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 3.1

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
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End Date:	31/08/2022

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	**3**
Work Area	**Showing empathy in diverse environments and overcoming barriers/Challenges to empathy**
Unit	**3.1 Showing empathy in diverse 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 cultural competence in multicultural and sociocultural environments and its effects on patient outcomes 2. Outline the different theoretical approaches to cultural competence 3. Outline research evidence on the importance of cultural competence on patient and working with colleagues from various cultural and social background 4. Define Interprofessional Learning (IPL) in undergraduate health care settings 5. Outline research evidence on the effectiveness of	6. Self-reflect and self-assess his/her level or lack of empathy in daily life in diverse environments. Use evidence-based techniques as listed below to develop empathy during information exchanges with patients and other health care professionals from various cultural and social background. 7. Use interpreters to eliminate linguistic barriers with adverse effects on language. 8. Show genuine interest and curiosity for the cultural beliefs of the patient/colleague	12. Evaluate the feedback from colleagues, and patients on his/her level of empathy and ways of improving in culturally diverse environments and with culturally diverse people. 13. Adapt his/her empathetic behaviour into the patient's and other health carers' needs from culturally diverse environments.

(IPL) in undergraduate health care settings	9. Demonstrate avoidance of making assumptions 10. Demonstrate avoidance of stereotyping 11. Deal sensitively with issues of sexuality, unease of some physical examinations, use and abuse of alcohol and other substances, etc.	

2. TRAINING TECHNIQUES

☐ Classroom Teaching

☒ Asynchronous electronic learning

☒ Directed Self Learning

3. TRAINING METHODS

☒ Student Centred Lecture

☒ Role Play

☒ VR Video

☒ Educational Videos

☐ Case Study

☐ Other: ……

4. WORK AREA 3.1 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**	**3.1**	**3.1**	
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**	**3.1**	**3.1**	
Welcome and reflections on Day 2 (Ask the students to discuss any issues and questions they may have from their first day of training)	**60**	**3.1**	**3.1**	
Ppt Part I: on empathy and cultural competence in multicultural and sociocultural environments This part will be face-to-face power point presentation with interactive exercises. **Question and answer session** (at the end of the ppt students may have more questions and the tutors need to encourage these)	**90**	**3.1**	**3.1**	**1-11**
BREAK				
VR Scenario 2 **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**	**60**	**3.1**	**3.1**	**1-13**
BREAK				
VR Scenario 3 **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**	**60**	**3.1**	**3.1**	**1-13**
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**			
	340 min=5.6 hours			

5. TRAINING MATERIALS

5.1. DIRECTED SELF-LEARNING

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

Students need to read the papers by:

- Ben J, Cormack D, Harris R, Paradies Y. (2017). Racism and health service utilisation: A systematic review and meta-analysis. PLoS One, 18;12(12): e0189900
- Eleftheriadou Z., Noble L. (2019). Communicating with people from different cultural backgrounds. In Clinical Communication Skills for Medicine, 4th Edition **,** Lloyd M, Bor R, & Noble L.M. Elsevier.

Students need to read and familiarize themselves with 1) Handout 1. The Calgary Cambridge guide for Cross Cultural Communication and Social Diversity 2) Handout 2. Calgary Cambridge guide for Medical Interview for Elderly Patients (Calgary Cambridge guide for Medical Interview for Elderly Patients) and 3) Handout 3. The Cultural Competence Self-Evaluation Checklist (Cultural Competence Self-Evaluation Checklist)

Furthermore, students to be directed to the online resource in order to find additional material for:

1. Different models of Cultural Competence

2. Working with interpreters

3. Interprofessional Learning

5.2. POWER POINT PRESENTATION: WORK AREA 3.1

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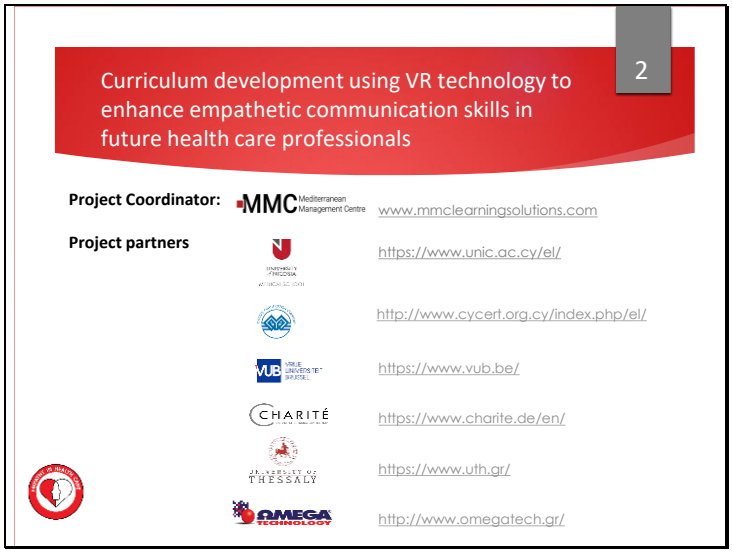
Slide 2



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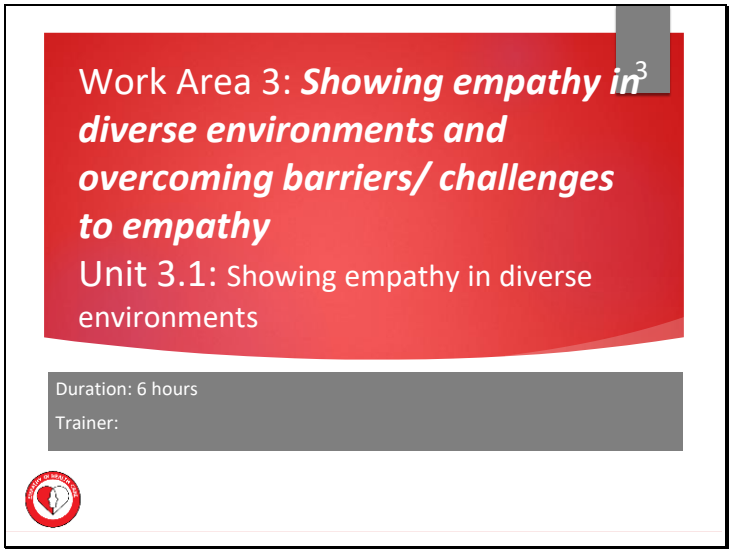

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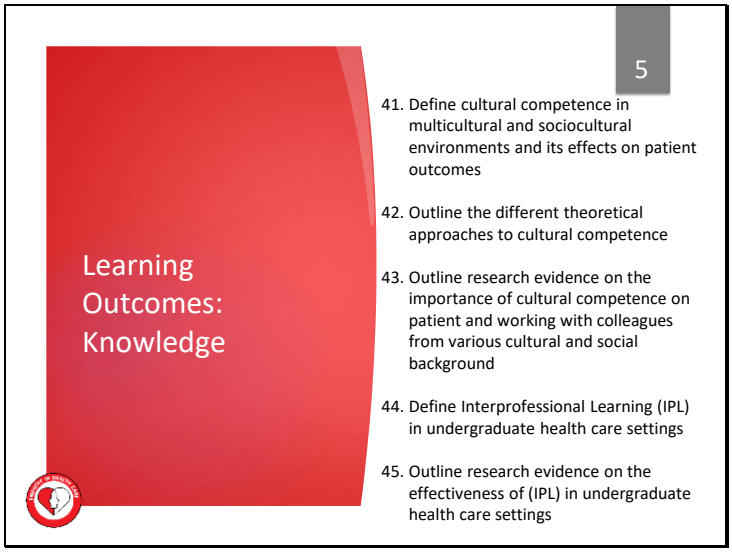

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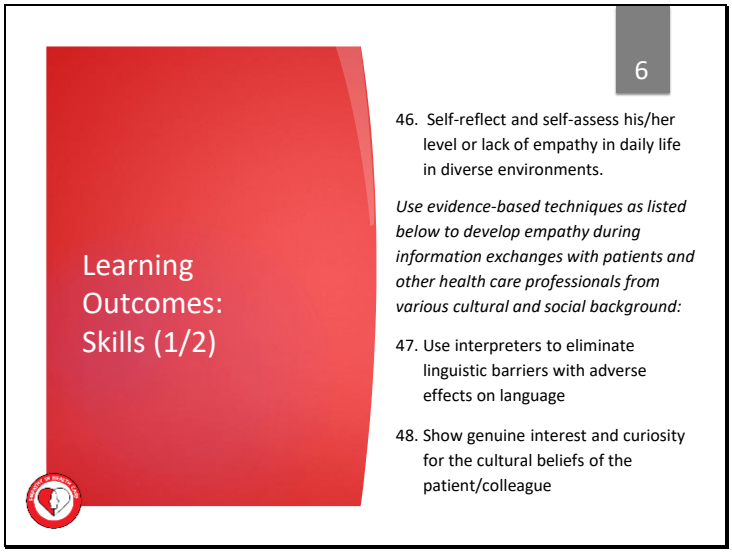

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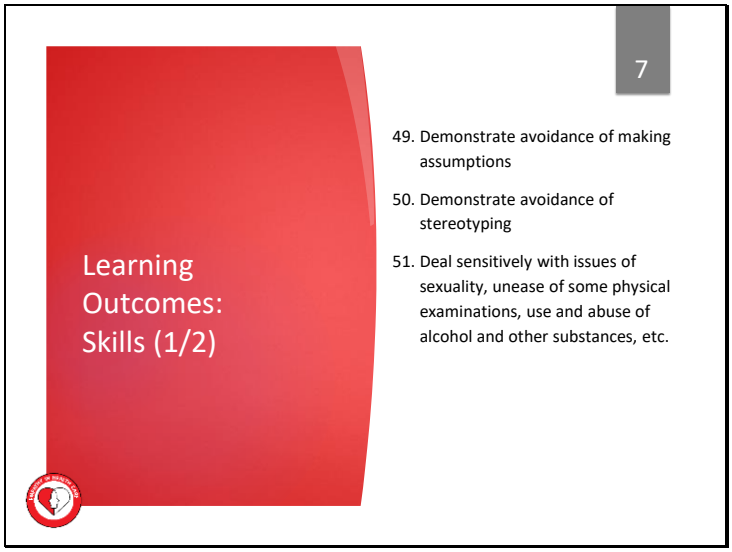

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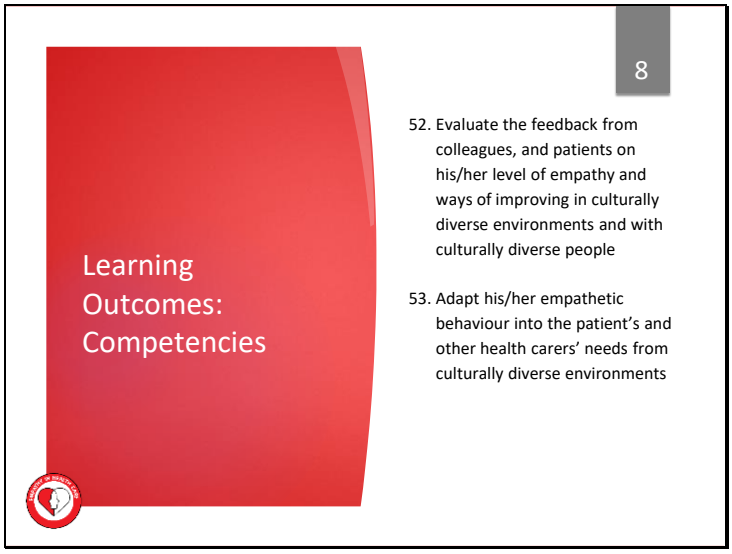

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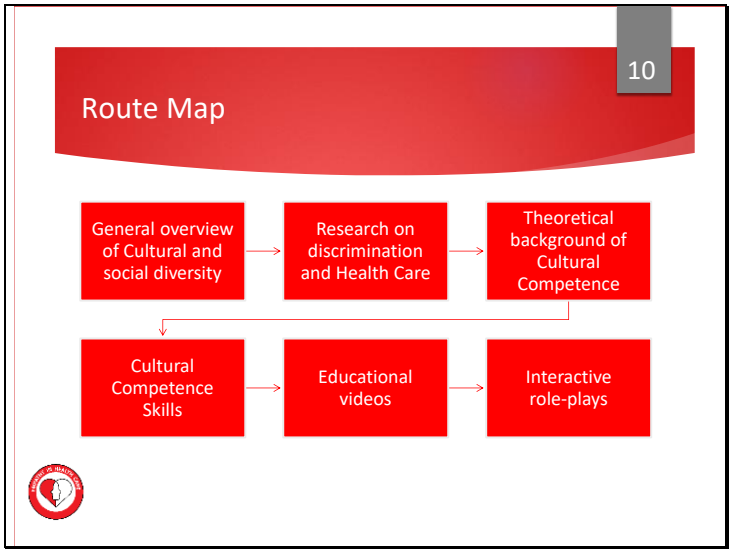
Feel Free to Change

Slide 10



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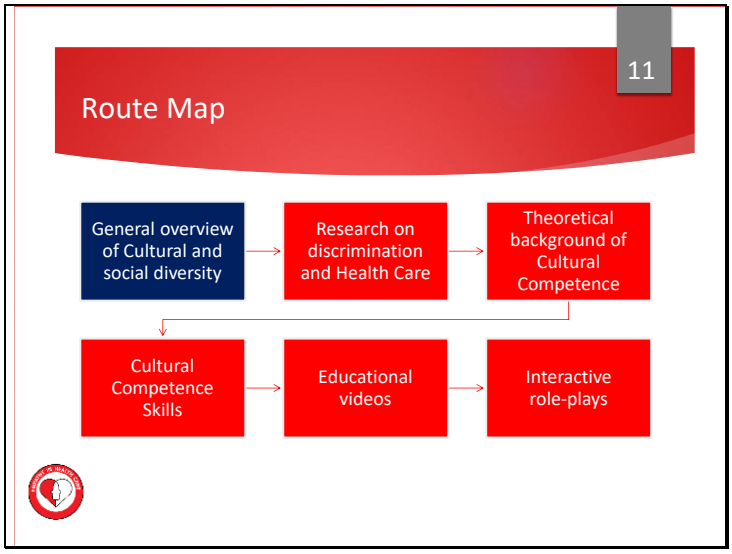

Slide 12

A warm up, brain storming (5 mins)

Ask your students to complete this short self-assessment test. Decide which statements are true and

which are false.

1. When we use the term diversity we are referring only to persons of other races. F

2. A person's religious traditions should have no bearing on his or her health care. F

3. Recognizing our own personal biases can improve communication with diverse patients. T

4. We should consider an adult patient's age when instructing them. T

(Frain, 2020)

Slide 13

When we engage with people who look like us, act like us, and share our values, we generally find that communication is simple; but as we engage with people who are **diverse**, or different from ourselves, both patients and coworkers, we may discover that communication is more challenging. Sometimes differences are easy to identify. Sometimes differences may be subtle and we may not be aware of them. When you hear the word diversity, what comes to mind? Initially you might think of cultural or ethnic differences, but diversity has many forms and layers. Consider, for example, that age, race, sex, sexual orientation, gender, gender identity, ability, socioeconomic status, and religion are among the many characteristics of diversity, and that multiple dimensions

are present in every individual. Although differences present challenges, awareness of the diversity of our patients and their experiences provides useful information for effective communication. As we practice awareness, we will begin to recognize not only differences but also similarities in “diverse” groups of people. This recognition and awareness will provide a strong foundation for effective communication.

Slide 14

Activity:
This activity requires no special materials, it can be conducted in almost any setting. It is a particularly good activity for groups that are just forming.

Goal
To help participants recognize the differences among people, as well as the many similarities people share.

Time
10–15 minutes

Materials
Open space large enough for two people to take a short walk

Procedure
Two “volunteers” come forward and stand with backs together. Ask the “audience” to call out things about these two volunteers that are different. Differences sometimes pull us apart. As each difference is called, the volunteers take one step apart. When they reach the end of the available space, have them turn and face each other. Now, ask the audience to call out similarities of the volunteers. As each similarity is called out, the volunteers take one step toward each other.

Discussion

1. Think about the things that were noted as differences. How many were things that we can easily see (gender, size, hair color, skin color, dress, wearing glasses or not, etc.)?
2. What were some of the similarities?

While certain physical characteristics are similar, many other similarities are not so visible. Perhaps both "volunteers" are enthusiastic or both have similar interests or goals in life.

3. Talk about the importance of the differences and of the similarities among members of the group. Be sure to talk about the importance of accepting and welcoming all members into the group.

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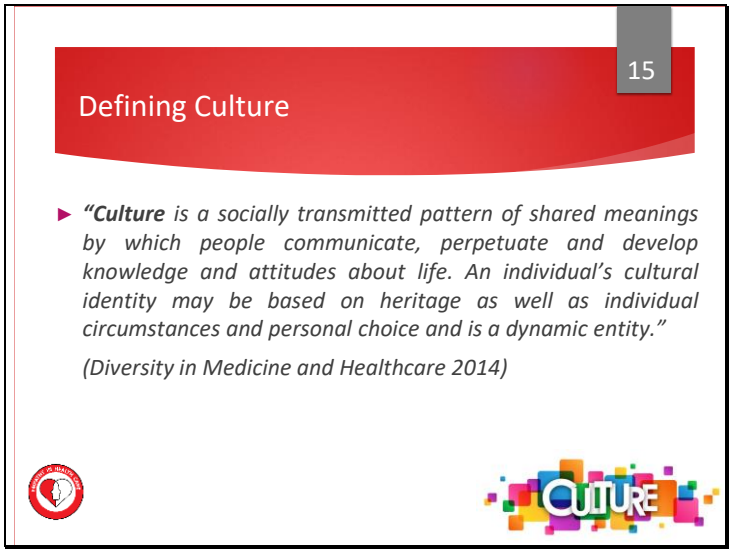


Culture definition

Slide 16

Last years with immigration, Europe has becoming a multicultural region

Slide 17

Increasingly we encounter ethnic complexities and mobility of peoples throughout the world. Johnson *et al.* (1995) have said that 'each culture is a textured pattern of beliefs and practices, some of which are coherent and consistent and others contested and contradictory'. They suggest that doctors must explore a patient's health beliefs and views of their symptoms and illness in every medical interview. If HCP ignore this advice, they risk making assumptions or value judgements and stereotyping patients. This can lead not only to conflict but also inaccuracy.

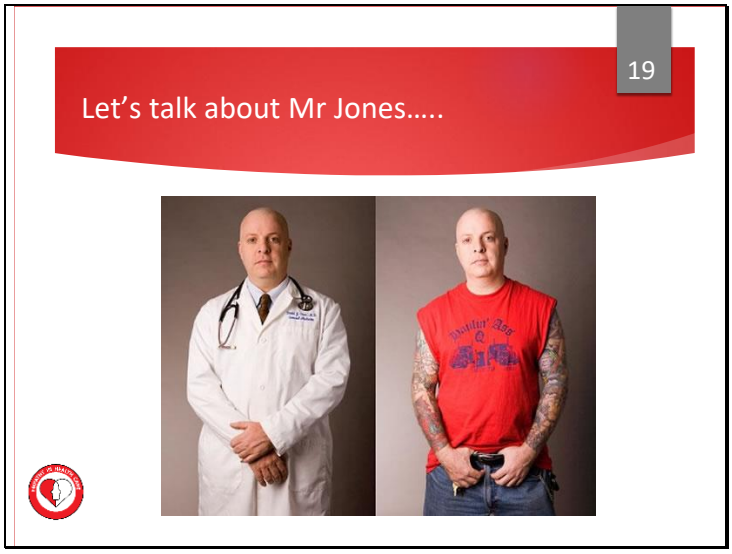
Slide 18

Brainstorming

A warm up, brain storming (5 mins) for stereotyping.

Ask students what they believe Mr jones occupation is. Ask them to explain how they reached to this conclusion.

Slide 19



Inform students that Mr Lones is a doctor, however he loves tattoos and he rides a Harley-Davidson.

Slide 20

Explain what stereotyping is

The word *stereotyping* was first used by journalist Walter Lippmann in 1922 to describe judgments made about others on the basis of their ethnic group membership. Today, the term is more broadly used to refer to judgments made on the basis of any group membership. Psychologists have attempted to explain stereotyping as mistakes our brains make in the perception of other people that are similar to those mistakes our brains make in the perception of visual illusions (Nisbett, 1980). When information is ambiguous, the brain often reaches the wrong conclusion. As illustrated in Figure 1, the Moon looks larger near distant buildings than nearby ones in this simulated skyline. The brain's estimation of distance changes, as does the apparent size of the moon.

What we see, the most readily available image, is what we expect to see. We can reject any information that challenges that expectation. In Figure 2, a sign appears to read “Paris in the spring,” but it actually has an extra *the.* As we don't expect to see a double *the,* often we do not perceive it. In a like manner, if we expect that heads of corporations are tall, slender, White males, we don't see people with disabilities, women, and people of color in that group, similarly to our doctor, Mr Jones.

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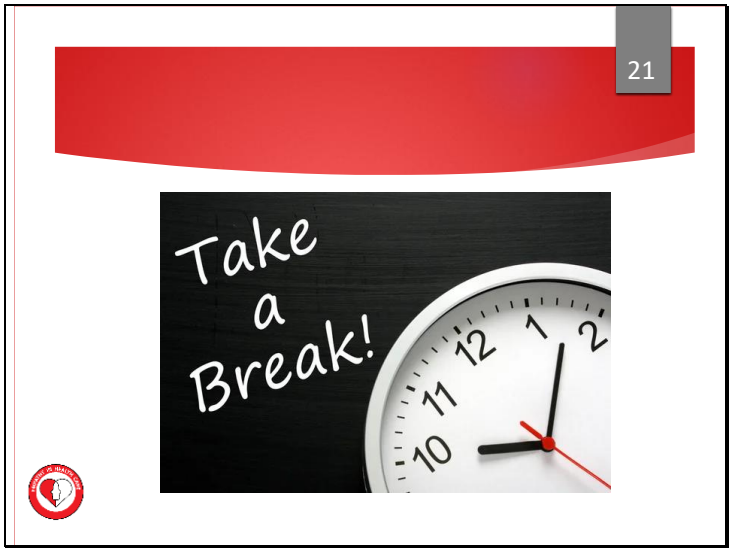

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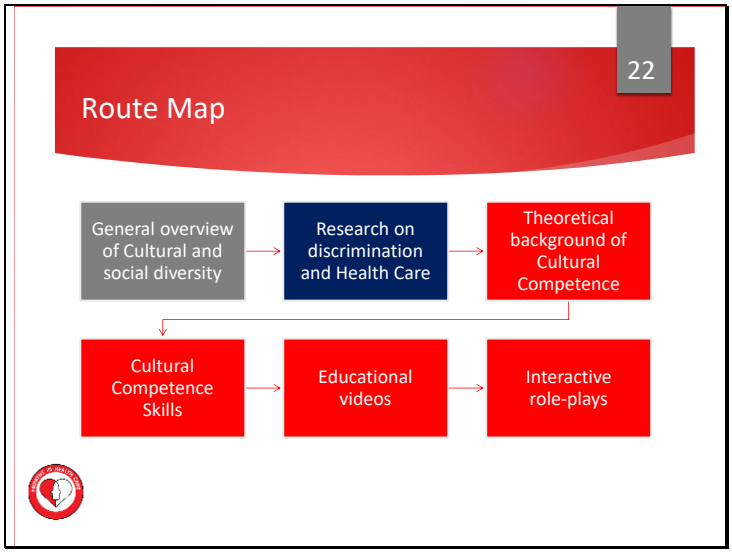

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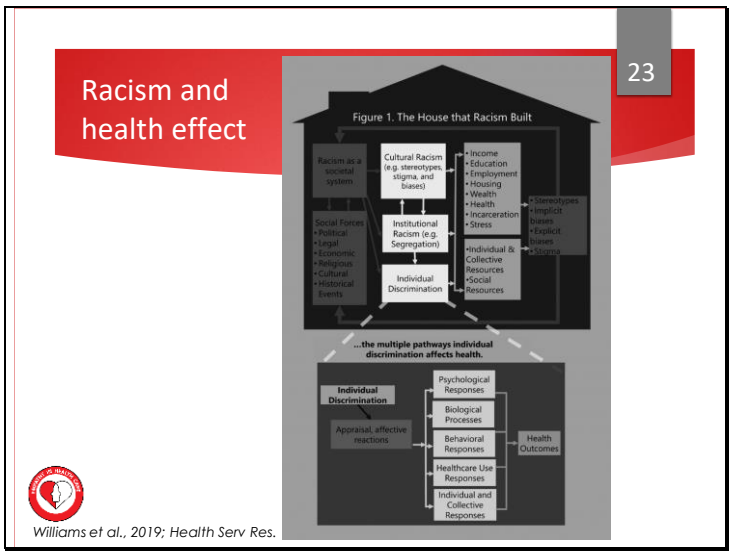

Figure indicates that the persistence of stark racial inequities in multiple domains of society can confirm racial stereotypes and stigma, and thus serve to reinforce the system of racism.

Moreover, the pathways by which racism affect are interrelated and mutually reinforcing.

The lower panel of Figure delineates how discriminatory incidents of which the individual is aware can trigger appraisal and affective reactions that can be experienced as stressful life exposures, and they have a cascade of negative effects on health. They can lead to negative emotions that can adversely affect psychological well-being, leading to symptoms of distress and increasing the risk of discrete psychiatric disorders. These negative emotions can also lead to biological dysregulation that can contribute to indicators of subclinical disease and chronic physical illness. Coping with negative emotional states can also lead to increases in risky health behaviors, including declines in the utilization of and engagement with health care services.

Figure also acknowledges that in the face of exposure to discrimination, individuals and groups can respond in ways that can neutralize at least some of the negative effects of discrimination.

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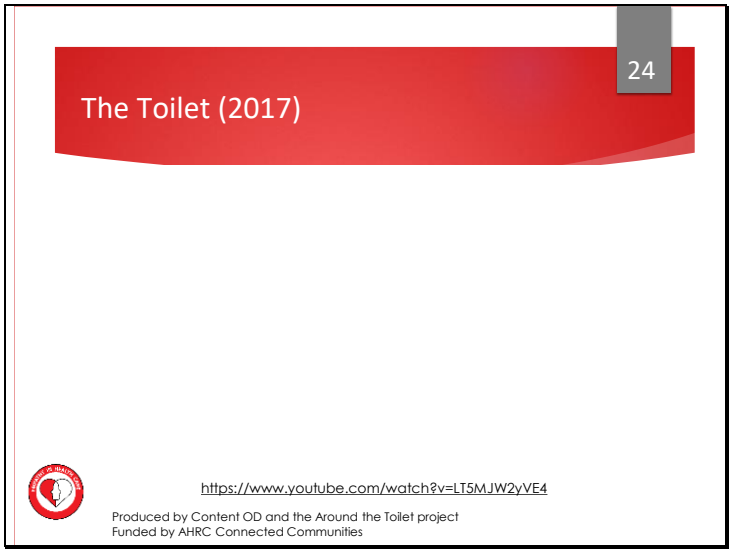

*Students will watch this **video**, titled the toilet, in order to realize how important is to understand that all have grown up with different values, views, and perspectives.*

This quirky animation weaves together personal accounts from transgender, disabled and Muslim people, who share the trials and tribulations of accessing and using public toilets in a society where some are made to feel welcome and others are not.

The video will help students to understand that it will be important to pause and consider their own personal biases as they engage with their patients. It is their responsibility to listen to their patient's concerns and adapt their communication style to communicate effectively during each patient interaction.

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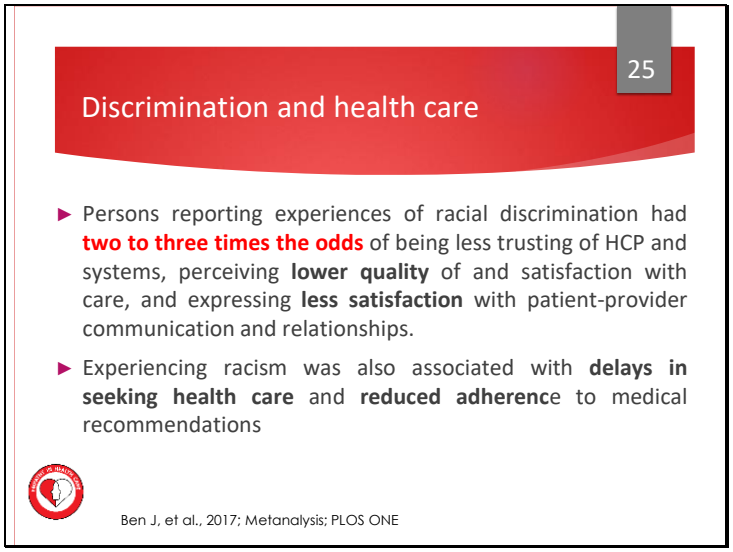
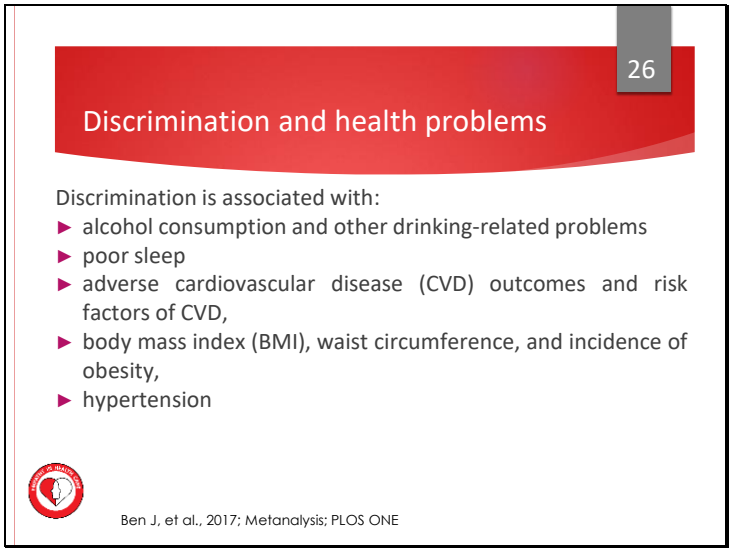


Persons reporting experiences of racial discrimination had **two to three times the odds** of being less trusting of HCP and systems, perceiving **lower quality** of and satisfaction with care, and expressing **less satisfaction** with patient-provider communication and relationships.

Experiencing racism was also associated with **delays in seeking health care** and **reduced adherence** to medical recommendations

Slide 26



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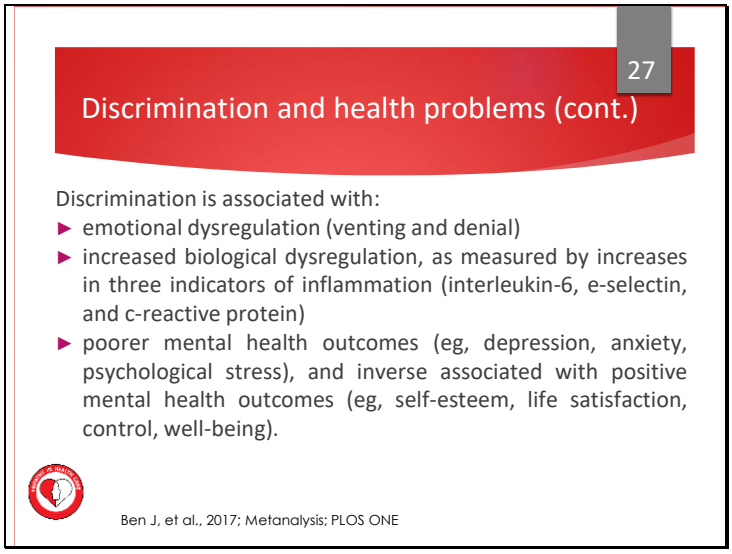

Slide 28

Brainstorming

Lay health beliefs are considered important barriers

A warm up, brain storming (5 mins) for lay health beliefs.

A quick video for evil eye (Greek movie, or other more cultural adapted material according to the country). In case it is not applicable for your culture, you may replace it with another video or photo accordingly.

Ask students:

- **What are lay health beliefs?** ("Lay health beliefs" refer to beliefs or sets of ideas ordinary people have about health and illness),
- **What are the types of health beliefs?** (Health beliefs can be ideas about what is health or healthy, what is causing diseases and how conditions can be managed),
- **Could you think of any examples of lay health beliefs?**

(Belief about health: Health as functional capacity (ability to do things despite the presence of a condition).

Belief about the cause: evil eye (inflicted by other people), supernatural (inflicted by supernatural entities) (these two are not the same and students have been taught about the difference).

Belief about management: invocation, prayer, cultural healers etc.)

- **How lay health beliefs could be a barrier between patient and HCP**?

Health beliefs could make patient to have resistance and not be willing to be informed about evidence-based treatments being difficult to reach a share decision making.

Slide 29

The most common issues and barriers in cross- cultural communication and social diversity

There is a DIRECTED SELF-LEARNING material for learning (IPL).

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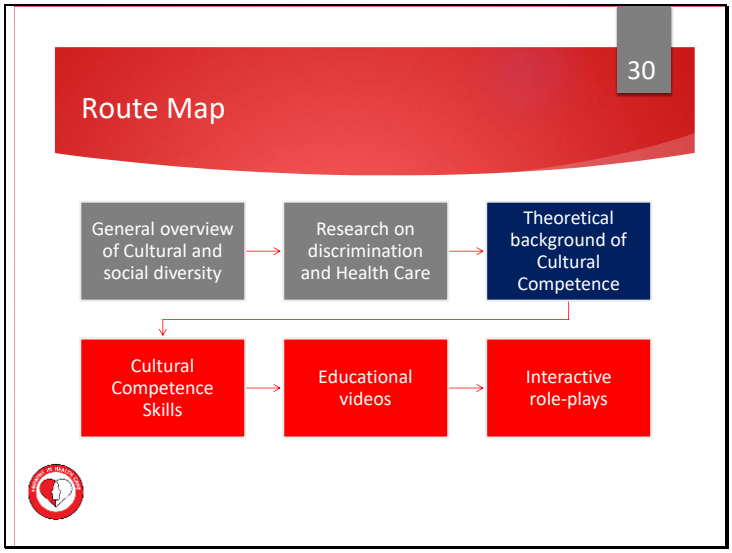

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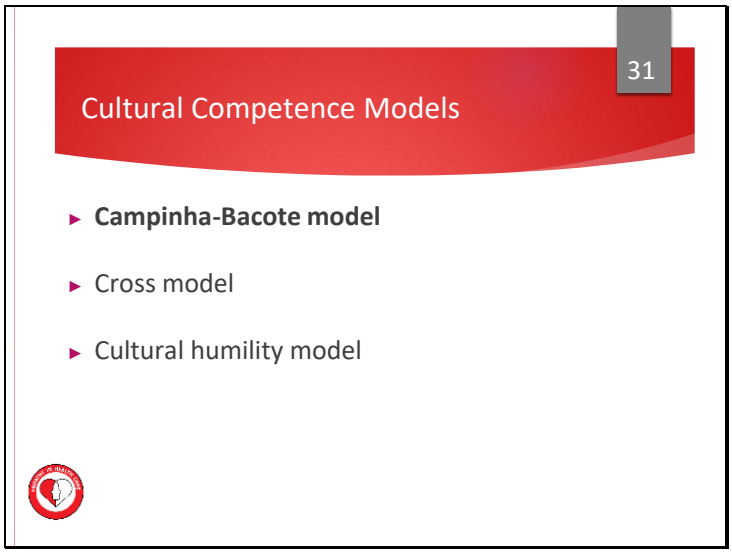

More than 15 models of cultural competence are presented within the healthcare literature, with most identifying cultural awareness, cultural

knowledge and cultural skills or behavior to be important elements of culturally competent practice (Alizadeh & Chavan, 2016). The most commonly use models are Campinha-Bacota moel and Cross model, whereas a new model is the Cultural humility model. In the current presentation we will focus on Campinha-Bacota model however there is a DIRECTED SELF-LEARNING material for learning more in depth about Cross model and Cultural humility model.

We should note there is no universally agreed-upon definition of the Cultural Competence term. **However, most of the definitions in use today contain the idea that cultural competence requires an understanding of one's own culture and background in order to understand other cultures**. Moreover, there is no agreed-upon best method or path for an HCP to learn cultural competence.

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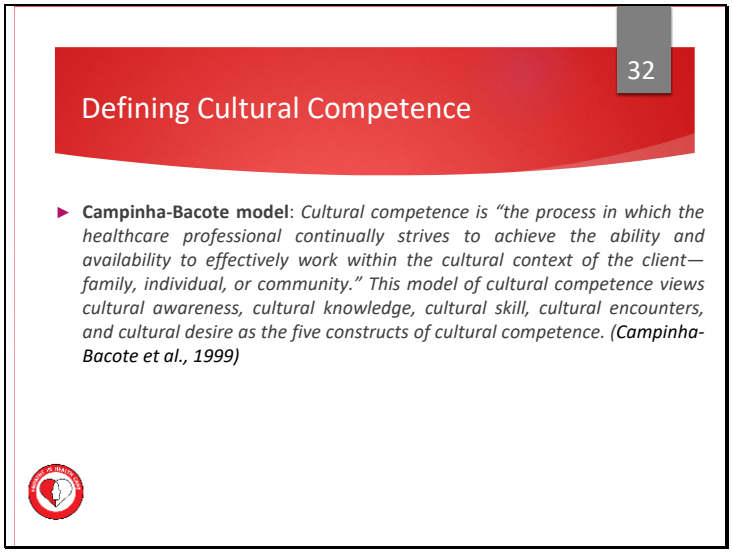

As an example of models….

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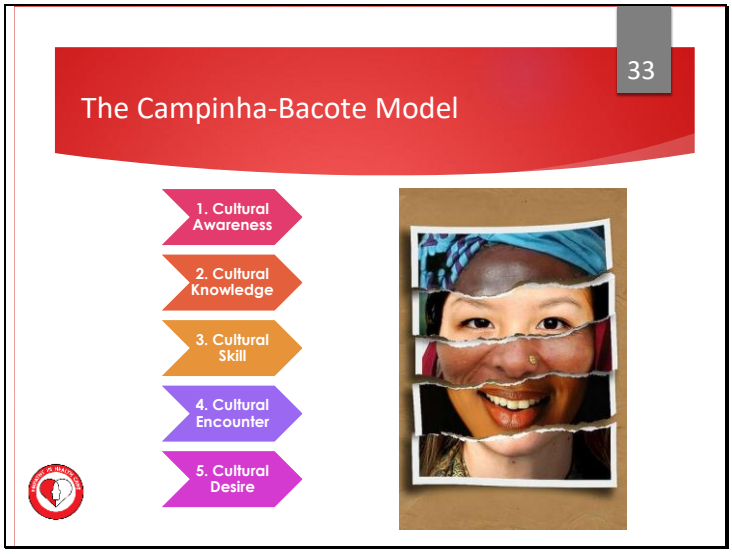

The process of cultural competence in the delivery of healthcare services, developed by Campinha_Bacote

It is a process of *becoming* culturally competent, not *being* culturally competent" (Campinha-Bacote).

This process contains the following five steps:

1 Cultural Awareness. This is the process of looking closely and honestly at your own biases toward other cultures, as well as examining your own cultural background. Cultural awareness includes an awareness that racism and other forms of discrimination exist in healthcare delivery;

2 Cultural Knowledge. This is the process of seeking a thorough understanding of the attitudes and beliefs of other cultural and ethnic groups, as well as the health conditions and diseases that exist among diverse ethnic groups;

3 Cultural Skill. This is the ability to accurately understand the cultural details surrounding the patient's presenting problem and to physically assess the patient within the context of their culture;

4 Cultural Encounter. This is when the HCP actively seeks face-to face encounters with members of other cultures in order to better understand the HCP's own beliefs about other cultures and to prevent stereotyping;

5 Cultural Desire—This is the all-important desire of the HCP to become more culturally knowledgeable and skillful. It is important to emphasize that this has to be something the HCP genuinely wants to do instead of merely a need to fulfill a job requirement.

* *Cultural Encounter and Desire will be further discussed using the educational video*

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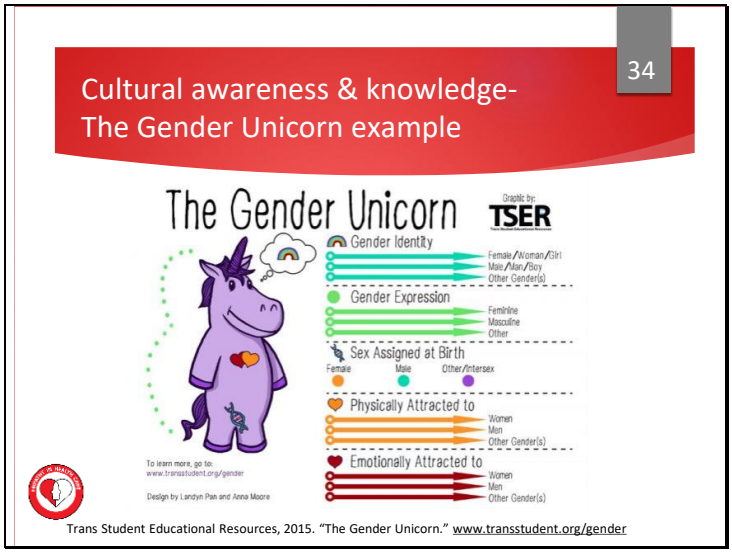

Trans Student Educational Resources, 2015. "The Gender Unicorn." www.transstudent.org/gender

Cultural awareness & knowledge example: The Gender Unicorn, giving the opportunity to the students learn about gender mapping concepts and get familiar with LGBD (lesbian, Gay, Bisexual, Transgender) culture.

Ask students whether they are familiar with Gender Unicorn (cultural awareness) and then give them the definitions as an example of cultural knowledge:

Gender Unicorn Definitions:

Gender Identity: One's internal sense of being male, female, neither of these, both, or another gender(s). Everyone has a gender identity, including you. For transgender people, their sex assigned at birth and their own internal sense of gender identity are not the same. Female, woman, and girl and male, man, and boy are also not necessarily linked to each other but are just six common gender identities.

Gender Expression/Presentation: The physical manifestation of one's gender identity through clothing, hairstyle, voice, body shape, etc. Many transgender people seek to make their gender expression (how they look) match their gender identity (who they are), rather than their sex assigned at birth.

Sex Assigned at Birth: The assignment and classification of people as male, female, intersex, or another sex based on a combination of anatomy, hormones, chromosomes. It is important we don't simply use "sex" because of the vagueness of the definition of sex and its place in transphobia. Chromosomes are frequently used to determine sex from prenatal karyotyping (although not as often as genitalia). Chromosomes do not always determine genitalia, sex, or gender.

Physically Attracted To: Sexual orientation. It is important to note that sexual and romantic/emotional attraction can be from a variety of factors including but not limited to gender identity, gender expression/presentation, and sex assigned at birth.

Emotionally Attracted To: Romantic/emotional orientation. It is important to note that sexual and romantic/emotional attraction can be from a variety of factors including but not limited to gender identity, gender expression/presentation, and sex assigned at birth. There are other types of attraction related to gender such as aesthetical or platonic. These are simply two common forms of attraction.

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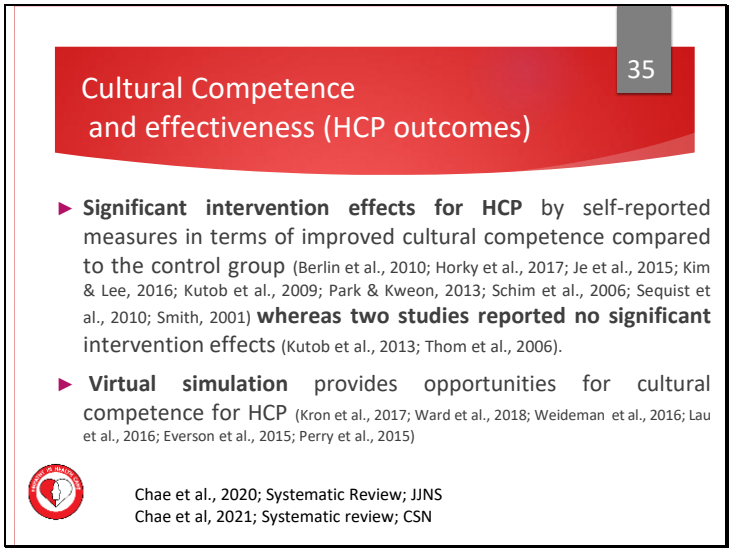

Evidence for Cultural Competence and effectiveness (HCP outcomes)

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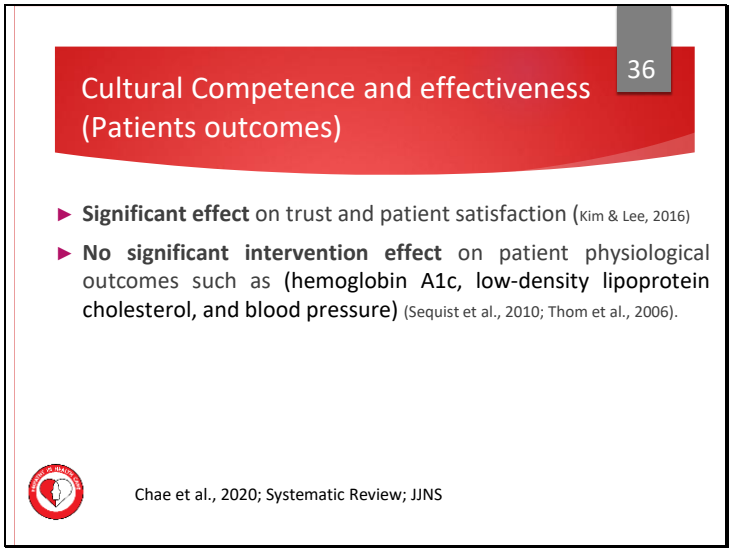
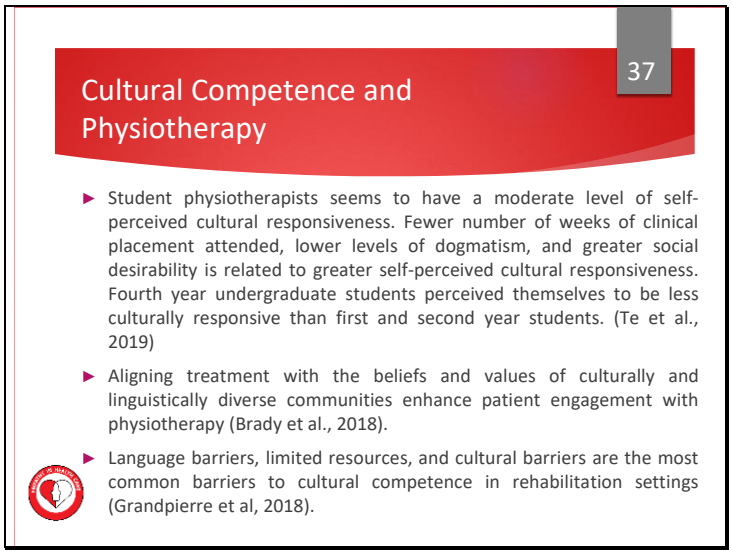


Evidence for Cultural Competence and effectiveness (patients' outcomes)

Patient outcomes were reported in three studies (Kim & Lee, 2016; Sequist et al., 2010 ; Thom et al., 2006). Kim and Lee (2016) reported satisfaction and trust. Sequist et al. (2010) reported physiological outcomes (hemoglobin A1c, low-density lipoprotein cholesterol, and blood pressure). Thom et al. (2006) reported both satisfaction and trust and physiological outcomes. Patient satisfaction and trust were obtained from self-reported measures (Kim & Lee, 2016; Thom et al., 2006), and physiological outcomes were derived from patients' medical records (Sequist et al., 2010; Thom et al., 2006).

Slide 37



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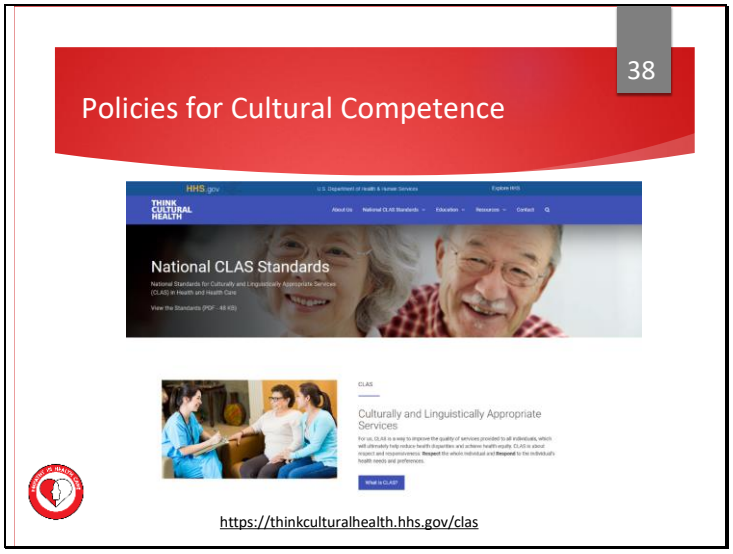


Some countries have certain policies for cultural competence and have specific published standards that are intended primarily for healthcare organizations. Although not legally binding—that is, they are not required by law—these standards should be practiced at all levels of patient care to ensure that the different cultural communities served have sufficient access to appropriate care.

The standards of USA are presented, written and published by the Office of Minority Health (OMH) in the U.S. Department of Health and Human Services (DIRECTED SELF-LEARNING materials for learning more in depth about policies).

Slide 39

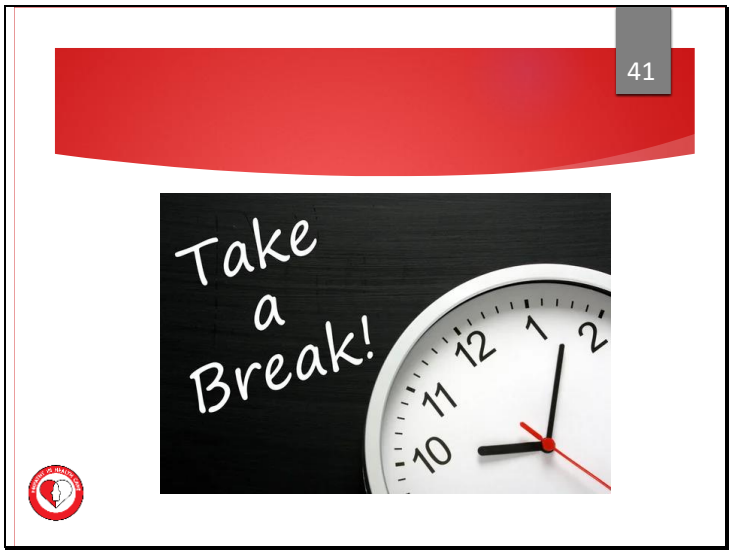
Cultural Competence Self-Evaluation Checklist [PDF] – This self-assessment tool has designed to help students: (1) think their skills, knowledge, and awareness in interactions with others and (2) identify areas of strength and areas that need further development. After they have completed the assessment, ask them to make a list of the areas where they need further development (those they rated a 1 or 2).

Instructions: Read each entry in the Awareness, Knowledge and Skills sections Place a check mark in the appropriate column which follows. At the end of each section add up the number of times you have checked that column. Multiple the number of times you have checked "Never" by 1, "Sometimes/Occasionally" by 2, "Fairly Often/Pretty well" by 3 and "Always/Very Well" by 4. The more points you have, the more culturally competent you are becoming.

Slide 40

Now ask your students to set three goals for becoming culturally competent and practicing cultural humility: one short-term goal that you can accomplish immediately, one medium-term goal that you can accomplish over the next several weeks, and one long-term goal that you can accomplish over the next year.

Slide 41



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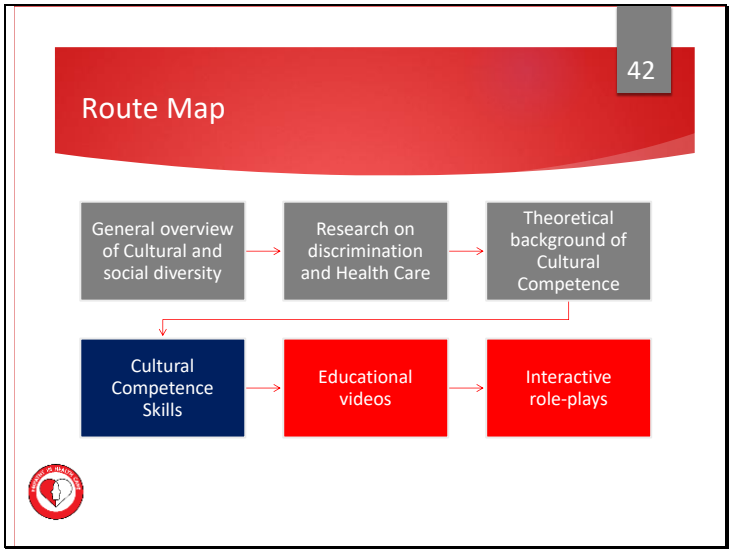

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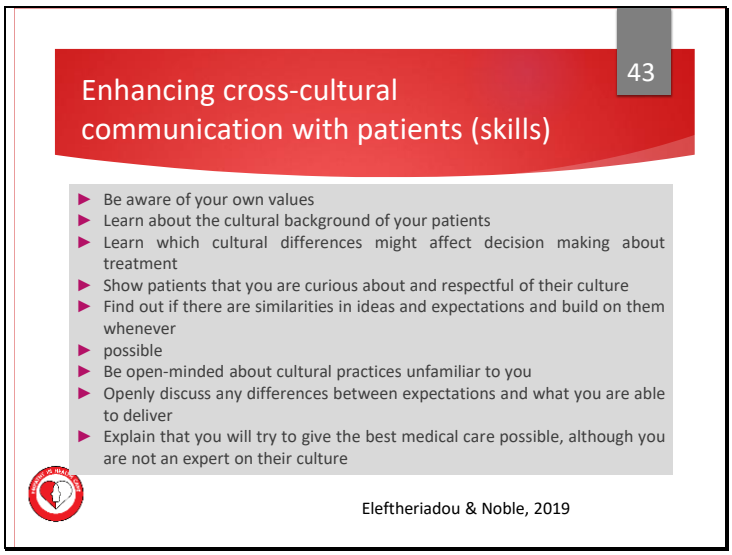
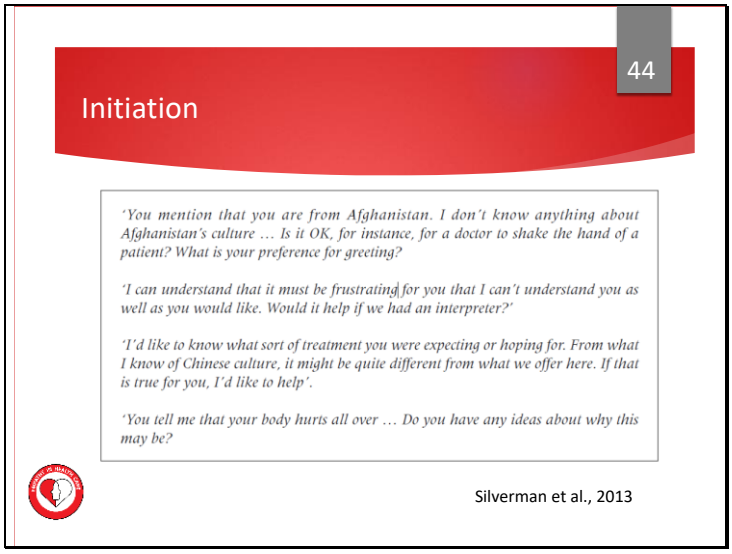


These are some evidence-based tips for Enhancing cross-cultural communication with patients.

CALGARY - CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW–CROSS- CULTURAL COMMUNICATION AND SOCIAL DIVERSITY can be presented.

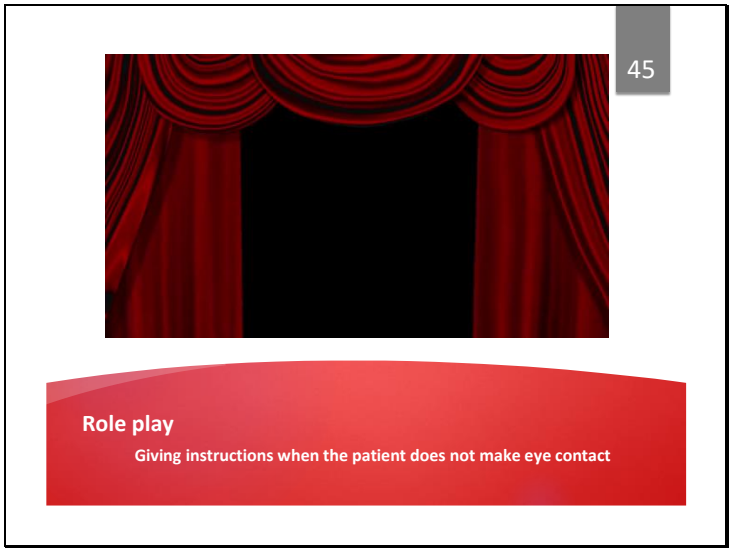
There is a DIRECTED SELF-LEARNING material for learning more in depth about working with interpreters.

Slide 44



Some common questions used at the initiation of the session in order to communicate with a patient from different cultural background.

Slide 45



Giving Instructions When the Patient Does Not Make Eye Contact

With a partner, where one is the HCP and the other the patient, act out the following scenario. The HCP needs to give the patient detailed instruction in hand washing and the patient does not make direct eye contact while the HCP speaks. As the HCP, practice giving the instructions and not losing the train of your thought despite the fact that the patient may be looking away or at the floor. Discuss the strategies that worked when instructing a patient who does not make eye contact. Which strategies didn't work?

Slide 46

This slide gives an example of nonverbal Communication (smile) in Cross-Cultural Contexts

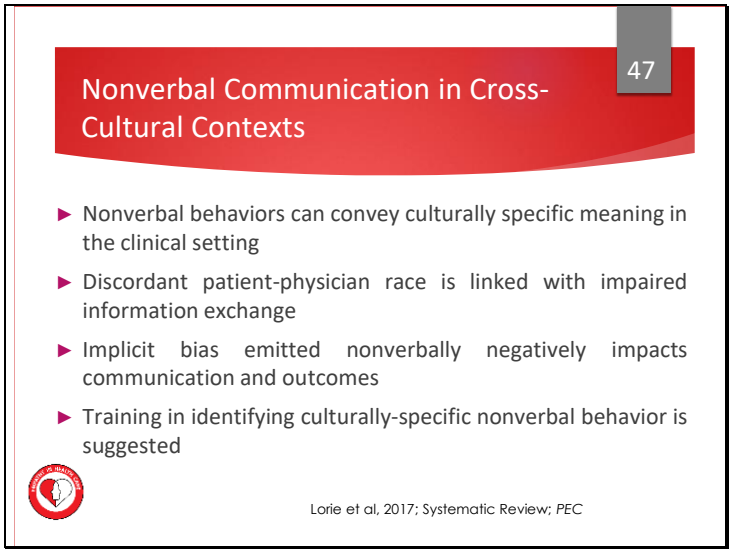
Smile in different cultures (American, German, Japanese, Thailand)

The Smile—Everyone knows how to smile. However, not all the members of all cultures smile or the same reason, and not all cultures believe that smiling is appropriate in the same situations.

Smiling is an expression of happiness in American culture. Germans also smile as an indication of happiness, but only smile when with people they know closely and really like. In many Asian cultures the smile can mean something else altogether. Some Chinese, for example, may smile when they are discussing something sad or uncomfortable. In Japanese culture, a smile can be used to hide an emotion or to avoid answering a question. Even within Japanese culture there can be differences. For instance, a person of lower social status in Japan may use a smile when taking orders from a superior when in fact they feel anger or contempt toward the superior.

In Korean culture, smiling too much can be interpreted as the sign of a shallow person, leading many Koreans to smile less in public. One scholar notes that this "lack of smiling by Koreans has often been interpreted as a sign of hostility." People in Thailand, however, smile a lot, leading that country to be called "The Land of Smiles" by some students of culture.

Slide 47



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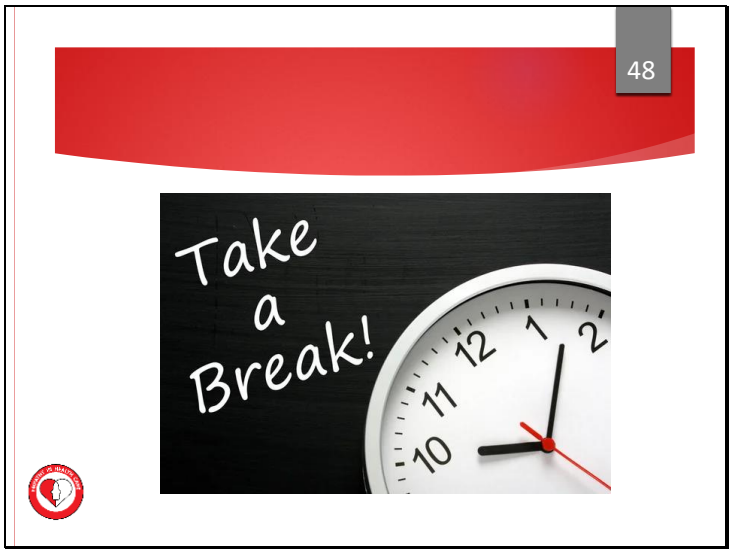

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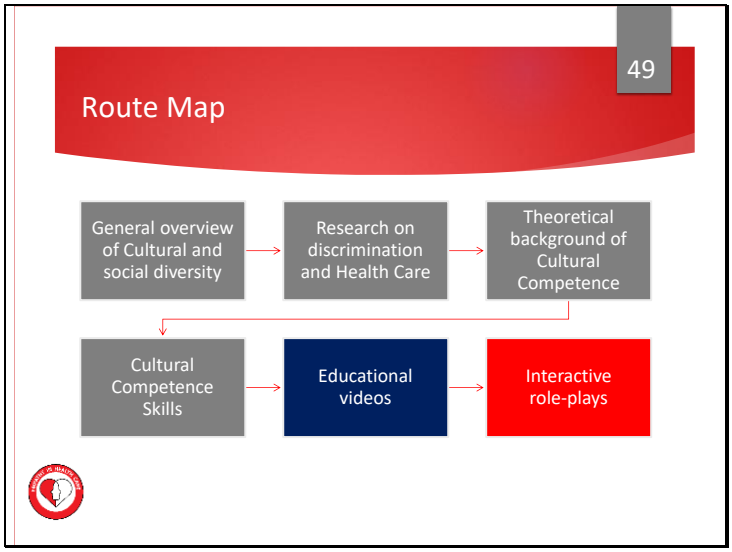

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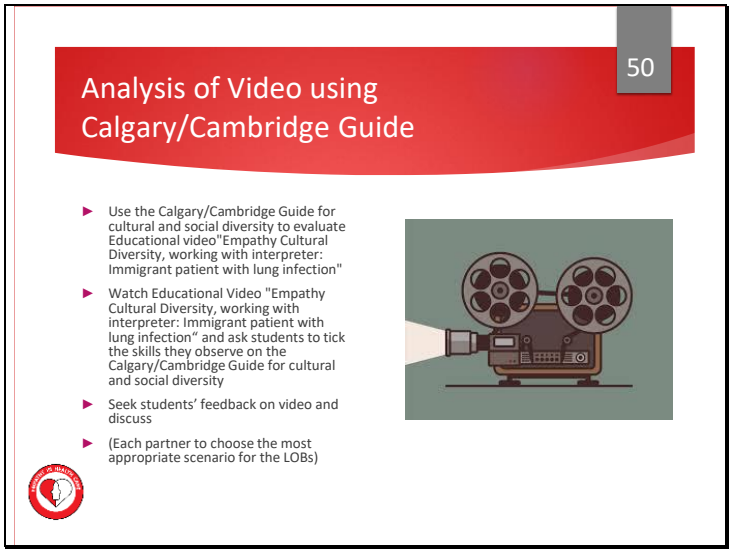


Use the Calgary/Cambridge Guide to evaluate Educational video (**Scenario: 6. Empathy Cultural Diversity, working with interpreter: Immigrant patient with lung infection**).

Use the Calgary/Cambridge Guide to evaluate Educational video (Handout 2)

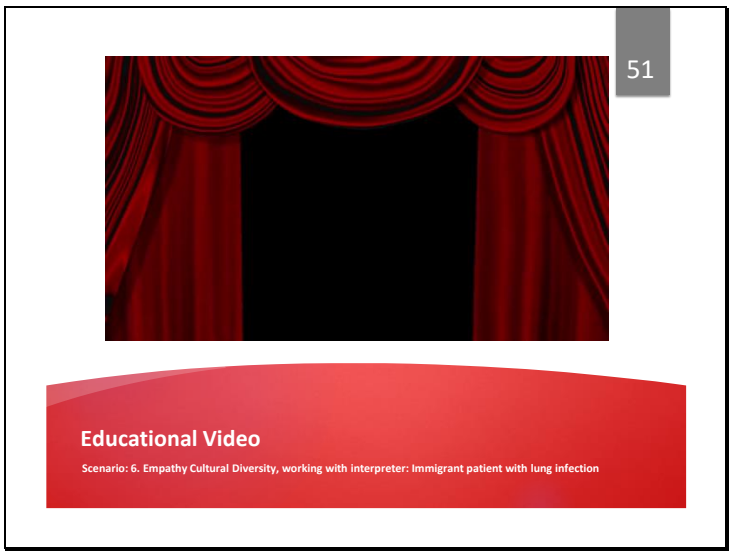
Handout 2 can be given to students as a hard copy or electronically as a word document. Give students 5 min to read the skills individually. Ask them as a group if they have any questions in relation to any of the skills. Before the tutors embark on explaining the skills to the students, ask if any of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

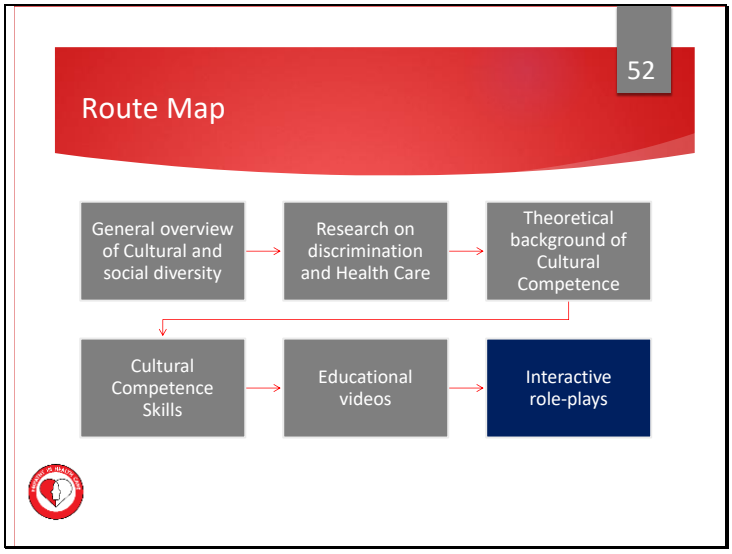
There is a DIRECTED SELF-LEARNING material for learning more in depth about working with interpreters.

Slide 51



Watch the educational video and provide feedback

Slide 52



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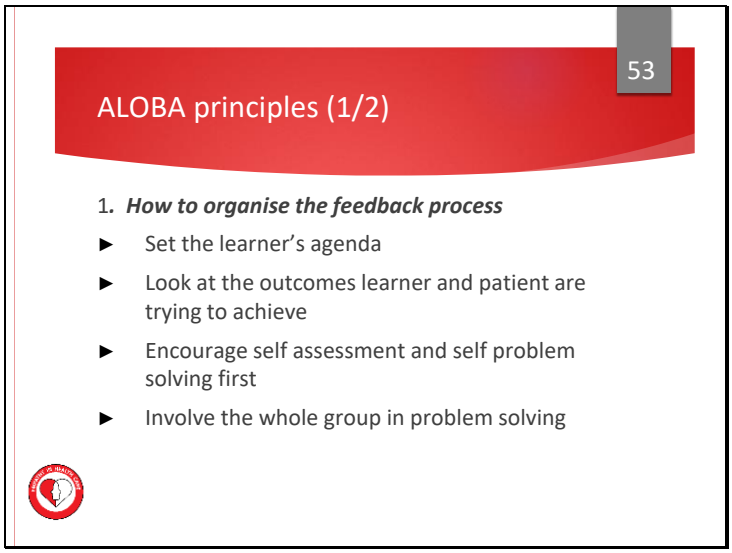


ALOBA, overcomes the disadvantages of the conventional rules and promotes self-assessment. It helps us organise the feedback process.

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

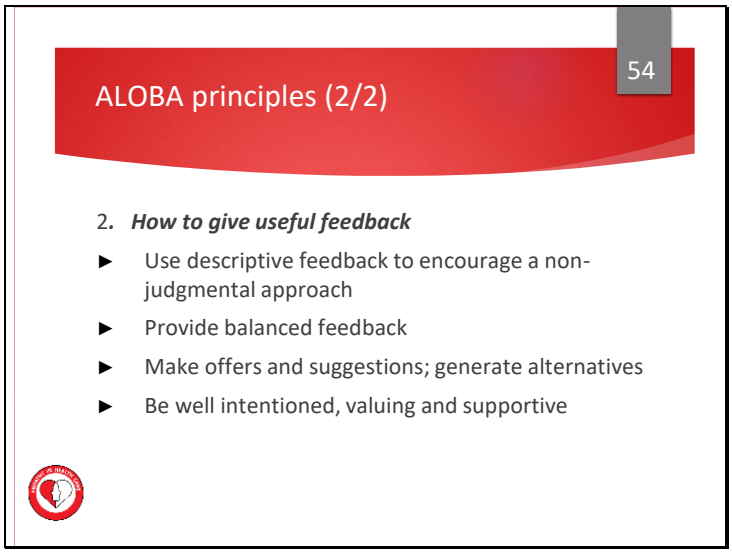
Before the role-play starts, we need to set the learner's agenda: ask what problems the learner experienced in their practice so far and what help he/she would like from the rest of the group (i.e attend and give suggestions for body language)

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.

Slide 54



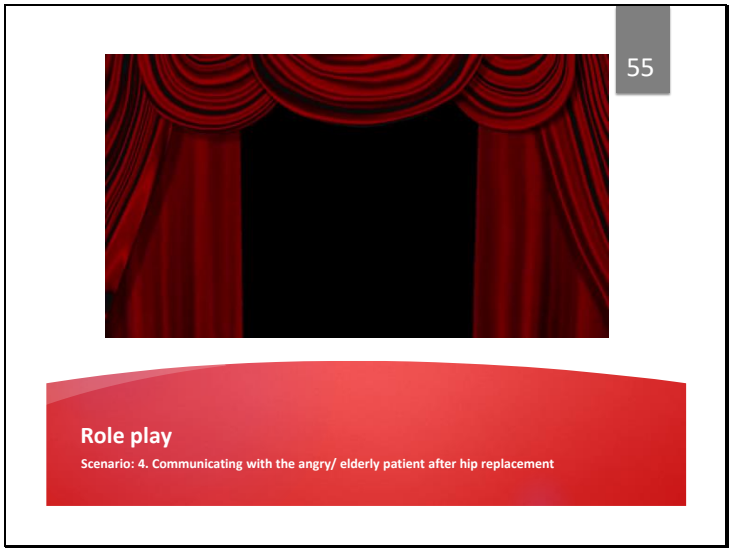
Descriptive feedback: specific comments are made which prevent vague generalisation (e.g. not good consultation)

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

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

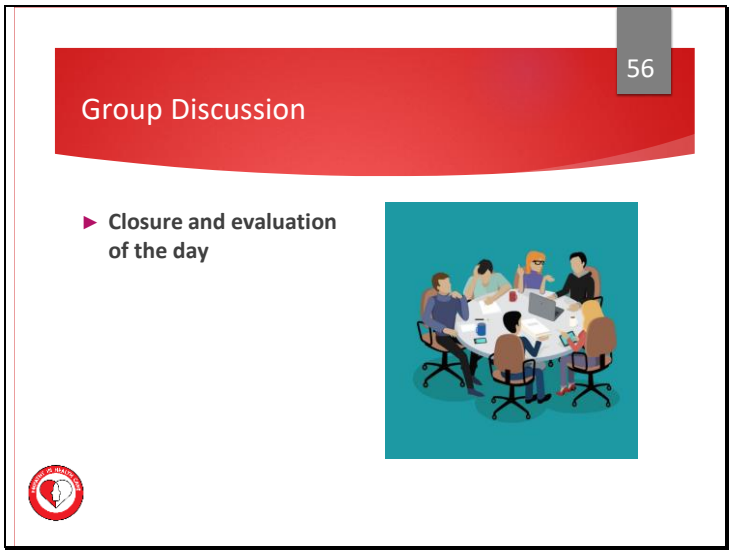
It is the facilitators' group's responsibility to be respectful and sensitive to each other.

Slide 55



Ask the students to get into groups 3 and then hand out the Calgary-Cambridge Framework (elderly). One student plays the patient, one student plays the physiotherapist and the third student is the observer.
After the session, the observer gives feedback to the other two students.

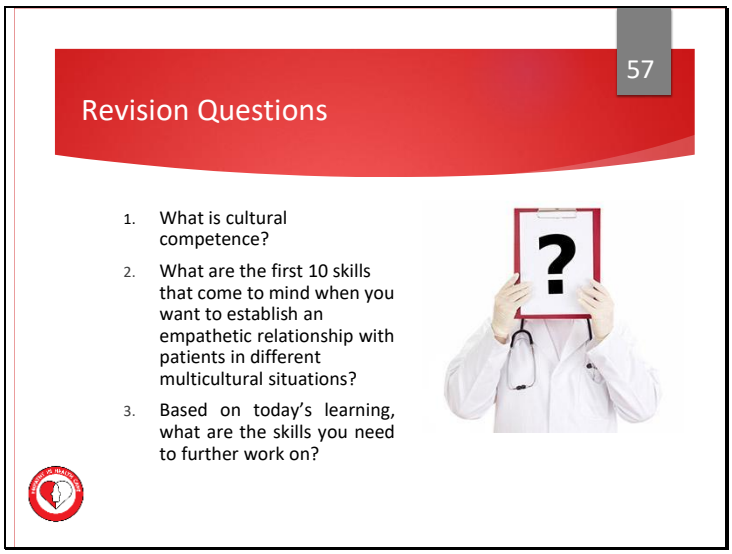
Slide 56



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.

Slide 57



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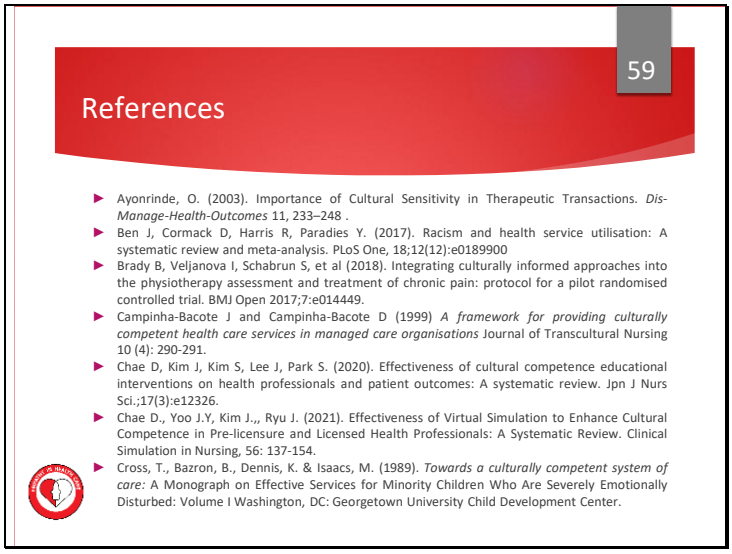

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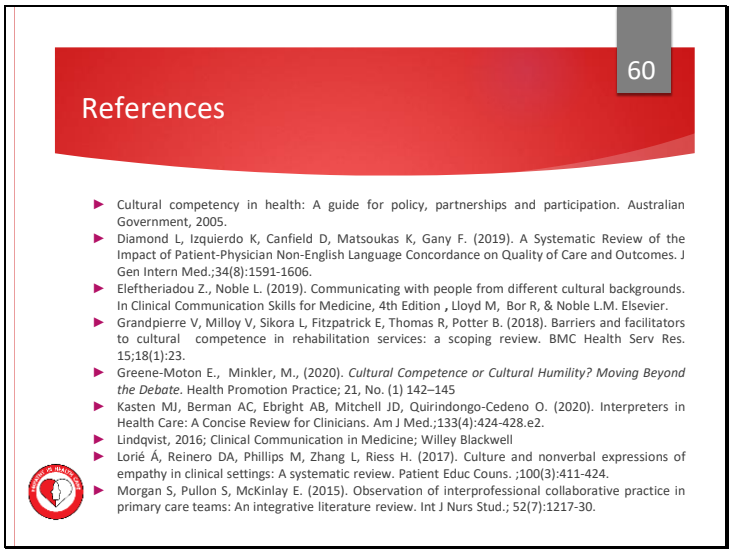

Slide 61

Slide 62

5.3. EDUCATIONAL VIDEOS

Use Handout 1 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 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 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: A WARM UP, BRAIN STORMING (5 MINS)

Slide 12.

A warm up, brain storming (5 mins)

Ask your students to complete this short self-assessment test. Decide which statements are true and which are false.

1. When we use the term diversity we are referring only to persons of other races.
2. A person's religious traditions should have no bearing on his or her health care.
3. Sex and gender have the same meaning.
4. Recognizing our own personal biases can improve communication with diverse patients.
5. We should consider an adult patient's age when instructing them.
6. When caring for patients who are transitioning or transgender, always refer to them according to their sex at birth.

Results

Statements 4 and 5 are true; all other statements are false. (Frain, 2020)

EXERCISE 2: THE TOILET

Slide 24.

Students will watch this **video**, titled the toilet, in order to understand how important is to understand that all have grown up with different values, views, and perspectives.

This quirky animation weaves together personal accounts from transgender, disabled and Muslim people, who share the trials and tribulations of accessing and using public toilets in a society where some are made to feel welcome and others are not.

The video will help students to understand that it will be important to pause and consider their own personal biases as they engage with their patients. It is their responsibility to listen to their patient's concerns and adapt their communication style to communicate effectively during each patient interaction.

EXERCISE 3: WALK APART—WALK TOGETHER ACTIVITY

Slide 14.

This activity is appropriate for a wide variety of ages, ranging from elementary school to adult. Since it requires no special materials, it can be conducted in almost any setting. It is a particularly good activity for groups that are just forming.

Goal

To help participants recognize the differences among people, as well as the many similarities people share.

Time

10–15 minutes

Materials

Open space large enough for two people to take a short walk

Procedure

Two "volunteers" come forward and stand with backs together. Ask the "audience" to call out things about these two volunteers that are different. Differences sometimes pull us apart. As each difference is called, the volunteers take one step apart. When they reach the end of the available space, have them turn and face each other. Now, ask the audience to call out similarities of the volunteers. As each similarity is called out, the volunteers take one step toward each other.

Discussion

1. Think about the things that were noted as differences. How many were things that we can easily see (gender, size, hair color, skin color, dress, wearing glasses or not, etc.)?

2. What were some of the similarities?

While certain physical characteristics are similar, many other similarities are not so visible. Perhaps both "volunteers" are enthusiastic or both have similar interests or goals in life.

3. Talk about the importance of the differences and of the similarities among members of the group. Be sure to talk about the importance of accepting and welcoming all members into the group.

EXERCISE 4: LETS TALK ABOUT MR JONES…..

Slides 17 & Slide 18.

A warm up, brain storming (5 mins) for stereotyping.

Ask students what they believe Mr jones occupation is. Ask them to explain how they reached to this conclusion.

Inform students that Mr Lones is a doctor, however he loves tattoos and he rides a Harley-Davidson.

EXERCISE 5: LAY HEALTH BELIEFS

Slide 28.

A warm up, brain storming (5 mins) for lay health beliefs.

A quick video for evil eye (Greek movie). Ask students:

- **What are lay health beliefs?** ("Lay health beliefs" refer to beliefs or sets of ideas ordinary people have about health and illness),
- **What are the types of health beliefs?** (Health beliefs can be ideas about what is health or healthy, what is causing diseases and how conditions can be managed),
- **Could you think of any examples of lay health beliefs?**

(Belief about health: Health as functional capacity (ability to do things despite the presence of a condition).

Belief about the cause: evil eye (inflicted by other people), supernatural (inflicted by supernatural entities) (these two are not the same and students have been taught about the difference).

Belief about management: invocation, prayer, cultural healers etc.)

- **How lay health beliefs could be a barrier between patient and HCP**?

Health beliefs could make patient to have resistance and not be willing to be informed about evidence-based treatments being difficult to reach a share decision making.

5.7. ADDITIONAL HANDOUTS

HANDOUT 1: CALGARY CAMBRIDGE GUIDE FOR CROSS CULTURAL COMMUNICATION AND SOCIAL DIVERSITY

CALGARY - CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW – CROSS- CULTURAL COMMUNICATION AND SOCIAL DIVERSITY

INITIATING THE SESSION

1. Greet and make introduction

- Check pronunciation of name and how patient would like to be addressed.

2. Demonstrate interest, concern, respect, and attend to the patient's physical comfort

- Demonstrate sensitivity to patient's wish to be interviewed with a family member or by a male or female doctor.
- Offer the help of an interpreter and if agreed, include negotiations during the agenda setting process about the role the interpreter will play.
- Check preferred language to be used in the interview.
- Offer to postpone the interview if the language barrier is too great.
- Consider gender issues between doctor and patient in the interview and in the physical examination.

GATHERING INFORMATION

1. Discover the patient's perspective: ideas, concerns, expectations, effects on life and feelings

Explore the patient's:

- beliefs about causation
- culturally determined expectations of treatment
- family, marital, religious and social more
- understanding of social and community networks
- use of complementary or alternative sources of healthcare.
- Patients from some cultural or social backgrounds may be less aware of links between psychosocial issues and their physical symptoms. Exploring underlying depression and

somatisation in these circumstances is not easy and may depend on remaining open to the patient's point of view and building up trust over a long period of time. Physicians may have to judge when to accept the patient's healthcare choices or views of their illness, rather than risk challenging the patient unsuccessfully with consequent damage to trust or the doctor–patient relationship

2. Involve the patient, encourage them to contribute and to ask questions

- Patients need to be encouraged to ask questions. In a US study, black patients were less likely to ask questions of their oncologists and were less likely to have a companion with them (Eggly et al. 2011).

BUILDING THE RELATIONSHIP

1. Demonstrate appropriate non- verbal behaviour

- Be aware of possible cultural differences in non- verbal behaviour e.g. eye contact, touch, proximity.

2. Accept the patient's views and feelings nonjudgmentally

- Value the patient's ideas and beliefs non- judgementally, without stereotyping or patronising the patient (e.g. accept the patient's and family's wishes for examination, investigation and referral). Avoid making assumptions or check them out. Show sensitivity to cultural differences around issues such as sexual problems, use and abuse of alcohol or other substances, and domestic violence.

3. Provide support

- Overtly express support.

EXPLANATION AND PLANNING

1. Assess the patient's starting point

- Check out cultural context before giving information. This is particularly important when working with disabled patients where the research suggests that these patients feel less well listened to and respected, are given less information and are less commonly involved in planning treatment (Duggan et al. 2010).
- Work with an interpreter during the interview if necessary.
- Check that the interpreter has given information accurately and completely and that the patient understands.

2. Relate explanation to the patient's perspective

- Check cultural context/linguistic ability before giving information. Check whether the patient's concerns have been addressed.

3. Check understanding

- Checking understanding frequently is particularly important where there is a language problem, even if an interpreter is present.
- Give real choices based on the patient's background and situation.

4. Negotiate mutually acceptable plan

- The patient who is unused to a collaborative and sharing partnership with the doctor may find this unfamiliar or difficult to cope with.

References:

Silverman, J., Draper, J., & Kurtz, S. *Skills for communicating with patients* (3rd ed., pp. 237-238). Boca Raton London, New York: CRC Press Taylor & Francis Group.

HANDOUT 2: CALGARY CAMBRIDGE GUIDE FOR MEDICAL INTERVIEW FOR ELDERLY PATIENTS

CALGARY - CAMBRIDGE GUIDE TO THE MEDICAL INTERVIEW – "ELDERLY PATIENTS"

INITIATING THE SESSION

1. Develop rapport

Special consideration needs to be given, for instance, to people who are frail, hearing impaired or partially sighted. Many older patients see the doctor with a relative or other caregiver – here rapport needs to be carefully developed with all parties.

2.Screen

The physician needs to remember that screening and

prioritisation are particularly important with older people because of the potential presence of multiple problems or disabilities over time. Remember that:

● the type and number of problems do not necessarily

predict function

● not all problems are current

● not all problems need help

● not all problems are on the patient's agenda.

3. Listen attentively

Gauging the patient's emotional state early and throughout the interview is very important when consulting with the elderly. Both anxiety and depression are common in the elderly and may not present overtly. Greet and make introduction

GATHERING INFORMATION

1. Ask clarifying questions

Time- frame

Summarise

Often with older patients, the doctor listens to a complex narrative, with large amounts of seemingly elusive data – here the skills of clarifi cation, time- framing, summarising and checking become very important. For example, explicitly requesting that the patient explain their problem from when it fi rst began up to the present or over a particular time period can be helpful.

2. Pick up cues

The patient may be embarrassed but keen to discuss issues such as incontinence, a scrotal hernia or a breast lump – picking up, checking out, and responding to non- verbal or verbal cues is particularly important.

3. Use language appropriately

Clear language is required if the patient is confused, disoriented, upset or has speech or hearing difficulties. Begin by checking out assumptions about what is contributing to the communication difficulties. Are pain or other medications a factor? Are jargon or the language in which you are speaking a problem? When a patient is dysarthric or deaf, check their understanding and ascertain whether the patient would find it easier to communicate via the written word. In hospital check if the patient uses hearing aids and, if so, whether the aids are in place and inworking order.

4. Discover the patient's perspective

The patient's perspective is all- important here. The effect that the condition has on the patient's life often predicts the patient's expectations or follow through regarding treatment and needs to be carefully taken into consideration. Discover the patient's perspective: ideas, concerns, expectations, effects on life and feelings

BUILDING THE RELATIONSHIP

1. Demonstrate appropriate non- verbal behaviour

Patience and time – going at the patient's pace is vital.

2. Demonstrate sensitivity, empathy, acceptance and

support

Older patients and their significant others may need a great deal of emotional as well as practical support. Attempting to appreciate the predicament the patient is in may help you to understand what at first sight is awkward or unusual behaviour. The response to such embarrassing problems as incontinence should be empathic and respectful – offer practical help.

STRUCTURING THE INTERVIEW

1. Summarise

Signpost

Using these two skills in tandem may be particularly useful with older patients, particularly those who have hearing difficulties and loss of memory. Elderly patients can become lost in their own complex narrative and need help in structuring their own account – summary and signposting therefore help both patient and doctor. Structuring the consultation allows the doctor to check out questions or plans with carers as well as the patient: *'I know that you fi nd it hard to get out to do the shopping now … Can I just check with your daughter a moment … where do you live?'*

A memory test can be a useful tool of assessment with elderly patients; this needs to be signposted carefully to avoid embarrassment or anger.1. Assess the patient's starting point

EXPLANATION AND PLANNING

1. Chunk and check

Chunk and check, using clear language free from jargon.

2.Use diagrams

Using diagrams and written instructions particularly in relation to medication is helpful for those with memory loss and their caregivers.

References:

Silverman, J., Draper, J., & Kurtz, S. *Skills for communicating with patients* (3rd ed., pp. 242-243). Boca Raton London, New York: CRC Press Taylor & Francis Group.

HANDOUT 3: THE CULTURAL COMPETENCE SELF-EVALUATION CHECKLIST

Cultural Competence Self-Assessment Checklist

This self-assessment tool is designed to explore individual cultural competence. Its purpose is to help you to consider your skills, knowledge, and awareness of yourself in your interactions with others. Its goal is to assist you to recognize what you can do to become more effective in working and living in a diverse environment.

The term 'culture' includes not only culture related to race, ethnicity and ancestry, but also the culture (e.g.

beliefs, common experiences and ways of being in the world) shared by people with characteristics in common, such as people with disabilities, people who are Lesbian Bisexual, Gay and Transgender (LGBT), people who are deaf, members of faith and spiritual communities, people of various socioeconomic classes, etc.) In this tool, we are focusing on race, ethnicity and ancestry. However, remember that much of the awareness, knowledge and skills which you have gained from past

relationships with people who are different from you are transferable and can help you in your future relationships across difference.

Read each entry in the Awareness, Knowledge and Skills sections Place a check mark in the appropriate column which follows. At the end of each section add up the number of times you have checked that column. Multiple the number of times you have checked "Never" by 1, "Sometimes/Occasionally" by 2, "Fairly Often/Pretty well" by 3 and "Always/Very Well" by 4. The more points you have, the more culturally competent you are becoming.

This is simply a tool. This is not a test. The rating scale is there to help you identify areas of strength and areas that need further development in order to help you reach your goal of cultural competence. Remember that cultural competence is a process, and that learning occurs on a continuum and over a life time. You will not be asked to show anyone your answers unless you choose to do so.

While you complete this assessment, stay in touch with your emotions and remind yourself that learning is a journey.

Awareness		Never	Sometimes/ occasionally	Fairly Often/Pretty Well	Always/very well
Value Diversity	I view human difference as positive and a cause for celebration				
Know myself	I have a clear sense of my own ethnic, cultural and racial identity				
Share my culture	I am aware that in order to learn more about others I need to understand and be prepared to share my own culture				
Be aware of areas of discomfort	I am aware of my discomfort when I encounter differences in race, colour, religion,				

	sexual orientation, language, and ethnicity.				
Check my assumptions	I am aware of the assumptions that I hold about people of cultures different from my own.				
Challenge my stereotypes	I am aware of my stereotypes as they arise and have developed personal strategies for reducing the harm they cause.				
Reflect on how my culture informs my judgement	I am aware of how my cultural perspective influences my judgement about what are 'appropriate', 'normal', or 'superior' behaviours, values, and communication styles.				
Accept ambiguity	I accept that in cross cultural situations there can be uncertainty and that uncertainty can make me anxious. It can also mean that I do not respond quickly and take the time needed to get more information.				

Be curious	I take any opportunity to put myself in places where I can learn about difference and create relationships				
Aware of my privilege if I am White	If I am a White person working with an Aboriginal person or Person of Colour, I understand that I will likely be perceived as a person with power and racial privilege, and that I may not be seen as 'unbiased' or as an ally.				
		1 pt x	2 pt x	3 pt x	4 pt x
Knowledge		Never	Sometimes/ occasionally	Fairly Often/Pretty Well	Always/very well
Gain from my mistakes	I will make mistakes and will learn from them				
Assess the limits of my knowledge	I will recognize that my knowledge of certain cultural groups is limited and commit to creating opportunities to learn more				
Ask questions	I will really listen to the answers before asking another question				

Acknowledge the importance of difference	I know that differences in colour, culture, ethnicity etc. are important parts of an individual's identity which they value and so do I. I will not hide behind the claim of "colour blindness".				
Know the historical experiences of non-European Canadians	I am knowledgeable about historical incidents in Canada's past that demonstrate racism and exclusion towards Canadians of non-European heritage (e.g. the Chinese Head Tax, the Komagata Maru, Indian Act and Japanese internment).				
Understand the influence culture can have	I recognize that cultures change over time and can vary from person to person, as does attachment to culture				
Commit to lifelong learning	I recognize that achieving cultural competence involves a commitment to learning over a life-time				
Understand the impact of racism, sexism, homophobia . . .	I recognize that stereotypical attitudes and discriminatory actions can dehumanize, even encourage violence against individuals because of their membership in groups				

	which are different from myself				
Know my own family history	I know my family's story of immigration and assimilation into Canada				
Know my limitations	I continue to develop my capacity for assessing areas where there are gaps my knowledge				
		1 pt x	2 pt x	3 pt x	4 pt x
Skills		Never	Sometimes/ occasionally	Fairly Often/Pretty Well	Always/very well
Adapt to different situations	I am developing ways to interact respectfully and effectively with individuals and groups				
Challenge discriminatory and/or racist behaviour	I can effectively intervene when I observe others behaving in racist and/or discriminatory manner.				
Communicate across cultures	I am able to adapt my communication style to effectively communicate with people who communicate in ways that are different from my own.				

Seek out situations to expand my skills	I seek out people who challenge me to maintain and increase the cross-cultural skills I have.				
Become engaged	I am actively involved in initiatives, small or big, that promote understanding among members of diverse groups.				
Act respectfully in cross-cultural situations	I can act in ways that demonstrate respect for the culture and beliefs of others.				
Practice cultural protocols	I am learning about and put into practice the specific cultural protocols and practices which necessary for my work.				
Act as an ally	My colleagues who are Aboriginal, immigrants or People of Colour consider me an ally and know that I will support them with culturally appropriate ways.				
Be flexible	I work hard to understand the perspectives of others and consult with my diverse colleagues about culturally respectful and appropriate courses of action.				

Be adaptive	I know and use a variety of relationship building skills to create connections with people who are different from me.				
		1 pt x	2 pt x	3 pt x	4 pt x

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.	**180**	**3.1**	**3.1**	
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**	**3.1**	**3.1**	
Welcome and reflections on Day 2 (Ask the students to discuss any issues and questions they may have from their first day of training)	**60**	**3.1**	**3.1**	
Ppt Part I: on empathy and cultural competence in multicultural and sociocultural environments This part will be face-to-face power point presentation with interactive exercises. **Question and answer session** (at the end of the ppt students may have more questions and the tutors need to encourage these)	**90**	**3.1**	**3.1**	**1-11**
BREAK				
VR Scenario 2 **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**	**60**	**3.1**	**3.1**	**1-13**
BREAK				
VR Scenario 3 **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**	**60**	**3.1**	**3.1**	**1-13**
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.	**60**			

• Ask the students to complete the Training Evaluation Form (Handout 4).		
	340 min=5.6 hours	