ORIGINAL REPORTS

Qualitative Analysis of a Cultural Dexterity Program for Surgeons: Feasible, Impactful, and Necessary

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OBJECTIVES: Ineffective cross-cultural communication contributes to adverse outcomes for minority patients. To address this, the authors developed a novel curriculum for surgical residents built on the principle of cultural dexterity, emphasizing adaptability to clinical and sociocultural circumstances to tailor care to the needs of the individual patient. This study's objective was to evaluate the feasibility, acceptability, and perception of this program upon conclusion of its first year.

DESIGN, SETTING, AND PARTICIPANTS: The curriculum was implemented at 3 general surgery programs. The flipped classroom model combined independent study via e-learning modules with interactive role-playing sessions. Sessions took place over 1 academic year. Four focus groups were held, each with 6 to 9 participants, to gain feedback on the curriculum. Focus groups were recorded and transcribed, and the data were analyzed using a grounded theory approach.

RESULTS: Five major themes emerged: (1) Role modeling from senior colleagues is integral in developing communication/interpersonal skills and attitudes toward cultural dexterity. (2) Cultural dexterity is relevant to the provision of high-quality surgical care. (3) Barriers to providing culturally dexterous care exist at the system level. (4) "Buy-in" at all levels of the institution is necessary to implement the principles of cultural dexterity. (5) The shared experience of discussing the challenges and triumphs of caring for a diverse population was engaging and impactful.

CONCLUSION: Early implementation of the curriculum revealed that the tension between surgical residents' desire to improve their cultural dexterity and systemic/practical obstacles can be resolved. Combining surgically relevant didactic materials with experiential learning activities can change the paradigm of cross-cultural training. (J Surg Ed ■:■■■-■■■. © 2018 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEY WORDS: cultural dexterity, focus groups, flipped classroom, health care disparities

COMPETENCIES: Interpersonal and Communication Skills, Professionalism

INTRODUCTION

As the United States becomes increasingly diverse in its sociocultural composition, interventions on the behaviors and practice patterns of health care providers to better serve the needs of the population are required. Racial/ethnic and cultural minority patients are more likely to suffer adverse outcomes as a result of medical errors, including errors due to miscommunication or language barriers.[1] These observations represent a potential source of health care inequities that could be addressed by improvements in cross-cultural training.[2]

Despite the consensus from governing bodies such as the National Institutes of Health (NIH), the National Academies of Science, Engineering, and Medicine (NASEM), the Accreditation Council for Graduate Medical Education (ACGME), and the American College of Surgeons (ACS) that cross-cultural training is a priority for eliminating health care disparities, few residency programs have

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successfully integrated such training into their curricula. Seminal work by Chun et al. describes 5 surgery programs that sought to provide cross-cultural training, as well as the challenges each program encountered.[3] Components of only 3 of the 5 programs currently remain in place, 5 years after the original study.[4]

The absence of a standardized, relevant, and sustainable model of cross-cultural training for surgical residents was the impetus for the development of the Provider Awareness Cultural Dexterity Toolkit for Surgeons (PACTS). Central to the innovation of PACTS is its use of a cultural dexterity framework, which places a greater emphasis on skills acquisition and adaptability to dynamic interpersonal circumstances than the traditional cultural competency framework. The significance of this theoretical approach was made evident through one of our qualitative studies, in which surgical residents and faculty remarked on the effectiveness of emphasizing skills application rather than the traditional recitation of facts.[5] The PACTS curriculum follows a "flipped classroom" design, in which participants complete interactive e-learning modules prior to participating in an in-person experiential learning session. This session deviates from the classic lecture format in that the typical didactic content is delivered via an interactive slide deck beforehand, with the opportunity for discussion, role-playing, and feedback during the session itself. As an educational model, the "flipped classroom" approach has been described in the literature as an effective way to foster learning, engagement, and camaraderie for adult learners in health care professions.[6-10]

The PACTS curriculum was implemented at 3 general surgery programs, with plans to expand to five additional academic medical centers. The primary objective of current pilot study was to explore surgical residents' perspectives on the relevance and effectiveness of the PACTS curriculum in modifying (1) their clinical practice, (2) attitudes about providing cross-cultural care, and (3) cross-cultural communication skills. Understanding the barriers and challenges associated with incorporating cultural dexterity, both at the individual and institutional level, was a secondary objective of this study.

METHODS

Participants and Setting

Focus group participants constituted a convenience sample of general surgery residents from 3 academic medical centers in Boston, MA at which the PACTS curriculum had been pilot tested over the preceding year. Depending on the individual program's academic curriculum, residents are separated according to level of training for certain educational activities. As a result, both the PACTS curriculum sessions and the focus groups were administered to residents of varying levels of training. At 2 institutions, only first-year (PGY-1) residents received the curriculum, and therefore participated in the focus groups, whereas residents of all levels of training were included at the third institution. The variety in clinical experience was deliberately introduced into the sample to ensure diversity of perspectives.

Data Collection

The study team developed the semistructured interview guide to elicit rich descriptions of the residents' experience with the PACTS curriculum and with caring for diverse patients. Program directors informed their residents that the focus groups would be held during the upcoming didactic sessions and that participation was voluntary. Four focus groups were held (2 focus groups were conducted simultaneously at one of the sites). Each group consisted of 6 to 9 residents and lasted approximately 1 hour.

Focus groups were moderated by 3 investigators with qualitative experience (A.F.H., A.C., and M.C.A.). Two of these investigators are physician trainees, whereas the third is a research specialist with a background in public health. One of the investigators is a current resident at one of the programs included in the study; however, this investigator was not involved in the design or dissemination of the curriculum, and the potential for bias as a result of this individual conducting a focus group with her peers was thus deemed to be minimal. Brief demographic questionnaires were distributed at the beginning of the focus group. Participants were asked about their general perception of the PACTS curriculum, the logistical aspects of the curriculum's delivery, how PACTS differed from their prior experiences with cross-cultural training, and what they perceived to be barriers in implementing the curriculum's recommendations (Appendix A). Focus group sessions were recorded and the audio files were stored on the secure institutional server.

Qualitative Data Analyses

Focus group recordings were transcribed verbatim and all potential identifying information was removed. The transcriptions were coded using an inductive, grounded theory approach by a team of 3 investigators (R.U., A.F.H., and M.C.A.). Grounded theory was originally defined by Glaser and Strauss as a means of deriving theory to explain a phenomenon. It occurs in 3 stages: (1) open coding, when codes are assigned to summarize textual data; (2) axial coding, to begin identifying relationships between the open codes; and (3) selective coding, where the data are refined into a single phenomenon, thus forming the grounded theory.[11] The team members coded each manuscript independently, and a finalized codebook was created. The team then met multiple times to discuss codes and achieve consensus among coders. Recurrent themes were identified and relevant quotes were classified according to these themes. All data were entered into Atlas.ti Version 1.0.38

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