

The Refinement of a Cultural Standardized Patient Examination For a General Surgery Residency Program

Maria B.J. Chun, PhD,* Peter Deptula, BA,[†] Sarah Morihara, BS,[†] and David S. Jackson, PhD[‡]

*Department of Surgery, John A. Burns School of Medicine, University of Hawaii at Manoa, Honolulu, Hawaii; [†]John A. Burns School of Medicine, University of Hawaii at Manoa, Honolulu, Hawaii; and [‡]State of Hawaii Department of Health, Honolulu, Hawaii

BACKGROUND: Recent articles have documented the importance of cultural competency in surgery. Surgical residency programs have used the Objective Structured Clinical Examinations or cultural standardized patient examinations as a training tool. Past studies evaluating cultural competency have noted the importance of including an observational (control) arm, which would allow for a more objective assessment of a resident's competency in this area. The purpose of our article is to present the results of a follow-up study to a pilot cultural standardized patient examination for surgery residents.

METHODS: All first-year surgery residents were required to participate in the videotaped cultural SP examination as part of the general surgery residency curriculum. Two measures were used to assess resident performance. On the day of the examination, the *Cross-Cultural Care Survey* was administered. The examination was assessed by the residents themselves, faculty observers, and standardized patients, using a written checklist that was developed to evaluate residents on all 6 Accreditation Council for Graduate Medical Education competencies.

RESULTS: The current study includes 20 first-year surgery residents from academic years 2011 to 2012 and 2012 to 2013. The examination of pretest differences in groups found that students born outside of the United States had significantly higher scores on attitude ($t = -2.68$, $df = 18$, $p = 0.02$), but no statistically significant differences were found in skillfulness or knowledge or in the overall rating scale. For the overall rating scale, change from pretest to posttest was statistically significant ($t = -2.25$, $df = 18$, $p = 0.04$). Further analysis revealed that students who were born in the United States demonstrated a significant

increase in ratings ($t = -3.08$, $df = 10$, $p = 0.01$) whereas students who were not born in the United States showed little change ($t = -0.35$, $df = 7$, $p = 0.74$). These results show that the means in attitude scales changed little for all groups, but both white and US-born students showed greater improvement on skillfulness and knowledge.

CONCLUSIONS: Training and measurement of cross-cultural health care skills remains challenging. However, studies like these provide a good starting point from which to build. (J Surg 71:398-404. © 2014 Association of Program Directors in Surgery. Published by Elsevier Inc. All rights reserved.)

KEY WORDS: cultural competence, surgical resident education, standardized patient, general surgery

COMPETENCIES: Patient Care, Professionalism, Interpersonal and Communication Skills

INTRODUCTION

The inclusion of cultural competency or consideration of cultural factors in training and practice is no longer foreign to surgery. Recent articles have documented this need.¹⁻⁷ Surgical residency programs have used the Objective Structured Clinical Examinations (OSCEs) or cultural standardized patient (SP) examinations as a training tool.^{3,5,7-9} Past studies evaluating cultural competency have reported on the importance of including an observational (control) arm, which would allow for a more objective assessment of a resident's competency in this area.^{6,7} Moreover, professionalism and cultural competency have been effectively taught to residents via standardized patient examinations.^{8,10-14} Recent articles also suggest that increasing the ethnic diversity of surgical residents and providing international surgical mission experiences are effective ways of incorporating

Correspondence: Inquiries to Maria Bow Jun Chun, PhD, Department of Surgery, John A. Burns School of Medicine, University of Hawaii at Manoa, 1356 Lusitana Street, 6th Floor, Honolulu, HI 96813; fax: (808) 586-3022; e-mail: mariachu@hawaii.edu

cultural competency into resident training.^{1,2} Hamilton¹⁵ maintains that the OSCE is the most reliable and suitable method for assessing intercultural skill sets.

The purpose of our article is to present the results of a follow-up study to a pilot cultural standardized patient examination for surgery residents.⁵ The pilot study centered on the implementation phase of our cultural SP examination, including both the successes and the difficulties encountered. Initiated in 2008, the project is now in its fifth year. The results of the initial study did not demonstrate statistically significant improvement regarding surgery resident knowledge, skill, and attitude toward cross-cultural care.⁵ However, Chun et al. found significant differences by resident race/ethnicity. Specifically, there were significant racial/ethnic differences in all 3 categories of the *Cross-Cultural Care Survey* (attitude, knowledge, and skills) on the pretest and in the category of knowledge on the posttest. Chun et al. suggest that these results demonstrate a “one-size fits-all” approach to cross-cultural training may not be optimal. We, therefore, revisit the possible influence of race/ethnicity in this article as well.

METHODS

We obtained Institutional Review Board approval from the University of Hawaii Human Studies Program (CHS #16439) before implementing the pilot. The study was deemed as exempt.

Subjects

All first-year surgical residents are required to participate in the SP examination. Annually, our sample size typically comprises 10 to 11 subjects each year (pretest and posttest). The current study includes 20 residents from academic years 2011 to 2012 and 2012 to 2013.

Research Design/Procedures

We believe that formal training (preparedness) in cross-cultural care issues is positively correlated with a surgeon's ability to work effectively with diverse patient populations (skillfulness). In consultation with the University of Hawaii at Manoa's Department of Family Medicine and Community Health, which has been using cultural standardized patients for more than a decade in its residency curriculum, we designed a standardized patient scenario. The scenario involves a surgeon attempting to obtain informed consent from an elderly Samoan man who needs to have his leg amputated or face certain death. Two additional standardized patients also participate in the scenario—the patient's wife and a medical interpreter. Samoan medical interpreters (certified) from a local community health clinic

provided input on the authenticity of the case during its formulation.

Protocol

The SP examination was assessed by trained surgery teaching faculty using a written checklist that was developed by the Department of Family Medicine and Community Health. The tool allows faculty to evaluate residents in all 6 Accreditation Council for Graduate Medical Education (ACGME) competencies. Surgery residents received immediate feedback from the faculty preceptor and 1 of the study investigators as part of a debriefing process. In addition, the SP completed an evaluation form, and the surgery residents completed a self-assessment. This self-assessment/self-reflection form allowed the residents to compare self-perceptions with the ratings of both the faculty and the SP. The sessions were also video recorded so that other faculty may review and rate the interactions using the same standardized checklist. Additionally, the residents have access to the video recordings to assess their own performance. Within a month, the surgery residents participated in a journal club or a didactic session.

The posttest was conducted 3 months later, and we readministered the Cross-Cultural Care Survey and the cultural SP examination to determine whether the lecture/didactic session/journal club, initial SP examination, and the debriefing had any effect on resident perception of preparedness to provide cross-cultural care. [Figure 1](#) provides the timeline for the study protocol.⁵

Measurement and Instrumentation

We employ 2 measures to assess resident performance: (1) The *Cross-Cultural Care Survey* (CCCS) developed by Weissman and Betancourt.¹⁶ Keeping the survey's scales intact, this abbreviated version of the survey focuses on preparedness and skillfulness. The edits to the original version of the survey did not affect the reliability and validity of the survey.¹⁷ (2) A revised version of a written checklist developed by the University of Hawaii at Manoa's Department of Family Medicine and Community Health or Checklist.

Analysis

Owing to small sample size ($n = 20$), race was dichotomized to provide sufficient group sizes to compare whites and non-whites. Rating scale scores on patient care, interpersonal and communication skills, professionalism, and cultural awareness as well as scores by self, faculty, and SP were combined into a single overall mean rating scale score. For the CCCS scales of attitude, skillfulness, and knowledge, items were summed to create scores for each of these scales, consistent with the study from a previous cohort.

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