STORYAID.EU
DELPHI STUDY REPORT

ERASMUS+ PROGRAMME

2014-2020

KEY ACTION 2: STRATEGIC PARTNERSHIP

HUMANIZING HEALTHCARE EDUCATION THROUGH THE USE OF STORYTELLING

AGREEMENT N°2019-1-ES01-KA203-065728

StoryAidEU
Humanizing Healthcare Education through the use of Storytelling
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RGU ABERDEEN
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AGENFOR ITALIA
International Network for Health Workforce Education
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Delphi Study Report

October 2020

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Introduction

Why undertake a Delphi Study?

The project team decided it would be appropriate during the first year of the project to undertake a needs analysis of the sector and that it would be essential for a high degree of consensus to be reached among the relevant stakeholders. The first project meetings made clear that there was a need in the initial stages for a scoping literature review to be completed alongside the development of key concepts as the foundations for the project. Once these were completed it was decided that a Delphi consensus survey would establish a baseline for the second year of the project and allow the team to develop the StoryAidEU teaching resources on a strong and a widely agreed evidence base which considered the needs of key stakeholders.

What is a Delphi Study?

A Delphi study is a consensus methodology used to determine the extent to which experts or lay people agree about a given issue and with each other. If there are areas where they disagree, the method is used to achieve a consensus opinion. A Delphi study is usually conducted through questionnaires to collect data to develop consensus over ideas, concepts or processes. The online Delphi approach used in this study is often selected over other consensus methods, such as the nominal group technique, as it allows for data collection at a distance, avoiding the need for experts/participants to meet face-to-face, leading to a broader group base. This was also a highly appropriate method to be used during the Covid-19 crisis. It allows a set of decisions to be developed based on a structured group of participants.

Consensus research methods are particularly suited to the development of policies, quality indicators and professional norms and attempt to systematically gather opinion usually in areas where there is a lack of, or incomplete, evidence. The purpose of this research was to gather consensus guidance to facilitate the development of resources to humanize healthcare through the technique of storytelling.

The Delphi technique has features that are beneficial to this type of research:

- Participants are a discrete group of individuals with expertise or experience of the topics seeking consensus;
- Consulting with the participants follows a structured format that allows research to be democratic, transparent and time-limited;
- Conclusions carry more weight than those from a less formal decision-making process such as a focus group or a survey questionnaire.

Expert participants

The project team decided that having a small discrete group of stakeholders, as might be the more normal for a Delphi study, was not appropriate for this type of research where multi stakeholder, multi professional, and multi country or area perspectives were needed. Therefore a larger, more diverse group throughout Europe and globally with key strategic and operational roles in implementing health care and education initiatives were invited to be participants in the research. The International Network for Health Workforce Education (INHWE) website was the main dissemination point for the survey, and social media and email were used to introduce and promote the survey. Stakeholders were invited to express an interest in participation and to also identify and forward the survey link to other key individuals in their organization or networks which expanded the reach of the survey to a wider network of participants. The INHWE website included the comprehensive study information, and the survey link.

Method

Questionnaire development

The first round of data collection in the Delphi technique usually involves a synthesis of statements to be used in later rounds. This was not necessary in this project for two reasons: an initial scoping review of the literature identified issues to be considered; and three concept analyses had already been conducted by the research team. This allowed the questionnaire to be developed based on this previous research.

Participants were recruited from stakeholders in Interprofessional Education (IPE) digital health, health care and storytelling with key strategic and operational roles in implementing educational or practice initiatives. An introductory email was sent to potential participants, as well the use of targeted social media posts with embedded links to the INHWE website. Initial contacts were asked to forward the email to other key individuals in their organization or networks. Individuals expressing interest were able to access the questionnaire, complete it anonymously, and read the study information and informed consent details from the INHWE website.

In the prefunding stage of the project the ethical issues of the research were reviewed by one of the project partners at the Robert Gordon University in Aberdeen, UK. There were no ethical issues identified as the survey was anonymous for the participants and conformed to the latest General Data Protection Regulation (GDPR) 2018 EU legislation.

Organizations targeted include those listed below:

Organization	Multi profession	Single Profession	Geographical Area
Centre for the Advancement of IPE	x		UK mainly but with Global reach
Aberdeen Student IPE society	x		Aberdeen, Scotland
University of East Anglia Student Society	x		South of England, UK
IP. Global	x		Global
Caregiver trainers	x		Italy
Nursing student society		x	Ireland
School of Economics, Law and Medical Sciences	x		Poland
INHWE network	x		Global

The initial review of the literature identified issues to be considered in the survey, and the project team decided it would be appropriate to gain consensus (or not) related to the three concept analyses already developed by the team. This research facilitated the development of criteria, which were organized into the three themes of IPE, humanism in healthcare and storytelling. These were presented as statements and a five-point Likert scale was used to measure strength of agreement or disagreement, with space for free text comments. The participants were also given the opportunity to provide additional comments or statements. Demographic details were collected on age, gender, profession, role, and geographical area. This was to allow for more in-depth statistical testing analysis if appropriate. Details on preferred types of teaching resources, a gap analysis of experience, and some preliminary comments on the response to COVID-19 for teaching and learning were also collected. These responses would inform plans for Year 2 of the project and the development of the teaching resources. The draft questionnaire was tested for face and content validity by the project team (which consists of highly experienced individuals in the area under study) and was further piloted on the INHWE website with the workgroup convenors for technical issues and sense checking. Small changes in wording were made. The project team also tested the technical functionality and found no issues.

Full study data collection

One week prior to the Delphi link going live an email alert was sent to all INHWE members and shared widely on social media. The data collection commenced with the web link to the questionnaire being disseminated on the INHWE website and on social media accounts as well as to relevant organizations identified by the project team. The questionnaire was open to participants for two weeks from 4 August 2020 until 21 August 2020. The anonymous, completed questionnaires were submitted to the INHWE team online and a .CSV file of the responses were sent to the research team at The Robert Gordon University (RGU) (LD and MF) for statistical analysis. Following the completion of Round One, the data was analysed for achievement of consensus. Definition of consensus has been noted to be one of the most contentious components of the Delphi method. Consensus was defined for this study as ≥70% agreement (ranked strongly agree/agree) with each statement, which followed the consensus from a systematic review on Delphi studies (Diamond et al, 2014). The results in Round One of the study achieved consensus and it was therefore deemed unnecessary to conduct further rounds.

Results

StoryAid Delphi Survey Round One

156 responses were received. This section details the profiles of the respondents and their responses to the closed and open-ended questions. Its findings are presented in terms of:

· Frequency of responses
· Associations between responses and participant characteristics
· Analysis of qualitative responses

The quantitative data (closed-ended questions) were analysed using SPSS (Version 25) and the qualitative (open-ended questions) with NVivo (Version 12).

Associations between responses and participant characteristics were explored, where the criteria for analysis was met, using Chi-square analysis. However, due to small numbers for some responses the criteria for Chi-analysis were not met for many questions; i.e., more than 20% of cells in a table had an expected cell count of less than five.

For analysis purposes some demographic characteristic categories and some responses were amalgamated. As there were no missing responses actual percentages are reported.

3.1 Demographics

i. Location of participants

There was coverage across the five continents, with responses from 37 countries. The majority of participants were Europe based: 22 countries in Europe; three in Africa; five in Asia; two in Australia/Oceania; two in North America, and three in South America. Table 1 details the location of where the participants are based.

ii. Age profile of participants

There was representation across all age groups. Table 2 outlines the age profile of the participants.

iii. Role of participants

Responses were received from all designated roles in the survey. Table 3 outlines the role that the participants hold.

TABLE 1: LOCATION OF PARTICIPANT

	Frequency	Percent
Europe	129	82.7
Africa	4	2.6
Asia	5	3.2
Australia/Oceania	6	3.8
North America	9	5.8
South America	3	1.9
Total	156	100.0

TABLE 2: AGE OF PARTICIPANT		
	Frequency	Percent
Under 20	7	4.5
21 to 30	37	23.7
31 to 40	29	18.6
41 to 50	27	17.3
51 to 60	36	23.1
Over 60	20	12.8
Total	156	100.0

TABLE 3: ROLE OF PARTICIPANT		
	Frequency	Percent
Educator	61	39.1
Practitioner	19	12.2
Researcher	17	10.9
Student	48	30.8
Trainer	7	4.5
Other	4	2.6
Total	156	100.0

Four participants responded 'Other', these were further detailed as: 'Educator, research and consultant'; 'Independent adviser' and 'EU nursing and planner' (one missing response).

All participants aged under 20 were Students, 73% of those aged 21-30 were Students. For analysis purposes the age groups 'under 20' and '21 to 30' were combined: in the age group '30 and under' 77% were Students.

For the age group '31-40' the main roles were: 31% Student, 28% Educator, 21% Practitioner and 10% Trainer.

- '41-50' age group: 41% Educator, 19% Researcher, 19% Student and 11% Trainer;
- '51-60' age group: 61% Educator, 19% Researcher and 17% Practitioner;
- 'over 60' age group: 85% Educator, and
- one 'Other' was reported in each of the four age groups, aged from 31 to 60 and over.

iv. Discipline of participants

Table 4 outlines the disciplines in which the participants work. 31 participants responded 'Other' and these were re-categorized.

TABLE 4: DISCIPLINE OF PARTICIPANT					
	Frequency	Percent		Frequency	Percent
Engineering	3	1.9	Psychology	3	1.9
Manager	5	3.2	Public Health	5	3.2
Medical	29	18.6	Radiography	5	3.2
Midwifery	4	2.6	Physiotherapist	3	1.9
Nursing	84	53.8	Psychology	3	1.9
Pharmacist	4	2.6	Other	11	7.1
Physiotherapist	3	1.9	Total	156	100.0

Additional single responses (0.6%) were also received for: Allied health professionals; Arts and health; Dietician; Education and leadership; Entrepreneurship; Generic (soft) skills; Health care innovation technology; Health education policy; Healthcare administration, and Occupational Therapist (one missing response).

3.2 Concept definition

Using a five-point Likert scale, participants were asked to rate to what extent they agreed with the definitions given for 'humanism', 'storytelling' and 'interprofessional education' (IPE). This section included a 'neutral' response for where participants neither agreed nor disagreed with the statements. A neutral response can indicate that the participant does not understand the question, that they feel that the question is not relevant to them, or they are uncertain of their response; as such neutral responses are reported where they may have particular relevance to responses to the statements.

Combining responses of 'agree' with 'strongly agree', and 'disagree' with 'strongly disagree', a high level of consensus was reported with the definitions:

"Humanism is defined as an authentic relationship embracing presence, mutuality and commitment, by becoming part of another person's story, resulting in human growth"

- 77% agreed with this statement (25% 'strongly agree'), only four percent disagreed; 19% did not agree nor disagree ('neutral' response).
- There was a high level of agreement across geographical location: from 75% of participants based in Europe and Africa; 78% in North America; 83% in Australia/Oceania, to 100% in Asia and South America[1] [2].
- Agreement varied across age, with the greatest agreement in the over 60 age group (95%) and the 41-50 age group (89%). Seventy eight percent of those aged 51-60 agreed. The lowest was in the age groups under 30 (68%) and 31-40 (66%).
- 80% of Educators; 74% of Practitioners; 82% of Researchers, and 77% of Students agreed. The lowest agreement was with Trainers (57%, four participants) and 'Other' (50%, two participants).
- Across the different disciplines there was a high level of agreement in the two largest groups: nursing 80% (84 participants, 54% of participants) and medical 86% (29 participants, 19% of participants). This was also found across the other disciplines: radiography 80%; midwifery and pharmacy (both 75%); physiotherapy and psychology (both 67%); public health (60%), and 'other' (73%). The lowest was for engineering (33%, one participant; 67% 'neutral') and manager (40%, two participants; 60% neutral).

"Interprofessional education is defined as developing healthcare students to learn with, from and about each other to teach them to work collaboratively in practice, resulting in improved patient care"

- 90% agreed with this statement (49% 'strongly agree', only four percent disagreed; six percent neither agreed nor disagreed).
- There was a high level of agreement across geographical location: from 78% of participants based in North America; 90% in Europe, and 100% in Africa, Asia, Australia/Oceania and South America.
- Agreement again varied across age but there was a high level of consensus, with the greatest agreement in the over 60 age group (100%) and the 41-50 age group (96%). 91% in the under 30 age group agreed and 89% of those aged 51-60 agreed. The lowest was in the age group 31-40 (79%).
- 93% of Educators; 95% of Practitioners; 88% of Researchers and 92% of Students agreed. The lowest agreement was among Trainers (71%, four participants) and 'Other' (50%, two participants).

[1] Participant numbers for each of the continents other than Europe was less than eight

[2] Criteria for Chi-square analysis not met with for demographic characteristics due to small numbers in some categories

- Across the different disciplines there was once again a high level of agreement: nursing (92%) and medical (93%). Again, this was found across the other disciplines: midwifery, pharmacy, physiotherapy and radiography (all 100%); public health 80%, and 'other' 92%. The lowest was for engineering and psychology (both 67%, both two participants) and manager 60% (three participants; 40% 'neutral').

"Storytelling is defined as a holistic and culturally co-created experience, which authentically navigates and engages human beings in a dynamic process of sharing, learning and celebrating our interconnected lives"

- 80% agreed with this statement (33% 'strongly agree'), only two percent disagreed; 18% neither agreed nor disagreed.
- Again, there was a high level of agreement across geographical location: from 75% of participants based in Africa; 78% in North America; 79% in Europe; 83% in Australia/Oceania, and 100% in Asia and South America.
- Agreement again varied across age but slightly less so than with the other definitions, with the greatest agreement in the over 60 age group (90%) and the 41-50 age group (85%). 83% in the 51-60 age group agreed. The lowest was in the age groups 31-40 (76%) and under 30 (73%).
- 89% of Educators; 94% of Researchers; 86% of Trainers, and 100% of 'Others' (four participants) agreed. The lowest agreement was in Practitioners (68%) and Students (67%).
- Participants in nursing and medical disciplines reported a high level of agreement (75% and 90% respectively). The highest agreement was for manager, physiotherapy and radiography disciplines (all 100%). Public health reported 80%; midwifery 75%, and 'other' 91%. The lowest was for pharmacy 50%, and engineering and psychology (both 67%).
- The responses indicate that there was consensus with the concept analysis definitions of 'humanism', 'interprofessional education' and 'storytelling', particularly interprofessional education.
- Although there was some variance, there was a high level of consensus across the demographic groups. With reference to age, the greatest consensus was in the over 60 and 41-50 age groups, and the lowest consensus generally in the younger age groups.
- The greatest variance related to the humanism definition, related to the over 60 age group (95%) compared to the 31-40 age group (66%). There was less consensus for those employed in Trainer and 'Other' roles (humanism and interprofessional education concepts); also those in engineering, manager and psychology disciplines. A limitation to this study relates to the small participant numbers in some roles and disciplines and this needs to be taken into consideration when interpreting the results.

Concept definition additional comments

Participants were asked for additional comments relating to the concept definitions. 20 responses were received (% rate of 12%)

- Generally there was agreement that humanism and interprofessional education (IPE) need to play a greater role in the education of health professionals, and that the three concepts have to work together more than ever to the benefit of the healthcare setting. It was commented that healthcare focuses too much on 'care and cure' and that it needs to focus more on the 'core' (heart) and that humanism strongly relates to this. Furthermore, it was stated that IPE is core to building teamwork, to identifying diverse patient needs, and to understanding how to help patients from different perspectives.

- There was some question over the terminology of the concept of ‘humanism’ as a specific religion, and concern that this would bring a particular religious belief into the learning environment. It was commented that humanism was not a word that was heard often or that is commonly used. There was concern that concepts like ‘humanizing’ and ‘storytelling’ could become ‘buzz words’ and thus become meaningless. There was a query as to whether ‘humanism’ and ‘storytelling’ are general concepts or specific tools and methods.
- Participants evidenced the current use of using the patient experience and students working with patients together on patients’ priorities, which was termed ‘patient advocacy’. Moreover, it was stated that all methods involving storytelling (such as case studies and simulated clients) can be used to support IPE. Students were found to engage well when storytelling is integrated into teaching, as they can relate teaching to a story or experience.
- Additionally, it was expressed that healthcare students need to learn not only from each other and health professionals, but also from other professions that may not necessarily be working in healthcare settings. From this multi-disciplinary interaction mutual experience can inform learning.

3.3 Concept experience

Again there was a high level of participants reporting that they had either used or felt comfortable using humanism (77%), interprofessional education (65%) and storytelling (72%). Table 5 details responses relating to participants' experiences of the concepts.

TABLE 5: EXPERIENCE OF CONCEPTS

	Humanism		IPE		Storytelling	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
I have never heard of it	36	23.1	55	35.3	43	27.6
I feel comfortable using	57	36.5	45	28.8	45	28.8
I have used it	63	40.4	56	35.9	68	43.6
Total	156	100.0	156	100.0	156	100.0

Concept experience across geographical location

Due to small numbers of participants based on some continents, statistical analysis could not be conducted for comparison across location. For those participants based in Europe, 24% had never heard of humanism, 40% had never heard of interprofessional education, and 33% had never heard of storytelling. Overall 76% had either used humanism or felt comfortable using it; 60% had either used interprofessional education or felt comfortable using it, and 67% had either used storytelling or felt comfortable using it. Participants reported feeling less comfortable using storytelling and interprofessional education, with 24% and 26% respectively reporting that they feel comfortable using them, compared to 36% for humanism.

Notable findings across the other continents were: low awareness in Asia of humanism with 40% (three participants) never having heard of it; the majority of participants in Africa (75%, three participants) feeling comfortable using it, and all participants in North America (nine participants) and South America (three participants) either having used or felt comfortable using humanism.

50% of participants in Africa had not heard of interprofessional education (two participants). With the exception of Europe and Africa, all participants based on the other continents reported that they had either used or felt comfortable using interprofessional education. Again, with the exception of Europe, on the other continents there was awareness of the concept of storytelling with participants all either having used or felt comfortable using it. Those based in Asia reported the highest level, with 80% (four participants) reporting feeling comfortable using storytelling. While there is not enough evidence in this small cohort of responses it is worthwhile pondering whether this reflects that the culture in Asia is more accepting of storytelling.

Concept experience across age group

Humanism

A third of those aged 31-40 (35%) and just over a quarter aged 30 and under (30%) had never heard of humanism. 100% of those aged over 60 had either used it or felt comfortable using it; 82% of the 41-50 age group, and 78% of those aged 51-60. Despite this difference, 66% of those aged 31-40 and 63% of those aged 30 and under had either used it or felt comfortable using it; although only 25% of those aged 30 and under reported feeling comfortable using it, similarly for those aged 51-60 (25%). This was compared to 40% of those aged over 60, and 59% of those aged 41-50 reporting feeling

comfortable using it. This difference across the age groups in experience was found to be statistically significant (χ2 (8) = 18.94, (p > 0.05), V = .246)[3].

Interprofessional education

Half of those aged under 30 (50%) and over a third of those aged 31-40 (38%) had never heard of interprofessional education. Eighty five percent of those aged over 60 had either used it or felt comfortable using it, and 70% of the 51-60 and 41-50 age groups. Although 62% of those aged 31-40 had either used it or felt comfortable using it, only 24% reported feeling comfortable using it; similarly for those aged 30 and under with 50% and 14% respectively. This was compared to 55% of those aged over 60, and 37% of those aged 41-50 reporting feeling comfortable using it. Across the age groups no significant difference was found in experience (p > 0.05).

Storytelling

Half of those aged 30 and under (52%) and just over a third of those aged 31-40 (38%) had never heard of storytelling. 95% of the 51-60 age group had either used it or felt comfortable using it; 90% of those aged over 60, and 81% aged 41-50. This compared to 62% in the 31-40 age group and 48% of those aged 30 and under. As with humanism and interprofessional education, those in the under 30 and 31-40 age groups felt less comfortable using it, 16% and 24% respectively. However, in contrast those aged over 60 felt less comfortable using storytelling (20%) than humanism or interprofessional education. This difference across the age groups in experience was found to be statistically significant (χ2 (8) = 35.95, (p > 0.001), V = .335).

Comparison across the age groups highlighted that those in the 30 and under and 41-50 age groups felt less comfortable using all three concepts, whilst those aged 41-50 reported a consistently high level across all three concepts.

Concept experience across role

Across the different roles, there was a high number of participants who had either used humanism, or felt comfortable using humanism: 84% Educator; 74% Practitioner; 65% Researcher; 77% Student, and 50% 'Other' (four participants). The highest number of participants by role who had never heard of humanism was amongst the Researchers (36%); however, they also reported the highest level of feeling comfortable using humanism (59%).

With the exception of Educators, the number of participants who had used interprofessional education, or felt comfortable using interprofessional education in their role was less than humanism: 85% Educator; 53% Practitioner; 53% Researcher; 50% Student, and 75% 'Other'. There was a greater number of participants who had never heard of the concept, with the highest amongst Trainer (57%), Researcher and Practitioner (both 47%) roles.

Again, high levels of usage were reported for storytelling: 94% Educator; 68% Practitioner; 82% Researcher; 42% Student; 72% Trainer, and 100% 'Other'. There was consistency with the majority of Educators reporting using the concepts, with level of comfortableness highest with interprofessional education (46%) compared to 41% for storytelling, and 33% humanism. There was no consistent pattern of not feeling comfortable using the concepts across the roles: the lowest reported was 13% of Students and 14% of Trainers for interprofessional education, and 11% of Practitioners and 15% of Students for storytelling; levels for humanism were generally higher across the roles.

[3] Criteria met for Chi-square analysis across age group for all three concepts

Concept experience across discipline

The two largest disciplines were 'nursing' (54%, 84 participants) and 'medical' (19%, 29 participants). 82% of those in nursing and 86% in the medical discipline responded that they used humanism or felt comfortable using humanism; 37% and 45% respectively responding that they felt comfortable using it. Only 18% and 14% respectively responded that they had never heard of it. Although there were smaller numbers involved, participants in each of the other disciplines responded that they had either used humanism or felt comfortable using humanism.

61% in nursing and 66% in the medical discipline responded that they had used interprofessional education or felt comfortable using interprofessional education; 26% and 17% respectively responding that they felt comfortable using it, which was less than that for humanism. Approximately a third from each discipline had never heard of it (39% and 35% respectively); although across the other disciplines there was generally more awareness of it than humanism. Again, participants in each of the other disciplines responded that they had either used interprofessional education or felt comfortable using it; with all those involved in physiotherapy responding that they felt comfortable using interprofessional education (three participants).

A similar number in nursing had used storytelling or felt comfortable using it (61%); whilst 96% in the medical discipline responded that they had used storytelling or felt comfortable using it. However, only approximately a quarter of these participants reported feeling comfortable using storytelling (23% and 28% respectively). 39% of participants involved with nursing had never heard of the concept, in comparison with only 3% involved in the medical discipline.

Overall, a comparison across the disciplines found that there was greater awareness of storytelling than interprofessional education, and a greater awareness of interprofessional education than humanism. Similarly participants reported feeling more comfortable using storytelling than interprofessional education, and interprofessional education more than humanism. There was greater awareness of the concepts of those in the physiotherapy, medical and psychology disciplines, and less so in the management, engineering and midwifery disciplines.

3.4 Concept application

Table 6 details the level of agreement to the application of the concepts in the health and social care setting. Level of agreement with the statements pertaining to humanism, storytelling and interprofessional education was obtained by combining 'agree' and 'strongly agree' responses. This section also included a 'neutral' response for where participants neither agreed nor disagreed with the statements. Response rates ranged from 6% to 38%, with an average of 21%.

A considerable number of participants responded positively towards the application of humanism in the healthcare setting. Seventy eight percent agreed (27% 'strongly agree') that they 'understand how humanism can be applied to health and social care'. This was even more so for that 'humanizing health and social care is necessary', with 89% agreeing (46% 'strongly agreeing'). No participants 'strongly disagreed' with this, and there was a small number of 'neutral responses (10%).

However, with reference to 'already teaching humanism in health and social care', less than half of participants (44%) already do so (16% 'strongly agree'). Furthermore, 79% responded that they 'need more skills to teach humanism in health and social care', with nearly a half 'agreeing' (46%) and a third 'strongly agreeing' (33%).

The responses indicate that there is consensus with the importance of humanism in the health and social care setting, but at present it has limited application to teaching, and there is a need for more skills to teach humanism in health and social care. The majority of participants agreed that 'storytelling can help to humanize health and social care' (83%), with 40% 'strongly agreeing' with this statement. No participants responded that they disagreed. Again, a large number of participants (70%) agreed that they 'understand how storytelling can be applied in health and social care' (24% 'strongly agree'); only a small number disagreed with this statement (11%).

However, with reference to 'already using storytelling in my teaching', only half of participants agreed (50%) that they already do so (21% 'strongly agree'). Thirty one percent disagreed with this statement. Furthermore, 71% responded that they 'need more skills to use storytelling in my courses', with nearly a half 'agreeing' (44%) and just over a quarter 'strongly agreeing' (28%); only a small number disagreed (five percent), 24% gave a 'neutral' response.

TABLE 6: CONCEPT APPLICATION	'Agree' or 'Strongly agree'	'Neutral'	'Disagree' or 'Strongly disagree'
	Percent	Percent	Percent
I understand how humanism can be applied to health and social care	78.2	16.7	5.1
Humanizing health and social care is necessary	89.1	10.3	.6
I already teach humanism in health and social care	43.6	28.2	28.2
Storytelling can help to humanize health and social care	82.7	17.3	0
I need more skills to teach humanism in health and social care	78.8	16.7	4.5
I understand how storytelling can be applied in health and social care	69.9	19.2	10.9
I already use storytelling in my teaching	50.0	19.2	30.8
I need more skills to use storytelling in my courses	71.2	24.4	4.5
Storytelling is vital to help humanize health and social care	71.2	28.2	.6
To humanize health care I need to use storytelling	53.8	37.8	8.3
Interprofessional education is important in teaching health care students	92.3	6.4	1.3
I need more skills to teach interprofessional education	60.3	26.3	13.5
I already am involved in teaching interprofessional education	62.2	22.4	15.4
Interprofessional education is more necessary than ever	73.1	23.7	3.2
I understand how storytelling, humanism and interprofessional education can work together	70.5	19.2	10.3
Interprofessional education can help to humanize health and social care	82.1	16.7	1.3

Over two thirds of participants agreed that 'storytelling is vital to help humanize health and social care' (46% 'agree'; 26% 'strongly agree'); only one person disagreed with this statement, 28% gave a 'neutral' response. However, there was less agreement that the participants themselves needed to use storytelling to humanize health care (54%): 'to humanize health care I need to use storytelling' (34% agree; 20% 'strongly agree'). Thirty eight percent responded that they neither agreed nor disagreed with the statement.

The responses indicate that there is consensus with the importance of storytelling in the health and social care setting, but at present it has limited application to teaching, and there is a need for more skills to teach storytelling in health and social care.

The majority of participants agreed that 'interprofessional education is important in teaching health care students' (92%), with 59% 'strongly agreeing', and no participants 'strongly disagreeing', and a small number of 'neutral' responses (six percent). There was also a high level of agreement that 'interprofessional education is more necessary than ever' (73%; 44% 'strongly agree'); whilst 82% agreed that 'interprofessional education can help to humanize health and social care ('strongly agree' 30%).

Sixty two percent of participants responded that they are 'already involved in teaching interprofessional education' (26% 'strongly agree'). However, 60% of participants responded that they 'need more skills to teach interprofessional education' (19% 'strongly agreed'); only 14% disagreed with this statement.

The responses indicate that there is consensus with the importance of interprofessional education in the health and social care setting, but at present just over half of them apply it to their teaching; although this is a higher application than humanism and storytelling. There is a need for more skills in interprofessional education, though this is less than humanism and storytelling.

There was a high level of agreement that the participants 'understand how storytelling, humanism and interprofessional education can work together' (71%; 17% 'strongly agree'); 10% disagreed with this statement, with only 2% of these 'strongly disagreeing'.

Across the continents the greatest agreement was from those participants based in Australia/Oceania, North America and South America (100%); combined responses of 'agree' and 'strongly agree'. This was less so for Europe (67%), Asia (60%) and Africa (50%); though small numbers of participants based on some continents needs to be taken into consideration.

The greatest agreement across age was in the over 60 age group with 95% agreeing with the statement; 78% in the 51-60 age group; 74% aged 41-50 and 66% for those aged 30 and under. The lowest agreement was in the 31-40 age group, with 52% also answering 'neutral', which was considerably higher than in the other age groups which ranged from five percent to 17%.

Educators had the highest level of agreement (85%); 58% Practitioner; 59% Researcher; 63% Student; 71% Trainer, and the lowest was 'Other' (50%). With the exception of the Educator discipline, there was a considerable number of 'neutral' responses, ranging from 23% to 35%.

Across disciplines the greatest agreement was from participants working in midwifery (100%, four participants) and radiography (100%, five participants). Ninety one percent of those who responded 'Other' were in agreement [see demographic section for details of 'Other' disciplines]. Seventy four percent in nursing were in agreement and 72% in the medical discipline (with nearly a quarter giving a 'neutral' response). The lowest agreement was with 'Pharmacy' (50% 'disagree'), 'Engineering' (33% 'disagree' and 67% 'neutral') and 'Physiotherapy' (33% 'disagree'); though each category comprised four or fewer participants.

3.5 Learning and teaching styles

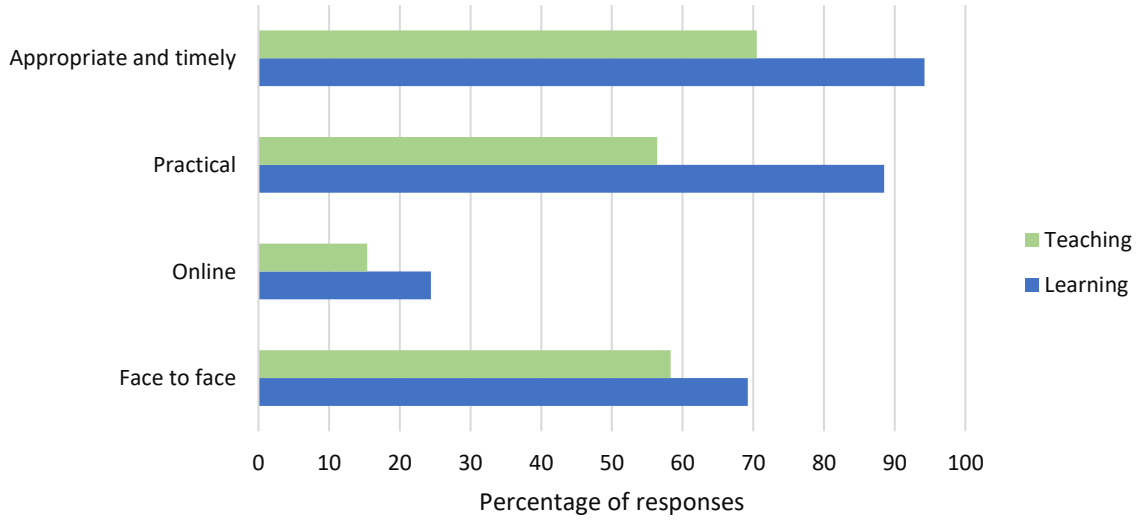
Table 7 details levels of agreement related to the preferred learning styles of Students and the preferred teaching styles of Staff.

TABLE 7: LEARNING AND TEACHING STYLE

	'Agree' or 'Strongly agree'	'Neutral'	'Disagree' or 'Strongly disagree'
	Percent	Percent	Percent
Students prefer to learn face to face	69.2	23.1	7.7
Students prefer to learn online	24.4	36.5	39.1
Students prefer learning that is practical	88.5	10.3	1.3
Students prefer appropriate and timely learning	94.2	5.1	.6
Staff prefer to teach face to face	58.3	39.1	2.6
Staff prefer to teach online	15.4	59.0	25.6
Staff prefer teaching that is practical	56.4	38.5	5.1
Staff prefer appropriate and timely teaching	70.5	28.2	1.3

There were differences regarding the preferred learning styles of Students and the preferred teaching styles of Staff. Graph 1 highlights the differences in responses. Whilst 58% agreed that Staff prefer to teach face to face (17% 'strongly agree'), this preference was reported as higher for Students (69%; 28% 'strongly agree'); there was a higher number of 'neutral' responses regarding Staff than Students (39% and 23% respectively). There were similarly agreed low levels of preference for online learning, Students 24% (three percent 'strongly agree') and Staff 15% (two percent 'strongly agree'), with 39% disagreeing that it is a preference for Students, compared to 26% for Staff; there was a high number of 'neutral' responses (37% and 59%).

Graph 1: Preferred learning and teaching styles



There was a considerable difference in preference for practical learning and for practical teaching, with 89% responding in agreement that Students prefer practical learning (50% 'strongly agree'), compared to 56% for Staff for practical teaching (19% 'strongly agree'; 39% 'neutral' responses). Again, there was a difference in the reported agreement for preference of appropriate and timely learning and appropriate and timely teaching (94%, 51% 'strongly agree' compared to 71%, 28% 'strongly agree').

The responses show that overall there are differences in perceived preferences for learning styles and for teaching styles. There was a large number of responses relating to teaching style that did not agree or disagree with the statements, ranging from 28% to 59%; this was less so for learning styles, ranging from five percent to 37%.

i. Learning and teaching styles across geographical location

Comparison of responses across geographical location found the following reported agreed learning preferences:

- Face to face: Europe 72%; Africa 75%; Asia 80%; Australia/Oceania 17%; North America 44% and South America 100%.
- Online: Europe 26%; Africa 25%; Asia 0%; Australia/Oceania 17%; North America 11% and South America 33%.
- Practical: Europe 86%; Africa 100%; Asia 100%; Australia/Oceania 100%; North America 100% and South America 100%.
- Appropriate and timely: Europe 94%; Africa 100%; Asia 100%; Australia/Oceania 100%; North America 89% and South America 100%.
- Overall the findings show a general agreed preference across continents for face to face learning compared to online learning. There was also consensus of agreed preference for practical, and appropriate and timely, learning.

Comparison of responses across geographical location found the following reported agreed teaching preferences:

- Face to face: Europe 59%; Africa 75%; Asia 60%; Australia/Oceania 50%; North America 44% and South America 67%.
- Online: Europe 14%; Africa 50%; Asia 40%; Australia/Oceania 0%; North America 11% and South America 33%.
- Practical: Europe 54%; Africa 75%; Asia 80%; Australia/Oceania 67%; North America 56% and South America 100%.
- Appropriate and timely: Europe 69%; Africa 75%; Asia 80%; Australia/Oceania 67%; North America 78% and South America 100%.
- Overall the findings show a general agreed preference across continents for face to face teaching compared to online teaching. There was variance in agreed preference for practical, and appropriate and timely, teaching, but in general there was consensus of preference.

ii. Learning and teaching styles across age groups

Comparison of responses across age groups found the following reported agreed learning preferences:

- Face to face: 71% aged 30 and under; 31-40 (79%); 41-50 (78%); 51-60 (58%), and over 60 (60%).
- Online: 39% aged 30 and under; 31-40 (17%); 41-50 (19%); 51-60 (22%), and over 60 (15%).
- Practical: 89% aged 30 and under; 31-40 (90%); 41-50 (93%); 51-60 (83%), and over 60 (90%).
- Appropriate and timely: 93% aged 30 and under; 31-40 (90%); 41-50 (93%); 51-60 (97%), and over 60 (100%).
- Overall the findings show a general agreed preference across age groups for face to face learning compared to online learning. Although agreed preference for online learning was higher in the 30 and underage group, this was not found to be a statistically significant difference to the other age groups ($p > 0.05$)[4]. There was consensus of agreed preference for practical, and appropriate and timely, learning.

Comparison of responses across age groups found the following reported agreed teaching preferences:

- Face to face: 34% aged 30 and under; 31-40 (66%); 41-50 (74%); 51-60 (67%), and over 60 (65%).
- Online: nine percent aged 30 and under; 31-40 (24%); 41-50 (11%); 51-60 (22%), and over 60 (10%).
- Practical: 50% aged 30 and under; 31-40 (66%); 41-50 (52%); 51-60 (20%), and over 60 (70%).
- Appropriate and timely: 55% aged 30 and under; 31-40 (76%); 41-50 (59%); 51-60 (81%), and over 60 (95%).
- Overall the findings show a general agreed preference across age groups for face to face teaching compared to online teaching. Although agreed preference for online teaching was higher in the 31-40 age group, this was not found to be a statistically significant difference to the other age groups ($p > 0.05$)[5]. There were more 'neutral' responses (neither agree nor disagree) across the different styles of teaching, particularly face to face and online; possibly indicating uncertainty regarding teaching methods in relation to the Covid-19 pandemic. Covid-19 has arguably forced a push towards online learning that may not have occurred otherwise, and this has been reflected in the responses to this section.

iii. Learning and teaching styles across roles

Comparison of responses across roles found the following reported agreed learning preferences:

- Face to face: Educator 66%; Practitioner 74%; Researcher 71%; Student 73%; Trainer 71% and 'Other' 50%.
- Online: Educator 16%; Practitioner 26%; Researcher 24%; Student 38%; Trainer 0% and 'Other' 25%.
- Practical: Educator 84%; Practitioner 95%; Researcher 94%; Student 90%; Trainer 86% and 'Other' 100%.
- Appropriate and timely: Educator 97%; Practitioner 90%; Researcher 94%; Student 92%; Trainer 71% and 'Other' 100%.
- Overall the findings show a general agreed preference across roles for face to face learning compared to online learning. The greatest preference for online learning was by Students (38%, 42%

[4] Criteria met for Chi-square analysis
[5] Criteria met for Chi-square analysis

disagreed), but this was considerably less than for face to face learning. There was also consensus of agreed preference for practical, and appropriate and timely, learning.

Comparison of responses across roles found the following reported agreed teaching preferences:

- Face to face: Educator 69%; Practitioner 63%; Researcher 88%; Student 29%; Trainer 71% and 'Other' 75%.
- Online: Educator 16%; Practitioner 11%; Researcher 24%; Student 15%; Trainer 0% and 'Other' 25%.
- Practical: Educator 84%; Practitioner 95%; Researcher 94%; Student 90%; Trainer 86% and 'Other' 100%.
- Appropriate and timely: Educator 97%; Practitioner 90%; Researcher 94%; Student 92%; Trainer 71% and 'Other' 100%.
- Overall the findings show a general agreed preference across roles for face to face teaching compared to online teaching. The lowest agreed preference for face to face teaching was by Students (29%, 71% 'neutral'); however, there was only 15% agreed preference for online teaching by Students (73% 'neutral'). There was also consensus of agreed preference for practical, and appropriate and timely, teaching with the exception of Students (38%, 60% 'neutral' for practical; 38%, 63% 'neutral' for appropriate and timely). This may possibly have been due to uncertainty regarding the Covid-19 pandemic.

iv. Learning and teaching styles across disciplines

Comparison of responses across disciplines found the following reported agreed learning preferences:

- Face to face: engineering 67%; manager 60%; medical 76%; midwifery 75%; nursing 70%; pharmacy 50%; physiotherapy 0%; psychology 100%; public health 80%; radiography 80%, and 'other' 55%.
- Online: engineering 0%; manager 20%; medical 38%; midwifery 0%; nursing 24%; pharmacy 25%; physiotherapy 0%; psychology 0%; public health 0%; radiography 40%, and 'other' 27%.
- Practical: engineering 100%; manager 100%; medical 93%; midwifery 100%; nursing 87%; pharmacy 100%; physiotherapy 67%; psychology 100%; public health 80%; radiography 100%, and 'other' 73%.
- Appropriate and timely: engineering 67%; manager 100%; medical 97%; midwifery 100%; nursing 93%; pharmacy 100%; physiotherapy 100%; psychology 100%; public health 100%; radiography 80%, and 'other' 100%.
- Overall the findings show a general agreed preference across disciplines for face to face learning compared to online learning. The greatest preference for face to face learning was in the psychology, medical and midwifery disciplines, and this may be due to the nature of these disciplines. The lowest for online learning was engineering, midwifery, psychology and public health (all 0%). In the psychotherapy discipline all respondents indicated a 'neutral' response for both preference for face to face learning and online learning. There was consensus of agreed preference for practical, and appropriate and timely, learning across the disciplines.

Comparison of responses across disciplines found the following reported agreed teaching preferences:

- Face to face: engineering 67%; manager 60%; medical 76%; midwifery 75%; nursing 70%; pharmacy 50%; physiotherapy 0%; psychology 100%; public health 80%; radiography 80%, and 'other' 55%.
- Online: engineering 0%; manager 20%; medical 38%; midwifery 0%; nursing 24%; pharmacy 25%; physiotherapy 0%; psychology 0%; public health 0%; radiography 40%, and 'other' 27%.
- Practical: engineering 100%; manager 100%; medical 93%; midwifery 100%; nursing 87%; pharmacy 100%; physiotherapy 67%; psychology 100%; public health 80%; radiography 100%, and 'other' 73%.

- Appropriate and timely: engineering 100%; manager 100%; medical 90%; midwifery 50%; nursing 60%; pharmacy 75%; physiotherapy 100%; psychology 67%; public health 60%; radiography 80%, and 'other' 82%.
- Overall the findings show a general agreed preference across disciplines for face to face learning compared to online learning. The greatest preference for face to face learning was in the psychology, medical and midwifery disciplines, and this may be due to the nature of these disciplines. The lowest for online learning was engineering, midwifery, psychology and public health (all 0%). In the psychotherapy discipline all respondents indicated a 'neutral' response for both preference for face to face learning and online learning. There was some variance in agreed preference for practical, and appropriate and timely, teaching, but in general there was agreed consensus of preference.

Learning and teaching styles: additional comments

Participants were asked for additional comments pertaining to learning and teaching styles. Eleven comments were received.

- It was commented that with the increased move to online teaching, particularly in response to the Covid-19 pandemic, and with the associated lack of human contact, that humanism, storytelling and IPE have taken on new levels of importance. Everybody is learning, and what is required is to enable the provision of whole person care.
- There was consensus that preferences greatly depend on students' circumstances (e.g. work commitments or childcare) and their needs, with some students preferring or requiring more interaction with their peers and teaching staff. Some styles are better suited to a student's personality, with those who may be quiet in class being very active online. Similarly staff also have preferences, with some styles best suited to their personality, and that some preferred teaching methods, e.g., practical lectures, require more work than others.
- There are times that the different learning styles are best suited to, depending on the topic of the course or module. Students have been found to prefer a combination of teaching methods, encouraging motivation and social learning. There was agreement that a mixture of methods was the best approach. The quality and content of material was highlighted as the key aspect rather than the forum of delivery. Practical issues, such as equipment availability and connectivity, were highlighted.

3.6 Impact of Covid-19 pandemic

There was a high level of agreement that the Covid-19 pandemic has changed teaching and learning (96%, 67% 'strongly agree'), and how participants view teaching and learning (70%, 30% 'strongly agree').

This may be reflected in the number of 'neutral' responses in section five regarding teaching and learning styles preferences. Nearly a quarter of participants 'strongly agreed' that it is even more important to teach humanizing healthcare through storytelling, with 62% agreeing overall. Table 8 details the level of agreement with statements pertaining to the impact of the Covid-19 pandemic.

i. Impact of Covid-19 across geographical location

There was a high level of agreement across the continents that Covid-19 has changed teaching and learning: Europe 95%; Africa 100%; Asia 100%; Australia/Oceania 83%; North America 100% and South America 100%. However, this was lower for Australia/Oceania 33% (three participants, 50% 'neutral'), North America (67%, six participants) and South America (67%, two participants) for how it had changed how they view teaching and learning.

TABLE 8: IMPACT OF COVID-19 PANDEMIC ON TEACHING AND LEARNING

	'Agree' or 'Strongly agree'	'Neutral'	'Disagree' or 'Strongly disagree'
	Percent	Percent	Percent
The Covid 19 pandemic has changed teaching and learning	95.5	4.5	0
The Covid 19 pandemic has changed how I view teaching and learning	69.9	14.1	16
The Covid 19 pandemic has not changed anything in teaching and learning	3.2	9.0	87.8
It is now even more important to teach humanizing healthcare through storytelling since the Covid 19 pandemic	61.5	35.9	2.6

There was variance in consensus that it is even more important to teach humanizing healthcare through storytelling, from 50% in Africa and 59% in Europe to 100% in South America; disagreement scores were low, and 'neutral' scores ranged from 17% to 50%.

ii. Impact of Covid-19 across geographical location

There was a high level of agreement across the continents that Covid-19 has changed teaching and learning: Europe 95%; Africa 100%; Asia 100%; Australia/Oceania 83%; North America 100% and South America 100%. However, this was lower for Australia/Oceania 33% (three participants, 50% 'neutral'), North America (67%, six participants) and South America (67%, two participants) for how it had changed how they view teaching and learning.

There was variance in consensus that it is even more important to teach humanizing healthcare through storytelling, from 50% in Africa and 59% in Europe to 100% in South America; disagreement scores were low, and 'neutral' scores ranged from 17% to 50%.

iii. Impact of Covid-19 across age

All age groups responded with a high level of agreement that Covid-19 has changed teaching and learning: 96% aged 30 and under; 97% aged 31-40; 93% aged 41-50; 100% aged 51-60, and 90% over 60. Again, there was a lower perception that Covid-19 had changed how they view teaching and learning, with the lowest for those aged 30 and under (59%, 23% 'neutral') and the highest aged 51-60 (81%): 31-40 (66%); 41-50 (78%), and aged over 60 (70%).

There was variance in consensus that it is even more important to teach humanizing healthcare through storytelling, with the highest in the over 60 age group (80%) and the lowest in the 30 and under age group (48%); disagreement scores were low, and 'neutral' scores ranged from 10% to 50%.

iv. Impact of Covid-19 across roles

All roles reported a high level of agreement that Covid-19 has changed teaching and learning: Educator 98%; Practitioner 95%; Researcher 94%; Student 92%; Trainer 100%, with 'Other' reporting 100%. All roles reported a lower perception that Covid-19 had changed how they view teaching and learning, with the lowest for Students (52%) and the highest for Trainer (86%); Educator (75%); Practitioner (84%); Researcher (71%), and 'Other' (100%).

There was variance in consensus that it is even more important to teach humanizing healthcare through storytelling, with the highest for Educators (77%) and the lowest for Students (44%); disagreement scores were low across roles, and 'neutral' scores ranged from 21% to 52%.

v. Impact of Covid-19 across disciplines

All disciplines reported a high level of agreement that Covid-19 has changed teaching and learning: engineering (100%); manager (100%); medical (93%); midwifery (100%); nursing (95%); pharmacy (100%); physiotherapy (67%); psychology (100%); public health (100%); radiography (100%), and 'other' (100%).

All disciplines reported a lower perception that Covid-19 had changed how they view teaching and learning, with the lowest for physiotherapy (33%) and the highest for manager (100%) and psychology (100%): engineering (67%); medical (72%); midwifery (75%); nursing (66%); pharmacy (50%); public health (60%); radiography (80%), and 'other' (91%).

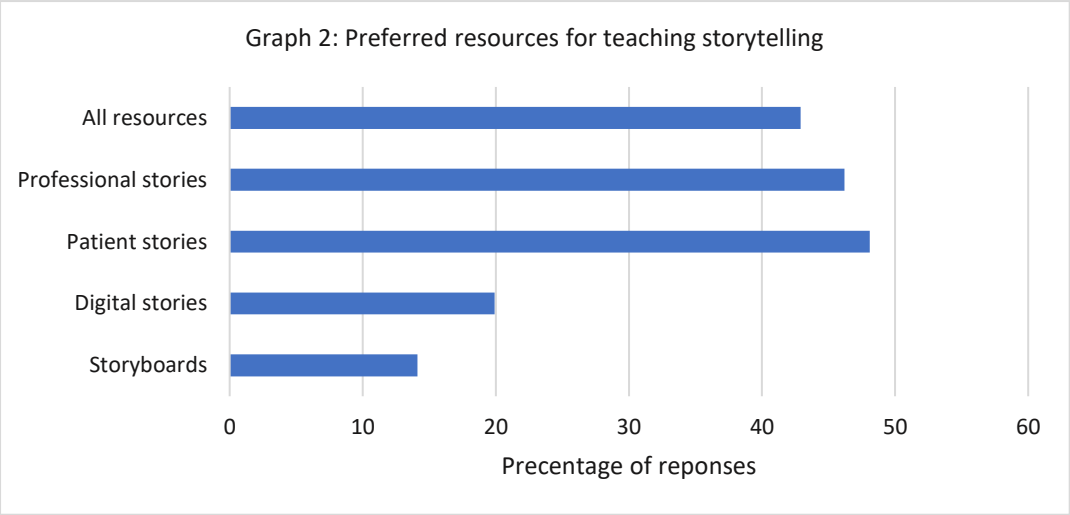
There was variance in consensus that it is even more important to teach humanizing healthcare through storytelling, with the highest for midwifery (75%) and the lowest for engineering (33%) and physiotherapy (33%); disagreement scores were low across most disciplines, with the exception of physiotherapy (33%) and pharmacy (25%), and 'neutral' scores ranged from 25% to 67%.

3.7 Resources and methods for teaching

i. What types of resources would you like to see for teaching storytelling?

Participants were asked to indicate what type of resources they would like to see for teaching storytelling, by ticking a yes box for all types that applied to them . Graph 2 details the responses given.

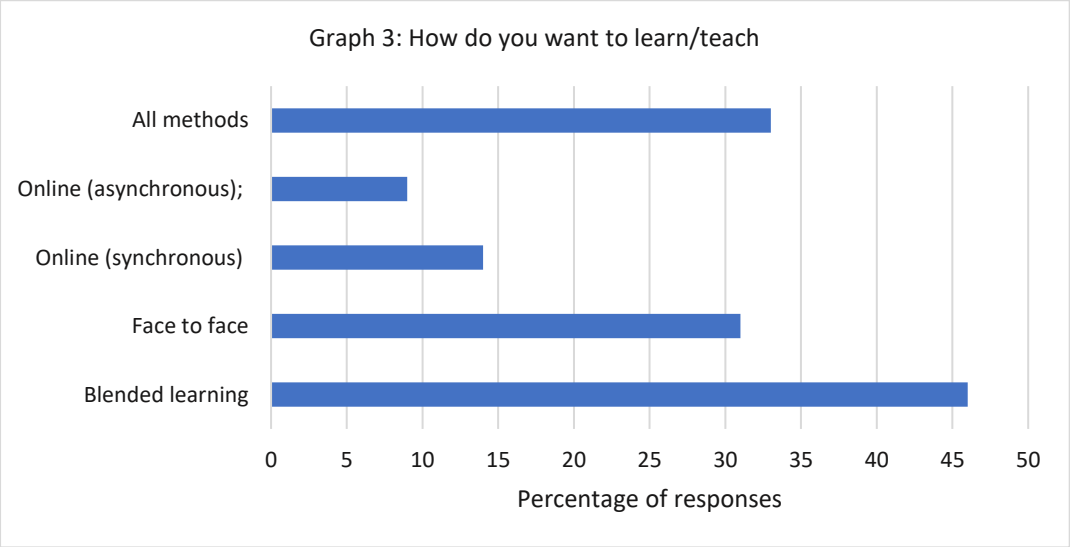
The greatest preference was for patient stories (48%): compared to professional stories (46%); digital stories (20%), and storyboards (14%), with 43% responding all resources.



ii. How do you want to teach/learn?

Participants were asked to indicate what types of methods they would like to use for teaching/learning, by ticking a 'yes' box for all types that applied to them[6]. Graph 3 details the responses given.

The greatest preference was for blended learning (46%): compared to face to face (31%); online (synchronous) (14%), and online (asynchronous), with 33% reporting all methods.

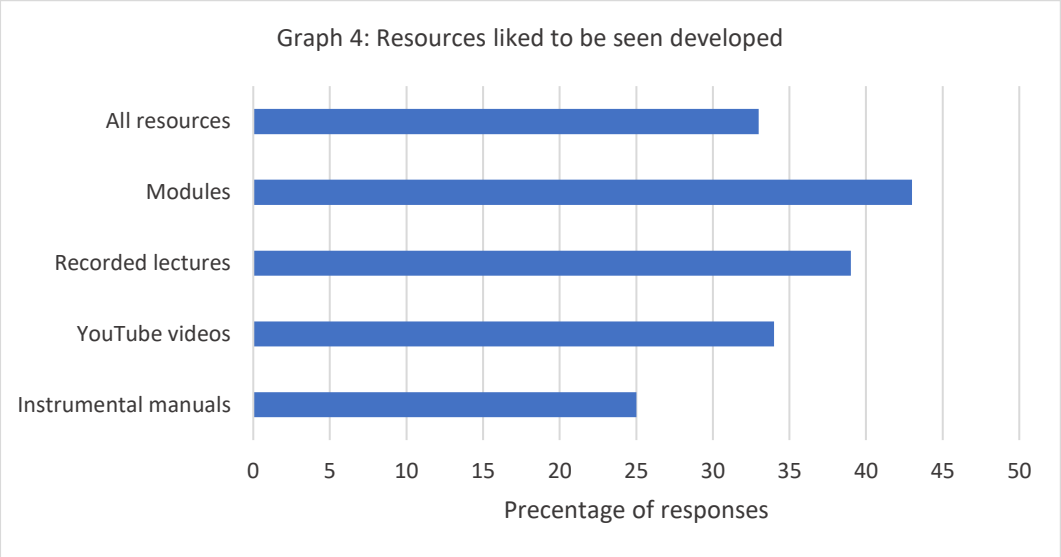


[6] Frequencies across sub-groups did not meet criteria for Chi-square analysis

iii. What type of resources would you like to see developed?

Participants were also asked to indicate what types of resources they would like to see developed, again by ticking a 'yes' box for all types that applied to them. Graph 4 details the responses given.

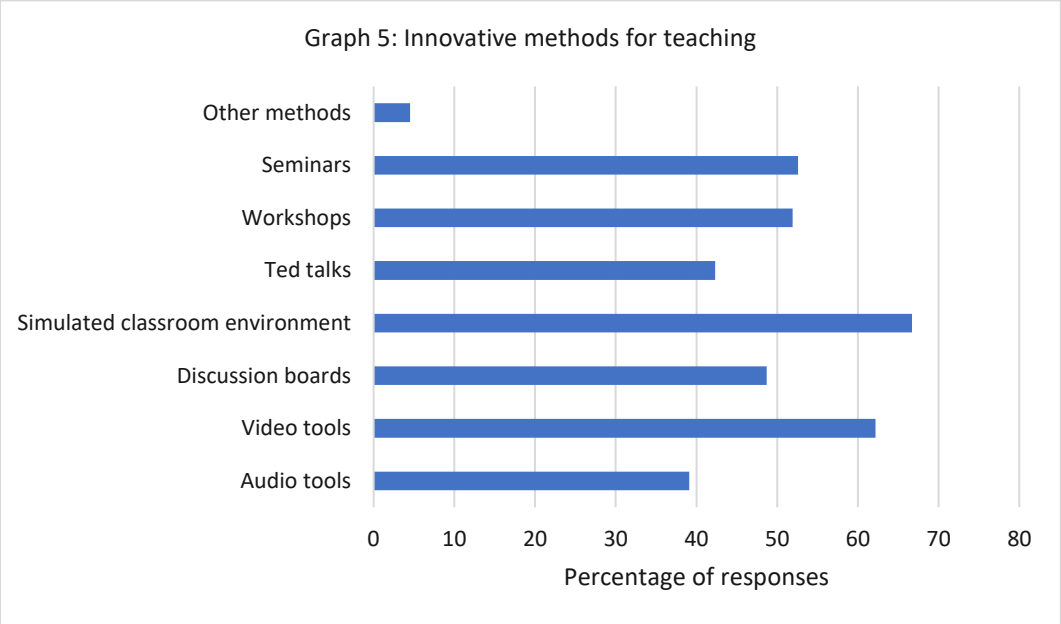
The greatest preference was for recorded lectures (39%): compared to YouTube videos (34%); modules (33%), and instructional manuals (25%), with 43% reporting all resources.



iv. What innovative methods would you like to see used for teaching?

Participants were also asked to indicate what innovative methods they would like to see used for teaching, again by ticking a 'yes' box for all types that applied to them. Graph 5 details responses given.

The greatest preference was for simulated classroom environment (67%): compared to video tools (62%); seminars (53%); workshops (52%); discussion boards (49%); ted talks (42%), with five percent responding 'other methods'.



3.8 Further comments

i. Impact of Covid-19

Participants were asked for additional comments relating to the impact of Covid-19. Eighty three comments were received representing 53% of respondents.

The majority of comments pertained to having to move to online learning necessitated through social distancing guidance by governments in response to the pandemic. Although many responded that they had previously taught online or used online learning, the majority of teaching provision had now moved online. Both positive and negative comments were made about this change in teaching delivery and learning method.

The main concern regarding the move to online learning was the negative impact on the student experience. There was particular concern relating to: the lack of physical face to face interaction; students becoming socially isolated; limited contact for information sharing and consulting; not receiving lecturer facilitation and support to meet the individual abilities and needs of students; limited access to materials, and concerns of students being disconnected, and less motivated and engaged. There was concern that this would be detrimental to the student/educator relationship, especially with new students, and efforts needing to be made to address this. These factors need to be taken into consideration in the student experience, and measures need to be incorporated into teaching to facilitate the learning process in digital surroundings, and the testing of learned knowledge and experience. There had been an assumption that students may have had a preference for, and adapted to, online learning, but comments from students to their educators found this not to be the case.

It was commented that online learning had impacted workloads, both in the short-term with the setting up of online facilities (e.g., greater liaison with IT departments and setting up student access to helplines); also in the longer term (e.g., preparation of material such as module information and creating new assessments for courses). Educators need more time to prepare these materials, and Institutes need to acknowledge this.

Whilst some responses expressed a preference for online teaching, a lack of preference for online teaching was also highlighted: with reference to 'forced' online education; being forced to communicate digitally; energy consuming, and a lack of direct feedback. Comment was made about the impersonal nature of online teaching and feeling disengaged with those they are teaching. It was expressed that there was a development need to facilitate skills, especially technical skills, for the move online.

Other responses from students, educators and other roles about remote working related to technical issues concerning reliability, such as access to, and issues with, broadband connections particularly at key times, such as exam periods. Students had reported to educators that their home environment was not suited to online learning, since other family members were home based and this resulted in difficulties accessing online lectures.

There was concern that elements of hands on teaching had to be removed, including mandatory practical classes which were vital for the nature of some of the courses and essential for meeting compliance, e.g., nursing. Some face to face teaching would take place but this would need to be prioritised. Different modalities of learning for knowledge need to be addressed. A lack of contact between students and patients was also expressed as a concern. The importance of involving patient voices and storytelling was stressed, and it was felt that this could not be achieved through telephone

calls. One comment expressed concern about producing practitioners who were not fit for purpose because of a lack of time to obtain and practice skills.

Positive responses related to the move online due to the Covid-19 pandemic evidenced that teaching delivery could be done online, and the potential for other formats for learning; which may be to the benefit of students. Furthermore, some responses argued that blended learning has been in place for some time, and this would encourage more blended learning. An existing example given was the use of interactive sessions with Microsoft Teams. Old style teaching and learning would be challenged and teaching methods would become more innovative. Educators reported: learning new skills contributing to their personal development; increased acknowledgement of the importance of networking; finding new ways to support students and colleagues; and finding new ways to stay in contact.

Students themselves gave a range of responses to the move to online learning. Some expressed that there had been no impact on them, whilst others expressed that it had a considerable or disruptive impact on them. Reference was made to stress during exam times; a lack of motivation when learning on your own; missing one to one contact; being unable to consult with educators; difficulties navigating educational platforms, and a negative impact on the effective transmission of knowledge, particularly if it was to become a permanent rather than a temporary measure. However, some responded that it had facilitated their learning and the flexibility was beneficial. Additionally, adaptation had been made; they had become more disciplined to work at home; better at time management and planning, and improved at self-learning.

ii. General additional comments

Participants were asked for additional general comments relating to the survey. Twenty five comments were received, reflecting 16% of participants.

A number of comments pertained to the importance of the study, and the importance of IPE, humanism and storytelling in the healthcare setting, and the necessity and challenge to communicate their importance. It was remarked that these concepts are often dismissed as 'soft science', and it can be difficult to convince medical staff of their benefit; with fewer resources allocated owing to the perception that they are not as valuable as 'hard science'. It was commented that humanism should be the basis of all health care and at the core of healthcare professionals' work, rather than pushed to the background. Students should therefore be educated to understand that humanism is part of everyday practice. Yet it is a skill that needs to be practiced by educators to promote its importance or use in healthcare.

With reference to storytelling, it was acknowledged by practitioners that their everyday activities already involve storytelling with their patients, colleagues and students. The sharing of experiences is an important aspect, which can be done by storytelling or other methods. Patients' voices should be heard, and relating patient stories and experiences is a powerful way of learning.

There were suggestions about how teaching could be developed, through the use of different mediums, e.g., art, music and drama. It was also suggested that as storytelling is often a practice of familiarity, that ethics and codes of conduct for storytelling need to be addressed, and for students to learn to meet the individual needs of each patient. Connecting working and educational environments in new ways would support the development of interprofessional collaboration in working practice. It was remarked that students should be taught at an early stage what interprofessional collaboration, humanism and storytelling can look like, and that IPE should be mandatory for health and social care students, and a substantive part of their learning path.

New tools and strategies for education should be revised and reconsidered, such as distance learning, e-learning and peer-to-peer strategies; whilst continuing to acknowledge the importance of the direct relationship with patients. It was remarked that the 'connectedness' of students would need to be built into online learning, as it is crucial when developing storytelling. It was also commented that it would be helpful if relevant material were made available in different languages.

Conclusion

Overall the Delphi study has yielded some useful and important responses to guide the next stages of the project. While the project team initially never expected to undertake research during a global pandemic it has not impacted the development and timescales for undertaking the Delphi study. However, there are indications that it may have affected some of the views towards teaching and learning as both staff and students have had to develop more skills in technology enhanced learning over a short period of time.

Whereas staff and students predominantly prefer face to face teaching there is an awareness that online learning and teaching is likely to become a 'new normal' or be integrated with a more blended learning approach. Students appear to like the advantage of greater flexibility but highlight the downside of less interaction with others, which ironically is what humanism is attempting to ensure: a greater connectedness or understanding between individuals.

This survey had a diverse and global coverage of a targeted population interested and experienced in healthcare education. Respondents included educators, trainers, practitioners and students, and participants were aged from under twenty to over sixty.

The findings detailed above suggest that there is a consensus around the three concept statement definitions. However, there was a perceived need for further training on the concepts identified. It was interesting to note that of the three concepts IPE scored lowest (65%) in experience, but highest in agreement with the concept, and indicates that there is a need for increased and ongoing training and mentoring on the topic. The results indicate that just over half of the respondents apply it in their teaching and that therefore there is a need for more skills in IPE, but also in the other two concepts, storytelling and humanism, although to a lesser degree. It maybe that although IPE has been encouraged for numerous years that the practicalities and cost of it has been a prohibitive factor in its development in healthcare.

In analysing the preferred teaching and learning styles of the two groups - staff and students there was a preference for more practical and timely learning from the students who preferred their courses to include clinical simulation. Younger age groups were happier using online learning.

Both staff and students perceived a push to online learning due to the effects of the COVID-19 pandemic rather than this being a natural evolution. Yet they realized that this was the most likely scenario for their teaching and learning in the near future. Nevertheless, there was a preference for some form of blended learning to be included in their curriculum.

The move to online learning was felt to have: increased the staff workload creating stress at a time of crisis; been detrimental to staff/student relationships; created technical issues, including the need for improved broadband, for both staff and students; and created an increased dichotomy between home and office or study space.

While there was a difference in the views of the groups there was a general consensus for the need for further training in IPE, humanism and storytelling and that if due to public health concerns this had to be achieved online this was possible.

The results of this Delphi study have given the project team an understanding of the three fundamental concepts for the research, answered questions about specific needs for training and identified the preferred methods for this training. Collectively, the development of the concept analyses and statements, the scoping literature reviews, and the Delphi survey allow the project team to now undertake the planning of the training during Year 2 of the project.

References

Diamond I.R., Grant R.C., Feldman B.M., Pencharz P.B, Ling S.C., Moore A.M., Wales P.W., (2014) Defining consensus: A systematic review recommends methodologic criteria for reporting of Delphi studies. *Journal of Clinical Epidemiology 67 pp401-409.*

Appendices

What is your experience of IPE? *

- Select -

What is your experience of storytelling? *

- Select -

Section 2 – Concept Definitions

Do you agree with the following statements:

"Humanism is defined as an authentic relationship embracing presence, mutuality and commitment, by becoming part of another person's story, resulting in human growth" *

- Select -

"Interprofessional education is defined as developing healthcare students to learn with, from and about each other to teach them to work collaboratively in practice, resulting in improved patient care" *

- Select -

"Storytelling is defined as a holistic and culturally co-created experience, which authentically navigates and engages human beings in a dynamic process of sharing, learning and celebrating our interconnected lives" *

- Select -

Section 3 - Humanizing Healthcare through Storytelling

Do you agree with the following statements:

I understand how humanism can be applied to health and social care *

- Select -

Humanizing health and social care is necessary *

- Select -

I already teach humanism in health and social care *

- Select -

Storytelling can help to humanize health and social care *

- Select -

I need more skills to teach humanism in health and social care *

- Select -

I understand how storytelling can be applied in health and social care *

- Select -

I already use storytelling in my teaching *

- Select -

I need more skills to use storytelling in my courses *

- Select -

Storytelling is vital to help humanize health and social care *

- Select -

To humanize health care I need to use storytelling *

- Select -

Interprofessional education is important in teaching health care students *

- Select -

I need more skills to teach interprofessional education *

- Select -

I already am involved in teaching interprofessional education *

- Select -

Interprofessional education is more necessary than ever *

- Select -

I understand how storytelling, humanism and interprofessional education can work together *

- Select -

Interprofessional education can help to humanize health and social care *

- Select -

Further comments

Section 4 – Resources and Methods for Teaching

Do you agree with the following statements:

Students prefer to learn face to face *

- Select -

Students prefer to learn online *

- Select -

Students prefer learning that is practical *

- Select -

Students prefer appropriate and timely learning *

- Select -

Staff prefer to teach face to face *

- Select -

Staff prefer to teach online *

- Select -

Staff prefer teaching that is practical *

- Select -

Staff prefer appropriate and timely teaching *

- Select -

The Covid 19 pandemic has changed teaching and learning *

- Select -

The Covid 19 pandemic has changed how I view teaching and learning *

- Select -

The Covid 19 pandemic has not changed anything in teaching and learning *

- Select -

It is now even more important to teach humanizing healthcare through storytelling since the Covid 19 pandemic *

- Select -

Further comments

Section 5 - Resources and Methods for Teaching

Please select all answers that apply by holding the control (ctrl) key down and clicking each answer

What type of resources would you like to see for teaching storytelling? (please tick all that apply by holding the control [ctrl] key down and clicking each answer) *

Storyboards
Digital Stories
Patients Stories
Health and Social Care Professional Stories for Learning

How do you want to teach/learn? (please tick all that apply by holding the control [ctrl] key down and clicking each answer) *

Blended Learning (involving synchronous and asynchronous and face to face)
Face to Face
Online (synchronous)
Online (asychronous)

What type of resources would you like to see developed? (please tick all that apply [ctrl] key down and clicking each answer) *

Instructional manuals
YouTube videos
Recorded lectures
Modules

What innovative methods would you like to see used for teaching? (please tick all that apply [ctrl] key down and clicking each answer) *

Audio tools
Video tools
Discussion boards
Simulated classroom environment

In what ways, if any, has the Covid 19 pandemic changed your teaching/learning?

Section 6 - Any Further Comments on Humanizing Healthcare Through Storytelling

Please add further thoughts

Preview