80–84.

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Summary

41

- Different types of empathy
- Different approaches when researching empathy
- Relevant research findings in relation to empathy in different health care settings

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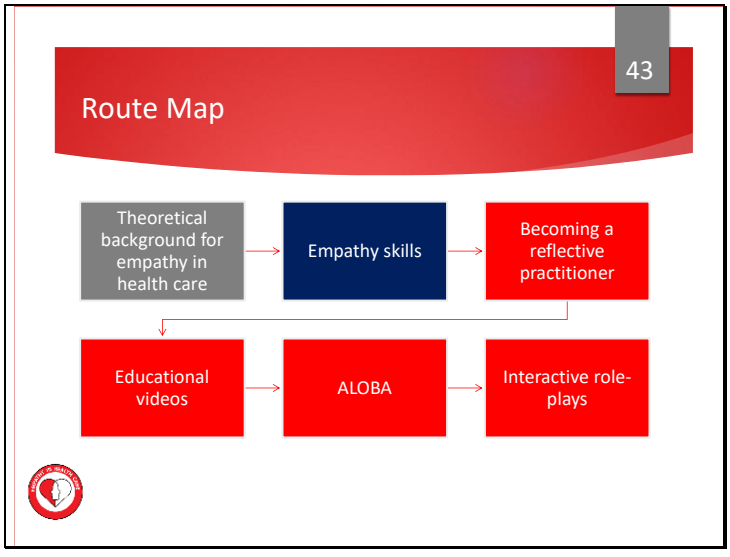

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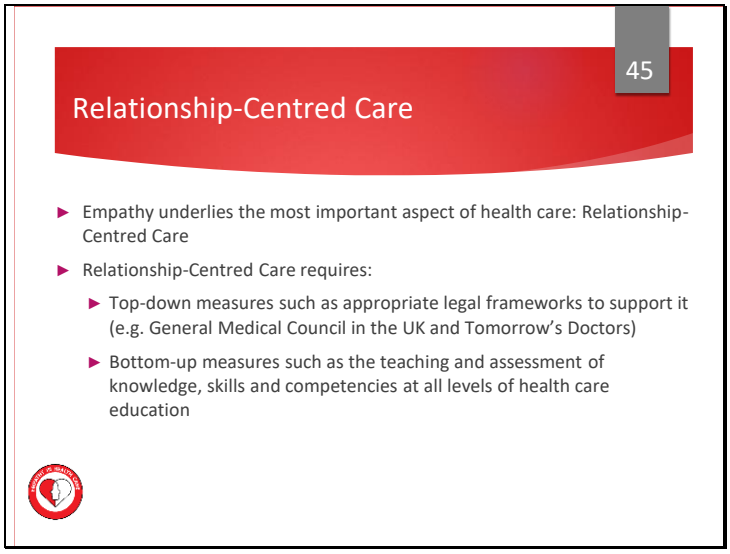

The General Medical Council in the UK and Tomorrow's Doctors (1993, 2003) legitimized the teaching and assessment of clinical communication in the UK, but there was still lack of clarity in the interpretation of what needed to be taught and assessed in both undergraduate and graduate medical education.

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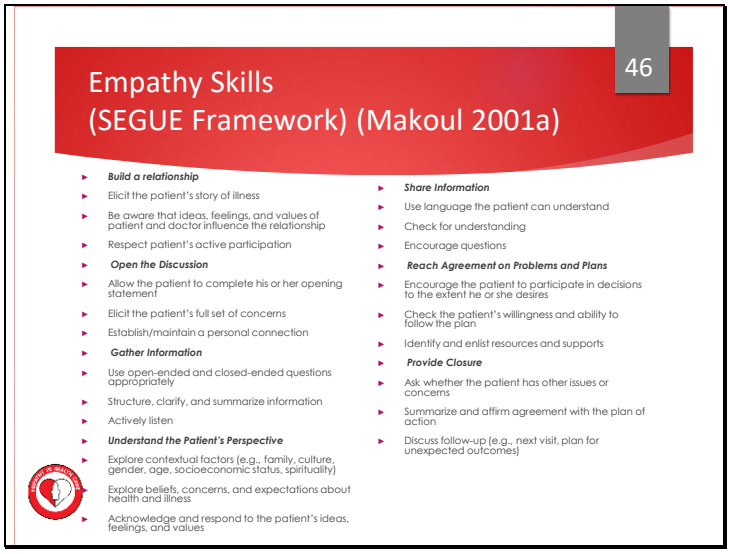

During the beginning of 2000, the need for consensus and common tools for teaching, assessing and research arose at both sides of the Atlantic.

North American experts in the field came together and created the SEGUE Framework during their meeting in Kalamazoo (Makoul 2001a, Makoul 2001b).

In 2008, clinical communication skills educators in the UK came together to create their own consensus statement (von Fragstein et al 2008).

The consensus statements provided a conceptual model and skills which could enable students and doctors to face very complex interactions with their patients, their carers and their colleagues in different health care settings and situations. They also provided guidance for doctors' continuous professional development.

As long as these conceptual models are integrated within the continuum of medical education and clinical practice and are evaluated along the way, the medical consultation will continue to evolve and be refined.

Both consensus statements attempted to provide a whole picture of what is important in clinical communication, how to teach and how to assess the subject. They described processes, tasks, professional ideology and skills. Particular emphasis was placed on the 'hidden curriculum', the culture outside the classroom that can undermine modern communication skills teaching, which will be covered more extensively during the last section of this book.

Other health care disciplines (e.g. physiotherapy, occupational therapy, nursing, midwifery) are following suit and have identified the need to incorporate empathy skills and competencies in their undergraduate trainings.

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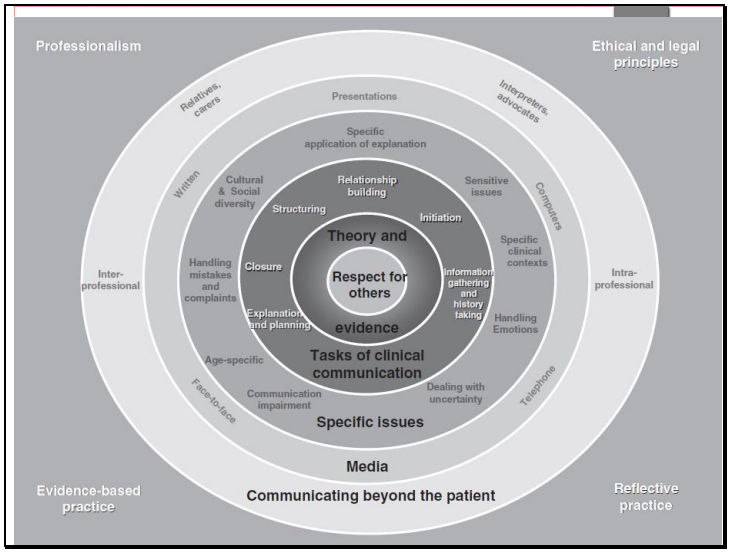

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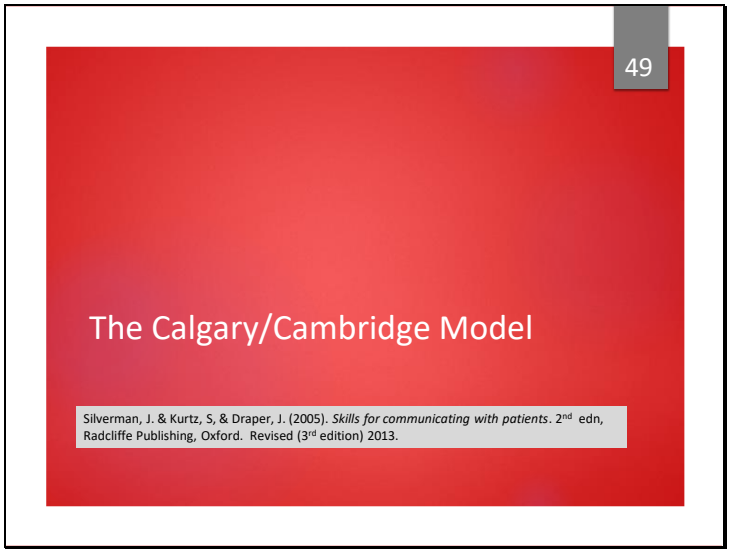

Tomorrow's Doctors (1993, 2003) legitimized the teaching and assessment of clinical communication in the UK, but there was still lack of clarity in the interpretation of what needed to be taught and assessed in both undergraduate and graduate medical education.

The development of the Calgary-Cambridge Guide to the Medical Interview in 1996 gave a framework for overcoming the barriers of implementation in teaching and assessment, and has been used extensively in the UK since (Kurtz and Silverman 1996, Silverman et al 2005). This model divided the medical interview into five basic tasks that have to be achieved in order for the consultation to be patient-centred, efficient and effective for both the doctor and the patient. These tasks included **information gathering, physical examination, explanation and planning and closing the consultation**. Under each task a number of skills had to be mastered in order for the doctor to achieve the task. In addition, the doctor had to use appropriate skills in order to structure the consultation and build and maintain a therapeutic relationship with the patient. All in all, the **Calgary-Cambridge model provided about 70 skills and a visual representation of the consultation to be used for both teaching and assessment purposes** (Kurtz et al 1996, Kurtz et al 1998, Silverman et al 2005).

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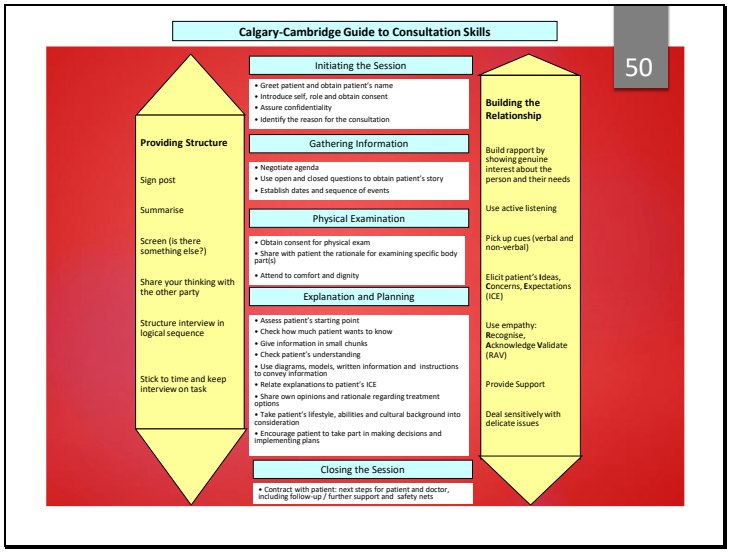

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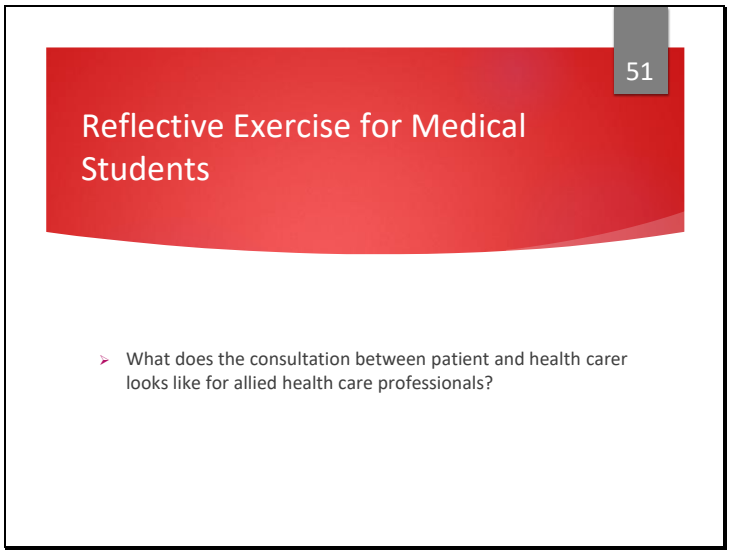

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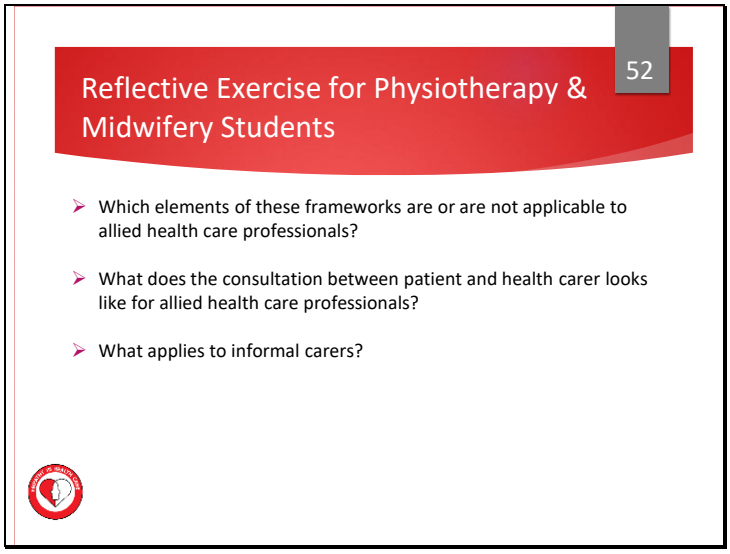

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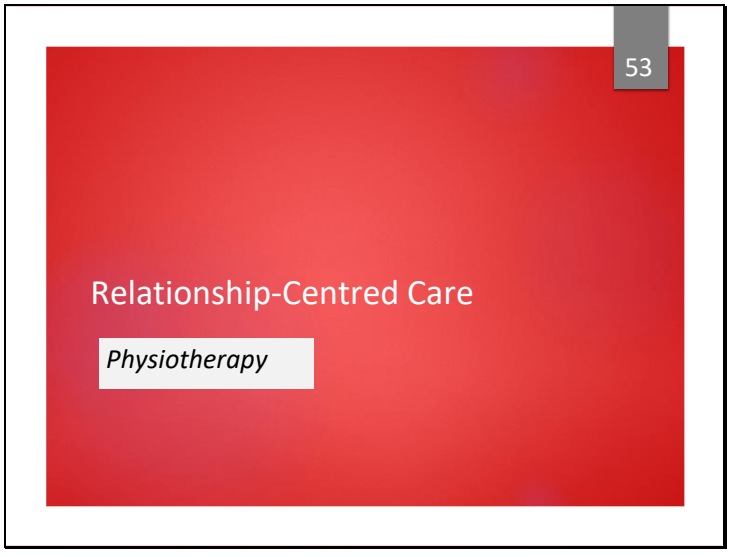

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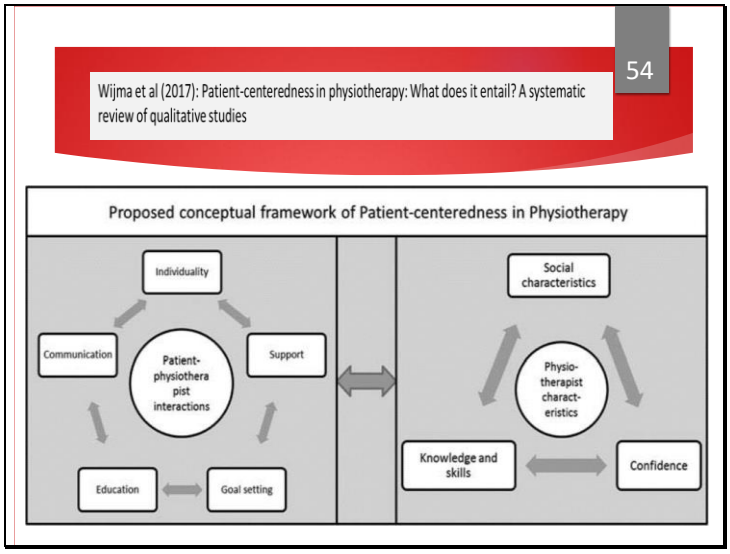

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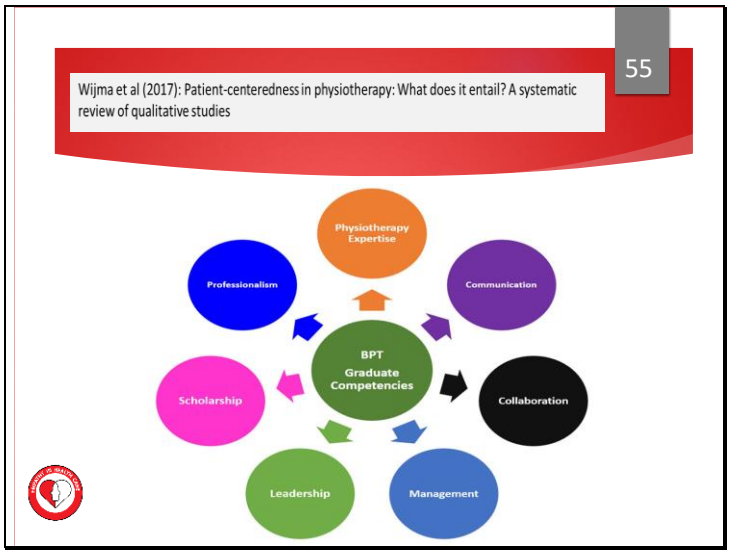

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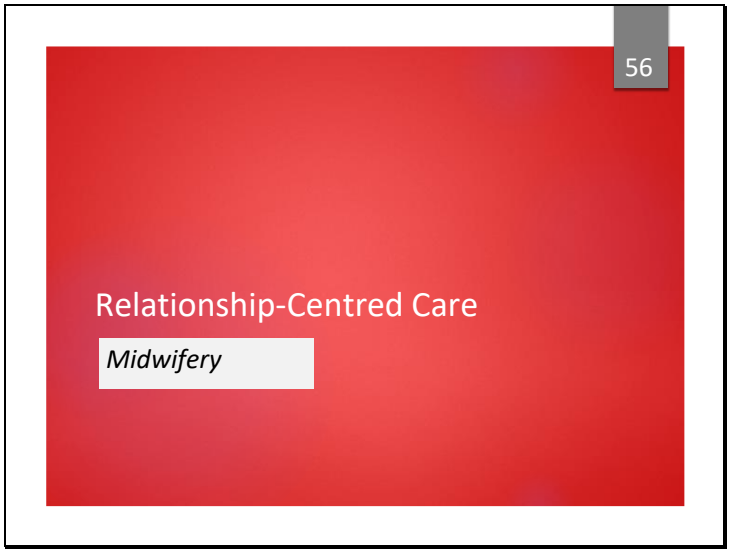

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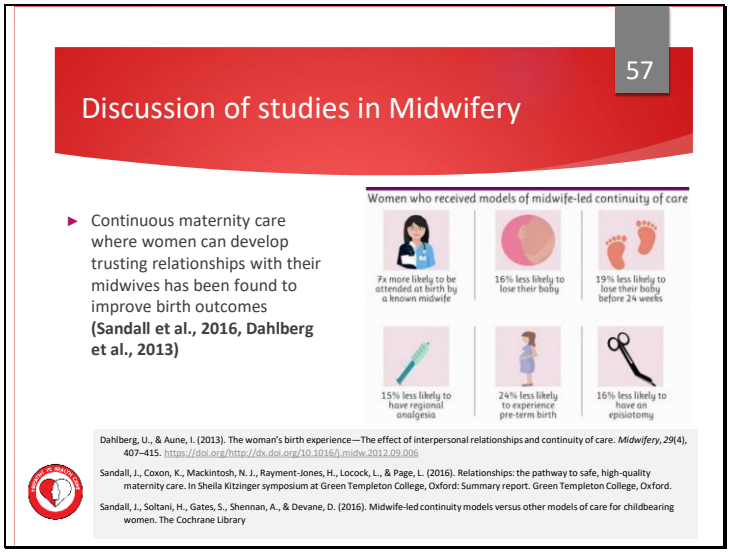

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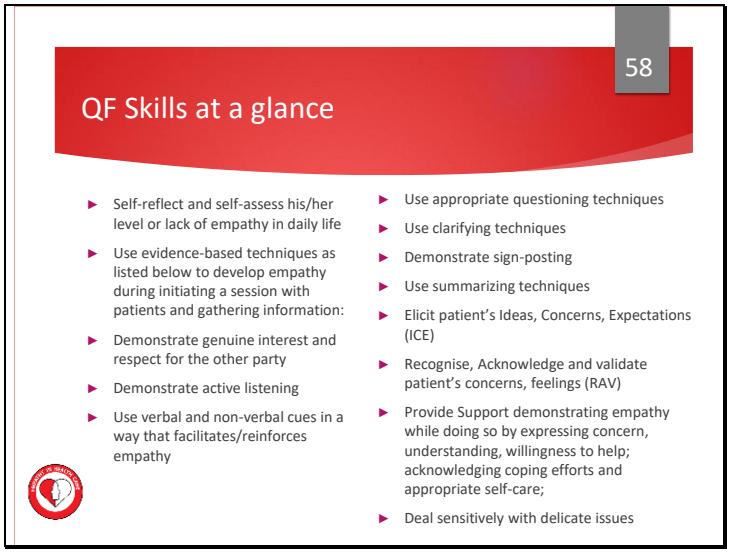

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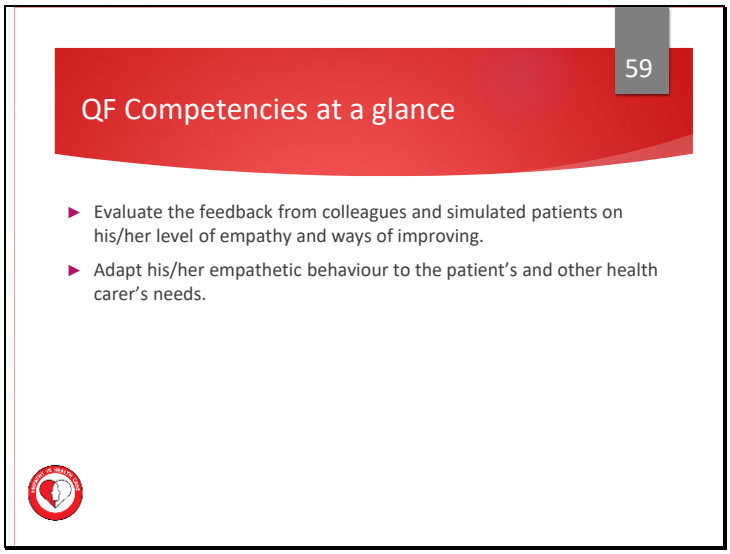

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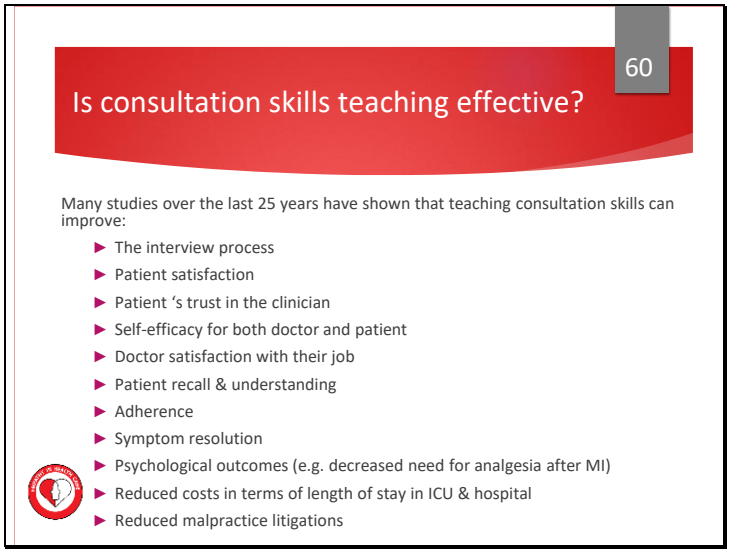

The interview process:

- **The longer the doctor waits before** interrupting the patient at the beginning of the interview, the more likely it is to discover the full range of issues the patient wants to discuss & the less likely it is that new complaints will arise at the end of the consultation.
- Active listening without interrupting until patients had completed their initial descriptions of their problems resulted in patients' mean talking time of 92sec.
- **Picking up and responding to patients' cues shortens rather than lengthens medical consultations.**

Patient recall and understanding: Asking patients to repeat in their own words what they understand increases their recall by 30%.

Patient recall is increased by categorisation, sign-posting, summarising, repetition and use of diagrams.

Adherence: Explicitly asking patients about their knowledge, beliefs, concerns and attitudes to their own illness significantly increases adherence.

Reduced malpractice litigations: Adamson et al (2000): In a study of 103 orthopaedic surgeons, those who had better rapport with their patients, who took more time to explain and who were available had fewer malpractice suits.

Levinson et al (1997): physicians who used sign-posting, asked for patients' opinions, checked for understanding, encouraged patients to talk, laughed and used humour had fewer malpractice suits.

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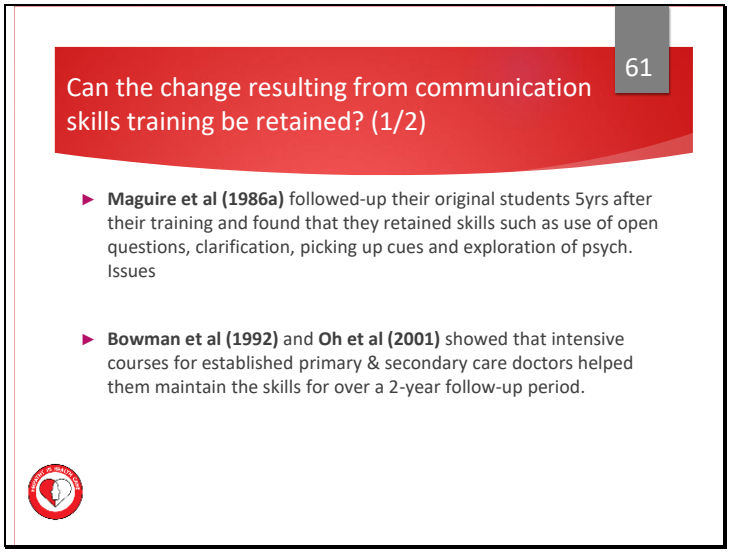

Maguire, Peter, Susan Fairbairn, and Charles Fletcher. "Consultation skills of young doctors: I--Benefits of feedback training in interviewing as students persist." *Br Med J (Clin Res Ed)* 292.6535 (1986): 1573-1576.

Oh, Jeong, et al. "Retention and use of patient-centered interviewing skills after intensive training." Academic Medicine 76.6 (2001): 647-650.

Bowman, F. M., et al. "Improving the skills of established general practitioners: the long-term benefits of group teaching." *Medical Education* 26.1 (1992): 63-68.

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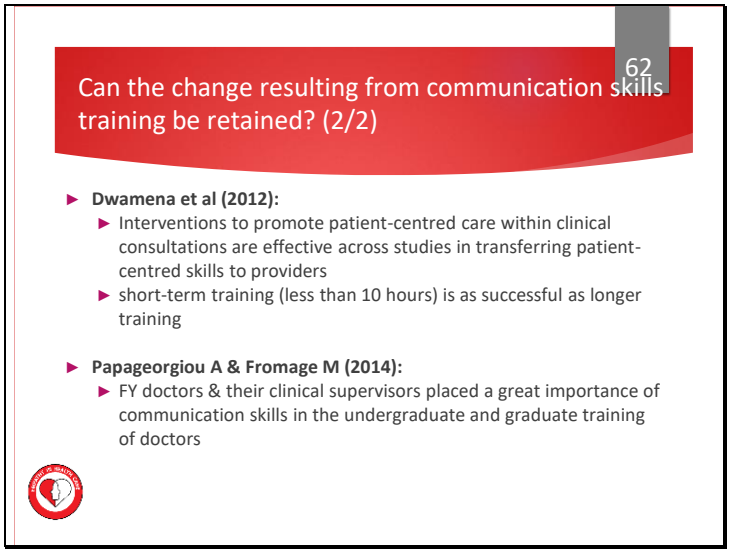

Dwamena, Francesca, et al. "Interventions for providers to promote a patient-centred approach in clinical consultations." *Cochrane database of systematic reviews* 12 (2012).

Papageorgiou A & Fromage M (2014): (PhD Thesis unpublished data)

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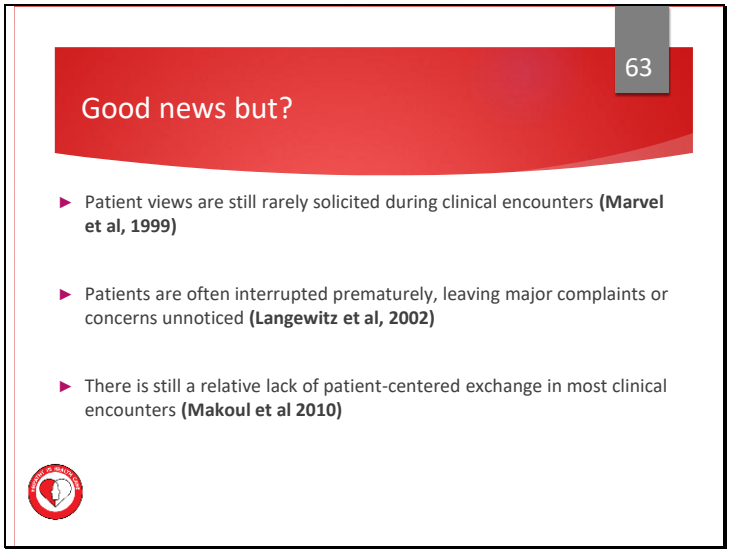

Marvel, M. Kim, et al. "Soliciting the patient's agenda: have we improved?." *Jama* 281.3 (1999): 283-287.

Langewitz, Wolf, et al. "Spontaneous talking time at start of consultation in outpatient clinic: cohort study." *Bmj* 325.7366 (2002): 682-683.

Makoul G, Myerholtz L, Williams M, Wolf S. Priorities for effective communication: patterns emerging from Communication Assessment Tool (CAT) data. Presented at the International Conference on Communication in Healthcare. Verona, 2010

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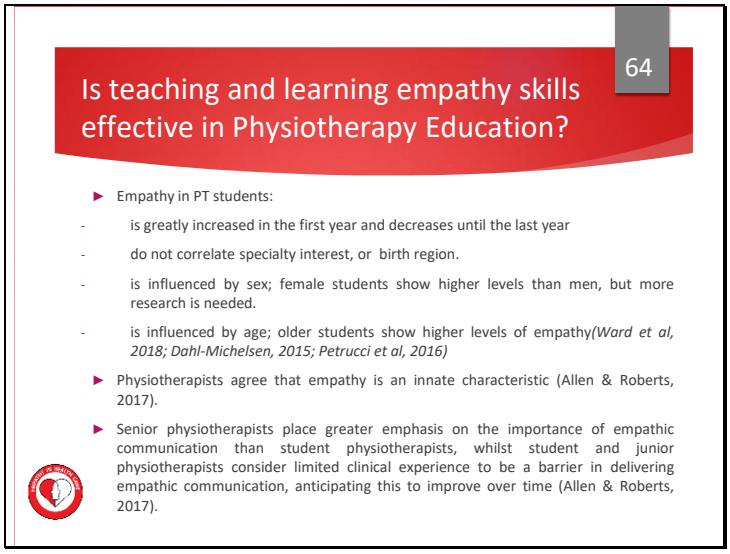

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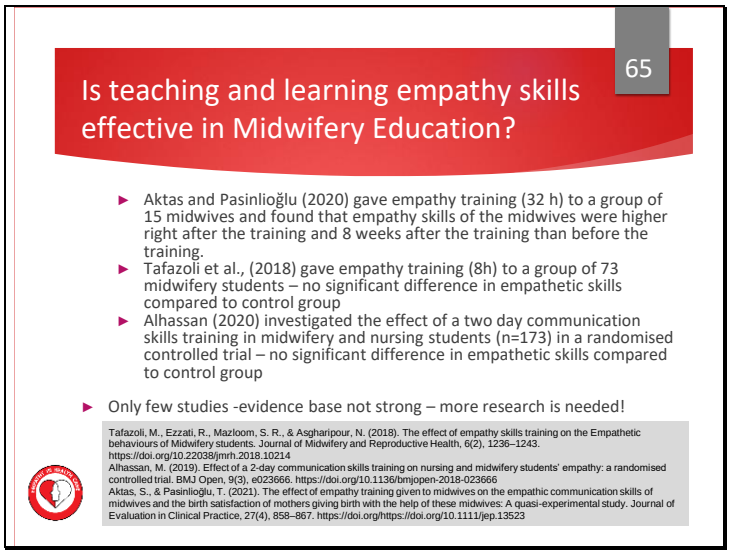

Tafazoli, M., Ezzati, R., Mazloom, S. R., & Asgharipour, N. (2018). The effect of empathy skills training on the Empathetic behaviours of Midwifery students. *Journal of Midwifery and Reproductive Health*, *6*(2), 1236–1243. https://doi.org/10.22038/jmrh.2018.10214

Alhassan, M. (2019). Effect of a 2-day communication skills training on nursing and midwifery students' empathy: a randomised controlled trial. *BMJ Open*, *9*(3), e023666. https://doi.org/10.1136/bmjopen-2018-023666

Aktas, S., & Pasinlioğlu, T. (2021). The effect of empathy training given to midwives on the empathic communication skills of midwives and the birth satisfaction of mothers giving birth with the help of these midwives: A quasi-experimental study. *Journal of Evaluation in Clinical Practice*, *27*(4), 858–867. https://doi.org/https://doi.org/10.1111/jep.13523

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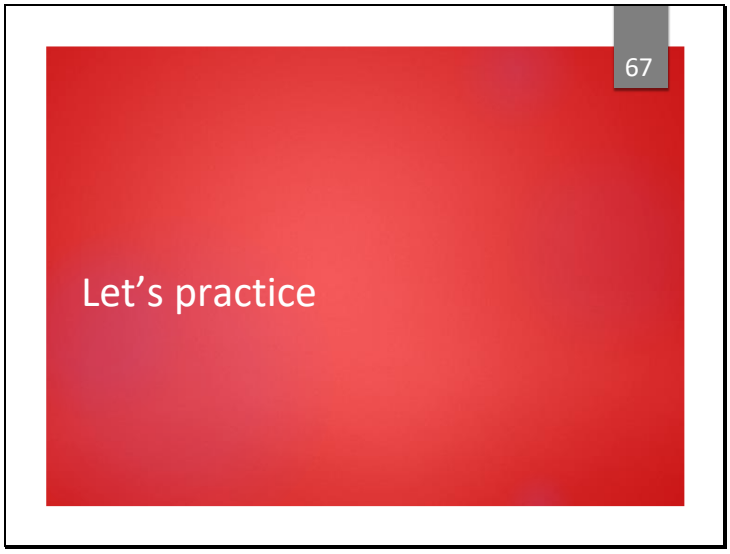

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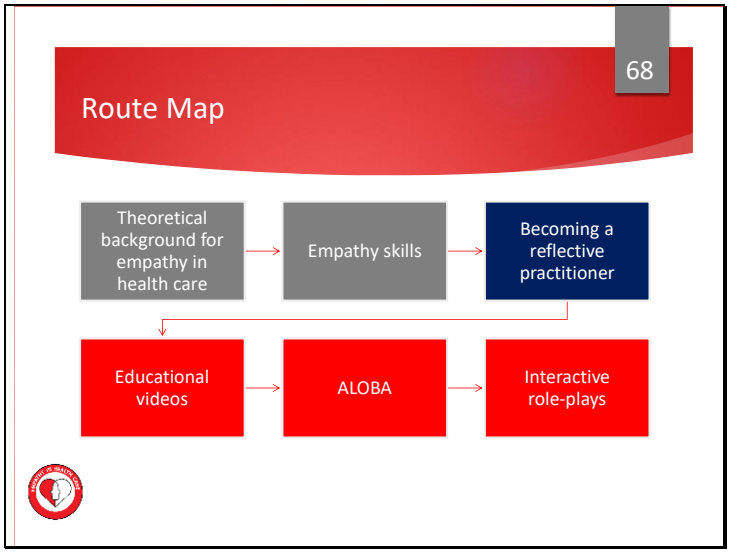

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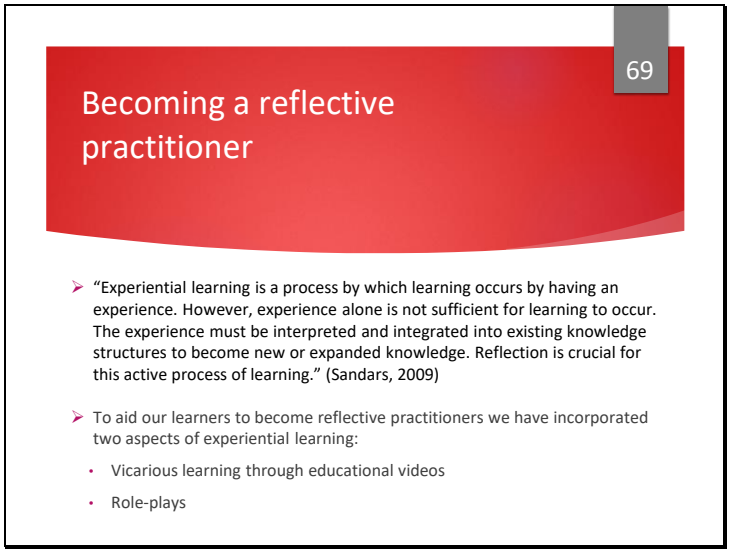

For tutors who would like to read more about the topic of reflection a good paper is: Sandars, John. "The use of reflection in medical education: AMEE Guide No. 44." *Medical teacher* 31.8 (2009): 685-695.

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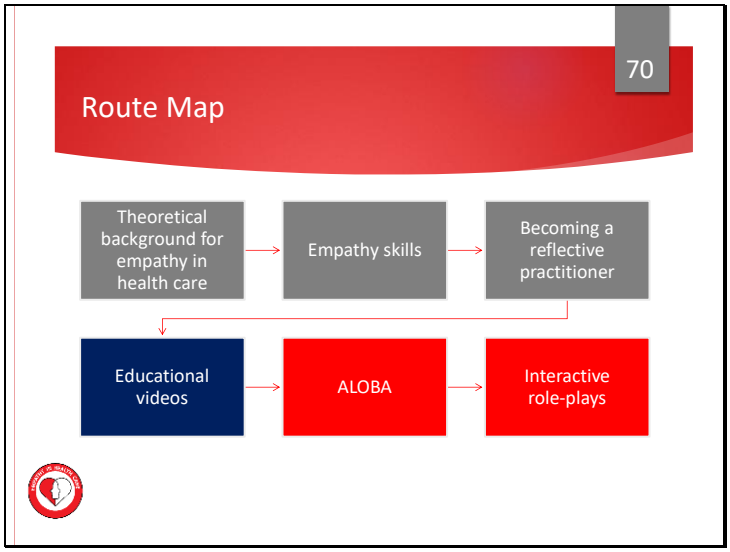
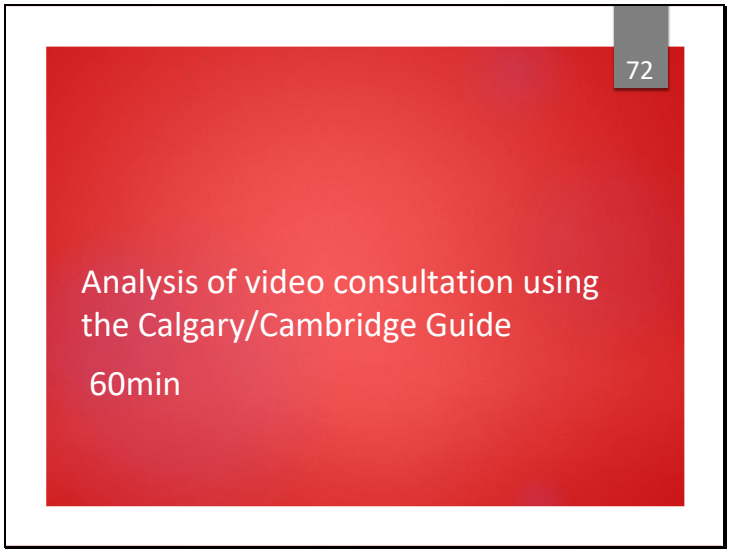


Slide 71

Tutors can use this link to show students videos with the Calgary/Cambridge guide.

https://www.hse.ie/eng/about/our-health-service/healthcare-communication/module-2/

Slide 72



Use the Calgary/Cambridge Guide to evaluate Educational video

Handout 2 can be given to students as a hard copy or electronically as a word document. Give students 5 min to read the skills individually. Ask them as a group if they have any questions in relation to any of the skills. Before the

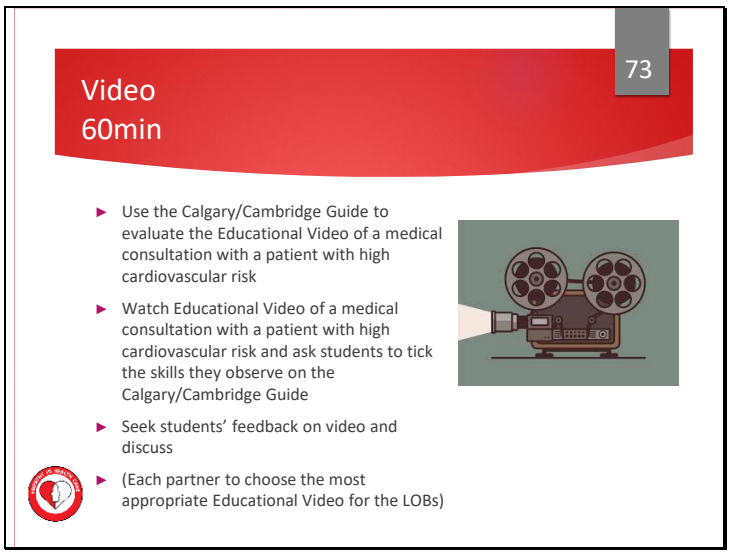
tutors embark on explaining the skills to the students, ask if any of the students could answer the question. Students may be able to answer each other's questions. Don't spend more than 10-15min answering questions on the skills.

Watch the Educational Video and ask students to tick the skills they observe on the Calgary/Cambridge guide

Seek students' feedback on video and discuss

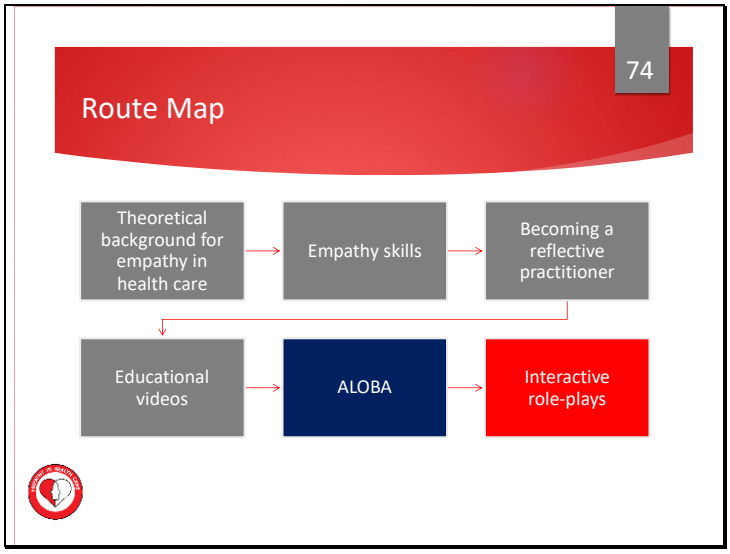
(Each partner to choose the most appropriate scenario for the LOBs)

Slide 73



Use the Calgary/Cambridge Guide to evaluate Educational Video of your choice. For medical students the most appropriate video is a medical consultation with a patient with high cardiovascular risk.

Slide 74



Slide 75

The participants will perform role-plays with the simulated patient that will last between 8-20 minutes depending on the learning outcomes of the session. In order to help you facilitate this experiential exercise we recommend the use of ALOBA for organising the feedback process. Tutors need to use **HANDOUT 3: ALOBA_ How to set-up and carry out the role-play**

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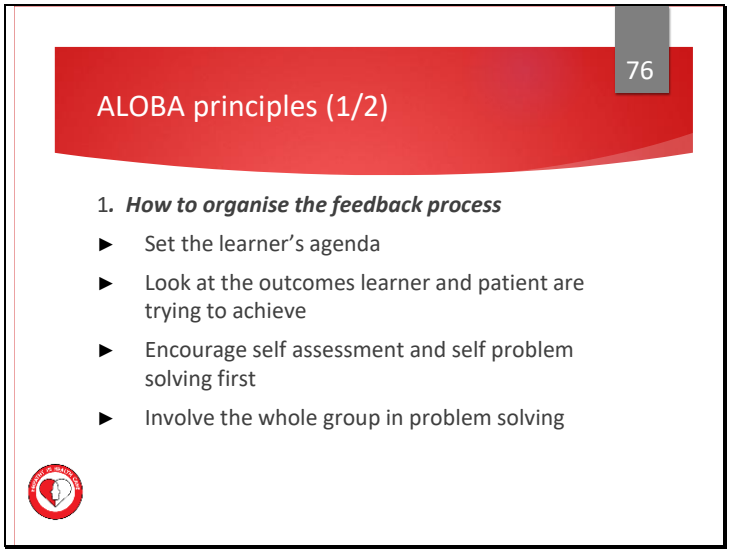

ALOBA, overcomes the disadvantages of the conventional rules and promotes self-assessment. It helps us organise the feedback process.

It also encourages a mix of problem-based experiential learning, centred on learner's agenda.

Before the role-play starts, we need to set the learner's agenda: ask what problems the learner experienced in their practice so far and what help he/she would like from the rest of the group (i.e attend and give suggestions for body language)

We then look at the outcomes...: where the learner is aiming at and how she might get there (i.e. negotiate a treatment plan)

When the role-play finishes, we encourage self-assessment: allow the learner space to make suggestions of what they could do differently if they did the same role-play again.

After that we involve the role-player and the rest of the group: we encourage them to find solutions not only for the learner but for themselves in similar situations.

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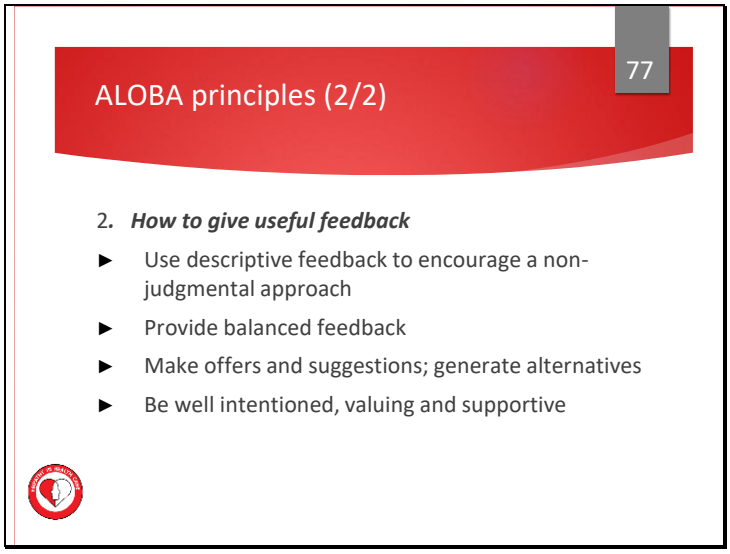

Descriptive feedback: specific comments are made which prevent vague generalisation (e.g. not good consultation)

Balanced feedback: about what worked well and did not work well

Generate alternatives and reflect them back to the learner for consideration.

It is the facilitators' group's responsibility to be respectful and sensitive to each other.

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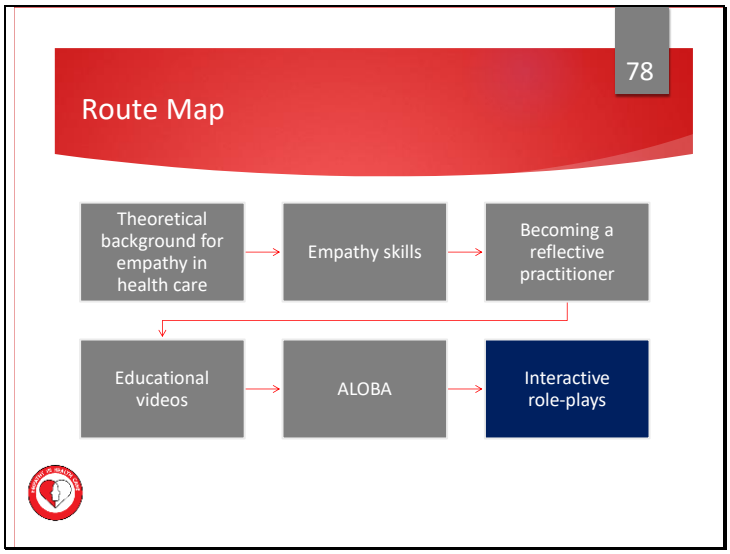

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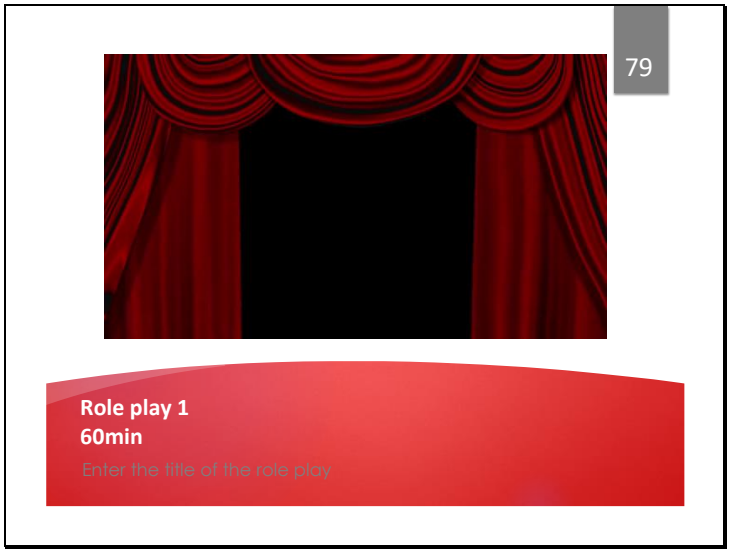
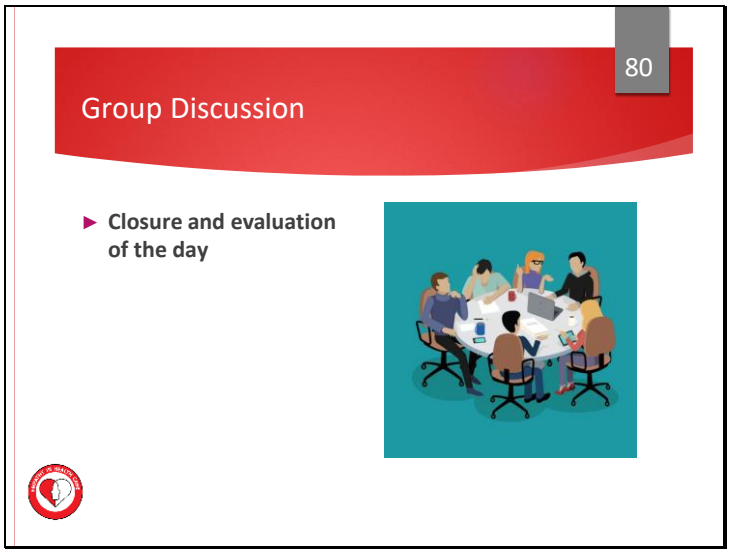


The participants will perform role-plays with the simulated patient that will last between 8-20 minutes depending on the learning outcomes of the session. In order to help you facilitate this experiential exercise please use **Handout 3: ALOBA_How to set-up and carry out the role-play**

Slide 80



Ask each student to tell you one thing they learnt and would like to take with them

Give students the training evaluation form to complete and sign-post what the 2nd training day will involve. Point them to any electronic resources they need to access in order to further improve their learning and practice.

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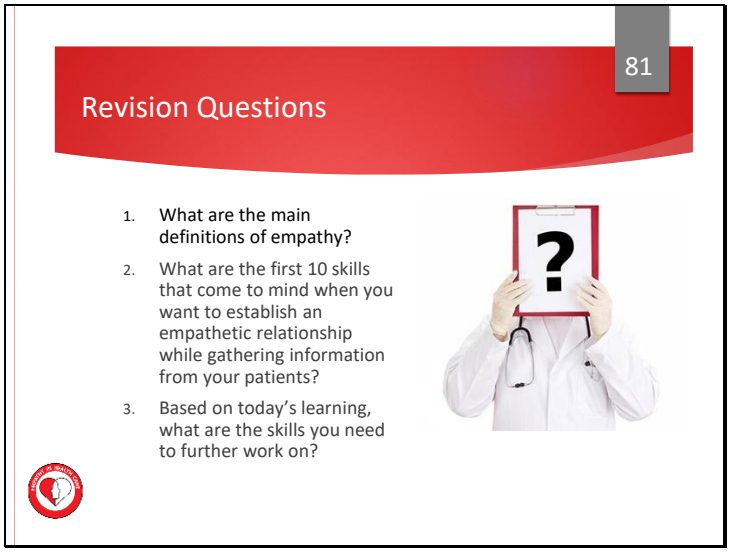

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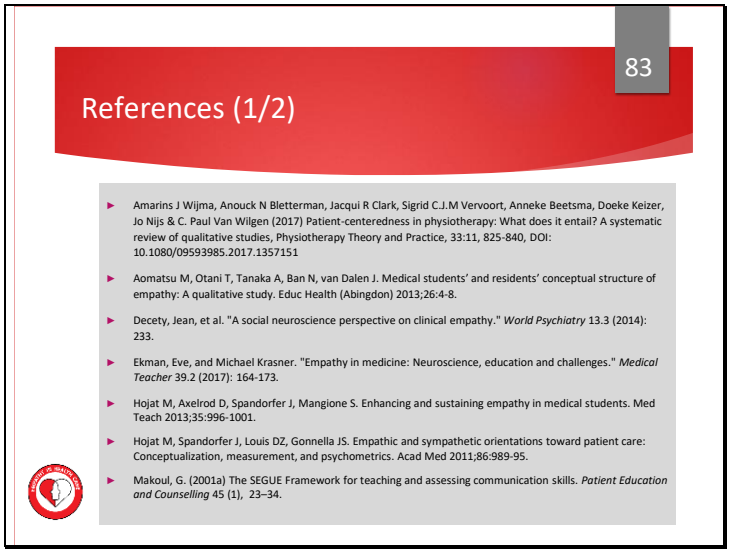

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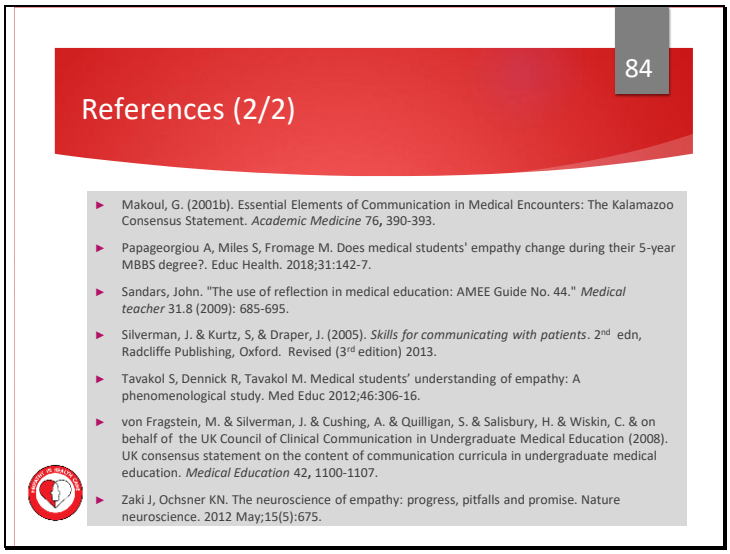

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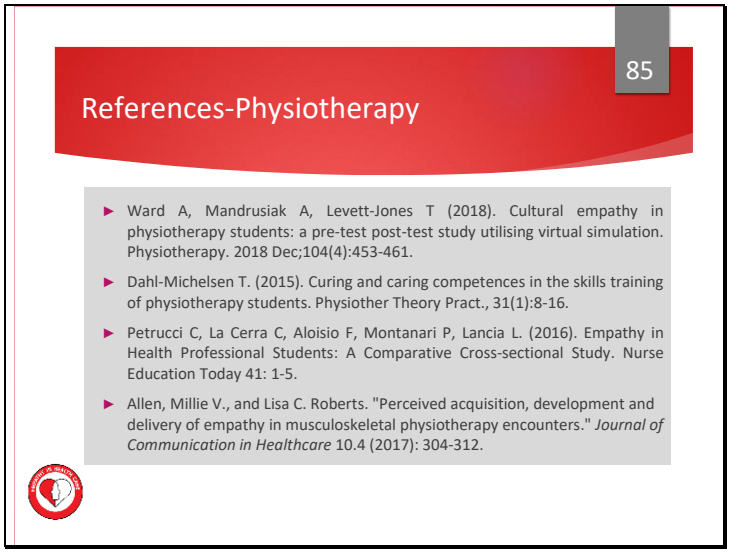

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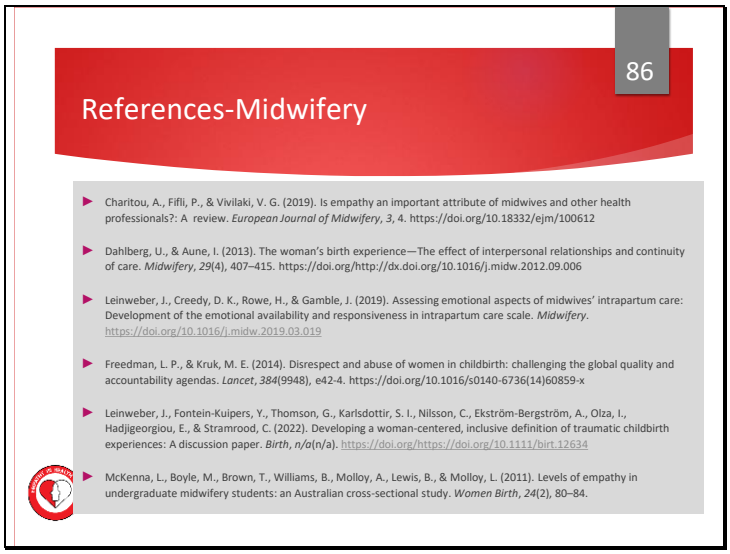

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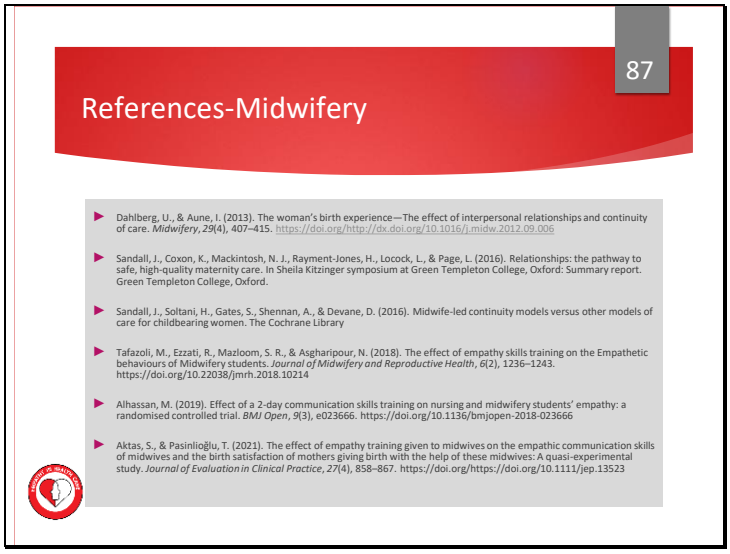

Slide 88

5.3. EDUCATIONAL VIDEOS

Use Handout 2 Calgary/Cambridge Guide to evaluate the videos.

5.3.1. EDUCATIONAL VIDEO 1: SCENARIO 13 (REGISTRATION FOR BIRTH AND DISCUSSING BIRTH PLAN WITH RECENTLY MIGRATED CLIENT)

Scenario Number: 13

Title: Registration for birth and discussing birth plan with recently migrated client

Discipline: Midwifery/Medic

Developed by: Charite

Work areas: Work Area 1, 2 and 3.1

Specific features: Providing woman-centered care, shared decision making, cultural diversity

Description of scenario: Mrs. Kurt has recently migrated from Turkey to Berlin and she is expecting her second child. She would like to know what to expect when she comes to the hospital when she is having her baby. The midwife is discussing with her what her options are regarding the management of the labour pain and the time following the birth of the baby and where the care may differ from the care she has received when giving birth to her first child in Turkey.

5.3.2. EDUCATIONAL VIDEO 2: SCENARIO 8 (MEDICAL CONSULTATION: PATIENT WITH HIGH CARDIOVASCULAR RISK)

Scenario Number: 8

Title: Medical Consultation: patient with high cardiovascular risk

Discipline: Medicine

Developed by: UNIC

Work areas: Work Areas 1 and 2

Specific features: Risk communication in an obese middle age man with several risk factors for cardiovascular disease

Description of scenario: A 55-year-old obese man attends the GP clinic following an annual health review. The annual health review showed that he is at increased risk for cardiovascular disease (10 year risk of

32.2%) based on a number of risk factors (overweight, hypertension, raised cholesterol and blood sugar levels, smoking history and family history of cardiovascular disease).The patient is not concerned about his lifestyle but decided to attend this year's annular health review as his brother was recently diagnosed with cardiovascular disease and because of his wife being concerned about his health. The student is asked to discuss with patient the results of his annual health review and his risk of cardiovascular disease and address any relevant lifestyle modifications such as diet, physical activity, smoking.

5.3.3. EDUCATIONAL VIDEO 3: SCENARIO 6 (EMPATHY CULTURAL DIVERSITY, WORKING WITH INTERPRETER: IMMIGRANT PATIENT WITH LUNG INFECTION)

Scenario number: 6

Title: Empathy Cultural Diversity, working with interpreter: Immigrant patient with lung infection

Discipline: Physio/ Medic/VET

Developed by: UTH

Work areas: All work areas

Specific features: Cultural diversity, giving- gathering information, working with interpreter

Description of scenario: Man (20s) refugee (Muslim), Arabic speaking (interpreter) leaving in a refugee camp had a lung infection and he is in the pulmonary clinic now (fear, breathing difficulty, difficulty of communication, female therapist issues*). His wife is with him. A female physio is in charge, she has to give information and demonstrate respiratory exercises to him before his discharge.

5.4. ROLE PLAYS

Use Handout 3 on ALOBA and how to set up the role play

5.4.1. ROLE PLAY 1: SCENARIO 2 (ASSESSMENT AND PAIN MANAGEMENT IN PREGNANT CLIENT WITH LANGUAGE BARRIER)

Scenario Number: 2

Role play Title: Assessment and pain management in pregnant client with language barrier

Discipline: Interprofessional

Developed by: Charite

Work areas: Work Area 1, 2 and 3.1

Specific features: Assessing risk/performing triage when communication is difficult, cultural diversity

Scenario description: The bell rings, and Meral Navid and her husband Hamid Navid arrive at the birthing suite. The midwife goes to the door to meet the new arrival. When she gets to the door, she sees a woman bent over, breathing through a contraction. The woman is wearing a hijab and is with her husband. Meral Navid is gesturing and does not feel confident speaking German, but she does understand many things. Her husband is trying to help by explaining the situation. The midwife introduces herself, and communicates with the couple to assess what should happen next.

5.4.2. ROLE PLAY 2: SCENARIO 3 (NEWBORN WITH WEIGHT GAIN CHALLENGES: SHARING INFORMATION AND COMMUNICATING RISK)

Scenario Number: 3

Role play Title: Newborn with weight gain challenges: sharing information and communicating risk

Discipline: Interprofessional

Developed by: Charite

Work areas: Work Area 1 and 2

Specific features: Shared decision making postpartum, communicating risk to client who wishes to leave the hospital against medical advice

Scenario description: Mrs Lea Kowalsky, a 36-year-old woman had a C-section with her first child 4 days ago. She is set to leave the hospital with her baby boy Paul and is awaiting the results of the discharge examination. The midwife who is weighing the baby is aware that Mrs Kowalsky very much wishes to leave the hospital that day. The midwife sees that the baby has continued its weight loss, and she needs to communicate this and the associated risk to Mrs Kowalski. She recommends against leaving the hospital today. Mrs Kowalsky is very upset and feels sure that the breastfeeding would go better at home. She insists on being discharged. The midwife is challenged to communicate how another day in hospital will be of benefit to Mrs. Kowalski and her baby.

5.4.3. ROLE PLAY 3: SCENARIO 4 (ELDERLY PATIENT AFTER HIP REPLACEMENT: COMMUNICATING WITH THE CONFUSED/ANGRY PATIENT)

Scenario Number: 4

Role play Title: Elderly patient after hip replacement: communicating with the confused/angry patient

Discipline: Physio/Medic/VET

Developed by: UTH

Work areas: All work areas

Specific features: Manage angry patient, exploring patient concerns, shared decision making

Scenario description: Elder man (70s) in orthopaedics clinic, two days after having total hip replacement. He has mental problems (dementia, confusion) and due to his medical concurrent problems, he needs to be mobilized (standing up and walk with aid). He refuses to cooperate with the therapist.

5.4.4. ROLE PLAY 4: SCENARIO 9 (ADOLESCENT WITH DIABETES: SHARED DECISION MAKING IN CHALLENGING SITUATIONS)

Scenario number: 9

Role play Title: Adolescent with diabetes: shared decision making in challenging situations

Discipline: Medicine

Developed by: UNIC

Work areas: Work Areas 1,2 and 3.1

Specific features: Info gathering, info giving, shared decision making, showing empathy to a patient who does not comply with treatment

Scenario description: A 17y.o. adolescent boy with Type I Diabetes, is attending the GP practice for review of hypoglycemic episodes and his overall glucose control. The student is asked to explore potential reasons behind the patient's challenges with his blood glucose control and insulin treatment including exploring behavioural issues such as missing insulin treatment because he feels that diabetes is an obstacle to normal living and he wants to be like his peers and use of substances like alcohol, smoking of cigarettes and cannabis. The student is asked to use his empathic skills to explore challenging issues around the boy's health and behavior and discuss with him a mutually agreed treatment plan.

5.5. EXERCISES

EXERCISE 1: "GOLDEN MINUTE EXERCISE"

- "Golden Minute Exercise"
- Tutor to keep the time using a stop watch
- In dyads please talk to your partner for one minute about a topic that you feel comfortable with and is true about yourself. Your partner can not take notes and cannot ask you any questions. He/she has to listen attentively.
- After one minute you switch. Your partner talks for one minute and you have to remain silent listening to him/her.
- When the two minutes are over each pair has to report to the whole group what they have learnt for each other

This exercise facilitates attentive/active listening. Research has shown that doctors interrupt patients 18 seconds after they start explaining their problem. Patients who were allowed to complete their opening statement without interruption mostly took less than 60 seconds and none took longer than 150 seconds even when encouraged to continue. Silverman et al 2005 (2nd Ed). Page 46.

EXERCISE 2: ESTABLISH GROUND RULES

See Handout 1 For Background Reading

- Ask students to think about some of the best group discussions they have been a part of; then ask them to reflect on what made these discussions so satisfying. They should write these things down. (example: felt comfortable to participate, felt tutor was approachable, etc)
- Next, ask students to think about the worst group discussions they have participated in and reflect on what made these discussions so unsatisfactory. They should write these down as well.
- For each of the positive characteristics identified, ask students to suggest three things the group could do to ensure that these characteristics are present.
- For each of the negative characteristics identified, ask students to suggest three things the group could do to ensure that these characteristics are not present.

- Use students' suggestions to draft a set of ground rules to which you all agree, and distribute them in writing.
- Periodically, ask the class to reflect on whether the ground rules established at the beginning of the semester are working, and make adjustments as necessary.

Some ground rules that each group should have ….

- Be on time
- Mobiles off
- Do not interrupt others
- Equal participation by all members
- Feel free to ask questions
- Do not put down or make fun of others
- You have the right to disagree but do so respectively
- Always offer positive feedback first and then feedback on things that can be improved on, in a constructive manner
- Every person in the group and not just the tutor has the responsibility to confront a student if they disrupt the group's function by ignoring the group rules
- If you are offended by something/someone bring it up immediately
- Consequences

EXERCISE 3: BRAINSTORMING

- The group to allocate a scribe who will write on the whiteboard the answers on the following questions:
- What is your understanding of empathy?

EXERCISE 4: KNOWLEDGE QUIZ

- What are the main differences between the 3 aspects of empathy as these are defined in the triangle of empathy?
- Please provide an example for each type of empathy as it is defined in the triangle of empathy.

Answer: Cognitive empathy, mentalising, perspective taking, theory of mind is about understanding what another person feels without us necessarily sharing the same feeling which is what Affective empathy, experience sharing, shared self-other representations, emotional contagion are mainly about.
Prosocial concern, empathic motivation, sympathy, empathic concern, compassion, altruism refers to how motivated we feel to perform an altruistic behaviour based on our cognitive and/or affective empathy.
Examples
Cognitive empathy: "I can see you are delighted with the results of your final year exam."
Affective empathy: "I feel glad too that your results are so good."
Prosocial concern: "Let's go out and celebrate your success."

EXERCISE 5: REFLECTIVE EXERCISE

- In dyads discuss your experience to empathize with patients you encounter in your clinical placements.
- What type of empathy do you feel you experience during these encounters?

EXERCISE 6: EDUCATIONAL VIDEO 1

Use the Calgary/Cambridge Guide to evaluate Educational Video 1.
Handout 2 can be given to students as a hard copy or electronically as a word document. Give students 5 min to read the skills individually. Ask them as a group if they have any questions in relation to any of the skills. Before the tutors embark on explaining the skills to the students, ask if any of the students could answer the question. Students may be able to answer each other's questions. Don't spend more than 10-15min answering questions on the skills.

Watch Educational Video 1 and ask students to tick the skills they observe on the Calgary/Cambridge guide Seek students' feedback on video and discuss (Each partner to choose the most appropriate scenario for the LOBs)

EXERCISE 7: ROLE PLAY

Use Handout 3: ALOBA and How to set up and carry out the role play.

EXERCISE 8: CLOSURE AND EVALUATION OF THE DAY

Ask each student to tell you one thing they learnt and would like to take with them

Give students the Training Evaluation Form to complete and sign-post what the 2nd training day will involve. Point them to any electronic resources they need to access in order to further improve their learning and practice.

5.6. ADDITIONAL HANDOUTS

HANDOUT 1: ESTABLISHING GROUND RULES FOR GROUPS

What are ground rules?

Ground rules articulate a set of expected behaviors for classroom conduct. They can be set by the instructor or created by the students themselves (some people believe that students adhere more to ground rules if they have a role in creating them).

How can we use ground rules?

Ground rules should be established at the beginning of a course, and the instructor should explain the purpose they serve (for example, to ensure that everyone is heard or that all group members contribute, etc.)

Some instructors ask students to sign a contract based on the ground rules; others simply discuss and agree to the ground rules informally. It is important for instructors to remind students of these ground rules periodically, particularly if problems occur (for example, students cutting one another off in discussion or making inappropriate personal comments).

Instructors should also be sure to hold students accountable to these rules, for example, by exacting a small penalty for infractions (this can be done in a lighthearted way, perhaps by asking students who violate the rules to bring in a snack for everyone), by factoring conduct during discussions into a participation grade for the course, or by pulling aside and talking to students whose conduct violates the agreed-upon rules.

Sample Ground Rules

Each group should come up with their own ground rules that are appropriate for the specific group. They should be written on flipchart paper and placed in the room at a place where they are visible to all. Once the ground rules are established all members of the group agree to adhere to them. Ground rules can be revisited during the semester and modified if necessary. The following are suggested ground rules that you can generate in your group.

- Listen actively and attentively
- Come to class on time
- Come prepared
- Ask for clarification if you are confused
- Do not interrupt one another
- Mobiles should not be used during group. If you are expecting an important call let the tutor know and take it outside if necessary.
- Laptops should only be used for note taking if the student requires it (ie for learning difficulties)
- Equal participation by all group members
- Don't be afraid to ask questions
- You have the right to disagree but do so respectfully
- Challenge one another, but do so respectfully.
- Remember to offer constructive and specific feedback
- Do not put down or make fun of others
- Do not monopolize discussion
- If you are offended by anything said during discussion, acknowledge it immediately
- If you have a grievance with the tutor bring it up as soon as possible so it can be resolved
- Consider information shared during class by group members regarding personal experiences as confidential and do not share it outside of class
- Inform tutor if you need to leave early
- You don't have to like everyone in your group to work with them
- Everyone deserves to be heard even if you don't agree with what is being said
- Rotate responsibilities in group (ie scribe)
- Consequences: group members who disrupt the group's function by ignoring the group rules can be confronted by group members and suffer the specified consequences.

Note: If a group wishes to establish consequences at the very beginning they can do so. If the tutor sees that the group members are not so keen on doing this at this stage they can suggest that the members think about it and you can revisit this at a later time. In the meantime, however, ask them to think about what consequences they think might be appropriate.

Some ground rules that each group should have ….

- ❖ Be on time
- ❖ Mobiles off
- ❖ Do not interrupt others
- ❖ Equal participation by all members
- ❖ Feel free to ask questions

- Do not put down or make fun of others
- You have the right to disagree but do so respectively
- Always offer positive feedback first and then feedback on things that can be improved on, in a constructive manner
- Every person in the group and not just the tutor has the responsibility to confront a student if they disrupt the group's function by ignoring the group rules
- If you are offended by something/someone bring it up immediately
- Consequences

How to generate ground rules

One way to generate ground rules is to just ask students to think of rules they would like to have as a group. Another method involves the following steps:

1. Ask students to think about some of the best group discussions they have been a part of; then ask them to reflect on what made these discussions so satisfying. They should write these things down. (example: felt comfortable to participate, felt tutor was approachable, etc)
2. Next, ask students to think about the worst group discussions they have participated in and reflect on what made these discussions so unsatisfactory. They should write these down as well.

3. For each of the positive characteristics identified, ask students to suggest three things the group could do to ensure that these characteristics are present.

4. For each of the negative characteristics identified, ask students to suggest three things the group could do to ensure that these characteristics are not present.

5. Use students' suggestions to draft a set of ground rules to which you all agree, and distribute them in writing.

6. Periodically, ask the class to reflect on whether the ground rules established at the beginning of the semester are working, and make adjustments as necessary.

References:

www.cmu.edu/teaching

https://mgrush.com/blog/2017/02/02/ground-rules/

Brookfield, S.D., Preskill, S. 2005. *Discussion as a way of Teaching: Tools &Techniques for Democratic Classrooms.* San Francisco: Jossey-Bass (2nd Edition)

https://teachingcenter.wustl.edu/resources/inclusive-teaching-learning/establishing-ground-rules/

Collective agreement for all group members

Group ground rules:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Consequences:

Group members who disrupt the group's function by ignoring the group's rules can be confronted by the other group members or the tutor and suffer the following consequences:

_____

_____

_____

_____

_____

_____

_____

We individually and collectively agree to the ground rules that we have set as a group and we also agree on the set consequences.

Group member's name	**Signature**
_____	_____
_____	_____
_____	_____
_____	_____

Group Facilitator/Tutor **Date: _____**

_____

HANDOUT 2: CALGARY CAMBRIDGE GUIDE-THE SKILLS

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CALGARY - CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW – COMMUNICATION PROCESS

INITIATING THE SESSION

ESTABLISHING INITIAL RAPPORT

1. **Greets** patient and obtains patient's name

2. **Introduces** self, role and nature of interview; obtains consent if necessary

3. **Demonstrates respect** and interest, attends to patient's physical comfort

IDENTIFYING THE REASON(S) FOR THE CONSULTATION

4. **Identifies** the patient's problems or the issues that the patient wishes to address with appropriate **opening question** (e.g. "What problems brought you to the hospital?" or "What would you like to discuss today?" or "What questions did you hope to get answered today?")

5. **Listens** attentively to the patient's opening statement, without interrupting or directing patient's response

6. **Confirms list and screens** for further problems (e.g. "so that's headaches and tiredness; anything else……?")

7. **Negotiates agenda** taking both patient's and physician's needs into account

GATHERING INFORMATION

<u>Exploration of patient's problems</u>

8. **Encourages patient to tell the story** of the problem(s) from when first started to the present in own words (clarifying reason for presenting now)

9. **Uses open and closed questioning technique**, appropriately moving from open to closed

10. **Listens** attentively, allowing patient to complete statements without interruption and leaving space for patient to think before answering or go on after pausing

11. **Facilitates** patient's responses verbally and non–verbally e.g. use of encouragement, silence, repetition, paraphrasing, interpretation

12. **Picks up** verbal and non–verbal **cues** (body language, speech, facial expression, affect); **checks out and acknowledges** as appropriate

13.**Clarifies** patient's statements that are unclear or need amplification (e.g. "Could you explain what you mean by light headed")

14. **Periodically summarises** to verify own understanding of what the patient has said; invites patient to correct interpretation or provide further information.

15. **Uses** concise, **easily understood questions and comments**, avoids or adequately explains jargon

16. **Establishes dates and sequence** of events

Additional skills for understanding the patient's perspective

17. Actively **determines and appropriately explores**:

- patient's **ideas** (i.e. beliefs re cause)
- patient's **concerns** (i.e. worries) regarding each problem
- patient's **expectations** (i.e., goals, what help the patient had expected for each problem)
- effects: how each problem **affects** the patient's life

18. **Encourages patient to express feelings**

PROVIDING STRUCTURE

Making organisation overt

19. **Summarises** at the end of a specific line of inquiry to confirm understanding before moving on to the next section

20. Progresses from one section to another using **signposting, transitional statements**; includes rationale for next section

Attending to flow

21. Structures interview in **logical sequence**

22. Attends to **timing** and keeping interview on task

BUILDING RELATIONSHIP

Using appropriate non-verbal behaviour

23. **Demonstrates appropriate non–verbal behaviour**

- eye contact, facial expression
- posture, position & movement
- vocal cues e.g. rate, volume, tone

24. If reads, writes **notes** or uses computer, does **in a manner that does not interfere with dialogue or rapport**

25. **Demonstrates** appropriate **confidence**

Developing rapport

26. **Accepts** legitimacy of patient's views and feelings; is not judgmental

27. **Uses empathy** to communicate understanding and appreciation of the patient's feelings or predicament; overtly **acknowledges patient's views** and feelings

28. **Provides support**: expresses concern, understanding, willingness to help; acknowledges coping efforts and appropriate self-care; offers partnership

29. **Deals sensitively** with embarrassing and disturbing topics and physical pain, including when associated with physical examination

Involving the patient

30. **Shares thinking** with patient to encourage patient's involvement (e.g. "What I'm thinking now is....")

31. **Explains rationale** for questions or parts of physical examination that could appear to be non-sequiturs

32. During **physical examination**, explains process, asks permission

EXPLANATION AND PLANNING

Providing the correct amount and type of information

33. **Chunks and checks:** gives information in manageable chunks, checks for understanding, uses patient's response as a guide to how to proceed

34. **Assesses patient's starting point:** asks for patient's prior knowledge early on when giving information, discovers extent of patient's wish for information

35. **Asks patients what other information would be helpful** e.g. aetiology, prognosis

36. **Gives explanation at appropriate times:** avoids giving advice, information or reassurance prematurely

Aiding accurate recall and understanding

37. **Organises explanation:** divides into discrete sections, develops a logical sequence

38. **Uses explicit categorisation or signposting** (e.g. "There are three important things that I would like to discuss. 1st..." "Now, shall we move on to.")

39**. Uses repetition and summarising** to reinforce information

40. **Uses** concise, **easily understood language**, avoids or explains jargon

41. **Uses visual methods of conveying information:** diagrams, models, written information and instructions

42. **Checks patient's understanding** of information given (or plans made): e.g. by asking patient to restate in own words; clarifies as necessary

Achieving a shared understanding: incorporating the patient's perspective

43. **Relates explanations to patient's illness framework:** to previously elicited ideas, concerns and expectations

44. **Provides opportunities and encourages patient to contribute:** to ask questions, seek clarification or express doubts; responds appropriately

45. **Picks up verbal and non-verbal cues** e.g. patient's need to contribute information or ask questions, information overload, distress

46. **Elicits patient's beliefs, reactions and feelings** re information given, terms used; acknowledges and addresses where necessary

Planning: shared decision making

47. **Shares own thinking as appropriate:** ideas, thought processes, dilemmas

48. **Involves patient** by making suggestions rather than directives

49. **Encourages patient to contribute their thoughts:** ideas, suggestions and preferences

50. **Negotiates** a mutually **acceptable plan**

51**. Offers choices:** encourages patient to make choices and decisions to the level that they wish

52. **Checks with patient** if accepts plans, if concerns have been addressed

CLOSING THE SESSION

Forward planning

53. **Contracts** with patient re next steps for patient and physician

54. **Safety nets**, explaining possible unexpected outcomes, what to do if plan is not working, when and how to seek help

Ensuring appropriate point of closure

55. **Summarises session** briefly and clarifies plan of care

56. **Final check** that patient agrees and is comfortable with plan and asks if any corrections, questions or other items to discuss

OPTIONS IN EXPLANATION AND PLANNING (includes content)

IF discussing investigations and procedures

57. Provides clear information on procedures, e.g., what patient might experience, how patient will be informed of results

58. Relates procedures to treatment plan: value, purpose

59. Encourages questions about and discussion of potential anxieties or negative outcomes

IF discussing opinion and significance of problem

60. Offers opinion of what is going on and names if possible

61. Reveals rationale for opinion

62. Explains causation, seriousness, expected outcome, short and long-term consequences

63. Elicits patient's beliefs, reactions, concerns re opinion

IF negotiating mutual plan of action

64. Discusses options e.g., no action, investigation, medication or surgery, non-drug treatments (physiotherapy, walking aides, fluids, counselling, preventive measures)

65. Provides information on action or treatment offered, name steps involved, how it works, benefits and advantages, possible side effects

66. Obtains patient's view of need for action, perceived benefits, barriers, motivation

67. Accepts patient's views, advocates alternative viewpoint as necessary

68. Elicits patient's reactions and concerns about plans and treatments including acceptability

69. Takes patient's lifestyle, beliefs, cultural background and abilities into consideration

70. Encourages patient to be involved in implementing plans, to take responsibility and be self-reliant

71. Asks about patient support systems, discusses other support available

References:

Kurtz SM, Silverman JD, Draper J (1998) Teaching and Learning Communication Skills in Medicine. Radcliffe Medical Press (Oxford)

Silverman JD, Kurtz SM, Draper J (1998) Skills for Communicating with Patients. Radcliffe Medical Press (Oxford)

HANDOUT 3: ALOBA_HOW TO SET-UP AND CARRY OUT THE ROLE-PLAY USING AGENDA-LED OUTCOME-BASED ANALYSIS (ALOBA)

Communication requires planning and thinking in terms of outcomes. ALOBA, overcomes the disadvantages of the conventional rules of feedback and promotes self-assessment. It helps us organise the feedback process. It also encourages a mix of problem-based experiential learning, centred on learner's agenda. ALOBA is divided into two parts.

Part 1

Before the role-play starts, we need to set the learner's agenda: ask what problems the learner experienced in their practice so far and what help he/she would like from the rest of the group (i.e attend and give suggestions for body language).

We then look at the outcomes...: where the learner is aiming at and how she might get there (i.e. negotiate a treatment plan).

When the role-play finishes, we encourage self-assessment: allow the learner space to make suggestions of what they could do differently if they did the same role-play again.

After that we involve the role-player and the rest of the group: we encourage them to find solutions not only for the learner but for themselves in similar situations.

Part 2

How to give useful feedback

Ask the students to provide descriptive feedback: specific comments are made which prevent vague generalisation (e.g. not good consultation).

Balanced feedback: about what worked well and did not work well.

Generate alternatives and reflect them back to the learner for consideration.

It is the facilitators' group's responsibility to be respectful and sensitive to each other.

<u>Part 1-Getting started</u>

1. In these consultation skills sessions, it is essential to balance their exploration of the disease aspects within the interview with their exploration of the patient's perspective. Overall, it is necessary to work with effective ways of gathering information about both disease (the physical/biochemical etc) and illness (the person's reaction to the disease process) and also practice explanation and planning.

2. Each session should allow you to helically review beginnings, information gathering, structuring the session and building the relationship. It will be interesting to see how much learning from the previous years has been undone by their experiences so far.

3. Describe the specific scenario in enough detail to orientate the group (for example, setting, age, some information already known, but not the whole history of presenting complaints)

4. Specifically explain to the students that they are medical students or, if they feel it will help them to perform better, that they are F1 doctors.

5. Try to get the group to explore what the difficulties might be for them and the patient.

6. It is helpful for the facilitator to have two or three objectives for each role clearly in his or her mind.

7. When a student is beginning to prepare for the role play it is helpful to check the following.

- What are the particular issues for you here (try to get the participant to hone them down)
- What are your personal aims and objectives for the role-play
- What would you like to practice and refine and get feedback on
- How can the group help you best
- How and what would you like feedback on

8. Emphasise to role-players that is OK to stop and start whenever they need to, to take time out, to re-play a section, re-play all, or just stop when they need help.

9. After the role play or during a break in the role play, when the learner rejoins the group as a student, provide consultation skills feedback on the work so far.

Part 2- Structuring the practice session

1. There are many ways of running a session and each facilitator will have their own style. But one way of structuring the session, as a whole, and for each individual student when doing the role play, is to break the interview down into small parts**.** Although the flow of the interview is broken, using this method, it does have its advantages:

- you can get more participants involved: five minutes or so each student rather than 40 minutes for one
- the feedback on consultation skills works much better because you can remember what happened in each small section and therefore give more focused feedback
- you can rehearse different approaches so that students discover how to do the stages of the interview and find different ways to do so

- you can use the actor's feedback which enables the students to see the importance of working with the actor instead of being on trial.

2. An example of the way in which an interview can be broken down is:

- at the end of the introductions and establishing rapport
- after taking an open history and before asking detailed questions.

At each stage it is possible to do good well- paced consultation skills teaching.

Points for feedback

1. Remember to:

- look at the micro-skills of communication and the exact words used
- practise and rehearse new techniques after suggestions from the group
- make sure to balance positive and negative feedback
- bring out patient centred skills (both direct questions and picking up cues) as well as discovering facts
- utilise actor feedback

2. Start with the learner:

- how do you feel?
- can we go back to the objectives? have they changed?
- how do you feel in general about the role-play in relation to your objectives?
- tell us what went well, specifically in relation to the objectives that you defined?
- what went less well in relation to your specific objectives?
- or "you obviously have a clear idea of what you would like to try."
- would you like to have another go?
- what do you want feedback on?
- Then get descriptive feedback from the group

3. Using participants' suggestions

- ask the prime learner if he or she would like to try this out or would like the other group member to have a go
- try to get others to role-play a section if they make a suggestion for doing it differently
- ask, "would anyone else like to practise?"
- ask actor, in role, questions that the group has honed down

- bring in the actor for insights and further rehearsal

Reference

Silverman J, Kurtz S and Draper J. Skills for Communicating with Patients. Radcliffe Medical Press, 2013. 3rd edition

HANDOUT 4: TRAINING EVALUATION FORM

EVALUATION OF PILOT TESTING OF CURRICULUM AND TRAINING MATERIALS

Training Session for Work Area: _____

Location: _____ **Date:** _____

1. What was your overall impression of the training?

☐ Excellent ☐ Good ☐ Fairly Good ☐ Poor ☐ Very Poor

2. How well do you think that the course met the following Learning Outcomes?

Learning Outcomes	Very Well	Satisfactorily	Unsatisfactorily
	☐	☐	☐
	☐	☐	☐
	☐	☐	☐

If unsatisfactory, please state why:

3. How useful to you personally was each session?

Session	Extremely Useful	Useful	Fairly Useful	Not Useful	Not relevant but of interest
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

4. How would you evaluate the Empathy in Health Care Curriculum in terms of the following aspects?

	Excellent	Good	Fairly Good	Poor	Very Poor
Structure	☐	☐	☐	☐	☐
Duration	☐	☐	☐	☐	☐
Relevance	☐	☐	☐	☐	☐
Thoroughness	☐	☐	☐	☐	☐

Comments:

5. How useful did you find the following training materials?

	Extremely Useful	Useful	Fairly Useful	Not Useful	Not relevant but of interest
PPT Presentations	☐	☐	☐	☐	☐
Educational Videos	☐	☐	☐	☐	☐
VR Videos	☐	☐	☐	☐	☐
Role Plays	☐	☐	☐	☐	☐

6. How would you evaluate the trainer/instructor who delivered the training?

☐ Excellent ☐ Good ☐ Fairly Good ☐ Poor ☐ Very Poor

7. Did you feel there were enough opportunities for discussion / questions?

☐ Yes ☐ No

Comments:

8. Did you feel there were enough opportunities to meet colleagues / network?

☐ Yes ☐ No

Comments:

9. Overall, how useful did you find this course for your current post?

☐ Extremely Useful ☐ Useful ☐ Fairly Useful ☐ Not Useful

Comments:

10. Do you anticipate any changes to your practice following this course?

☐ Yes ☐ No

If yes, please specify:

11. If this course was not useful, please explain why.

12. Could we improve any aspect of this course?

13. Please evaluate the organisation and venue of the training.

	Excellent	Good	Fairly Good	Poor	Very Poor
Organisation	☐	☐	☐	☐	☐
Venue	☐	☐	☐	☐	☐

14. Please write here any additional comments or suggestions.

6. TRAINERS GUIDE ON HOW TO USE THE TRAINING MATERIAL (HANDBOOK)

How to Use the Training Materials

Use the table below to have an overview of all the activities and the time in minutes it requires for each activity. You then following

Activity	Time in minutes	Work Area	Unit	LOBS
Directed Self-Learning				
Students to be directed to the online resource to prepare themselves before the session.	**180**	**1**	**1.1**	
Face to Face Training				
Welcome and Introductions (see Exercise 1)	**30**	**1**	**1.1**	
Ground rules (See Exercise 2 and Handout 1)	**30**	**1**	**1.1**	
Plan of the day (Located in PowerPoint Slide 8)	**15**	**1**	**1.1**	
Brainstorming: what is your understanding of empathy? (It is located in PowerPoint Slide 9, Exercise 3)	**40**	**1**	**1.1**	**1**
BREAK				
PowerPoint presentation on general overview of empathy and qualities necessary for empathy This part will be face-to-face power point presentation with interactive exercises which are outlined in trainer handbook under **PowerPoint presentation**. Trainers have to follow the ppt slides and look at the notes under each slide for guidance. **Self-directed learning activity: Email students the C/C guide and ask them to familiarize themselves with the skills**	**90**	**1**	**1.1**	**1-6**
Question and answer session to follow each ppt presentation. There are plenty of opportunities for questions throughout the ppt presentation and the trainers will be able to view these in the slides. However, at the end of the ppt students may have more questions and the tutors need to encourage these.	**10**	**1**	**1.1**	**1-6**
BREAK				
Introduce Calgary/Cambridge guide on how to analyse video consultations (See Power Point Slide 73, Exercise 6 and Handout 2)	**15**	**1**	**1.1**	**6-17**
Watch Educational Video 1 and ask students to tick the skills they observe on the Calgary/Cambridge Guide Seek students' feedback on video and discuss	**60**	**1**	**1.1**	**6-19**

(Each partner to choose the most appropriate scenario for the LOBs) **(See Power Point Slide 73, Exercise 6 and Handout 2)**				
Introduce ALOBA for Role-Plays **(See Power Point Slides 75-77, Exercise 7 and Handout 3)**	**15**	**1**	**1.1**	**6-19**
Role play 1 with student feedback **(See Power Point Slide 79, Exercise 7 and Handout 3)**	**60**	**1**	**1.1**	**6-19**
BREAK				
Closure and evaluation of the day **(See Power Point Slide 80 and Handout 4)**	**60**			
	425min=7.083 hours			