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RESEARCH ARTICLE

Identifying interest of pharmacy faculty for formal cultural competence training or credentialing

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Abstract

Background: Accreditation standards in the United States acknowledge the link between health disparities and cultural differences while going beyond recognising that health disparities exist with higher expectations. Pharmacy trainees must practice cultural competence; however, faculty are unprepared to teach this content. This project aims to assess pharmacy faculty's perceived need and interest in targeted and specialised training in cultural competence. **Methods:** This was a cross-sectional study using an electronic survey which was built with items based on study objectives. The survey collected information on demographics, cultural competence terminology, and perceptions of training and resulting credentialing. **Results:** The survey had 398 respondents. The mean response regarding interest in an advanced credential was 3.09 on a scale of one to five. The most common response was "*probably yes*". A theoretical model emerged from the analysis of qualitative comments that describe respondents' perceptions of cultural competence training. **Conclusion:** Intentional design when developing a cultural competence credential and/or training is necessary to ensure value. Pharmacy faculty have strong differing opinions regarding the need for a credential in this space. Additional reflection on the design and structure of any potential training is necessary before moving forward.

Introduction

Over the last few decades, the population in the United States has become increasingly diversified (US Census Bureau, 2022). This diversification is projected to continue, leading to reflective changes in the patients seeking health care. To effectively serve these patient populations, corresponding changes should occur in the healthcare workforce and the way patient care is delivered (Arya *et al.*, 2020). These population changes have increased the need to tackle health disparities and for healthcare providers to be culturally competent (Govere & Govere, 2016).

Cultural Competence is defined as "*a set of values, behaviours, attitudes, and practices within a system, organisation, programme or among individuals that enables them to work effectively cross-culturally*" (Isaacs & Benjamin, 1991). The Accreditation Council for Pharmacy Education (ACPE) Standards 2016

acknowledge the link between health disparities and awareness of cultural differences (Standard 3.5) (Accreditation Council for Pharmacy Education, 2015). Furthermore, the recent 2022 American Association of Colleges of Pharmacy (AACP) Curricular Outcomes and Entrustable Professional Activities Educational Outcomes' Domain 2.3 focuses on "*cultural humility and structural humility*". This domain goes beyond recognising that health disparities exist but reaches for higher expectations, including that students should be able to mitigate and navigate cultural and structural factors (Medina *et al*., 2023). Yeager and Bauer-Wu (2013) defined cultural humility as "*a process of self-reflection and discovery to understand oneself and then others in order to build honest and trustworthy relationships*". A newer concept than cultural competence, cultural humility is a lifelong journey. To practice cultural humility is to have more of an inward self-reflecting approach as opposed to practising cultural competence, where the approach is focused on another party (the patient). Regardless of the term used, there is a need for pharmacy trainees to hone their own skills when addressing cultural issues. Despite this need, pharmacy faculty are often left unprepared or uncomfortable with teaching/modelling this content in the curriculum.

Few investigations have been conducted evaluating the inclusion of cultural competence in pharmacy curricula across the United States and Canada. In 2007, Onyoni and Ives conducted the first assessment of this kind. Less than half of respondents reported having integrated cultural competence content into their curriculum. There was a recognition of the need for this content in the pharmacy curriculum, and several schools/colleges acknowledged working on this integration. Chen and colleagues (2021) eventually followed up with another assessment of pharmacy curricular content as it relates to health disparities and cultural competence (HDCC). Most respondents did report that they included content related to HDCC in their respective curricula but to varying degrees with limited required content. The authors thought that this suggests further and more consistent coverage, especially outside of didactic courses. This signalled that most practising pharmacy faculty have not received formal training around cultural competence.

To date, there has not been an evaluation of the desire for specialised training or credentialing in this area of cultural competence. Therefore, the aim of this project is to assess the perceived need and interest of pharmacy faculty for targeted and specialised training via an advanced credential in cultural competence. For this study, the authors define "*advanced credential*" as a type of additional training that one can choose to pursue after obtaining a terminal degree, leading to more than continuing education credits and up to an additional field of specialisation. The authors are defining "*training*" as the delivery of knowledge and experience that culminate in a credential. The research objectives are: 1) to investigate faculty interests in a credential for cultural competence, 2) to identify what level of credential for cultural competence are faculty interested in, 3) to examine what format of training in cultural competence are faculty interested in, and 4) to identify possible barriers to developing training programmes for cultural competence.

Methods

This study was given exempt status (File No: 4276-091522-02) by the IRB of St. John Fisher University. Each participant gave their informed consent prior to participating. Investigators in this study were faculty from eleven universities across the United States. They were all active members of AACP's HDCC Special Interest Group's Scholarship Committee. This cross-sectional study was conducted using an electronic survey. All members of the research group built the survey collaboratively. Items for the survey (Likert type and free text) were drafted based on the research objectives. They collected information on institution and faculty demographics, meaning of cultural competence and similar terminology, the need for advanced training, the type and how much training was offered by schools, colleges and universities, the preferred format of training, possible barriers to training, the desire for an advanced credential to signify that this training was received and the desired type of advanced credential.

Over several months, revisions were made to an initially drafted pool of questions, with input from the entire group (initially 16 persons). Once all revisions were made within the group, investigators shared the survey questions with a convenience sample of at least two colleagues for pilot testing. The survey was then refined based on this additional input into the final version for dissemination. The population used to determine the sample size was 6,182, which represents the total number of pharmacy faculty in the 2022-2023 AACP Pharmacy Faculty Demographics and Salaries report from the Profile of Pharmacy Faculty (AACP, 2023). A sample of 362 was calculated to detect a difference using a 95% confidence interval with a 5% margin of error using Yamane's formula for means of a known population 〖_0〗 (〖^2〗 〖^2〗)/ 〖^2〗 (Yamane, 1967).

The survey was distributed for the first time on November 1st, 2022, using Qualtrics (Qualtrics XM Version 112022) to all registered AACP faculty and administrative members (almost 3100 persons) at universities across the US and Canada. Follow-up emails were sent in two to three-week increments after this initial distribution, up to the middle of December 2022. A final distribution was done in January 2023 due to faculty absences for the holidays.

Quantitative analysis

Data were analysed using IBM SPSS Statistics (IBM Corp Version 28.0.1.0). Descriptive statistics were performed for institutional and respondent demographics. Faculty interest in an advanced credential in cultural competence was assessed with the question stem, "*Are you interested in pursuing an advanced credential in cultural competence?*". This item used a mutually exclusive 5-point Likert scale multiple choice question and was measured by conversion of answer choices to interval data (one = definitely not, two = probably not, three = not sure, four = probably yes, five = definitely yes). It was analysed by a one-sample binomial test with a test median of three (Sullivan & Artino, 2013). Furthermore, a relationship map between personal demographic variables with mutually exclusive answer choices (not asked as "*select all that apply*" items) and the answer to the item "*Do you think there should be an advance credentialing for pharmacy faculty and administrators in [cultural competence]*" was generated to determine individual factors that may influence this sentiment for future studies. Relationships with less than 10 associations were excluded from the analysis for clarity.

Objectives 2-4 were measured using a one-sample, two-sided Z proportions test. The one-sample Z proportions test was used to determine if the sample mean was truly different (greater or less than) than the population proportion which is estimated via conditional probability using Field's method (Field, 2018). The sign of the Z-value indicated the direction of the result, the magnitude of the Z-value was proportional to the magnitude of the result, and *the p*-value < 0.05 was considered statistically significant. Assessment of the preferred level of cultural competence credential (objective 2), training format and delivery (objective 3), and possible barriers to formalised cultural competence programmes (objective 4) occurred with the question stems "*What type of advanced credential in cultural competence would you be interested in pursuing?*" "*What format of advanced training in cultural competence would you prefer?*," and "*In your School/College, what are some of the barriers to offering cultural competence training?*" respectively. The format of answer options for all these items was "*select all that apply*". These "*select all that apply*" items were each separated into individual binomial variables for analysis for each component of each item. Of note, the "*other*" selection was used as an option for those who did not feel that the options available captured the respondents' desired response. The statistically significant negative Z score should not be interpreted as a "*strong preference for* "*not other*".

Qualitative analysis

Free-text comments were extracted from Qualtrics for five questions related to interest in pursuing an advanced credential, type of credential, motivations, and barriers. Three qualitative researchers (RK, KL, LS) conducted initial independent open coding. Consensus was then conducted to establish a codebook that would allow for consistency across coders, with a clear name, definition, and description of each code (MacPhail *et al*., 2016). A larger qualitative team of five researchers (RK, KL, LS, DD, SA) next convened to review the code book and provide further consensus and refinement. Following consensus, the group then conducted a thematic analysis and developed a theoretical framework based on the full codebook. Qualitative comments were categorised using the established codebook and theoretical model. Final revisions to the model were made in consultation with the full quantitative research team at a virtual roundtable discussion of findings.

Results

The survey had 398 respondents (response rate 12.85%). All responses were included in the analysis, and indications of the sample size of each analysis are included in each table. For the respondent and institution demographics, missing responses were excluded from the analysis of each item, as indicated in Tables I and II.

Table I: Study respondent demographics (n=395)

Respondent demographics	n (%)
Gender	
Female	234 (59.2)
Male	76 (19.2)
Other	1 (0.3)
Prefer not to say	10 (2.5)
Did not answer	74 (18.7)
Race/Ethnicity	
Asian	21 (5.3)
Black or African American	33 (8.4)
Hispanic or Latinx	12 (3.0)
Middle Eastern or North African	2 (0.5)
Mixed race	6 (1.5)
Native American	1 (0.3)
Native Hawaiian or other Pacific Islander	2 (0.5)
White	230 (58.2)
Other	2 (0.5)
Prefer not to say	12 (3.0)
Did not answer	74 (18.7)
CC or DEI administrative role at school/college	
No	272 (68.9)
Yes	52 (13.2)
Did not answer	71 (18.0)
Length of employment at current school/college	
0-5 years	101 (31.4)
6-10 years	73 (22.7)
11-14 years	50 (15.5)
15-20 years	56 (17.4)
>20 years	42 (13.0)
Faculty role[a]	
Administrator	101 (43.2)
Tenured / tenure track	93 (39.7)
Teaching faculty	96 (41.0)
Research faculty	18 (7.7)
Other	9 (3.8)

[a] Sum of parts do not equal 100% due to the "*select all that apply*" question format. CC = cultural competence; DEI = diversity, equity, and inclusion

Table II: College/school of pharmacy demographics (n=395)

Pharmacy college/school demographics	n (%)
Regional location of university	
Midwest	101 (25.6)
Northeast	65 (16.5)
South	146 (37.0)
West	53 (13.4)
Did not answer	30 (7.6)
Number of faculty in pharmacy programme	
<20	24 (6.1)
20-30	109 (27.6)
31-40	75 (19.0)
41-50	50 (12.7)
51-60	28 (7.1)
>60	77 (19.5)
Did not answer	32 (8.1)
Institutional characteristics[a]	
Private	154 (42.2)
Public	175 (47.9)
Research	178 (48.8)
Teaching	286 (78.4)
HBCU	14 (3.8)
Urban	146 (40.0)
Suburban	0 (0.0)
Rural	74 (20.3)

[a] Sum of parts do not equal 100% due to the "*select all that apply*" question format. Midwest = IL, IN, IA, KS, MI, MN, MO, NE, ND, OH, SD, WI; Northeast = CT, ME, MA, NH, NJ, NY, PA, RI, VT; South = AL, AR, DE, District of Columbia, FL, GA, KY, LA, MA, MS, OK, SC, TN, TX, VA, WV; West = AK, AZ, CA, CO, HI, ID, MT, NV, NM, OR, UT, WA, WY; HBCU = Historically Black Colleges and Universities

Quantitative

The quantitative analysis results are available in Table III. The mean response regarding interest in an advanced credential was 3.09, with the most common response being "*probably yes*" with 88. The probability of a positive response of > 3 was statistically significantly higher than a negative response of ≤ 3 ($p = 0.011$). Regarding the type of credentialing preferences, the respondents were less likely to indicate the following types: board of pharmacy specialty, educational degree, and residency certificate (all $p < 0.001$). For the format of the advanced training, respondents were more likely to indicate a preference for remote online asynchronous delivery ($p < 0.001$) and in-person ($p = 0.046$), while they were less likely to indicate a preference for practical experience incorporated into the training ($p < 0.001$). When asked about barriers to the respondents' School or College offering cultural competence training, respondents were more likely to identify "*lack of personnel who can dedicate time to organise such training*" ($p < 0.001$) and less likely to identify "not part of the institution's mission or strategic initiatives" ($p < 0.001$) as a barrier. The relationship map (Figure 1) revealed that no cultural competence or DEI administrative role and white race were most closely associated with a "no" answer for whether an advanced cultural competence credential should be offered. Female identity, no administrative appointment, and white race were most closely associated with a "*maybe*" answer to the same item. No administrative role and female sex were most closely associated with a "*yes*" answer to that item.

Table III: Pharmacy faculty preferences for credential and training format

Objective 1	n (%)	*p*-value
Interested in advanced credential (n=331)		0.011
Definitely not	50 (12.7)	
Probably not	65 (16.5)	
Not sure	74 (18.7)	
Probably yes	88 (22.3)	
Definitely yes	54 (13.7)	
Did not answer	64 (16.2)	
Objectives 2-4	**Z value**	***p*-value**
Type of credential preferences (n=282)		
Assessment-based certificate programme such as for MTM and immunisations	-0.715	0.476
Board of Pharmacy Specialty	-13.815	<0.001
Certified training programme, such as for certified anticoagulation care providers	0.238	0.812
Educational degree	-12.982	<0.001
Residency certificate	-15.125	<0.001
Other	-7.860	<0.001
Format of advanced training preferences (n=307)		
Remote online synchronous	0.514	0.607
Remote online asynchronous	4.166	<0.001
In person	1.998	0.046
Hybrid (part online, part in person)	-1.084	0.278
Self study/home study included	-1.427	0.154
Practical experience incorporated	-7.705	<0.001
Other	-15.923	<0.001
Barriers to school/college offering CC training (n=316)		
Not part of the institution's mission or strategic initiatives	-14.401	<0.001
Lack of buy-in from faculty and staff or resistance to change	-1.463	0.144
Lack of personnel who can dedicate time to organise such training	7.763	<0.001
Lack of financial resources	0.675	0.500
Other	-11.926	<0.001

MTM = medication therapy management CC = cultural competence

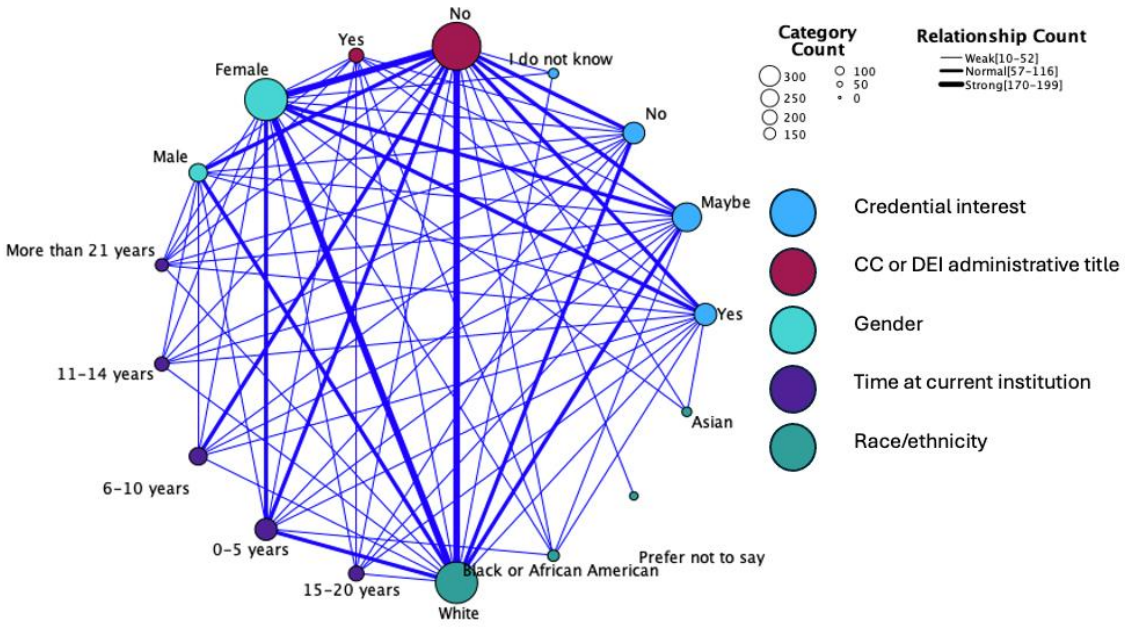

Figure 1: Relationship concept map between individual mutually exclusive faculty demographics and credential interest

Qualitative

A total of 333 unique qualitative comments were included in the analysis. The authors developed a theoretical model (Figure 2) illustrating constructs and themes relating to respondent perceptions of cultural competence credentialing. Table IV breaks down these constructs and themes of the model, indicating the total number of comments coded to each theme as well as representative quotes. Respondents perceptions of the value of any potential cultural competency training (Perceived Value of Cultural Competency Training) were informed by their beliefs regarding the importance of cultural competency in general (Cultural Competency Matters). While some responses reflected negative or inconsequential attitudes towards cultural competency, most participants reported that cultural competence was essential in clinical, educational, and organisational environments. Again, the positions were informed by the complex interaction of Individual Characteristics (personal identities, age, career stage) and Individual Worldviews (political beliefs, perspectives on social justice, and personal values). However, those who held the belief that Cultural Competency Matters (as a clinician, as an educator, to public health) did not always perceive value in training as respondents highlighted both positive aspects of training programmes as well as criticisms of existing training models (reinforcing stereotypes, hesitancy in individuals feeling they were "*competent*" in all cultures and finished learning, etc.). Regarding support in favour of, against, or uncertain of a potential credentialing/training programme was further informed by personal and professional motivations and potential barriers to completing such a programme. Overall, perceptions around the value of cultural competency did not clearly align with support for or against a credentialing/training programme, with responses representing a wide range of perspectives around the potential benefits and unintended consequences of creating a credentialing programme.

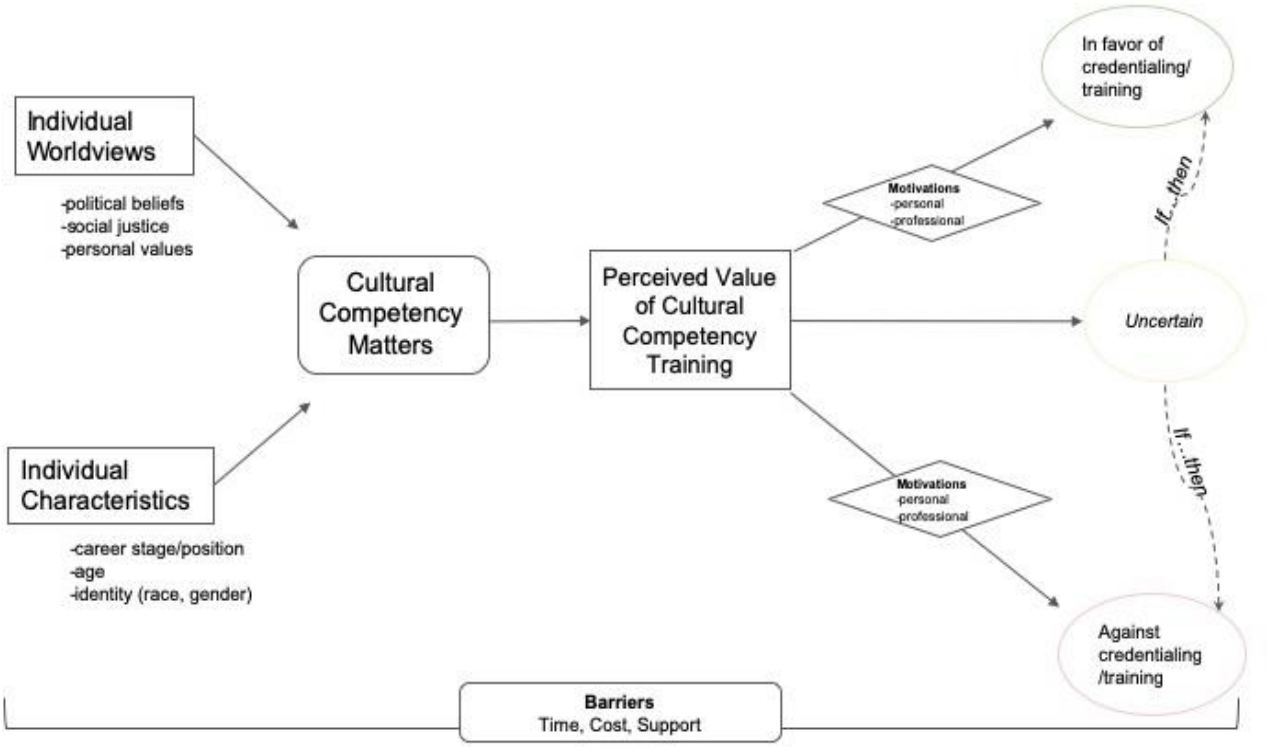

Figure 2: Theoretical model describing pharmacy faculty perceptions of cultural competency credentialing

Table IV: Conceptual themes from pharmacy faculty qualitative comments on advanced cultural competence credentialing

Conceptual theme	Total references	Representative quotes
Individual worldview	75	There's no point. It's a political issue that is used to drive a wedge between people, not bring them together. And that's coming from an independent voter. I believe DEIA is a core personal value. Therefore, I do not believe I need a document to demonstrate to others that I possess it.
Individual characteristics	36	I'm approaching the end of my career and while it would still be helpful for me as I continue to grow as a person I'm not sure it would have any professional relevance. I live it daily and have conducted workshops surrounding these topics in the past.
Cultural competency matters	118	:Cultural competence and diversity and inclusion are often overlooked but important aspects of being an educator that does impact diverse students who provide care to diverse populations that are usually underserved. I need to know what I can do as an educator and in turn teach my students to become better practitioners that accept they will have biases, but do not allow them to affect how they treat their patients.
Perceived value of cultural competency training	108	EVERYONE needs these types of trainings. Everyone needs to engage on their own self- education in these areas. Some are farther along than others, but an unanticipated consequence of "*advanced credentials*" is that it implies that some people specialise in this area, and everyone else specialises in other areas (i.e. don't need to do the work). These efforts must be system-wide to be effective. No one gets off the hook. Few programmes support personal growth and instead focus on creating bias and stereotypes through their focus on learning about one element of personal difference versus allowing the individual a structure to learn about themselves while also learning about others.
Motivation	105	I want to be informed, understand terminology and ensure I am creating an inclusive learning and practice environment. To make me a better person.
Barriers	48	I am interested in additional training but do not feel I have capacity to commit to something that would like be a more significant time commitment. There would likely be other trainings I would select before that when it comes to allocating time. Cost is a major barrier, especially if the employer does not assist in paying the costs
In favor of credential	95	Hopefully it can be a "*credentialed*" way to show leadership and colleagues the importance of this work. I also believe it's a lifelong learning process as cultures change overtime. want training that allows me to put into action what I learn. I have grown up very privileged and want to use this to amplify others and reduce disparities
Against credential	86	Training should be required in some form for everyone; having an advanced credential will just separate people more; those that are particularly interested will seek out the credential while those that could potentially benefit the most from the training will not receive it. I do not think that this is something that lends itself well to credentialing; this is something that is best shown through living one's values.
Uncertain for credential	61	I do not see how cultural competency is an "*advanced*" topic, it should be core competency to all health care professionals not an elective "*add on*". To categorise it as advanced credentialing means that there are some facets of pharmacy practice in which cultural competency is not important (to which I strongly disagree). We do not have advanced credentialing on prescription counselling because it is a core function of a pharmacist, and I see cultural competency in the same way. It would depend upon the amount of time, content covered and what type of certificate is given.

Discussion

This study explored and assessed the interest of pharmacy faculty for a credential for cultural competence, the level of this credential and the format of training. Potential barriers to training programmes for cultural competence were also identified. Literature to date is lacking regarding the desire for and format of focused training in this area for pharmacy faculty. The findings of this study present rich data that meets this gap by providing insight into the desired or undesired credentials, and structure and design of cultural competence training.

Overall, participants varied in their responses about their desire for a credential in cultural competence. For those who provided feedback on their reasoning, it was rooted in their worldviews, individual characteristics and beliefs around their values of cultural competency (see Table IV). Having a credential for cultural competence and

diversity, equity, and inclusion (DEI) areas is of interest to pharmacy faculty, as indicated by statistically significant positive responses. However, controversy was found among respondents regarding the structure and format of training and the outcome obtained (ex. certificate). It is important to note that respondents did not favour any of the levels of credentialing we presented, which negates the development of a board of pharmacy specialty, a residency certificate, or even an educational degree. They were clear in choosing the preferred formats for credentialing cultural competence in in-person or remote online asynchronous training. Both these findings support each other. The current climate in academia supports the use of various educational methods to address logical challenges, including limited time and alignment with institutional initiatives, among others. The increased availability of online pharmacy programmes shows there is a growing desire for flexibility among students. The findings suggest that pharmacy faculty desire this flexibility as well. On the other hand, this could also suggest that perhaps pharmacy faculty feel that training in cultural competence should be a lifelong journey, so obtaining one level of credential is simply not enough, or there is no one type of credential that is better than the other for this type of content. Respondents identified one clear barrier to cultural competence training at their respective institutions. Lack of personnel who can dedicate time to organise such training signals a possible lack of institutional and financial support for these types of initiatives. While the quantitative findings raise multiple questions, investigation of the qualitative findings provides clearer insight and reconciliation of this data.

Credentialing has historically been a common practice among healthcare professionals (Institute of Medicine (US) Committee on Quality of Health Care in America, 2000; Wollen *et al*., 2023a). As pharmacy practice has continued to advance through interprofessional models to include direct patient care, the use of certification and the need for credentialing has also evolved (Council on Credentialing in Pharmacy, 2014). Limited data is available regarding pharmacist perceptions or willingness to participate in credentialing processes (Wollen *et al*., 2023a). Lee and colleagues conducted a survey study in 2019 evaluating the perspectives of 446 pharmacists regarding credentialing. The researchers reported that pharmacists overall valued credentialing and felt it was important to the profession but had concerns regarding ease of use and information security. The findings echo this conundrum as survey respondents expressed differing views on the perceived impact of a cultural competence credential on culture and pharmacy education. The need for increased cultural competence in healthcare is indisputable (Beach *et al*., 2006; Schouten *et al*., 2007; Tucker *et al*., 2011). Cultural competence training has been shown to improve self-reported understanding of the healthcare experiences of patients with diverse backgrounds and improve health professional skills by providing effective care in cross-cultural situations (Khanna *et al*., 2009). The qualitative findings of the study are very saturated and diverse with regard to the impact of cultural competence training. However, the overall importance of being a culturally competent educator is high among respondents.

As differences in patient, system and provider characteristics only continue to evolve in healthcare and impact health disparities, worldview constructs play a key role in how care is provided. Worldview, or the set of beliefs and assumptions used to interpret and explain an experience, directly impacts cultural competence through the intersection of belief and culture (Tilburt, 2010). This is equally evident in the varying perspectives and worldviews revealed within the qualitative findings, as some respondents expressed concern about whether a cultural competence credential will only serve as a "*check-box*" or further the current progress of DEI-related initiatives. Likewise, the findings suggest an underlying professional controversy among pharmacy educators regarding the perceived value of a cultural competence credential as a means of improving health professional abilities to educate and navigate health disparities. In a study by Shepherd and colleagues, similar concerns regarding the value of cultural awareness-based initiatives and utility were noted (Shepherd *et al*., 2019). The motivations of an individual in the study who indicated a desire or lack of desire for cultural competence training and/or credentialing, unsurprisingly appear to be largely rooted in the worldview of the individual. The qualitative data of this study indicates a broad range of factors can possibly influence the desire of an individual to seek additional training in this space (Table IV).

Future studies with a deductive methodological approach using multivariate analysis can shed insight into the impact of demographic and other factors on interest in such a credential. With data collected in this study, there seems to be a spectrum of association of less interest among white faculty and more interest from female faculty with no specific relationship associated with no cultural competence in the DEI administrative position. The association with all three outcomes to the interest item is likely due to the skew towards no administrative, cultural competence or DEI appointment. Some caution must be used in interpreting these associations as there is no hypothesis testing performed in this method, and no application of standard error is performed. The associations only measure the frequency only frequency of categorical variables that occur simultaneously.

This study had some limitations. This data set represents one point in time, potentially influenced by semester peak cycles, the traditional winter holiday, vacations, and admission timelines. The findings of this study may also be influenced by ongoing public events, including increasing public violence and political polarisation (Sharif *et al*., 2022). Of the 3,098 AACP members invited to participate, the response rate of 12.85% is also worth noting as a limitation when considering generalisability. It is acknowledged that the topic covered in this survey, in the current climate, does not encourage participation. This is an unfortunate theme experienced by researchers in this realm. The richness of the qualitative data collected from participants in this study helps outweigh this limitation. The voluntary survey design and specific survey population also introduce the potential for response and selection bias. This is also a known issue with survey research, as subjects with stronger beliefs on the subject are more likely to answer. However, the racial and gender distribution of the survey respondents was similar to the 2022–2023 American Association of Colleges of Pharmacy published faculty data (American Association of Colleges of Pharmacy, 2022). Lastly, the findings of this study may not fully represent the perspectives of individuals of underrepresented populations.

The impact of individual experiences on worldview formation and trust is clear when reconciling the quantitative and qualitative findings of the study. The limited trust in whether a cultural competence credential would provide the intended value, advocacy, and recognition respondents desired echoes the findings of other published literature (Cook et al., 2005; Boutin-Foster *et al*., 2008; Wollen *et al*., 2023b). Self-reflection also appears to play an important role in impacting the desire to seek training in cultural competence. The findings of this study provide valuable insight for educators and others considering professional credentialing in cultural competence. The study findings indicate the need for caution and intentionality when developing future credentials. This research also emphasises the critical nature of varying perceptions of what cultural competence entails and individual worldviews on social justice, what is right/wrong, and the importance of being credentialed, particularly if a pharmacy credential is developed. Further, consideration of the significant variability in desire for obtaining a credential-based on individual characteristics such as age, career goals/stage, and identity will be important. These challenges align with current literature indicating issues with learner resistance, stereotypes, and labelling of groups as "*other*" when teaching cultural competence (Boutin-Foster *et al*., 2008; Wollen *et al*., 2023b). Ongoing dialogue with frequent input will be important when navigating these diverging perspectives. Finally, consideration of the ultimate intended purpose and mechanisms utilised for improving cultural competence among pharmacy educators and practitioners is essential to ensure buy-in.

Conclusion

The need for cultural competence among health professionals is undeniable to ensure high-quality, person-centred care. Intentional design when developing a credential and/or training in this space is necessary to ensure value and meaning are conveyed. Results from this study provide critical insight into the perceptions and desires of pharmacy educators regarding targeted and specialised training in cultural competence. The findings reveal strong differing opinions regarding the need for a credential in this space. Additional reflection on the design and structure of any potential training is necessary before moving forward.

Acknowledgement

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Conflict of interest

The authors declare no conflict of interest.

Ethics Approval and Informed Consent

This study was given exempt status (File No: 4276-091522-02) by the IRB of St. John Fisher University. Each participant gave their informed consent prior to participating.

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