# Protocol for a realist review of the influence of cultural factors on understanding the role of feedback in developing clinical competencies of health professional students in Asia — **Source link** ⧉

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1  Protocol for a realist review of the influence of cultural factors on understanding the

2  role of feedback in developing clinical competencies of health professional students

3  in Asia.

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22  **Word Count:**          3225

23

24    **Abstract:**

25    **Background:**

26    Clinical education has moved to a "competency-based" model with an emphasis on

27    workplace-based learning and assessment which, in turn, depends on feedback to be

28    effective. Further, the understanding of feedback has changed from information about a

29    performance directed to the learner performing the task, to a dialogue, which enables the

30    learner to act and develop.

31    In health professional education, feedback is a complex interaction between trainee,

32    supervisor and the healthcare system.  Most published research on feedback in health

33    professional education originates in Europe and North America.  Our interest is on the

34    impact of culture on this process, particularly in the context of Asian cultures.

35    A realist approach looks at complex interventions in social situations, and so would seem

36    appropriate lens to use to examine the influence of cultural factors on utilising feedback.

37    **Methods:**

38    An initial search has been performed to define the scope of the review question and develop

39    our candidate / "best guess" program theory.  The formal electronic search was carried out

40    in February 2020 and included: CINAHL, ERIC, MEDLINE, and PsycInfo, and repeated in

41    October 2020.  Retrieved articles were imported into Covidence for screening and data

42    extraction, after which components of the Context – Mechanisms – Outcomes configurations

43    will be sought to refine the initial program theory.

44    **Discussion:**

45    Feedback   has   been   recognised   as   critically   important   in   competency-based   health

46    professional education, yet feedback is a complex, socially based "intervention".  Most of the

47    published literature on feedback originates from "Western" cultures.  This protocol aims to

48  provide further information that may lead to improving the usefulness of feedback in the

49  South East Asian region.

50  **Systematic Review Registration:**

51  Registration was sought with PROSPERO and advice given was that this review was not

52  eligible for registration as it did not have a "direct and clinically-relevant health-related

53  outcome".

54  **Keywords:** Realist review, Realist Synthesis, Health professional students, Medical

55  students, Feedback, Asia

56

57  **ARTICLE SUMMARY:**

58  **Strengths and limitations of this study:**

59  • A Realist approach potentially best explains the complexities of **C**ulture's impact on

60      feedback.

61  • To our knowledge, there are few studies of feedback seeking and provision to health

62      professional trainees in Asia.

63  • In addition to formal literature database searches, we will need to conduct citation

64      mining to locate other relevant resources.

65  • The typical assessment of "Risk of bias" does not apply to the Realist approach.

66

67

68  **BACKGROUND:**

69  Clinical education has moved to a "competency-based" model with an emphasis on

70  workplace-based learning and assessment which, in turn, depends on feedback to be

71  effective(1,2). Indeed Ramani *et al* (2019) (p744) describe feedback as "*a vital cog in the*

72    *wheel of competency-based medical education.*"   Embarking on workplace learning will

73    require understanding of the tools used, and acceptance of the feedback process, by both

74    supervisors and trainees.

75    <u>Complexity of Feedback</u>:

76    Early definitions of feedback emphasised information giving to change behaviour(3–5).  In a

77    widely quoted paper, Ende (1983) described feedback as ***information*** given to trainees

78    about a particular activity which was meant to guide performance of that or a similar activity

79    in the future.   The emphasis was that feedback was something supervisors directed at

80    trainees, preferably after observation of the activity in question.    University students

81    commonly complain that they do not receive enough feedback, or that it is done poorly,

82    such that academic staff are advised to "signpost" when feedback was being given(6).  This

83    dissatisfaction is still experienced particularly in the lead-up to visits by course accreditation

84    bodies.   Ajjawi and Regehr (2018) suggest that perhaps learners and teachers define

85    feedback quite differently(7).

86    Over time, feedback has been understood as more than simply providing information –

87    information is only feedback when it is ***used*** to improve work or learning and is part of a

88    sociocultural interaction.  Furthermore, feedback value is influenced by the credibility of the

89    feedback source(8–10).   As it is essential to close the feedback loop, we can think of

90    feedback as sense-making in the context of information provided from many sources to

91    improve work and learning(11).   The importance of relationships and trust between the

92    supervisor and trainee, especially when the feedback relates to assessment has been

93    emphasised (12).  Many factors are recognised to impact the effect of feedback including

94    context (e.g. the workplace – hospital or ambulatory settings, teaching a skill, formative

95    assessment, summative assessment)  (13,14) regulatory focus(15), self-efficacy(16,17); the

96    person's "theory of intelligence" (their understanding of whether intelligence is "fixed" or

97      "improvable"), and therefore whether effort is worthwhile(18,19).  If a person's belief is that

98      intelligence is fixed, effort may not seem to be worthwhile, whereas if they feel there is

99      opportunity for improvement, effort becomes worthwhile.

100     This raises the question of whether cultural factors influence acceptance and engagement

101     with "dialogic feedback" in a non-Western or Asian context, and how does it compare with

102     the "Western" situation?  An initial literature review of feedback within health professional

103     education suggests that the literature is heavy with a North American and European focus,

104     but is limited from South East Asia or Asia-Pacific perspective, except notably in

105     Indonesia(20,21).  As such, a number of questions remain unanswered.  For example, which

106     cultural background of students / trainees and their teachers / supervisors influences their

107     engagement with feedback, and how does it do so?  Is it the "ethnic culture" (e.g. Confucian

108     heritage, Malay / Muslim, or Indian cultures, in the Malaysian context), the national culture

109     (e.g. Malaysia, Singapore, Indonesia) (22), or the education system culture (e.g. school

110     education, university, or even discipline cultures) that have the predominant effect – or is

111     there no dominant effect?  We will return to this later.

112     Feedback within the clinical learning environment is particularly complex and influenced by

113     such things as the workload of providing patient care, hierarchies, time constraints and

114     limited opportunities to observe a student's performance, the supervisor's experience of

115     feedback during their training and therefore understanding of feedback, as well as the

116     student's expectations and engagement with feedback provided.  These complexities will be

117     recognised by clinical teachers in Western environments but are potentially magnified within

118     the Asian setting.

119     Complexity of Culture:

120     When we consider culture in the context of health professional education there are three

121     predominant and interdependent cultures – the "big-Culture", the Workplace culture and the

122     Education culture.

123 A useful description of **C**ulture comes from Edward Hall, an early cultural anthropologist, in a

124 book first published in 1959:

125  *"Culture is a mould in which we are all cast, and it controls our daily lives in many*

126  *unsuspected ways. It is part of a person's behaviour in which he takes for granted -*

127  *the part he doesn't think about, since he assumes it as universal or regards it as*

128  *idiosyncratic…. Culture hides much more than it reveals and strangely enough, what*

129  *it hides it hides most effectively from its own participants."* (23) (p. 29)

130 **C**ulture (sometimes referred to as "big-Culture") in this context is defined by Hofstede as

131  *"The collective programming of the mind that distinguishes one group or category of*

132  *people from another … culture is (a) a collective, not individual, attribute; (b) not*

133  *directly visible but manifested in behaviours; and (c) common to some but not all*

134  *people."* (24) (p58).

135 While there are several classifications of characteristics of Culture, Hofstede's typology is

136 widely used and can help in our understanding of the issues.   Initially there were four

137 dimensions described(25):

138  1.  Individualism – Collectivism

139  2.  Power Distance

140  3.  Uncertainty Avoidance

141  4.  Masculinity – Femininity.

142 Subsequently, two further dimensions were added(26):

143  5.  Long versus Short-term Orientation

144  6.  Indulgence versus Restraint

145 Of these dimensions, Individualism-Collectivism and Power Distance appear to be the most

146 significant big-Culture influences in the clinical learning environment in South-East Asia(21)

147     In focussing on the Asian region, we can recognise several *broad* cultural groups – the

148     "Confucian Heritage Culture", Indonesian-Malay / Muslim cultures, the Indian subcontinent

149     cultures, then overlaid by the cultural impacts of colonialism.

150

151     Workplace culture can be viewed as another cultural layer that interacts with the "big-

152     Culture", particularly in clinical teaching and hospital environments.  Medicine around the

153     world tends to be hierarchical and paternalistic.  However, within the Asian region teaching

154     by humiliation is common, and in Malaysia the term "scolding" is commonly used to describe

155     teaching in the clinical environment.  Another term frequently heard is *kiasu* – particularly

156     applied to students of Chinese ethnicity.  According to the Oxford Dictionary(27), *kiasu*

157     refers to a person who is *"governed by self-interest, typically manifesting as a selfish,*

158     *grasping attitude arising from a fear of missing out on something.".*  Kiasu is a Hokkien word

159     meaning "fear of loss".  There are two aspects to *kiasu,* the negative side of being selfish

160     and grasping, as seen in the Oxford dictionary definition, and a positive aspect of being

161     successful through hard work – not evident in that dictionary definition(28).  (*Kiasu* is

162     related to the concept of "face", which western stereotypes frequently regard as a

163     characteristic of Asian Culture).

164     The education system clearly has an overarching culture which influenced the students'

165     experiences of school.  Over the past decade, Singapore has been modifying the approach

166     to assessment in pre-school and early primary school.  Even at that early age high-stakes

167     examinations have been a feature and there has been significant push-back against

168     reducing that emphasis.  The following quotes from teachers in an article reviewing the

169     reception of the changes to early primary school education are informative(22):

170          *"Doing away with SA1/2 is not a good idea. We still need to maintain the competitive*

171          *edge and to instil that habit of doing so in our society. Our young are already too*

172    *pampered, and I do not agree to taking away the SAs to reduce stress. I'll agree to*

173    *more pathways to success but not taking away tests. Life is a test in itself."*

174    And ...

175    *"parents do not read the comments or look at the stars given. Instead, they flip the*

176    *pages in the paper and start to calculate how many marks their child had scored.*

177    *Imagine the amount of time and effort the teachers have to go through writing*

178    *feedback, which is hardly read. This is especially so because their parents were*

179    *educated and brought up to look for a mark to their examination paper. They get*

180    *better feedback through these marks they see on their children's script."*

181

182    There has been much written about the influence of the "Confucian Heritage Culture" of

183    learning (CHC) on students from South East Asia as well as from China, Japan and Korea.

184    In his writings Confucius saw learning as a means of social change and to overcome social

185    differences, but also placed much emphasis on personal effort(29).   Wang (2006) sees

186    parallels in Confucius' writings about education with Plato's "philosopher king".  The Chinese

187    philosophy of education also highlighted a mutually respectful relationship between teacher

188    and learner, with the teacher guiding the learner, rather than pulling the learner along (30).

189    This parallels the role of *guru* seen in the Indian culture of education – with the *guru*

190    (teacher) nurturing the learner(31,32).

191

192    Malaysia is a predominantly Islamic country, and a former British colony.  Clearly both these

193    aspects of its history have shaped the education system of the country and are as important

194    factors as the Confucian heritage.   In an editorial for a special edition of Comparative

195    Education Review in 2006, Kadi highlights the great diversity in Islamic education and gives

196    a perspective to the colonial experiences(33).  The school culture clearly responds to the

197     education system's overarching culture but adds its own layer.  An examination-oriented

198     curriculum was seen as a legacy of the colonial era.

199         *"A great deal of teaching preparation at this time involved equipping students for the*

200         *examination. An exam-oriented curriculum had been in place in the Malaysian*

201         *education system since it was introduced during the colonial era by the British.*

202         *Although the curriculum had been revised many times over a period of more than*

203         *five decades, assessment had been an integral part not only in schools but also at*

204         *tertiary level. Teachers realised that they needed to gear their students towards the*

205         *exam as pressure from every corner awaits them; the Ministry of Education demands*

206         *schools produce good, intelligent students; the local education department*

207         *pressurises heads of schools to produce excellent results, who then order teachers to*

208         *do their best to at least beat the results of neighbouring schools, not to mention*

209         *being under pressure to meet the expectations of parents who want their children to*

210         *do well under the guidance of the teachers."*(34)(p59)

211

212     Tertiary education culture varies enormously across the region, from hierarchical approaches

213     to being more collegial (especially in the later stages of the degrees).  The high school

214     experiences clearly impact students transitioning to university, coming with an expectation

215     that university would simply be an extension of school – first year medical students in

216     Malaysia clearly started university with the idea that knowledge was fixed and largely

217     unchanging, and that their teachers or lecturers functioned as sources of knowledge who

218     were not to be questioned.  Knowledge was facts, and facts were immutable(35).  As school

219     had emphasised rote learning of fixed knowledge, and an important part of those students'

220     adaptation to university was coming to terms with thinking for themselves.  As they move

221     into workplace-based learning, the culture of the medical workplace is likely to have an

222     impact.

223 **Realist Synthesis methodology:**

224 The (scientific) Realist approach is a methodology that is useful for researching complex

225 interventions in the social environment, such as healthcare and education, and asks: *"What*

226 *is it about this intervention that works, for whom, in what circumstances, in what respects*

227 *and how?"* (36,37). It seeks to find "mechanisms (M)" that fire in particular "contexts (C)"

228 to produce "Outcomes (O)" in question – so called CMO Configurations. Realist synthesis or

229 realist review (the terms are used interchangeably) is a theory driven, iterative and

230 explanation-building approach, that usually starts with a "best guess" or candidate program

231 theory and uses findings from primary sources to understand how and why the outcomes

232 have occurred, and therefore refine the initial program theory(38). Interpretation involves

233 looking for both confirming and negating data and explanations.

234

235 The specific research questions for this synthesis are as follows:

236

237     In the Asian or non-Western health professional education environment:

238       1. How, why and in what circumstances do **health professional trainees** (e.g.

239           students and junior doctors) seek, respond to, and use feedback given in the

240           clinical environment?

241       2. **Supervisors** (e.g. consultants, clinical tutors, preceptors): What do supervisors

242           feel about providing feedback? How do they provide feedback, in what

243           circumstances? Do they see their feedback being used?

244       3. **Both trainees and supervisors**: How do they perceive feedback?

245

246 The review is following the five steps of a realist review as enunciated by Pawson and

247 colleagues(36), namely

248      1. Clarify the scope and purpose of the review question

249      2. Search for evidence – commencing with an exploratory search, with subsequent

250          focussing and purposive and "snowball" sampling

251      3. Appraise primary studies and extract data

252      4. Synthesise the evidence to obtain conclusions, and …

253      5. Disseminate.

254    In appraising studies, **Relevance** is assessed by whether it can contribute to theory

255    building or testing, while **Rigor** assessment is based on whether the methods which

256    generated a *particular piece of data* is trustworthy(39). Pawson argues that the

257    methodological quality of a study is not appropriate grounds for excluding a study in realist

258    reviews – "*There are often nuggets of wisdom in methodologically weak studies"*(40).

259

260    **METHODS AND ANALYSIS:**

261    The protocol for this review was judged to be ineligible for registration with the International

262    Prospective Register for Systematic Reviews (PROSPERO), as it did not *"have a direct and*

263    *clinically-relevant health-related outcome".*

264    A PRISMA-P checklist has been completed and available as an additional file(41).

265

266    **Search Strategy:**

267    An initial search has been performed to define the scope of the review question and develop

268    our candidate / "best guess" program theory. This initial search utilised MEDLINE and

269    PsycInfo, searching "Trainee" (and variations), Feedback (and debrief) and Culture

270    (including cross-cultural, ethnic differences, anthropology).

271   The formal electronic search was carried out in February 2020 and included: CINAHL, ERIC,

272   MEDLINE, and PsycInfo.  Search terms were developed in discussion with a librarian and the

273   research team, with the same broad categories as before, although only articles available in

274   English were retained.  An example of the search strategy is given in *Table 1*.  Both MeSH

275   (medical subject headings) and free text were employed to ensure sufficiently wide article

276   coverage.   This search was repeated in October 2020, for articles published since the

277   February search.  A hand search will also be made of the following journals:  Academic

278   Medicine, Medical Education, Medical Teacher, BMC Medical Education, Education for Health,

279   Teaching and Learning in Medicine, Perspectives on Medical Education, Medical Journal of

280   Malaysia, Annals of the Academy of Medicine Singapore, and Singapore Medical Journal.

281   Citation mining (Snowball or Pearl growing) searches of the reference list in included articles

282   and searching for articles that cite these articles will occur.  Although dissertations were

283   initially excluded, relevant published articles arising from the excluded dissertations will be

284   sought by hand-searching.

285

| Concept: **Learner** | Concept: **Feedback** | Concept: **Culture** |
|---|---|---|
| Subject Headings e.g. MeSH | Subject Headings e.g. MeSH | Subject Headings e.g. MeSH |
| • Students, Health Occupations<br>• Clinical clerkship<br>• Education, medical/ or education, nursing/ or education, pharmacy/ or education, public health professional/<br>• Clinical competence<br>• Faculty<br>• Faculty, dental/ or faculty, medical/ or faculty, nursing | • FORMATIVE FEEDBACK<br>• Debrief | • CULTURE<br>• Cross-Cultural Comparison<br>• Cultural diversity<br>• Cultural difference |
| Keywords and phrases | Keywords and phrases | Keywords and phrases |

| Trainee | Feedback | Culture |
|---|---|---|
| Student | Feeding back | Cultural difference |
| Learner | Feed-back | Cultural diversity |
| Graduate | Feedforward | Cultural understanding |
| Intern | Feed forward | Cross cultural |
| Supervisor | Feeding forward | Ethnic |
| Teacher | Fed back | |
| Lecturer | Debrief | |
| Instructor | | |
| Professor | | |
| Tutor | | |

286

287    **Table 1:** Example of Search strategy used in Ovid MEDLINE

288

289    **Selection criteria**:

290    Following the searches as outlined, the citations were imported into Covidence(42) for "Title

291    and Abstract Screening".   Duplicates were removed before title and abstract screening

292    began with two team members reviewing a sample of the articles retrieved to ensure that

293    criteria are agreed upon.   The rest of this phase was carried out by any one of the team

294    members but with the intention to err on retaining studies for closer evaluation at the full

295    text screening stage.

296    Core inclusion criteria sought studies relating to

297    • Workplace-based learning and assessment,

298    • Feedback giving, seeking and acceptance,

299    • Culture (Ethnic and institutional),

300    • Post-secondary and vocational education involving health professional training.

301

302    Exclusion criteria centre around:

303    • Biological cultures – microbiologic, tissue culture

304    • Workplace safety / Organisational culture / Organisational development

305 • Feedback in physiology or therapeutic situations - e.g. Psychiatry

306 • Describing and/or feedback on new teaching methods, including technology

307 • Teaching cultural competency

308 • Reviews: Literature reviews, Book reviews

309 • Primary and secondary school, learners with a disability, Community health education

310 • Clinical trials

311 • Patient satisfaction

312

313 Following title and abstract screening, the full texts of the retained articles were imported

314 into Covidence for further screening. From here, all full text articles in the process of being

315 screened by two members of the team, and any discrepancies will be discussed to resolve

316 the disagreements. Notes will be made to justify inclusion or exclusion and will assist with

317 both resolving discrepancies and providing transparency. Selecting papers for the review

318 will be guided by the research study questions – Does the study involve students in health

319 professional courses (especially in their clinical training) or their supervisors? Does the

320 study pertain to students in Asian countries (noting the possible need to expand to include

321 non-Western countries if insufficient studies pertain to Asian countries)? Therefore,

322 exclusion criteria at this stage will be expanded to exclude studies not related to health

323 professional education, and "Western studies".

324

325 Studies remaining after the full text screen will be assessed for Quality and Rigour using the

326 Critical Appraisal Skills Programme (CASP-Qualitative) checklist(43) and the Medical

327 Education Research Study Quality Instrument (MERSQI) (44). Each study will be appraised

328 by at least two team members, and any discrepancies will be resolved by the full team.

329

330 **Extracting Data:**

331    Data extraction will follow, with data entered into a table within Covidence 2.0. Data

332    extracted will include citation details, country or region where study was performed,

333    population studied, methodology used, and an empirical judgement of Realist Relevance will

334    also be made at this stage. Comments of potential context, mechanism and outcome will be

335    recorded. Data extracted in Covidence will be exported as a .csv file into Excel, to be used

336    in the synthesis phase. Finally, included articles will be entered into NVivo software(45) for

337    further data extraction, coding and identification of CMO configurations.

338

339    **Synthesise findings to draw conclusions**:

340    NVivo software in conjunction with the Excel spreadsheet exported from Covidence will be

341    used to synthesise findings and modify our original "best guess" program theory. Discussion

342    among the team members with the use of realist logic will aim to identify Contexts (C),

343    Mechanisms (M) and Outcomes (O) and infer CMO configurations. The process will look for

344    confirming and contradictory findings and will be iterative.

345    **Ethics and Dissemination**:

346    As this study is a literature review, ethics approval is not required.

347    The findings will be documented in line with the RAMESES publications standards for Realist

348    syntheses(39), and we plan to disseminate the findings by means of a peer-reviewed journal

349    article and conference presentation(s).

350

351    **DISCUSSION**:

352    Feedback has been recognised as critically important in competency-based health

353    professional education, yet feedback is a complex, socially based "intervention". Most of the

354    published literature on feedback originates from "Western" cultures. There is reason to

355    expect that components of Culture – "big-Culture", workplace culture and education system

356    cultures will impact the provision, acceptability and use of feedback. ***Again***, complex

357    interactions come into play. The realist approach is a relevant way to examine these

358    processes. This protocol aims to provide further information that may lead to improving the

359    usefulness of feedback in the South East Asian region.

360

361    **Systematic Review Registration:**

362    Registration was sought with PROSPERO and advice given was that this review was not

363    eligible for registration as it did not have a "direct and clinically-relevant health-related

364    outcome".

365

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377

378    **Author Contributions:**

379    PF developed the original idea for this review protocol in collaboration with MS, WMcK and

380    SH.   PF wrote the original draft of the protocol, which was subsequently refined by MS,

381    WMcK, SH, and PF.  All authors agree to be accountable for all aspects of this protocol.  PF

382    is guarantor of the review.

383

384    **Competing interests:**

385    All authors declare that they have no competing interests.

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387    This research received no specific grant from any funding agency in the public, commercial

388    or not-for-profit sectors.

389    **Ethics:**

390    Not applicable.

391    **Patient and Public Involvement:**

392    None – Literature review.

393

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