



Evaluating a healthy lifestyle training program for a group of China medical students

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Abstract

Introduction Learning and developing a healthy lifestyle through training are crucial for individual wellbeing in the long run to prevent lifestyle-induced diseases. The study aimed to screen participants' health risk indicators and evaluate the effectiveness of a healthy lifestyle training course for them.

Method A cross-sectional design was used to evaluate an 8-hour structured healthy lifestyle course over one week. The course was conducted for 48 China medical students during their learning visit in Hong Kong in August 2017. A case scenario of potential lifestyle-induced health problems and workbook were provided for participants' discussion, reflective learning, practice and application. Health risk indicators measurement was demonstrated for their self-measured analysis and awareness of risks with lifestyle intervention. Their health learning experience was evaluated by 12 questions posed after training.

Results Participants' indicators were measured and identified at moderate/high health risks which included overweight 15% (7/47), lifestyle-related hypertension 45% (21/47), excessive stress 13% (6/48), lack of adequate exercise 94% (44/46) and inadequate sleep 50% (23/46). A Pearson Correlation of BMI to Metabolic Age Gain is positive (coefficient=0.726, $p < 0.001$). The participants strongly agreed that the learning method facilitated their health practice and enhanced their interest to change lifestyle habits in the learning process.

Conclusion Education of healthy lifestyle for healthcare students is pivotal to prevent and control lifestyle-induced non-communicable diseases as a global concern. Training and coaching with reflective health practice are effective in skills learning for health gain and recommended to other healthcare professionals and community population of patients, family, staff and students.

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Introduction

The number of individuals suffering from NCDs is rising rapidly which poses severe threats to the cost of the healthcare system and individual well-being world-wide. NCDs account for the three leading causes of global years of life lost in 2013, which are ischemic heart disease, and cerebrovascular disease (1). More alarmingly, and almost all the top nine causes of global death in 2015 were NCDs as well (2).

Lifestyle can be a major risk factor of NCDs. Derose (1998) found out that seven negative lifestyle habits including unhealthy eating, sedentary lifestyle, inadequate sleep, or unrelieved stress, smoking and excessive use of alcohol could predispose healthy age reduction and early death (3). Thus, to prevent

lifestyle-induced diseases, learning and developing a healthy lifestyle through training is crucial for individual wellness in the long run.

Translating reflection and practice in the healthy lifestyle course

Reflective learning or reflection involves intellectual and affective activities, theory and practice, in which individuals engage to explore their experience and feeling or self-awareness, evaluate and analyze for new understanding and insight, appreciation of strength and weakness, and expected action in future (4, 5). It can be divided into reflection-on-action or reflection-in action. This type of learning process and practice can be used both within and outside the profession of nursing (6). This is an effective and vital



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way of learning especially in healthcare professional education with hands-on skill practice to acquire new perspective through critical analysis of a given case or event in the learners' reflection process (6).

Educators' view and the use of reflective practice have been investigated in the field of nursing education and profession. The findings showed that nurse educators integrating reflective learning in their clinical teaching can elicit positive learning outcome and new insight throughout their practice of laboratory or clinical skills experience by students (7, 8). The education mode has also been used in public health and implemented by nurses to work with a family in partnership and collaboration (9). Its benefits on the program quality and learning outcome need to be further examined and its advantage among health seekers is still uncertain. Therefore, this education method was integrated into our healthy lifestyle course for a screening of participants' health indicators at risks and learning of lifestyle skills aiming to achieve effective health gain.

Study aim and objectives

The study aimed to screen participants' health indicators at risk and to assess their learning experience after participating a healthy lifestyle training course. The health indicators for screening at risks and learning included Body Composition, Lifestyle-induced Hypertension Risks, Mental Stress and Health Habits.

Method

In August 2017, we conducted a 10-hour healthy lifestyle course for a group of 48 medical students seeking health practice during their one-week learning visit in Hong Kong. The training and learning process were described as follows:

- Lectures and workshops on nutrition and exercise, hypertension, stress relief, and health belief were offered.
- Structured learning activities with health materials in a workbook design were administered to the participants.
- A case scenario of a family potential lifestyle-induced health problems was included for discussion, analysis, and application in lifestyle practice.
- The training contents were taught and learning activities were facilitated by a physician, a health nurse educator, and a dietitian.
- Potential or actual health problems in the case scenario were discussed among six groups with eight members for each.

- Demonstration and return-demonstration were performed hands-on practice to measure their individual health risk indicators.
- The outcome measure indicators included participants' body composition, blood pressure, mental stress and health habits associated with healthy age.
- Questions and discussion are facilitated in the workshops schedule over one week on the skill practice of measurement equipment and scale for their indicators and perceived benefits in predicting personal healthy lifestyle.

Ethical consideration

Ethical approval has been sought from the Hospital Administration and Chaplaincy Department of Hong Kong Adventist Hospital - Stubbs Road for data collection, dissemination, evaluation and release of different health training and development programs. These programs aim for training participants to adopt a healthy lifestyle to prevent and control common chronic diseases or improve their health state. The participants could be a hospital and corporate staff, patients, family, clients in the community, and/or oversea professional visitors. The data collection process fulfills Health Promoting Hospital International Network requirements and Australian Council of Health Standards for hospitals and complies the hospital policy HKAH-SR MERD-011 Release of Information (10). The data may be used for publication in newsletters, evidence-based health, or research journals of which had been explained to participants with their written or verbal/implied consent as appropriate.

Summary measures

To evaluate the effectiveness and quality of the healthy lifestyle course, 12 questions were posed to elicit the participants' health learning experience at the end of the training program. To collect their responses, the questionnaire was evaluated by a 7-point Likert scale. The questions covered the topic, workbook contents, notes, course length, teaching preparation, learning, facilitation, and guidance. To evaluate the participants' confidence and sustainability of their health learning experience, on top of the program structure, participants were asked to evaluate if their expected learning needs were met; their interest in healthy lifestyle has increased or not; lastly, whether the program could assist in changing their lifestyle which shaped them for effective health gain.

To assess the health indicators of participants, health screening activities were conducted. Skills demonstration with return demonstration of how to measure



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individual health indicators for evaluation included manipulation of the body composition and blood pressure measurement machines, questionnaires for mental stress and health habits. These were presented in four workshops and the 48 students were divided into eight groups for discussion and team works to complete the assigned self-measured indicators and their questions were addressed. Health indicators measured for practice in related discussion of the given case scenario included were:

- 1. Body composition risks** of participants were self-measured by a Tanita Machine (11). The health risks were determined by their gender, real age and metabolic age, body fat, visceral fat index and BMI.
- 2. Hypertension risks** were self-measured by the Lifestyle-induced Hypertension Risks Rating Scale scoring of contributing factors and their blood pressure measured by a machine for comparison (12).
- 3. Mental stress risks** were self-assessed by a Mental Stress Scale consisted five categories of a 17-item questionnaire developed by the Department of Health Hong Kong (13). The five categories including time-induced stress (3 items), work performance (4 items), personal emotion (3 items), temper tantrums (3 items), and self-induced guilt (3 items) were summarized with a graded risk score.
- 4. Health habit risks** were self-evaluated by a Healthy Ageing Questionnaire (3). This is a 7-item personal health habit questionnaire including adequate sleep, eating breakfast every day, no snacks, drinking alcohol or smoking, normal body weight and regular exercise. Their BMI and metabolic age were also measured and correlated. These provided substantial evidence in figures for them to understand how individual overweight or obesity can affect their metabolic age and health state. Their health habits were briefed of how to associate with a healthy age in the learning process (3).

Statistical analyses

All the statistical analyses, including descriptive comparison and correlation test, were carried out in SPSS Version 22 (15). The statistical tests were two-tailed, and the effect would be considered as statistically significant when the p-value was smaller than 0.05 (confidence level = 95%).

Results

Key health indicators of the participants divided into six groups were conveniently self-measured and fruitfully discussed during the workshop activities. Among the 48 participants, a majority (77% (37/48)) of them were female. All of them aged between 20 and 23 (100% (48/48)). A summary of our structured healthy lifestyle training plan, learning activities and outcome measures were exhibited in Appendix 1.

1. Body Composition

From the body composition measurement results, 4% (2/48) of participants had excessive body fat and 15% (7/47) of them were found to be overweight. None of them had excess visceral fat. Regarding waist size measurement, 23% (11/47) of them was found at risk of central obesity.

2. Hypertension

By measuring a list of non-modifiable and modifiable contributing factors of hypertension for the participants (N=47 missing value=1), the overall risks of the participating groups were scored and rated (see Table 1a and Table 1b). The screening results of the students with moderate-to-high risk factors for lifestyle-induced hypertension were BMI 5% (7/47), fruits and vegetables consumption 89% (42/47), saturated fat intake 94% (44/47), salt intake 85% (40/47), and exercise performance 93% (44/47).

Overall hypertension risks were scored and rated at an increased risk (scoring 50-70) of 45% (21/47) among the participants. The estimation of increased hypertension risks using lifestyle-induced factors is higher than the actual measured blood pressure for the participants having pre-hypertension of 24% (11/47) and hypertension 2% (1/47) (see Table 1b and Table 1c).

Table 1a. Hypertension Risks Rating by Participants (N=47 Missing Value=1)

Hypertension Risk Factors	A	B	C
	Low	Moderate	High
1. Age	47 (100%)	0 (0%)	0 (0%)
2. Ethnicity	0 (0%)	47 (100%)	0 (0%)
3. Family history	22 (47%)	22 (47%)	3 (6%)
4. BMI	40 (85%)	7 (15%)	0 (0%)
5. Fruits and vegetables	5 (11%)	25 (53%)	17 (36%)
6. Saturated fat	3 (6%)	31 (66%)	13 (28%)
7. Salt	7 (15%)	40 (85%)	0 (0%)
8. Alcohol	47 (100%)	0 (0%)	0 (0%)
9. Regular Exercise	3 (7%)	17 (36%)	27 (57%)



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Table 1b. Lifestyle-induced Hypertension Risks of Participants (N=47, Missing Value=1)

Scores	A summary of hypertension risks rating	
0	Very Low Risk	0 (0%)
10-40	Low Risk	26 (55%)
50-70	Increased Risk	21 (45%)
80-100	High Risk	0 (0%)
	Total:	47 (100%)

3. Mental Stress

A scale of 0-none-1-sometime-2-always was used to measure the mental stress level of 17 lifestyle items (2). The "always" stressful lifestyle items concerned and perceived were grouped into five categories for the analysis of the participants' stress responses (N=48, see Table 2a and 2b).

To sum up, a minority of the participants 13% (6/48) (scoring 16-34) were found to rate above average stress level as measured by the Mental Stress Scale.

Table 1c. Blood Pressure Measurement and Rating for participants (N=47, Missing Value=1)

Systole/Diastole (mmHg)	A summary of blood pressure rating	
120-90 / 80-60	Normal	35 (74%)
120-139 / 80-89	Pre-Hypertension	11 (24%)
≥140 /90	Hypertension	1 (2%)
	Total:	47 (100%)

Among the five categories (relaxation, worry, symptoms, social relationship, and negative feeling) of stress related items, the most frequently reported was their study load and parents' expectation.

Table 2b. A Summary of Mental Stress Rating N=48

Very Low	Low	Average	High	Very High	Total
0-5	6-10	11-15	16-27	28-34	
4 (8%)	16 (33%)	22 (46%)	5 (11%)	1 (2%)	48 (100%)

Table 2a. Mental Stress Rating by Participants (N=48)

Stress Items Description	Participants' Response	
Scores: (2) Always - (1) Sometimes - (0) Never	(2) Always	
A1 Homework/job in hand is too much	14	29%
A2 No time to relax, always think about homework/job	16	33%
A3 Cannot waste a minute for works, same as a drive to rush across red light across the road	2	4%
	Stress items A	32 67%
B1 Too much homework/job/activities for perfect works	7	15%
B2 Feel angry when losing games (e.g. playing chess/sports)	2	4%
B3 Perceive teacher/boss/family do not appreciate what has been performed	4	8%
B4 Worry about comments of parents'/peer's own performance	13	27%
B5 Worry current financial situation	11	23%
	Stress items B	37 77%
C1 Often with headache/cervicodynia/back pain/stomach	8	17%
C2 Control own's unsettled emotion by smoking/drinking/eating snacks	2	4%
C3 Inadequate sleep/need to take drugs for insomnia	4	8%
	Stress items C	14 29%
D1 Some classmates/family/friends/colleagues always making you to loose temper	4	8%
D2 Always interrupt others during conversation with others	0	0%
D3 Lots of worry before sleep even in the weekend having break	3	6%
	Stress items D	7 15%
E1 Feel guilty of own decision/action without consideration	9	19%
E2 Feel guilty when taking leisure time	5	10%
E3 Often feel that you should not enjoy/play	8	17%
	Stress items E	22 46%



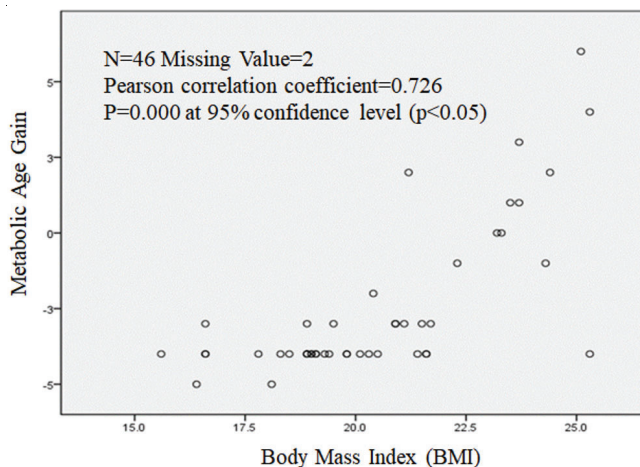
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4. Health Habits

The participants assessed their seven personal health habits and learnt the relationship between their health habits and healthy age. The health educator demonstrated how to match their health habits to a healthy age with a table of statistics rating (3). Half of the participants (50% (23/46)) did not have enough sleep; a minority of them (15% (7/46)) did not have breakfast every day; more than half (67% (31/46)) would consume snacks regularly; about a minority (15% (7/46)) were overweight; however, a great majority was (93% (43/46)) without regular exercise; only 2% (1/46) had regular alcohol consumption; none had the habit of smoking. See Table 3 for a summary of the seven healthy habits deficit.

Furthermore, the participants' metabolic age gain was obtained by subtracting their metabolic age measured by Tanita from their real ages (see Figure 1). They learnt that a positive correlation existed between BMI and metabolic age gain. From the results, a Pearson

Table 3. Body Mass Index and Metabolic Age of Participants



correlation coefficient of 0.726 was calculated using SPSS version 22 and it was significant at 95% confidence level ($p < 0.01$) (15).

Table 3. Healthy Age and Lifestyle Habits of Participants (N=46, Missing Value=2)

	Not Achieved	Achieved
Adequate Sleep	23 (50%)	23 (50%)
Everyday Breakfast	7 (15%)	39 (85%)
No Snack	31 (67%)	15 (33%)
Normal Body Weight	7 (15%)	39 (85%)
Regular Exercise	43 (93%)	3 (7%)
No Alcohol	1 (2%)	45 (98%)
No Smoking	0 (0%)	46 (100%)

5. The quality and effectiveness of healthy lifestyle training

Forty-eight participants took part in a healthy lifestyle course and responded to a learning evaluation questionnaire after training. Each item was graded on a scale from 5 (extremely agree) to 1 (extremely disagree). All the participants responded positively (13% (6/47) extremely agreed - 42% (20/47) verily agreed - (45% (21/47) agreed) that their expected learning needs were met. See Table 4 for the evaluation results. The overall learning feedback of participants was positive and fruitful after the health training.

Table 4. Healthy Lifestyle Course Evaluation (N=48)

Evaluation Contents	Extremely Agree	Verily Agree	Agree	Total
1. Meeting expectations and learning needs	6 (13%)	20 (42%)	21 (54%)	47 (100%)
2. The topic is properly enriched	7 (15%)	17 (36%)	23 (49%)	47 (100%)
3. The content is clear and easy to understand	2 (4%)	18 (38%)	27 (58%)	47 (100%)
4. The training notes are moderate and reasonable	6 (13%)	22 (47%)	19 (40%)	47 (100%)
5. Lecture time is appropriate	7 (15%)	13 (28%)	27 (57%)	47 (100%)
6. Preparation is adequate	2 (4%)	10 (21%)	36 (75%)	48 (100%)
7. Teaching skills are professional	3 (6%)	15 (31%)	30 (63%)	48 (100%)
8. Learning is guided	4 (8%)	13 (27%)	33 (69%)	48 (100%)
9. Questions are answered	2 (4%)	13 (27%)	33 (69%)	48 (100%)
10. This training will increase your interest in or consolidate healthy living	2 (4%)	13 (27%)	33 (69%)	48 (100%)
11. This training method will assist you in changing lifestyle habits	3 (6%)	10 (21%)	35 (73%)	48 (100%)
12. I will support more health promotion activities	5 (10%)	9 (19%)	34 (71%)	48 (100%)



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Discussion

The tour learning visit in Hong Kong was a group of China medical students aiming for health training with lifestyle method. Our structured and innovative method provided a classroom and workshop learning mode for them to acquire screening skills of some key and self measured indicators with identified out-of-range figures. Reflective learning and practice was also incorporated in four workshops with one theme each meaningful for the students. The health issues were shared and discussed for learning purpose through this training method.

About one quarter of the students indicating overweight, a minority had excessive body fat or at risk of central obesity, and their metabolic ages were also identified. These indicators were personally meaningful and alert them of how their lifestyle habits could result in out-of-range indicators. A small proportion of 15% (7/47) of the participants' body weight was found over the normal range and a minority 4% (2/47) had excessive body fat. It is important that body fat in excess needs to be controlled at an early stage to prevent obesity and three highs induced complication.

Almost half of the participants (21 (45%)) were at moderate to high risks of hypertension. These can be contributed to their improper intake of saturated fat, salt, fruits and vegetables and exercise frequency (see Table 2). In the long run, these lifestyle risks are noteworthy of early attention before hypertension develops in the end.

One third 29% (14/48) of the participants had above-average stress which was most likely due to the workload of their study. Long term mental stress is detrimental to individual well-being which results in depression and other emotional problems (14). During their professional training, the medical students might come across a great deal of psychosocial distress and anxiety leading to improper lifestyle habits (14) and consequently, health-related quality of life plays an impact upon their study and wellness (15). To improve stressful study load, it is recommended to integrate structured health teaching into healthcare professional's existing curriculum over a cohort period to sustain individual health gain.

Seven health habits in Derose's study (1998) (3) were related to healthy age gain in the ageing process (3). The participants' health habits and healthy age gain were also estimated to enhance their interest in healthy lifestyle. The group members shared and discussed with guidance to understand how their lifestyle habits

could affect healthy age and metabolic age (see Figure 1). Half of them (50% (23/46)) within a normal range of BMI demonstrates substantial positive metabolic age gain which was due to healthy lifestyle habits. Moreover, they were also aware of non-achieved lifestyle habits such as their inadequate sleep 23% (23/46), snack intake 67% (31/46), over bodyweight 15% (7/46) and lack of regular exercise 93% (43/46) could contribute to hypertension risks and more chronic health problems in the long run.

Health experience, learning and practice

Our evaluation showed that a great majority of the student 100% (48/48) ranging extremely verily-agreed that (i) the training method would increase their interest in a healthy lifestyle; (ii) assist them in changing lifestyle habits; and (iii) support more similar health promotion activities. They gave positive feedback which tends to motivate their healthy lifestyle and learning experience at completion of the course.

The classroom and workshops settings provided a structured training program with health experience for self-measurement of simple and user-friendly indicators related to lifestyle habits meaningful to participants. Potential or actual chronic health problems based on the case scenario were discussed, disseminated, and applied among the participants. Their out-of-range health indicators triggered their alertness and attention, made them become aware of self-care improvement, individual weakness and strength identified, and developed new insight from the facilitated reflective learning process (7). Positive health learning experience was gained by participants from their reflective learning and practice in the workshops.

The health education and training method in reflective practice mode could be integrated into public health nursing, lifestyle medicine education (16), or existing nursing curriculum of primary health care to booster individual health gain (9). Further exploration in the field of public health and other healthcare education with structured health teaching and clinical health promotion is recommended.

Limitation

Although the participants' health indicators were measured and screened, some limitations should not be overlooked. First, the use of a Likert scale in the questionnaire for evaluation may be susceptible to central tendency bias. When eliciting responses with the Likert scale, a questionnaire with respondents' results may aggregate in the middle of the scale. Second, the participants' confidence level to conform



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to healthy lifestyle habits has not measured; a trial control or cohort design will provide stronger evidence of effective lifestyle change than this cross-sectional study for sustainable health outcome. Third, some important metabolic indicators including hyperlipidemia and hyperglycemia were not measured which are also common lifestyle-induced risks. Forth, the reliability and validity of the scales to measure hypertension risks, mental stress and unhealthy age should be addressed more vigorously.

Conclusion

Our health education and promotion program are designed for a group of healthcare learners, and medical students in this study with screening activities on their own in a learning mode. Their lifestyle related health risks of eating pattern, exercise frequency, high stress level in their study needed to be personally addressed. Reflective learning experience aroused their interest and alarmed for healthy lifestyle practice. This training and coaching method is recommended for public health nursing and lifestyle medicine education to prevent and control lifestyle induced diseases in a cost-effective manner.

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Appendix 1. Summary of structured healthy lifestyle training plan, learning activities and outcome measures

Health Risks & Learning Activities	Learning Activities (Theory & Practice)	Duration (hour)	Measurement Tools (Reference)	Indicators	Outcome Measures
Body Composition	Health knowledge Input, Case Discussion, Self-measurement (Demonstration & Return demonstration) & Reflection	2	Tanita Machine (11)	gender, real age and metabolic age, body height, body weight, body Fat, visceral fat index, BMI	Figure 1
Hypertension	Health knowledge Input, Case Discussion, Self-measurement (Demonstration & Return demonstration) & Reflection	2	9-item questionnaire (12)	age, ethnicity, family history, BMI, fruits and vegetables, saturated fat, salt, alcohol, regular exercise	Table 1a, 1b, 1c
Mental Stress	Health knowledge Input, Case Discussion, Self-measurement (Demonstration & Return demonstration) & Reflection	2	17-item questionnaire (13)	relaxation, worry, symptoms, social relationship, negative feeling	Table 2a,2b
Health Habits	Health knowledge Input, Case Discussion, Self-measurement (Demonstration & Return demonstration) & Reflection	2	7-item questionnaire (3)	adequate sleep, everyday breakfast, no snack, normal body weight, regular exercise, no alcohol, no smoking	Table 3
Activities Summary & Learning Experience	Self-evaluation of Health Learning Experience	2	12-item questionnaire	training method, positive health learning experience	Table 4