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 2

ACTIVITY IO7A2: DEVELOPMENT OF THE TUTOR GUIDE

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PROJECT MAIN DETAILS

Programme:	Erasmus+
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Project title:	Curriculum Development using VR technology to enhance empathetic communication skills in future health care professionals
Project Acronym:	EmpathyInHealth
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PROJECT PARTNERS

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1. DETAILED TOPIC LIST

Work Area ID	**2**	
Work Area	**Empathy in relationships and information exchanges in different health care contexts/environments**	
Unit	**2.1 Understanding empathy in relationships and information exchanges in different health care contexts/environments**	
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. Define patient-centred relationships 2. Describe the characteristics of a relationship that fosters and nurtures empathy and trust 3. Outline relevant research evidence on the importance of empathetic/patient-centred relationships on patient outcomes in the different health care contexts/environments (in this part partners could focus on contexts relevant to the scenarios they developed) 4. Describe the skills necessary during information exchanges according to Calgary/Cambridge model and refer to USA consensus statement	5. Self-reflect and self-assess his/her level or lack of empathy in relationships and information exchanges in daily life. Use evidence-based techniques as listed below to develop empathy during information exchanges (e.g. in obstetrics and gynaecology, when sharing bad news, when caring for patients with dementia and mental health issues, etc) with patients and other health care professionals: 6. Share his/her thinking with other party 7. Explain rationale for questions or parts of physical examination 8. Assess patient's starting point	21. Evaluate the feedback from colleagues, and patients on his/her level of empathy in relationships and information exchanges and ways of improving.

	9. Chunk and check: give information in small bites and checks for understanding by using the patient's responses as a guide to how to proceed 10. Screen: ask patient what other information would be helpful 11. Organize explanation by dividing it into discrete sections that follow a logical sequence 12. Use signposting: (e.g. There are three important things that I would like to discuss. First….Now we move on to…., etc. 13. Use appropriate language without jargon 14. Use visual methods for conveying information 15. Check patient's/other party's understanding 16. Elicit patient's other party's ICE 17. Explore different management options with regards to treatment by ascertaining the level of involvement that patient wishes in	

	making the decision at hand 18. Ascertain level of involvement patient/other party wishes 19. Negotiate mutually acceptable plan 20. Provide forward planning: contract with patient regarding next steps for patient and health carer (e.g. "I will enter in the system the request for your blood tests. You will need to make an appointment with the lab to have the tests done. I will call you when your results come in to discuss what needs to be done.) and Safety netting: Explain what the patient should do if things do not go according to plan.	

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 2 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.	**90**	**2**	**2.1**	
Face to Face Training				
Plan of the day	**10**	**2**	**2.1**	
Welcome and reflections on Day 1	**60**	**1 & 2**	**1.1 & 2.1**	
PPT a relationship that fosters and nurtures empathy **Information exchanges and empathy** Use the Calgary/Cambridge model and refer to USA consensus statement This part will be face-to-face power point presentation with interactive exercises.	**120**	**2**	**2.1**	**1-20**
Question and answer session	**40**	**2**	**2.1**	**1-20**
BREAK				
VR Scenario 1 **The class can observe what the student with VR headset is doing on a TV monitor so that the class can discuss the student's journey and the different pathways using ALOBA**	**140**	**2**	**2.1**	**5-21**
Closure and evaluation of the day	**60**			
	430min=7.1 hours			

Self-directed Activity: Watch Educational Video 2 and ask students to analyse it using the Calgary/Cambridge Guide

5. TRAINING MATERIALS

5.1. DIRECTED SELF-LEARNING

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

Directed self-learning activity 1:

- Students need to read and familiarize themselves with the Calgary Cambridge guide:

  Handout 1: Calgary Cambridge Guide At A Glance

  Handout 2: Calgary Cambridge Guide - The Skills

Directed self-learning activity 2:

- Use the Calgary/Cambridge Guide to evaluate Educational Video 2 Scenario No. 8: "Medical consultation with patient with high cardiovascular risk"

5.2. POWER POINT PRESENTATION: WORK AREA 2

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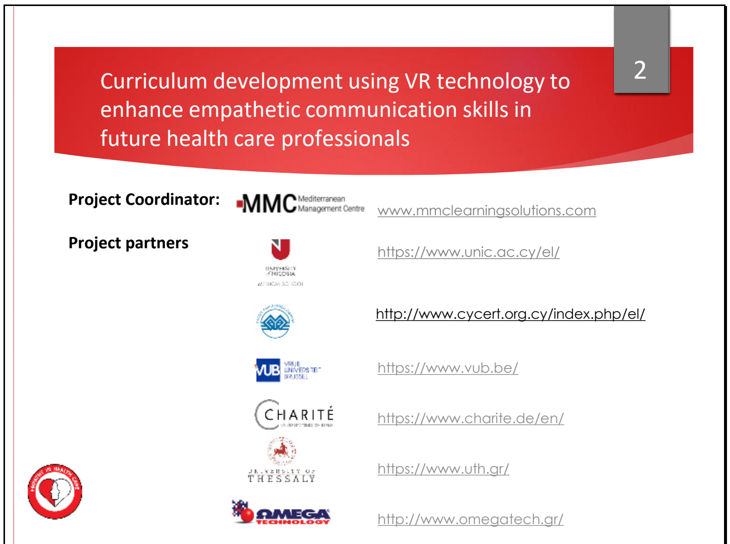

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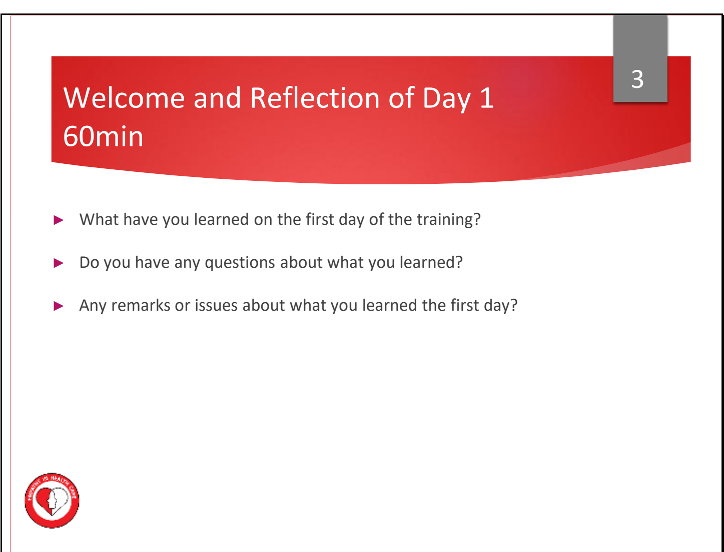

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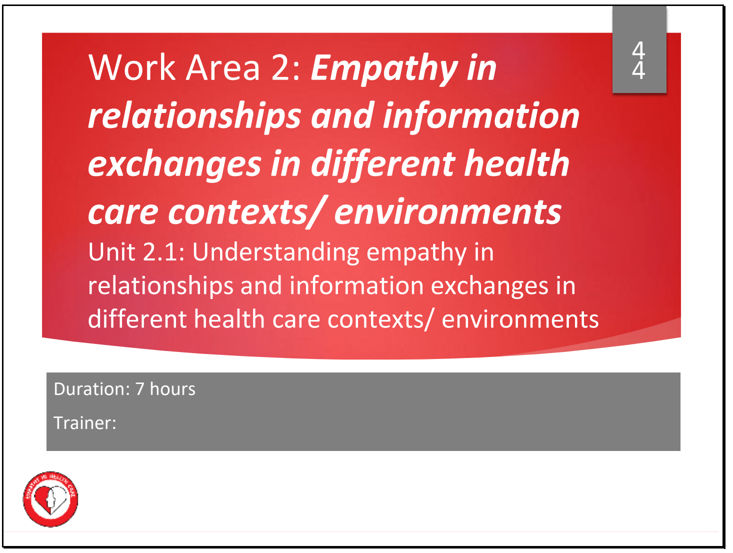

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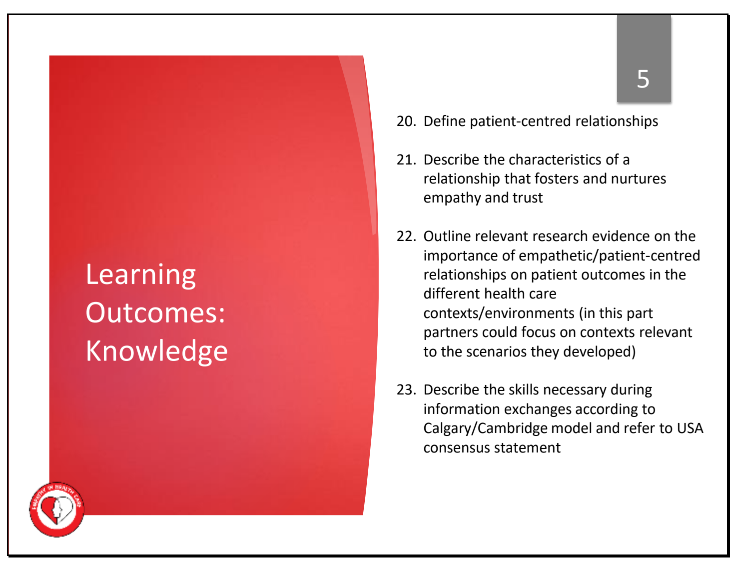

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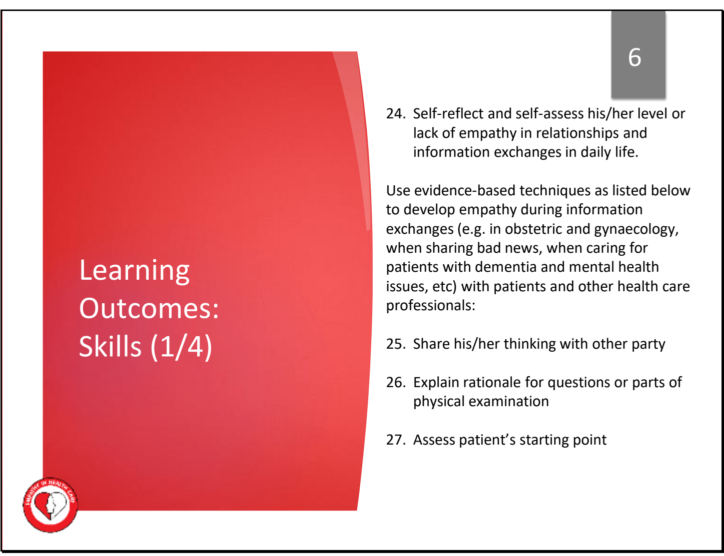

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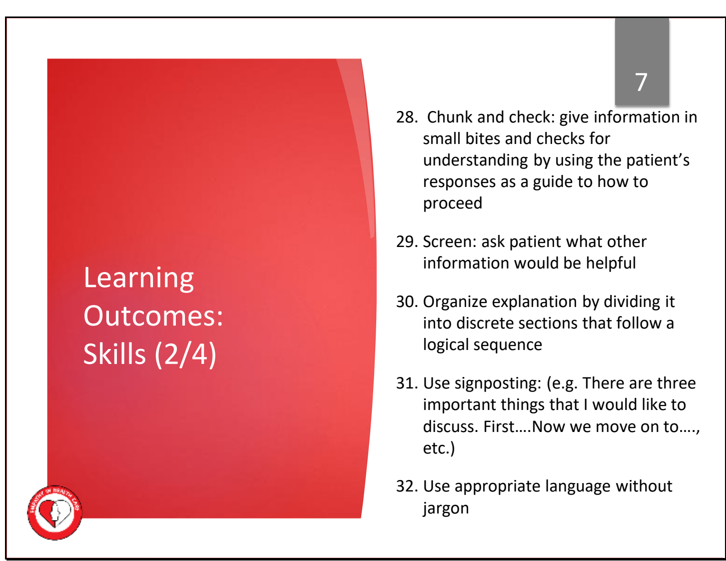

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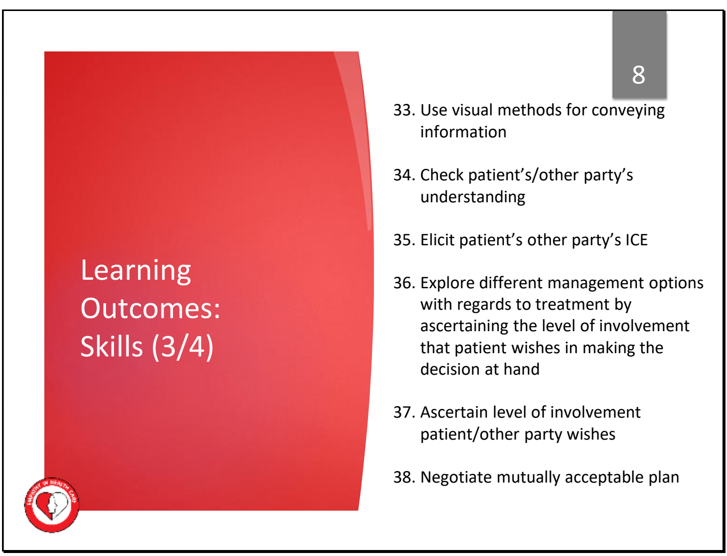

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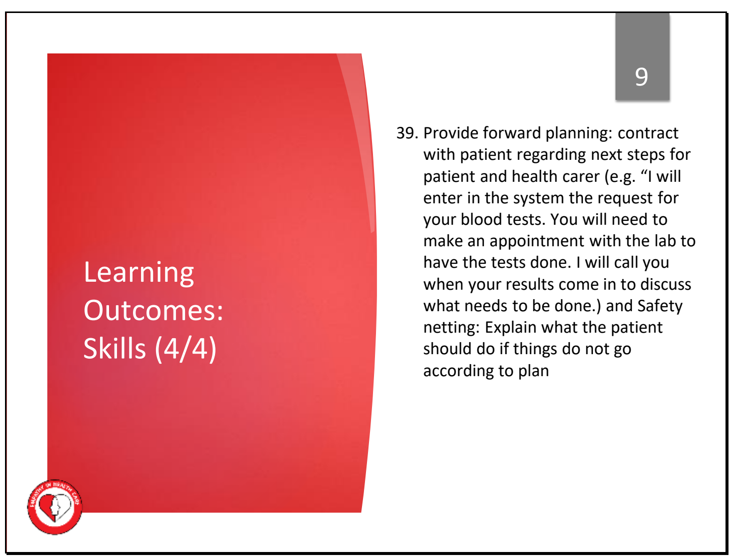

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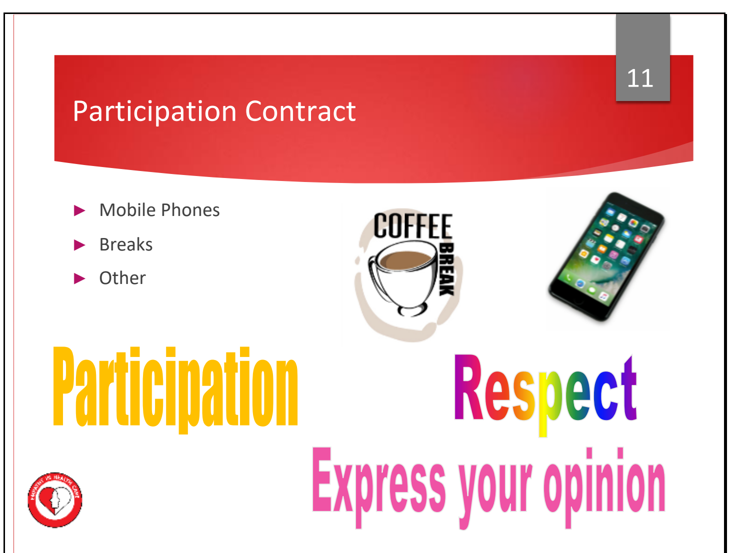

Feel Free to Change

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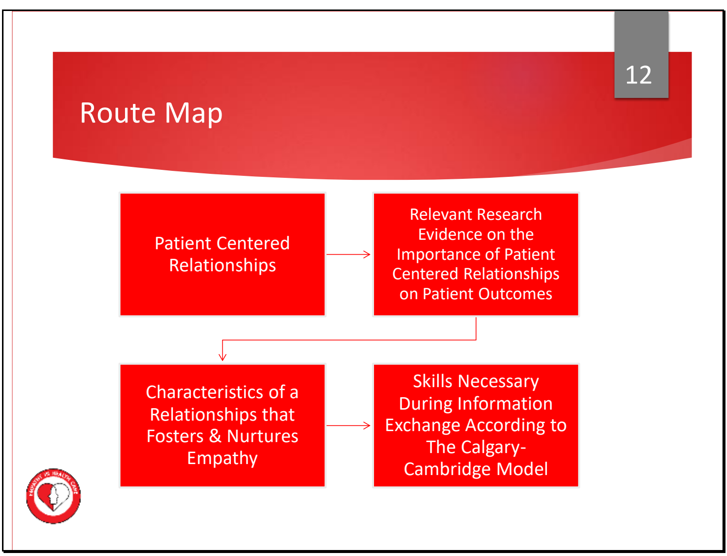

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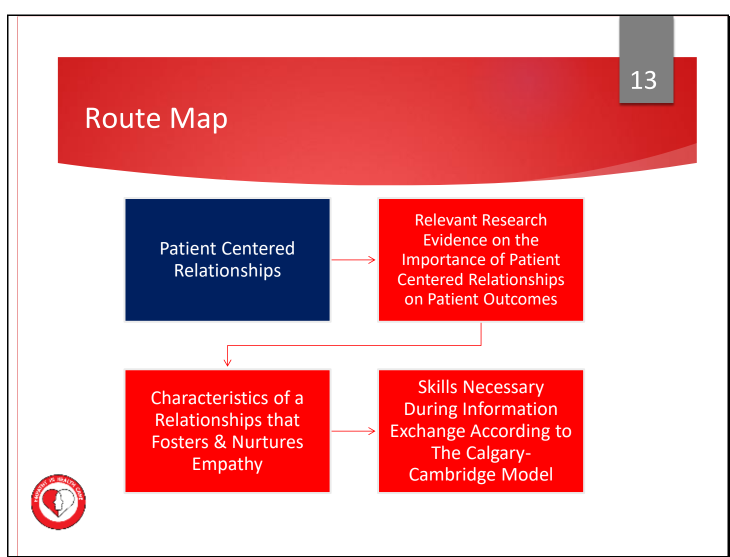

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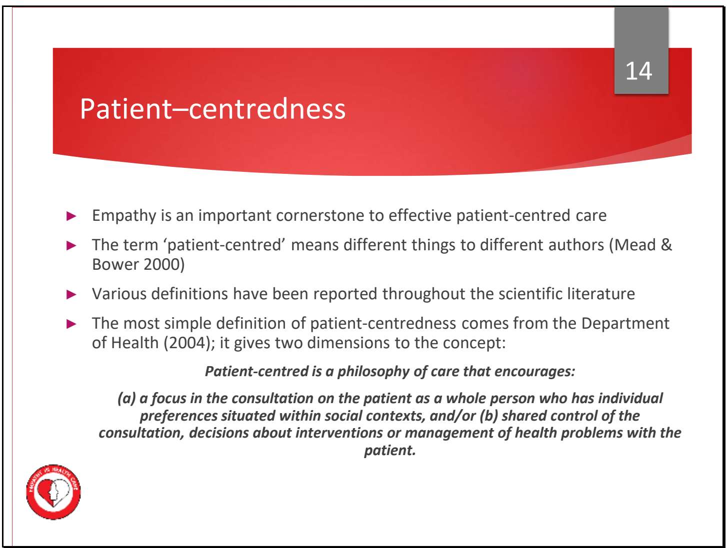

It was Enid Balint, in the UK, who appears to have first used the term 'patient-centred' to conceptualise the idea of 'the whole person' needing to be taken into account to make an 'overall diagnosis' (Balint 1969).

In 1995 the phrase 'patient-centered medicine' appeared as the title of a model of the consultation (Stewart 1995). Stewart identified six interactive components of the patient-centred approach:

●exploring both the disease and the individual's illness experience;

●understanding the whole person within his or her social context;

●finding common ground;

●incorporating prevention and health promotion;

●enhancing the patient–doctor relationship through sharing and caring;

●being realistic and working within the constraints of time and resources.

Since the concept is hard to encapsulate, assumptions are made about its meaning. A global meaning is taken to be that the patient is at the centre of his or her own healthcare. However, this does not convey the subtlety of the concept.

3 definitions: Mead and Bower (2000), Department of Health (2004) and Scholl et al. (2014)

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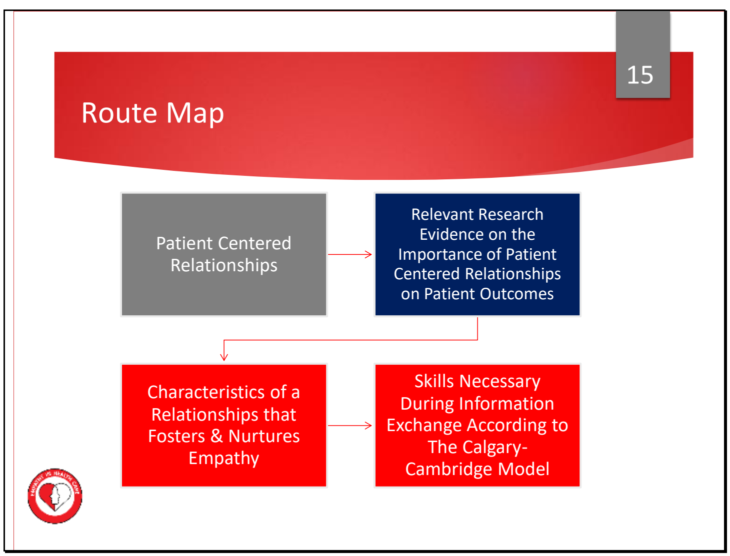

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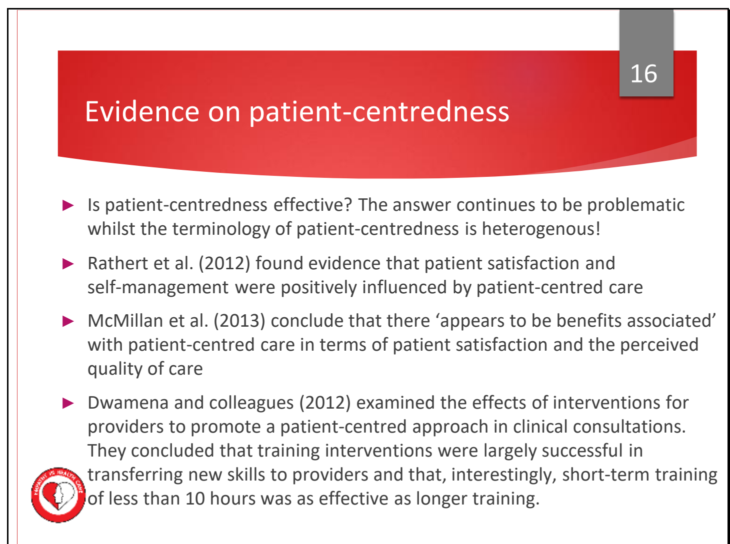

In essence studies lack comparability and the evidence is mixed

Rathert et al. (2012) conducted a systematic review of the patient-centred care literature to examine the evidence for the concept and for its outcomes. They categorised patient-centred care using the Institute of Medicine definition (Institute of Medicine 2001). Their results, with a detailed examination of 40 studies, found contradictory evidence. Whilst some studies demonstrated a significant relationship between specific elements of

patient-centred care and outcomes, other studies found no relationship. There was evidence that patient satisfaction and self-management were positively influenced by patient-centred care.

McMillan et al. (2013) specifically evaluated the efficacy of patient-centred care interventions for people with chronic conditions and, via a systematic review, identified 30 randomised controlled trials. They took a robust study approach by categorising aspects of patient-centred care using the Morgan and Yoder categorization (Morgan & Yoder 2012). In doing so, they identified that most interventions used the aspect of 'empowering care', alongside educating patients; an aspect that encourages patient autonomy and self-confidence. They classified outcomes under three headings: patient satisfaction, perceived quality of care and health outcomes, with the latter further broken down into clinical, functional, personal and system outcomes. For future researchers it is worth looking at the detail of their findings. However, overall McMillan et al. could conclude no more than there 'appeared to be benefits associated' with patient centred care in terms of patient satisfaction and the perceived quality of care.

Dwamena and colleagues (2012) examined the effects of interventions for providers to promote a patient-centred approach in clinical consultations. Hence it is of direct relevance to readers here as an evidence base for clinical communication. The definition of patient-centredness they used was akin to the Department of Health definition (Department of Health 2004). They concluded that training interventions were largely successful in transferring new skills to providers and that, interestingly, short-term training of less than 10 hours was as effective as longer training. This conclusion was drawn from studies across numerous high-income countries and several clinical settings.

What is less clear was the effect on healthcare outcomes for patients. A proportion of the studies were found to include interventions to educate patients as well as the providers. In these cases they reported 'modest support' for an effect on health status. Overall, however, there are mixed effects on patient satisfaction, health behaviour and health status. Their tentative conclusion was that in complex interventions involving providers and patients that include condition-specific educational materials, there is some indication of beneficial effects. Researchers however are very cautious about their claims so more robust research is needed to examine the effect on health outcomes!

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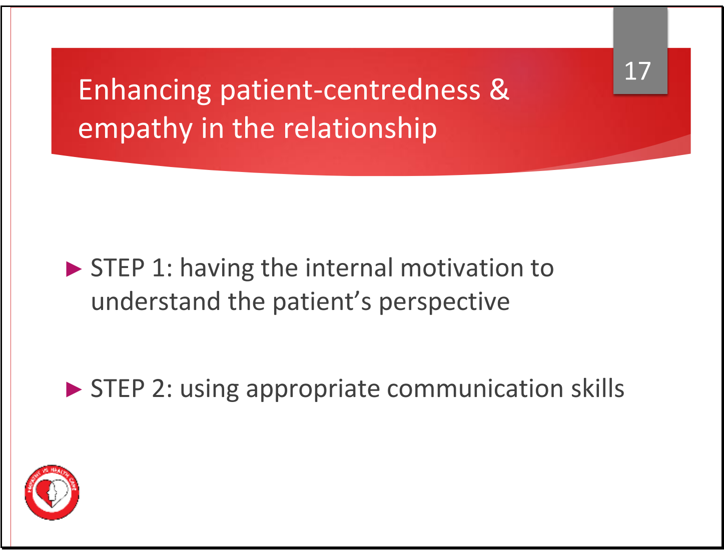

Traditional teaching values medical knowledge and the clinical setting emphasizes task completion and in fact, exposes students to complex interpersonal interactions with patients that they are unable to interpret and unprepared to negotiate effectively in the absence of faculty members (McNelis et al., 2014). Not surprising, communication skills and empathy decline throughout clinical training leading to poor communication patterns in practicing nurses and physicians (Bry et al., 2016, Levinson et al., 2000; Neumann et al., 2011, Nightingale et al., 1991, Roter et al., 1997;).

Forging a patient-centred relationship through empathy with the patient is central to the success of every consultation, whatever the context. And yet, building a relationship is a task easily taken for granted by healthcare practitioners.

The challenge in teaching adequate communication and relationship building is to identify the building blocks of the empathic response and enable learners to integrate the elements of empathy into their natural style (Bellet & Maloney 1991; Platt & Keller 1994; Gazda et al. 1995; Coulehan et al. 2001; Buckman 2002; Frankel 2009).

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The Influence of the Patient-Clinician Relationship on Healthcare Outcomes

- General empathy in a meaningful patient-clinician relationship appears to improve patient's well being, not only emotionally but also physically
- On a micro level, a clinician's interactions with a patient should be viewed as an opportunity to improve patient's health
- On a macro level, hospitals should emphasize the importance of the patient-clinician relationship in their overall healthcare delivery to achieve the best possible outcomes and improve patient satisfaction

Excellent clinicians strive to master not only the theory of disease and treatment, but also to cultivate a therapeutic presence that is commonly believed to improve the experience of patients and to have a beneficial effect on medical outcomes.

Most previous studies or reviews focussing in this effect have been observational studies – recording aspects of clinical encounters and any potential associations with health outcomes – which cannot prove whether observed differences actually caused any outcome changes. Some studies have examined intermediate measures such as how well patients understood advice they were given or how satisfied they were with their care, but did not look at whether or not there were any health improvements.

A systematic review of Kelly et.at. (2014) investigated whether the patient-clinician relationship has a beneficial effect on either objective or validated subjective healthcare outcomes studied through randomized controlled trials, considered the gold standard for medical research. In these trials the patient-clinician relationship was systematically manipulated (e.g., improved communication skills, increased empathy, better attention to nonverbal signals, not interrupting, etc.), and where there was either an objective outcome measure (e.g., blood pressure) or a validated subjective measure (e.g., pain scores). All included studies compared the outcomes in an interventional group (in which physicians, nurses or other health professionals received training) to those of a control group delivering standard care.

For this review, a meta-analysis on thirteen RCT-studies was conducted showing that the patient-clinician relationship has a small (*d* 11), but statistically significant (*p* 02) effect on healthcare outcomes such as weight loss, blood pressure, blood sugar and lipid levels, and pain – in patients with conditions such as obesity, diabetes, asthma or osteoarthritis. Interestingly, the studies found that the size of the effect of the interventions was greater than previously reported effects of aspirin in reducing the incidence of heart attack over five years or the influence of statins on the five-year risk of a cardiovascular event.

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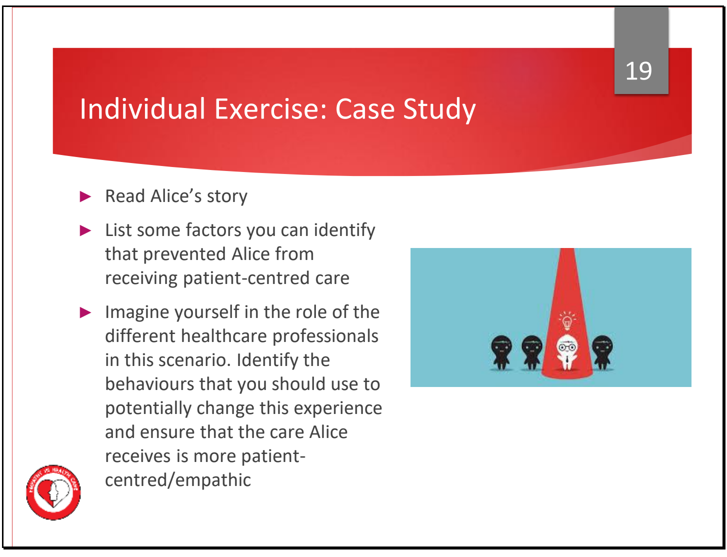

Story of Alice:

I'm Alice, 25 years old. I had abdominal pain for six days and I was really frightened because, a year ago, my sister came down with similar symptoms and now has intestinal cancer and is undergoing very aggressive treatment. I decided to go alone to the hospital in order not to scare the whole family.

I arrived at the hospital early in the morning. I didn't know exactly what to do or who to see; it was my first time at the hospital. Everybody looked like they were in a hurry and they did not look very friendly. Some of them looked as frightened as I was. I took a deep breath and asked a young lady, who looked at me and smiled, if she knew where the gastrointestinal department was located. She laughed a little and said: 'I'm a student and I'm lost, too. Let's try to find it together. I have to go to the same place.' She said: 'Why don't we go to the information office?'. I thought this was a good idea and, all of sudden I started to feel in some way protected.

A person I considered to be a healthcare professional was with me. We arrived at the information office to find it crowded with a lot of people shouting, some of them angry. There was only one person providing information. Lucy, the student, said, 'I don't think we will get anywhere if we try to get information here.' I suggested that we follow the signs I had seen at the main entrance. After walking through the crowd, we arrived at the main entrance. We finally arrived at the gastrointestinal department.

Lucy said: 'Oh, yes, this is the place, ask the nurse over there. I should go to my class, good luck.' The nurse told me that I shouldn't have come directly to the gastrointestinal department. She said I should go to the emergency department, where they would decide about my condition. So, I had to return to the emergency room.

When I arrived, plenty of people were waiting. They told me I would have to wait. 'You should have come earlier,' the nurse said. (I arrived early). A general practitioner eventually saw me and ordered X-rays and lab tests. Nobody said anything and no explanations were provided to me. At that moment, I was more scared than when I woke up with the pain. I was at the hospital all day, going from one place to another.

At the end of the day, a doctor came and told me, in few words, that I was okay and that I had nothing to worry about, and then I started 'breathing' again. I would like to say to the hospital authorities that they should realise

that every person coming to the hospital, even if they do not have any important disease, is feeling stressed and often unwell. We need friendly people taking care of us, who try to understand our story and why we feel so bad. We need clear communication between healthcare workers and patients. We need clear information on how we should use the hospital facilities.

I understand that you cannot cure everybody - unfortunately, you are not gods - but I am sure that you could be friendlier to patients. Doctors and nurses have the incredible power in that, with their words, gestures and comprehension of the patient's situation, they can make a patient feel secure and relieved. Please do not forget this power which is so incredibly useful for those human beings who enter your hospital.

With all my respect,

Alice

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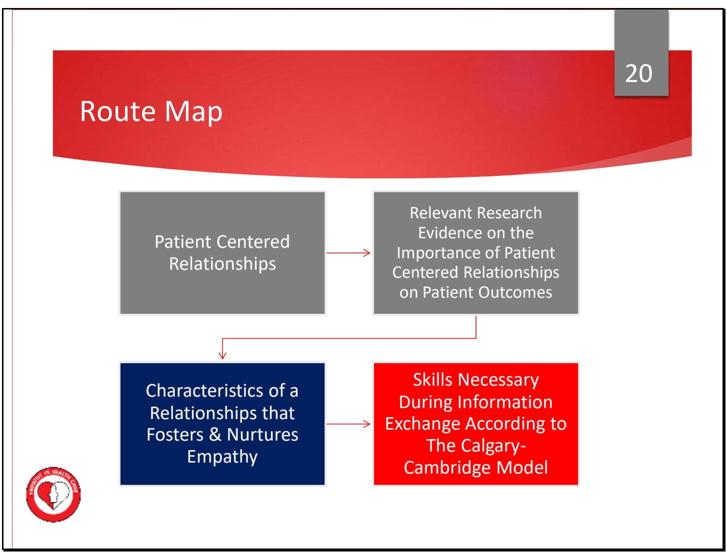

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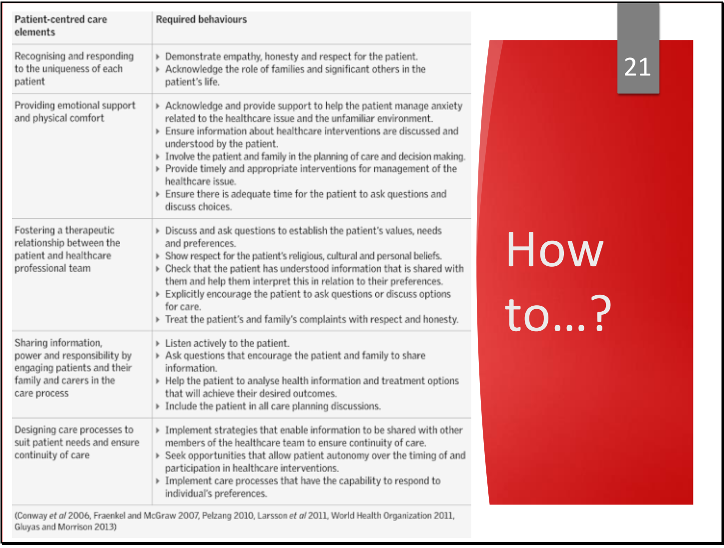

Patient-centred care elements	Required behaviours
Recognising and responding to the uniqueness of each patient	‣ Demonstrate empathy, honesty and respect for the patient. ‣ Acknowledge the role of families and significant others in the patient's life.
Providing emotional support and physical comfort	‣ Acknowledge and provide support to help the patient manage anxiety related to the healthcare issue and the unfamiliar environment. ‣ Ensure information about healthcare interventions are discussed and understood by the patient. ‣ Involve the patient and family in the planning of care and decision making. ‣ Provide timely and appropriate interventions for management of the healthcare issue. ‣ Ensure there is adequate time for the patient to ask questions and discuss choices.
Fostering a therapeutic relationship between the patient and healthcare professional team	‣ Discuss and ask questions to establish the patient's values, needs and preferences. ‣ Show respect for the patient's religious, cultural and personal beliefs. ‣ Check that the patient has understood information that is shared with them and help them interpret this in relation to their preferences. ‣ Explicitly encourage the patient to ask questions or discuss options for care. ‣ Treat the patient's and family's complaints with respect and honesty.
Sharing information, power and responsibility by engaging patients and their family and carers in the care process	‣ Listen actively to the patient. ‣ Ask questions that encourage the patient and family to share information. ‣ Help the patient to analyse health information and treatment options that will achieve their desired outcomes. ‣ Include the patient in all care planning discussions.
Designing care processes to suit patient needs and ensure continuity of care	‣ Implement strategies that enable information to be shared with other members of the healthcare team to ensure continuity of care. ‣ Seek opportunities that allow patient autonomy over the timing of and participation in healthcare interventions. ‣ Implement care processes that have the capability to respond to individual's preferences.

(Conway *et al* 2006, Fraenkel and McGraw 2007, Pelzang 2010, Larsson *et al* 2011, World Health Organization 2011, Gluyas and Morrison 2013)

The patient-clinician relationship has both emotional and informational components – what Di Blasi and colleagues have termed emotional care and cognitive care. Emotional care includes mutual trust, empathy, respect, genuineness, acceptance and warmth. Cognitive care includes information gathering, sharing medical information, patient education, and expectation management.

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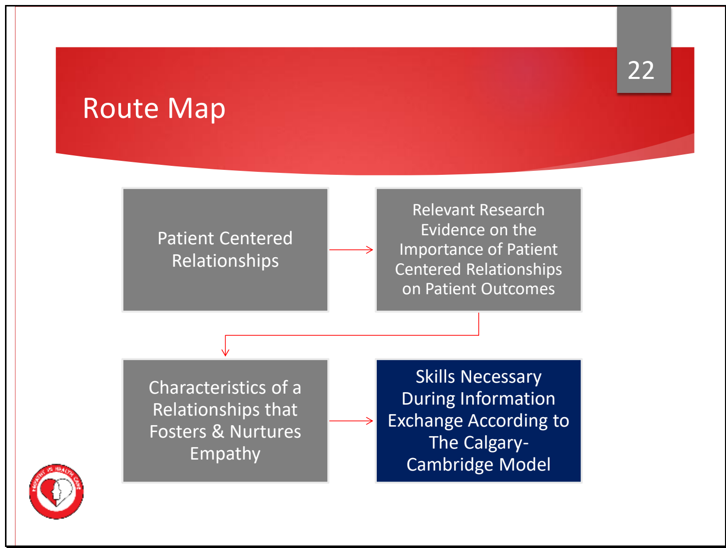

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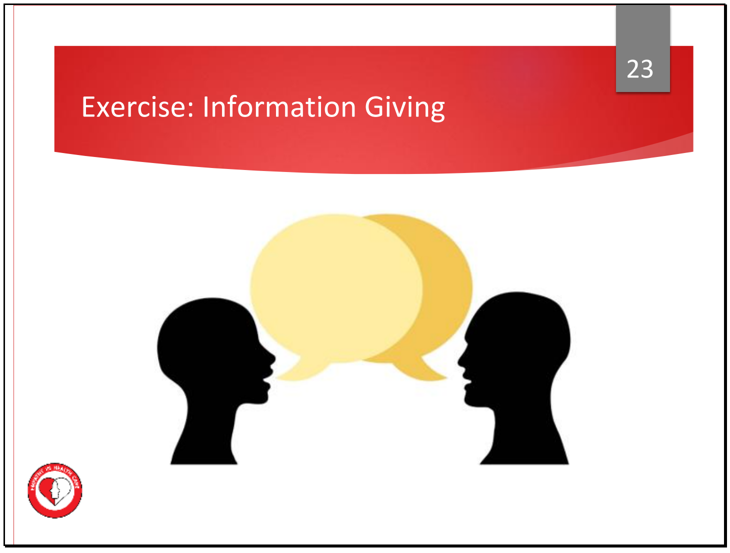

Although this initial exercise is non-medical, we will be able to relate the feedback that they give after doing this exercise to principles for giving information to patients and they should be able to see the relationship.

Instructions:

1. Tell the students that this is an exercise on giving information and ask them to arrange their chairs in pairs with the chairs back-to-back but in a wide, spread out circle.
2. Make sure they spread out round the room (in a big circle) and that one chair faces the wall. The person sitting in that chair will be the receiver of information and the person facing into the room is the giver. If the group is large, get some to work in 3's, so that one person sits at the side of a pair and observes but does not comment until the end.
3. The receivers need a pad to rest a piece of paper on and a pen or pencil. Ask each receiver to take out a plain piece of paper or give them one.
4. Provide the "givers" of information the picture and explain that they are meant to describe this so that their "receiver" can draw it on their sheet of paper. They can ask any questions they like of each other. The only thing they cannot do is to look at each other's drawings, or look at each other. They will be given 5 minutes to do the task.
5. Give out the pictures to the givers. It is probably a good idea to get all the receivers to close their eyes while you do this, so that they do not see the picture! (The point of arranging the chairs carefully is to avoid this).
6. Start the exercise and stop after 5 minutes (give a one-minute warning first).
7. Ask the pairs to look at each other's drawings. After a minute or so, ask them to spend a couple of minutes discussing what each did that was helpful in conveying/ understanding the information.
8. Ask the group to move their chairs back to form a group, and using the flip chart, ask the receivers first of all what was helpful. Then ask the givers and finally the observers, if any.
9. The task of the tutor(s) here is to relate the students' feedback to clinical practice. Below is a list of what students commonly say that they learned from the exercise (in bold), along with points you might like to make in response.

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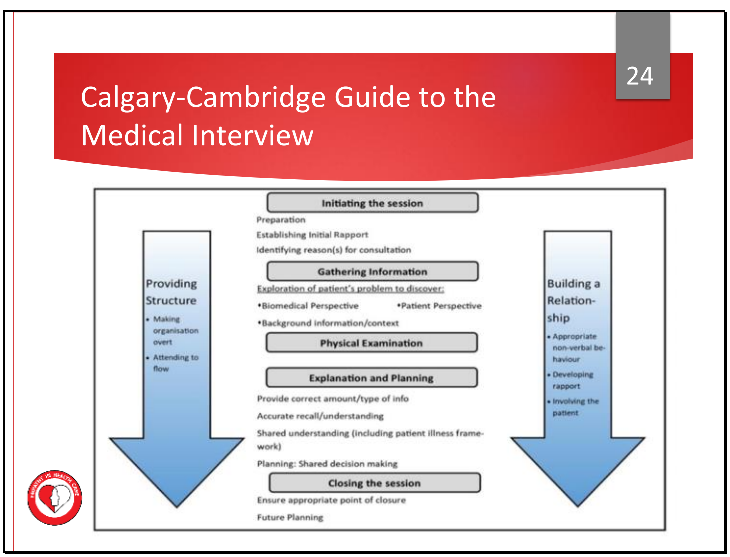

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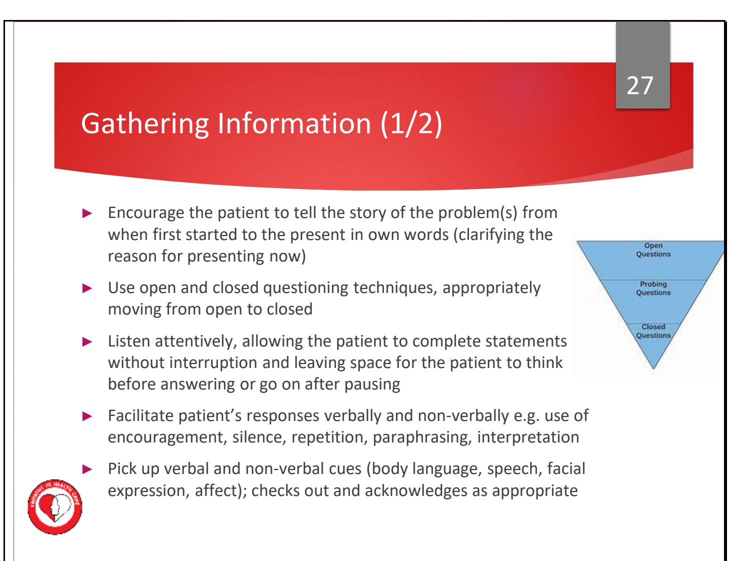

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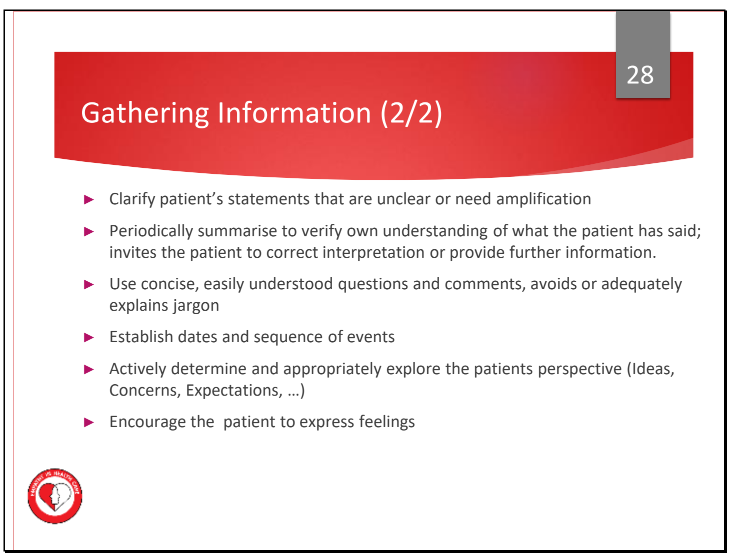

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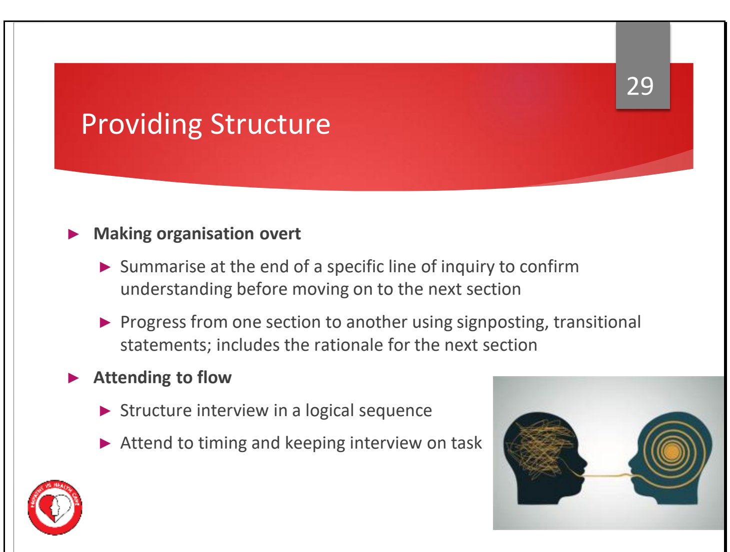

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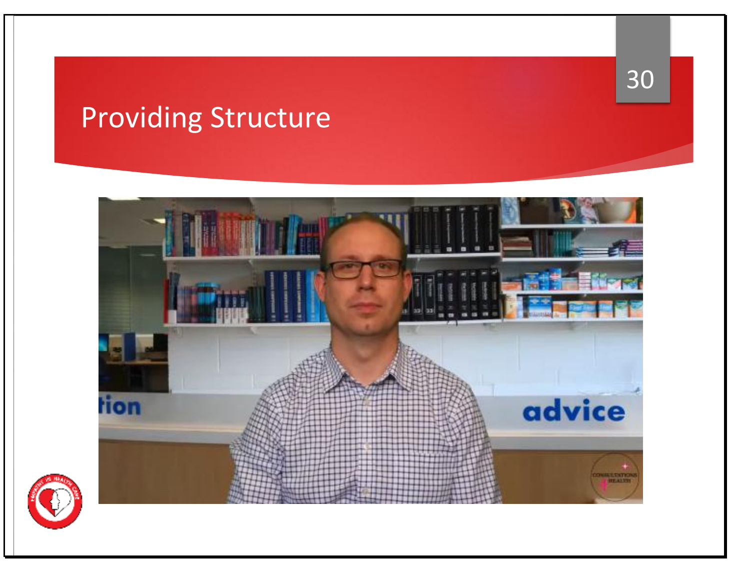

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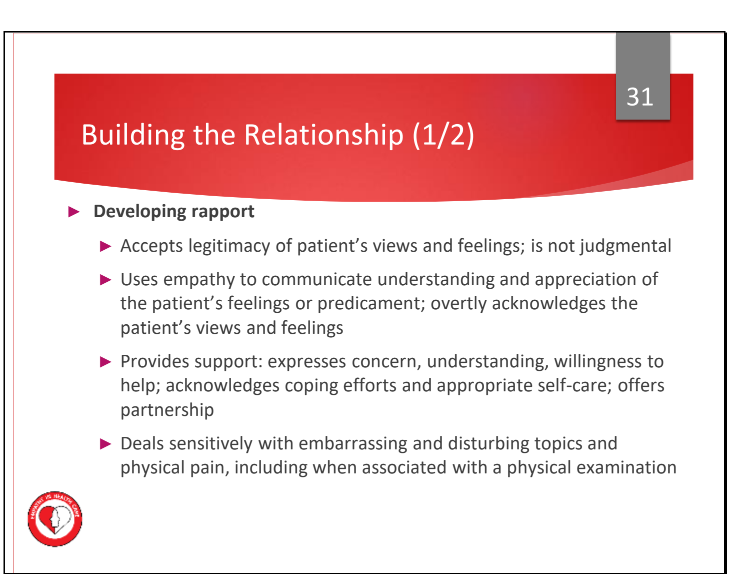

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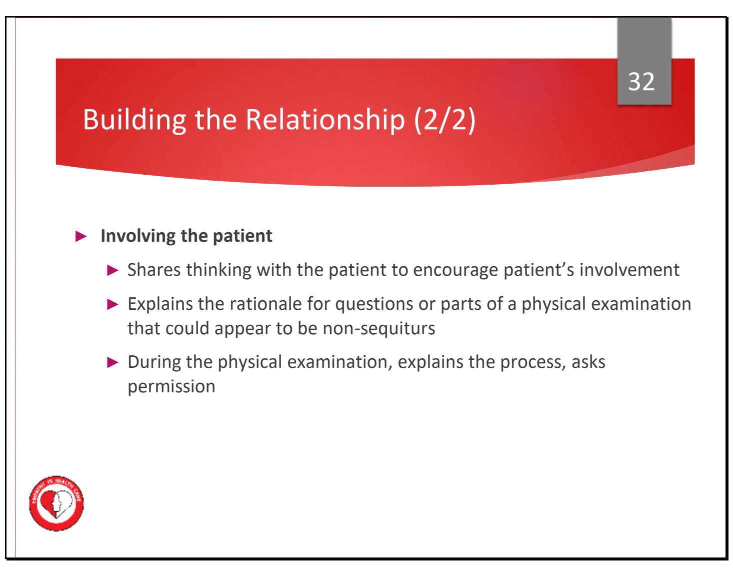

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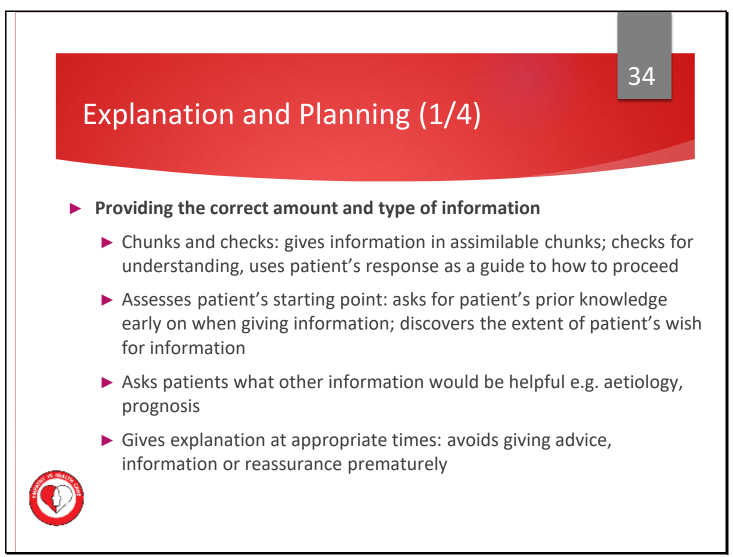
https://www.youtube.com/watch?v=SXw-tPGUlHY&t=30s

Slide 34



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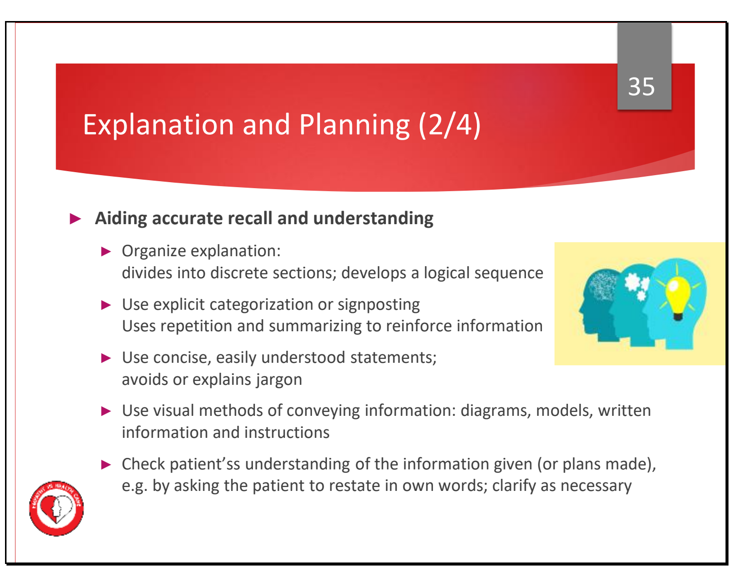

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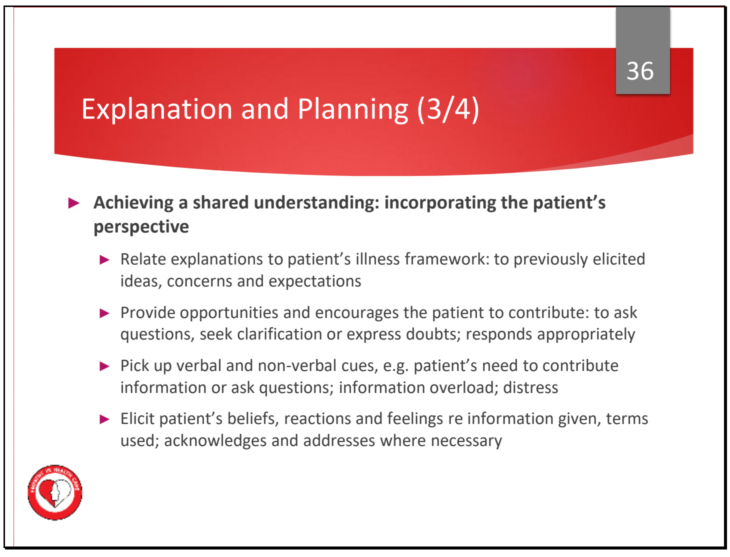

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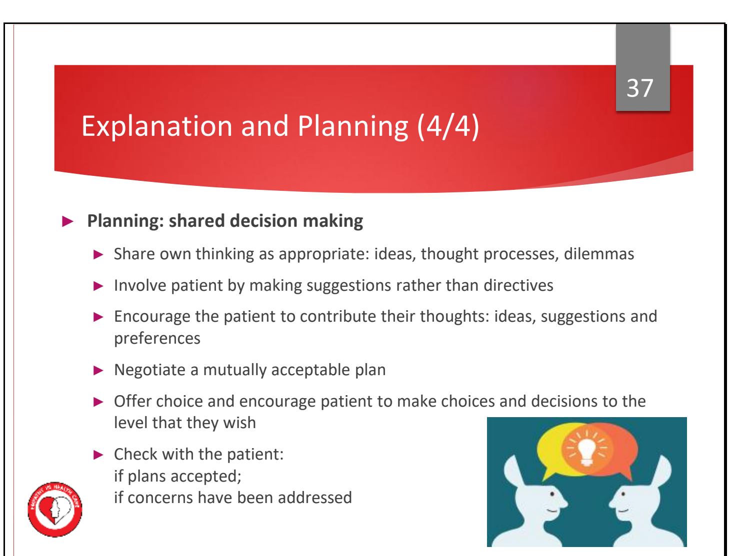

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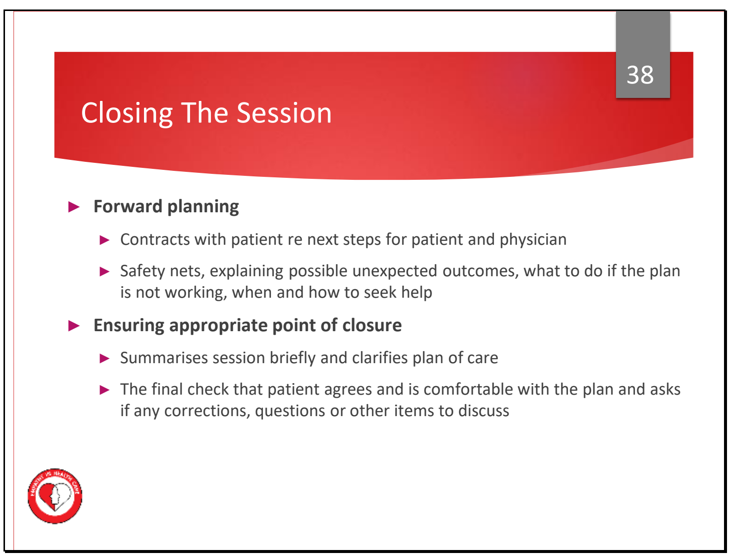

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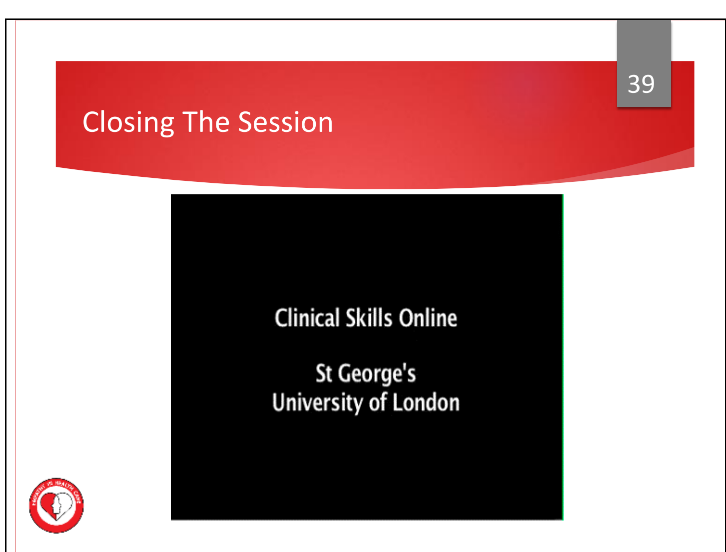

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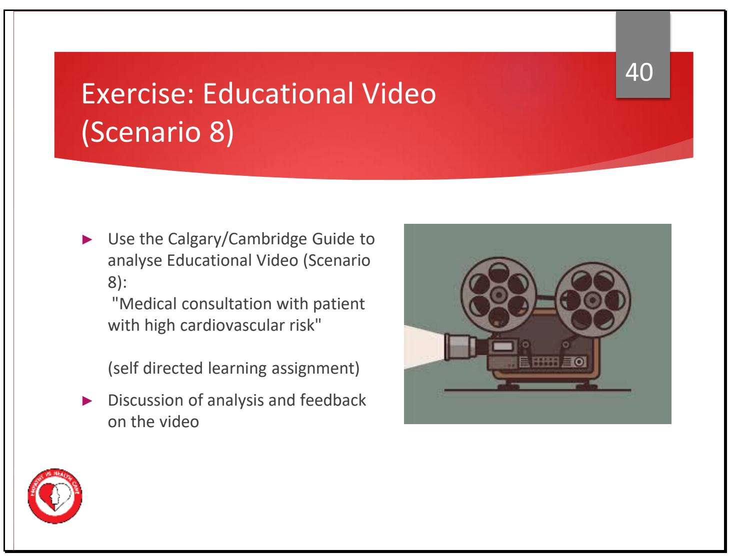
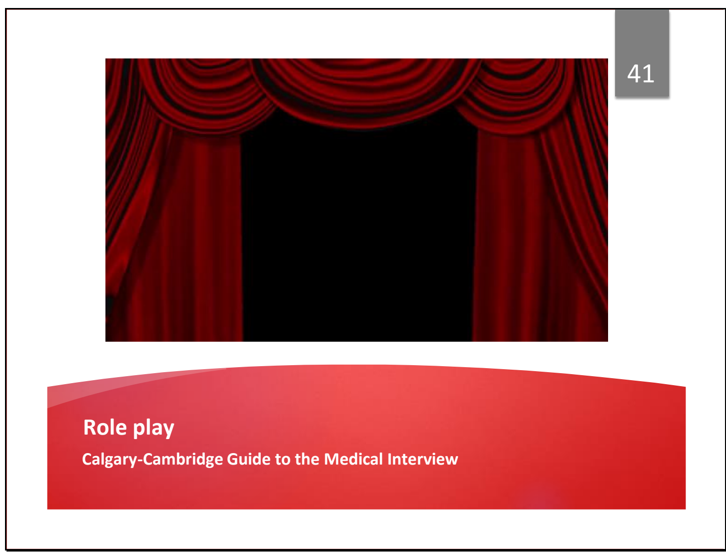


Use the Calgary/Cambridge Guide to evaluate Educational video

Slide 41

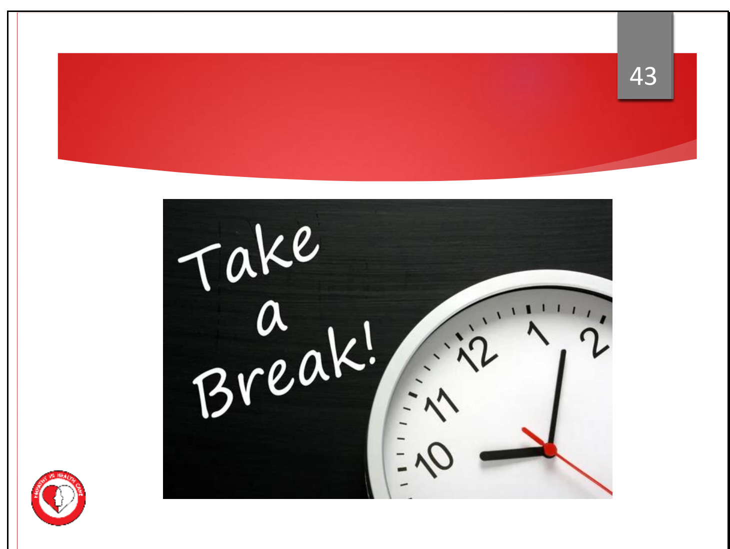


Ask the students to get into groups 3 and then hand out the Calgary-Cambridge Framework. One student plays the patient (with a particular medical problem), one student plays the physician and the third student is the observer.

After the interview, the observer gives feedback to the other two students.

Slide 42

Slide 43



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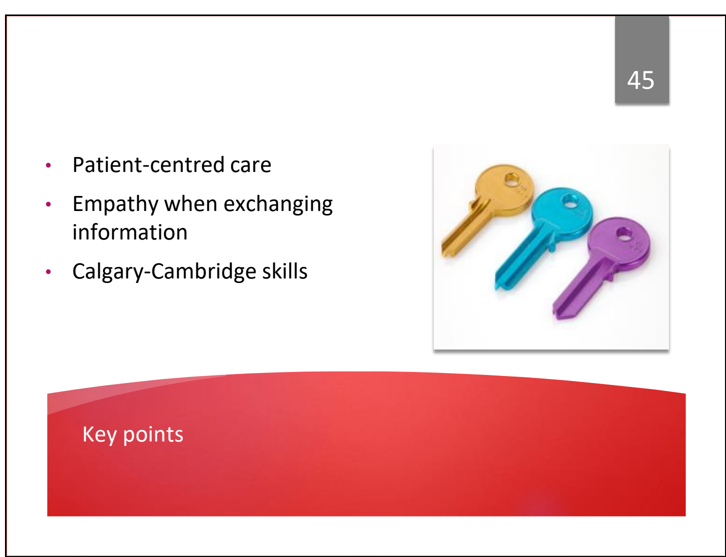
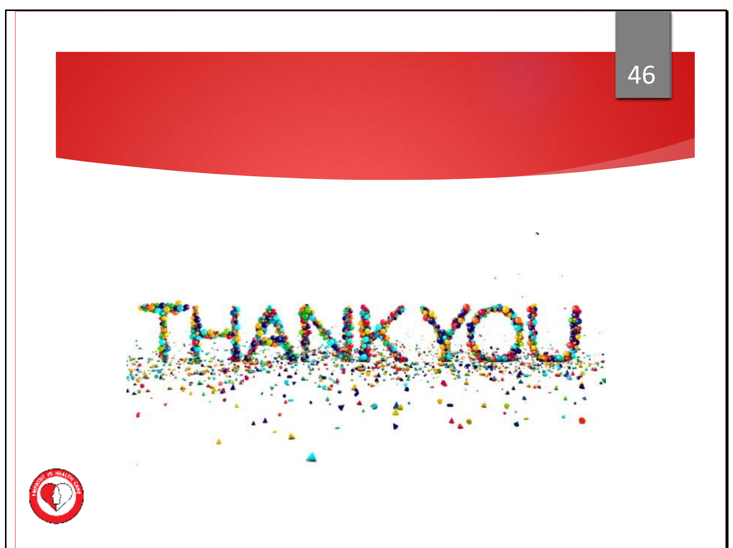


What knowledge will the students take home from this second day of training?

Students need to fill in Training Evaluation Form.

Self directed learning assignment: Watch educational video 2 and analyse it using the calgary-cambridge guide

Slide 46



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. VR SCENARIOS

Use Handout 3 on ALOBA to facilitate the feedback process

5.5.1. VR SCENARIO 1: SCENARIO 1 (MANAGEMENT OF A WOMAN IN LABOUR: THE PROCESS OF PROVIDING PATIENT CENTRED CARE)

Scenario number: 1

Title: Management of a woman in labour: the process of providing patient centred care

Discipline: Midwifery/ Medicine

Developed by: Charite

Work areas: Work Area 1 and 2

Specific features: Providing woman - centered intra- partum care, supporting the woman to find the best way to cope with labour pain

Description of scenario: Mia Schmidt, a 28-year-old woman, is pregnant with her first child and has been in the delivery room for two hours. She is lying on the bed, her husband is sitting at her side. The midwife has been coming in and out of the room to check on her but has not stayed for a longer time with her. Mia is in quite a bit of pain when she has a contraction, and is feeling uncertain and unsafe because she can no longer manage the pain. In order to be able to choose the most appropriate pain relief for the stage of labour that the woman is in, the midwife tells her that it would be helpful to perform a vaginal exam to assess her progress in labour. Mia is scared and does not want a vaginal examination, but is also afraid she won't get good care/pain relief if she doesn't let the midwife exam her vaginally. The midwife is challenged to provide woman-centered empathic intrapartum care.

5.5.2. VR SCENARIO 2: SCENARIO 5 (YOUNG PATIENT WITH CHRONIC MUSCULOSKELETAL PAIN: SHARED DECISION MAKING WITH PATIENT AND FAMILY)

Scenario number: 5

Title: Young patient with chronic musculoskeletal pain: shared decision making with patient and family

Discipline: Interprofessional

Developed by: UTH

Work areas: Work areas 1, 2 & 3.2

Specific features: Exploring patient concerns, communicate with a patient's family, giving- gathering information, shared decision making

Description of scenario: Woman (40s) in chronic musculoskeletal pain (low back pain, somatization), with psychosocial problems (stress, anxiety, difficulties with sleep, kinesiophobia) that comes to physiotherapy clinic in order to get helped (doctor referral, otherwise she will have a surgery). The problem started after giving birth to her 3 years old son. Other therapies have not helped, she is disappointed, angry. The physiotherapist will propose a new therapy in order to help including exercise- behaviour change. She is accompanied by a member of her family (her father), she is divorced and she leaves at her parents' house with her 3 children.

5.5.3. VR SCENARIO 3: SCENARIO 7 (YOUNG PERSON WITH NEW DIAGNOSIS OF CANCER: THE PROCESS OF SHARING BAD NEWS)

Scenario number: 7

Title: Young person with new diagnosis of cancer: the process of sharing bad news

Discipline: Medicine

Developed by: UNIC

Work areas: Work Areas 1, 2

Specific features: Sharing bad news, overcoming social and environmental barriers to empathy

Description of scenario: A female patient in her early 40s is admitted to hospital with bowel obstruction. A CT scan on admission indicates a large mass blocking her large intestine and she is taken to theatre. The preliminary diagnosis of the excised mass indicates that this is cancerous. The mass is removed at surgery. The following day, the patient is visited by her mother and young daughter when the doctor comes in to share the bad news of the preliminary diagnosis of bowel cancer and explain the next steps in her management. The student is asked to communicate the bad news to the patient in an empathic way, explain the next steps in the patient's management, deal with her initial shock and realization of her diagnosis combined with her worry of being the only parent of a young child and deal with environmental barriers to empathic communication.

5.6. EXERCISES

EXERCISE 1: 'ALICE'S STORY'

- Read Alice's story
- List some factors you can identify that prevented Alice from receiving patient-centred care
- Imagine yourself in the role of the different healthcare professionals in this scenario. Identify the behaviours that you should use to potentially change this experience and ensure that the care Alice receives is more patient-centred/empathic
- Story of Alice:
- I'm Alice, 25 years old. I had abdominal pain for six days and I was really frightened because, a year ago, my sister came down with similar symptoms and now has intestinal cancer and is undergoing very aggressive treatment. I decided to go alone to the hospital in order not to scare the whole family.
- I arrived at the hospital early in the morning. I didn't know exactly what to do or who to see; it was my first time at the hospital. Everybody looked like they were in a hurry and they did not look very friendly. Some of them looked as frightened as I was. I took a deep breath and asked a young lady, who looked at me and smiled, if she knew where the gastrointestinal department was located. She laughed a little and said: 'I'm a student and I'm lost, too. Let's try to find it together. I have to go to the same place.' She said: 'Why don't we go to the information office?'. I thought this was a good idea and, all of sudden I started to feel in some way protected.
- A person I considered to be a healthcare professional was with me. We arrived at the information office to find it crowded with a lot of people shouting, some of them angry. There was only one person providing information. Lucy, the student, said, 'I don't think we will get anywhere if we try to get information here.' I suggested that we follow the signs I had seen at the main entrance. After walking through the crowd, we arrived at the main entrance. We finally arrived at the gastrointestinal department.
- Lucy said: 'Oh, yes, this is the place, ask the nurse over there. I should go to my class, good luck.' The nurse told me that I shouldn't have come directly to the gastrointestinal department. She said I should go to the emergency department, where they would decide about my condition. So, I had to return to the emergency room.

- When I arrived, plenty of people were waiting. They told me I would have to wait. 'You should have come earlier,' the nurse said. (I arrived early). A general practitioner eventually saw me and ordered X-rays and lab tests. Nobody said anything and no explanations were provided to me. At that moment, I was more scared than when I woke up with the pain. I was at the hospital all day, going from one place to another.

- At the end of the day, a doctor came and told me, in few words, that I was okay and that I had nothing to worry about, and then I started 'breathing' again. I would like to say to the hospital authorities that they should realise that every person coming to the hospital, even if they do not have any important disease, is feeling stressed and often unwell. We need friendly people taking care of us, who try to understand our story and why we feel so bad. We need clear communication between healthcare workers and patients. We need clear information on how we should use the hospital facilities.

- I understand that you cannot cure everybody - unfortunately, you are not gods - but I am sure that you could be friendlier to patients. Doctors and nurses have the incredible power in that, with their words, gestures and comprehension of the patient's situation, they can make a patient feel secure and relieved. Please do not forget this power which is so incredibly useful for those human beings who enter your hospital.

- With all my respect, Alice

EXERCISE 2: INFORMATION GIVING EXERCISE

Although this initial exercise is non-medical, we will be able to relate the feedback that they give after doing this exercise to principles for giving information to patients and they should be able to see the relationship.

Instructions:

1. Tell the students that this is an exercise on giving information and ask them to arrange their chairs in pairs with the chairs back-to-back but in a wide, spread out circle.

2. Make sure they spread out round the room (in a big circle) and that one chair faces the wall. The person sitting in that chair will be the receiver of information and the person facing into the room is the giver. If the group is large, get some to work in 3’s, so that one person sits at the side of a pair and observes but does not comment until the end.

3. The receivers need a pad to rest a piece of paper on and a pen or pencil. Ask each receiver to take out a plain piece of paper or give them one.

4. Provide the “givers” of information the picture and explain that they are meant to describe this so that their “receiver” can draw it on their sheet of paper. They can ask any questions they like of each other.

The only thing they cannot do is to look at each other's drawings, or look at each other. They will be given 5 minutes to do the task.

5. Give out the pictures to the givers. It is probably a good idea to get all the receivers to close their eyes while you do this, so that they do not see the picture! (The point of arranging the chairs carefully is to avoid this).

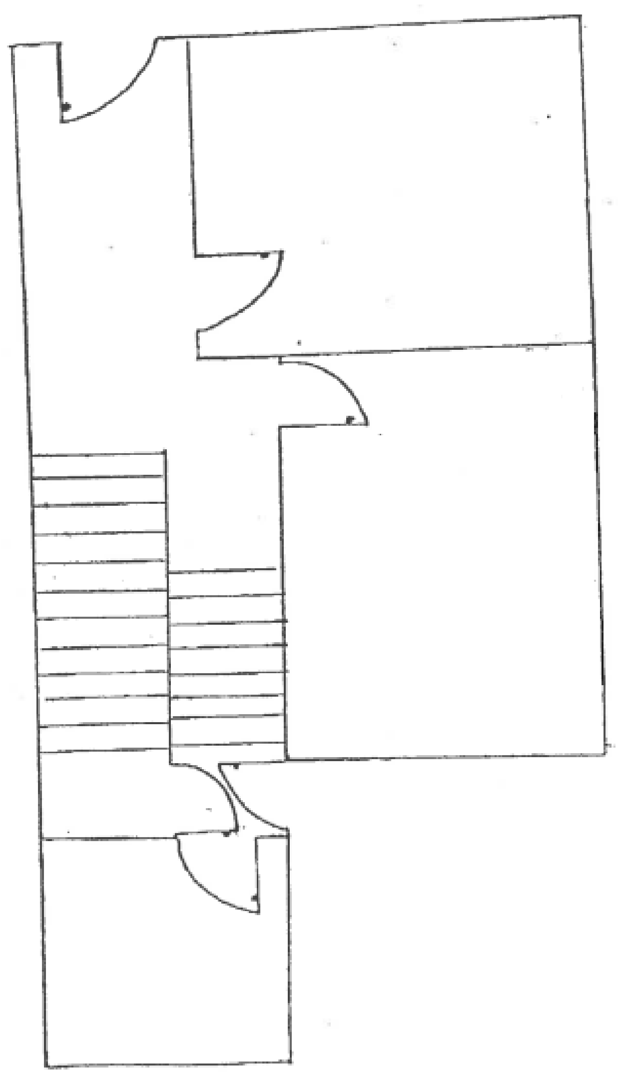
6. Start the exercise and stop after 5 minutes (give a one-minute warning first).

7. Ask the pairs to look at each other's drawings. After a minute or so, ask them to spend a couple of minutes discussing what each did that was helpful in conveying/ understanding the information.

8. Ask the group to move their chairs back to form a group, and using the flip chart, ask the receivers first of all what was helpful. Then ask the givers and finally the observers, if any.

9. The task of the tutor(s) here is to relate the students' feedback to clinical practice. Below is a list of what students commonly say that they learned from the exercise (in bold), along with points you might like to make in response.

Floor plan for Exercise 2



5.7. ADDITIONAL HANDOUTS

HANDOUT 1: CALGARY CAMBRIDGE GUIDE AT A GLANCE

Calgary-Cambridge Guide to Consultation Skills

Providing Structure

Sign post

Summarise

Screen (is there something else?)

Share your thinking with the other party

Structure interview in logical sequence

Stick to time and keep interview on task

Initiating the Session

- Greet patient and obtain patient's name
- Introduce self, role and obtain consent
- Assure confidentiality
- Identify the reason for the consultation

Gathering Information

- Negotiate agenda
- Use open and closed questions to obtain patient's story
- Establish dates and sequence of events

Physical Examination

- Obtain consent for physical exam
- Share with patient the rationale for examining specific body part(s)
- Attend to comfort and dignity

Explanation and Planning

- Assess patient's starting point
- Check how much patient wants to know
- Give information in small chunks
- Check patient's understanding
- Use diagrams, models, written information and instructions to convey information
- Relate explanations to patient's ICE
- Share own opinions and rationale regarding treatment options
- Take patient's lifestyle, abilities and cultural background into consideration
- Encourage patient to take part in making decisions and implementing plans

Closing the Session

- Contract with patient: next steps for patient and doctor, including follow-up / further support and safety nets

Building the Relationship

Build rapport by showing genuine interest about the person and their needs

Use active listening

Pick up cues (verbal and non-verbal)

Elicit patient's **I**deas, **C**oncerns, **E**xpectations (ICE)

Use empathy: **R**ecognise, **A**cknowledge **V**alidate (RAV)

Provide Support

Deal sensitively with delicate issues

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 eg, 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.

Part 1-Getting started

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.

<u>Part 2- Structuring the practice session</u>

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.

<u>Points for feedback</u>

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

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)

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.	90	2	2.1	
Face to Face Training				
Plan of the day (Tutors to add this table in their ppt or write this on the white board before the session starts)	10	2	2.1	
Welcome and reflections on Day 1 (Ask the students to discuss any issues and questions they may have from their first day of training)	60	1 & 2	1.1 & 2.1	
PPT a relationship that fosters and nurtures empathy **Information exchanges and empathy** This part will be face-to-face power point presentation with interactive exercises which are outlined in trainer handbook under power point presentation. Trainers have to follow the ppt slides and look at the notes under each slide for guidance. We need to add a knowledge quiz or other student testing methods as there are not many opportunities in the current ppt.	120	2	2.1	1-20
Question and answer session (at the end of the ppt students may have more questions and the tutors need to encourage these)	40	2	2.1	1-20
BREAK				
VR Scenario 1 **The class can observe what the student with VR headset is doing on a TV monitor so that the class can discuss the student's journey and the different pathways using ALOBA**	140	2	2.1	5-21
Closure and evaluation of the day • Ask the students to tell/write down the main things they are going to take away in terms of learning. • Ask the students to complete the Training Evaluation Form (**Handout 4**).	60			

• Self-directed activity: Ask students to watch **Educational Video 2** and to analyse it using the Calgary/Cambridge Guide		
	430min=7.1 hours	