

Identifying key elements of cultural competence to incorporate into a New Zealand undergraduate pharmacy curriculum

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Abstract

Background: Culturally competent practice is now mandatory for New Zealand (NZ) pharmacists.

Aims: This research sought the opinions of those with expertise in different facets of cultural competence, to inform the content and teaching strategies for this subject within a pharmacy undergraduate programme in NZ.

Methods: An exploratory, qualitative study design analysing the transcriptions of nineteen audio-recorded, semi-structured interviews was used. Prior to the interviews, participants received a copy of the Revised Tool for Assessing Cultural Competence Training (TACCT-R).

Results: Seven main themes were identified: teaching challenges; curriculum content; content positioning; teaching delivery; teaching staff; assessment of student learning; and positioning Māori (the indigenous peoples of NZ) health in cultural competence. Challenges included the topic broadness and sensitivity. With modifications, the TACCT-R was found to have a scope relevant to the NZ pharmacy environment.

Conclusions: The findings reveal similarities with previous research but also tensions including the place of Hauora Māori and cultural experiences.

Keywords: *Cultural Competence, New Zealand, Pharmacy, Qualitative Research, TACCT-R*

Introduction

Culture can be viewed as an integrated set of beliefs and behaviours that are learned and shared within groups (Betancourt *et al.*, 2003). Consideration of culture is important within healthcare as it can influence how people define health and illness (Kleinman, Eisenberg, & Good, 1978). Cultural differences between health consumer and practitioner can also be a barrier to accessing quality healthcare (Qureshi *et al.*, 2008). In pharmacy, culture can affect choices regarding drug therapy (Zweber, 2002) and the acceptability of recommendations made by pharmacists (Qureshi *et al.*, 2008). A lack of disclosure and/or misunderstandings between patients and pharmacists can occur because of cultural differences. These differences can contribute to health disparities via various mechanisms including patient disengagement with the health service, inappropriate use of medicines, poor medication adherence, lack of medication effect, or toxicities (O'Connell *et al.*, 2007; O'Connell *et al.*, 2009). This can result in higher hospitalisation rates, more severe

illnesses and more presentations at emergency departments (O'Connell *et al.*, 2007; 2009).

Cultural competence has been defined in many ways, but in its broadest sense can be considered a:

“set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, & Isaacs, 1989: p.13).

It is postulated that cultural competence facilitates health practitioners to deliver the highest quality care to all patients (Betancourt & Green, 2010).

In New Zealand (NZ), the legal and professional requirement for all registered health professionals to practice in a culturally competent manner arises from section 118(i) of the Health Practitioners Competence Assurance Act 2003 (Health Practitioners Competence Assurance Act, 2003). In 2012, it became mandatory for

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all pharmacists and intern pharmacists registered with the Pharmacy Council of New Zealand/Te Pou Whakamana Kaimatu o Aotearoa (PCNZ) to provide evidence to demonstrate their culturally competent practice.

The PCNZ defines cultural competence as being:

“the ability to interact respectfully and effectively with persons from a background different from one’s own. It goes beyond an awareness of or sensitivity to another culture, to include the ability to use that knowledge in cross-cultural situations” (Pharmacy Council of New Zealand, 2011: p.2).

Their range statement, describing culture states that:

“Culture includes but is not restricted to age, gender, sexual orientation, race, socioeconomic status (including occupation), religion, physical, mental or other impairments, ethnicity and organisational culture” (Pharmacy Council of New Zealand, 2011: p.2).

Becoming a pharmacist in NZ requires the successful completion of a four year Bachelor of Pharmacy degree followed by a one year supervised internship. As cultural competence is a relatively new competence for NZ pharmacists to achieve it has implications for BPharm curricula and continuing professional development providers.

In NZ specifically, the Treaty of Waitangi is a unique agreement signed in 1840 between the British Crown and Māori, the indigenous peoples of NZ. The significant relationship between Māori and the Crown under the Treaty (Ministry for Culture and Heritage, 2012) means that cultural competence for pharmacists in NZ also requires Māori leadership, an important and unique focus when compared with other countries. Indeed the health disparities experienced by Māori in NZ (Ajwani *et al.*, 2003; Blakely *et al.*, 2005; Blakely *et al.*, 2007) can be viewed as stark evidence that the obligations of the Crown under the Treaty of Waitangi are not always observed. (New Zealand Ministry of Justice, 2015). These disparities also highlight the need for Māori participation in developing culturally competent healthcare practitioners in NZ.

Much of the early published literature focussed on the scope of cultural competence, the need for healthcare professional students to receive training in this area and individual educational interventions (Kai, Bridgewater & Spencer, 2001; Cuellar & Fitzsimmons, 2003). Few publications have explained how to successfully integrate the topic into undergraduate teaching programmes, nor were they explicit regarding the elements important to ensure a comprehensive programme (Dogra, 2001; Chun, 2010; Kamaka, 2010).

This research project was thus conceived to inform the development of the cultural competence teaching stream at the University of Auckland School of Pharmacy. The main aim was to explore the opinions of those with expertise in different facets of cultural competence regarding teaching cultural competence in a pharmacy undergraduate programme in NZ. Topics specifically explored were content, staff, pedagogy, and pitfalls. We

were also interested in exploring the use of the Revised Tool for Assessing Cultural Competence Training (TACCT-R) (Lie *et al.*, 2008) which was originally developed by the Association of American Medical Colleges (The Association of American Medical Colleges, 2005) to assist those involved in teaching health professional students to develop and evaluate the cultural competence in their curricula. Although the political environment and population make-up differ between the United States of America (USA) and NZ, the definitions of cultural competence and associated health professional behaviours expected in both countries are similar and include knowledge, skills and attitudes. Therefore a secondary aim was to assess the potential for using the TACCT-R to evaluate pharmacy curricula in NZ.

Methods

Study design

We used an exploratory, qualitative study design comprising a series of face-to-face and telephone interviews, using a semi-structured interview guide, with participants with experience in areas pertinent to this research, such as the teaching of relevant subject areas to healthcare students and community pharmacists practising in areas of diversity.

Instrument development

A draft interview guide, informed by the research aims and a literature review was developed. This was piloted with academics and refined according to their feedback. The guide covered interviewee experiences of both being taught and teaching cultural competence, opinions on what should be taught to pharmacy undergraduates, and how it should be taught and assessed. To aid in addressing the ‘What to teach?’ research question, the guide also included questions about the TACCT-R. This instrument consists of six domains and 42 learning objectives and can be used to map existing curricula or inform new ones. Prior to the commencement of the interviews, participants were primed for the interview by being asked to read the TACCT-R domains and learning outcomes, the interview questions, the PCNZ definition of cultural competence, and statement defining culture with respect to pharmacy in NZ.

Data collection (Figure 1)

Potential research participants were purposively selected and approached via telephone or e-mail to assess their willingness to be interviewed. Eligibility criteria included having: expert knowledge of cultural competence and communication; experience in teaching Hauora Māori (Māori health/wellbeing); experience in teaching aspects of cultural competence to healthcare professionals or undergraduates within NZ; experience of teaching pharmacy undergraduate students overseas; or experience working as a pharmacist in culturally diverse areas of NZ. In NZ it has been compulsory for nurses and doctors to

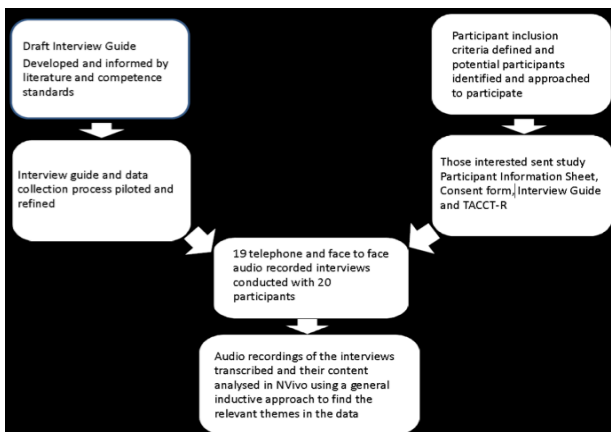
practice in a culturally competent manner for a number of years (Medical Council of New Zealand, 2006; Nursing Council of New Zealand, 2011). Therefore, in addition to seeking the views of practising pharmacists we also sought to be informed by the experiences of those teaching undergraduate nurses and doctors. Potential participants were identified from their employment positions, research interests, practice areas (geographical and employment scope).

Individuals who expressed an interest in being interviewed received a participant information sheet, and a consent form.

Interviews were conducted between January and April 2012 by a final year undergraduate pharmacy student researcher from Europe [FH], (self-identified ethnicity, European). They were between 37 and 141 minutes in duration and all were audio-recorded. Field notes of all the interviews were also made. Audio files were transcribed *verbatim* by either the researcher [FH] who conducted the interviews or a professional transcriber and were subsequently reviewed with the audio file, for accuracy (and amended where necessary) by another member of the research team [TA].

Twenty-six people were approached and 19 interviews were conducted, involving 20 participants (one interview involved two participants). The sample consisted of 14 pharmacists, two nurses and three doctors, working within academia and/or hospital or community practice and a health professional trainer for two cultural groups. One was based overseas. Those interviewed were all offered a NZ \$30 voucher as a token of thanks.

Figure 1: Flow diagram of the data collection and analysis methods used



Data analysis

Given the exploratory nature of the research, a general inductive approach to thematic analysis was undertaken (Thomas, 2006). An initial review of a selection of the transcripts by one member of the research team was

undertaken [RB], and a coding framework informed by the research aims was developed. Following discussions with two other researchers [TA and JS], this was modified and subsequently used to code the remaining transcripts (using NVivo). One researcher [TA] then read all the transcripts again and reviewed the coding framework and the text attributed to each code. To increase the robustness of the analysis and ensure that a Māori perspective of the content of the interviews was included, a Māori health researcher [MH], experienced in qualitative analysis techniques, reviewed the transcript sections and coding relating to Māori issues.

The research was approved in November 2011 for three years by the [University Ethics Committee ref no 7606].

Results

The results presented here focus on seven main themes identified during analysis.

Teaching Challenges – Highlighting the importance of cultural competence

Cultural competence was differentiated strongly from other health-related topics typically taught within a pharmacist training programme (e.g. pharmacology). In particular, this included its association with more “emotional” and sensitive concepts, and its potential to challenge existing beliefs and attitudes held by students and staff:

Cultural competency education is one of the few places where people come with baggage. You know? ...There are a lot of people bring a lot of baggage to a cultural competency class. [Interviewee 2; pharmacist]

It was acknowledged that cultural competency training brings with it a number of challenges and responsibilities, including the need to ensure teaching and learning takes place in a safe and supportive environment (discussed further later). Participants highlighted the need to overcome student resistance to the topic, including perceptions that it is unimportant, irrelevant to a clinical role, or does not apply to their particular situation. Indeed, it was reported that some students viewed cultural competence teaching in a slightly disparaging way: as being “soft”, “politically correct (PC)”, or “airy fairy”:

I think for a certain proportion of students...there is a bit of a resistance to even engage with the concept of cultural competence, 'cause it's seen as a bit soft or a bit PC you know and so some of the barriers are around even just getting people to think about it and to want to engage with cultural competence. [Interviewee 15; doctor/academic]

Adding to this, it was noted that some students have very fixed attitudes or beliefs which can be difficult to shift. One interviewee spoke about the “quiet ones” posing the greatest challenge:

It's the hidrs that you have to find within the group. The quiet ones, the ones who can walk in, take it down and walk out and not be influenced at all. They are the ones that you have to find and they are the ones that you have to hold a conversation with.
[Interviewee 2; pharmacist]

Other anticipated difficulties were related to the complexity and broad nature of the concept of cultural competence, and the need to consider it as a complex, fluid and dynamic competence rather than something to be achieved once and “ticked off” indefinitely. This included the challenge of deciding which content to prioritise and the need for resources to support the development of the teaching material and experiences. Practical barriers (e.g. transporting large numbers of students to off-site visits) were also discussed.

Curriculum content – Adapting existing tools and material for NZ pharmacy context

Participants were in general agreement, and some were quite surprised, that despite arising from the USA, the TACCT-R provides a useful starting template to inform the curriculum content for pharmacy undergraduates in NZ. Adapting some of the items to better fit the context of NZ, such as including a broader range of cultures was recommended by participants. Ensuring the content around disparities avoided presentation from a deficit/blame model, and reflected current and future pharmacy practice, was considered essential.

Key curriculum areas identified by participants as essential for inclusion can be grouped as follows:

- *Health disparities/inequalities* (including structural/systemic issues, bias/stereotyping, colonisation/historical context)
- *Self-awareness/reflection* (i.e. awareness of own culture and biases/prejudices)
- *Specific ethnic cultures*, with Māori culture being a key component of this (including historical context, Treaty of Waitangi, world views, medicine beliefs, traditions and protocols).
- *Other cultural groups* (e.g. people with disabilities and drug misusers)
- *Communication and relationship-building skills.*

Positioning of the content – Embedding cultural competence throughout the curriculum

There was a strong sense amongst interviewees of an integrated approach as the preferred option. This was expressed in different ways (e.g. that it should span the curriculum or that every topic or course should have a cultural competence component).

...I suppose every module, every learning...people are constantly thinking about the cultural competency. So it doesn't matter if you're doing a study on diabetes or asthma or whatever. It always has a cultural competency component to it. [Interviewee 7; pharmacist]

However, the key sentiment expressed was that cultural competence should not be separated from other aspects of the teaching programme. One interviewee asserted that this also entailed ensuring that other BPharm content was in line with the key principles of cultural competence.

One of the general pieces of advice that I would have is to not think about cultural competence as something which you compartmentalise or silo off into discrete sessions or courses or blocks of teaching. It is something that has to kind of run right across. [Interviewee 15; doctor/academic]

Adopting an integrated approach was seen to have an important role to play in demonstrating that cultural competence was not an ‘add-on’, and thus central to pharmacist training and relevant to, and important in, pharmacy practice and everyday work.

Because it's not separate is it? It's not a separate thing. You don't practice cultural competence separately. It has to be integrated, because it is.
[Interviewee 12; pharmacist]

This view was also reflected in some participants' comments regarding the need to ensure that cultural competence teaching was compulsory and not “dodgeable” by students.

Beyond this, interviewees spoke about the need for on-going teaching on the topic, including that it should be taught over the whole of the programme, and concepts revisited throughout. Some also emphasised that this should be undertaken in a staged manner, starting with foundational knowledge and moving up to more complex concepts, including clinical work:

You'll do the self-awareness in the first year and then you would be moving into working with each other, role plays, experiential learning and then with simulated patients and then in the real world...
[Interviewee 17; doctor/academic]

Delivery – Experiential learning is key

A mixed pedagogical approach drawing on different teaching and assessment formats was seen to be most appropriate due to the complexity of the topic, the need to maintain student interest, and in recognition of students' different learning styles:

A variety, because you know students learn [in] all different ways and have all different learning styles. You've gotta have a bit of a mixture. Delivering some content either in a lecture or online, but you have to have lots of small groups and lots of experiences... [Interviewee 17; doctor/academic]

The lecture format was thought to have limited scope when teaching cultural competence (e.g. appropriate only in relation to content such as health disparity statistics). Due to the complexity of issues to be conveyed, as well as the potential lack of interaction with students and their capacity to “hide” in this type of teaching setting, other approaches were considered more fitting.

We've got videos and we've got real patients saying how they felt stigmatised and this is where they felt stigmatised and how that made them feel, and I think it's quite powerful, ...that may be more helpful [than lectures] in moving people's attitudes. [Interviewee 11; pharmacist]

Formal and informal experiential learning was viewed as a crucial component. As a part of this, some interviewees spoke about students participating in learning/teaching activities where they were exposed to and engaged with different cultures and communities. This included, for example visits to a marae or different patient groups, as well as observing community pharmacists within their day-to-day practice:

...They can read an article, they can see it on a video, they can hear someone's story about it, but the best thing of all is if they get to experience it in some way. [Interviewee 14; doctor/academic]

Maybe some experience with a pharmacist who practises in a very culturally appropriate way and seeing how that person does that. [Interviewee 12; pharmacist]

A number of benefits were associated with such an approach, including its ability to facilitate a deeper level of learning and understanding and the application of reflective techniques.

...That the cultural competence teaching is developed quite strongly into reflective practice and the practice of professionalism and communication and listening. [Interviewee 14; doctor/academic]

In addition, the opportunity for students to observe the translation of theory into practice, was considered hugely beneficial.

A peer learning approach (e.g. via small group work, on-line discussions, group presentations) was also highlighted as being a potentially powerful format for teaching cultural competence. This included students working alongside each other in small groups to complete a task and/or discuss a set issue. Role plays were often mentioned as being a particularly effective approach.

We get people to practice how they would engage with a client, engage with patients and they introduce themselves, how they look for cues, how they listen... the first few times [they] mess it up, so you give them the opportunity to mess it up a few times in big and small groups...The main thing is to practice. [Interviewee 14; doctor/academic]

Perceived benefits of this approach were increased engagement with course material and learning (via the smaller setting), the ability to learn from others, and the opportunity to develop and practice communication and reflection skills. This type of format was also seen to play a role in personalising the issues for students, given the requirement to share their views with others, and potentially confront their own prejudices.

Another key issue arising was the need for teaching to take place within a supportive context. This included

ensuring that learners were given the space to express their views in a non-confrontational environment, whilst also maintaining the safety of students who may (sometimes inadvertently) be targeted within discussions, or even course content.

I think it's really important never to shame anyone in your training...You wanna model what you are teaching...I remember going to cultural competence sessions where I was made to feel really bad and guilty and wrong and it's totally not about that. [Interviewee 20; trainer/facilitator]

Some interviewees noted that the safety of teachers should also not be overlooked.

...The process has to feel safe for everybody in the room, no matter what their viewpoint is. [Interviewee 11; pharmacist]

Teaching staff – Skills, knowledge, authenticity and credibility

The credibility and skill level of teaching staff was an important consideration, and was seen by interviewees as playing a crucial role, not only in relation to how students engaged with new material, but also by the way in which the overall concept was received. This was generally assessed via generic teaching abilities, the perceived cultural identity of teachers, and their level of proficiency and expertise in the area.

In terms of specific teaching proficiencies, research participants spoke about the need for strong facilitation skills, the ability to build rapport and engage with students, and expertise in 'interactive teaching':

If you didn't have interactive teaching and you stood up and tried to say 'This is the way you do it' as opposed to talking to the students and getting them to understand and discuss the different opinions and discuss the different values and ideas that they have, I think that it would be quite detrimental and that would actually cause quite a barrier. [Interviewee 16; nurse/academic]

Self-awareness and attitudes towards different cultures amongst teachers was highlighted as an important issue. This included being "culturally competent" themselves, and having a good grasp of the sensitivities and breadth of the concept. For some interviewees, all individuals employed in teaching positions were viewed as potential role models for students and thus carrying a certain level of responsibility, which does not end in the classroom:

You have to be prepared to be a role model, not just when you are teaching the cultural competency course, but in the way that you try to live your life. It's not something that you pick up and put down as you please. [Interviewee 2; pharmacist]

Comments from the research participants suggest an individual's academic or other background plays an important role in determining suitability to teach certain elements of cultural competence to pharmacy students. For some it was vital that pharmacists (or other health professionals/school of pharmacy staff) lead the teaching

in this arena, due to their practical experience and the degree of “legitimacy” it conferred. It was felt that pharmacy staff involvement in teaching communicated an important message with regard to cultural competence being an integrated component of the BPharm degree:

From a student's point of view [cultural competence] can't be that important if our own pharmacy school teachers don't have the expertise to teach it. [Interviewee 15; doctor/academic]

However, it was acknowledged that pharmacists could not be expected to be “experts” in all areas, and thus the employment of external teaching staff (often termed “guest speakers”) was deemed appropriate. It was anticipated that this would involve individuals with expertise in particular areas being invited to teach on specific issues (e.g. members of local communities or trainers for certain cultural groups). Advantages of this were the level of personal experience and insight they brought to teaching, the diversity that it modelled to students, and the associated integrity it brought to the content:

You need to have people coming from the outside. Coming and talking to students about what it's like to have their particular disease conditions or coming from their cultures or religions or ethnicities. [Interviewee 7; pharmacist]

Beyond this, the cultural identity of teachers was a key consideration for some; this was mostly spoken about in relation to ethnicity, although other cultural groups (e.g. based on gender or sexual identity) were also discussed with regard to this issue. The research identified mixed views in relation to whether teachers could speak on behalf of people outside of their own culture (e.g. a NZ European teaching Māori related content). For some, this was considered appropriate in certain situations, including at a practical level, given the possibility of a shortage of individuals with the necessary skills:

They might say “Well we want to have Māori people teaching Māori” but to actually find a person, a Māori person with the skills in pharmacy to actually teach and review might be more challenging. [Interviewee 9; pharmacist]

Others stipulated specific criteria to be adhered to if this was undertaken, including teachers acknowledging their limitations and ensuring that they did not “co-opt” a culture that was not their own. There was also an expectation that those taking on this role would be teaching in a way that supported the development of marginalised cultural groups and the content of these sessions needed to align with the cultural competence learning outcomes and philosophy of the institution.

I think you have to mix it up and see, but you gotta have people who teach to your tree. [Interviewee 14; doctor/academic]

In contrast, some interviewees believed that people could only ever speak to their own culture (whether ethnicity or another group).

I guess the thing to avoid is to assume that some Pākehā can teach you all that you need to know about Māori. 'Cause I think it's kind of unlikely [Interviewee 13; pharmacist]

Additional issues raised included the need for monitoring and supervision of staff and recognition that investment in the up-skilling of all pharmacy teaching staff may be required.

Assessment of student learning – Difficult but important

Assessment of student learning was seen to be an important component of a cultural competence teaching programme, not only as a means of charting student progress, but also as a way of demonstrating the importance and value of the topic. In this regard, interviewees highlighted that assessment tools and processes needed to be “serious” and undertaken professionally:

Because there are difficulties in assessing cultural competence it's often not assessed as well or as comprehensively as it should be...If it's not assessed or not assessed to the extent that it should be then students won't value it as much. [Interviewee 15; doctor/academic]

The need to assess a mix of skills, knowledge and attitudes was raised as an issue. For example, interviewees spoke about having to assess student attitudes (e.g. empathy and compassion; openness to other cultures), levels of knowledge (e.g. of health models, legal and regulatory issues, cultural customs), degree of understanding of pertinent issues, communication skills, and overall level of cultural competence.

It was widely acknowledged that assessment of learning within a course of this type poses a number of challenges, including the need for different forms of assessment. Of note, objective measurement of student attitudes was considered particularly difficult, given that it was a less tangible concept to assess, and could potentially be masked or hidden by students within some assessment formats such as self-assessment.

When considering appropriate assessment tools, exams were deemed appropriate for appraising “basic knowledge”, and/or where there was a clear “right and wrong answer”. However, such a format was seen to be limited which regard to assessing levels of understanding or attitudinal aspects, given the potential to “regurgitate” information and/or mask biases:

I guess your risk is going to be is someone goes through their course and says what they think you want them to say and it doesn't actually change their attitude. [Interviewee 11; pharmacist]

One interviewee highlighted that assessment of skills, processes and ability to engage respectfully with patients was more important than knowledge of a particular culture's practices:

I don't hold strongly to that view [the need for a knowledge-based test]. I think it's very much a process thing. I think I can be culturally competent as a GP with a person from a culture that I've never met by the way I work with them, by the way I use interpreter, by the way I work with their family. [Interviewee 17; doctor/academic]

Practical assessments such as observed role plays, objective structured clinical examinations (OSCEs) and reflective writing pieces on clinical experiences were seen to be effective at assessing communication skills, student attitudes, and the learning from other experiential components:

If you're trying to assess somebody's attitude you need to see that in practice and then you're starting to look at observations they had, you're looking at their reflective learning to demonstrate these things. You're talking about OSCEs, observe the situations... so maybe their attitude component might be tutorially based and maybe their skills could be OSCE based. [Interviewee 6; pharmacist]

Some interviewees also spoke about self-reflection as a form of assessment, whereby students would be required to critique their own performance and attitudinal shifts as a means of gauging development.

Other issues raised in relation to measuring student progress included the benefits of this being undertaken (in a staged manner) over the duration of teaching, and the potential for combining with assessments for other teaching/courses, as a means of ensuring students are not overloaded.

Māori and cultural competence – Incorporating the Treaty of Waitangi

The place of Māori and Māori health within cultural competence was a key theme identified by interviewees. Some interviewees simply assumed 'Māori' would be included in cultural competency training, whilst others had a rationale for its place.

We also have to respect the Treaty of Waitangi... We have a duty and a responsibility to first and foremost honour that Treaty by understanding Māori culture. And yes lots of other cultures live in New Zealand and that's fantastic... By understanding Māori culture that will help us to see our own culture differently which will help us understand other cultures. [Interviewee 2; pharmacist]

A 'rights-based' approach was taken by some for whom Māori are tangata whenua, or indigenous peoples, of NZ, and Treaty of Waitangi partners:

We need to be able to recognise that Māori are legislated through the Treaty and also by being the first people. That they have a special place within cultural competency. [Interviewee 3; pharmacist]

To have some inkling of where we've got to, how we've got to, where we are in terms of Treaty of Waitangi and poor health outcomes for Māori. [Interviewee 10; pharmacist]

As articulated above, the second argument for considering Māori in cultural competency was 'health-need'; that the compelling health disparities between Māori and non-Māori required health professionals to know and understand health disparity statistics, and have confidence to address these:

...Health disparities impact on so many other dimensions of society that it would be really nice if someone could really give a clear picture of why bother doing something about this. [Interviewee 12; pharmacist]

Many participants acknowledged the roles of Kaupapa Māori research and Māori health professionals and educators in the development of both the theory and practice of cultural competency. This was reflected in some of the descriptions of cultural competency training (linking health disparities to basic root causes, such as colonisation and racism; a focus on the culture of the health system rather than the patient; and health providers motivated to change their practice in response to learning about Māori health). However, further work specific to pharmacy was required.

When they start seeing the whole nature of health disparities and the fact that they can't just be explained away by people who are not doing what they're told. Then they start to care... to be on the side of whoever is disadvantaged but to do that they also need to see who is the advantaged ...and the different way that indigenous health always suffers in every country... The critical part there is it's got to be targeted to just pharmacy. [Interviewee 6; pharmacist]

The need for Māori involvement and collaboration in the development and provision of cultural competency teaching was evident. However, there were diverse views and experiences from participants about what this meant in practice. Whilst some considered Māori expertise on health disparities (and the historical and political contexts in which these occurred and are maintained) critical to informing and delivering content, others saw value in having Māori-led cultural immersion activities such as marae-stays where students learnt Māori language and practices. Immersion was considered positive for the interactive learning and the impact it had on improving relationships with Māori clients:

...We had discussion around cultural engagement... One of the concepts... [is] whakawhanaungatanga, which is this idea of having a conversation with a person, ...getting to know the person and as a whole and not just treated like a prescription... And I particularly find, since having done that training, the relationships that I have with Māori have improved a lot when I've deliberately sought to use that principle in my interactions. [Interviewee 9; pharmacist]

The variability in the experiences and expectations of participants regarding 'cultural competence' and 'Māori' perhaps highlights the tensions and complementarity of the two topics. A coordinated cultural competency strategy for training pharmacists in NZ would perhaps

address the queries raised in the interviews – the why, the what, the how, and by whom ‘Māori’ is taught. A collective belief from the majority of participants was that much would be gained for both the profession and for NZ society by collaborating with Māori expertise to develop safe and quality programmes.

Hauora Māori will give participants insights into Te Ao Māori and tikanga and Te Reo Māori and kawa and protocol which is wonderful... Cultural competency is a bit about how you use that knowledge that you've gained from Hauora Māori and how you might pick that up and actually put that into your pharmacy practice. [Interviewee 2; pharmacist]

Discussion

Whilst acknowledging the existence of a plethora of theoretical cultural competence teaching frameworks (Grote, 2008), the purpose of this research was to explore the views of those with experience and expertise in different facets of cultural competence in order to inform cultural competence teaching of pharmacy undergraduates in NZ. The interviews collected a substantial body of information relevant to the project aims. Analysis revealed consistent and diverse perspectives and the findings appear to have relevance to other health professions in NZ and other countries. The findings reflect the complex nature of this concept – a finding that has been reported elsewhere (Wear, 2003; Engebretson, Mahoney & Carlson, 2008). According to those interviewed cultural competence teaching should be compulsory, integrated, reinforced, span the whole of the curriculum and comprise a range of delivery and assessment formats. This is consistent with others' recommendations for pharmacy undergraduate curricula overseas (Jungnickel *et al.*, 2009; Vyas & Caligiuri, 2010). With respect to content, participants' suggestions indicate that some foundational cultural competence learning objectives should be consistent across health professions, such as self-awareness of own culture, a knowledge of the root causes of health disparities including exploring the power differences between groups, a focus on the individual, a sensitive and non-judgemental manner and effective communication skills. What might differ between professions and countries are the roles of different health professionals and therefore the nuanced skills required and opportunities arising during practice to improve the health outcomes of members of different cultural groups. Those interviewed emphasised the need for the material, activities and experiences to be relevant and tailored to what actually happens in pharmacy practice.

The TACCT-R was found to provide a useful starting point to ensure curriculum coverage of a broad range of cultural competence-related knowledge, skills and attitudes pertinent to pharmacists practising in NZ. The content identified within this study as being important is consistent with existing literature on important practices

facilitating cultural competence within the pharmacy setting (Zweber, 2002) summarised these into 12 key points, which can be broadly grouped as: awareness of own cultural background; knowledge of, and interest in clients' culture(s); avoidance of generalising and stereotyping about client preferences and needs; and, communication and relationship building strategies. Others have highlighted the importance of students examining their own biases and belief systems (Poirier *et al.*, 2009; Vyas & Caligiuri, 2010).

Changes to the focus of some of the TACCT-R domains to better reflect current pharmacy practice in NZ and the use of pharmacy specific scenarios were also suggested. Unsurprisingly, most of our participants recommended adding elements of Hauora Māori teaching into the curriculum. However, when considering whether Hauora Māori should be taught separately or as part of cultural competence, participants' opinions were divided.

Currently Te Ara is a graduate profile for Hauora Māori for all the undergraduate programmes in the Faculty of Medical and Health Sciences at the University of Auckland and the competence standards for pharmacists place Understand Hauora Māori and Practise Pharmacy Within New Zealand's Culturally Diverse Environment as two competencies within the mandatory Professionalism in Pharmacy domain (University of Auckland/Te Whare Wānanga o Tāmaki Makaurau, 2009; Pharmacy Council of New Zealand, 2015).

This leads into the next important finding: all staff in the school should be aware of, act, and teach according to the philosophy of cultural competence adopted by the school of pharmacy. This has also been identified by others where in order to ensure credibility, it is important that the relevance and importance of cultural competence is understood by all staff and that identifying inequalities permeates all aspects of the school's business, not just the cultural competence components of teaching (Beagan, 2003). Jensen (2005) described the fear associated with implicit biases being exposed and making mistakes around this sensitive topic. This fear and potential for embarrassment must be acknowledged and addressed by providing a safe environment in which staff can up-skill. There is also a need for careful consideration of the experience, expertise, and in some cases the cultural identity of teachers used to deliver the material focussing on specific cultural groups. The importance of the involvement of Māori health professionals and academics in Hauora Māori and cultural competence teaching was also evident from participant responses. However, presentations by school or faculty staff or “experts” from certain cultural groups run the risk of being seen by students as speaking for others and encouraging stereotyping and group think (Alcoff, 1992). Thus, presenters need to understand the risks and their role. The need for compulsory staff training and the use of multidisciplinary teams of educators has also been advised for medical curricula (Dogra *et al.*, 2009). Given its complex and dynamic nature, at certain times students and staff may need guidance from specific experts to support them along

their cultural competence journey. An alternative to recruiting experts when required could be the formation of a learning community as described by Chou *et al.* (2014). This may also help to embed cultural competence philosophy into the organisational culture and day to day running of the school.

It is generally accepted that assessment drives learning (Wormald *et al.*, 2009). Assessment of students' levels of cultural competence, and overall learning from teaching material and courses was considered important by participants in this study, not least because of the value that it ascribes to the topic. Many evaluations of teaching interventions in this area are assessed via pre and post testing of student attitudes and knowledge *e.g.* Vyas & Caligiuri (2010). Self-assessment is notoriously unreliable (Dunning, Heath, & Suls, 2004; Illing, 2007) and participants in our study identified difficulties in attaining an objective marker of levels of cultural competence amongst students and the potential for students to 'game' the assessment by providing disingenuous but socially desirable responses. This is also linked to the need to challenge and monitor fundamental student beliefs at times and the perception that it is a "soft subject". Muzumdar *et al.* (2010) also noted the limitations of describing numerically a student's level of cultural competence, particularly given that it can be viewed as a continuum rather than an endpoint (Poirier *et al.*, 2009; Muzumdar *et al.*, 2010). It was acknowledged by some participants in our study that expecting students to graduate having reached cultural competence is unrealistic. Indeed, Poirier and colleagues when assessing pharmacy undergraduate learning of cultural competence at the end of a training programme found that students did not attain 'cultural proficiency', although other objectives of the teaching were achieved (*e.g.* improvement in self-awareness of biases/prejudices, *etc.*) (Poirier *et al.*, 2009). This implies that ongoing training, skill and knowledge acquisition and reflection in this area will be necessary for graduates. (Jungnickel *et al.*, 2009; Hawala-Drury & Hill, 2012; Jeffreys & Dogan, 2012).

When teaching cultural competence, interactive learning experiences beyond the lecture format are recommended for improving students' depth of understanding of the topic (Dogra, Reitmanova & Carter-Pokras, 2009; Jungnickel *et al.*, 2009), with team-based approaches receiving positive student evaluations with regard to the learning experience (Poirier *et al.*, 2009). Although cultural experiences were a teaching method favoured by many interviewees, there were some differences regarding the purpose of such experiences. Recent research suggests they are useful to increase awareness, sensitise and change the attitudes of participants in a manner that is safe for both parties (Sharma, Lalinde & Brosco, 2006; Vanlaere, Coucke, & Gastmans, 2010; Kratzke & Bertolo, 2013; Thomason *et al.*, 2013) rather than experiences or presentations that could be considered to be cultural safaris (Wear, 2003; Kumagai & Lympson, 2009). This can occur if culture is regarded as static and unchanging, teaching focuses on the group rather than the individual, and where visits and

presentations are focussed on the acquisition of cultural knowledge as advocated in transcultural theory (Leninger, 1988). To enhance the learning from these sessions it has been suggested that they must be accompanied by assessed critical reflection around thinking and awareness to ensure that the intended learning has occurred (Kelly, 2011). As cultural beliefs and individuals' values can change, care must be taken that stereotypes are not perpetuated and students learn to think at the level of the individual. The benefits of individuation and perspective taking with respect to reducing implicit bias in physicians has been discussed (Chapman, Kaatz, & Carnes, 2013) and could be expected to apply to all healthcare professionals. It has been postulated that, as the beliefs and values of individuals are constantly changing, cultural competence should not just involve the teaching of knowledge or skills, but should build the capacity for critical thinking and awareness in students (Wear, 2003; Kelly, 2011). This lends itself to using reflective practice.

Indeed the contribution of reflection towards learning and/or assessment was also mentioned frequently by interviewees. Schon (1983) described reflection as a way to learn from our own experiences, with a view to improving behaviour or practice. There are many different types of reflection but a recent concept analysis of reflection by Tashiro *et al.* (2013) identified six essential components of a reflection cycle: emotional reaction, description, internal examination, critical analysis, evaluation and planning new action. Kumagai & Lympson (2009) discuss the need for reflection to be personalised where questions such as "What would 'you' do?" or "How would 'you' feel?" are used, where students are encouraged to see themselves in a specific social and economic position and recognise power differentials between parties (Wear, 2003). Therefore, to optimise learning, experiences and associated activities need to be carefully planned with this cycle in mind. Student portfolios and blogs have been suggested to facilitate reflective practice in pharmacy students and prepare them for lifelong learning (Tsingos, Bosnic-Anticevich & Smith, 2014). Mini-ethnographies which involve an element of reflection have also recently been reported to be an effective teaching method to assist in the development of cultural competence in medical students (Hsieh, Hsu & Wang, 2016). These might also be useful to facilitate the development of pharmacy students' cultural competence.

This study had some limitations. Diversity was an important recruitment consideration and whilst many of those interviewed had a NZ pharmacy background, participants from different disciplines were also chosen in order to benefit from the 'head start' in experience and knowledge that the other health professions in NZ and overseas have had in teaching in this area. However, we interviewed only one person based overseas, and therefore the nuanced NZ view was mainly captured. The interviewer was naïve to the socio-political environment of NZ, with limited knowledge and awareness of cultural competence, prior to reviewing the literature. Whilst this may have limited her ability to recognise issues to probe

further in the interviews it brought a relatively bias free perspective to the topic which may also have made interviewees less guarded in their responses. Due to time constraints the interviewer was not involved in the final analysis of the transcripts which was conducted by a research team of four with strengths and experience in pharmacy, medical practice and qualitative analysis. Two were born in NZ and the two pharmacists have lived in NZ for well over a decade.

Whilst logistically challenging, reflecting on, discussing and where possible accommodating many of these rich and varied perspectives, can only add depth and assist in the development of a multi-faceted and engaging programme which ultimately leads to an increase in pharmacists' contributions to reducing disparities and improving patient health outcomes in NZ.

Conclusion

Our participants believed that cultural competence should be fully integrated into the curriculum, demonstrated by all staff at all times and that reflection was an important aspect of learning and assessment of learning around cultural competence. These are findings that are consistent with findings from previous studies looking at cultural competence teaching to a range of healthcare professional students. However, this research also revealed tensions including the place of Hauora Māori in cultural competence in NZ and the role of guest speakers and cultural experiences.

Glossary

Hauora Māori - Māori health and wellbeing

Hapū - "kinship group, clan, tribe, subtribe - section of a large kinship group and the primary political unit in traditional Māori society". <http://maoridictionary.co.nz/>

Iwi - "extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor and associated with a distinct territory". <http://maoridictionary.co.nz/>

Kaupapa Māori - a research paradigm with an analytical approach where being Māori is the norm. It includes critiquing "Pākehā (non-Māori) constructions and definitions of Māori and affirming the importance of Māori self-definitions and self-valuations". <http://www.katoa.net.nz/kaupapa-maori>

Kawa - marae protocols. <http://maoridictionary.co.nz/>

Marae - "a traditional meeting place for whānau, hapū and iwi members usually characterised by a named wharenuī [meeting house] and named wharekai [dining house]". <http://www.tkm.govt.nz/glossary/>

Pākehā - New Zealander of European descent, <http://maoridictionary.co.nz/> or Non-Māori New Zealanders (King, M. (p12, 1985). *Being Pakeha*. Auckland: Hoder & Stoughton Ltd.)

Te Ao Māori - Māori world

Te Reo Māori - Māori language

Tikanga - "correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention, protocol - the customary system of values and practices that have developed over time and are deeply embedded in the social context". <http://maoridictionary.co.nz/>

Whānau - "extended family, family group, a familiar term of address to a number of people - the primary economic unit of traditional Māori society. In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members". <http://maoridictionary.co.nz/>

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