Developing a Co-Curricular Activity to Introduce Student Pharmacists to the Cultural Proficiency Continuum Framework

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Abstract

Background: *As the United States becomes more culturally diverse, health professionals must be able to demonstrate competency in caring for a multitude of diverse patients. The cultural proficiency continuum has proven to be an effective framework to assess where individuals and institutions are on the continuum of cultural sensitivity and competence in educational settings.*

Innovation: *A co-curricular activity was developed as an exercise in self-awareness to allow first year pharmacy students the opportunity to explore potential biases by evaluating comfort in both social and patient care settings. The 90-minute activity employed a lecture, followed by both small and large group discussions and a debriefing session.*

Findings: *Student survey responses showed their appreciation of this framework and its application to patient-centered care. Student self-rated knowledge increased by 3 points on a 10-point scale after completion of the activity. Students agreed that their level of cultural awareness would lead them to respond appropriately in cross-cultural situations, and that the provision of care is dependent on approaches that are culturally proficient.*

Conclusion: *This activity dismantles the misconception of cultural competence as an attainable finite skill, but instead presents it as an ongoing process of self-awareness. The co-curricular activity offers an easy to implement model of education that could potentially fit the needs of pharmacy programs searching for ideas to teach cultural competency and social determinants of health, while circumventing the need to affect curricular structure.*

Key words: cultural proficiency continuum; cultural competency; co-curricular; social determinants of health; self-awareness

Description of the Problem

As the United States (US) becomes more culturally and ethnically diverse, health professionals must be competent in caring for a multitude of diverse patients whose communication, beliefs and customs regarding health contrast with their own. In the classroom, the approach to integrate culture has mostly focused on race or ethnicity.[1] This categorical representation of culture precludes health professionals from seeing a patient as a multi-dimensional individual whose health outcomes are impacted by all aspects of their culture, not just one dimension of their cultural identity, such as ethnicity. Furthermore, health professionals must be able to recognize the way in which their own cultural identity influences how they act and think, and acknowledge that cultural differences exist in their interaction with patients.

Cultural competency is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations".[2] While current efforts to incorporate cultural competency instruction into the pharmacy curriculum has yielded positive results,[3] there remains a need to identify additional methods to teach the delivery of culturally competent care to diverse populations.[4] While cultural competency is not enough to meet the needs of a multicultural society and public health demands,[5] it is unquestionably an essential tool to move toward a more culturally proficient healthcare workforce. Cultural proficiency is an adaptation to another's differences in values and practices, and an interest in closing the gap through alliance and personal transformation.[6] The achievement of cultural proficiency can occur alongside the Pharm.D. curriculum, as a co-curricular activity. While cultural competency can be taught in the classroom, and does occur through learning and self-exploration, it is best achieved through interactions with diverse individuals outside of a formal learning environment. Cultural proficiency should be viewed as a goal towards which future pharmacists can strive. In order to achieve this, individuals and/or organizations must be able to assess where they are in the process of becoming more proficient as they respond to cultural differences.

The cultural proficiency continuum can be an effective framework to assess where individuals and organizations are on the continuum of cultural proficiency in educational settings.[6] It provides a framework to describe destructive and proficient values and behaviors of individuals and organizations as it relates to cross-cultural differences. The continuum can help individuals plan for positive movement along the continuum and allows individuals to evaluate their values and actions to move from cultural tolerance to transformation.[6] This tool has not previously been utilized in a co-curricular setting to reinforce efforts in other core curriculum courses. As an exercise in self-awareness, this activity allowed students the opportunity to explore potential biases by evaluating comfort in both social and patient care settings.

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The Innovation

This innovative approach introduced a cohort of 100 first year student pharmacists to the cultural proficiency continuum during orientation, which is used by the college of pharmacy to address cultural differences. Faculty in the college refer to this continuum when educating students in both didactic and experiential experiences. The objectives of the activity were to provide instruction and an opportunity for interaction, so that upon completion student pharmacists would be able to: 1) differentiate between cultural sensitivity, cultural competency, and cultural proficiency, 2) critically analyze cross cultural statements using the cultural continuum conceptual framework, and 3) compare and contrast cross cultural experiences with peers. The activity was conducted in 90-minutes, with a 30-minute lecture given by faculty to introduce the cultural proficiency continuum framework (Figure 1),[6] followed by both small and large group discussions, concluding with a debriefing session. The activity was offered during the afternoon session on the first day of orientation as part of a four-day program. The activity offered student pharmacists an opportunity for self-assessment by allowing the student to place themselves (their beliefs, attitudes, behaviors, etc.) on the continuum with respect to the various cultural groups in a community, clinical, or social setting.

In accordance with the Center for the Advancement of Pharmacy Education (CAPE) 2013 educational outcomes,[7] this activity has been mapped to the third domain of CAPE, or Approach to Practice and Care. The activity debrief addressed social determinants of health (SDOH), and students were asked to discuss the role of culture in healthcare. Through reflection and dialogue with other classmates, students were asked to examine and reflect on their personal knowledge, beliefs, biases, and emotions (comfort) that could enhance or limit personal and professional growth.

Design and Structure

The activity was developed, implemented, and facilitated by two faculty members. While one faculty member holds a Ph.D. in medicinal chemistry and the other in social administrative sciences, both have received post-graduate training and experience teaching health disparities. The activity began with an instructor-led lecture (25 minutes) emphasizing diversity and the intersectionality of each individual person (based on categories, such as gender, ethnicity, sexual orientation, physical/mental abilities, religion, socioeconomic status, political beliefs, age, health literacy, education, etc.) as the key to providing patient-centered care. Additionally, the faculty facilitators introduced the topic and definition of culture as it relates to health behaviors and outcomes. A differentiation between surface versus deep culture was discussed in the context of cross-cultural interactions between patients and health professionals using the iceberg concept of culture.[8] Furthermore, students were introduced to the differences between cultural sensitivity and cultural competency. The second half of the lecture was devoted to guiding students through the cultural proficiency continuum framework in an effort to understand the process of becoming culturally competent and achieving cultural competency both at the individual and institutional levels. Each step of the continuum was defined and healthcare-related examples given to assist students in comprehending how our responses and actions in cross-cultural situations may affect communication. The continuum was divided in two phases: a reactive phase, where the individual demonstrates tolerance at best, and a proactive phase, which is a more transformative response to a situation (Figure 1).

At the end of the lecture, students were given a worksheet, instructed to read each statement individually and asked to determine which level of cultural proficiency was reflected. Students then divided into groups of five and discussed their answers (10 minutes), in preparation for a large-group discussion (10 minutes) and debriefing session (45 minutes). The following statements were used:

- “The dean of student affairs is requesting a student for the University Diversity Committee, so let’s assign Marcus because he is the president of the Minority Health Sciences Student Organization.” (Cultural Incapacity)
- “If we could get rid of Jessica with her broken English, our group presentation grade would probably go up.” (Cultural Destructiveness)
- “We value all cultures. During the Chinese New Year, we had Zhang Li make her famous spring rolls.” (Cultural Pre-competence)
- “The LGBTQ student organization is for all students who want to raise awareness about LGBTQ issues, not just for students who identify as LGBTQ.” (Cultural Proficiency)
- “You know those Muslim students in our class are not Christian so I wouldn’t invite them to our Christian Pharmacists Fellowship International sponsored event.” (Cultural Incapacity)
- “Racism and discrimination don’t exist anymore. I really hate it when our classmates use the race card.” (Cultural Blindness)
- “Why do we need to have a Black Student Association? We don’t have a White Student Association” (Cultural Destructiveness)
- “The American Pharmacists Association inviting representatives of marginalized communities allows us to relate better to some of our patients.” (Cultural Competence)
- “For a Hispanic girl, her grades in Pharmacology are surprisingly high.” (Cultural Incapacity)

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Evaluative Data
Prior to and after the co-curricular activity session, students were asked to complete an anonymous pre-activity survey, including basic demographics, using Qualtrics (Qualtrics, Provo, UT). The survey received an exemption from Belmont University Institutional Review Board. Students were asked to define culture in their own words prior to completing the co-curricular activity and their responses were read by one of the instructors to identify which aspects of culture were identified. The most frequent aspects identified by the student participants included customs/traditions/behaviors, followed by environment, beliefs/ideologies, social identity, food/arts/music/fashion, ethnicity, values/morals, language, locality, religion, experiences, gender, and education.

Students were asked to provide a baseline assessment of their perceived cultural awareness using a 5-point Likert scale (1=strongly agree and 5=strongly agree). The statements were created by the faculty facilitators based on shared experiences of colleagues and students at institutions of higher education. Overall, students were in agreement of the existence of cultural stereotypes (4.72±0.48), their own personal biases as it relates to different cultures (4.16±0.75), and how their cultural perspective influences their judgement of how others behave (4.09±0.79). The respondents reported that while there may be limitations to their skills when interacting with individuals from cultures other than their own (4.05±0.87), they were less likely to feel that they lack the capacity to respond appropriately to those differences (2.98±1.30). This suggests a more cognizant provider who understands there is room to grow and learn more about the cultures around them. Furthermore, students were aware that the provision of care is dependent on policies (4.21±0.72) and approaches that are culturally proficient (4.11±0.78).

The post-activity survey asked participants to use their recently gained knowledge of the cultural proficiency continuum to critically evaluate and determine the placement of a different set of 12 statements generated by the faculty in one of the six steps on the continuum (Table 1). Student self-rated perceived knowledge of the continuum increased by 3 points on a 10-point scale (0=not knowledgeable and 10=very knowledgeable) after completion of the activity (5.79±2.48 versus 8.89±0.92; p=0.001 by t-test). The use of statements and the debriefing process helped students contextualize each step of the continuum so that may have increased knowledge. The activity allowed students to develop awareness of their own cultural shortcomings through the cultural lenses of their peers' experiences.

Critical Analysis
Students struggled to recognize the intersectionality of cultural identities prior to the activity as they would only recognize one or two aspects of culture. Student lived experience and contextualization of the statements might explain the placement of the situation in the continuum. In group discussion, affirmation or rejection of the placement of the statement, along with justification, could possibly change student perspectives going forward. Key issues, or limitations of the activity include homogeneity of groups due to self-selection, which may have limited the sharing of divergent perspectives. Individual bias in interpreting the statement is difficult to control for. Social desirability may have contributed to inflated self-evaluations of cultural awareness. Instructors were faculty, and despite the assurance of anonymity, students might overestimate their level of comfort with certain types of statement to create an impression that their cohort was culturally competent. Students might feel compelled to confirm the perspectives that were vocalized by others in the discussion. Finally, without intentional reinforcement in the curriculum, one-time sessions may not have long term impact on movement toward proficiency.

The development and implementation of this co-curricular activity generated an opportunity for students to enhance their knowledge and awareness about the cultural proficiency continuum. It also offered students an opportunity to see the role of pharmacy practice in eliminating health disparities. Moreover, this activity dismantles the misconception of cultural competency as an attainable finite skill, but instead presents it as an ongoing process of self-awareness and willingness to learn about their future patients' intersectionality as part of the cultural proficiency framework.

Next Steps
If we want pharmacists to be effective in cross-cultural interactions with their patients in the communities that they serve, intentional efforts by pharmacy programs must be a priority. The personal and professional cultural competency standards must be set high the moment student pharmacists enter pharmacy programs. While many faculty members agree that integration of cultural competency or sensitivity into pharmacy curricula is important, it is unclear if all faculty have the necessary ability or experience to teach these topics.[9]

The themes and concepts covered in this co-curricular activity have been reinforced elsewhere in the curriculum in courses such as Healthcare Delivery, Communications and Counseling, and Ethics. From a curricular standpoint, enhancing the aspects of the social history component of the patient interview is imperative in these courses. Creating opportunities for students to continue to share their perspectives and continue their journey towards cultural proficiency can be achieved through didactic and experiential activities such as, identifying an issue and proposing an intervention using the socio-ecological model, role-playing interactions with multicultural standardized patient actors, and considering social justice in the provision of ethically responsible patient care.

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Summary
This activity delivered a viable and reproducible model tailored to the pharmacy profession that avoided the need to affect curricular structure. In addition, it encompassed multiple aspects surrounding patients' identity and SDOH and introduced students to the cultural proficiency continuum framework to assist student pharmacists in being more transformative in their cross-cultural interactions.

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Figure 1. Cultural Proficiency Continuum Framework[6]

Reactive: Tolerance — Proactive: Transformative

Cutural Destructiveness → Cultural Incapacity → Cultural Blindness → Cultural Pre-competence → Cultural Competence → Cultural Proficiency

Stage	Response	Action
Cultural Destructiveness	"See the difference, stomp it out"	Using one's power to eliminate the culture of another.
Cultural Incapacity	"See the difference, make it wrong"	Believing in the superiority of one's own culture.
Cultural Blindness	"See the difference, act like you don't"	Expressing a philosophy of viewing and treating all people as the same
Cultural Pre-Competence	"See the difference, respond to it inappropriately"	Recognizing that cultural differences exist.
Cultural Competence	"See the difference, understand the difference and value it"	Ongoing acceptance and respect exist for differences among cultural groups.
Cultural Proficiency	"See the difference, respond positively. Engage, adapt, and advocate."	Valuing the positive effect and transformation of understanding and engaging different cultures. Becoming an advocate.

Table 1. Participants' Critical Analysis of Statements Using the Cultural Competency Continuum Framework

Statement	Cultural Destructiveness N (%)	Cultural Incapacity N (%)	Cultural Blindness N (%)	Cultural Pre-Competence N (%)	Cultural Competence N (%)	Cultural Proficiency N (%)
"Discrimination and racism in the health care system doesn't exist anymore."	5 (8.77)	5 (8.77)	47 (82.46)*	0 (0)	0 (0)	0 (0)
"A pharmacy technician made a derogatory remark about a transgender patient and the pharmacy manager used it as a teachable moment to remind everybody of the right thing to do."	6 (10.53)	4 (7.02)	2 (3.51)	17 (29.82)	20 (35.09)*	8 (14.04)
"For an Asian administrative assistant, she writes very well."	21 (36.84)	32 (56.14)*	2 (3.51)	1 (1.75)	1 (1.75)	0 (0)
"When you come to work in this pharmacy you cannot wear your hijab (head covering worn by some Muslim women)."	47 (82.46)*	8 (14.04)	1 (1.75)	1 (1.75)	0 (0)	0 (0)
"We need to hire a Spanish-speaking pharmacy technician to help out with our Hispanic patients."	1 (1.75)	2 (3.51)	2 (3.51)	23 (40.35)*	23 (40.35)	6 (10.53)
"My job as a pharmacist is not only to counsel patients. I also openly embrace my role as an advocate for my marginalized patients."	0 (0)	0 (0)	0 (0)	3 (5.26)	11 (19.30)	43 (75.44)*
"You know black patients don't comply with their diabetes management program."	33 (58.93)	19 (33.93)*	3 (5.36)	1 (1.79)	0 (0)	0 (0)
"If we could get rid of those low socio-economic patients we wouldn't have to sit through this two-hour Medicaid training program."	49 (85.96)*	6 (10.53)	2 (3.51)	0 (0)	0 (0)	0 (0)
"I don't see the point of tailoring an HIV prevention action program based on sexual orientation."	12 (21.05)	21 (36.84)	21 (36.84)*	2 (3.51)	0 (0)	1 (1.75)
"My pharmacy manager game me a pink ribbon to wear during breast cancer awareness month."	0 (0)	0 (0)	2 (3.51)	31 (54.39)*	15 (26.32)	9 (15.79)
"As a result of my personal interest in HIV prevention, my boss brought in a consultant from a successful needle exchange program on our city so that we can implement one in our pharmacy."	0 (0)	0 (0)	0 (0)	3 (5.26)	8 (14.04)	46 (80.70)*
"The company I work for reimburses employees 100% of all continuing education costs that are related to cultural competency training."	0 (0)	4 (7.02)	0 (0)	2 (3.51)	10 (17.54)*	41 (71.93)

N – number of responses

* – denotes correct placement of statement on the continuum