Assessment of cultural safety in a post–Objective Structured Clinical Examination (OSCE) era

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Kay Brumpton, Tarun Sen Gupta, Rebecca Evans, Raelene Ward

Background
As The Royal Australian College of General Practitioners (RACGP) introduces alternatives to the Objective Structured Clinical Examination, it is imperative that standards are continually set for a culturally safe general practice workforce. Assessments have many functions and should be continually reviewed to ensure that they require general practitioners (GPs) to demonstrate genuine cultural safety.

Objective
The aim of this article is to highlight the complexities in assessing the cultural safety of GPs when consulting with Aboriginal and Torres Strait Islander peoples.

Discussion
Presently there is a lack of validated approaches for assessing cultural safety of GPs. This creates challenges for the RACGP in redesigning fellowship examinations. Yet in this challenge is an opportunity to consider assessment design that is not competency based, amplifies Aboriginal and Torres Strait Islander peoples' voices and reflects the complexity of cultural safety.

THE ROYAL AUSTRALIAN COLLEGE OF GENERAL PRACTITIONERS' (RACGP's) decision to cease using Objective Structured Clinical Examinations (OSCEs) in the high-stake fellowship assessments has created both educational opportunity and uncertainty.[1] The RACGP envisages '... a modernised assessment that focuses on competency and is more educationally aligned to what [general practitioners] in training are learning'.[1] In this article, the authors reflect on what this change in assessment might mean for the specific, critical issue of assessing cultural safety for Australian Aboriginal and Torres Strait Islander peoples. The RACGP advocates cultural safety to improve health outcomes for Aboriginal and Torres Strait Islander peoples,[2] and while this article focuses on the RACGP curriculum and assessment, the arguments are undoubtedly relevant for other specialist colleges and medical schools.

First, it is important to explore the concept of competency-based assessment in the Aboriginal and Torres Strait Islander health education sector. Many have described the pitfalls of using this approach,[3–6] summarised by Curtis:[7]

> *'Achieving cultural competence is often viewed as a static outcome. One is "competent" in interacting with patients from diverse backgrounds in much the same way as one is competent in performing a physical exam or reading an EKG. Cultural competency is not an abdominal exam. It is not a static requirement to be checked off some list ...'*

> *The consequence of this narrow approach is the 'othering' of patients who are not part of the dominant culture. This leads to over-simplified understandings based on cultural stereotypes but also the tendency to group [I]ndigenous people into a collective 'they'. Meanwhile those patients at the receiving end of 'othering' report that they experience exclusion, fewer opportunities to explore health care and questions, and marginalisation.*

So, if competency-based assessment is not an optimal approach, what options do the postgraduate colleges have? The RACGP Aboriginal and Torres Strait Islander Health curriculum[8] (the Curriculum) lists alternative assessment modalities, albeit as a means of demonstrating competence. These include case reviews and discussions, observations, supervised consultations/clinical attachments, feedback from patients/families, clinical audits, communities of practice and participation in cultural safety training.[8] Currently, there is minimal evidence

for the effectiveness of any of these modalities for assessment of cultural safety or improvement in healthcare outcomes.[9–13] This evidence gap is partially due to lack of valid measures of cultural safety[13,14] and the complexity of defining cultural safety.[3,15]

Developing a robust approach to the assessment of cultural safety requires alignment with an accepted definition of cultural safety – that is, starting with the end in mind. The literature contains many different terminologies and definitions for the concept of cultural safety.[3,15,16] The cultural provenance and cultural voice in these definitions is frequently absent or unclear.[17] In 2019, the Australian Health Practitioner Regulation Agency (AHPRA) released a consensus definition of cultural safety (Box 1) that engaged Aboriginal and Torres Strait Islander members.[18]

If indeed 'assessment drives learning',[19] then redesign of assessment provides opportunities to drive learning toward improving health outcomes for Australian Aboriginal and Torres Strait Islander peoples. The AHPRA cultural safety definition may provide a guide to developing a modern approach to assessing cultural safety. In this article, the authors briefly consider each of the bolded key words and components of the AHPRA definition (Box 1) in the context of RACGP assessment. What would it look like to have assessment aligned with this definition?

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities

Many elements of cultural competency are derived from a paradigm of the dominant culture,[17] and any new assessment must reverse this archetype. In the interim, Aboriginal and Torres Strait Islander patients' satisfaction and experience can be integrated into learner assessment. This can be achieved through surveys already routinely conducted in general practice becoming part of a portfolio of assessment[20] and through multisource feedback (MSF)[21] that incorporates patient opinion. The Australian College of Rural and Remote Medicine requires registrars to complete an MSF; however, there is currently no requirement for inclusion of Aboriginal and Torres Strait Islander patients in this process.[21,22]

Cultural safety is ongoing critical reflection

Self-reflection is considered essential for lifelong learning[23] and for development of cultural safety.[24,25] Learning portfolios that include case-based discussions and reflective essays have attempted to assess critical reflection.[23] However, these modalities are generally assessed by the dominant culture.[26] West, an Aboriginal nurse and researcher, has developed the Cultural Capability Measurement Tool (CCMT), which scores five self-reported key factors: respect, communication, safety and quality, advocacy and reflection.[25] The CCMT may provide an important starting point to enable the critical skills of self-reflection/reflexivity. The assessment challenge remains to incorporate learner insight with patient-driven measures of cultural safety to drive learning, attitude and behavioural change.

Cultural safety is ongoing critical reflection of ...

Knowledge, skills and practising behaviours

Identification of ongoing impacts of historical events on the social and cultural determinants of health is a Curriculum outcome.[8] 'Identify' is a lower-level taxonomy of knowledge assessment[27] that does not require active application of knowledge and risks registrars stereotyping and making assumptions.[28] As an alternative, adopting a patient-centred care approach may improve health outcomes:[29]

> *... rather than focusing on knowledge of differences, social workers should concentrate on critically listening to our clients' autobiographies to reveal over time what aspects of their social and cultural lives matter to them.* (Reproduced with permission from Taylor & Francis Ltd, www.tandfonline.com)

This person- or patient-centred care, promoting flexibility in healthcare to accommodate patient preferences and values, is a primary approach to Australian general practitioner (GP) consultations.[30,31] However, instruments for the objective assessment of patient-centred care are not commonly used in Australia.[32] They are not used for GP assessments nor appear to have been validated in the Australian population.[32] Furthermore, there are no reported Australian quality indicators for cultural safety in patient-centred care.[33] Nonetheless, many attributes of culturally competent care align with patient-centred care.[31] Pitama et al[34] have adapted the Calgary–Cambridge guide[35] to a culturally specific, and ultimately increasingly culturally safe, model of consultation for Māori patients. This model incorporates consideration of how factors such as marginalisation, colonisation, migration, racism, connection to country, family and cultural protocols affect patients.[34] Within the Australian context, McKivett[3] incorporates similar domains to the Meihana Model as described by Pitama et al.[34] This work will likely shape cultural safety assessment models within Australia.

Attitude

Assessing the attitude of a general practice registrar is challenging. For example, who should make the assessment? If a registrar self-assesses using a questionnaire such as the previously mentioned CCMT[25]

Box 1. Australian Health Practitioner Regulation Agency (AHPRA) definition of cultural safety[18]

'Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practise is ongoing **critical reflection** of health practitioner **knowledge**, **skills**, **attitudes**, **practising behaviours** and **power differentials** in delivering safe, accessible and responsive healthcare free of racism.'

Released following a consultation and consensus process led by the Aboriginal and Torres Strait Islander members of AHPRA Aboriginal and Torres Strait Islander Health and Cultural Safety Group.

or Ryder measure of attitude change,[36] this may not reflect actual behaviour or patient experience. If a patient assesses a registrar's attitude, imposition of their own biases and worldview will likely have an impact on the validity of this judgement. The Curriculum simply describes the required attitude as:[8]

> *... an openness to cultural immersion experiences, respect and willingness to learn from cultural educators and mentors, value for perspective of health that incorporates family and community wellbeing, value for holistic approach to healthcare that incorporates social, emotional, cultural aspects and understanding of the importance of developing trust with Aboriginal and Torres Strait Islander patients and the time that this takes.*

Again, linking these relatively passive requirements to any assessment measure or outcome in a standardised assessment form will be very difficult. It is possible that MSF[21] by patients and all members of the supervisory team may provide a better metric for this attribute.

Power differentials

Power differentials are normative in general practice, with GPs commonly privileged through at least income, education and employment.[13,37] One Curriculum competency is 'developing strategies to optimise patient empowerment to enhance health outcomes'.[8] The strategies listed include assisting with problems accessing transport, appropriately involving family and community, accessing cultural mentors, encouraging shared decision making and creating a safe environment in which individuals feel empowered to make decisions about their own lives.[8] Again, these can be classified as components of patient-centred care. However, this approach does not identify individual racism. The Curriculum[8] mentions individual racism only twice and each time as a determinant of health rather than an attribute to be assessed. The Curriculum does, however, refer to demonstrating respect and using communication free of discrimination and judgement[8] – both potentially assessable attributes.

Conclusion

As the RACGP develops new assessments, there are opportunities to think differently about what and how we assess – and what we do daily as clinicians and teachers. Assessment can be used as one approach to ensure all GPs obtain skills in cultural safety, as was observed by Murray et al: 'Robust assessment processes can ensure confidence in standards despite variations in training pathways and experiences'.[38] By inference, a properly designed cultural safety assessment can drive learners toward cultural safety. As the RACGP seeks to develop a replacement for the OSCE, it is necessary to consider an assessment approach that combines patient-centred care metrics, patient feedback and learner self-reflection. It is important to start with the end in mind: what should someone be able to do at the end of training? While there continues to be racism and inequality, we need to do whatever we can to address this. Some practical suggestions for assessment of cultural safety can be found in Box 2. If the RACGP is serious about 'every patient, every family, every community',[39] then establishing a culturally safe assessment of cultural safety, determined by Aboriginal and Torres Strait Islander peoples, should be prioritised as an essential component of future registrar assessment.

Box 2. Practical suggestions for designing cultural safety assessment for general practitioners

- Consideration of alternative methods of assessment that involve Aboriginal and Torres Strait Islander people and patients defining and determining cultural safety, for example the Australian Health Practitioner Regulation Agency definition of cultural safety.[18]
- Acceptance and use of a nationally agreed definition of cultural safety for all curriculum and assessment processes.
- Recognition that a competency-based framework for assessment of cultural safety is not an ideal approach.
- Further exploration of models of assessment for patient-centred care and application to culturally safe care.
- Continued emphasis on the importance of ongoing self-reflection and reflexivity in developing cultural safety.

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Competing interests: TSG is Chair of the Australian College of Rural and Remote Medicine Assessment Committee and Training Adviser for the Queensland Rural Generalist Pathway.

Funding: None.

Provenance and peer review: Not commissioned, externally peer reviewed.

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