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A Standardized Narrative Profile Approach to Self-Reflection and Assessment of Cross-Cultural Communication

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None

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A Standardized Narrative Profile Approach to Self-Reflection and Assessment of Cross-Cultural Communication

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ABSTRACT

Objectives: 1) to explore clinical assessor's values regarding behaviours related to cultural aspects of care, 2) to generate standardized narrative profiles regarding cultural behavioural outcomes within clinical teaching settings, and 3) to rank order standardized narrative profiles according to performance expectations. **Methods:** Ten interviews were completed with clinicians to determine values and performance expectations for culturally competent behaviours. Transcripts were produced and coded. Six narrative profiles were developed based on data obtained. Twenty clinicians categorized profiles according to performance expectations and rank ordered. Intraclass correlation coefficients (ICCs) determined inter-rater reliability. Clinicians rated usability of profiles in clinical training settings. **Results:** Eighteen categories were coded with communication, awareness and ability most frequently reported with each ranging from 9.6-11.5% of the utterances. Consensus for categorization of all profiles was achieved at a level of 70% (ICC = 0.837, 95% CI 0.654-0.969). High inter-rater reliability was achieved for rank ordering (ICC = 0.815, 95% CI 0.561 to 0.984). Seventeen (85%) clinicians agreed that the profiles would be usable in clinical training settings. **Conclusions:** Standardized narrative profiles may aid assessment and self-reflection for student performance within culturally diverse interactions.

Keywords: cultural competency, communication, student performance, assessment, culture

INTRODUCTION

Health professionals around the world are required to practice within culturally diverse environments by interacting with patients and colleagues with differing values and belief systems.^{1,2} As such, curricula and training programs must expose and immerse students in, either real or simulated learning settings, to the knowledge, skills, and attitudes that will foster behaviours congruent with providing culturally appropriate care.³ The aim is to prevent discrepancies in care and avoid cultural conflicts within the workplace. The importance of this aim is recognized throughout health professions education and most recently as accreditation requirements for development of curricula to address cultural competence, health literacy, and health care disparities.⁴

Cultural competence, although difficult to define, is typically recognized as a set of congruent behaviours, attitudes, and policies that are embodied among professionals and enable work within cross-cultural situations.⁵ While recognized as a fundamental competency for health professionals worldwide, the concept is commonly criticized for its assumption that individuals can inherently acquire these attitudes and skills and then effectively demonstrate them in a measurable context.⁶ This is at least partly attributable to the unknown nature of when one might encounter an interaction where these attitudes and skills are necessary. For example, one situation deemed culturally diverse to one person may have no cultural implications on another person. Take, for instance, socioeconomic status. This 'cultural' consideration may cause communication or behaviour challenges for an individual due

to lack of understanding of the specific needs, values, and beliefs of someone with a differing perspective. However, these feelings may not be mutual between one practitioner and others, as cultural moments depend on one's own unique reactions to what they encounter and perceive during an interpersonal interaction. Perhaps other practitioners have more experience or better relate with patients identifying with differing socioeconomic statuses and therefore do not encounter cultural conflict. This reality makes it difficult to design assessments and measure cultural competence within any structured setting, especially as these cultural moments cannot be predicted.

In the past, provider-related cultural competence training focused on facts pertaining to distinct populations (primarily ethnic), but it was recognized that this approach was not effective for improving patient care and led to stereotyping.⁷ Newer approaches focus on communication training and alert providers to be aware that cross-cultural social issues and health beliefs are present in all cultures.⁸ These approaches are conducive to using the patient as the method of instruction to shape providers' attitudes and skills when faced with cultural conflict. However, there is a gap in knowledge regarding effective assessment of student performance during these training initiatives. Effective formative assessment, summative assessment, and provision of feedback regarding student performance must accompany teaching and practice methods, in order to promote student growth and development.⁹

While there are many tools (such as checklists and self-assessment instruments) available to evaluate cultural competency, it still remains a difficult concept to assess.¹⁰ A systematic review was conducted to evaluate assessment methods and findings revealed many assumptions that current assessment methods appear to be based on.¹¹ The first assumption identified was that culture was often deemed to be a matter of ethnicity and race. While an important consideration, it is known that other factors such as gender, socioeconomic status, sexual orientation, and simply differing beliefs also attribute to cultural diversity in healthcare.³ A second assumption was that culture is always part of the 'other person' and that the practitioner must be aware and knowledgeable about the 'other person'.¹¹ A third assumption determined cross-cultural healthcare to be about white practitioners working with patients of differing ethnic backgrounds. This self-centered and white-centric approach is irrelevant in times of globalization and likely harmful, especially for multicultural or international settings. Practitioners must recognize their own cultural values and beliefs and their influence on a patient or colleague during an interaction, instead of always focusing on 'the other'.¹¹ Therefore, there is an urgent need to develop new assessment tools outside of these assumptions that better promote self-reflection and student growth.

An alternate approach to cultural training in healthcare is one of cultural humility.⁶ This is a theoretical concept that defines cultural competence not as a discrete endpoint, but as a commitment and engagement in a dynamic, lifelong process that a person enters with patients, colleagues, other care providers, and themselves.¹² It actively shifts the focus from 'the other' to integrate both intrapersonal and interpersonal components for better self-awareness and reflection.¹³ From an intrapersonal perspective, those who are humble have an accurate view of themselves and their own cultural values and beliefs. The interpersonal component suggests humble people can maintain a stance that is focused on the 'other', rather than self, and characterized by mutual understanding and respect.¹³ Cultural humility endorses critical consciousness and reflection of one's social location; it is these skills that ultimately should result in self-growth and support effectiveness of cross-cultural interactions.¹⁴ Stimulating students to reflect on concepts relating to cultural humility should be a goal of teaching and assessment of cultural-related training. However, current practices do not necessarily support this, largely due to a lack of recognition and understanding from both the student and teacher (or assessor) of culturally sensitive interactions and behaviours.

The use of narrative in teaching and assessment is a new area of educational research that may help to promote cultural humility concepts. Narrative allows for accumulation of rich

data that describes experiences that are authentic, reflective, and diverse. There have been a number of studies published describing the generation and use of 'standardized narratives' to assess student performance within practice settings.¹⁵⁻¹⁷ This approach may not only provide a better tool for assessment, but may also give students and assessors context to reflect on student performance, promoting self-awareness and growth through self-assessment and feedback. As cultural moments within clinical practice are personal experiences and difficult to recognize, it is our belief that providing narrative examples to students and practitioners may help to ignite their own reflective processes and lead to better recognition of cultural conflict encountered in clinical practice during experiential training.

The objectives of this study were to explore clinical assessor's values regarding behaviours related to cultural aspects of care, to generate standardized narrative profiles regarding cultural behavioural outcomes within clinical teaching settings, and to rank order standardized narrative profiles according to performance expectations. Ideally, these profiles would be suitable for use as self-reflection or assessment tools.

METHODS

Setting

This study took place at the College of Pharmacy at Qatar University. Qatar itself is a country bordering Saudi Arabia and is part of the Gulf Cooperation Council (GCC). In order to modernize health and education systems to provide care in line with Western standards, Qatar is currently undergoing major healthcare and education reforms.¹⁸ Ethnic diversity is high in the country, as expatriates comprise over 90% of the working population.¹⁹ As such, it is an excellent setting for development of authentic training and assessment practices that address cultural considerations in healthcare.

Phase 1: Determination of Assessor Values Regarding Cultural Competency

Participants

An initial sample of 10 pharmacists, who supervise students on clinical internships, were recruited for interviews. Practicing pharmacists were chosen as interviewees, due to their experience witnessing student interactions with patients and coworkers in culturally diverse settings. Participants could work for an educational institution, but must have had direct patient care and student supervision responsibilities. Participants were selected through purposive sampling based on place of residence, training, and practice setting. Participants were eligible to participate if they held a professional pharmacy degree and had recent experience as a preceptor for students (undergraduate or graduate) on clinical internships. Recent experience was defined as within two years from when the interview took place. Potential participants were first contacted

via an email describing study objectives and procedures and were required to give consent to participate in the interview process, if interest was expressed.

Procedures

Once consent was obtained, investigators began to interview participants. At least two investigators were present for 6 (60%) interviews. At this point, it was deemed one interviewer could be consistent in approach and completed the remaining 4 interviews alone. All interviews were audio recorded. Investigators followed a predefined script for the interview that used three set questions that asked participants to vocalize experiences where students 1) met, 2) exceeded, and 3) did not meet expectations when being observed interacting within culturally diverse settings. Definitions of culture were not immediately given to participants to avoid biasing how questions were interpreted, however general descriptors of ethnicity, gender, socioeconomic status and differing values and beliefs than that of the student were provided according to the predefined script, if asked by participants. Minimal prompts were given throughout the interview but investigators did commonly encourage participants to provide more details and examples regarding experiences described. Participants were asked if they had anything additional to add at the end of the interview. Upon completion of the ten interviews, investigators met to ensure a point of saturation was reached.

Analysis

Once the interview was complete, one of the investigators administering the interview produced verbatim transcripts within 24 hours. Transcription errors were minimized by having a second investigator review transcripts. Next, a content analysis technique was used to assess each transcript. Content analysis was chosen to capture specific examples given by interviewees. Two investigators independently separated each transcript into unique thoughts, phrases, or ideas that related to study objectives and assigned each of these a specific code. Codes were developed using a 'bottom up' approach and generated based on the data obtained. For example, a situation discussing a student's ability to modify behaviour to better suit an individual patient or colleague would be labeled as 'adaptability'. After a transcript was coded, the two investigators met to unify code word choices and discuss any discrepancies. A third investigator resolved conflicts that could not be resolved through discussion alone by achieving consensus between all three investigators. This investigator had expertise within inter-cultural interactions, as well as qualitative research methodology. Coded phrases were labeled as positive or negative, depending on the behavioural context of the interaction noted. Phrases that described specific examples of student performance were extracted under each code to be built into the narratives, as described below. The same process was repeated for coding of each transcript.

Codes were entered into a spreadsheet according to each participant and whether or not the code was spoken in a positive or negative context. Descriptive statistics were used to calculate the proportion of participants mentioning each code and how many times each code was mentioned overall per interview and in total.

Phase 2: Narrative Profile Building

Procedures

Using the coded frequency data described above, six narrative profiles were generated. After assessing the content of the coded interview data, six profiles were chosen as a target. Each code was assessed separately as part of a standardized process for inclusion in the individual profiles. If a code was mentioned by 100% of participants, then all generated profiles contained a related behavioural example extracted from the transcripts. If only 50% of participants mentioned a specific code, then 50% of profiles contained associated examples and these were distributed randomly across all profiles. This technique was used for all percentages affiliated with coded categories. For example, empathy was mentioned by 6 (60%) of participants. Therefore, spoken examples of empathy were placed in 3 (50%) of profiles. As per this method, not all coded categories were included in each narrative and this was done deliberately to maintain the uniqueness and wording assessors used to describe student examples. A modified version of this approach has been documented before, where authors created narratives based on identified categories but did not consider frequency data when determining which categories to include in each narrative.¹⁶ Two investigators (ML and AT) initially drafted the narratives as these two investigators completed all interviews and were most familiar with the contexts of examples given. The narratives were then reviewed by the lead investigator (KJW) and subsequently passed to all investigators for edits and comments.

Phase 3: Rank Ordering and Categorization

Recruitment and Procedures

A total of 20 additional subjects were recruited to rank order and categorize generated narrative profiles as previous studies have reported.²⁰ Rank ordering and categorization was completed to determine the credibility of narrative profiles to represent differing performance levels of cultural-related behaviours. For example, if consensus could be achieved regarding the categorization and ordering of profiles, standards could be set for what would be required of a student that meets or does not meet expectations. Ranking assessors were recruited from a convenience sample of pharmacists working within international settings. Subjects were included if they were clinical pharmacists and had at least 2 years of experience supervising students on clinical internships.

Narrative profiles were uploaded onto online survey software (SurveyMonkey®, SurveyMonkey Inc. San Mateo, California, USA). Each subject was asked to read each profile and determine whether the example did not meet, met, or exceeded expectations for provision of culturally competent care according to expected student performance levels. A randomization function was used to display profiles in a random order to subjects. The first question asked participants to categorize according to expectations described above and the second question asked them to rank order each profile on a scale of 1 (lowest performing) to 6 (highest performing). No profile could receive the same ranking.

Finally, ranking assessors were asked a number of demographic questions and also if they believed the profiles would be beneficial as an assessment tool in clinical training settings (yes or no). Participants were also provided the opportunity to provide comments regarding usability of the profiles in practice.

Inter-rater reliability was calculated for both rank order results and categorization of profiles into performance level categories using a two-way random model intraclass correlation coefficient (ICC) (absolute agreement, single measure). Significance was set at an alpha level of 0.05. All statistics were completed using IBM SPSS Statistics for Macintosh, version 22.0 (Armonk, NY: IBM Corp).

This project was exempted from IRB approval by the Qatar University Institutional Review Board (QU-IRB 469-E/15).

RESULTS

Narrative Profiles

Demographics of participants recruited for both the interview stage and the ranking stage are given in Table 1. Participants from both study phases originated from a wide variety of countries and all had experience being a preceptor for students on clinical internships. Interview codes, number of utterances, and proportions are given in Table 2. *Communication* was the most commonly described behaviour followed by *awareness* and *ability*. All coded categories were mentioned by at least three participants.

After first generation of the profiles, only minor changes were made based on investigator review. Alterations included wording changes and substitution of examples for profiles to be applicable in international settings. The initial drafts also included generic names (i.e. Laura, Ahmed, Carlos) to label the profiles, but these were removed and replaced with a letter (i.e. Student Y) to ensure participants involved in the ranking process were not biased based on gender or name recognition. Finalized narrative profiles are given in Table 3.

Categorization and Rank Ordering

Results from the categorization and rank order procedures are given in Table 3. The single measure ICC for categorization demonstrated high reliability (0.837, 95% CI 0.654-0.969). The six profiles were evenly distributed with two profiles for each rating of not meeting expectation, meeting expectations, and exceeding expectations. The range of consensus for categorization was between 70-100% for each profile. The two profiles deemed to be at the extreme ends of 'does not meet expectations' and 'exceeds expectations' were the two achieving unanimous consensus. The overall single-measure ICC for rank order results between raters demonstrated high reliability (0.815, 95% CI 0.561 to 0.984).

Usability

Clinical preceptors indicated usability of profiles for student assessment or self-reflection pertaining to culturally diverse interactions to be high, with 17 (85%) stating 'Yes' and 3 (15%) stating 'Unsure.' Three qualitative comments were provided. The first spoke to the usefulness of the profiles:

"Cultural interaction is a difficult area to teach and so narrative profiles or examples would provide some concrete scenario for the student to understand some of these issues."

The second comment suggested a checklist might be more suitable for assessment:

"I think a checklist with some examples might be more useful than narrative profiles, such as the ones in this survey."

Finally, the third comment spoke to the challenges preceptors face when trying to understand, teach, and assess cultural competency as a learning outcome:

"I believe there is a lack of my own understanding as to how cultural diversity impacts patients' health and health care beliefs. More recently, I personally have begun to understand this, providing patient care to overseas visitors and refugee populations. How can I expect competency of my students when I feel this is not adequately addressed in the curriculums I precept in?"

DISCUSSION

This study determined assessor values regarding student performance expectations within culturally diverse settings and used these data to generate six narrative profiles designed to aid assessment and reflection practices within clinical teaching contexts. High reliability obtained from rank order and categorization processes, along with positive feedback from

assessors regarding usability, demonstrate the potential application of this approach in teaching and assessment.

The broad scope of codes obtained from the interviews demonstrates the highly individualistic nature of interpreting these behaviours in practice. It may be that there is no standard defined behaviour or performance expectation between assessors and that values are likely dependent on the context of the interaction. Therefore, there may not be a specific set of behaviours or skills that students can perform to demonstrate competence in line with a general definition of cultural competency. Instead, it appears that it is a combination of multiple behaviours, attitudes, and abilities that influence assessors' perceptions of culturally competent care. This finding aligns well with cultural humility, as a lifelong process of committed learning and personal growth.¹²

The behavioural examples elicited from assessors were used to generate 6 narrative profiles using a distribution technique that allowed us to maintain the words and language assessors used to describe these behaviours. This was important to relate the profiles to target users (assessors) and to also demonstrate to students how assessors interpret and explain assessment decisions. Examples encompassed both interpersonal and intrapersonal behaviours, which align with cultural humility principles and will facilitate student self-awareness, if used as a reflection tool. We believe that assessors and students will better relate to these examples, rather than having to understand and interpret assessment criteria arising from rubrics or other evaluation mechanisms. The high usability ratings given by assessors support this argument and future implementation studies should further assess the acceptability of this approach by both students and assessors alike. Specifically, it should be determined how assessors relate the standardized profiles to student-specific behaviours and what influences their decision to choose a performance level for the student, especially if behaviours are not matching the examples given. From a student perspective, it should be determined how students interpret the assessments and whether the profiles can be used to foster behaviour modification.

We achieved high reliability in both rank order and categorization of the profiles. This supports credibility in practice, as assessors, without preliminary training, agreed on performance level expectations described within the narrative profile examples. The results show the profiles designed to reflect the extremes of good and poor performance were uniformly rated and categorized, while the four profiles within the extremes were not rated or categorized as consistently. This was not an unexpected finding as each assessor has his or her own performance expectations that influence given ratings.²¹ It would be interesting to repeat the study with only 2 categories (meets expectations or does not meet

expectations) to see if assessors are better able to reliably categorize, when faced with only one performance decision.

Based on the findings above, we support further exploration of the use of standardized narrative profiles in assessment of student performance during experiential internships. We do not, at this time, advocate for the use of the profiles outside of experiential training, as they were developed solely within a practice-based context. As an assessment tool, assessors can be trained on recognizing the global behaviours appearing within the profiles and subsequent relating of these behaviours to a specific profile and associated performance level. For example, if a student's behaviour is related to a profile that has been categorized as 'does not meet expectations,' then remedial action should be taken to help improve student performance within culturally diverse interactions. Of course, the validity of these profiles as an assessment tool must be further studied.

Pending results of future studies looking at acceptability and validity as an assessment tool, the profiles may be able to be adapted for use within practice labs or perhaps case-based learning contexts. We also believe the use of the profiles as a tool to stimulate student reflection should be pursued. For example, formative training related to the cultural aspects of care could be conducted in a classroom setting by exposing the students to the narrative profiles and having them reflect on related past experiences during experiential internships or school/workplace encounters. Combining these reflective exercises with theory pertaining to cultural competency and cultural humility may assist in the development of attitudes, behaviours, and skills required to provide effective care.

Our findings are novel in the sense that this is the first known report of using standardized narrative profiles within the context of cultural aspects to care. Other studies have also focused on developing a standardized narrative scale with agreed upon cut points to determine performance in clinical teaching settings.¹⁶ The authors found high consistency in rankings, which was in line with our own findings. This demonstrates that assessors can synthesize narrative data to form similar performance-based decisions and speaks to the credibility of using this approach in assessment. One other study was identified that also found consistency in ratings in narratives intended for use in frame of reference training for professionalism in general surgery.¹⁷ The missing component between each and these studies and ours, however, is piloting use of narratives in practice.

The study has limitations that should be noted. We consider this an exploratory study to generate and refine standardized narrative profiles for application within clinical teaching settings. Further study is needed to determine the effectiveness of these profiles within practice settings, with

input from both assessors and students regarding usability and impact of profiles in teaching. Also, our interview sample was small, which may limit generalizability of examples to all settings and limited the number and types of examples elicited from assessors. Finally, seeking student and patient input in the design and evaluation of profiles was beyond the scope of this first exploratory report.

CONCLUSION

This study found that clinical preceptors value a wide range of attributes and behaviours pertaining to culture-related performance expectations, yet communication, ability and adaptability emerged as leading emphasis categories. Based on these values, a set of 6 narrative profiles was developed for use as a reflection and assessment instrument within culturally diverse interactions in practice. These profiles must be further tested to determine usability in practice and any associated impact on student learning outcomes. If positive impact is achieved, this innovative approach could be adapted to other curricular components to develop assessment methods that drive student learning and optimize student growth.

REFERENCES

- Hofstede G, Hofstede GJ. *Culture and Organizations: Software of the mind*. New York, NY: McGraw-Hill; 2004.
- Trompenaars A, Woolliams P. *Business Across Cultures*. Mankato MN: Capstone Press; 2004.
- Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep*. 2003;118:292-302.
- Accreditation Council for Pharmacy Education. Accreditation standards and key elements for the professional program in pharmacy leading to the Doctor of Pharmacy degree ("Standards 2016"). 2015. <https://www.acpe-accredit.org/pdf/Standards2016FINAL.pdf>. Accessed March 5, 2017.
- Definitions of cultural competency. National Center for Cultural Competence, Georgetown University Center for Child and Human Development. <https://nccc.georgetown.edu/foundations/frameworks.html/>. Accessed March 5, 2017.
- Prasad SJ, Nair P, Gadhvi K, Barai I, Danish HS, Philip AB. Cultural humility: treating the patient, not the illness. *Med. Educ. Online* 2016;21:30908.
- Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. *J Natl Med Assoc* 2010;100:1275-85.
- Blue AV, Thiedke C, Chessman AW, Kern DH, Keller A. Applying theory to assess cultural competency. *Med Educ Online*. 2005;10:13.
- Sadler DR. Formative assessment and the design of instructional systems. *Instr. Sci*. 1989;18:119-44.
- Betancourt JR. Cross-cultural medial education: conceptual approaches and frameworks for evaluation. *Acad Med*. 2003;78:560-9.
- Kumas-Tan Z, Beagan B, Loppie C, MacLeod A, Frank B. Measures of cultural competence: examining hidden assumptions. *Acad. Med*. 2007;82:548-57.
- Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *J Health Care Poor Underserved* 1998;9:117-25.
- Hook JN, Davis DE, Owen J, Worthington Jr. EL, Utsey SO. Cultural humility: measuring opening to culturally diverse clients. *J. Couns. Psychol*. 2013;60:353-66.
- Rajaram SS, Bockrath S, Cultural competence: new conceptual insights into its limits and potential for addressing health disparities. *J. Health Dispar. Res. Pract*. 2014;7:82-9.
- Pearson AS, McTigue MP, Tarpley JL. Narrative medicine in surgical education. *J. Surg. Educ*. 2008;65:99-100.
- Regehr G, Ginsburg S, Herold J, Hatala R, Eva K, Oulanova O. Using "standardized narratives" to explore new ways to represent faculty opinions of resident performance. *Acad. Med*. 2012;87:419-27.
- Rawlings A, Knox AD, Park YS, Reddy S, Williams SR, Issa N, et al. Development and evaluation of standardized narrative cases depicting the general surgery professionalism milestones. *Acad Med* 2015;90:1109-15.
- Homepage. National Health Strategy. 2015. <http://www.nhsq.info/>. Accessed March 5, 2017.
- Qatar Population Statistics 2012: Three years after launching the population policy. Permanent Population Committee. [http://www.ppc.gov.qa/en/Publications/Documents/Studies/2012حالة%20سكان%20قطر%20انجليزى.pdf](http://www.ppc.gov.qa/en/Publications/Documents/Studies/2012%20حالة%20سكان%20قطر%20انجليزى.pdf). Accessed March 5, 2017.
- Ginsburg S, Regehr G, Lingard L, Eva KW. Reading between the lines: faculty interpretations of narrative evaluation comments. *Med. Educ*. 2015;49:296-306.
- Williams RG, Klamen DA, McCaghie WC. Cognitive, social and environmental sources of bias in clinical performance ratings. *Teach. Learn. Med*. 2003;15:270-92.

Table 1: Baseline characteristics of clinician interviewees and rank ordering process

Characteristic	Interviews (n=10) Number (%)	Rank ordering (n=20) Number (%)
Gender		
Female	3 (30)	16 (80)
Male	7 (70)	4 (20)
Age – mean (SD)	37.1 (8.5)	Not recorded
Faculty preceptors	3 (30)	Not applicable
Non-faculty preceptors	7 (70)	Not applicable
Country of origin		
MENA	4 (40)	7 (35)
North America	2 (20)	9 (45)
South America	1 (10)	1 (5)
Sub-Saharan Africa	1 (10)	0 (0)
South Asia	1 (10)	2 (10)
East Asia	1 (10)	1 (5)
Country of current practice		
Qatar	7 (70)	10 (50)
Canada	2 (20)	8 (40)
Australia	1 (10)	1 (5)
Kuwait	0 (0)	1 (5)
Practice Setting		
Hospital	8 (80)	16 (80)
Primary Care	2 (20)	4 (20)
Highest Degree		
Masters of Science	4 (40)	1 (5)
Doctor of Pharmacy	4 (40)	13 (65)
Doctor of Philosophy	2 (20)	2 (10)
Bachelor of Science	0 (0)	4 (20)
Number of students supervised during career		
<10		
10-50	2 (20)	12 (60)
>50	6 (60)	6 (30)
	2 (20)	2 (10)

MENA: Middle East and North Africa

Table 2: Clinician valued behaviours within culturally diverse interactions

Codes	Number (%) of participants mentioning category	Number of total utterances (% of total)
Communication	9 (90)	30 (11.5)
Awareness	7 (70)	25 (9.6)
Ability	5 (50)	25 (9.6)
Adaptability	7 (70)	21 (8.0)
Respect	6 (60)	19 (7.3)
Relationship	6 (60)	17 (6.5)
Mediator	6 (60)	16 (6.1)
Response to patient	6 (60)	15 (5.7)
Empathy	6 (60)	15 (5.7)
Offensive	5 (50)	14 (5.4)
Dedication	3 (30)	14 (5.4)
Justice/Equality	5 (50)	13 (5.0)
Open-minded	6 (60)	12 (4.6)
Training	4 (40)	7 (2.7)
Organization	4 (40)	6 (2.3)
Defensiveness	3 (30)	5 (1.9)
Satisfaction	4 (40)	4 (1.5)
Patience	3 (30)	3 (1.1)

Table 3: Standardized narrative profiles based on assessor behavioural values

Number	Profile
1	<p>Student H is a pharmacy student who has poor communication skills; lacks empathy; is defensive when receiving feedback; and comes across as abrupt. Student H does not follow their preceptor's advice and their actions can cause conflict during interactions with coworkers. Student H's interactions with patients and co-workers do not lead to satisfying or positive relationships. The patient may even feel victimized or not even acknowledged after the encounter. Student H is unaware of cultural differences and doesn't understand culturally sensitive issues, for example commenting on the patient's age or other sensitive topics for the patient. This lack of understanding can often lead to inappropriate interactions between Student H and patients or coworkers where Student H is viewed as offensive. Student H does not understand the cultural differences at the beginning of the rotation, but also does not show increased understanding as the rotation progresses.</p> <p>Rank order = 1 (75% of rankers), Categorization = Does not meet expectations (100% of rankers) Mapped Components = communication, empathy, defensive, training, patience, relationship, response to patient, awareness, offensive</p>
2	<p>Student J is unaware of cultural differences, as Student J may have not been exposed to a situation with a multi-diverse community. Student J has preconceived ideas about culture but as the rotation progresses becomes more open to acknowledge differences between cultures and interact with people of these different cultures. In Student J's daily interaction with patients or co-workers, Student J sometimes lacks respect, is impatient and can be viewed as offensive. Student J may start caring for a new patient without making sure that the current patient doesn't have any more questions. Additionally, Student J may provide better care preferentially to patients of similar cultural background to their own. Student J is working toward providing a structured approach for managing patients. When receiving feedback from preceptors, he or she seems to be defensive at first, but becomes more receptive as the rotation progresses.</p> <p>Rank order = 2 (65% of rankers) Categorization = Does not meet expectations (70% of rankers) Mapped Components = awareness, training, adaptability, justice/equality, respect, patience, offensive, response to patient, empathy, open-mindedness, structure, defensive, communication</p>
3	<p>Student Y is aware of some cultural differences at the beginning of the rotation and learns more about them as the rotation progresses. Student Y's approach to patient care is structured even though it lacks a "humanistic approach." When he or she does something culturally inappropriate, Student Y is receptive to feedback from the preceptor or from coworkers. Student Y is able to recognize his or her mistakes and apologizes to the offended person, thus being able to maintain cordial relationships. Student Y respects different points of view. During Student Y's interactions with patients, he or she sometimes has difficulty communicating or finding the appropriate way of conveying information and does not always have the initiative to find a solution to the problem. Overall, Student Y starts off the rotation with some limitations and does not meet all the expectations, but is opened to learning as the rotation progresses.</p> <p>Rank order = 3 (84% of rankers) Categorization = Meets expectations (80% of rankers) Mapped Components = awareness, structure, relationships, respect, communication, mediator, open-mindedness</p>
4	<p>Student L is aware of cultural differences, is able to recognize when his or her own cultural background differs from the patient's background and is generally able to adjust his or her approach to patient care. Student L can communicate with people with different cultural views and knows where to find help for communication. Student L's work is generally well done, and although he or she meets the rotation's expectations, Student L will not go beyond them to exceed expectations for patient care. When interacting with a patient, Student L comes across as professional, capable and fair even though he or she does not always understand what the patient requires. Student L is open to feedback and demonstrates desire to improve his or her skills.</p> <p>Rank order = 4 (89% of rankers) Categorization = Meets expectations (85% of rankers) Mapped Components = awareness, adaptability, communication, mediator, ability, response to patient, satisfaction, respect</p>

5	<p>Student A is adept in his or her interactions and able to build meaningful relationships with patients and co-workers. Student A demonstrates patience and excellent communication skills. Specifically when dealing with patients, Student A asks open ended questions, speaks slowly, and will use specific tools, such as pictures, to help explain information if needed. Afterwards, most of the time, Student A asks for feedback to make sure that the patient has understood him or her. Student A tries to understand and relate to his or her patients. Additionally, Student A is able to adapt his or her interactions with patients of differing cultural backgrounds, in order to provide appropriate care.</p> <p>Rank order = 5 (85% of rankers) Categorization = Exceeds expectations (75% of rankers) Mapped Components = ability, relationships, patience, communication, adaptability, response to patient, dedication, mediator, open-mindedness</p>
6	<p>The relationships Student G builds during the rotation are positive, strong and might even leave lasting effects on the department and his or her patients. The preceptor is beyond satisfied with their interactions with Student G and the relationship benefits both of them. During Student G's interactions with patients, he or she demonstrates a high level of understanding, relates with many people from diverse cultural backgrounds, adapts counselling sessions and appears to be able to put himself or herself in the shoes of the patient. For example, when required to provide care to a patient from a different cultural background, such as a patient who speaks a language Student G does not speak, Student G will proactively find a translator and always checks to ensure that the patient understood the information at the end of the interaction. Additionally, Student G is respectful of the patient's values and beliefs and incorporates these into management plans for the patient. Other health-care professionals enjoy working with Student G as he or she acknowledges and understands the roles of others. Overall, Student G demonstrates a high level of dedication for his or her patients.</p> <p>Rank order = 6 (85% of rankers) Categorization = Exceeds expectations (100% of rankers) Mapped Components = relationships, ability, justice/equality, empathy, mediator, communication, respect, dedication, response to patient, open-mindedness</p>