

Does a student's ethnicity affect their understanding of cultural competency?

Tino Knight

The University of Huddersfield, Queensgate, Huddersfield, West Yorkshire, HD1 3DH

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ABSTRACT

Cultural competency has been described as the ability to provide care to patients with various behaviours, beliefs, and values. In essence, creating a working culture and practices that recognise, respect, value and harness differences for the benefit of the organisation and individuals (Nayar, 2013). However, this is just one of the many definitions present; there is currently no widely accepted definition of cultural competency used for the healthcare sector. This lack of a clear explanation is both a reason and a contributing factor to the increasing research into cultural competency.

The research method used in this study was an explorative semi-structured focus-group. It involved pharmacy students studying at the University of Huddersfield. Students were interviewed in a focus group style setting and data was transcribed and then coded into themes, which were then further coded into sub-themes utilising a system of semantic thematic analysis. Students showed a holistic understanding of cultural competency and could define it in-line with standard definitions. However, findings showed there was still a gap as to how to apply it in practice especially when dealing with patients of a different ethnicity. The results highlight the positive and negative attributes of student and patient ethnicity towards patient care. The majority of students showed confidence when serving patients of the same ethnicity as them. When dealing with some patients of different ethnicities, students indicated that they knew little about other cultures and therefore struggled to overcome cultural barriers.

Introduction

One of the most frequently used definitions of culture is the one established by Sir Edward B. Tylor who describes culture as a 'complex whole which includes knowledge, beliefs, arts, morals, law, customs, and any other capabilities and habits acquired by members of society' (Helman, 1990, p. 2). The notion of cultural competency has been built upon this very idea, and so to understand cultural competency, one must first understand culture (Jongen et al., 2001). Cultural competency has also been described as 'a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals that enable that system, agency or profession to work

effectively in cross-cultural situations' (Cross et al., 1989, p. 14). This definition may be one of the most

widely used and cited definitions; Cross et al. (1989) present it in their seminal monograph on a culturally competent system of care.

Other more recent definitions within the healthcare sector describe cultural competency as the ability to provide care to patients with various behaviours, beliefs, and values. In essence, creating working culture and practices that recognise, respect, value and harness differences for the benefit of the organisation and individuals (Nayar, 2013). In a world that is becoming more diverse, it is imperative that healthcare providers learn cultural

competency skills. Nonetheless, there is currently no dependable definition of cultural competency used for the healthcare sector in the United Kingdom (UK) or across the world. This lack of a clear explanation is both a reason and a contributing factor to the increasing research into cultural competency.

Background

Understanding cultural competency means understanding that health approaches may vary from patient to patient based on several factors such as their race, age, gender, religion, disability, and sexuality (Swihart & Martin, 2019). A one-size fits all approach, does not work. All healthcare professionals should aim to have health literacy, which is being able to adequately assess and apply knowledge with perception and reasoning to make appropriate health care decisions (Bau et al., 2019). A lack of cultural competence in care can contribute to poor experiences and outcomes for certain groups in society (Owiti et al., 2013). According to Purnell's (2002) guide to Culturally Competent Health Care, if health disparities are to decrease, more attention must be paid to individuals, cultural values, beliefs, and practices. The Purnell Model for Cultural Competence is primarily used for educating students about cultural competence, especially within the nursing profession (Purnell, 2002).

Laws such as the Equality Act 2010 have been implemented in order to try to reduce the incidences of health disparities. The Act aims to eradicate unlawful judgment, provocation and harassment and other conduct prohibited by the Act. In the field of pharmacy, to further advocate for this equality, the first General Pharmaceutical Council (GPhC) standard is that pharmacy professionals must provide person-centred care (GPhC, 2017). This does not mean everyone should be treated the same, but rather that pharmacists should create a custom service for each patient based on their values and needs. Similarly, the nurse's first standard is; treat people as individuals and uphold their dignity, which is further explained as needing to avoid making assumptions and recognise diversity and individual choice (Nursing & Midwifery Council, 2018). Both standards have an element of cultural competency built in, which shows that healthcare governing bodies recognise the importance of it in healthcare.

Literature review

Improving pharmacy student's cultural competency

skills is vital as the duties and responsibilities of pharmacists are fast growing, meaning increased patient interactions (Echeverri et al., 2013). As the Royal Pharmaceutical Society (RPS) states in their 'Shaping Pharmacy for the Future' report, there are increased opportunities in various areas such as clinical practice, general practice and accident and emergency for pharmacists (RPS, 2014). A study into general practice (GP) pharmacists showed that over the past five years, the recruitment of pharmacists into general practice in the UK has increased due to a pilot funded by National Health Service England (NHSE) (Nabhani-Gebara et al., 2019). The study found that over four months, the pharmacists saved the GPs 628 appointments and 647 hours that they usually dedicated to medication reviews and repeat prescriptions. With such staggering numbers showing the benefits of the role of pharmacists expanding, it seems safe to expect that this trend will continue. Alongside this expansion comes increased patient contact; therefore, it is imperative that pharmacists learn cultural competency skills to provide effective, patient centred care (Bauer & Bai, 2018).

A study was conducted exploring cultural competence amongst occupational therapy students which aimed to investigate the cultural competence of final year students as well as their own perceptions of their aptitude in this area. This focused on language and culture in their practice as students. The study was conducted in South Africa with 21 participants (Govender, Mpanza, Carey, Jiyane, Andrews, & Mashele, 2017). An explorative qualitative study design was used to collect the data for the research in the form of a focus group. The target population was comprised of a diverse group of students who speak different home languages and who hail from different cultural backgrounds. Qualitative data collected from the focus groups, using inductive reasoning. The study found that participants described cultural competency as 'a mixture of beliefs, one's traditions, values, and interests. It is how we explain things, how we make sense of the world and everything...around us'. (Govender et al., 2017, p. 4). Culture was further identified by participants as an influence capable of both positive and negative effects. 'There is some emotional attachment...with people of the same culture they sort of take advantage of the fact that they are similar' (Govender et al., 2017, p. 5). The study also highlighted findings on the challenges of language barriers between students and patients and how it caused mutual frustration. However, the

key results of this study were that when trying to speak the client's language, participants noted positive changes in client-therapist rapport building (Govender et al., 2017). The study gathered qualitative data through focus group interviews and provided an in-depth reason as to how language can affect how students perceive cultural competency. Additionally, the sample group was made up of a diverse population; there are nine different languages involved in the study, which gives the study a good representation of different cultures. However, this study was conducted in South Africa so it may not be an accurate representation of the UK population, as the cultures in South Africa may differ from those in the UK. One way in which they differ is that the majority ethnicity of South Africa is Black African (76.0%) (Lehohla, 2011) while the majority ethnicity in the UK is White British (86.0%) (Public Health England, 2017). This difference would affect the kind of patients that healthcare professionals interact with.

A possibly more representative study is one that was conducted in Ireland which focused on evaluating the experiences of both students and nurses when caring for patients from diverse cultures. This study consisted of one focus group and individual face-to-face interviews (Markey et al., 2018). The results demonstrated the lack of cultural awareness among participants. With one student saying, 'I find when I am working on the wards that we don't know enough about their actual... their background, and that's a big challenge' (Markey et al., 2018, p. 262). The study also found that students thought a possible reason for their lack of knowledge was their upbringing. One student said: 'I think we were maybe you know, brought up when there were white people in Ireland, no black people... you know. And it's...it's a pity really, and now we are just not used to it' (Markey et al., 2018, p. 264). Another theme that appeared in the study was that most students felt they received a lack of teaching regarding cultural competency in their studies (Markey et al., 2018). Data was analysed using thematic analysis, which from the previous studies mentioned seems to be a commonly used analytic technique for qualitative data. The research is still not fully representative of the UK as it was conducted in Ireland, but it may be more representative than the study conducted in South Africa. Additionally, the participant's ethnic backgrounds were not very diverse and are therefore not necessarily representative of other ethnic minority nurses.

Numerous studies have shown how cultural competency models and courses can improve students' understanding of cultural competency; some studies have also investigated the challenges that come with dealing with a diverse population. Only a few studies have explored how an individual's, own ethnicity and cultural background will affect how they perceive and approach other cultures. Many of the studies have been conducted in the USA, and lack diverse ethnic participants thus limiting widespread representation. In response, this study aimed to gain an insight into the relationship between student's ethnicities and an understanding of cultural competencies using an explorative semi-structured focus group.

Aims and objectives

Aim: To gain insight into the relationship between student's ethnicities and the wider understanding of cultural competencies.

Objective 1: To examine whether third-year pharmacy students at Huddersfield University understand the term cultural competency.

Objective 2: To investigate how an individual's ethnicity contributes to how they perceive and interact with patients from different cultures.

Methodology

This study was done as part of a research project at Huddersfield University. Currently, the information available surrounding cultural competency is minimal. This is especially true in the topics surrounding students' understanding of cultural competency, hence why this study has further explored this subject.

The data collection method used in the study was an explorative semi-structured focus group. It involved eight female third-year Pharmacy students currently studying at the University of Huddersfield. The eight students were interviewed in a focus group style setting. The focus group interview was recorded on an encrypted file on a laptop then transcribed onto a word document and later analysed using inductive thematic analysis. The encrypted recording was transcribed and then coded into themes which were then further coded into sub-themes utilising a system of thematic analysis. Thematic analysis (TA) 'is a method for identifying, analysing, and interpreting patterns of meaning ('themes') within qualitative data' (Clarke

& Braun, 2016, p. 297).

Inclusion and exclusion criteria

To be included in the study, participants needed to be a female third-year pharmacy student, aged between 21-23 at the time of the study. Exclusion criteria included participants who were not female and in other year groups of the pharmacy course, outside of the age group of 21-23.

Study site and population

This study was conducted at the University of Huddersfield. The semi-structured focus group interview and data collection took place in a university room. The room provided a safe enclosed environment for participants to answer the focus group questions. Only third-year female pharmacy students between the ages of 21-23 were included in the study. Only third-year pharmacy students were chosen in order to increase consistency and reduce any bias that a changing curriculum would introduce. If the study was to include other students from other year groups, their curriculum might be different, and therefore their level of understanding cultural competency may be different. Additionally, this is also why only female participants were chosen with a very narrow age range to increase consistency and eliminate factors that may cause bias to the study such as age and gender. Participants in the study were not given any information about the focus group questions beforehand; only an information sheet that briefly outlined the purpose of the study.

When it came to selecting the eight participants, a stratified sampling technique was used. All third-year female pharmacy students that were willing to participate in the study were grouped into stratas based on their ethnicity. There were ten different ethnicities in total amongst the available candidates, and eight participants were chosen while ensuring that each belonged to a different strata. Random selection was used to pick out the eight ethnicities that would be used from the ten available, so as to protect against bias. Table 1 shows the ten ethnicities involved, and the eight highlighted that were chosen for the study.

Table 1: Ethnicities included in the study

Ethnicity	Pseudonym
Algeria	001
Bangladeshi	002
British	003
British-Chinese	004
Israeli	005
Kurdish	006
Lebanese	007
Nigerian	008
Pakistani	009
Sudanese	100

Using random sampling one individual was chosen to participate in the study from each of the selected eight ethnic groups. Some stratas only had one individual so that individual was automatically selected for inclusion in the study.

Focus group design

The focus group was given a small introduction to create a warm and friendly environment. The focus group was told what the study was about and how results would be used. An outline of the basic rules was provided, and it was made clear that there were no right or wrong answers, only differing points of view. Participants were told that they did not need to agree with others, but that they should listen respectfully as others shared their views. A tape recording was made with the participants' consent, and only one person was allowed to speak at any given time.

There were six main questions asked, devised to be open-ended and therefore allowing participants to give their views and expand on them. The questions were structured in order that they were not leading; this was done so that participant's answers would not be biased in relation to how the question was asked. Additionally, dichotomous questions were avoided. Alongside the questions, probing techniques were also used during the discussion to obtain further information from the participants. For example, 'Would you explain further?' 'Could you give an example?' 'I don't understand. Please say it again'. When the study was complete, the recording was transcribed, and the thematic analysis process was finalised.

Confidentiality and ethical issues

The study was granted ethical approval by the School of Applied Sciences. Data collection was completed on the 1st March 2019.

Participants were asked to sign a consent form after reading the participant information sheet. This was done before the focus group commenced.

The only known information about the participants was their ethnicity, age and that they were currently in their 3rd year of a Pharmacy undergraduate degree at the University of Huddersfield. This was the only information necessary for my study.

Each student was allocated a number to identify them from 1-8. The laptop that the information was collected on was password protected. The information was only available to the researcher and supervisors.

Results

The demographic information of the eight pharmacy students was taken down and is represented in the table below.

Table 2: Demographic information

Ethnicity	Age	Assigned No.
Algeria	22	1
British	23	2
Chinese	22	3
Israeli	22	4
Lebanese	23	5
Nigerian	21	6
Pakistani	21	7
Sudanese	22	8

Five main themes emerged;

- Cultural awareness
- Reciprocal association
- Preconceived notions
- Ethnicities as an influencer
- Institutional input.

Each theme was then further broken down into subthemes as shown in the figure below.

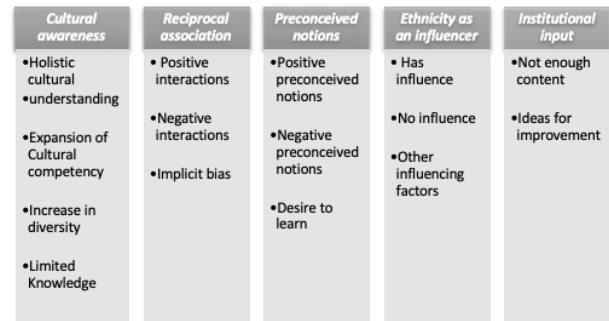


Figure 1.0: Themes and subthemes

Cultural awareness

This is where participants described what they thought the concept of being culturally competent meant; it turned out that there was a cohesive definition. One student described it as:

'understanding different cultures, understanding there are many different types of people even people in the same race and ethnicity they are not the same and so being able to apply this when taking action when dealing with patients.' (Chinese 3).

This was supported by another student who said:

'Understanding that people have different beliefs, feelings and being able to communicate effectively and deliver services to people of these different cultures in the workplace.' (British 2).

One participant further identified cultural competency as something that not only applied when dealing with patients but also with individuals outside the workplace:

'Accepting everyone and being able to work with that person. Like... we all have difference, but can we look past those things and work together. Not just at work but also in life in general, like at university.' (Sudanese 8).

Another student reinforced this in agreement and said:

'What number 5 said but not just limited to patients and healthcare settings just everywhere in general. Friends, uni, lectures.' (British 2).

Participants indicated that they acknowledge that the number of different cultures were on the increase and this would mean an increased demand in being culturally competent:

'we are now living in a very multicultural world and our understanding of cultures is going to have to increase, especially here in England.' (Israeli 4).

'Yeah, and even the cultures that we know of that are common like white, black, Asians there are so many now with the increase of inter-racial couples.' (Pakistani 7).

Some participants also highlight how even though they knew what being culturally competent meant, it was a challenge applying it in practice:

'Personally, I don't have enough knowledge to understand the needs of some patients like all advice we give is the same for patients, but I find I can go the extra mile with Asian patients but maybe not so much with other cultures because what I know about their culture is limited.' (Lebanese 5).

This was further backed up by another student saying:

'you don't know if the patient has fully understood everything you have said. You hope they have, but sometimes you can't tell, and you can't tell yourself because you don't know if what you have said is culturally competent to them.' (British 2).

Reciprocal association

Participants identified how being the same ethnicity as a patient can affect the way you interact with them. Six out of eight participants (75%) expressed their interactions as positive in this context:

'I have experienced it, and they were unable to speak well in English I tried to break the language barrier and speak in Arabic to give them the right care they needed and to understand them better.' (Sudanese 8).

Another student also expressed a similar point of view:

'I speak my language with them to help them understand somethings. One time a patient was complaining in Yoruba, and they didn't know I spoke it as well and they were complaining about the pharmacy, so I was actually able to speak back to them and clarify any misunderstandings they had.' (Nigerian 6).

This theme of breaking language barriers flowed in a lot of the participant's responses. Another student said:

'The pharmacist was struggling to understand a Pakistani patient whose first language is not English. So, I went to the front of the shop and eased the communication between the pharmacist and the patient.' (Pakistani 7).

While another said:

'There are a few regular Lebanese patients who come into the pharmacy, and they always want to talk to me' (Lebanese 5).

Another student shared a similar experience and said:

'An Arab tourist came into the community pharmacy I worked in and was struggling to explain their inquiry to the non-Arabic speaking pharmacy assistant. I explained to the assistant that it might be easier if I communicated with the patient as I spoke Arabic this has happened a few times, and I found that patients are more likely to effectively communicate with a native speaking PA.' (Algerian 1).

This participant went on to say:

'I do however notice that patients whom I speak to in their native language are more likely to 'let their guard down' and be more honest with answering questions.' (Algerian 1).

One participant described their interactions as good with patients of the same ethnicity:

'Mine is generally good, most of the people are British and so communicating with them is easy.' (British 2).

One participant found their experience with someone of the same ethnicity to have been negative:

'For me it's quite difficult because although I am Chinese, I was raised up here in the UK, but Chinese people will automatically look at me and want to be served by me, but I can't even speak Chinese, so I don't know how to interact with them, and it always makes me feel awkward and uncomfortable.' (Chinese 3).

Other participants had not had an experience with a patient of the same ethnicity.

Some of the participants found themselves in a situation of unconscious bias when dealing with

patients of the same ethnicity:

'I don't want to say I feel more comfortable serving someone the same ethnicity as me, but I think I automatically approach the situation more alert like than someone of different ethnicity.' (Nigerian 6).

Participants also found that unconscious bias was not just coming from them but also from patients.

'Mostly we get Chinese people in our pharmacy as well, and most Chinese people who come in even from the door will aim to speak to this Chinese lady. Even if I am at the counter so they will bypass me and go to her.' (Nigerian 6).

In support of this, another student said:

'There are a few regular Lebanese patients who come into the pharmacy, and they always want to talk to me, but I think it's not because they feel I know more but because they can relate with me because we are the same.' (Lebanese 5).

Preconceived notions

This is when ideas or opinions are formed before having the evidence. Some participants found that patients had positive preconceived notions and when seeing someone who was the same ethnicity as them, automatically want to be served by them.

One student said:

'where I work there are a lot of Nigerians, so when patients see my name tag, they actually say my name and express a sense of joy from seeing someone from the same place as them. They would want me to do everything for them and serve them every time they come in.... but I feel they want to speak to me and be served by me because they believe I am from the same place as them and understand them better.' (Nigerian 6).

On the contrary, some students found that patients had negative preconceived notions and said:

'I also get white Caucasian people who come up to me and ask do you speak English so it's like already they think I can't help them. Some people just don't know how to interact with people like me.' (Chinese 3).

Another student agreed with this and said:

'HMMMMM that true, you can see patient's attitudes when they come in and sometimes, they are rude, and you automatically feel like they don't want to be served by you. And you can't

help but think of maybe it's because of my ethnicity.... I also worry that the patient is looking down on me because I am not the same race as them like they might be thinking what does this one knows.' (Nigerian 6).

The majority of students showed a desire to learn about other people's cultures:

'Sometimes I don't understand what they are saying, so I ask them to write it down because I want to make sure I get it right.' (Chinese 2).

'I then realised I needed to learn the British culture to communicate with people better. Like we don't call people love in Nigerian, but I soon realised people here do, and when I started doing that at work, I actually saw a better reception from the patient. Like maybe it made them feel more comfortable or more related able to me.' (Nigerian 6)

'We can all be able to be culturally competent as long as you want to learn more about a culture. Can do this in the workplace at uni etc. The more you try to learn the more you will know. You can never know everything about l the different cultures, but if there is an opportunity to learn, then we should take it.' (British 2).

Ethnicity as an influencer

Participants described how ethnicity might affect how they interacted with patients. Some participants expressed that they thought it had an influence:

'I think being Sudanese and having grown up in the UK I understand those two cultures more and feel more cc to give patients of those backgrounds more care because I speak their language and can relate I have more than one identity so I feel like I can understand more people having been exposed to two different cultures like compared to a person who has only been exposed to one culture.' (Sudanese 8).

'Also, I think being Nigerian, gives me an advantage with Nigerian people not so much with other cultures but I know my own culture, so it's easier.' (Nigerian 6).

'I think we don't really look beyond our little bubble so often we think we are culturally competent, but we are actually not. Maybe for our own ethnicity like for me, the majority of people are British so the patients I come into

contact with I feel I am cc enough to help them.' (Israeli 4).

In contrast, some of the participants thought that culture had no influence and said:

'For me personally - nope! Ethnicity would never play a role in how I acted towards someone as to me everybody should be treated the same with the same amount of respect.' (British 2).

Some participants said that ethnicity did influence cultural competency, but it was not the only thing that could influence it:

'Yeah, however, it is not only due to ethnicity. There are other factors such as religion and upbringing.' (Lebanese 5).

'I don't think it is as black and white as to which ethnicity someone is. Many other factors must be considered to assess one's level of competence.' (Algerian 1).

Institutional input

Throughout the discussion students revealed how they felt the university did not do enough to prepare them to be culturally competent:

'It was talked about briefly, but it would have been within the context of one module and maybe even in the context of one lecture which focused only on the differences or beliefs and religions.' (Sudanese 8).

'It was just literally touched on in the lecture... like just once.' (Israeli 4).

'University gives a bit of base but go into the depth and don't teach you how to get around these barriers.' (Chinese 3).

'Although we have had a few lectures it's not like we are being actively taught it's a bit passive.' (British 2).

Students then expressed how they thought the university could better prepare them on being culturally competent:

'I think it would be a good idea for uni to run a session where situations are involving a person's culture (e.g., such as the animal products thing) to see how culture can affect healthcare decision making and see how we can solve the problems.' (Sudanese 8).

'Although we have had a few lectures, it's not like we are actively taught it's a bit passive. Like maybe if we had objective structured clinical examination that incorporated these kinds of situations of dealing with different ethnicities would be good.' (British 2).

Discussion

The key findings of this study indicated that for many of the participants, ethnicity had an impact on patient interactions. This interaction may have been positive or negative, but nonetheless there was an influential relationship present between student's ethnicity and cultural competency interactions.

The student cohort who formed the study sample understood what the term cultural competency meant independent of their ethnicity. Participants described cultural competency as understanding how each person is different and being able to deliver adequate care while considering these differences. In the study, students used their own words to describe the term with much of what was said encompassing ideas from both Cross et al. (1989) and Nayar (2013) with reference to their respective definitions of cultural competency. The student's responses were also similar to those found in Govender et al. (2017) which found that participants who were able to describe cultural competency were also able to cater to individuals with a mixture of beliefs and values.

Participant definition of cultural competency was not only limited to the healthcare sector, students also went further with their interpretation of cultural competency and described it as something that is not just limited to the healthcare setting but which can also be applied to other areas such as work and university. This showed a holistic understanding of cultural competency. The participants' understanding was also evident from their acknowledgment that diversity was on the increase, and so the demand for healthcare professionals to be culturally competent was also increasing. This is in agreement with current data from Public Healthcare England which showed that in the 2011 decennial census, the percentage of people who identified as "White" in ethnicity decreased from 94.1% to 86.0%, contrary to an increase of people identifying as one of the minority ethnic groups.

Students did, however, highlight that although they felt they understood the term cultural competency,

they struggled with applying it in practice when faced with certain challenging situations. This seemed to express not a lack of understanding of cultural competency, but rather a lack of knowledge of other cultures. A similar finding was found in Markley et al's (2018) study which highlighted that when nursing students were working on a ward, they struggled to communicate effectively with patients from ethnic minority backgrounds, as they knew little about their culture.

Six out of eight students (75%) expressed having had a positive interaction when dealing with patients of the same ethnicity as them. Many of the students were able to break language barriers with patients who did not speak English very well, therefore allowing them to have the opportunity to fully understand what they needed regarding their health and medication. Additionally, other students also showed a desire to learn about new cultures to better communicate with patients. From these encounters, it can be deduced further that the student participants understand cultural competency and how health approaches vary from patient to patient based on several factors such as age, race and ethnicity, as described by Swihart and Martin (2019). Although speaking English is the status quo and the majority of the UK population speak this language, for patients of different ethnic groups who struggle with understanding English because it is not their first language, speaking to them in their native language may be a way to better improve their health as well as reducing health disparities. Govender et al's (2017) study found that participants noticed a positive change in the client-therapist rapport when healthcare professionals tried speaking to them in their language. However, the practicalities of this are very low, and it would be challenging to train healthcare professionals to learn several different languages in order to communicate effectively with patients from different ethnic groups. What would be practical however is to make healthcare professionals aware of the resources available to them such as the telephone translation service provided by the NHS language line.

The student cohort showed elements of understanding ways of possibly easing communication issue when dealing with patients of different ethnicities, who may find it difficult to understand English. Some students described how they would ask patients to write down on a piece of paper what they were trying to say or to show them

a picture of the medicine they were asking about. This is similar to how healthcare professionals, as noted by Shepherd et al. (2019), tried to overcome language barriers by printing medical information in different languages. Being able to show a desire to overcome cultural barriers such as language displays an aspiration to be more culturally competent and in turn, shows understanding.

Some of the participants expressed how they can sometimes be unconsciously biased towards patients of the same ethnicity as them. They stated how they felt more comfortable when serving someone of the same ethnicity and automatically approached the situation differently as opposed to if they were dealing with someone of a different ethnicity, views which are supported by Shepherd et al. (2019). Campinha-Bacote (2002) identified this bias in her research as a potential problem, and said healthcare professionals should be working on developing self-cultural awareness, by understanding their own culture and that they may be biased towards individuals of their own culture. Being aware of this bias will help when interacting with patients of other cultures, so you can consciously be unbiased towards them. Some students, however, disagreed with this and said they felt someone's ethnicity did not influence how they treated them. This may be true in terms of their intent, but put in real life situations we cannot say that individuals will be capable of doing this. The study by Echeverri et al. (2013) showed that a significant amount of implicit bias existed among healthcare professionals in the study, but some individuals were not aware of it. From this, we can conclude that the student's ethnicity contributes to how they interact with patients of the same and different ethnicities.

It was not just participants who showed bias in their interactions; patients also showed a form of bias with how they interacted with healthcare professionals. Few studies look at how patients may perceive healthcare professional and what impact this can have on the level of care the healthcare professional then provides. This is something that was highlighted in this study. Some participants found that patients who shared their ethnicity would naturally select them to approach for service or care, over other available colleagues. On the other hand, some participants expressed how patients of a different ethnicity to them can sometimes be intimidating, through actions such as questioning their competency and ability to speak

English. Other participants agreed with this and admitted to feeling intimidated by patients and expressed that sometimes it feels as if they are looking down on you. A participant saying that in her pharmacy, patients of Chinese backgrounds were keen to be served by her Chinese colleague even if they had to wait, further reinforced this. Reasons cannot be given as to why patients may act a certain way with the pharmacy students, however, what can be said is that patients' actions may influence how the students care for them and others in the future. If a pharmacy student is to associate a joyful patient with someone who is the same ethnicity as them, they will be more eager and culturally competent to serve that group of people. In contrast, if the pharmacy student comes to associate patients of particular ethnic groups with rudeness or of possessing a condescending attitude they may not be so keen when serving that ethnic group, and in turn it may reduce the level of cultural competence that they give those patients. From this, it can be seen that not only student's ethnicity can impact upon their level of cultural competency to other cultural groups, but also the patient's ethnicity.

Overall, participants expressed that the university as an institution was not doing enough to prepare them to be pharmacists that can effectively serve a diverse society in a culturally competent way. Participants said how little the subject is touched upon and that there are no opportunities to gain practical experience in this area. The study by Markey et al. (2018) also showed this finding, with the majority of students feeling that they received a lack of teaching regarding cultural competency. Participants in the study suggested an Objective Structured Clinical Examination (OSCE) style practice with patients from different ethnicities to try to incorporate more learning about cultural competency. A more practical way may be to run a course based on one of the cultural competency models such as Campinha-Bacote (2002). This model was determined to effectively improve student's cultural competency in the studies by Bauer and Bai (2018) and Wall-Bassett et al. (2018). If a student's cultural competency skills were to be built upon and improved during their time at university, their level of cultural competency might be increased, and therefore the student becomes better prepared for serving a diverse community.

This study has shown that there is an influential relationship presented between participants'

ethnicities and cultural competency interactions. Other studies have shown this as well; Shepherd et al. (2019) and Govender et al. (2017) found that ethnicity can play a role in how culturally competent an individual is. However, participants in this study highlighted that this was not the only determining factor. Participants expressed how religion, upbringing, the circle of friends they have and their level of exposure to diversity can also be an influence. Markey et al. (2018) also found that students believed their upbringing influenced how culturally competent they were. It is difficult to statistically measure the effect ethnicity has on how culturally competent an individual is, however from this study it can be concluded that it has a certain level of influence when dealing with patients of the same or different background.

Limitations

The major limitation of this of the research is that a small sample size was used, and it may not be a very accurate representation of the larger population. Other limitations include difficulties in finding a time that suited everyone as the pharmacy course is very demanding and everyone is busy. Additionally, there is a potential problem with qualitative research as a methodology as the interpretation is limited, and the personal experience and knowledge of the researcher can influence the observations and conclusions of the study.

Focus groups are not as great in covering maximum depth on a particular issue compared to other data collection techniques such as individual interviews. A distinct disadvantage of a focus group is the chance that the participants may not say their honest and personal thoughts about the topic. They may be hesitant to express their thoughts, especially when their ideas oppose the views of another participant.

Moderators can also significantly impact the outcome of a focus group discussion. They may, intentionally or inadvertently, inject their personal biases into the participants' exchange of ideas. This can result in inaccurate results.

Conclusion

Pharmacists, just like all healthcare professionals, are expected to be prepared to serve a diverse community when they become qualified. With many healthcare standards stating that healthcare professionals should be able to provide patient centred care as well as avoiding making

assumptions, recognising diversity and individual choice. Participants showed a holistic understanding of cultural competency and how its applications do not just have to be limited to healthcare. However, hearing the realities from this study has shown that although participants understand the term cultural competency and can define it in line with common definitions, there is still a gap as to how to apply it in practice. For many participants the extent of their situational uncertainty increased when they interacted with patients from a different ethnic group to them, suggesting a narrow view and a multidimensional context of how culture and cultural difference were viewed through the lens of the pharmacy students.

The findings highlight the positive and negative attributes of ethnicity towards patient care. The majority of participants showed confidence when serving patients of the same ethnicity as them and were able to give culturally competent care with many of them breaking barriers such as the language. When dealing with patients of different ethnicities, participants said that they knew little about other cultures, and although there was a level of desire shown in the study to want to learn and overcome barriers in order to give a more culturally competent care, participants still faced some challenges. Additionally, it was highlighted that a patient's ethnicity and the way they treat the pharmacy student can also have an impact on how the student then cares for that patient and future patients.

In conclusion, the study showed that there was an influential relationship present between the student's ethnicity and cultural competency interactions.

Recommendations

More research should be conducted into how best students can be better prepared to serve different ethnicities. Additionally, further research should go into finding out how patients can play a role in helping healthcare professionals be more culturally competent in their dealings with them.

Having found that ethnicity is not the only contributing factor towards an individual's level of cultural competency, further research could go into investigating other influencing factors such as gender and upbringing.

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