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Using Standardized Patients to Teach and Evaluate Nurse Practitioner Students on Cultural Competency*

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Abstract

With the increasing diversity in the American population, it is imperative that nurse practitioners learn to manage patients with varying healthcare beliefs and needs. In order to develop culturally competent nurse practitioners, a number of methods have been developed. Many of the current methods focus on improving the awareness and knowledge of nurse practitioners regarding diverse populations. However, very few of the current programs focus on improving the skills and increasing the encounters the students have with diverse populations. This paper focuses on providing nurse practitioner students with diverse encounters using culturally enhanced standardized patient scenarios. The standardized patient programs provide nurse practitioner students with the opportunity to develop knowledge and skills related to cultural competency in a safe environment where the students can practice communication and physical assessment skills as they receive feedback from the patients they are seeing.

KEYWORDS: Culture, Nurse Practitioners, Standardized Patients,

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“This is so frustrating. I just don’t seem to be able to help Clara Jones. She is only 40 years old and her health is declining. She is already hypertensive and obese. She will likely have diabetes and knee trouble before she is 45. If she would just lose weight, her health would drastically improve. But she seems to have so many excuses for not changing her behavior, which I know are true for her. I told Ms. Jones to start walking in her neighborhood. She said her neighborhood was too dangerous. I suggested that she eat more fresh fruits and vegetables. She said that fresh foods were too expensive. She was not even taking her medications as prescribed because they too were expensive. I keep running into similar scenarios with middle-aged, black women. How can I make a difference? I just feel like giving up.”

It is not uncommon for an impasse to develop between healthcare providers and their patients as a result of cultural differences. All too often, neither person is able to understand the other’s perspective. As a result, they are unable to reach a consensus on how to address the patient’s healthcare needs.

INTRODUCTION TO CULTURAL NEEDS

It has been estimated that one in four Americans (67 million) is classified as African American, Latino/Hispanic, Native American, or Asian/Pacific Islander (Kaiser Commission, 1999). Due to higher birth rates and immigration among racial and ethnic populations, by 2050, people of color will represent one in three Americans. Diversity is not only found between major ethnic groups but within groups as well. For instance, with the term Latinos/Hispanics, many subcultures with differences in beliefs and health practices are represented from people with Puerto Rican heritage to Spanish/indigenous cultures in Central America (US Census Bureau, 2000). Cultural difference within ethnic groups, including White Americans, may be the result of issues such as religious beliefs, age, gender, sexual orientation, occupations, disability, and environmental factors.

Bias, prejudice, and stereotyping about race or culture may be contributing factors for disparities in health care. Well meaning providers who are not overtly biased may demonstrate unconscious negative cultural attitudes and stereotypes (Institute of Medicine, 2002). Nurse practitioner (NP) students in clinical learning environments may be influenced by this subtle bias to adopt similar views and approaches with clients as they take on the advanced practice skills. This may be the result of real or perceived discrimination resulting in mistrust of providers (Grisso, 1999). As a result, minorities and persons from different cultures are less likely to develop and maintain consistent relationships with a provider and are

more likely to miss vital opportunities for health screening and health promotion education (Institute of Medicine, 2002).

The role of the provider in the care of diverse populations may be affected by the lack of specific cultural education, participation in culturally enriched learning experiences, and clinical experiences with diverse cultures (McHorney & Bricker, 2002). In order to address this issue, nursing education programs must evolve in response to the changing demographics in the United States. Learning experiences that help students communicate with an understanding of the influence of culture on the quality of health care provided are needed. As was noted by the Institute of Medicine committee in review of its report, *Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care* (2002), the provider is obviously the more powerful actor in clinical encounters and should shoulder more of the responsibility for seeing that disparities in care do not occur. Based on this, the Nurse Practitioner Primary Care Competencies (2002) were developed from the partnership among the National Organization of Nurse Practitioner Faculties, the American Association of Colleges in Nursing, and the Department of Health and Human Services. These competencies include cultural competence as a required outcome for all NP educational programs.

It is unreasonable to expect NPs to know about all clients from all diverse communities. Instead, it is important for them to understand that there are differences in cultures that must be considered in order to provide the patient with optimum care. It is thus vital that the student become competent in gathering data about each patient's culture in a thorough, relevant, and non-offensive manner.

CURRENT WEAKNESSES IN TEACHING METHODS

Courses devoted to teaching health history interview and physical examination skills are the foundation of NP education and are offered in varying formats, combining learning in the classroom and practice in the skills laboratory. Faculty demonstrations, videotapes, interactive computer programs, and practice with peer partners are strategies traditionally used to help students acquire the skills needed in the clinical setting.

Teaching basic health assessment skills, particularly health history interviewing, is considered routine. Often, instructors take for granted that students are able to engage in appropriate conversation and solicit answers to specific questions. Therefore, practice of these skills may not be closely supervised. Likewise, using peer partners for practice puts students in the awkward position of providing feedback to classmates that may be

uncomfortable, incorrect, or inappropriate. Because there is no opportunity for students to question diverse patients before they get into the clinical setting, they enter the clinical environment largely unaware of behaviors that would offend diverse patients and compromise the interview. At best, these formats provide the student with some awareness, knowledge, and desire related to other cultures. But they rarely provide the student with the skills and encounters needed to become culturally competent.

Nurse practitioner students need instructional experiences that provide specific feedback, especially on sensitive cultural and ethical issues, from someone with expertise in giving feedback from a patient's perspective. By offering NP students opportunities to work with patients with a variety of health problems and cultural issues in a non-threatening instructional environment, the student may overcome some of the fears and insecurities they have in anticipation of clinical assignments. Furthermore, they may be prepared to be better communicators, and ultimately, better NPs.

CULTURAL COMPETENCY MODEL

In order to provide NP students with the opportunity to improve their cultural competency, a new format of training is needed. The format introduced in this paper integrates cultural content into standardized patient encounters utilizing the Cultural Competency Model developed by Campinha-Bacote (2002). This model includes constructs of cultural awareness, knowledge, skills, encounters, and desire. According to the model, cultural competency is improved when students have the opportunity to increase their awareness, knowledge, and skills regarding cultural issues through encounters with members of various cultures. Through cultural experiences, it is hoped that the students will have an increased desire to work with other cultures.

An example of the integration of the model into a standardized patient case might include the obese, black low social economic status (SES) female patient with hypertension. In this situation, the students would be provided with *encounters* with a patient that has these characteristics. Students would conduct a history and physical on the patient and receive feedback about their performance. The focus would be on student abilities to address cultural issues in a sensitive and knowledgeable manner. This would enable them to increase their *awareness*, *knowledge*, and *skills* regarding patient care. Specific emphasis would be placed on how the patient's culture (low SES, being black, and living in a dangerous neighborhood) impacts on their health and ability to address their healthcare needs. Through experiences such as this, the student should become more

comfortable with providing care to patients with similar issues. This should increase their *desire* or at least decrease their frustration in working with such patients in the future. The goal of the culturally oriented curricula presented in this paper is to provide NP students with the educational opportunities through standardized patient encounters to become culturally competent providers.

THE STANDARDIZED PATIENT PROGRAM

Background

A standardized patient is an individual (actor) that has been taught to portray a patient seeking medical care. Standardized patients are used to train healthcare students in gathering a history and conducting a physical exam through cases that are generic as well as disease specific. On occasion, a standardized patient may present a case that has a cultural component, however, this is not the norm.

In 2001, the graduate nursing program began working with the Assessment Center at a local medical school in order to educate NP students in history gathering and physical examination skills. The center is a national leader in professional skill education for medical, physical therapy, and health professions students. The faculty and staff at the Assessment Center have developed over 600 standardized patient case encounters that have been used primarily with medical students as part of their training. The focus of the center is to teach and assess the clinical competencies in medical interviewing, clinical reasoning, ethical decision-making, communication skills, physical examination, and the application of clinical knowledge. The cases use standardized patients who are individuals from the community trained to present a clinical scenario, assess performance, and provide feedback to learners. The center has standardized cases representing patients, aged 16-78. Selected encounters are videotaped for faculty, and student review and evaluation. Rating formats have been developed for each case to provide feedback to the students and faculty. The standardized patients complete these forms based on their evaluation of the student's performance. The standardized patients can provide real time immediate feedback to the students stating, "this is how I felt when you asked me about..." This can be very effective for learning history taking and assessment skills especially related to cultural issues.

The Development of the Cases

By meeting with focus groups, the graduate nursing program has been able to develop culturally enhanced standardized patient cases based on a “grassroots” or “lived experience” approach. A faculty member, a research assistant, and a member of the cultures represented meet with members of a specific culture in a focus group, to identify factors that impact health and healthcare. The focus groups come from church activities, support groups, and cultural organizations. The focus groups address the cultural needs resulting from ethnicity, alternative lifestyle, religion, domestic violence, homelessness, SES, and disability. The specific emphasis of the focus groups is on identifying culture-specific barriers to care and effective methods for overcoming them. The focus group members tell stories of healthcare encounters that have either gone very well or very poorly from a cultural perspective. They are encouraged to share their experiences, desires, and recommendations regarding healthcare. These stories are utilized to develop the standardized patient scenarios. The focus groups are audiotaped for use by other faculty and notes are taken by the research assistant during the sessions.

Once the information from the focus group is transcribed and reviewed by the NP faculty, it is given to the staff from the Assessment Center who is responsible for the development of the standardized patient cases. They write the scenarios that are reviewed by the NP faculty as well as members of the culture being represented, to determine if relevant healthcare and cultural issues have been addressed appropriately. The cases are reviewed for content, completeness, and correctness. Modifications are then made to the cases. The staff at the skills center recruits and screens potential standardized patients to meet the cultural specifications. The chosen standardized patients are then trained to portray the scenarios.

Arranging Sessions

The standardized patient program is implemented with on-campus students as well as with distance students. The local students go to the Assessment Center for their standardized patient encounters. To accommodate distance students, the standardized patients are transported by van to designated facilities near the distance sites. The students are provided with the dates and times that the standardized patient program is provided at their site. They e-mail the coordinator at the Assessment Center with several preferred times for their encounter. The coordinator then assigns one of the times to the students.

Three Standardized Patient Formats

Three different formats are used to train the students in cultural competency and to evaluate their performance. These include the group training interview, the group physical assessment, and the one-on-one interaction.

Group Interview. The first method, the group interview, consists of four to six students with a standardized patient and a faculty member. These encounters are utilized primarily for educating students in history gathering on sensitive issues. During the group session, the students are given opportunities to interview the standardized patient with the entire group watching. The students interview the patient using a “tag team” approach. When students are unsure of additional questions, they can turn the interviewing over to other students. If a student feels that an issue needs further exploration, the student may tag in and continue the interviewing process. The faculty member acts as facilitator during this encounter. Once the interview is completed, the students assess their performance before the group. The standardized patient then gives feedback regarding what the students did well, as well as things the students did that were not appropriate, and could even be offensive. The students are then able to ask the standardized patient how they can address certain issues without offending a patient, yet gather the information needed for a complete health history. Once the patient and students have completed their discussion, the faculty member reviews the encounter and concludes the session. This format has been used very successfully at the Assessment Center with students focusing on issues such as chronic illness, alternative lifestyle, death and dying, and spirituality.

Group Physical Exam. The second format is the three-on-one physical exam, in which three students meet with a standardized patient for a learning encounter. The standardized patient, after extensive training on physical exam techniques by the staff at the Assessment Center, shows the students how to conduct a physical exam and then the students each conduct the exam. The standardized patient gives the students feedback on how they are doing and makes suggestions for improvement. Nurse practitioner students are currently being taught by standardized patients to do the male and female GU exams as well as a complete physical. During these encounters, each student is able to conduct the exam on the standardized patient while the patient talks them through the technique. Previously, the cases focused strictly on exam techniques without any reference to history or culture. Through the culturally enhanced program, the standardized patients are taught to present cultural issues as part of the case they portray. The students must complete their exam considering the cultural issues presented. An example of a culturally enhanced case is one in which a Hispanic

woman experiences an injury to her arm. During the exam, the patient responds as an abused patient might by being vague about the cause of the injury, avoiding eye contact, and being resistant to further evaluation. Following the exam, the standardized patient discusses how the student could address issues such as domestic violence, as well as consider the context of her cultural environment, during the exam.

One-on-One Format. The third format, the one-on-one encounter, consists of one NP student with one patient. This format is used for both educating and evaluating the student's performance in many of the NP clinical courses as well as comprehensive examination. Through this program, each student individually conducts a culturally appropriate assessment and physical examination utilizing a standardized patient. An example of a case presented as part of the class on chronicity includes an obese black patient with diabetes and hypertension who lives in poverty. The students are required to assess the patient to identify potential compliance issues, generate a plan for managing the diabetes and hypertension, and address the barriers encountered by black women living in poverty. For instance, the student would have to address medication issues, when the patient is having a difficult time affording the medication, as well as exercise issues, when the patient lives in a dangerous neighborhood. The plan often includes providing the patient with information on how to obtain cheaper or discounted medication (i.e., mail order, drug company programs, samples) and alternative exercise plans (i.e., walking in malls, walking with church groups, walking steps in the house).

When the student arrives at the Assessment Center, they are provided with the case in the form of a chart. The "chart" includes some basic information about the patient, similar to what would be available upon presentation for a clinic visit. The students use the time prior to going into the room with the patient to consider the case and plan for the interview. Each student is given between 40 minutes and 1.5 hours to complete the health history interview and/or physical with the standardized patients. The time varies based on the complexity of the case. Upon conclusion of the interview, the standardized patient discusses the interview with the student and offers suggestions for improving future client interactions. When needed, a videotape of the student's encounter can be produced and available for review and self-evaluation, as well as for faculty to use when coaching a student demonstrating marginal performance.

The standardized patients use the online, web-based application (WebSP), to document components of the health history and physical that were addressed or missed by the students during the interview (Lionis Corp., 2004). A 'yes' or 'no'

response is required for whether the student included items on biographical data (i.e., race, age, cultural heritage, sexual orientation), reason for seeking health care, history of present illness, past medical history, functional assessment, social history, and family history. Each component of the physical exam is rated as “correct technique,” “incorrect technique,” or “not done.”

The standardized patients use the Master Interview Rating Scale (MIRS), a tool developed by the Assessment Center for use with medical students and revised and validated for use with nurse practitioner students, to rate the student’s interpersonal skills in conducting the health history interview. The MIRS contains 15 items that are rated on a 5-point scale (1=poor to 5=excellent) and includes the following behaviors: timeline, questioning skills, lack of jargon, patient perspective, support system, verbal facilitation skills, empathy and acknowledgement of patient cues, encouragement, admitting lack of knowledge, closure, organization, pacing, transitional statements, and summarizing. To guide the assignment of a score, items have a set of defining characteristics for each rating that describes the expected performance. This tool has been enhanced to include the assessment of culturally competent interviewing skills relevant to each case. These might include items such as: “The student made me feel comfortable revealing my sexual orientation,” “The student was sensitive to cultural issues related to dietary changes,” or “The student was able to make realistic recommendation related to my living environment.”

Summary reports of the case item analysis and MIRS scores for each student, along with aggregate statistics on the performance of students are made available to faculty. The faculty is provided with a password to log into the database at the Assessment Center. There they can access individual and aggregate data for each case. Students are e-mailed data regarding their performance on the standardized patient cases.

The students are also required to submit a written note documenting subjective and objective data, as well as assessment and plan (SOAP) on some of the standardized patients they see. This enables the faculty to understand the decision-making process students used to handle the data they obtained as a result of the history and physical examination.

EVALUATION OF PROGRAM

Reports confirm that the integration of standardized patient experiences in an advanced practice nursing curriculum enables practice times to be more efficiently used, aids students to develop comfort and confidence in performing a

complete history and physical examination, and offers better assessment and feedback on the development of students' clinical skills (Gibbons, Adamo, Padden, Ricciardi, Graziano, Levine, et al., 2002; O'Connor, Albert, & Thomas, 1999;). In studies that compared instruction in medical interviewing by standardized patients versus that provided by faculty, findings suggest that instruction by the standardized patient is comparable to that provided by faculty, yet the instruction by the standardized patient generates greater student satisfaction (Vannatta, Smith, Crandall, Fisher, & Williams, 1996; McGraw & O'Connor, 1999). This was attributed to the level of supervision, quality of feedback, and amount of practice time during standardized patient experiences. As Vannatta, Smith, Crandall, Fisher & Williams (1996) noted, just eight hours of interaction with the standardized patient was highly beneficial and effective in improving students' abilities to use open-ended questions and demonstrate empathy skills during medical interviewing.

Student evaluation of the standardized patient experiences have been conducted using the Quality Report on the Use of Standardized Patients form, which was developed by the Assessment Center. The evaluation is a 5-item survey that asks students to rate their experience with the standardized patient on a 5-point Likert scale (1=poor to 5=excellent). This is followed by a section for comments including: "What did you learn?" "How could the program better suit your needs?" and "general comments."

Overall, the feedback on the standardized patient program has been very positive. The mean scores for the one-on-one encounters are, "format of the session" (mean=4.19), "instruction from the standardized patient" (mean = 4.81), "standardized patient's knowledge of the exam" (mean = 4.85), "standardized patient's facilitative teaching style" (mean = 4.81), and "standardized patient's professionalism" (mean = 4.90). The students rated the same categories as 5.0 when standardized patients were used for the female and male genital exams.

In the comment section of the evaluation, students stated that they learned a lot about interviewing a patient effectively using open-ended questions and being more specific. They also increased their ability and accuracy in the performance of various clinical skills, such as diaphragmatic excursion, reflexes, and heart sounds. Students stated that the standardized patients made them feel comfortable and that they would like to receive more training from them. Many of the students emphasized that they would be willing to pay an additional lab fee to have more sessions with the standardized patients. Some students even requested refresher encounters after they had spent some time in the clinical settings. The main criticism related to students' uncertainty regarding the level of preparation

needed for the standardized patient experience and a desire to know what to expect before they went to the Assessment Center.

BENEFITS OF STANDARDIZED PATIENT PROGRAM

There are a number of benefits to using a standardized patient program to train and evaluate the performance of NP students. These include consistency of clinical encounters, feedback to faculty and students, decreasing student anxiety, and videotaping of encounters.

Availability and Consistency of Clinical Encounters

The growth of the standardized patient experience as an instructional approach in health education stems from the need to provide students with structured learning situations in which they are challenged to apply clinical knowledge during an actual, albeit staged, patient encounter. Cases are uniquely designed to allow students to interact with patients across the lifespan who represent a variety of health conditions and cultural issues. The ability of the standardized patient to portray the same case consistently over time, and for several standardized patients to accurately depict the same case concurrently, offers a degree of reliability not found in actual patient assignments in the clinical setting (Colliver & Williams, 1993; Tamblyn, Klass, Schnabl, & Kopelow, 1991).

The most common uses of the standardized patients in healthcare involve educating and evaluating students on history taking, interviewing skills, complete physical examination, segments of the physical examination (i.e., neurological or cardiovascular problems), patient education and counseling, female breast and pelvic examination, male genitourinary examination, and focused encounters involving brief history and physical examination (Anderson, Stillman, & Wang, 1994). These experiences can be tailored to meet the educational objectives established for a course or curriculum, assure that all students are engaged in comparable instructional activities, and provide consistent and accurate evaluations of student performance. Furthermore, the cases can guarantee that all of the students are exposed to patients with various cultural issues.

Feedback to Faculty

The standardized patient methodology enables faculty to receive structured, objective, and standardized feedback on student performance from the standardized patients, and provides information on attributes that cannot necessarily be assessed by written examinations or SOAP notes (Solomon,

Szauter, Rosebraugh, & Callaway, 2000). This performance feedback enables faculty to distinguish between the prepared/unprepared, more skilled/less skilled, and confident/ insecure students (Arthur, 1999). As a result, faculty members are able to address the weaknesses identified in students in order to institute remedial programs as needed. Furthermore, biases and prejudices of the students become more apparent enabling the faculty to address the impact on clinical encounters.

Feedback is also instrumental in identifying weaknesses in a program. By analyzing the aggregate data, faculty is able to identify content areas where a substantial number of students have difficulty. Based on this information, the faculty is able to make improvements to the program. An example of how this was used includes a case on generalized anxiety where the standardized patient was a lesbian. Three quarters of the students did not obtain the information on alternative lifestyle. As a result, the program is now instituting a greater focus on alternative lifestyles.

Decrease Anxiety/Increase Confidence

Student interaction with the standardized patient provides an opportunity for a comprehensive patient experience in a safe environment where mistakes can be made and feedback can be obtained to correct the mistakes without compromise to the patient. The non-threatening learning environment allows students to develop confidence in clinical knowledge prior to actual patient experiences. The students are able to question knowledgeable patients regarding both history taking and physical exam techniques. Furthermore, they are able to get feedback on their questioning techniques and cultural competence. For example, in addressing a patient with an alternative lifestyle, the students are able to ask the patient about questions that could be taken as offensive as well as the correct use of terminology.

Feedback to Students

The standardized patients provide verbal feedback to the students immediately after they complete the assessment and/or exam. This enables the students to get clarification regarding their weaknesses and strengths during the encounter with the standardized patient. In situations where the weaknesses are related to the physical exam, the student is able to practice the correct technique during the feedback portion of the session. When the weaknesses are related to the history and communication skills, students can try different ways to communicate with the standardized patient and then get feedback on what works best. This increases the competency level of the students related to cultural skills.

Videotaped Encounters

Students can be videotaped during many of their encounters with standardized patients. The videotapes can be used for the students to review and evaluate their own performance. The faculty can also use the videotapes to further evaluate the student. This can be done by the faculty member alone or while the student is present. The videotapes are especially helpful in counseling a student that is demonstrating a deficit in clinical care. Finally, the videotape can be used if there is a discrepancy between the standardized patient and the student regarding skills demonstrated during the encounter.

BARRIERS TO THE PROGRAM

A number of advanced practice programs have not been able to offer a standardized patient program due to financial and organizational barriers. However, there are approaches that can be used to overcome some of the barriers.

Cost

Fees for a standardized patient experience may range from \$20 to \$400 per student depending on whether the standardized patient is used for instruction and/or performance assessment, and whether students work individually or in groups with the standardized patient. To address costs, students pay an additional lab fee. This fee is used to develop, implement, and evaluate the standardized patient cases. Many students have been so pleased with their experience, they have asked for more encounters and have been willing to pay additional lab fees.

Resources to Implement Program

Also of concern to nursing faculty are the human and financial resources needed to develop and refine scenarios, create evaluation tools, and coordinate the actual experiences (O'Connor, Albert, & Thomas, 1999; Vessey & Huss, 2002). The location of a medical school with a well-developed standardized patient program has eliminated the need to develop these resources. The program at the Assessment Center is established. It only requires that faculty from the NP program provide the staff with input needed to develop or refine the cases and train the standardized patients. A number of medical schools have developed these resources and may welcome prospective partners from advanced practice nursing graduate programs.

Many programs like the one at the Assessment Center are willing to travel to other schools and help them set up similar programs. The staff at the Assessment Center transports the patients to our distance sites so that all of our students can have similar experiences. In addition, the staff and standardized patients from various programs travel to other medical schools, medical conferences, and clinical sites throughout the United States to provide medical students, residents, MDs, and other health care professionals with the standardized patient experiences.

Many of the tools used to evaluate the standardized patient experiences such as the WebSP (Lionis Corp., 2004) and the Master Interview Rating Scale (MIRS) are now available for others to use. As a result, less emphasis has to be placed on developing new methods for evaluation. These tools can be refined for the particular case that is being implemented, cultural content, or the level of the students being evaluated.

Access to Standardized Patients

There may not be easy access to an existing standardized patient program. Some schools have developed their own standardized patient program. This has been accomplished by having members of the community come in for students to gather histories and conduct physical examinations. This was one of the approaches used in initially developing the Assessment Center. Members of community groups allowed students to interview them about topics such as death and dying, chronic illness, and alternative lifestyles. They then gave the students feedback.

To provide students with cultural encounters that are realistic, patients must be recruited from various cultural groups. This has been made possible through word of mouth, focus groups, and community organizations. Patients from various cultural groups are able to enhance the encounter by sharing some of their own experiences while providing students with feedback.

Student Comfort Level

Students may be anxious, unsure of what to expect, and afraid to make a mistake the first time they participate in the standardized patient program. This is especially problematic if the student's only encounter with the standardized patient is for a testing session. Vessey & Huss (2002) point out that the use of one-time standardized patient experiences for the evaluation of outcomes may lack the validity and reliability needed to accurately judge performance,

particularly in the advanced practice role of NP, and consequently be of less value than direct observation by faculty or visits to students and preceptors at clinical sites. Furthermore, students unfamiliar with the concept of standardized patient experiences for teaching and evaluation may feel intimidated and apprehensive about the expectation to perform and be evaluated in situations involving standardized patients (Gibbons, Adamo, Padden, Ricciardi, Graziano, Levine, et al., 2002; Vessey & Huss, 2002). In order to overcome the performance anxiety, students from the NP program now participate in a learning experience with the standardized patients before they are tested with the patients. This enables the students to have the experience without worrying about making mistakes. They realize that this first experience is for learning a skill that they are not already expected to know.

SUMMARY

Nurse practitioner students are expected to master skills needed to assess and manage patients in the clinical setting, but are often asked to do so after only practice in a skills laboratory. The instruction may not be individualized and the quality of the feedback may be insufficient to change behavior or assure the confident transfer of knowledge and skills to actual patient care. More importantly, practice with a peer partner does not enable the student to develop an appreciation of the uniqueness of the nurse-patient relationship, understand the complexity of health care problems, or recognize the cultural issues that can impact the quality of patient care. Once students begin clinical practice, their experiences are often confined to only the type patients that come into their site. The diversity of patients may be somewhat limited in many of the sites, thus minimizing the exposure of the student to other cultures.

The standardized patient experience guarantees the student will be exposed to patients representing diverse groups. The faculty can select the cases based on the diversity of cultures experienced and the practice skills required to work effectively with the specific client. Furthermore, the students are provided feedback from the patients related to their performance and methods for meeting the needs of the respective culture. The advanced practice student is more likely to accomplish the cultural competencies described by Campinha-Bacote (2002) with a curriculum that includes culturally enhanced standardized patient cases as well as culturally oriented didactic courses. Not only will they achieve the awareness and knowledge related to cultural competency, but they will also be provided with cultural encounters that enhance their cultural skills. With this added experience, the students should become more comfortable with other cultures, thus increasing their desire to appropriately manage diverse patients.

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