



Project Number: 2016-1-RO01-KA203-024630

Communicating with Parents

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Video Tutorial

Communicating with parents



Introduction

During the medical examinations doctors and parents should understand each other, without this there won't be a mutual confidence. This kind of relationship is really complex, there are cognitive and affective barriers in the communication. To ensure good communication between parents and health care providers it's necessary to understand what parents consider important about doctor-patient/parent relationships and what are the most critical points of medical encounters. This chapter present the base of the relationship between doctors and parents and will show how this can be improved by communication skills.

2.1. Transparency of Information about Treatment and Therapy

2.1.1 Introduction

Health care quality level is largely dependent on safety, timeliness, effectiveness, efficiency, equity and good communication between healthcare worker and patient. To provide professional and patient centered healthcare service, improvement of communication skills is essential. Patient centeredness can also be defined as a biopsychosocial approach to medical treatment. The biopsychosocial model, in contrast to the biomedical model, states that health and diseases are determined by a dynamic interaction between biological, psychological, and social factors and no single illness, patient or condition can be reduced to any one aspect. As opposed to this, the biomedical model attributes illness to biological factors, such as viruses, genes, or somatic abnormalities (Borrell-Carrió et al. 2004).



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2.1.2 Paternalistic, mutualistic, consumerist model

When doctors and patients are interacting, the communication takes place between people in non-equal position usually in an emotionally taxing situation. Therefore, this kind of relationship is one of the most complex of human relationships. According to (Roter 2010) there are four basic forms of doctor-patient relationship: paternalistic, mutualistic, consumerist and default. In paternalistic relationships, doctors are dominant while patients stay passive (assume a more passive role). Consumerism is characterized by an active patient and a doctor whose main obligation is to provide medical service and consider the patients' rights. Mutualism is associated with shared decision making and is often advocated as the best type of relationship (patient recall, patient compliance, patient satisfaction improved when physicians applied more positive talk and focused more on partnership building). Default relationships are characterized by the lack of control on each side and considered as the worst of the four types.

Mutualistic approach can be used as an effective tool to communicate with parents and children as well. A recent literature review (Tates & Meeuwesen 2001) indicates that children aged 7 years and older are more accurate than their parents in providing health data that predicts future health outcomes, although they are worse at providing past medical histories. The reliability of reports by children 8-11 years old is quite good on health questionnaires developed especially for this age group. Children's personal reports provide a viable means of monitoring internal experiences of health and distress during childhood and adolescence, which can enhance understanding about trajectories of health and development of illnesses.

Online Resources

Borrel-Carrió F. et al. (2004) The Biopsychosocial Model 25 Years Later: Principles, Practice and Scientific Inquiry. *Annals of Family Medicine*, 2, 576-582.

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1466742/>

The biopsychosocial model is both a philosophy of clinical care and a practical clinical guide. In this article, authors defend the biopsychosocial model as a necessary contribution to the scientific clinical method.

Roter D. (2010) Models of Doctor-patient relationship.

<http://ocw.ihsp.edu/courses/isbtii/PDFs/Session21roterinteraction2010.pdf>

This presentation explores the theoretical and philosophic basis defining the therapeutic relationship and the expression of the therapeutic relationship in actual practice based on empirical study

Tates K., Meeuwesen L. (2001) Doctor-parent-child communication. A (re)view of the literature. *Social Science and Medicine*, 52, 839-851.

https://www.researchgate.net/publication/12096746_Doctor-parent-child_communication_A_review_of_the_literature

Studies on doctor-patient communication focus predominantly on dyadic interactions between adults. The aim of this review study is to evaluate the state of the art of research into doctor-parent-child communication, and to explore the specific role of the child.

2.1.3 Communication Barriers

Good communication with parents is essential. Most of the cases parents are experts in identifying when their child's behavior is not normal for them and may indicate ill health. Pediatricians should acknowledge parents' understanding of their children's personality and health, particularly if the child's age or disability makes it difficult to communicate with them. Pediatricians should discuss any concerns they have about a child's or adolescent's safety or welfare with their parents and keep them informed about what is happening.

Communication barriers mean all those blocks which stop or interrupt the process of communication. There are many hurdles to good communication in the doctor-parent relationship, including cognitive and affective barriers. To reach a common goal of better child health, the physician needs to identify



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the most common communication barriers and learn certain soft skills besides the medical knowledge he holds.

On the cognitive level, pediatricians should check whether they provided enough, too much or just the right amount of information and if the information is understandable for both parent and child. Sometimes physicians have unrealistic expectations towards parents and patients in terms of the level of understanding of the medical jargon and the ability to handle complex information in a stressful situation. Medical jargon must be avoided in almost all cases, even where the parent is a skilled health care professional.

To deliver proper communication on the affective level a pediatrician must take into account the generation the parents belong to, the parent's gender, cultural differences and personal values. The families' value system and expectation must be respected by the healthcare workers. Nonverbal clues such as eye contact, touch, tone of voice is also important. A researcher group comparing patient claims of surgeons found that doctors judged to have more dominant voice tone were almost three times as likely to be in the sued group. Those doctors whose voice tone conveyed concern or anxiety were half as likely to be in the sued group. A negative voice tone (anxiety) coupled with positive words (sympathetic and calming) was associated with more patient satisfaction and better appointment keeping over a 6- month period (Ambady et al. 2002).

Online Resources

Ambady N. et al. (2002) Surgeons' tone of voice: A clue to malpractice history. *Surgery*, 132, 5-9

<http://emerald.tufts.edu/~nambad01/surgeons%20tone%20of%20voice.pdf>

Interpersonal aspects of care, such as the communication behaviors of physicians, are often cited as central to patients' decisions to initiate malpractice litigation. In the current study, authors investigated the relationship between judgments of surgeons' voice tone and their malpractice claims history.



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2.2. Communicating with Parents

2.2.1 Introduction

The pediatrician-parent-patient relationship is built on trust. The most important predictive factors of effective communication between physicians and patients/parents are the perception of interest, caring, warmth, and responsiveness. Trust during pediatric encounters is generally defined as a parent's belief that the pediatric health care provider has their child's best interest in mind. Bad relationship with practitioners is the main source of parents' criticism. Good relationship has a greater influence on patient satisfaction, patient recall and treatment adherence than written instructions or even the time of the medical encounter (Levetown 2008).

To ensure good communication between parents and health care providers it's necessary to understand what parents consider important about doctor-patient/parent relationships and what are the most critical points of medical encounters. The following list is based on the Softis-ped parent questionnaire and parent interviews conducted during the project:

- Clarity, directness: talk the patients' language, direct the conversation to relevant directions, avoid last-minute surprises when feasible
- Honesty: withholding information is only acceptable if the physician is convinced that telling the parents may increase the risk of harm to the child or young person or anyone else. Advice from an experienced colleague or lead clinician may help to find out what is the best way to approach the situation.
- Respect: greet the child and the parent by name, smile
- Listening: engage the parents and the child in a dialogue, at the end of the consultation, ask if the parents have any questions. Give time for the parents to absorb and understand the content of your explanations
- More and better information about the illness, treatment plan, and expected outcome
- More openness about the hazards and side-effects of treatment
- Discussing benefits, risks, information on other treatments available (including not doing the procedure at all). Dismissing complementary and alternative medicine offhand does not convince parents.



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2.2.2 Parents' Role in the Pediatrician-Child-Parent Communication Triangle. Toddlers/ Children/ Adolescents

Parents' role in the doctor—child communication varies according to the child's age. Up to the age of 6-7 the parent is the person who can communicate better and functions as a main translator of the child's symptoms, questions and wishes in general. Around the age of 6-7 children can provide a better description of their symptoms than their parents (Tates & Meeuwesen 2001). In the age group of 6-12-year-old children, parents' role consists mainly of encouraging the child to communicate directly with the doctor, telling the symptoms in his own words, providing help when needed. For pediatricians, parents' stories about the child's hobbies and interests are an excellent information source in building trust and finding out how to build a common ground with little patients. Teenagers' and young adults' medical visits are mostly characterized by a more passive parent or a parent isn't present at the medical encounter at all.

In 2000, Tates and Meeuwesen published a study about Dutch children's participation in medical encounters after examining videotaped observations of 106 medical interviews taken over a period of almost 20 years. Results showed that the child's control in the medical consultation is rather limited, though, over the years, they participate more actively. Another important finding of the study was "the difference in the way GP and parent accommodate their turntaking patterns to the child; **parental control appears to be constant over the years, and is not related to the age of the child, whereas the GP is considering the child's age**" (Tates & Meeuwesen 2000).

The same researchers found that most of the studies have ignored the implications of a child's presence in medical encounters (Tates & Meeuwesen 2001). Instead of focusing on the doctor-child-parent interaction studies on doctor-patient communication examine predominantly the dyadic interactions between adults. Many previous researches that claim to focus on the interaction in the doctor-parent-child triad used methodologies based on dyads. As the interactional dynamics of a triad differ fundamentally from those of a dyad Tates and Meeuwesen proposed to conduct more triadic analyses.

A triadic analysis was carried out by Tates et. al (2002) with the purpose of developing a typology for doctor-parent-child relationships and providing empirical validation for the typology proposed. In total, three different groups have been found by the research team: 1) both adults supportive (was found mainly in interactions with older children) 2) both adults non-supportive (the younger the child the more GP and parent were non-supportive) 3) GP supportive and parent non-supportive (this pattern was also age-related and occurred more frequently in older children). Based on the analyzed videotapes recorded in pediatrician offices the researchers concluded that "ninety **percent of the consultations conclude in a non-participatory manner**, partly due to the **decrease in the GP's supportive behavior**. The finding that GPs are less child-oriented towards the end of the consultation is in accordance with previous studies which state that physicians seldom discuss treatment decisions with children. (...) the parental need to express their concern and to be involved in treatment decisions (...) may explain the shifts in GP's supportive behavior towards the child (...) **The GP hardly ever resumed his or her supportive behavior towards the child after the dyadic discussion with the parent**" (Tates et al. 2002). In total, 58 GPs participated in the study, the majority, 91%, being male.

Therefore, a doctor's main responsibility in the parent-child-doctor communication is 1) to evaluate if the child is ready to participate actively or not in that specific situation (for example, a child with a child with an open, outgoing personality can be different when ill); is there any constant factor that prevents the child from communicating openly (shyness); is the child old/cognitively developed enough to tell his own symptoms 2) to ensure the possibility for the child to tell the symptoms, express his emotions and ask questions, maintain the child's active role in the conversation and reduce parent involvement/engagement when necessary).



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Online Resources

Tates K., Meeuwesen L. (2001) Doctor-parent-child communication. A (re)view of the literature. *Social Science and Medicine*, 52, 839-851.

https://www.researchgate.net/publication/12096746_Doctor-parent-child_communication_A_review_of_the_literature

Studies on doctor–patient communication focus predominantly on dyadic interactions between adults. The aim of this review study is to evaluate the state of the art of research into doctor–parent–child communication, and to explore the specific role of the child.

Tates et al. (2002) Doctor-parent-child relationships: a “pas-de-trois”. *Patient Education and Counseling*, 48, 5-14

https://www.researchgate.net/publication/11168264_Doctor-parent-child_relationships_A_%27pas_de_trois%27

The child’s opportunities to participate are rather limited and parental speaking for the child is, in a way, institutionally co-constructed. This study aimed at further characterizing the relationships within this triad by developing a typology of doctor–parent–child interactions, which classified adult behavior in terms of supporting versus non-supporting child participation.

Tates K., Meeuwesen L. (2000) “Let Mum have their say”: Turntaking in doctor-parent-child communication. *Patient Education and Counseling*, 40, 151-162

<http://www.sciencedirect.com/science/article/pii/S0738399199000750>

Legislation in the Netherlands requires that children should play a part in decision making regarding their own health care. In order to get a grip on aspects of asymmetry and control in doctor–parent–child communication, the present study explores the turntaking patterns in this triad at the general practitioner’s surgery, and makes a comparison over the years.



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2.3. Soft Skills

2.3.1 Patience and listening. Shared attention (multitasking)

Listening well is an essential part of communication. This requires the provision of adequate time and patience, and the willingness to listen to parents' concern. A quiet room, lack of interruptions, provision of chairs for the parents, sitting at an appropriate distance, good eye contact, etc., are helpful to enhance listening and learning from the parents.

The Softis-ped questionnaire found that pediatricians' listening skills are good. However, according to Pilling (2008) a lot of physicians tend to interrupt patients after listening to the symptoms for only 18 seconds because they have only a very limited time to spend with patients. Later, they may lead the entire conversation in a way that the patients will never be able to finish their sentences. Consequently, this often leads to an incomplete description of the child's problems with more than half (54%) of the total symptoms remaining hidden or untold. In case of primary paediatric care this time might be even shorter and more information might be missed as doctors must communicate with two persons instead of only one. Although in case of younger children it is the parent who is more trusted by physicians in terms of providing the correct information about symptoms, the child cannot be ignored during the visit either. Listening to patients doesn't require that much time doctors suppose: most patients finish their first sentences without interruption in 60 seconds and none of them required more than 150 seconds not even when encouraged to do so.

Doctors also tend to overestimate the importance of the symptom mentioned first and interrupt the patient right after the first symptom was told. Patients are often unable to decide which symptom is the most significant and often the order in which they are presenting them has nothing to do with the clinical importance of the given symptom. During control check-ups and appointments most physicians resume the conversation where the previous one ended, continuing the last topic of the previous visit and skipping all the introductory questions.

Most of the times patients have no possibility to ask questions related to the doctor's explanation as 75% of physicians don't give the opportunity to patients to ask more questions. Besides the limited time a doctor can spend with one patient there are also some practicing physicians who don't like being questioned. 76% of patients still have concrete questions after the visit is finished or they left the PCP's office. Without giving enough information, patients might even fail to recognize the good intentions of a doctor. If trust is broken, drug compliance will be worse and patients won't follow doctor's instructions. Patients who are more satisfied with their physicians are more likely to adhere to treatment recommendations and that physicians who are more skilled in the emotional domain of patient interaction are likely to have more satisfied patients. (Pilling 2008)

Online Resources

Pilling J. (2008) Orvos-beteg kommunikáció

<http://egeszsegugyimarketing.hu/orvos-beteg-kommunikacio-pilling-janostol/>

The author present the stages of a medical interview and explain in the detail the task of the several stages.



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2.3.2 Empathy and emotional intelligence (managing emotions, solving things, bad news)

Parents of sick children are going through a difficult experience. Because pediatricians interact with both kids and their parents, they need especially strong interpersonal skills. Bonding with the child's family, showing empathy and understanding the parents' plight is a very important part of the treatment. Parents can react in various ways to stressful situations and a pediatrician must be prepared to handle common negative reactions like blame, anger, a sudden outpouring of grief.

It's very important to accept what the parents say, without judging it. Appreciating parents' efforts and affirming their ability to care for the child both verbally and non-verbally helps building confidence and trust. Parents deserve to know the truth, but its delivery should be tempered with common sense and empathy. If the child's condition is particularly serious, the information can be delivered in small parts over two or more visits. However, if parents express a desire to know everything, it must be told to them.

Many physicians report some level of discomfort with communication, particularly when they must tell parents upsetting or unwelcome information. Breaking bad news alongside the challenge of handling difficult constitute the two main areas doctors experience the most difficulty with. When hearing bad news, parents value a physician who clearly demonstrates a caring attitude and who allows them to talk and to express their emotions. Parents are more attentive to the affective relationship with the doctor than the ability of the doctor to fix the problem.

Levetown and the Committee of Bioethics proposed the following way to communicate bad news:

Open the conversation asking parents what do they know about what is happening to their child. Most likely parents will become upset hearing bad news. Waiting until their attention turns back to the doctor and acknowledging their grief and fear can be a clear sign that a pediatrician is supportive, non-judgmental considers the parents' emotional state. Doctors can use empathetic sentences like "I can see you were not expecting this." (Silence). Once parents told their ideas to the pediatrician, misperceptions should be corrected.

Asking whether they know someone else with this diagnosis or situation and inquiring about their associated experience can also be helpful. Pediatricians can tell parents, for example: "You seem quite upset; I would be, too. (Silence.) Do you know anyone who has had this illness? (Silence.) How did things go for them? "

Gradually sharing additional illness and treatment information might be greatly appreciated by parents. Pediatricians can give complete information over several visits if needed. Written materials and providing a means to contact the physician when additional questions arise give parents the feeling that they are supported by the healthcare team.

Parents might want to have the opportunity of touching or holding the child, particularly newborn infants or children from whom they have been separated during a transport. Ensuring physical contact whenever possible can reduce the child's fear and parents' traumatic experience of the events.

Online Resources

Levetown, M., (2008) Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information. Pediatrics VOLUME 121 / ISSUE 5

<http://pediatrics.aappublications.org/content/121/5/e1441>

This article provides a review of the evidence regarding clinical communication in the pediatric setting, covering the spectrum from outpatient primary care consultation to death notification, and provides practical suggestions to improve communication with patients and families, enabling more effective, efficient, and empathic pediatric health care.



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2.3.3 Simple language, expressive communication

Not all parents have a good educational and intelligence level. Explaining things in simple, clear, and direct language is very important. Clarity and directness are particularly important with parents of limited health literacy. Most patients are not familiar with the medical terms and 89-93% of doctors fail to check if they understood the explanation or not. Therefore, patients memorize only 50-60% of the information provided (Pilling 2008). Parents may have trouble following dosing and care instructions, calculating the correct amount of medication to take and reading nutrition labels. Simple language is a strategy that can be applied on both written and verbal communication.

There are many useful and effective techniques to make communication with parents easier. Using simple words, short sentences and explaining medical jargon constitute the first step in avoiding misunderstandings. Breaking complex information in short statements and providing the most important information first and later focusing on the two or three most important concepts can also be helpful to parents, especially if they have no possibility to take notes. Visual aids like drawings, models and diagrams might facilitate better understanding of biological facts and statistics.

Sometimes language barriers, cultural and personality differences can also influence effectiveness of information transmission. Patients may need another type of information than doctors suppose. Patients want to know the diagnosis, prognosis and what caused the illness while doctors are more treatment and medication centered (Pilling 2008).

Online Resources

Pilling J. (2008) Orvos-beteg kommunikáció

<http://egeszsegugyimarketing.hu/orvos-beteg-kommunikacio-pilling-janostol/>

The author present the stages of a medical interview and explain in the detail the task of the several stages.



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2.3.4 Repetition

To make sure that the parent will understand the information provided first the pediatrician should check what the parents already know about their child's illness. With knowledgeable parents, the discussion can begin at a higher level although it's important to check whether their knowledge or understanding is correct. A lot of parents visit sources without review or control, like websites or health magazines. Parents' comprehension abilities might be influenced by language problems as well as emotional states. Pacing the information, providing it in a logical sequence or breaking it into two or more sessions can result in improved understanding and better information retention. Between two sessions parents have time to absorb the information and cope with the new situation. Pediatricians should be prepared to patiently repeat information and answer questions. It's also important to pay attention to how much information the parents want to know: some of them are interested in every little detail of the child's condition while others simply want a prescription and an assurance that all will be well (Mehta 2008).

After answering parents' questions, a pediatrician can use a teach-back method to find out whether they understood the instructions. Instead of asking if the parents understand what has been told to them a pediatrician can ask questions about how they will implement the treatment plan, what they plan to tell their spouse or the grandparents about the child's care and treatment or about the functioning of the child's medical device.

Audiotapes can serve as effective communication aids although pediatricians still have many concerns using such tapes. Parents can repeatedly listen to the information and can also show them to other family members. Audiotapes are one of the most efficient methods for dissemination of accurate information as "tapes made during outpatient encounters were listened to by parents nearly universally; grandparents listened to them more than half the time (52.8%), 70% were listened to more than once, and one third of parents made a copy to keep for themselves. The tapes were found to be helpful >99% of the time" (Levetown 2008).

Online Resources

Mehta PN. (2008) Communication Skills – Talking to Parents. *Indian Pediatrics*, 45, 300-304.

<http://medind.nic.in/ibv/t08/i4/ibvt08i4p300.pdf>

Good communication is an art that is so far acquired, developed and improved by experience. It enhances patients' understanding and adherence to therapy, and has a therapeutic effect. However, it can also be taught, and assessed, by means of structured programs

Levetown, M., (2008) Communicating With Children and Families: From Everyday Interactions to Skill in Conveying Distressing Information. *Pediatrics* VOLUME 121 / ISSUE 5

<http://pediatrics.aappublications.org/content/121/5/e1441>

This article provides a review of the evidence regarding clinical communication in the pediatric setting, covering the spectrum from outpatient primary care consultation to death notification, and provides practical suggestions to improve communication with patients and families, enabling more effective, efficient, and empathic pediatric health care.



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2.4. Teaching Soft Skills

There are several methods of teaching soft skills in communicating with parents. This chapter presents how soft skills can be taught and learned using: standardized patients/simulations, case-based learning, team-based learning, role-plays and problem-based learning.

2.4.1 Standardized patients

Standardized patients is a method, when someone playing the role of a patient using a clinical scenario to aid doctors/students in applying skills and knowledge. Their purpose is to teach and evaluate patient assessment and interviewing skills. Standardized patients is very useful because it's a real life simulation. It has challenges, because it is based on improvisation and the feedback can be variable.

SPs is one of the best evolving methodologies in medical education.

Online Resources

Kierstan Hanson, Patience for Patients: The Joys and Challenges of Using Standardized Patients in the Clinical Skills Lab

http://www.aacp.org/governance/SIGS/laboratoryinstructors/Documents/Lab_SIG_webinar-16-05-25.pdf

2.4.2. Case-based learning

In CBL doctors/students are motivated to learn their own, hereby they learn the habit of self-learning and integrating knowledge from different subjects to solve problems. It is a small-group method, learning issues are preidentified. CBL method offers more opportunities for problem-solving skills within a session. Case based learning is a more suitable way of learning compared with problem-based learning.

Online Resources

Queen's University: What is Case-based learning?

<http://www.queensu.ca/ctl/what-we-do/teaching-and-assessment-strategies/case-based-learning>

Herreid, C. F. (2007). Start with a story: The case study method of teaching college science. NSTA Press.

http://pal.lter.net.edu/docs/outreach/educators/education_pedagogy_research/start_with_a_story.pdf



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2.4.3. Role-plays

Role-play is widely used method for learning communication in medical education. The use of role-play in small groups is an important method to help learners cultivate the skills required to engage in nuanced, often difficult conversations with seriously ill patients. Though role-play decision-making and interpersonal communication skills can be evaluated.

Online Resources

Vicki A. Jackson, M.D., M.P.H., Anthony L. Back, M.D.: Teaching Communication Skills Using Role-Play: An Experience-Based Guide for Educators (2011)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3155105/>

2.4.4. Team-based learning

Team based learning (TBL) is a student-centered but instructor-led method of learning. The method employs strategies to incorporate the effectiveness of small group learning methods like Problem based learning (PBL) into large-group lecture oriented sessions. (Yeswanth, Ganesh 2013).

the 4 essential principles of Team-based learning (1) properly form and maintain groups; (2) hold students accountable for individual and team work; (3) provide frequent and timely feedback; and (4) design team assignments to promote learning and team development

This method encourages students to become active players, rather than be passive recipients of information. TBL exist of four elements: teams, accountability, feedback, and assignment design.

Online Resources

Yeshwanth K. Rao, Ganesh K. Shenoy: Introducing team based learning in undergraduate pharmacology (2013)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3608283/>

Dhiren Punja, Shivananda N Kalludi, Kirtana M Pai, Raghavendra K Rao, and Murali Dhar: Team-based learning as a teaching strategy for first-year medical students (2014)

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4286580/>

Farland MZ, Sicat BL, Franks AS, Pater KS, Medina MS, Persky AM. Best practices for implementing team-based learning in pharmacy education. Am J Pharm Educ. 2013;77(8):177

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3806961/>



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2.4.5. Problem-based learning

PBL is a learning that results from the process of working towards the understanding or resolution of a problem. (Barrows and Tamblyn, 1980). It is student-centred, problem based, problem-solving, self-directed, reiterative, collaborative, self reflecting and authentic. Problem-based learning has two fundamental postulates-the learning through problem-solving is much more effective for creating a body of knowledge usable in the future, and that physician skills most important for patients are problem-solving skills, rather than memory skills.

Problem based learning enhances the importance of critical thinking and problem solving.

Online Resources

Howard S. Barrows, MD, Robyn M. Tamblyn, BScN: Problem-Based Learning: An Approach to Medical Education

<http://apps.fischlerschool.nova.edu/toolbox/instructionalproducts/edd8124/fall11/1980-BarrowsTamblyn-PBL.pdf>



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2.5. Practical activities

It is very difficult to learn soft skills from literature or on theoretical basis. The best way to develop soft skills is to practise them in real life environment. The following practical activities advise different complex situations in which the above listed soft skills as careful listening, expressive communication, emotionally reach behaviour can be put into practice.

Practical Activity - Listening

This practical activity improve your listening skills with active listening

<http://softis-ped.pixel-online.org/files/training/IO2/2/PA1-Listening.pdf>

Practical Activity - Simple language and expressive communication

This practical activity addresses the following problem: how to explain complex issues in an understandable way; parents who only understand simple language/doctors using medical jargon

http://softis-ped.pixel-online.org/files/training/IO2/2/PA2-Expressive_communication.pdf

Practical Activity - Older child & non-supportive parent & supportive paediatrician (Emotional intelligence)

This practical activity describes how to communicate with older child or non-supportive parent or supportive pediatrician/GP. The activity focuses on the role emotional intelligence. The used method is role-play.

http://softis-ped.pixel-online.org/files/training/IO2/2/PA3-Emotional_Intelligence.pdf

Practical Activity - Communicating bad news (Emotional intelligence; empathy)

Using a Standardized Parent simulation participants will be trained how to communicate bad news and how to manage different responses.

<http://softis-ped.pixel-online.org/files/training/IO2/2/PA4-Empathy.pdf>

Practical Activity - Difficult parents (Emotional intelligence; persuasion)

This activity is an exercise how to handle difficult parents. In the example parents resisting vaccination of the child is selected.

<http://softis-ped.pixel-online.org/files/training/IO2/2/PA5-Persuasion.pdf>



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2.6. Case Studies

The case studies intend to emulate relatively complex situation in which a given learning objective is demonstrated. The case studies on one hand complex, on the other hand reflect only a selected aspects of learning objectives. Students are expected coping with rather the specifics of the cases however during this exercise the indirect concepts also should be addressed.

Case Study - Parent withholding information from the child (Emotional intelligence; empathy)

Problem addressed: parent withholding information from the child

http://softis-ped.pixel-online.org/files/training/IO2/2/Case1-Withheld_information.pdf

Case Study - Content/dosage of information (Emotional intelligence, empathy; expressive communication, persuasion)

Part of the consideration of content/dosage of information is evaluating how the information may be perceived. Is there a risk a person may be hypersensitive or “allergic” to certain information? Complications may occur if this is not considered in advance.

http://softis-ped.pixel-online.org/files/training/IO2/2/Case2-Information_dosage.pdf

Case Study - Cultural/religious differences (Emotional intelligence, empathy; expressive communication, persuasion)

Cultural and religious backgrounds may influence how things said with the best of intentions may be interpreted in unexpected ways.

http://softis-ped.pixel-online.org/files/training/IO2/2/Case3-Cultural_differences.pdf

Case Study - Statements intended to comfort and maintain hope were interpreted as factual medical information (Emotional intelligence, empathy; expressive communication, persuasion)

In this case statements intended to comfort and maintain hope were interpreted as factual medical information.

http://softis-ped.pixel-online.org/files/training/IO2/2/Case4-Maintain_hope.pdf



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