Addressing Unconscious Bias, Power, and Privilege to Increase Cultural Competence Skills in Healthcare Faculty: Intersecting Critical Race Theory and the Pyramid Model for Intercultural Competence

Christina B. Gunther

Follow this and additional works at: https://scholarcommons.sc.edu/etd

Part of the Curriculum and Instruction Commons

Recommended Citation
Addressing Unconscious Bias, Power, and Privilege to Increase Cultural Competence Skills in Healthcare Faculty: Intersecting Critical Race Theory and the Pyramid Model for Intercultural Competence

by

Christina B. Gunther

Bachelor of Arts
Florida Atlantic University, 1994

Master of Arts
University of Bridgeport, 2014

Submitted in Partial Fulfillment of the Requirements

For the Degree of Doctor of Education in

Curriculum and Instruction

College of Education

University of South Carolina

2020

Accepted by:

Suha Tamim, Major Professor

Todd Lilly, Committee Member

Jin Liu, Committee Member

Terrance McAdoo, Committee Member

Cheryl L. Addy, Vice Provost and Dean of the Graduate School
DEDICATION

This dissertation is dedicated to my late grandfather, The Reverend Dr. Gordon M. Torgersen, who instilled in me a sense of social justice that has guided me throughout life. To my great-grandfather, The Reverend Dr. Edwin T. Dahlberg, who inspired in me the allyship I have been developing from the age of 12. To my father, James H. Barnhill, who reminded me at 19 years old in my one-room rental in Hoboken, NJ, that our course in life is like a rocket – constantly readjusting its path. To my mother, Dr. Joan Torgersen Magill, who always let me know she loved me no matter what decisions in life I chose. Thank you to my stepmother, Georgia Barnhill, and stepfather, Thomas Magill, who are often my voices of reason. To my number one editor, my sister, Caroline Barnhill and to my husband, Fred, and my children, I thank you for your patience and support.
ACKNOWLEDGEMENTS

I fully acknowledge that this dissertation would not have been possible without the expert guidance from my dissertation chair, Dr. Suha Tamim. I am very fortunate to have worked with Dr. Tamim who provided immediate and patient feedback after every draft I sent her – and there were many. Dr. Tamim is a brilliant guide who generously passes on her wealth of knowledge.

I am also thankful for the participation and feedback from my committee members: Dr. Todd Lilly, Dr. Jin Liu, and Dr. Terrance McAdoo. I was privileged to have had each as a course professor. Without them, I would not have come so far. I gained tremendous knowledge from you all. Thank you.
ABSTRACT

Inequity in healthcare has long been understood to be caused by individual and structural racism in the health system. Little progress has been made in diminishing the disparities that exist between Black and African American minoritized populations and the White majority. Cultural competence training in healthcare has focused on surface level differences in ethnicities, including language and religious practices, while ignoring difficult to address topics such as race and racism. This action research study, using a convergent mixed-methods design, attempted to address the gap in knowledge of race and racial structures in healthcare for the faculty in the college of health professions at a medium-sized, private university in New England. Constructs such as diversity, unconscious bias, power, privilege, stereotype construction, and racism were addressed in a series of inservice workshops in order to increase skills in cultural competence. The framework guiding the workshops was an intersection of critical race theory and the pyramid model of intercultural competence. Results indicate a significant change effect in median scores on the Intercultural Development Inventory between the pre and post workshop administration of the instrument. Qualitative data support the findings and highlight robust themes of learning and discovery. Although participants learned a great deal and shifted perspectives in some cases, the overall sentiment is more training is required before teaching the constructs to students. An action plan suggesting additional learning material and concrete next steps are provided.
# TABLE OF CONTENTS

Dedication .......................................................................................................................... iii

Acknowledgements ............................................................................................................ iv

Abstract ................................................................................................................................v

List of Tables ..................................................................................................................... ix

List of Figures ................................................................................................................... x

List of Abbreviations ....................................................................................................... xi

Chapter 1: Introduction ....................................................................................................1
  Problem of Practice .......................................................................................................6
  Theoretical Framework ...............................................................................................8
  Purpose of the Study .................................................................................................12
  Research Questions ..................................................................................................13
  Research Design .......................................................................................................13
  Researcher Positionality ............................................................................................17
  Significance of the Study ..........................................................................................19
  Organization of the Dissertations .............................................................................21
  List of Definitions .....................................................................................................21

Chapter 2: Review of the Literature ...............................................................................24
  Historical Perspective ...............................................................................................27
  Theoretical Framework .............................................................................................31
  Cultural Competence Models and Frameworks .....................................................36
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Plan</td>
<td>104</td>
</tr>
<tr>
<td>Implication for Practice</td>
<td>112</td>
</tr>
<tr>
<td>Implications for Further Research</td>
<td>114</td>
</tr>
<tr>
<td>Summary</td>
<td>114</td>
</tr>
<tr>
<td>References</td>
<td>116</td>
</tr>
<tr>
<td>Appendix A: Email Invitation to Participate in the Study</td>
<td>126</td>
</tr>
<tr>
<td>Appendix B: Research Procedure Timeline</td>
<td>127</td>
</tr>
<tr>
<td>Appendix C: Inservice Workshop Teaching Plans</td>
<td>128</td>
</tr>
<tr>
<td>Appendix D: Dimensions of Diversity Wheel</td>
<td>135</td>
</tr>
<tr>
<td>Appendix E: Influences of Diversity</td>
<td>136</td>
</tr>
<tr>
<td>Appendix F: Sample Group Report – Intercultural Development Inventory</td>
<td>137</td>
</tr>
<tr>
<td>Appendix G: Workshop Midpoint Reflection Question Protocol</td>
<td>138</td>
</tr>
<tr>
<td>Appendix H: Post-Workshop Qualitative Question Protocol</td>
<td>139</td>
</tr>
<tr>
<td>Appendix I: Focus Group Question Protocol</td>
<td>140</td>
</tr>
<tr>
<td>Appendix J: Action Plan Level 2 Resources</td>
<td>141</td>
</tr>
<tr>
<td>Appendix K: Action Plan Level 4 Resources</td>
<td>145</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 3.1 Sample Type for Each Type of Data Collection ................................................56
Table 3.2 Data Collection Methods that Answer the Research Questions .................62
Table 3.3 Inservice Workshop Objectives Aligned with the Pyramid Model and CRT .................................................64
Table 4.1 IDI Developmental Orientations with Descriptions at Each Level ..........................................................72
Table 4.2 Participant Movement along the IDI Development Continuum .................................................................75
Table 4.3 Paired T-test for Cultural Competence Ability Pre-test and Post-test ..................................................................76
Table 4.4 Individual Score Differences on the Pre-test And Post-test IDI ...........................................................................77
Table B.1 Timeline of Data Collection, Analysis, and Interpretation of Results ........127
LIST OF FIGURES

Figure 4.1 Participant Pre-test Orientations on the IDI .....................................................73

Figure 4.2 Display of IDI Scores Pre and Post-test Highlighting Variance ......................76

Figure 4.3 Word Cloud Representing Participants’ Thoughts of Cultural Competence .................................................................81

Figure 4.5 Themes with Corresponding Pyramid of Intercultural Competence Level ................................................................................85

Figure 4.6 Themes with Corresponding Pyramid of Intercultural Competence Level ................................................................................92

Figure 4.7 Levels Attained on the Pyramid Model at the Midpoint in the Workshop Series (left) and at the end of the Workshop Series (right). Level 4 (circled) Requires Additional Time and Training Opportunities ........................................................................................................95

Figure D.1 Dimensions of Diversity Wheel ....................................................................135

Figure E.1 Influences of Diversity ...................................................................................136
LIST OF ABBREVIATIONS

CRT ......................................................................................................................... Critical Race Theory
IDI ......................................................................................................................... Intercultural Development Inventory
CHAPTER 1

INTRODUCTION

I had planned to conduct my dissertation action research study on cultural competence in healthcare faculty. I thought I would focus solely on white healthcare faculty because the faculty in the college of health professions where I teach are majority White. I am also White. We teach mostly White students. I thought I would cover power and privilege, and a section on unconscious bias, and then two events occurred. First, the world was forced to lock down because of the COVID-19 pandemic, which illuminated great disparities in healthcare due to race, and then George Floyd was murdered. I knew my study had to address the deep divide in health equity between the races in the United States through cultural competence development.

As I sat at my kitchen working from home during the COVID-19 stay-at-home orders, I reflected on the inequity in the U.S. healthcare system that the pandemic so unequivocally highlighted. The virus hit the Black and African American populations hard; much harder than the White majority. Data collected in the U.S. during March of the 2020 pandemic revealed that 33% of hospitalized patients were Black and African American, although Blacks and African Americans only make up 13% of the total population in the United States (Aubrey, 2020; Garg, Kim, Whitaker, et al., 2020). Across the nation the data as of April 7, 2020, reveals the inequities in each state; in New York 28% of COVID-19 deaths have been Black people and African Americans although they represent only 22% of the population (Owen, Carmona & Pomeroy, 2020).
Further, Owen, Carmona, and Pomeroy (2020) illustrate the inequity in Michigan, Illinois, and Wisconsin. Deaths of Blacks and African Americans in Michigan as of April 7, 2020, have been 41% of all deaths, yet they represent only 14% of the population. In Illinois, the inequity is starker with COVID-19 infection rates amongst Blacks and African Americans twice that of their population. In Milwaukee alone, 81% of deaths are of Blacks and African Americans; yet they represent only 26% of the population. (Aubrey, 2020; Garg, Kim, Whitaker, et. al., 2020; Owen, Carmona & Pomeroy, 2020).

Progress in health equity has been limited during the last 25 years (Zimmerman & Anderson, 2019), which contributes deeply to the COVID-19 inequities in infection and death rates. Inequities in health exist amongst racial groups in the U.S. due to limited access to healthcare (Schafer, et al., 2019; Jones, 2002), environmental exposures and residential segregation (LaVeist & Isaac, 2013; Mays, Cochran, & Barnes, 2007), and structural and individual racism (Carter, Lau, Johnson, & Kirkinis, 2017; Mouzon, Taylor, Woodward, & Chatters, 2017; Gordon, McCarter, & Myers, 2016; Priest, et. al., 2013; DeLilly & Flaskerud, 2012; Pascoe, & Smart Richman, 2009; Jones, 2002;). Higher rates of chronic disease and chronic psychosocial stressors that include neighborhood violence, financial hardship, discriminatory treatment, job insecurity, and residential crowding are a result of structural and systemic racism that have gone unchecked. (LaVeist & Isaac, 2013). Lack of culturally competent healthcare providers, biases in individual healthcare providers and healthcare systems, further the increases in health disparities and inequity for racial minorities.
(Schafer, et al., 2019; LaVeist & Isaac, 2013). These risk factors and barriers to health make racial minority populations more vulnerable to the clutches of COVID-19.

Healthcare provider cultural competence has long been on my radar as a full-time faculty member in a college of health professions at the university level because it is considered a critical skill for healthcare students to learn (Paul, Ewen, & Jones, 2014). I teach these students, future healthcare providers, about cultural competence and health inequities, but not about power, privilege and unconscious bias, which culminate in racism and inequity (LaVeist & Isaac, 2013; Jones, 2000; McIntosh, 1988). I began to reconsider how I could contribute best to the elimination of these persistent health inequities in the U.S. through cultural competence training. Cultural competence has long been focused on geographical cultural differences (ethnic differences) of patient populations and not race based differences (Capell, Dean, & Veenstra, 2008; Paez, Allen, Carson & Cooper, 2008; Rajaram & Bockrath, 2014). With the death of George Floyd, racism and unconscious bias came to the forefront of the media, and peoples’ consciousness. The tragic event reinforced my ideas for a new model of cultural competence in healthcare based on racism to help alleviate patient inequity.

Healthcare provider unconscious bias, racial minority patient mistrust of the healthcare system, differential health outcomes in racial minority patients all appear to be critical (LaVeist & Isaac, 2013; DeLilly & Flaskerud, 2012; Jones, 2002). I realized the amalgamation of these issues must frame a new model in cultural competence for healthcare providers. I asked my faculty colleagues what they know about cultural competence and racism in healthcare. The answer was revealing. They reported knowing nothing. Thus, this action research project was redeveloped.
The purpose of this action research study is to construct a new model for cultural competence training through in-service diversity workshops for the faculty in the college of health professions in which I work. Providing inservice workshops allows faculty to have formal training on skills required to teach students (Bullough, 2009). I plan to focus the workshops on principles of equity and racism in healthcare including, uncovering unconscious biases, power, and privilege in order to increase cultural competence skills. These paradigms contribute to advancing social justice and closing gaps in equity (Lechuga, Clerc, & Howell, 2009), which are goals of the college. Healthcare education demands that faculty be culturally competent to prepare students for diverse and multicultural patient populations that require cultural competence skills for best health outcomes and increasing equity in healthcare (LaVeist & Isaac, 2013; Jones, 2002). The College of Health Professions at my medium-sized university in New England provides students with a sound educational base for employment positions in healthcare as physician assistants, physical therapists, occupational therapists, speech-language pathologists, athletic trainers, healthcare administrators, informatics specialists or public health professionals. Whichever health profession a student chooses, all must be equipped with cultural competence abilities in order to alleviate disparities in health outcomes.

Student learning outcomes (SLOs) for the college are commensurate with the needs of the healthcare environment. Two of the critical SLOs include concepts of multicultural approaches to healthcare delivery and navigating health inequity of diverse populations. These two SLOs are critical due to the diverse make-up of the population in the United States and the gap in healthcare quality that widens when multicultural
approaches to healthcare are not used and providers are not culturally competent (Capell, Dean, & Veenstra, 2008; Paez, Allen, Carson & Cooper, 2008; Rajaram & Bockrath, 2014).

It has been well documented that health outcomes suffer when practitioners and policy makers are not culturally competent (Rajaram & Bockrath, 2014; Capell, Dean, & Veenstra, 2008; Paez, Allen, Carson & Cooper, 2008). For example, communication skills that do not consider the patient’s culture can affect the outcome of care. Cultural competence is essential in interpersonal communication (Capell, Veenstra, & Dean, 2007). Further, Davey et al. (2014) found that culturally competent providers positively influence the treatment adherence of the patient and the quality of care.

There is an increasing need for culturally competent healthcare professionals because clinical outcomes are better when providers interact in authentic ways with diverse populations. Saha et al. (2013) contend that cultural competence of healthcare providers is directly connected to healthcare quality and outcomes of patients. Their study of HIV care and patient outcomes found that minority patients who had a culturally competent provider were more likely to be on antiretrovirals than minority patients who had a provider who was not culturally competent.

The main justification for expecting our healthcare students to be proficient in multicultural approaches to healthcare delivery and navigating health inequity of diverse populations is the inequity in healthcare outcomes. The basis of this inequity in health of diverse populations is structural and individual racism in the healthcare field (Carter, Lau, Johnson, & Kirkinis, 2017; Jones, 2002), however, this is not the focus of current cultural competence training. This concept will be further discussed in chapter two. This action
research study will address how best to fill the gap in knowledge about cultural competence and diversity for a group of faculty who are mostly White who teach a mostly White student body, and who identify themselves as lacking cultural competence training and knowledge of unconscious bias, power and privilege.

**Problem of Practice**

The problem of practice I address in this research study is the gap in knowledge of cultural competence and diversity awareness in healthcare faculty. I will focus on developing a new model of cultural competence training through inservice workshops to fill the gap. Research suggests we cannot expect students to gain cultural competence without specific, guided pedagogy facilitated by educators or mentors (Van de Berg, Paige & Lou, 2012). There is a profusion of literature about the need for cultural competence in the field of healthcare; however, much of it leaves out the pedagogical best practices for effective mastery of the domain (Boutin-Foster, Foster, & Konopasek, 2008; Campinha-Bacote, 2003; Cushman et al., 2015) and omits inclusion of a race centered approach to cultural competence (Aggarwal, Cedeno, Lam, Guarnaccia, & Lewis-Fernandez, 2018; M. B. Hall & Guidry, 2013; Jongen, McCalman, & Bainbridge, 2018; Shepherd, 2019; Truong, Paradies, & Priest, 2014)). Further, Cushman and colleagues (2015) describe the literature as including “specific knowledge, attitudes, and skills that promote cultural ‘competence’ [yet] fully defining this complex, multidimensional term, and implementing activities to enhance it, remains a challenge” (p. S132). This challenge is particularly acute in my college because the faculty are not diverse and have told me that they need cultural competence training in order to align
their teaching with the college SLOs that comprise the multicultural approaches to healthcare delivery and navigating health inequity of diverse populations.

Cultural competence models are relatively new and continue to develop. Due to the nascent nature of the cultural competence paradigm, existing models differ greatly. For example, Cole and Gunther (2018) describe differences in two models:

[The Cultural Competence Assessment, (Schim, Doorenbos, Miller, & Benkert, 2003)] has three components: the circumstance in which the clinician incorporates the cultural diversity experience; the clinician’s awareness of his or her reactions to people who are different; and lastly, examining attitudes and cultural bias toward other sociocultural groups. In contrast, the Purnell Model for Cultural Competence (Purnell, 2002) uses a methodological approach to determine cultural competence. The basic assumptions of the model derive from multidisciplinary theories including organizational, administrative, communication, and family development as well as anthropology, sociology, psychology, and several other. (pp. 14-15)

Healthcare educators who attempt to teach students about cultural competence without the appropriate training or identification of their own cultural competence ability cannot effectively teach students. Notions of race and diversity are often implicit (Rae, Newheiser, & Olson, 2015). Unless educators have been exposed to theories of multicultural education or cultural competence training, it can be assumed that thoughts and attitudes about race may not have been explicitly developed.

To understand the new model of cultural competence that I am proposing, it is critical to articulate the idea of “diversity.” For purposes of this study, diversity will
include race, more specifically Black and African American and White races. I separate Black and African American into two groups because African American refers to a person whose ethnic background descends from countries in Africa and identifies as American, while Black encompasses African Americans and others with descent from areas other than Africa (Cross-Denny et al., 2015). The reason for this focus is because the greatest inequity in health in the U.S. has developed due to the divide between the White majority race and the Black/African American race (Jones, 2002). As movements such as BlackLivesMatter gain traction in the U.S., being a culturally competent healthcare provider will become increasingly more critical because racism will be less and less acceptable. For healthcare providers to be culturally competent, their education must include cultural competence pedagogy provided by culturally competent faculty. To do this effectively, a framework is required.

**Theoretical Framework**

An intersection of critical race theory and the pyramid model of intercultural competence will guide this study. Critical race theory (CRT) is a framework that provides a racial consciousness approach to understanding structural inequity and racism in the United States (Delgado & Stefancic, 2017). The framework places race at the center of the theoretical approach and offers guidance in understanding racism and power that results in inequity (Ladson-Billings & Tate, 1995). CRT will guide the conversation on race, racism, and power and how they relate to cultural competence ability. Racism is the primary factor for inequity in healthcare in the U.S. (LaVeist & Isaac, 2013; Jones, 2002; Jones, 2000) and must be understood in order to gain in cultural competence skills. The pyramid model of intercultural competence (Deardorff, 2006) will guide the overall
inservice workshop structure by scaffolding the steps to cultural competence growth. The pyramid model was developed by Deardorff (2006) for use with study abroad students preparing for cultural competence before traveling and has wide implications across disciplines.

**Critical race theory.** Race is a social construct that often represents culture and diversity in the United States (Groski & Slawel, 2015; Jones, 2002). As Gorski and Slawell (2015) explain, culture “is used, in effect, as a stand-in for race, class, language, and other issues that aren’t as comfortably discussed as broad, vague ‘cultures,’” (p. 36). Because of this, it is essential to position this study within an open dialogue about race and racism. In doing so, white privilege must be addressed through recognition of unconscious bias and power and privilege experiences. Gorski (2016) states that all cultural competence models and frameworks fail to address equity in any manner; therefore, they are “empty” and do not address the cultural competence paradigm at all (p. 222). This leads to the need for an intersection of critical race theory and cultural competence models to effectively provide cultural competence training that addresses racism and cultural competence in healthcare.

As race is a main cause of inequity in healthcare, it is a critical component to address in the inservice workshops. Critical race theory (CRT) can best guide the healthcare faculty in awareness of their implicit attitudes of race. Solórzano and Bernal (2001) explain, “CRT challenges claims of neutrality, color blindness, and meritocracy in policies and practices shaped around the dominant ideology” (p. 336). To be racially minded means to be socially minded with a focus on justice and equity, but many educators avoid the discussion of race, as it remains a controversial topic in the classroom
(Sue, Lin, Torino, Capodilupo, & Rivera, 2009). The silence allows whites to say there is no racism, to ignore the required infrastructure that includes all groups (Wise, 2001). White educators have to “own their racialization by naming its source in whiteness and recognizing it as fundamental to their development as alienated human beings” (Leonardo, 2002, p. 45). This will happen only with the applicable theory and pedagogy. CRT is a scholarly tool that exemplifies inequity based on race and power (Ladson-Billings & Tate, 1995).

CRT’s use of storytelling can provide a mechanism to disrupt the silence and ignorance, and aid faculty in understanding the genesis of issues of race and diversity. At the core of our ignorance is the issue of power. It was our nation’s forefathers who set the power standard in this country by establishing property rights on the backs of the Africans stolen from their homeland (Ladson-Billings & Tate, 1995). As “whiteness” evolved into ownership and permeated the law, Blacks suffered. This ownership of power evolved to include anyone considered the “other” throughout the development and evolution of society in the United States (Frederickson, 2002). Admitting this, or even recognizing this, can be difficult. Using storytelling as the pedagogical method can make faculty more amenable to understanding race and recognizing their own power because social reality is an “exchange of stories about individual situations” (Ladson-Billings & Tate, 1995, p. 57).

Understanding the relationship between living as a Black/African American person in the U.S. and the inequity related to the person’s race is the base level knowledge faculty will require to grow in cultural competence. Racial discrimination and the historical relation to power dynamics is complex and influences health outcomes
of Blacks and African Americans immensely (LaVeist & Isaac, 2013; DeLilly & Falskerud, 2012; Jones, 2002). According to Jones’s (2000) seminal framework of racism, there are three types of racism that influence negative health outcomes of Blacks and African Americans and create the deep inequities in health: “institutionalized racism, personally mediated racism, and internalized racism” (p. 1212). For purposes of this study, the focus on racism will include both institutionalized racism and personally mediated racism, both of which are embedded in the constructs related to structurally racist systems in the U.S. (Jones, 2000, LaVeist & Isaac, 2013). Institutionalized racism surrounds access to power while personally mediated racism includes “prejudice and discrimination about the abilities, motives, and intentions or others according to their race” (Jones, 2000, p. 1213).

**The pyramid model of intercultural competence.** Deardorff (2006, 2009) developed her model of intercultural competence based on theories of international education and culture. Deardorff employed the Delphi method to gather a panel of experts to discover common themes in cultural competence components (Dearforff, 2006b). The Delphi method, as described by Linstone and Turoff (1975) in Deardorff (2006b), “is a process for anonymous communication within a larger group of individuals to achieve consensus among group members” (p. 234). The resulting model builds a pyramid with each level requiring various skill building mindsets (Deardorff, 2006).

At the base of the model, the requisite attitudes set the stage for learning how to be culturally competent. Learners must have respect, be open to difference while withholding judgment, and learners must be able to tolerate uncertainty (Deardorff, 2006).
The next levels include:

- Level two: Knowledge and Comprehension; Skills (to listen, observe, and interpret and to analyze, evaluate, and relate)
- Level three: Desired Internal Outcome (adaptability to different communication styles & behaviors; flexibility (appropriate communication styles/behaviors & cognitive flexibility); ethnorelative view; empathy)
- Level four: Desired External Outcome (behaving/communicating effectively & appropriately)

During the inservice workshops, racial inequity, power, privilege and unconscious bias training will intersect with level three on the model – desired internal outcome. This is where CRT will intersect to guide the knowledge and comprehension of race and power. The rationale for this intersection is the need to understand race and power as the base of inequity in healthcare.

**Purpose of the Study**

The purpose of this action research study is to create a more effective model of cultural competence training through diversity workshops that focus on power, privilege and unconscious bias. The college faculty are mostly white and the student body of the college are mostly white. Because the college faces this lack of diversity, the inservice workshop plan will focus on how white faculty can best teach white students to be culturally competent in the healthcare environment through a focus on racial inequity, specifically, Black/African American versus White health inequities.
Research Questions

The research questions guiding this study are the following:

1. What is the change effect of diversity workshops on faculty development of cultural competence?

2. How does uncovering one’s own implicit biases affect their cultural competence development?

3. How does identifying one’s own power and privilege affect their cultural competence development?

Research Design

Herr and Anderson (2015) tell us that action research “transcends mere knowledge generation to include personal and professional growth and organizational and community empowerment” (p. 1). Traditional researchers look for a concrete positive or negative outcome, whereas, action researchers rely on a more cyclical form of outcome that includes a self-reflective aspect (p. 2). Action researchers include themselves as research participants, which contrasts with traditional researchers who distance themselves from their participants and settings (p. 3). Action research is collaborative with “insiders of an organization or community, but never to or on them (p. 3), which belies traditional research notions.

Further, Herr and Anderson (2015) assume that action research must be legitimized. They note that applied disciplines have been the fields that have typically accepted action research as a legitimate form of inquiry (p. 25). The reason legitimacy is necessary, they posit, is due to “threats to validity” of research outcomes (p. 26). History shows that research theory, particularly objectivist theory, contends that validity can only
be created through prescribed methods that include “empirical-analytical” means (p. 27). However, Herr and Anderson (2015) point out that Habermas (1971) insisted that knowledge and researcher interests can never be separated and it is through self-reflection that this is proved (p. 27). Habermas contended that knowledge validity is generated through researcher methodology using “technical, practical, and emancipatory” interests (p. 27). In this manner, the faculty and I will be self-reflective of our unconscious biases, power and privilege to transform own mindsets about race and inequity in healthcare. Although not without his critics, Habermas sets the groundwork for knowledge validity outside of the traditional empirical method. All methods in this action research study will acknowledge my insider position and offer validity measures to the design.

**Research site.** The site for this research study is a medium-sized, private, Catholic university in a suburban setting. The campus setting is a sprawling mixture of more contemporary style structures with classical style brick buildings. The College of Health Professions is one of six colleges comprising the make-up of the university. The college is housed in the state-of-the-art Center for Healthcare Education (CHE) that lies just down the road from the main campus.

Little diversity exists on campus. The majority of the faculty is White. The majority of the students are White. All upper leadership at the university is male, and only one member of the upper leadership is of color. The students are mostly middle-class and upper-middle class with educated parents. Overall, the campus is one of wealth and homogeneity.

**Participants.** The participants in this study will be fulltime faculty and adjunct faculty members who teach in the college of health professions. All faculty hold terminal
degrees either in a field of healthcare or they hold master’s degrees in their discipline of practice. Healthcare disciplines in the college include physician assistant studies, occupational therapy, physical therapy, athletic training, exercise science, nutrition, health science, communication disorders, public health, healthcare administration, informatics, and speech-language pathology.

**Data collection methods.** I will use a convergent mixed methods research design to collect data. A mixed method design will allow for both quantitative and qualitative measurement of the data (Creswell, 2014). I will include a quantitative measure because I want to know if a skill (cultural competence) has been mastered or at a minimum improved (Klehr, 2012). Quantitative results will best inform the answer to research question one. I plan to include qualitative methods for research questions two and three because, as Merriam and Tisdell (2016) describe, “There are multiple realities or interpretations of a single event” (p. 9). Incorporating open-ended questions to capture the richness and diversity of the faculty experience with the intervention can provide critical information that reducing my study to variables measured by closed-ended questions cannot, therefore, a mixed methods approach is best (Klehr, 2012). The study will include three phrases of data collection. Phase 1 will be the quantitative measure of cultural competence that will assess the initial level of cultural competence skill of faculty. An intervention will then take place, which will be the faculty inservice workshops in a series of three parts. This is Phase 2 and will include the qualitative data collection. Open-ended self-reflection questions will be sent via Survey Monkey after each workshop module. The questions will allow me to gain a more in-depth and richer understanding of what faculty learned about cultural competence, race, unconscious
biases, power, and privilege. Phase 3 will be the post-test, or second measure, of cultural competence skill and will include a debriefing of each individual faculty’s results.

The phases include two goals:

1. Faculty understanding of the workshop material is measured.
2. The learning material presented has validity to the research questions.

**Data collection instrument.** The quantitative instrument I will use is the Intercultural Development Inventory (IDI), a published survey with high validity and reliability. The IDI is a 50-item assessment that identifies and measures an individual’s capacity to adapt to diverse cultures and recognize one’s own cultural acceptance and diversity awareness (Hammer, 2011). The tool takes approximately 30 minutes to complete. The IDI has been extensively psychometrically tested for reliability and validity. This instrument places individuals along a developmental continuum from a monocultural (denial) mindset to an intercultural (adaptation) mindset (Hammer, 2011) and encourages a life-long learning approach to cultural competence. The IDI will not only measure the validity of the learning material presented in the workshops in terms of growth along the continuum, but it can be used as a formative assessment because each individual is provided with a debriefing session after the post-test measure that functions as information to better understand their cultural competence ability.

**Data analysis.** Data analysis for the quantitative and qualitative measures will be conducted at the end of the workshop period. The mean scores from the pre-intervention IDI and the post-intervention IDI will be entered into SPSS and will be analyzed using a two-tailed t-test with a .05 significance level. The data from all qualitative sources will be transcribed and entered into the software program, NVivo. Themes will then be
identified and compared between data sources as part of the triangulation process to validate the data (Creswell & Plano Clark, 2018).

**Researcher Positionality**

Because I am a member of the faculty participating in this study, positionality is important to acknowledge. I am a faculty member in the health science program, as well as the director of the health science program. In addition, I am the director of global health programs office. I have a master’s degree in global development with an emphasis on global health, as well as 10 years’ experience as an assistant research scientist and lab manager at two large, R1 institutions in the departments of social psychology. I will be checking my positionality throughout each phase of the study for validity purposes. My identity has the potential to impact the research process (Bourke, 2014). My positionality not only stems from my role in the research study and position in the college, but from my heritage.

Cultural heritage is an important factor in this study, influencing concepts like White privilege and race. I know my heritage is European because my family tree has been traced back to 1205 A.D. in Western Norway. I will not be able to discern the heritage, nor the race, of my faculty without an open dialog, as assumptions cannot be made on skin color (Jones, 2000). Race is a social-structure that cannot and should not be discerned by sight without regressing back to the census taking strategies pre-1970 (Jones, 2000). I will need open dialog to understand authentically how faculty experience their surroundings, their ideas of in-groups and out-groups, and ideas of White privilege if they apply. The first step in the workshops will be a discussion of identity construction and influences on racial beliefs.
My beliefs about race come from my family background. Both my great-grandfather and grandfather were Protestant clergy heavily involved in Martin Luther King Jr.’s efforts to break down racial barriers and segregation. I was taught from a young age that all people are created equal. Many family stories influenced my perceptions of how all people should be treated. For example, my grandfather was preaching quite regularly about equal treatment of all peoples when one evening three Ku Klux Klan members rang the front doorbell. They emphatically told my grandfather that if he did not stop preaching equality, they would kill my mother and aunt, who were four and two at the time. My grandfather did not relent, but instead contacted the local paper and requested that a story about the incident be published in a manner of public shaming. This is exactly what occurred.

When I took the IDI for the first time, I was dismayed at discovering that I was within the minimization mindset. As I sat perplexed during the debrief, the IDI administrator questioned my cultural heritage. Aren’t you Norwegian, she asked. I proudly responded that I am certainly Norwegian and very proud of my Norwegian heritage. She politely pointed out that Norway is a socialist country where all people are considered equal. Yes, I agreed. My grandfather, my great-grandfather, my parents — they all ingrained in me that we are all the same. The administrator suggested that it is wonderful to see all people as human, but perhaps I was missing differences in people that were important to them. I was color blind. I was stunned, but she was right. I did not stop thinking about being color blind for months. I wanted to grow past it.

More recently, my younger daughter is my beacon. My husband and I adopted her from Guatemala at age 28 months. I lived in Guatemala for seven months with her
and my older daughter, who was then seven, while we completed the process. My
daughter is reminded daily in many ways, in what are often called “microaggressions,”
that she is “brown” and different. Sue et al. (2007) define this term eloquently:

Racial microaggressions are brief and commonplace daily verbal, behavioral, or
environmental indignities, whether intentional or unintentional, that communicate
hostile, derogatory, or negative racial slights and insults toward people of color.
Perpetrators of microaggressions are often unaware that they engage in such
communications when they interact with racial/ethnic minorities. (p. 271)

And more than once she has returned home from school in tears because she has been
called a racial slur by a classmate, who she thought was a friend. An open discussion and
learning module will be required for faculty in this study in order to identify and learn
about this conduct.

I anticipate that my background and current family life will have a substantial
impact on this study as both an insider and outsider. I cannot truly know, however,
without first discussing my positionality with the participants. I will be open about my
perception of my positionality and discuss with the participants their backgrounds and
influencing factors on their perceptions of race and ethnicity during the qualitative data
collection. Learning outcomes of the workshops will include, in addition to an awareness
of microaggressions, understanding of White privilege, perceptions of self regarding
cultural competence, and openness to learning about and accepting other cultures and
ethnicities.
Significance of the Study

Action research was chosen for this study to fully investigate and improve how to fill a sizable gap in faculty knowledge of cultural competence and diversity, and therefore, student learning of both. I plan to revise how cultural competence training is provided to healthcare faculty that will trickle down to how cultural competence training is provided to healthcare students.

This study is not intended to be generalizable, although it may be of interest to other educators who teach cultural competence and diversity awareness and who practice within a homogeneous faculty and student body. This will be of particular interest to those teaching in healthcare because of the clearly identified role culturally competent healthcare providers play in health outcomes of Blacks and African Americans.

Limitations. There are several limitations to this study. First, the chance of interviewer bias is real and must be considered because I am asking faculty colleagues to self-reflect on difficult-to-discuss topics. Second, my background and close connection to diversity and experiences of racial discrimination, although secondhand, may influence the nature of the interview process. Third, due to the COVID-19 pandemic, the diversity workshops will have to be adapted to the virtual environment putting space in-between participants where a close community connection may be better. I will also adapt some learning material to be asynchronous in order to avoid screen fatigue during the synchronous workshops sessions. Due to the death of George Floyd, there has been a considerable interest in unconscious bias, and power and privilege recognition throughout the U.S. and particularly in my college. I have been asked by several department chairs to review their curricula for inclusion of the concepts and moderate town hall type
meetings with students to discuss the concepts. Because of this, faculty may come to the workshops with prior knowledge of the paradigms, which may be reflected in their pre-IDI survey. Finally, I will not be able to conduct member checks on qualitative data for validity purposes because the dean has requested that all data collected be anonymous.

Despite these limitations, this study will potentially allow faculty to gain cultural competence ability, which will permit them to pass on the knowledge to their students. Although a small step, it is not an insignificant one in the work that must be accomplished in the healthcare field to mitigate inequities in healthcare.

**Organization of the Dissertation**

Chapter 2 will provide in-depth detail of the background literature regarding cultural competence, race, the theoretical framework, and the model chosen to guide this study. Chapter 3 will provide insight into the methodological design and data collection methods. Chapter 4 will describe all findings for each research question. Ultimately, Chapter 5 will discuss the implications of the findings including recommendations and future directions this type of research might take.

**List of Definitions**

Following is a list of definitions included in this dissertation.

**Cultural Competence:** It is difficult to discuss human diversity without including the concept of culture. Culture is a construct of diversity. It is the totality of values, beliefs, and behaviors common to a large group of people. Human diversity means differences among people. The definition of cultural competence that we will use in the workshops comes from the Forum on Education Abroad (2016): “The ability to relate and
communicate effectively when individuals involved in the interaction do not share the same culture, ethnicity, language, or other common experiences.”

**Diversity:** Any person who is different than we are; the “other.” For this study, diversity includes racial groups – Black/African American and White.

**Institutionalized racism:** “…differential access to goods, services, and opportunities of society” (Jones, 2000, p.1213) because of race.

**Intercultural Competence:** Cultural competence and intercultural competence are used interchangeably in the literature. Both terms will be used interchangeably in this research study.

**Institutionalized racism:** “…differential access to goods, services, and opportunities of society” (Jones, 2000, p.1213) because of race.

**Micro-aggression:** “Brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults toward people of color” (Sue et al., 2007, p. 271).

Micro-aggressions can occur, whether intentionally or unintentionally, that will persist by the aggressor until explicit recognition of racially charged language is achieved.

**Minoritized:** This label is the social justice usage describing a group that has been devalued by society and given less access to resources (Vaccaro & Newman, 2016).

**Minority:** For the purposes of this study, minority refers to any individual or group who is part of a race other than the majority racial group in the United States (i.e. white).

**Personally mediated racism:** “…prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to
their race, and discrimination means differential actions toward others according to their race.” (Jones, 2000, p. 1213).

**Power:** Differences in status and governing authority between majority and minority groups within a given society. Fiske (2018) operationalizes the definition to mean, “The powerless attend to the powerful who control their outcomes,” (p. 621). In U.S. society, the white majority are the power group, while the “ethnic” minority is the powerless.

**Privilege:** Any unearned advantage within a given society (McIntosh, 1988).

**Unconscious bias:** Any action or behavior that is taken in an implicit way without conscious thought. Moule (2009) explains, “unconscious biases lead to unintentional racism: racism that is usually invisible even and especially to those who perpetrate it,” (p. 321)

**White Privilege:** In McIntosh’s (1988) seminal work, she describes white privilege as, “unearned assets which I can count on cashing in each day, but about which I was ‘meant' to remain oblivious. White privilege is like an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools and blank checks” (p. 30).

**Race:** A social classification of people based on phenotype such as skin color, hair texture, eye shape, etc. (Jones, 2000). There is no biological component to race, yet even in the healthcare field, that fact is often ignored (LaVeist & Isaac, 2013).

**Structural Racism:** The macro level of racism that is born from policies, practices, and institutions that limit access to power and opportunities based on race (Jones, 2000; Viruell-Fuentes, Miranda, & Abdulrahim, 2012).
CHAPTER 2

REVIEW OF THE LITERATURE

Because it has been well documented that minority populations in the United States suffer greater morbidity and mortality than the majority population (Brondolo, Gallo, & Myers, 2009; Kennedy, 2009), a call to action must take place in university health programs to adequately educate students to provide appropriate healthcare to diverse populations. African Americans experience the most extreme disproportion of healthcare outcomes than other minority population groups including higher rates of chronic disease and worse birth outcomes often due to healthcare provider bias (LaVeist & Isaac, 2013).

The problem of practice I address in this research study is the gap in knowledge of cultural competence and diversity in healthcare faculty. The faculty have indicated they are not knowledgeable about cultural competence, yet two of the college SLOs surround cultural competence abilities. In order for the faculty to teach cultural competence to students, they must first learn to be culturally competent. I will focus on developing a new model of cultural competence training through inservice workshops to fill the gap. To address the problem of practice, cultural competence inservice workshops will be conducted and evaluated. The workshop material will include racism in healthcare, practitioner privilege, power, and unconscious bias and stereotype representation literature with the intersection of critical race theory as a framework.
The aim of this study is to determine if a new model of cultural competence of focusing on power, privilege, unconscious bias and stereotype representations will result in the growth of cultural competence ability in healthcare faculty.

The research questions guiding this study are the following:

1. What is the change effect of diversity workshops on faculty development of cultural competence?

2. How does uncovering one’s own implicit biases affect their cultural competence development?

3. How does identifying one’s own power and privilege affect their cultural competence development?

This chapter will review the current literature on the history of racism in the healthcare structure, cultural competence development in the healthcare field, healthcare provider implicit bias and stereotype representations, and their effect on disparities in healthcare for minoritized patients. A critique of current cultural competence models will be included that contains identified gaps in treating the population of U.S. healthcare patients and the need for addressing implicit bias and stereotype representations for full cultural competence development. Finally, a justification for grounding the study in an intersection of critical race theory and the pyramid model of intercultural competence will be presented.

A review of the literature identified several themes. Keywords were used including diversity, ethnicity, racism, racism in healthcare, minority healthcare outcomes, cultural competence, cultural awareness, cultural competence curriculum, cultural competence pedagogy, health outcomes, health equity, implicit bias, and disparities in
healthcare in databases including CINAHL, MEDLINE, Academic Search Premier, Psych INFO, and Google Scholar. Machi and McEvoy (2016) state that the purpose of a literature review is to provide evidence that supports the need for the research. The proposed research should build from the literature that has been published previously (Machi & McEvoy, 2016). The purpose of this literature review is to identify the current scholarly knowledge about disparities in health for minoritized populations, Blacks and African Americans in particular, cultural competence skills of healthcare providers and their effect on patient health outcomes, and the gap that currently exists in cultural competence education for healthcare providers. The review will provide evidence regarding the need for culturally competent healthcare providers who are able to engage in classroom discussions of race and the platform for answering the research questions in this action research study.

Cultural competence in healthcare education has grown exponentially since the seminal 2002 Institute of Medicine Report (IOM) was published emphasizing the enormity of racial disparities in healthcare (Nelson, 2002). A sharpened focus ensued within the literature noting the predicted demographic changes in the U.S. population. A wealth of literature shows little evidence of the effectiveness of the cultural competence curriculum established in response to the IOM report and minoritized populations (Aggarwal, Cedeno, Lam, Guarnaccia, & Lewis-Fernandez, 2018; M. B. Hall & Guidry, 2013; Jongen, McCalman, & Bainbridge, 2018; Shepherd, 2019; Truong, Paradies, & Priest, 2014).

For healthcare students to be culturally competent and diversity aware, faculty must have the appropriate training to guide the learning and address race and racism
within the healthcare system and individual healthcare interactions (Vande Berg, Paige & Lou, 2012). Healthcare program faculty must be able to manage and guide discussions of racism, which are often difficult topics in which to engage (Cross-Denny, Betso, Cusick, Doyle, Marbot & Santos-Dempsy, 2015; Gorski, 2016). Research has suggested that we cannot expect students to gain cultural competence without specific, guided pedagogy facilitated by educators or mentors (Vande Berg, Paige & Lou, 2012). The literature stressing the need for cultural competence in healthcare providers is clear; however, much of the literature omits the pedagogical best practices for effective mastery of the domain (Boutin-Foster, Foster, & Konopasek, 2008; Campinha-Bacote, 2003; Cushman et al, 2015). Further, Cushman and colleagues (2015) describe the literature as including “specific knowledge, attitudes, and skills that promote cultural “competence” [yet] fully defining this complex, multidimensional term, and implementing activities to enhance it, remains a challenge” (p. S132). Additionally, while current cultural competence models should not be dismissed, existing models remain incomplete. Including power, privilege, unconscious bias and stereotype representations is imperative for mitigating health disparities through provider cultural competence ability (Brondolo et al., 2009; DeLilly & Flaskerud, 2012; Greene Jackson, Hamilton, Hutchinson, & Huber, 2009; Hagiwara, Elston Lafata, Mezuk, Vrana, & Fetters, 2019; Hall et al., 2015). The most relevant framework to guide this process is critical race theory.

**Historical Perspective**

An historical outline of the systemic racism in healthcare must be described here because it has been mostly ignored in healthcare education and institutions (Hoberman, 2012 as cited in Feagan & Bennefield, 2014). To remain silent continues to give it voice
in a racist system. Feagan and Bennefield (2014) provide a timeline of physician use of
African Americans as “guinea pigs” for the advancement of health that has contributed to
“racial framing” in the contemporary health system.

Feagan and Benefield (2014) discuss how in the mid-1800s, gynecologist, James
Marion Sims, experimented on black infants because black children were dying of a
neuromuscular disease caused by vitamin and mineral deficiency. They explain that
Sims believed the deaths were due to misplaced skull bones and therefore used a
cobbler’s tool to realign infant skull bones without the use of anesthesia. Further,
according to Feagan and Bannefield (2014), Sims forced an enslaved girl to kneel on the
ground as he inserted a scapula and began to suture fistulas while other whites held her
down as she screamed. He used her as his experimental patient to perfect the technique
and then treated white women, although he provided them with anesthesia (Feagan &
Bennefield, 2014).

Similarly, Feagan & Bennefield (2014) describe another instance in the early 20th
century of black women who were involuntarily exposed to sterilization treatments or
hysterectomies. Black women were also the guinea pigs for the development of the birth
control pill (Feagan & Bennefield, 2014). Because the first iteration of pill had high
levels of hormones, many women were subject to hypertension and stroke (Feagan &
Bennefield, 2014). With the intrauterine device, black women suffered from high rates of
infection (Feagan & Bennefield, 2014). Both forms of contraceptive were later
prescribed to white women after the initial deleterious side effects were resolved (Feagan
& Bennefield, 2014).
Other scholars continue the timeline, highlighting that black men were not spared the guinea pig role in healthcare progress. Black men were the subjects of the infamous Tuskegee experiment that researched treatments for syphilis LaViest & Isaac, 2013; Yearby, 2016; Barrett (2019). Even when a cure was discovered, experimenters excluded black men so they could continue to research the effects of the disease on the body. African Americans contributed substantially to the current understanding of medical procedures, treatments, and cures; however, it was contributed at a great price to them without specific benefit (LaVeist & Isaac, 2013; Barrett, 2019).

A persistence in racialized medicine continues that harms both racial minorities and Whites. For example, a common belief about diabetes is that it is more prevalent in African Americans, Latinos, and Native Americans. Even social organizations perpetuate the idea that risk is based on race. The American Diabetes Association states that “Diabetes is more common in African Americans, Latinos, Native Americans, Asian Americans, and Pacific Islanders. If you are a member of one of these ethnic groups, you need to pay special attention to this test” (American Diabetes Association, 2020, para. 4). What this statement does is allow for Whites to ignore this issue and racial minorities to be targeted. There is no connection between race and risk of diabetes, scientifically. Here is the confusion. Racial minorities have a higher rate of living in poverty in the U.S. than whites (LaVeist & Isaac, 2013; Feagin & Bennefield, 2014). Low birth weight is often a result of mothers living in poverty (Fee, 2006; LaVeist & Isaac, 2013). High birth rate is also a result, which is due to mothers with gestational diabetes that is often a result of poor nutritional habits (Fee, 2006). Both low birth weight and high birth weight result in a greater risk of obesity and diabetes later in life (Fee, 2006). Thus, a higher
proportion of racial minorities are at risk of diabetes but not because of a genetic component of race (LaVeist & Isaac, 2013). Healthcare practitioners must ask several questions about living conditions, weight at birth, and nutritional habits to determine diabetes risk (Fee, 2006). In fact, these questions should be considered for all patients including Whites, who may also be at risk due to similar living conditions or risk components.

The adoption of cultural competence curricula in healthcare education was first established in the 1980s and flourished after the publication of the IOM’s 2002 report and continues to gain traction (Nelson, 2002). The IOM report identified several serious disparities in health outcomes for minority populations. The findings suggest that disparities exist even when “insurance status, income, age, and severity of condition are comparable” (Nelson, 2002, p. 666). Further, the report describes these disparities as unacceptable because “death rates from cancer, heart disease, and diabetes are significantly higher in racial and ethnic minorities than in whites” (Nelson, 2002, p. 666). The report blames the disparities on healthcare systems, plan managers, and healthcare providers who hold biases, stereotypes, and prejudice (Nelson, 2002, p. 667).

Due to the IOM report and based on research studies providing additional evidence that health outcomes in minoritized patients suffer when healthcare providers are not culturally competent (Barksdale et al, 2012; Capell, Veenstra, & Dean, 2007; Davey et al, 2014; Gaston, 2013; Lie et al, 2010; Rajaram & Bockrath, 2014; Renzaho, Promios, Crock, & Soderlund, 2012; Saha et al, 2013), health systems and health education programs included pedagogical competence activities to improve student cultural competence skills. However, the focus of the cultural competence improvement
pedagogy was on cultural differences of immigrant cultures and left out cultural competence practice for racially minoritized populations (Gordon et al., 2016).

**Theoretical Framework**

Race is a social construct that often represents culture and diversity in the United States (Cornell & Hartmann, 2007). As Gorski and Slalwell (2015) explain, “[Culture] is used, in effect, as a stand-in for race, class, language, and other issues that aren’t as comfortably discussed as broad, vague “cultures,” (p. 36). Because of this, it is essential to position this action research study within an open dialogue about race and racism. In doing so, White privilege must be addressed through recognition of unconscious bias and stereotype representations, and power and privilege experiences (Gorski, 2016). Gorski (2016) states that all cultural competence models and frameworks fail to address equity in any manner; therefore, they are “empty” and do not address the cultural competence paradigm at all (p. 222). This leads to the need for an intersection of equity theory and cultural competence models to be able to master the cultural competence paradigm.

Learning outcomes focused on race and racism must be included in undergraduate healthcare curriculum for many reasons, but certainly in order to understand the lack of genetic component to race (Dennis, Gold, & Wen, 2019; Gordon et al., 2016; Kennedy, 2009; Smedley, 2019). Otherwise, students will continue to confuse ethnicity and culture with race and ignore very prevalent issues of White privilege (LaVeist & Isaac, 2013). Critical institutions will suffer including the healthcare system, which effects other institutions comprising economic, social welfare, and family structures (LaVeist & Isaac, 2013).
Encouraging an explicit recognition of racial biases can be enthused through the critical race theory (CRT) framework. Gorski (2012) applies this ideology to schools; and it is equally as applicable to higher education focused on healthcare pedagogy. Gorski aptly notes that “applying a stereotype – can affect…emotional well-being…At the systemic level, these stereotypes can misdirect well-intentioned efforts to develop and implement effective policies for mitigating or eliminating socioeconomic inequities in schools” (Gorski, 2016, p. 313). Likewise, socioeconomic inequities in healthcare are deeply affected by stereotypes that ultimately limit policies for equity (LaVeist & Isaac, 2013).

Ladson-Billings and Tate (1995) identify the core of our ignorance as the issue of power. They indicate that it was our nation’s forefathers who set the power standard in this country by establishing property rights on the backs of the Africans stolen from their homeland. As “whiteness” evolved into ownership and permeated the law, Blacks suffered. This ownership of power evolved to include anyone considered the “Other” throughout the development and evolution of society in the United States (Cornell & Hartmann, 2007). Looking back in time, the “other” has changed. Over time, the “Other” has been the Italians, the Irish, the Jews, the illegal immigrant, any group perceived as a threat to those holding the power (Cornell & Hartmann, 2007). Constant in this evolution are the Blacks who continue to be marginalized, particularly in healthcare (Bailey et al., 2017; Feagin & Bennefield, 2014; Lukachko, Hatzenbuehler, & Keyes, 2014; Nelson, 2002).

Critical race theory’s evolution to critical race pedagogy suggests that education has made the leap in applying race to the curriculum but this is not the case (Ladson-
Billings & Tate, 1995). Despite scholars’ efforts to address the inclusion of “others” beginning with Derrick Bell through Marvin Lynn, school curriculum at all levels neglects to include learning objectives addressing White privilege, minority groups, multiculturalism and remains completely ethnocentric (Ladson-Billings, 1998; Solórzano, & Yosso, 2002). It has been allowed to be this way because we have been silent. This is the result of silence (Jones, 2000; Gorski, 2016). Graham, Brown-Jeffy, Aronson, and Stephens (2011) describe CRT’s core principles, “Racism is ordinary, not aberrational; and the current system of white-over-color ascendancy serves important purposes” (p. 84).

We cannot move forward in reducing racial disparities in health, whatever forward may mean, as long as the white-over-color ascendancy themes are muted (Leonardo, 2002). If silence remains commonplace, no theory, pedagogy, nor evolution of either will make any difference (Cross-Denny, et al., 2015). Participatory pedagogy may reach some, but will fail to reach others (Lynn, Jennings, & Hughes, 2013). It would seem prudent that critical race theory become more concretely interdisciplinary in practice in order to reach many and help “shape and guide the professoriate” (Lynn, Jennings, & Hughes, 2013, p. 615). For example, Chou (2017) provides confirmation that race is not biological in a non-clinical style that is comprehensible across disciplines. Meanwhile, the rest of us will receive the privileges of being White or fitting into being White in a complicit system of superiority (Wise, 2011). CRT focuses on these privileges, the superiority of the dominant White culture over other minoritized group cultures (Graham, Brown-Jeffy, Aronson, & Stephens, 2011).
Critical race theory subscribes to the use of storytelling to address power and privilege (Ladson-Billings, 1998). Using storytelling to understand race and racism can be a non-threatening method for faculty to engage these concepts of cultural competence and begin to understand their own implicit biases and stereotype representations. Carter-Black (2007) emphasizes the use of storytelling pedagogy to support social work students to better understand “varying perspectives, worldviews, and paradigms inherent among divergent cultural contexts. Efforts to increase awareness, understanding, acceptance, and tolerance through instructional methods are enhanced when critical dimensions of cultural elements resonate with students” (p. 33) which can be accomplished through the practice of storytelling.

Deardorff’s (2006, 2009) pyramid model of cultural competence will frame the workshop learning outcomes that will be grounded in CRT. The model is built on four levels of building mindsets:

- Level one: Requisite attitudes (respect, be open to difference while withholding judgment, and tolerate uncertainty)
- Level two: Knowledge and Comprehension; Skills (to listen, observe, and interpret and to analyze, evaluate, and relate)
- Level three: Desired Internal Outcome (adaptability to different communication styles & behaviors; flexibility (appropriate communication styles/behaviors & cognitive flexibility); ethnorelative view; empathy)
- Level four: Desired External Outcome (behaving/communicating effectively & appropriately)
Culture competence skills require this scaffolded learning in order to build the skillset for effective interaction with people who have different experiences, practices, and ways of doing and knowing (Cross-Denny et al., 2015). Capturing the intersection of the pyramid model and CRT framework will provide workshop participants with knowledge of race, racism, cultural competence practices and an examination of their own power, privilege, unconscious bias, and stereotype representations.

The rationale for adopting the pyramid model for intercultural competence is twofold. First, in order to ask faculty to admit to unconscious biases, the requisite mindset must be adopted. Deardorff’s (2006, 2009) model employs a requisite mindset that includes being open to others without judgment. Second, the model requires the practice of empathy and using skills including listening, observing, and interpreting (Deardorff, 2006, 2009). What the model does not explicitly include are notions of power and privilege. In the U.S. this means white privilege (Kendall, 2012). Intersecting CRT with the model to include concepts of race, power, and privilege will frame the workshops to effectively improve cultural competence skills to the faculty.

**Racism and health.** In order for cultural competence to be understood, a background in race construction is necessary. Racism can be defined as assigning value and perpetuating discrimination and bias based on the social interpretation of phenotype (Bradby, 2010; Jones, 2000). Phenotype is defined as race and ethnicity; visual features of a person (Bradby, 2010; Feagin & Bennefield, 2014; Jones, 2000). Visual features are powerful identifiers in U.S. society that were first conceptualized during slavery. More than 336 years of slavery, legal segregation, and Jim Crow law has firmly denied African
American and other minority groups access to many social institutions including those in health (Feagin & Bennefield, 2014).

Although no biological component is connected to race, it is widely viewed as such and has propagated throughout time in various ways including the eugenics movement. Eugenics created social policies, such as the illegality of interracial marriage, to attempt to create a “superior” race. For example, European theorist Frances Galton wanted to use “government policy to restrict marriages between undesired people so that inferior traits would not be passed on and a superior racial stock could be created” (as cited in Daniels, 2003, p. 77). Racial categorization is a pejorative action by the majority group to establish and confirm control of other groups (Cornell & Hartmann, 2007). The result within the healthcare system has been a history of racialized medicine, unequal access to care, and disparities in health outcomes for minority populations (DeLilly & Flaskerud, 2012; Greene Jackson et al., 2009; Jones, 2000; Nelson, 2002; Smedley, 2019).

**Cultural Competence Models and Frameworks**

Several cultural competence models in healthcare resulted from the call for more culturally competent healthcare providers. Most of the models claimed to be in response to the changing demographic in the patient population estimated to be 47% diverse by 2050 (Passel & Cohen, 2008 as cited in Brondolo, Gallo, & Myers, 2009). As suggested, the cultural competence models and frameworks focused on cultural “differences” in “beliefs” rather than racism, prejudice, and biases.
The process model of cultural competence. Campinha-Bacote (2002) developed The Process Model of Cultural Competence in the Delivery of Healthcare Services, which focuses on the continuous nature of cultural competence development in all disciplines of healthcare provider. The model includes several overlapping constructs including the following:

1. Cultural awareness – a self-reflective process that requires the health provider to identify her own cultural background. This construct suggests that an identification of personal biases, prejudices, and assumptions about others take place.

2. Cultural knowledge – an understanding of other cultures and the worldview of people from other cultures.

3. Cultural skill - information collecting about patients from diverse cultures including “differences in body structure, skin color, visible physical characteristics, and laboratory variances”.

4. Cultural encounters – interacting with multiple patients from different cultural backgrounds and identifying language needs.

5. Cultural desire – wanting to engage in cultural difference rather than being required to do so. The model prescribes for all constructs to be addressed and engaged in for cultural competence development (Campinha-Bacote, 2002, p. 182).

Campinha-Bacote’s (2002) model ignores race and ethnicity and even suggests that phenotypical attributes of race are biological by noting physical characteristics of patients. Suggesting that the healthcare provider develop cultural self-awareness does not
correlate to an understanding of implicit bias and prejudices. An implicit bias is just that – implicit. Noting one’s own cultural make-up does not uncover implicit bias (LaVeist & Isaac, 2013). Recognizing implicit biases requires measurement through tools such as the Implicit Associations Test (IAT – see below), and ongoing exercises that directly target self-awareness abilities (McIntosh, 2015). Research indicates a positive relationship between implicit bias and lower quality care of patients (FitzGerald & Hurst, 2017).

**Purnell’s model for cultural competence.** In contrast, *Purnell’s Model for Cultural Competence* is an interdisciplinary model based on 12 domains that encompass a cultural competence framework (Purnell, 2002). The domains include “heritage, communication, family roles and organization, workforce, biocultural ecology, high-risk behaviors, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health care practice, and health care practitioner” (p. 195-196). The domains are applied in relation to primary and secondary characteristics of a culture. Purnell (2002) describes primary characteristics as:

Nationality, race, color, gender, age, and religious affiliation and secondary characteristics as educational status, socioeconomic status, occupation, military experience, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical characteristics, sexual orientation, gender issues, reason for migration, and immigration status. (p. 195)

Purnell’s focus is on non-Western cultural groups and/or cultures speaking different languages rather than the provider. For example, Purnell (2002) states:

It is recognized that some cultures do not have directly translatable words for these concepts . . . [and] in Western cultures, a person usually stands alone as a
unique individual. In other cultures, a person may be defined in terms of the family or another group. (p.195)

Purnell’s model repeats Camphina-Bacote’s (2002) suggestion that phenotypical attributes of race should be noted in patient appearance, which perpetuates the impression that race is biological and may even activate unconsciously held biases and stereotype representations (FitzGerald & Hurst, 2017). The model does not explicitly recognize power, privilege, nor stereotype representation. Health disparities of minority groups cannot be eliminated without provider recognition and awareness of these constructs because communication and behaviors will be influenced in interactions with minority group patients (Byrne & Tanesini, 2015; Chapman, Kaatz, & Carnes, 2013; Dovidio, 2016; Hagiwara et al., 2019; M. B. Hall & Guidry, 2013; Zestcott, Blair, & Stone, 2016).

**Leinenger’s theory of cultural care.** Leinenger (1988) developed the *Theory of Cultural Care* for nurses while caring for culturally diverse children. The gap, Leinenger noted, was that care for culturally different children did not meet their needs. Children required a different kind of care. Born from this discovery was a collaboration of anthropology and nursing perspectives. Leinenger (1998) posits:

Actions will be congruent with the lifeways of individuals, families, or groups as a basis to support the goal of cultural congruent care. If the latter goal of the theory is met, clients will find that nursing care reasonably fits with or is similar to cultural beliefs, values, and lifeways. Cultural congruent nursing care is, therefore, predicted to provide meaningful, satisfying, and beneficial care to clients (p. 155).
Leinenger (1998) does not address prejudiced communication or behaviors of nurses; therefore, culturally congruent care cannot truly be achieved. Training in implicit bias must occur in order to provide beneficial care that meets the needs of diverse patients (Zestcott et al., 2016).

**Patient centeredness and cultural competence.** Saha, Beach, and Cooper (2008) suggest an overlapping intersection between patient centeredness and cultural competence. They indicate that the primary aim of patient centeredness is to provide individualized quality to each patient emphasizing patient-provider relationships and a customer care approach to healthcare. The primary aim of cultural competence, according to this framework, is to improve equity and reduce disparities in health by improving care for disadvantaged populations. Saha, Beach, and Cooper suggest that the overlap includes competencies in respecting patient beliefs and values, trust building, awareness of biases, and unconditional positivity toward the patient and provides educational material that matches patients’ levels of comprehension.

All cultural competence models identify the requisite step of knowing one’s own cultural lens prior to gaining the capability of knowing others. If U.S. healthcare providers are to know their own lens first, they must acknowledge white privilege, power, and unconscious bias as the healthcare system is clearly predicated on these constructs (Byrne & Tanesini, 2015; Chapman et al., 2013; Dovidio, 2016; Gorski, 2016; Hagiwara et al., 2019; Hobbs, 2018; Hollingshead, Meints, Miller, Robinson, & Hirsh, 2016; Holm, Rowe Gorosh, Brady, & White-Perkins, 2017; Zestcott et al., 2016). In order to provide faculty with the greatest opportunity for cultural competence growth, faculty development workshops will include these three paradigms.
Related Research

There is a profusion of research from the 1990s and early 2000s surrounding specific health outcomes with specific races. For example, Echols et al. (2007) analyzed cardiac health disease in Whites, Blacks, and Hispanics. Results identified that Blacks were less likely to receive care for percutaneous coronary intervention and coronary artery bypass grafting than Whites, although there was no significant difference in rates of cardiac catheterization. Manhapra et al. (2004) conducted a study reviewing the death rates of Black patients versus White patients and acute myocardial infarction (AMI). The study included 40,903 blacks and 501,995 whites with AMI. The researchers found a statistically significant relationship with race, age and death rate. Blacks older than 65 had a significantly higher mortality rate than Whites of the same age.

In order to substantiate the effects of racism and unconscious bias and stereotype representation on health outcomes of all minority groups, several reviews of the literature and meta-analyses of these specific studies have been conducted and include disparities in health in relation to provider constructs of care.

Disparities in Health and Provider Constructs. Constructs that affect patient adherence to treatment, satisfaction, and health outcomes include white privilege and power, and unconscious bias (Carter, Lau, Johnson, & Kirkinis, 2017; Greene Jackson et al., 2009; Hagiwara et al., 2019; Hall et al., 2015; Nash, 2017; Nelson, 2002). The 2002 IOM report emphasized the rampant nature of these constructs within the healthcare system and individual provider – patient interactions (Bailey et al., 2017; Lukachko et al., 2014; Nelson, 2002). Much of the manifestation of these constructs is implicit rather than explicit meaning the healthcare provider is often unaware of the racist language or
actions perpetrated on the patient (Chapman et al., 2013; Dovidio, 2016; Hagiwara et al., 2019; Zestcott et al., 2016).

Carter et al. (2017) conducted a meta-analysis on drug use behaviors as a result of physical stress and health behaviors due to exposure to racism (p. 236). The aim of their study was to highlight the significant relationship of experiencing racism and physical health, mental health, and drug use of Asian, Native American, Latina/o, and Black Americans. The researchers set inclusion criteria for the meta-analysis of the literature including empirical, peer-reviewed studies that used self-reports of racism or instruments measuring experiences with racism, included measurement of physical and/or mental health and experiences with racism, with adult participants in the United States. Keywords including, “racial discrimination, racism, perceived racism/discrimination, racial oppression, ethnic discrimination, racial trauma, health, psychological effects, mental health, psychological symptoms, physical health effects, and psychological functioning” (p. 237) were searched in several databases such as PubMed, ProQuest, PsycINFO, PsycARTICLES, MEDLINE, and EBSCOhost. Further, journals that have previously published articles on the topic of the meta-analysis were individually reviewed. Studies that met the inclusion criteria and were published between 2000 and 2011 were included in the review. A total of 105 studies were included.

The results of Cohen et al.’s (2017) meta-analysis showed that racial discrimination has a negative effect on general health, both physical and mental. Although racism effects both physical and mental health, negative psychological health was more strongly related to racism exposure. The analysis also found that racism exposure negatively affected participant’s cultural identity, which can further implicate
negative health outcomes (p. 245). Because this meta-analysis included multiple participant races, it can be generalized across racial groups. Previous analyses have limited the participant populations to specific racial groups. The results of this meta-analysis support the idea that racism negatively affects health outcomes, which is reinforced by the results of Green Jackson et al.’s (2009) review of cardiac outcomes for minority patient populations.

Green Jackson et al. (2009) conducted an analysis of the literature focusing on cardiac heart disease outcomes and minority patients including an historical perspective, theoretical frameworks of racism, public health and race models, and the quality of studies conducted on cardiac health and minority populations. Study inclusion criteria included actual quantitative and comparative measures and measures of minority disparities in treatment of cardiac heart disease. A total of 28 studies were included in the review.

Results of the Green Jackson et al. (2009) analysis confirm several key findings in the literature. The first is that disparities in the level of care for minority patients exist. Most studies looking at disparities in cardiac health disease include comparisons of Black and White patients. Very few studies include other minority races such as Latino/a, Asians, or Native Americans. Part of the disparity comes from a history of deeply rooted segregation of Blacks and racism (p. 61). And, finally, the problem of disparities in care sits with both the providers of care and the health system.

A systematic review conducted by Hall et al. (2015) determined that most health care providers appear to have implicit bias in terms of positive attitudes toward Whites and negative attitudes toward people of color… results also showed that implicit bias was
significantly related to patient–provider interactions, treatment decisions, treatment adherence, and patient health outcomes (p. e60).

The review was conducted using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses. Inclusion criteria included studies conducted on healthcare providers who “provided or were in training to provide preventive, curative, therapeutic, or rehabilitative health services” (p. e62), measured implicit biases towards racial or ethnic groups, and were written in English. Fifteen studies were included in the review. Results of the study by Hall et al. showed that healthcare students represented similar racial and ethnic biases to those of already practicing providers. Healthcare provider implicit biases and stereotype representations have a profound effect on patient relationships and health outcomes.

**Implicit Bias and Stereotype Representations.** Implicit biases and stereotypical representations are not consciously recognized thoughts. They remain outside of conscious thought but lead to negative behaviors towards others or negative assessments of others, particularly those of a minority race (FitzGerald & Hurst, 2017). These unconscious thoughts can influence not only behavior but cognitive processes (Byrne & Tanesini, 2015; Chapman et al., 2013; Hagiwara et al., 2019; Maina, Belton, Ginzberg, Singh, & Johnson, 2018). Research has shown that healthcare providers hold implicit bias and stereotype representations against Blacks, Hispanics, and Native American (Byrne & Tanesini, 2015; Chapman et al., 2013; Dovidio, 2016; Maina et al., 2018; Zestcott et al., 2016)

One method of measuring implicit bias is through the Implicit Association Test (IAT) (FitzGerald & Hurst, 2017; Maina et al., 2018). The IAT measures response time
and error rate to positive or negative associations to many constructs including skin color (Greenwald et al., 1998 as cited in Maina et al., 2018). Maina et al. (2018) conducted a comprehensive review of 37 studies focused on implicit bias and health disparities. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines were used to conduct the review (Moher et al., 2015, as cited in Maina et al., 2018). Inclusion criteria included use of the IAT to measure implicit bias; race, ethnicity, or skin tone IAT was used; and participants were all healthcare providers (Maina et al., 2018, p. 221). The authors recognized that thirty-one of the studies found evidence of healthcare provider pro-White, anti-Black/Hispanic biases.

In a systematic review of implicit bias in healthcare provider literature, FitzGerald and Hurst (2017) found that implicit biases influence diagnoses, levels of care, and decisions about treatment for minority patients (p. 14). The researchers searched PubMed (Medline), PsychINFO, PsychARTICLE and CINAHL for empirical studies conducted on implicit bias in physicians or nurses. Twenty-seven articles met the inclusion criteria. Of the twenty-seven articles, all found “correlations between implicit bias and lower levels of care” (FitzGerald & Hurst, 2017, p. 1).

Further, implicit bias and stereotype research has shown a negative association with patient satisfaction and trust of healthcare providers in minority patients (Hagiwara et al., 2019). Hagiwara et al. (2019) contend that communication behaviors of healthcare providers are impacted by implicit biases and must be recognized and disrupted before adaptive behaviors can take place. They posit that the social psychology research on implicit racial biases and the patient perspective of provider-patient communication must be used as a framework for mixed methods designed research. The researchers suggest a
new model to reduce racial disparities in healthcare focused on provider implicit racial biases and including patient-provider communication, patient trust of the healthcare provider and patient health outcomes. This new model will better inform the cultural competence education for the healthcare provider community.

Studies that have held economic, educational, and access differences constant, have still found differences in care in racial and ethnic minorities suggesting that bias is the cause (Kressin & Peterson, 2001; Sheifer, Escarce, & Schulman, 2000, as cited in Zestcott et al., 2016, p. 2). Zestcott et al. (2016) highlight research showing that healthcare providers have more negative associations about African American patients, believing them to be less cooperative and less compliant than White patients even when provided with information that their beliefs were false (p.4).

**Study limitations.** Several limitations exist in implicit bias/stereotype representation research. First, most studies have not been conducted in the field and therefore limit real-world patient-provider interactions. Most studies capture provider participant data without collecting data from patients in the same study. Cross-sectional designs should be employed with geographically diverse participant populations (Hagiwara et al., 2019; W. J. Hall et al., 2015; Maina et al., 2018). This is paramount in order to best inform curricula for cultural competence education.

New Curricula for Cultural Competence Development. Both implicit bias and stereotypical “representations” are “automatic and unconscious” (Byrne & Tanesini, 2015, p. 1256). Cultural competence training cannot disrupt the activation of these processes nor inhibit the resulting behaviors without explicit attention to the constructs. Continuous training aimed at recognizing and disrupting the processes is required.
“Conscious effort” is necessary “on the part of the medical professional” (Byrne & Tanesini, 2015, p. 1257) to change discriminatory behaviors as a result of implicit bias. Recognition of biases and power and privilege experiences is the first step toward achieving cultural competence.

Ford (2012) tested whether White students can effectively learn about whiteness by themselves as well as in collaboration with students of diverse racial backgrounds. She used the Intergroup People of Color-White People Dialogues and Intra-Group White Racial Identity Dialogues to provide learning opportunities for White students (p. 138). Students’ articulation of race, racial identity, and whiteness was measured pre and post learning intervention through content analysis of personal essays. Learning constructs included social identities, identity structures, and dialogue experiences. Forty-eight of the 49 students self-reported growth in learning over the course of the semester. One student represented resistance to the learning constructs which manifested in cognitive dissonance – “the inability to reconcile or make sense of information that contradicts one’s current worldview” (Goodman, 2001, as cited in Ford, 2012, p. 146). In general, however, students presented a more nuanced understanding of race post learning intervention.

Gordon et al. (2016) posit that incorporating anti-racist coursework into health curriculum is necessary to increase cultural competence. After anti-racism content in cultural competence coursework at a midwifery program failed, a consultant team was hired to conduct a needs assessment and make recommendations to the program. A cross-section of students, former students, faculty and staff participated in individual interviews and focus groups. Several themes were identified:
1) Faculty (mostly White) did not have the skills to navigate discussions about race and racism;
2) Culture and race were not a part of the curriculum;
3) Limited support for students of color was part of the program;
4) Students of color experienced both overt and subtle forms of racism; and
5) Pedagogy focused on white-dominant norms; 100 per cent of students of color and several white students believed their learning was focused on serving only White patients (p. 721).

In response to the survey and focus group results, new curricula on cultural competence was created program-wide. The new curricula included a framework of power and privilege along with months long training about racism in healthcare in order to expand on the ineffective one-day workshop. Finally, faculty training included issues of race and racism so that faculty were equipped to handle discussions of such in the classroom.

Summary

Healthcare education demands that faculty be culturally competent in order to prepare students for diverse and multicultural patient populations. Projected trends in the make-up of the U.S. population include tremendous growth in multicultural groups. The growth in foreign-born Americans will steadily outnumber native-born Americans with an anticipated population share of 19% by the year 2060 (Colby & Ortman, 2015). The Hispanic, non-white population accounts for more than half that growth and currently represent the largest minority group in the United States (Passel, Cohn, & Lopez, 2011). This serves as the demographic of patients seeking healthcare representing multinational,
multiethnic and diverse racial groups. To meet the needs of this diverse patient population, healthcare providers must be culturally competent. This will require education provided by culturally competent educators.

Educators must analyze their thoughts and attitudes about race first through the development of consciousness of thought in order to increase cultural competence skills. Unless educators have been exposed to theories of multicultural education, it can be assumed that thoughts and attitudes about race may not have been explicitly developed or exposed. Implicit biases and stereotype representations are the baseline cultural competence skills necessary for successful patient interactions in the United States.

Race is a social construct that often represents culture and diversity in the United States. Because of this, it is essential to position this study within an open dialogue about race and racism. In doing so, White privilege must be addressed through recognition of unconscious bias and stereotype representations, as well as, power and privilege experiences. Critical race theory (CRT) can best guide the educator in awareness of their implicit attitudes of race in order to encourage growth in cultural competence. The purpose of this action research study is to discover how White faculty can learn to educate a predominantly White student population about cultural competence, diversity, and inclusion in an effective method. Skills in cultural competence are critical for future healthcare providers in order to mitigate the disparities in health outcomes of Black, Hispanic, and Native American populations.

Current models of cultural competence in healthcare provide a stepping-stone for cultural competence education; however, there exists a large gap in their criteria for growth. The constructs of implicit bias, stereotype representation, power and privilege
are either incomplete or lacking all together. In order to achieve truly effective cultural competence in order to mitigate current disparities in health outcomes for minority patients, healthcare providers and educators must recognize their implicit biases, stereotype representations, and understand the nature of power and privilege that has long been held within the U.S. healthcare system.
CHAPTER 3

METHODOLOGY

Healthcare patients who are Black or African American suffer greater health disparities than White patients in part because healthcare providers are not culturally competent or hold unconscious biases that are exhibited as microaggressions. Often differential diagnoses occur because of the patient’s skin color, and a lack of understanding about the lives of Black or African American patients affect patients overall health and wellbeing. All patients, despite their skin color, have a right to adequate and appropriate healthcare provided by culturally competent and unbiased healthcare providers.

It is the responsibility of healthcare faculty teaching their students, in any health related discipline, to be culturally competent providers. As with any skill, faculty must learn cultural competence before teaching it to students. Based on conversations with faculty peers in my college, it was identified that faculty do not have the training nor the knowledge to be culturally competent.

This action research study focused on several components of the cultural competence paradigm through a diversity workshop intervention. The workshops covered power, privilege, unconscious bias and stereotype representations. These components will, together, increase faculty cultural competence skills and mitigate racism in healthcare that is often unconsciously perpetuated. Therefore, the problem of
practice addressed in this study is the gap in cultural competence knowledge faculty
identified.

The research questions addressed were the following:

1. What is the change effect of diversity workshops on faculty development of
cultural competence?

2. How does uncovering one’s own implicit biases affect their cultural
competence development?

3. How does identifying one’s own power and privilege affect their cultural
competence development?

The theoretical frameworks guiding this study were an intersection of the pyramid
model of cultural competence and critical race theory. Critical race theory was chosen
because it places race at the forefront of the research being conducted while using a
storytelling approach to guide learning. Because Blacks and African Americans suffer
the greatest inequity in healthcare due to race, this theory is aptly applied. A storytelling
approach to learning can increase empathy and also be a non-threatening way of learning
difficult to discuss topics such as race. The pyramid model of cultural competence
scaffolds the learning of cultural competence into requisite mindsets required for learning
outcome mastery.

The methods used in this action research study are described within this chapter.
Details about the research approach, the setting, participants, a description of the
instruments used and inservice workshop plans, the implementation of the study, and
procedures for data collection and analysis are included in this chapter. An outline of the
inservice workshops, along with a timeline are discussed.
Research Approach

The inquiry process of action research allowed for an investigation of diversity and inclusion concepts in health education that should promote social change (Efron & Ravid, 2013). Action research allows the researcher to be a participant in the process, resulting in a reflection of my own processes (Efron & Ravid, 2013). In this case, the process of teaching and sharing knowledge of unconscious bias, stereotype representations, power and privilege were investigated through planning and presenting an intervention, collecting data, evaluating the results of the data, and making recommendations for my own teaching practice and the practice of colleague participants (Efron & Ravid, 2013; Kerr & Anderson, 2015).

This action research study moved the participants through the study using a pragmatist approach to reach an outcome (Herr & Anderson, 2015). Pragmatism encompasses both qualitative and quantitative approaches in a mixed-methods design to find an answer to the problem of practice (Creswell & Plano Clark, 2018). My interest was knowing what works to solve the problem (Creswell & Plano Clark, 2018) of the lack of knowledge in cultural competence of my healthcare faculty peers. A convergent mixed-methods design was employed.

Methods

A convergent mixed-methods study collects quantitative and qualitative data as a response to the research questions (Creswell, 2014). The two types of data were collected in three sequential phases. The two forms of data were then merged after sequential data collection occurred. Merging the data served as a validity strategy to check the data for accuracy (Creswell & Plano Clark, 2018). Another purpose for the convergent mixed-
methods design was to best match the nature of the data being collected. In a quantitative design, the relationship between two variables is examined (Creswell, 2014). However, reducing relationships to two variables can exclude richness of data captured by open-ended questions. A qualitative design can more closely serve a deeply contextualized setting (Klehr, 2012). Therefore, a mixed-methods design was most appropriate to answer the research questions.

**Research Setting**

The setting for this action research study was the College of Health Professions at a medium-sized, private institution in New England. The school is a Catholic university with a liberal arts foundation. Nestled in suburbia on 300 acres of land, the university provides a quintessential New England setting that attracts mainly students from the area.

The university offers over 80 undergraduate, graduate, and certificate programs among six colleges and two schools including the College of Health Professions. The College of Health Professions houses programs in physician assistant studies, occupational therapy, physical therapy, public health, healthcare administration, informatics, exercise science, athletic training, health science, communication disorders, and speech-language pathology.

The College is housed in the state-of-the-art Center for Healthcare Education that opened, newly renovated, in 2017. The most up-to-date classroom technology, lab space, simulation equipment, and study areas are available to students. The university census indicates that the majority of the college’s students are White and middle-class. Only 13% of the students are students of color: Asian, 7%; American Indian/Alaskan Native, 2%; Black/African American, 10%; Hawaiian/Pacific Islander, 1%; Hispanic/Latino,
17%. The majority of the students are female: 87% female, 11% male, according to the 2019 internal census.

**Sample**

The participants of this study comprise both a purposive sample and a sample of convenience. The focus group sample is considered purposive because the participants were deliberately chosen for the qualitative data collection (Etikan, Musa, & Alkassim, 2016; Efron & Ravid, 2013). All participants teach healthcare courses that require knowledge of cultural competence for patient care. Thus, they meet the exact needs of the study and qualitative component (Etikan, Musa, & Alkassim, 2016), which examines faculty thoughts and ideas about the study concepts. The focus group participants were chosen purposefully so that as many disciplines in the college could be represented. Only one participant per discipline was invited to join the focus group sample. Robinson (2020) suggests that no more than five or six participants be included in a focus group when the topic is of great importance. The sample is also considered one of convenience because the faculty were easily accessible (Etikan, Musa, & Alkassim, 2016). The quantitative data collection instrument was disseminated to all faculty who wished to participate in the workshops. In both cases, the sample types are not generalizable. Table 3.1 highlights the types of samples in the study.

All faculty in the college of health professions were invited to participate in the study. They were formally asked to participate in the study via email announcement with a description of the research plan (Appendix A). A total of 176 health professions faculty were emailed the invitation. Circumstances that may have influenced participation are
some department chairs made participation mandatory and the murder of George Floyd may have encouraged more participation, as well as make participants more receptive to the learning material.

Table 3.1 *Sample Type for Each Type of Data Collection.*

<table>
<thead>
<tr>
<th>Phase</th>
<th>Data Type</th>
<th>Instrument</th>
<th>Sample Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>One</td>
<td>Quantitative</td>
<td>Pre-IDI</td>
<td>Convenience</td>
</tr>
<tr>
<td>Two</td>
<td>Qualitative</td>
<td>Semi-structured focus group questions</td>
<td>Purposive</td>
</tr>
<tr>
<td>Three</td>
<td>Quantitative</td>
<td>Post-IDI</td>
<td>Convenience</td>
</tr>
</tbody>
</table>

**Intervention**

A series of three virtual inservice workshops were conducted to increase cultural competence ability in the healthcare faculty. The focus was on recognizing power, privilege, and unconscious bias and stereotype representations (Appendix C). Each workshop was 1.5 hours in length and occurred on three subsequent Fridays, as this is the day of the week that faculty typically schedule meetings or research activities. Some of the learning material was completed by participants as homework. Before COVID-19 social distance rules were in effect, I had planned the workshops to be three hours each. Because I had to hold the workshops virtually, I limited the synchronous time to avoid virtual platform burnout. The material that was not included synchronously was assigned as “homework” to be completed asynchronously between sessions. Reflection questions were assigned in between sessions because of the shortened synchronous sessions and prepared faculty for the next session. The homework material and questions were accessed through the university’s online learning platform. The first homework activity was assigned prior to the first workshop because faculty were asked to discuss the
material during the first synchronous session. In this assignment, participants were asked to consider 22 different dimensions of diversity and choose those that have influenced their perceptions and world-view. The worksheets are included in Appendix D.

Homework was included in between workshops one and two, as well. After workshop one, participants completed an implicit association test if they had not finished it during the workshop. They then watched a video “Cracking the Codes: Joy DeGruy ‘A Trip to the Grocery Store’”. In this video, Dr. Joy DeGruy tells her story of an experience of discrimination in the grocery store. Next, participants read White Water from Everyday White People Confront Racial and Social Injustice. In this essay Gary Howard leads the reader along his journey towards racial consciousness. Finally, participants responded to reflection questions in Survey Monkey. Questions included:

1. How truly open are you to those from different cultural, socioeconomic or racial backgrounds?

2. What experiences have you had that may influence how you view "others"?

Please describe.

See Appendix G for the full protocol. Homework following workshop two asked participants to view “Post Traumatic Slave Syndrome. How Is It Different From PTSD?” In this video, Dr. Joy DeGruy describes the theory as a multigenerational history of trauma that began in slavery. Directions to participants were, ‘As we continue to self-reflect on our own identities, we must learn the perspective of "others" to develop empathy and understanding. Please watch this short video.’ Participants then watched a series of slideshow videos on Race: The Power of an Illusion (PBS, 2003). The series defines the role race plays in everyone’s everyday life. Final directions for this
homework were to take time to reflect: ‘After watching the video and slideshows, think about our discussion of structural racism/inequity during the second workshop. Have you contributed to or been advantaged by a system or systems of structural racism/inequity (housing, education, healthcare, justice system, policing practices, hiring practices), either unconsciously or consciously? Have you been negatively affected by systems of structural racism? Please think about these questions during the week as you continue your self-reflection and identification of important differences in others.’

Data Collection Instruments

The Intercultural Development Inventory (IDI) was the main data source in the quantitative part of this study. It was essential that two goals were accomplished with the quantitative measure:

1.) Faculty understanding of the material presented is measured.

2.) The material presented has validity.

To accomplish both goals, the Intercultural Development Inventory was used as a pre- and post-test survey to the intervention.

The IDI is a published instrument with high validity and reliability. The survey is modeled on Bennet’s (1986, 1993) developmental model of intercultural sensitivity (DMIS). The DMIS consists of three ethnocentric orientations and three ethnorelative orientations of cultural difference (Hammer, Bennet, Wiseman, 2003). To measure content and construct validity and reliability of the IDI instrument, pilot testing, sample testing, and a panel review were conducted before testing the final version with a sample of 766 participants (Hammer, Bennet, Wiseman, 2003). Lower scores indicate “more ethnocentric orientations and higher scores indicate more ethnorelative orientations”
(Hammer, Bennet, Wiseman, 2003, p. 440). In addition, “higher score indicate lower
levels of prejudice and discrimination against culturally different others, less resistance to
diversity initiatives...[and] decreased conflict and/or violence toward people from
different cultures” (Hammer, Bennet & Wiseman, 2003, p. 441).

The Intercultural Development Inventory (IDI) must be administered by a
qualified administrator of the instrument. To become a qualified administrator, a three
and half day training seminar, referred to as a “qualifying seminar” must be attended and

I will work with an aggregate of the data only to further avoid potential
interviewer bias (Creswell, 2014). Faculty may not as honestly answer questions on the
survey if their individual data is reviewed by me as we are peers within the college.
Faculty may fear their answers will be shared with their supervisors or I may use the
information in other situations that could affect their employment at the university.
Therefore, group data will be analyzed only.

The data sources that will be utilized in the qualitative phase are observation,
open ended questions, a semi-structured focus group, as well as my own reflexive
memos. Multiple data protocols will be used for validity purposes (Herr & Anderson,
2015). The first qualitative protocol was via observation of participants during the
workshops. Noting how participants reacted to the learning material through verbal
reactions and active participation in the workshops was included in the observation notes
(Herr & Anderson, 2015). All faculty development workshops were observed and noted.

Formative assessments were included during the workshops using
PollEverywhere and in the homework as open-ended questions in Survey Monkey, which
were designed to capture faculty understanding of the learning objectives and collect qualitative data in the form of reflection questions (see Appendix B). PollEverywhere and Survey Monkey were utilized for these questions as the responses could be collected anonymously. Anonymous response collection preserved validity by avoiding possible interviewer bias (Creswell, 2014).

In addition to the qualitative protocol in the form of reflection questions, a final questionnaire following the last workshop was deployed. At the conclusion of the workshops, participants were asked to answer several open-ended questions to reflect on their position in terms of power and privilege and how they have gained from them. The final protocol asked participants their thoughts about what they learned from the workshops. For example, questions asked participants (see Appendix F for full protocol):

1. Prior to the workshop series, did you think about power and privilege, unconscious bias, and/or stereotype representations? Please describe.
2. Did you uncover any unconscious bias during the workshop?
3. If you uncovered unconscious bias, will you work to disrupt it? How?
4. What were/are your thoughts before and after the workshops about power and privilege between the majority group in U.S. culture and minoritized groups in U.S. culture, particularly of Blacks and African Americans? Please describe.

Finally, participants were invited to participate in a semi-structured focus group the week following the last workshop. The focus group questions asked about how well the workshop content met the learning objectives and participant satisfaction with the
content (Appendix G). Five participants volunteered for the focus group representing the occupational therapy, physician assistant studies, health science, social work, and admissions departments.

Data Collection Methods

As indicated, this action research study is a convergent mixed-methods design combining both qualitative and quantitative data collection measures to answer the research questions. The collection method for the first research question will be quantitative, using the pre and post intercultural development inventory survey. Open-ended reflection questions on Survey Monkey collected qualitative data after each assignment that served as a test of understanding of the learning material. Survey Monkey was used as the collection platform because it allows for anonymous collection of responses. Anonymity served to avoid potential interviewer bias (Creswell, 2018). Table 3.2 indicates which data collection methods answered each specific research question.

The inservice workshop plan was designed to address two college student learning outcomes (SLO):

1. Identify multicultural approaches to healthcare delivery.

2. Evaluate determinants of health (race and class) and their effect on health inequity. These two SLOs form the base of cultural competence learning and were identified in initial discussions with six faculty members who indicated that they do not have experience with cultural competence curriculum or they do not have experience with cultural competence curriculum that focuses on unconscious bias, power, and privilege. In order for faculty to effectively address each SLO, they must have the
opportunity to first become more culturally competent and diversity aware and then learn
about the tools necessary to integrate learning material, activities, and assessments that
address both SLOs into their course designs.

Table 3.2 Data Collection Methods That Answer the Research Questions

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Data Collection Method</th>
<th>Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is the change effect of diversity workshops on faculty development of cultural competence?</td>
<td>Quantitative</td>
<td>Intercultural Development Inventory</td>
</tr>
<tr>
<td>2. How does uncovering one’s own implicit biases affect cultural competence development?</td>
<td>Qualitative</td>
<td>PollEverywhere questions</td>
</tr>
<tr>
<td>3. How does identifying one’s own power and privilege affect cultural competence development?</td>
<td>Qualitative</td>
<td>PollEverywhere questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Survey Monkey reflection questions</td>
</tr>
</tbody>
</table>

The inservice workshop curriculum is based on addressing racist paradigms.

Through recognition of power and privilege, unconscious bias and stereotype
representations, the workshops’ main goals are to increase cultural competence ability
that will allow faculty to better equip students to achieve the same.

**Workshop design.** Prior to the first virtual workshop session, faculty will be
asked to complete a homework assignment on identity construction. The purpose of this
assignment is to set the stage for the self-reflection process throughout the workshop
series. The worksheets for this homework are provided in appendix C. Learning
objectives for each synchronous workshop session will follow the pyramid model of
cultural competence (Deardorff, 2006) and the CRT framework (Ladson-Billings & Tate, 1995). The following learning objectives are planned:

Workshop 1 The following instructional objectives are included:

1. Define critical terms - cultural competence/diversity/race/stereotypes/unconscious bias/power/privilege/identity construction
2. Identify personal biases
3. Recognize own position in terms of power and privilege through critical consciousness.
4. Identify the value of cultural competence/diversity awareness in the healthcare environment and healthcare classroom

Workshop 2. The following instructional objectives are included:

1. Identify ways in which structural racism contributes to inequity in healthcare.
2. Reflect upon barriers that limit equity, and how those barriers may be better managed.
3. Identify complicity in structurally racist systems.

Workshop 3. The following instructional objectives are included:

1. Identify multicultural approaches to teaching healthcare.
2. Develop teaching strategies and tools to help students achieve the ability to be culturally competent/diversity aware healthcare providers.
3. Review curricula for biases.

Table 3.3 provides an overview of the learning objectives intersected with the pyramid model and CRT.
Table 3.3 *Inservice Workshop Objectives Aligned with the Pyramid Model and CRT*

<table>
<thead>
<tr>
<th>Learning Objective</th>
<th>Level on Pyramid Model</th>
<th>Critical Race Theory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define critical terms</td>
<td>Level One: be open to difference while withholding judgment; learners must be able to tolerate uncertainty</td>
<td>Race</td>
</tr>
<tr>
<td>Identify personal biases</td>
<td>Level two: knowledge and comprehension; skills</td>
<td>Storytelling</td>
</tr>
<tr>
<td>Recognize own power and privilege</td>
<td>Level three: desired internal outcome</td>
<td>Race</td>
</tr>
<tr>
<td>Identify the value of cultural competence/Diversity awareness</td>
<td>Level two: knowledge and comprehension; skills</td>
<td>Storytelling</td>
</tr>
<tr>
<td>Structural racism and inequity in healthcare</td>
<td>Level two: knowledge and comprehension; skills</td>
<td>Race</td>
</tr>
<tr>
<td>Complicity in structurally racist systems</td>
<td>Level three: desired internal outcome</td>
<td>Storytelling</td>
</tr>
<tr>
<td>Multicultural approaches to teaching healthcare</td>
<td>Level four: desired external outcome</td>
<td>Race</td>
</tr>
<tr>
<td>Teaching strategies for student learning</td>
<td>Level four: desired external outcome</td>
<td>Race</td>
</tr>
<tr>
<td>Encourage students to address personal biases</td>
<td>Level four: desired external outcome</td>
<td>Race</td>
</tr>
</tbody>
</table>

**Instructional strategies.** Instructional strategies during the workshops include direct learning, small group discussion and reflection, formative assessments, individual reflection, multimedia activities, reading and reflection, and group conversations. The synchronous workshops will include an opening sequence with direct learning that includes identification of learning goals, provides descriptions of facts and concepts, and will include a check of understanding using polling software. Other strategies will include small group discussions and full-group conversations. The asynchronous
material will include multimedia activities, reading journal articles or web material followed by formative assessment and reflection questions, and activities that guide self-reflection of identity construction.

**Data Analysis**

Both quantitative and qualitative data will be analyzed in this convergent mixed-methods design to determine the change effect of the inservice workshops on cultural competence ability.

**Quantitative measure.** Once both the pre and post data sets have been collected and cleaned for any missing data, the mean scores from the pre-intervention IDI and the post-intervention IDI will be entered into SPSS. Descriptive statistics will be determined first including mean, median, mode, and standard deviation. Next, a two-tailed paired sample t-test with a .05 significance level will be used to calculate any statistical significance in change of group mean scores. This test is appropriate because I will be looking for statistically significant change pre and post intervention in the same group, which is considered a paired sample (Effron & Ravid, 2013). This statistical operation was also chosen because of the non-directional nature of the research questions (Cho & Abe, 2013). Any significant change affect will be determined. The results will be written and provided to study participants if requested.

**Qualitative measures.** The data from all open-ended questionnaires will be transcribed and stored electronically in an encrypted file on the researcher’s laptop computer. The software program, NVivo, will be utilized to code the transcribed data. First, words or phrases will be selected from the responses to the open-ended questions and focus group transcript. Then, categories will be determined so patterns and themes
can be identified (Efron & Ravid, 2013). Interpretation of the qualitative data will assist with my understanding of the results of the quantitative data (Efron & Ravid, 2013).

**Trustworthiness and Rigor**

In qualitative studies, a process of verification is required to ensure validity (Creswell, 2014). Several validation procedures are commonly used in qualitative research, including researcher reflexivity “member checking, triangulation, thick description, peer reviews, and external audits” (Creswell & Miller, 2000, p. 124). The validation procedures employed in this study are triangulation, researcher reflexivity, and member checking (Creswell & Miller, 2000). Several steps will take place in the triangulation process. First, the data collected from all qualitative protocols will be converged in order to define the themes and categories (Creswell & Miller, 2000). The converged qualitative data will then be compared to the researcher’s observation notes to check for accuracy (Creswell, 2014). The focus group will also serve to validate my notes and understanding of qualitative protocol responses. Because this is an action research study, meaning I am an insider to the process, a reflective practice will be employed throughout the intervention and data collection process to improve trustworthiness (Herr & Anderson, 2015). I initially reflected on my personal beliefs and values surrounding the workshop constructs in chapter 1. Throughout the data collection process, I noted any biases and assumptions I made and recorded them in my observation notes.

The quantitative instrument has undergone rigorous validation and reliability testing that ensures trustworthiness of the data collected in that phase of the study. The themes and categories defined in the converged, qualitative data set will be compared to
the group results of the quantitative data set to further ensure validity through the triangulation process (Creswell & Miller, 2000).

The last validation procedure I employed is member checking. Member checking serves to review the study findings from the lens of the participants (Creswell & Miller, 2000). I emailed the themes and categories defined from the converged qualitative data and asked participants if they agree with them and if they make sense (Creswell & Miller, 2000). I include participants’ comments in chapter 4 of this dissertation.

Procedures and Research Plan

This action research study will take approximately two to three months to complete once Institutional Review Board (IRB) approval is granted. The time period includes the sending of the IDI pretest, workshop series, the IDI posttest and follow-up qualitative protocol, coding, analysis, and writing of the results. Table B1 in Appendix B provides the timeline for the process.

Summary

This action research study revolves around my practice as a faculty supervisor and my own goals as a faculty member by providing inservice workshops to build cultural competence skills. The workshops will be conducted and evaluated using a mixed-methods study design. A mixed-methods study collects both closed-ended (quantitative) and open-ended (qualitative) data as a response to the research questions. The two forms of data will be merged after sequential data collection occurs. Several steps will be taken to avoid validity threats because of my insider position to this study. The study will be conducted in three phases over the span of approximately two months.
The phases of the study include a two-part quantitative phase and one qualitative phase. The quantitative phase is included to measure the effectiveness of the intervention, i.e. the inservice workshops. The qualitative phase will employ data collection measures to capture the rich nature of the workshop curricula and how faculty may have experienced the material, which cannot be captured through the quantitative reduction to two variables.

Action research is a method of study to improve one’s own practice. As an insider to my research, several threats to validity must be addressed. These threats include researcher bias and power differentials. To mitigate the threats, several remedies have been employed. They include multiple forms of data collection, researcher reflexive memos, and multiple types of data collection.

Data collection will begin at the beginning of July after IRB approval is granted. The full data collection process, including both quantitative and qualitative measures, will be complete by July 30th. At that point, data analysis will be conducted. The full write-up of the study is estimated to be finished by the end of September.
CHAPTER 4

FINDINGS

The goal of this action research study was to fill the gap in cultural competence ability and diversity awareness of healthcare faculty. A new model was developed to guide the inservice training using the pyramid model of intercultural competence and critical race theory. A new model was justified because little is found in the literature that describes effective pedagogy on cultural competence and diversity awareness training. Cushman and colleagues (2015) describe the literature as including “specific knowledge, attitudes, and skills that promote cultural ‘competence’ [yet] fully defining this complex, multidimensional term, and implementing activities to enhance it, remains a challenge” (p. S132). This challenge is particularly acute in my college because the faculty are not diverse and have told me that they need cultural competence training in order to align their teaching with the college SLOs that comprise multicultural approaches to healthcare delivery and navigating health inequity of diverse populations.

The research questions guiding the study were:

4. What is the change effect of diversity workshops on faculty development of cultural competence?
5. How does uncovering one’s own implicit biases affect their cultural competence development

6. How does identifying one’s own power and privilege affect their cultural competence development?

To answer the research questions, a convergent mixed-methods approach was employed, as discussed in chapter three. The two types of data were collected in three sequential phases. Phase one included a quantitative measure to collect information about participants’ cultural competence ability. Phase two included qualitative protocols to gather data about the material covered in the synchronous and asynchronous inservice training. The first protocol was administered following the first asynchronous workshop session and second asynchronous homework material, the midpoint in the inservice training. The protocol focused on self-reflection abilities and acceptance of others. The second protocol was administered after the last asynchronous session. The questions asked participants about their experience during the workshop series with concepts of unconscious bias, power, and privilege. Questions also asked whether participants feel comfortable with teaching students the topics. Phase three included the post quantitative survey to measure any change in cultural competence ability of the participants. Phase three also included a focus group with a semi-structured, qualitative protocol that included a purposive sample of six of the 28 participants. The purpose of the focus group was to discuss and clarify what participants had learned and what training they still need. The interview questions also aimed to determine the parts of the workshops that worked well and parts that needed modification or elimination from the inservice training.
A total of 26 faculty and three staff signed up to participate in the study. Almost all of the departments in the college were represented: physician assistant studies (29%, n=7), physical therapy (3%, n=1), occupational therapy (21%, n=6), speech-language pathology (29%, n=8), public health (7%, n=2), and health science (7%, n=2). In addition, the director of graduate student affairs, the coordinator for the Center for Excellence and Innovation in Teaching, and a transfer admissions counselor for undergraduate admissions, who also serves as an adjunct faculty member in the College of Arts & Sciences, participated in the study. Eighty-one percent (n=23) of the participants reported being White, 6% (n=2) reported being Black or African American, 6% (n=2) reported being Asian, and 6% (n=2) indicated “other”. Fifty-two percent (n=15) of the participants hold doctoral level degrees, while 48% (14) hold master’s degrees. Thirty-eight percent (n=11) reported having participated in prior cultural competence training and 25% (n=7) of participants reported prior training in diversity and inclusion.

This chapter provides an overview of the findings of all three phases of data collection. A presentation of the data and discussion of the findings is described. Triangulation of the collected data and their meaning in relation to the research questions is discussed. Field notes and observations are also presented.

**Results of the Quantitative Pretest and Posttest**

As outlined in chapter three, participants were asked to complete the Intercultural Development Inventory (IDI) prior to participating in the inservice workshops and immediately after participating in the workshops. The IDI measures cultural competence ability based on a developmental continuum starting at a monocultural mindset to a
multicultural mindset. Hammer, Bennet and Wiseman (2003) state that a “higher score indicate[s] lower levels of prejudice and discrimination against culturally different others, less resistance to diversity initiatives…[and] decreased conflict and/or violence toward people from different cultures” (p. 441). Developmental levels (orientations) include denial, polarization, minimization, acceptance, and finally, adaptation where denial represents a state of prejudice and discrimination and adaptation represents an authentic multicultural mindset. Development along the continuum is typically in a linear fashion. Table 4.1 outlines the orientations and their descriptions.

**Table 4.1 IDI developmental orientations with descriptions at each level**

<table>
<thead>
<tr>
<th>Orientation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denial</td>
<td>Recognizes only superficial differences (clothing, food) and often avoids or withdraws from difference</td>
</tr>
<tr>
<td>Polarization</td>
<td>Difference is viewed judgmentally as “us” versus “them”. It can take on two forms: defense – an uncritical view of one’s own cultural values with a critical view of other cultural values, or reversal – a critical view of one’s own cultural values and an uncritical view of other’s cultural values.</td>
</tr>
<tr>
<td>Minimization</td>
<td>Focuses on commonalities of values and practices but may overlook important differences.</td>
</tr>
<tr>
<td>Acceptance</td>
<td>Recognizes and appreciates commonalities and differences in cultural values and practices of self and others.</td>
</tr>
<tr>
<td>Adaptation</td>
<td>Ability to shift cultural perspective and change behaviors in culturally appropriate and authentic ways.</td>
</tr>
</tbody>
</table>

**Pre-test results.** One hundred percent (n=29) of the participants attended the first synchronous workshop. Ninety-six percent (n=28) participated in workshops two and three, however, because only 55% (n=16) of the participants completed both the pre and post IDI, I reduced the data pool for the quantitative data to those participants who
completed both surveys. The mean score of the pre-test was 101.5 (SD=12.95), placing the group at the “minimization” developmental level. Seventy-five percent (n=12) of the group fell into the minimization orientation. Other participants scored in the polarization orientation, 12.5% (n=2) and in the acceptance orientation, 12.5% (n=2). Figure 4.1 provides a visual layout of participant IDI orientation scores.

**Figure 4.1.** Participant Pre-Test Orientations on the IDI.

Minimization is an orientation that focuses on commonalities of people and overlooks differences in “values, perceptions, and behaviors” (Pre-IDI Group Report). A minimization orientation often assumes that all groups are “like me” and applies one’s own values across groups. This type of relational style often overlooks important cultural differences or disregards diversity issues because they go unnoticed. The strength of this relational style is the minimizer recognizes that diverse groups are human and attempts to act in tolerant ways (Pre-IDI Group Report). Additionally, minimizers attempt to avoid stereotyping and biased behaviors by relating to everyone as an individual without attaching group labels (Pre-IDI Group Report). The main relational strategy of the
minimization orientation is to focus on commonalities when interacting with diverse others. Another term for this type of cultural competence ability is “color blind”.

The remaining group members fell below and above the minimization orientation. Twelve point five percent (n=2) scored at the polarization orientation and 12.5% (n=2) scored at the acceptance level. A polarization orientation is one that views groups as “us” versus “them” and is often judgmental either of their own group or judgmental of other groups. An acceptance orientation is one that both recognizes and appreciates differences within their own group and differences across groups. Because the majority of the group fell into the minimization category, I focused the workshop discussions of differences by emphasizing the importance of first recognizing differences and then celebrating differences between groups of people.

**Post-test results.** Following the last workshop, the participants were asked to complete the exact same IDI survey to measure cultural competence ability. The mean score of the same 16 participants was 102 (SD=16.41) placing the group mean at the minimization orientation. Sixty-two point five percent (n=10) of the group scored at the minimization orientation. The polarization orientation increased to 18.8% (n=3) of the group, while the acceptance orientation remained the same at 12.5% (n=2). Interestingly, 6.3% (n=1) of the group moved to the adaptation orientation that is a level of cultural competence ability defined by the ability to shift between diverse groups of people in authentic and culturally appropriate ways (Post-IDI Group Report). Table 4.2 shows individual orientations both pre and post-test. Figure 4.1 displays the calculated change in mean scores showing variation in individual participants. Fifty percent of the group (n=8) increased their cultural competence ability with a mean increase of 11.5 (SD=5.4),
while 50% (n=8) decreased their ability with a mean decrease of -10.5 (SD=7.5). Thirty-seven point five percent (n=6) of the participants moved forward to the next level orientation on the development continuum, while 25% (n=4) moved back an orientation on the development continuum.

Table 4.2 *Participant movement along the IDI development continuum.*

<table>
<thead>
<tr>
<th>Participant Number</th>
<th>Pre-test Orientation</th>
<th>Post-test Orientation</th>
<th>New Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moved Forward on Development Continuum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>polarization-reversal</td>
<td>minimization</td>
<td>X</td>
</tr>
<tr>
<td>2</td>
<td>minimization</td>
<td>minimization</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>polarization-reversal</td>
<td>minimization</td>
<td>X</td>
</tr>
<tr>
<td>7</td>
<td>acceptence</td>
<td>adaptation</td>
<td>X</td>
</tr>
<tr>
<td>11</td>
<td>acceptence</td>
<td>adaptation</td>
<td>X</td>
</tr>
<tr>
<td>12</td>
<td>cusp of acceptence</td>
<td>acceptence</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>minimization</td>
<td>acceptence</td>
<td>X</td>
</tr>
<tr>
<td>14</td>
<td>minimization</td>
<td>minimization</td>
<td></td>
</tr>
<tr>
<td>Moved Back on Development Continuum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>minimization</td>
<td>minimization</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>minimization</td>
<td>minimization</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>minimization</td>
<td>polarization-reversal</td>
<td>X</td>
</tr>
<tr>
<td>8</td>
<td>minimization</td>
<td>minimization</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>minimization</td>
<td>polarization-reversal</td>
<td>X</td>
</tr>
<tr>
<td>10</td>
<td>cusp of acceptence</td>
<td>minimization</td>
<td>X</td>
</tr>
<tr>
<td>13</td>
<td>minimization</td>
<td>polarization-reversal</td>
<td>X</td>
</tr>
<tr>
<td>16</td>
<td>minimization</td>
<td>minimization</td>
<td></td>
</tr>
</tbody>
</table>

**Paired t-test results.** A paired t-test was conducted using the software, R, to compare the cultural competence ability between the pre-test and post-test. The overall mean scores in the pre-test and post-test IDI were used in the analysis. Table 4.3 displays the results. Results indicated that there was not a statistically significant change in cultural competence ability between the pre and post-tests for the group \( t(28)=1.7, p=0.93 \) (two-tailed assuming unequal variance).
Because of the unequal variance in the two data sets (pre-test $S^2=167.7$, post-test $S^2=269.1$), I conducted a two-tailed Wilcoxon signed rank test for paired samples using the software, R. Figure 4.2 displays the difference in pre-test and post-test scores for each individual participant indicating significant movement between the pre-test and post-test. Table 4.4 shows individual score differences between the pre and post-test. Results of the Wilcoxon signed rank test indicated a statistically significant change in the median pre-test scores, Mdn = 102.7 to the median post-test scores, Mdn=98.6, Z=40, p<0.039.

Table 4.3 Paired T-test Results for Cultural Competence Ability Pre-test and Post-test.

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Group</th>
<th>Pre-test</th>
<th>Post-test</th>
<th>95% CI for Mean Difference</th>
<th>t</th>
<th>df</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pair</td>
<td></td>
<td>M=101.5</td>
<td>M=102</td>
<td>0.92</td>
<td>1.7</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SD=12.95</td>
<td>SD=14.0</td>
<td>2.05</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 4.2: Display of IDI scores pre and post-test highlighting variance
Table 4.4. *Individual score differences on the pre-test and post-test IDI.*

<table>
<thead>
<tr>
<th>Subject Number</th>
<th>Pre-test Score</th>
<th>Post-test Score</th>
<th>Difference in Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>83.68</td>
<td>88.18</td>
<td>4.5</td>
</tr>
<tr>
<td>2</td>
<td>89.93</td>
<td>96.02</td>
<td>6.09</td>
</tr>
<tr>
<td>3</td>
<td>71.69</td>
<td>95.5</td>
<td>23.81</td>
</tr>
<tr>
<td>4</td>
<td>101.59</td>
<td>98.39</td>
<td>-3.2</td>
</tr>
<tr>
<td>5</td>
<td>105.23</td>
<td>98.72</td>
<td>-6.51</td>
</tr>
<tr>
<td>6</td>
<td>91.42</td>
<td>84.79</td>
<td>-6.63</td>
</tr>
<tr>
<td>7</td>
<td>121.09</td>
<td>130.88</td>
<td>9.79</td>
</tr>
<tr>
<td>8</td>
<td>110.16</td>
<td>102.9</td>
<td>-7.26</td>
</tr>
<tr>
<td>9</td>
<td>95.46</td>
<td>81.26</td>
<td>-14.2</td>
</tr>
<tr>
<td>10</td>
<td>114.73</td>
<td>110.88</td>
<td>-3.85</td>
</tr>
<tr>
<td>11</td>
<td>117</td>
<td>127.79</td>
<td>10.79</td>
</tr>
<tr>
<td>12</td>
<td>112.04</td>
<td>124.93</td>
<td>12.89</td>
</tr>
<tr>
<td>13</td>
<td>106.42</td>
<td>79.14</td>
<td>-27.28</td>
</tr>
<tr>
<td>14</td>
<td>98.21</td>
<td>111.14</td>
<td>12.93</td>
</tr>
<tr>
<td>15</td>
<td>102.01</td>
<td>113.04</td>
<td>11.03</td>
</tr>
<tr>
<td>16</td>
<td>103.35</td>
<td>88.36</td>
<td>-14.99</td>
</tr>
</tbody>
</table>

**M(SD)** 101.5(12.9) 102(16.4)

**Summary of Quantitative Results**

Results of the pre-test and post-test IDI indicate significant movement on the IDI developmental continuum following the inservice workshops. Analyzing the median scores using the Wilcoxon signed rank test identified a significant difference in scores. The variance in direction can be explained in two ways. The information in the workshops may have influenced direction or the initial orientation of minimization of most participants may have been influential. There were no correlations found between gender, race, or previous experience with cultural competence or diversity training and test scores.

The workshop material included difficult topics including individual racism, structural and systemic racism, legacies of slavery, power, privilege and unconscious
bias. The topics were presented through storytelling as prescribed by critical race theory in an effort to make the most impact with participants. Participants were also asked to engage in the material by testing their own power and privilege and unconscious bias. New insights about the self or the embedded racism that still exists in U.S. society may have become more salient with participants when they completed the post-IDI.

People who relate to difference within the minimization category employ strategies that focus on commonalities between people. Focus on commonalities, or being colorblind, overlooks differences that are important to others. Aiming the workshop material on recognition of differences may have disrupted the minimizer strategy and allowed for a new perspective on difference. The participants who fell back on the developmental continuum landed on the polarization orientation in the reversal category. Those in the polarization-reversal orientation have a tendency to be more critical of their own cultural group and more positive toward the “other”. The workshop material may have forced these participants to realize the differences they were avoiding were critical to others and caused by their own majority group.

The qualitative data results dig deeper into the richness of the participants’ experience. The following section describes the results of the qualitative protocols.

**Qualitative Results**

Qualitative data were collected at three separate points in this study. The first set of open-ended questions was deployed after the first synchronous session and second asynchronous homework period using Survey Monkey. Questions asked respondents to be self-reflective of their openness to others, their active reflection processes, and any experiences that may influence their views of others. The second set of open-ended
questions was deployed using Survey Monkey at the end of the inservice workshop series. The questions asked participants about their experience with concepts of bias, power, and privilege during the workshops and if they feel comfortable teaching students the concepts. The third set of open-ended questions were asked in a focus group on Zoom one week following the end of the workshop series. Questions asked participants to reflect on their learning and provide a critique of the workshop learning material.

Techniques described by Ryan and Bernard (2003) to identify themes in the data were used. I reviewed the data by looking for repetition, similarities and differences, and noting what was missing. Using the repetition technique, I looked for phrases and ideas that were recurrent. I then analyzed the recurrent ideas for possible relationships (Ryan & Bernard, 2003). I also attempted to identify relationships through the process of analyzing pairs of text from both the same participants and different participants and asking how the expressed ideas were similar or different (Ryan & Bernard, 2003). Asking myself how similar the idea was to my own experience helped relationships to emerge (Ryan & Bernard, 2003). Once I identified relationships, I charted them under categories in a Word table. I then identified themes by reviewing and comparing the categorized relationships.

Noting what was missing in participant responses was the most difficult technique yet the most illuminating. Ryan & Bernard (2003) suggest this technique is useful for hard to discuss topics as participants may be avoiding a discussion of topics they do not know how to discuss. For example, during the workshop series difficult topics such as racism, complicity in a racist system, and unconscious bias, were repeatedly discussed. None of the qualitative data included mention of participants’ complicity in a racist
system, yet to be White means you have been complicit in racist systems whether you realize it or not (Jones, 2000; Oluo, 2019). Eighty-one percent (n=23) of the participants were White.

Finally, I looked for connections between the themes and the theoretical framework using the levels of the pyramid model of intercultural competence and critical race theory. As described in chapter one, critical race theory provides a racial consciousness approach to understanding structural inequity and racism in the United States. The pyramid model of intercultural competence includes four levels of competency. At the base of the model, the requisite attitudes set the stage for learning how to be culturally competent. Learners must have respect, be open to difference while withholding judgment, and learners must be able to tolerate uncertainty (Deardorff, 2006). The other three levels are:

- Level two: Knowledge and Comprehension; Skills (to listen, observe, and interpret and to analyze, evaluate, and relate)
- Level three: Desired Internal Outcome (adaptability to different communication styles & behaviors; flexibility (appropriate communication styles/behaviors & cognitive flexibility); ethnorelative view; empathy
- Level four: Desired External Outcome (behaving/communicating effectively & appropriately)

The goal of the workshops was for participants to reach level three on the model by adopting a flexible view of others and showing empathy.
Self-Reflection Question Results

In line with the requisite attitudes at the base of the pyramid model of intercultural competence (respect, open to difference while withholding judgment, and tolerance of uncertainty) (Deardorff, 2006), the workshop series began with an introspective exercise that asked participants to map out their own dimensions of diversity in a self-reflective process. The first synchronous session began with a question asking participants what they thought of when they heard the term “cultural competence”. The purpose of the question was for my own understanding of how participants define cultural competence and where the responses fit on the pyramid model. The question was posed using Polleverywhere.com. Participants were able to respond either by text using their cell phones or directly on the Polleverywhere website. Figure 4.3 displays the word cloud made with the responses entered. Participants submitted a variety of words with overlapping perceptions, such as understanding, respect, acceptance, awareness, and others. Several participants focused on self-awareness or self-assessment, other terms included respect, open, tolerance, which are all part of the requisite attitudes on the first level of the pyramid model.

*Figure 4.3: Word cloud representing participants’ thoughts of cultural competence.*
The workshop continued focusing on the idea of self-awareness, self-reflection, and knowledge about our own cultural dimensions. After the first workshop, participants were asked to complete self-reflection exercises, including an implicit association test, which uncovers unconscious bias, then, read and view stories of two people becoming racially conscious. Participants were then asked to respond, as thoughtfully as possible, to open-ended self-reflection questions adapted from Deardorff (2009).

Ninety-six percent (n=28) of the participants responded to the questions. The data was coded and then categorized in order to identify relational themes (Saldaña, 2013). Four separate themes emerged from the categorized codes: lived experience, skill development, feeling unskilled, and minimization. The themes corresponded with the first and second levels of the pyramid model of intercultural competence.

**Lived experience.** Participants consistently reported several types of lived experience of racism, discrimination, or difference relative to reflecting on interactions with others. Experiences included feelings of anger over witnessing discrimination, or experiencing microaggressions or racism personally. Participants also equated their backgrounds of diversity or homogeneity with influencing their ability to interact with others. One participant commented that:

As a young child I was met with a great deal of antisemitism. We were a[n] observant Jewish family living in a town where there were only a handful of Jews. It shaped my view of others. I believed it was important to always view others as equals. Although I did not look different, the sting of being called a cheap Jew by a 5th grade boy who taunted me left a mark. I always treated all cultures and races with respect.
Another participant commented that he or she was exposed to “covert discrimination” while another commented that, “As a person of color, I’ve experienced many micro-aggressions from people throughout my life.” One participant was greatly influenced by experiences of discrimination describing:

I was born to a family of Holocaust survivors, grew up under Soviet regime and have been discriminated against in some form or shape most of my life. I have also interacted with many people who were Christians, Muslims, Beduins, Druz, Native Canadians, African Americans, Latino, etc. Some of these people have become my dear friends. All of the above has influenced how I view others.

Participants who reported more homogenous backgrounds stated that they worked to be more multicultural or have more multicultural experiences in order to understand others. Experiences included travel, working at clinics in inner-city neighborhoods, or focusing on multicultural studies in graduate school. One hundred percent (n=28) of the participants who answered this series of reflection questions reported that their experiences made them “slightly open” to “extremely open” to diverse populations of people. One participant describes her experience:

This started for me in college - which was the first time I really interacted with more diverse people. I grew up in a town that is essentially 98% white, middle to upper class, and primarily Christian-based faith. I did not really know or interact with many people of color before the age of 18. My college job specifically looked to hire college students from diverse backgrounds. I was one of very few white people on the staff - it was the first time I realized how wrong my parent’s views were!
Openness and lived experiences of the participants corresponds to levels one and two on the pyramid of intercultural competence. Openness (level one) is a prerequisite attitude required to develop cultural competence skills for successful interactions with others who have different life experiences. Lived experiences corresponds to self-awareness and learning about the self on the second level of the pyramid model.

**Skill development.** A common sentiment of participants was a desire to learn more about diversity with respect to power, privilege, and unconscious bias, as well as, learn about others different from them. One participant noted, “I feel like I have so much more to learn.” Other responses ranged from making a conscious effort to learn and reflecting on conversations with diverse others to having a curiousness about others in order to disrupt racism and discrimination. A participant reflected on her need to learn more:

I consistently try to listen more than I talk about the experience of others from different cultures. I want to learn. I want to be immersed. I was immersed in the [African American] culture for many years and now the Latino culture due to my second husband, his family in Peru and my children go to a bi-lingual Spanish/English school. I consider these things the blessings in my life. However, there is more to learn. I can see that I still have power and privilege in these relationships because I am white and I think my white privilege will always be there. But..... I can use it to prevent others needs from being ignored and to prevent racism.

Expressions of openness and curiosity fall on the first level of the pyramid model amongst the requisite attitudes. Skill development also corresponds to the second level
under listen, observe, interpret and analyze, evaluate, and relate. Figure 4.5 provides a visual representation of the themes and corresponding levels on the pyramid model. These skills are necessary in order to have successful interactions with others.

*Figure 4.5: Themes with corresponding pyramid of intercultural competence level.*

**Feeling unskilled.** Not all of the participants expressed confidence in the skills necessary to navigate diversity (29%, n=8). The theme of feeling unskilled emerged as an expression of concern. For example, one participant said he or she reflects but “primarily on a personal inability to engage in conversations on differences.” Another stated that he or she has, “limited confidence and [a] tendency to question myself [that] results in my reflecting on my interactions with all individuals from similar and diverse backgrounds.” Several participants noted their lack of confidence comes from an uneasiness over power and privilege:

I feel like I wait for direction from others, so I guess I put the burden of my response on the other. I am only becoming aware of the power/privilege I hold
as a white person during individual interactions (but was always aware of
privilege of whiteness at the societal level).

A lack of confidence in diversity skills, or feelings of being unskilled, represent the
minimization orientation on the IDI. As stated earlier in this chapter, the minimizer
orientation tends to focus on commonalities amongst groups as a strategy to relating. The
workshop material on power and privilege may have evoked a feeling of lack of
confidence by focusing perceptions toward differences in groups. In fact, the
minimization theme emerged clearly.

**Minimization.** It is not surprising that the theme of minimization emerged so
clearly in the data because the majority of the participants scored on the IDI development
continuum on minimization. The strength of the minimization orientation is that
minimizers view everyone as equal and minimizers attempt to behave in very tolerant
ways. The area of growth that is most acute is the fact that their attempts to act in very
tolerant ways and view all groups as equal may in fact cause discriminatory behaviors.
This is due to overlooking differences that are very important to others. Several
participants stated that they “treat everyone the same” or “try to treat everyone the same”.
Treating everyone the same does not acknowledge inequities minoritized people face,
however. Equality may be causing more inequity by overlooking important differences.
Other participants confirmed their minimization orientation by stating that, “all are
equal”. While minimizers often have the best of intentions, being color blind causes
more harm than good. Workshop two and the asynchronous homework assigned focused
on these paradigms.
End of Workshop Reflection Questions and Focus Group

Questions asking participants to reflect on what they learned during the inservice workshop series were deployed following the last synchronous workshop session. Two questions were yes/no answer questions asking if participants uncovered unconscious bias and if they were previously aware of the prevalence of unconscious bias in healthcare providers and healthcare practitioners. Four questions asked participants to reflect on bias, power, and privilege. One question asked if participants plan to teach students what they learned in the workshops. Eighty-nine percent (n=25) of the participants answered the questions.

The focus group was conducted immediately following the final synchronous workshop. Participants comprised a purposive sample representing several programs in the college, as well as transfer admissions, and the Center for Excellence and Innovation in Learning. Participants represented Health Science, Occupational Therapy, and the Physician Assistant Studies programs. The session was semi-structured: I asked participants to discuss what they thought about the workshop content, if they learned about the workshop constructs, and what recommendations they had for the future. The focus group took place over Zoom and was recorded with all participants’ agreeing to be recorded. Two volunteers with transcription experience separately transcribed the recording. Focus group themes confirmed themes in the end of reflection questions and are noted throughout this section.

Sixty-four percent (n=16) of the participants admitted to uncovering unconscious bias during the workshop series, while 84% (n=21) that they were previously aware of the prevalence of unconscious bias, power, and privilege issues in the healthcare industry.
and practitioners prior to the workshops. The participants who were aware of these issues reported learning about them from working in the field or during their graduate work, while a minority of the participants indicated learning about the concepts after the murder of George Floyd. Despite having previous knowledge, participants noted that they learned more about themselves. One participant wrote, “I have thought about unconscious bias and stereotype representations, but believe that these workshop[s] helped me recognize more about myself and my own personal bias.”

After coding and categorizing the data from the five open-ended questions, themes clearly emerged. Themes of disruption, new perspectives, and teaching related most to participants’ responses. The themes corresponded with the second and third levels of the pyramid model for intercultural competence. The themes also provided confirmation for the backwards trend on the IDI development continuum.

**Disruption.** The theme of disruption manifested in a few ways in the data. Participants noted that they wanted to interrupt personal unconscious bias as well as interrupt racist behaviors they may witness. A participant described one strategy:

> I have become more aware of what my unconscious biases are and now think about things in a different way. By facilitating conversations and sharing these biases is one way to disrupt them. Also, I plan to continue participating in faculty training workshops.

Some participants indicated they need to learn more and will continue to work to understand others. One participant described:

> [I need to] learn more about my biases. Learn more about my ‘Whiteness’. I know my upbringing shaped me differently from people around me. I am now
more acutely aware of dimensions that shaped me, and I need to use this awareness more as [I] interact to understand others.

The disruption theme also serves to show participants’ realization that treating all groups equally can cause more harm than good. One of the participants’ explained the realization,

In the Harvard study [implicit bias study], I was made aware that I had [a] slight bias towards white persons. I was immediately horrified. I try to be a good person, and treat everyone equally. I understand that understanding the social construct of race is more complicated than that, given the history/current state of inequality.

Yet another participant said, “I thought I was supposed to say ‘It doesn't matter what color we are, we are all equal.’ I needed someone to tell me that we aren't supposed to be colorblind.” Another participant stated, “In the past I was purposefully color blind… color blindness doesn’t cut it anymore.” The desire to disrupt previous ways of thinking and newly realized biases represents levels 2 and 3 on the pyramid model. Disrupting undesirable thoughts and behaviors corresponds to self-awareness (level 2) and flexibility (level 3). These realizations led to new perspectives of relating to diversity.

**New perspectives.** The new perspectives theme included a change in participants’ perspectives on the plight of African Americans, unconscious bias, power, and privilege. Participants also showed empathy in responses. One response suggested, “Now I’ve learned about redlining and all kinds of systemic racism. After the workshop, I’m feeling like I could act in different ways to change the balance of power and privilege. Use my voice more.”
Similarly, another participant noted:

“Before [the workshops]: Did not have a historical understanding of the severe oppression faced by African Americans in the US. Post [workshops]: An appreciation for the obstacles that African Americans have had to overcome, and knowledge of the persisting racism that exists.

More simply, an additional participant said, “Eye opening. I have a better understanding of perspectives.” Further, participants admitted they did not have a complete understanding of systemic racism prior to the workshops, but believe they have a better understanding of it after the workshops. Other participants noted they did not realize how pervasive unconscious bias and racism is in the U.S. One participant empathized, “Over the last several weeks I developed more anger and discomfort about the way AAs have been treated in this country. I became more aware of White power and privilege.”

Focus group responses confirmed the theme. All participants stated they learned a lot about themselves and gained a deeper knowledge and understanding of cultural competence and diversity awareness. One participant share:

I feel good about what I learned. I feel more aware and I’ve had conversations at dinner with my husband – interesting conversations. Just today I was reading something and I said ‘that’s code switching!’ The workshop has definitely made me much more comfortable talking about it – to have a conversation. You’re right. It’s a learning process.

The new perspectives correspond to the second level of the pyramid model surrounding a deep understanding and knowledge of culture (including contexts, role and impact of culture and others’ world views). This theme also connects directly to the third
level of the pyramid related to ethnorelative views. Participants’ responses show their new perspective views others relative to their own individual culture and not through their own cultural perceptions. Figure 4.6 provides a visual representation. Participants identified that differences are important. One participant emphasized the ethnorelativism perspective and new empathy for others:

As a white person, I did not recognize how easy I have it compared with Blacks and African Americans. My eyes were opened by the reality of the challenges that all Black and African American people face everyday - they are automatically at a disadvantage due to their skin color, despite the fact that they may have the same qualifications as a white person. It remains a constant struggle for them, yet as a white person this is something I have not had to ever think about.

Another participant continued:

I have a greater understanding of white privilege and how being a white person gave me advantages that I did not even realize. I have taken these things for granted. I have more understanding of basic life challenges from a black person's perspective (based on the videos we watched).

Despite this new ethnorelative and empathic perspective, some participants expressed concern about offending others or expressed a lack of confidence in teaching students because participants do not feel they are an “expert” in the field. Others expressed different ways in which they will incorporate material into their pedagogical practice.
Figure 4.6: Themes with corresponding pyramid of intercultural competence level.

**Teaching.** The theme of teaching included various methods of incorporating participants’ new knowledge and perspectives into their teaching. Several participants mentioned using the workshop material with students. Others suggested using examples from their own experience and sharing stories. One participant said, “I will include more case studies in my courses that represent people of minoritized groups and be sure to highlight the medical issues and challenges they encounter in healthcare.” Others explained that they plan to discuss as a department incorporating teaching materials into classes across the curriculum. Another participant said, “I am going to revisit my training modules and materials to make sure I capture power and privilege.”

Although participants believed they will teach students about power, privilege, and unconscious bias and named several methods of doing so, the expressed reticence in teaching was strong. Sixty-four percent (n=18) felt they are not ready to teach others yet. The focus group participants confirmed that more content and more time is needed to
build skills and ability to teach the constructs related to cultural competence and diversity awareness. The participants who indicated they felt confident (36%, n=10) also acknowledged they had already been teaching the concepts in classes.

When probed, focus group participants explained that they learned a great deal of information from the workshop material. Learning objectives were met; they learned a lot about themselves and gained a deeper knowledge of cultural competence and diversity awareness. However, they all suggested that more content and more time is needed to build skills and ability to teach the constructs related to diversity awareness and cultural competence. When probed even further, participants shared, “There was terrific material for expanding knowledge, but for increasing skills and ability, I need more.” Another participant agreed, “The content made me want to learn more.” The conversation confirmed further:

I certainly learned so much about myself to continue on this journey to learn about race and ethnicity. I’ve had a lot of great conversations, but I don’t feel confident teaching this to others at this point. Can I adapt what I learned here to dermatology principles of medicine? Let’s look at derm lesions of multiple races of people, I can do that. But I’d rather an expert teach about cultural competency.

I’m not there yet.

This conversation confirms the analysis of the end of workshop reflection data. Participants are reticent about teaching about racism, unconscious bias, power, and privilege. They do not feel skilled enough at this stage.
Another participant confirmed and added:

Can I add something? I still don’t feel confident teaching students this specific content but the workshop made me feel more confident sharing with students where I am in the process of learning and that it’s ok not to know everything about it if you’re willing to learn, which I think a lot of our students need to hear especially when they say things like ‘I don’t want to offend anyone’”

The participants indicated they believe it will take a long time to learn to teach others this content. It is a process of learning and continued development that requires intentional practice. One participant explained her journey:

Cultural competence was my dissertation too and I teach it to students. Even now with the IDI, and I’m an administrator, I wonder when am I going to get to the top level? How long is it going to take? I just want that A!

The focus group participants confirmed the results of the qualitative data analysis that participants learned a wealth of new knowledge about unconscious bias, power, privilege, and racism and expanded their understanding of the concepts. Participants improved their awareness of their own position of power and privilege. Despite this increase in knowledge and skill, participants did not feel they became skilled sufficiently to teach students. Continued development is desired.

Although participants reached anticipated levels on the pyramid model, confidence in teaching the material was not realized. Confidence in teaching requires more time and more learning material. With continued inservice training, participants may learn to feel confident in teaching the material and reach the corresponding pyramid level – level four, desired external outcome: Behaving and communicating effectively
and appropriately (based on one’s intercultural knowledge, skills and attitudes) to achieve one’s goals to some degree (Deardorff, 2006, 2009). Figure 4.7 identifies the levels attained on the pyramid model at the midpoint in the workshop series and at the end of the workshop series in a side-by-side view, along with the fourth level that requires additional training.

Figure 4.7. Levels attained on the pyramid model at the midpoint in the workshop series (left) and at the end of the workshop series (right). Level 4 (circled) requires additional time and training opportunities.

Triangulation

The convergent mixed model design of this study served to triangulate the data for validity purposes. The quantitative and qualitative data represent an illustration of the change effect of the inservice cultural competence workshops. The change effect in the participants represented significant variance with 50% (n=16) moving forward on the developmental continuum and 50% (n=16) moving back on the development continuum on the quantitative measure. The qualitative data suggests an explanation in the variance. The minimization strategies employed by the majority of the participants (75%, n=12) were disrupted during the inservice workshops. Those participants who moved back to
the polarization-reversal orientation were most likely affected by the workshop material in a way that alarmed them. They became critical of their own in-group and more positive of others as a response to learning the history and continuation of marginalization of Blacks and African Americans by White supremacist systems. Participants who moved forward on the continuum moved toward using strategies that identify difference and use the information in positive ways.

It is difficult to discern or probe the reasons further due to the requirement that I anonymize the qualitative data collection. I was limited to analyzing the data in aggregate; however, themes that emerged did provide a robust description and confirmation of the quantitative results. The minimization theme confirmed the results of the pre-IDI and the themes of disruption, new perspectives, and teaching indicate participants had become aware of strategies to minimize difference. The focus group participants confirmed that they learned new information and had a deeper understanding of differences in others after participating in the workshops. A disruption of minimization strategies requires a deep understanding of difference. For example, one focus group participant described being able to have conversations about racism, power, and privilege following workshop participation, while one participant described feeling more comfortable with her ability to understand racism, power, and privilege, but not in the skills she has to share the knowledge.

Participants indicated that they did not have a deep understanding of cultural competence, nor of constructs surrounding unconscious bias, power, and privilege. They described a lack of knowledge and ability to discuss “others” and racism. I designed
inservice workshops to discover whether employing the aforementioned constructs would find a change effect in cultural competence ability.

Results of the quantitative measure indicated a significant change effect occurred following workshop participation. Qualitative data results provided more robust information about that change effect. Uncovering unconscious bias and learning about power and privilege proved catalysts of cultural competence movement. Because of the minimization orientation of the majority of the participants, variance in the direction of the change resulted. Participants indicated their previous minimization strategies of viewing everyone the same were no longer viewed as effective. Participants described having their “eyes opened”. They also acknowledged learning about “systemic racism”, “institutional racism”, “how hard it is for Blacks and African Americans to get ahead”, and an understanding of the “history”. Minimizers who moved back on the continuum likely realized their minimization strategies do not work, but did not learn a sufficient amount in the workshops to adopt new strategies.

Summary

The goal of this action research study was to fill the gap in cultural competence ability and diversity awareness of healthcare faculty. A new model was developed to guide the inservice training using the pyramid model of intercultural competence and critical race theory. Three types of data collection were utilized to answer the research questions. The quantitative measure was administered both pre and post-workshop. The qualitative measures were administered at the midpoint in the workshop series and immediately following the end of the workshop series. A focus group was convened immediately following the last workshop.
The goals of the workshop series were to increase faculty cultural competence ability and increase their capabilities in teaching students cultural competence skills. Although the teaching goal was not achieved en masse, increasing cultural competence ability was. Minimization strategies were disrupted. Participants acknowledged they discovered difference is important; being colorblind can result in discriminatory behaviors. Participants identified new knowledge was obtained and acknowledged a deeper understanding of diversity was gained. Even participants who did indicate confidence in teaching the material (36%, n=10), indicated a desire to learn more. As one participant suggested, “it’s a work in progress”.
CHAPTER 5

IMPLICATIONS AND RECOMMENDATIONS

This action research study was derived from a critical social justice issue affecting
the health of Black and African Americans. The covid-19 pandemic emphasized the
huge gap in health outcomes for this population of people. Black and African Americans
experienced a rate of mortality that far surpassed their make-up of the U.S. population.
The murder of George Floyd then underscored the cause: individual and institutional
racism. Both types of racism in the healthcare system have long contributed to the
disparity in health outcomes of minoritized populations. This study attempted to
contribute to the mitigation of this disparity by training healthcare faculty to be more
culturally competent and diversity aware.

Lack of culturally competent healthcare providers, biases in individual healthcare
providers and healthcare systems, further the increases in health disparities and inequity
for racial minorities (Schafer, et al., 2019; LaVeist & Isaac, 2013). This study focused on
unconscious bias, power, privilege of healthcare providers placing race at the center of
the training. Inservice workshops were developed for the faculty of the college of health
professions at the medium-sized, private university in which I am a faculty member and
director of health science and global health.

Informal discussions with faculty at the college identified a lack of proficiency in
cultural competence and diversity awareness. Faculty identified that they were not aware
of the rampant individual and structural racism in healthcare caused by unconscious bias, power, and privilege. Faculty cannot be expected to teach students these critical constructs without receiving appropriate training to do so. A lack of proficiency in faculty and students perpetuates the disparity in health outcomes for minoritized populations (Hall et al., 2015).

The problem of practice I addressed in this research study is the gap in knowledge of cultural competence and diversity awareness in the healthcare faculty at my college. I focused on training through inservice workshops to fill the gap. The workshop material included racism in healthcare, practitioner privilege, power, and unconscious bias and stereotype representations framed by the intersection of the pyramid model of cultural competence and critical race theory. Critical race theory places race at the forefront of the research being conducted while using a storytelling approach as a guide. The pyramid model of cultural competence scaffolds the learning of cultural competence into requisite mindsets required for learning outcome mastery.

Current models of cultural competence in healthcare provide a stepping-stone for cultural competence education; however, there exists a large gap in their criteria for growth. The constructs of unconscious bias, power and privilege are either incomplete or lacking all together (Gorski, 2016). In order to achieve truly effective cultural competence to mitigate current disparities in health outcomes for minoritized patients, healthcare providers and educators must recognize their implicit biases, stereotype representations, and understand the nature of power and privilege that has long been held within the U.S. healthcare system race (Dennis, Gold, & Wen, 2019; Gordon et al., 2016; Kennedy, 2009; Smedley, 2019).
The aim of this study was to determine if focusing on power, privilege, unconscious bias and stereotype representations in cultural competence inservice workshops would result in the growth of cultural competence ability in healthcare faculty. The research questions guiding this study were the following:

4. What is the change effect of diversity workshops on faculty development of cultural competence?

5. How does uncovering one’s own implicit biases affect their cultural competence development?

6. How does identifying one’s own power and privilege affect their cultural competence development?

The first research question was answered with the quantitative data results. The results showed a significant change between the pre and post-test median scores. The non-parametric Wilcoxon sign ranked test was used because of the variance in mean scores in the pre-test and post-test survey. The variance in direction of the post-test mean score can be explained in two ways. The information in the workshops may have influenced direction or the initial orientation score of minimization of the majority of participants (75%, n=12) may have been influential. It is likely that both the workshop information and the minimization orientation of the majority of the participants influenced score direction. The qualitative data results confirm the salience of the workshop material in participant responses. Participants indicated they uncovered unconscious biases they did not know they held and indicated a desire to disrupt the biases. Participants noted how much they learned about the marginalization of Blacks and African Americans that continues in U.S. culture and the systemic white privilege
and power constructs that prevail. Participants also indicated they wanted/needed to learn more in order to teach students cultural competence skills.

More complex triangulation of the data was limited because I was required to collect the responses to the qualitative data anonymously. I was able to compare qualitative results to quantitative results in aggregate. I could confirm the quantitative data results; however, I could not definitively describe why there was such a variance in pre and post-test scores. Another study limitation was that only 57% (n=16) of participants completed both the pre and post-test quantitative instrument. I do not know if results of the quantitative data would have changed significantly had all 28 participants completed it. The indications from the qualitative data suggest that is not the case as one theme that emerged from the 28 participants was minimization.

The second research question, how does uncovering one’s own implicit biases affect their cultural competence development, was answered with the qualitative data. Sixty-four percent (n=16) of the participants recognized unconscious bias during the workshops. Uncovering the bias affected cultural competence ability by disrupting previously used strategies for navigating relationships with diversity mainly employed by those within the minimization orientation.

As discussed in chapter four, minimization is an orientation focused on commonalities between groups. Minimizers use a colorblind strategy by treating everyone “equally”, which they do not realize overlooks important differences. By disrupting this strategy in the workshops, participants significantly changed their cultural competence scores. Participants who moved forward on the cultural competence continuum were likely able to work toward new strategies of relating to others, while
those participants who moved back on the continuum were likely not able to do so. Byrne and Tanesini (2015) posit that healthcare professionals must make explicit efforts to change discriminatory behaviors as a result of their implicit bias. The study participants uncovered unconscious bias but also stated they were concerned about the “perception of others” or “offending” others. Once the bias was uncovered, minimization strategies were disrupted. Recognition of biases and power and privilege experiences is the first step toward achieving cultural competence. As indicated in the skill development theme, participants signified a desire to learn more about diversity in terms of power, privilege, and unconscious bias. Within the disruption theme, participants stated a desire to interrupt personal biases as well as racist behaviors.

The third research question, how does identifying one’s own power and privilege affect cultural competence development, was also answered by the qualitative data. The theme, new perspectives, shows that participants identified learning more about power and privilege and the advantages white privilege affords them. Participants expressed reticence about this knowledge. They felt an “expert” was required to teach students about these constructs. Gordon et al. (2016) found that when race and racism are not part of the program curriculum faculty do not have skills to navigate discussions about race and racism. The issue may be that skills can only develop through repeated exposure to discussions on race and racism with intentional training on how to guide classroom discussions. The workshop only briefly touched on that. A common theme throughout all of the collected qualitative data was a desire to learn more.

As stated in chapter one, there is a profusion of literature outlining the need for healthcare practitioners to recognize and incorporate patient differences in care, however,
there is a dearth of literature about how to do that. The following section provides an action plan for developing skills to not only advance cultural competence and diversity awareness skills, but also teach healthcare students to be culturally competent and diversity aware in their future practice.

**Action Plan**

Health education in the U.S. requires a new model of cultural competency with a race centered approach. Healthcare inequities surround race and racism; therefore, placing race at the center of the model is justified. This section outlines a possible action plan based on a new model approach that supports a continuing education strategy. Actions are aligned with the levels on the pyramid model of intercultural competence; however, I have renamed the levels to correspond with learner experience in cultural competence and diversity awareness training and provide learning strategies that correspond. The new levels include, Novice – Beginner; Advanced Beginner – Intermediate; Advanced-Intermediate – Semi-advanced; Advanced – Expert.

**Level 1 novice - beginner.** This level includes the requisite attitudes for cultural competence. Deardorff (2006, 2009) suggests a mindset of respect (valuing other cultures and cultural diversity), curiosity (tolerating ambiguity and uncertainty), and openness (withholding judgement). The study data confirm this mindset. Participants reported an openness and curiosity to learn more when answering the mid-study reflection questions.

*Requisite learning strategies.*

- Examine your own perspectives. What has shaped your cultural views and values?
- Complete the Dimensions of Diversity exercise.

- Read material about the dominant culture in which you live. Are you a member of the dominant culture? If yes, how does that shape your perspective? If no, how are you different from the dominant culture? What has most shaped your views?

- Challenge yourself to try new things if you do not have much experience with other cultures.
  - Dine at an ethnic restaurant.
  - Read travel books.
  - If possible, travel to other places not just as a tourist but also as a learner seeking to acquire new perspectives.

**Level 2 advanced beginner – intermediate.** The second level on the model includes knowledge and comprehension with sublevel actions indexed under *Skills*. The skills include listen, observe, and interpret; and analyze, evaluate, and relate. Deardorff (2006, 2009) suggests these skills are necessary in order to gain cultural self-awareness; a deep understanding and knowledge of culture; culture-specific information; and sociolinguistic awareness. This aligns with the findings from both the self-reflection and end of study protocols. Analysis shows that participants gained a self-awareness through the discovery of unconscious biases they held; new knowledge of the history of the African American culture; identified perspectives determined by their upbringing and/or lived experiences of discrimination or homogenous background. The following strategies will aid in adopting the skills that are necessary to acquire before proceeding to the next level on the model.
Requisite learning strategies.

- Continue examining your cultural specific lens. What have you discovered that has shaped your views of others?
  - Have you experienced or witnessed an event (discrimination, racism, xenophobia, a personal attack, either verbal or physical) by an “other” or a group of others? Does this experience still impact your cultural views, your views of diversity?
  - Determine your focus or foci for a growth mindset. What do you need to adopt an ethnorelative mindset? Do you need anti-racist material? Do you need allyship material? Do you need cultural specific material? Do you need to find a way to shed the impact of a negative experience or experiences from your youth that have impacted your views of others?

- Take an implicit bias test - https://implicit.harvard.edu/implicit/takeatest.html

Level 3 advanced-intermediate – semi-advanced. The goals of this level are to achieve the desired internal outcome: Informed frame of reference/filter shift. This includes adaptability (to different communication styles and behaviors); flexibility (selecting and using appropriate communication styles and behaviors; cognitive flexibility); ethnorelative view; and empathy. In order to achieve these skills, a more advanced knowledge of the self is required. Ethnorelativism can only be achieved once our own ethnocentric views are analyzed. The preceding pyramid levels and
learning materials should help the learner achieve knowledge of the self. To master the third level of the pyramid the following learning strategies and materials are recommended.

**Requisite learning strategies and materials.**

- Learning materials, adapted from the compilation by Sarah Sophie Flicker, Alyssa Klein, May 2020, full reference list in Appendix J:

- Articles to read:
  - “America’s Racial Contract Is Killing Us” by Adam Serwer | Atlantic (May 8, 2020)
  - Ella Baker and the Black Freedom Movement (Mentoring a New Generation of Activists
  - ”My Life as an Undocumented Immigrant” by Jose Antonio Vargas | NYT Mag (June 22, 2011)
  - The 1619 Project (all the articles) | The New York Times Magazine
  - The Combahee River Collective Statement
  - “The Intersectionality Wars” by Jane Coaston | Vox (May 28, 2019)
  - Tips for Creating Effective White Caucus Groups developed by Craig Elliott PhD
"White Privilege: Unpacking the Invisible Knapsack” by Peggy McIntosh

“Who Gets to Be Afraid in America?” by Dr. Ibram X. Kendi | Atlantic (May 12, 2020)

- Videos to watch:
  - Black Feminism & the Movement for Black Lives: Barbara Smith, Reina Gossett, Charlene Carruthers (50:48)
  - "How Studying Privilege Systems Can Strengthen Compassion” | Peggy McIntosh at TEDxTimberlaneSchools (18:26)

- Podcasts to subscribe to:
  - 1619 (New York Times)
  - Code Switch (NPR)
  - Intersectionality Matters! hosted by Kimberlé Crenshaw
  - Momentum: A Race Forward Podcast
  - Seeing White

- Books to read:
  - Black Feminist Thought by Patricia Hill Collins
  - Eloquent Rage: A Black Feminist Discovers Her Superpower by Dr. Brittney Cooper
  - Heavy: An American Memoir by Kiese Laymon
  - How To Be An Antiracist by Dr. Ibram X. Kendi
  - I Know Why the Caged Bird Sings by Maya Angelou
  - Raising Our Hands by Jenna Arnold
Level 4 advanced – expert. The last level on the pyramid by no means indicates development is over. Growth in cultural competence and diversity awareness is lifelong; however, the last level describes the desired external outcome, which comes from accumulated knowledge and skill: Behaving and communicating effectively and appropriately (based on one’s intercultural knowledge, skills, and attitudes) to achieve one’s goals to some degree. The participants indicated in the end of study reflection and focus group data that comfort in teaching students may require achievement of this level. Participants identified that they reached a comfort level with their own cultural views and their ability to discuss them, although more learning is desired before teaching the
skills. This level may be achieved after spending time with the level three learning material. To continue development in cultural competence continue to reflect and learn.

Requisite learning strategies and materials. See Appendix K for full reference list.

• Videos:
  o Allegories on Race and Racism by Camara Jones MD, MPH, PhD
  o Achieving equity with Results-Based Accountability Center for Social Inclusion
  o The impact of racism on the health and well-being of the nation American Public Health Association

• Research brief:
  o Addressing the social determinants of health through the Community Health Improvement Matrix National Association of County and City Health Officials

Teaching resources:

• Articles for educators


• Books for educators
  
  

• Websites for educators
  
o Race and Violence Should Be a School-Wide Subject by Travis Bristol, PhD
  
o Summary of Stages of Racial Identity Development Interaction Institute for Social Change
  
  5 Keys to Challenging Implicit Bias by Shane Safir
  
o https://healthequityguide.org/ Human Impact Partners
- Activities for educators
  - Anti-Racist Educator Self-Questionnaire and Rubric
  - Anti-Racist Student Self-Questionnaire
  - How to be an Anti-racist Educator

At level four of development, recognizing that cultural competence and diversity awareness is a continual process that may require revisiting a previously achieved level is important. As indicated by the quantitative data results, moving backward in development occurs, and does not necessarily indicate regression but can be an indication of learning new concepts in relation to one’s own cultural group.

**Implication for Practice**

The new model is simply a suggested guide to develop cultural competence and diversity awareness with race at the center. The guide was developed as a result of this action research study and the implications of the data analysis. I noticed during this action research study, that my own practice of teaching and practice of cultural competence advanced. My orientation on the cultural competence continuum is adaptation, but as discussed, cultural competence is a lifelong process that benefits from continual learning. I realized I still code others based on phenotypic features. I had thought one participant who identified as a person of color was White. I realized I need to disrupt this practice in order to avoid assumptions about others. Avoiding assumptions is part of level one on the pyramid model.

I also noted that cognitive flexibility, as required for level three of the pyramid model, is not always straightforward. Upon self-reflection during the workshops, I noted that I resist using the pronoun “they” in singular use, as desired by some in the LGBTQ
community. I enjoy the study of grammar and I am rather rigid in application of appropriate use and structure. Using “they” in the singular violates rules of grammar. I must be more cognitively flexible and let go of my rigidity of thought. It is more important to me that I inclusively address others than apply a rule of grammar. This self-reflection leads me to believe I may need to scaffold activities for flexible thinking and/or add more learning material that encourages cognitive flexibility in future teaching.

It is also clear from the qualitative data results, confirmed by the focus group, that more training is required. While positive results were derived from the inservice workshops, they did not provide a sufficient amount of time or learning material to reach the goal of teaching students. This critical goal requires further review as implicated by Hall et al. (2015) who showed that healthcare students represented similar racial and ethnic biases to those of already practicing providers. Healthcare provider implicit biases and stereotype representations have a profound effect on patient relationships and health outcomes, adding to the inequity in health (DeLilly & Flaskerud, 2012; Greene Jackson et al., 2009; Jones, 2000; Nelson, 2002; Smedley, 2019).

Immediate, more concrete steps, to improve my teaching process will be developing resources for discussing race in the classroom, creating a community of practice, and starting a book club. Longer-term plans include holding two or three inservice workshops each year. First, I will develop and disseminate a resource handbook that includes readings, videos, and an instructional manual for navigating difficult classroom conversations. Next, I will create a community of practice on Microsoft Teams that will house resources and serve as a virtual place for anyone to join who wants to learn together. Finally, a book club can serve as a motivating and engaging
way to read through the booklist found in level three of the suggested new model. The book club can serve as an extension of the community of practice as an additional platform to learn together. I will continue to offer workshops that provide new iterations and expanded learning material based on the inservice workshops I provided for this study.

**Implications for Further Research**

Several research studies could be conducted in the future as implicated by the current research. The first is a replication of this study that allows for participant identification in the qualitative protocols. Parsing the data to determine the reasons for the pre and post-test variance in median scores may prove helpful. Second, research testing the proposed model for cultural competence training could be conducted. At this time, the model is simply suggested based on the literature and results of this action research study. Testing whether or not the model is significantly effective in increasing cultural competence ability and teaching skills should be determined.

Additionally, results from this study indicate the need for faculty training to facilitate classroom conversations on race and racism. Faculty expressed the need for an expert to conduct conversations; however, training material can be developed and tested. This may be the most critical of the future studies in order to tackle the disparities in health outcomes that are caused by racism in healthcare professionals (Cohen et al., 2009; Green Jackson et al., 2009; Hall et al., 2015; Laviest & Isaac, 2013). Studies testing the practical implications of the training in the professional setting could also be conducted.
Summary

This study resulted in a significant change effect on cultural competence ability from participation in inservice workshops on unconscious bias, power, privilege and stereotype representations. The qualitative data results confirm the salience of the workshop material. Participants indicated they uncovered unconscious biases, noted how much they learned about the marginalization of Blacks and African Americans via power and privilege, and expressed a desire to learn more in order to teach students cultural competence skills.

A suggested action plan in the form of a new model approach that supports a continuing education strategy was developed. Strategies are aligned with the levels on the pyramid model of intercultural competence. The levels have been renamed to correspond with learner experience in cultural competence and diversity awareness training. Suggested learning strategies and materials correspond to the learner experience. This may allow learners to use the model in an autodidactic manner by matching their experience to the level names. The new levels include, Novice – Beginner; Advanced Beginner – Intermediate; Advanced-Intermediate – Semi-advanced; Advanced – Expert.

Immediate steps to improve my practice of teaching cultural competence and diversity awareness will be implemented, including additional resources, a community of practice, and book club. Results of the immediate steps will serve as a guide for additional inservice workshop programming.
Additional research is needed to determine the exact reason for the variance in mean scores in the pre and post-test IDI. Other research including testing the suggested model for effectiveness is needed. Additional research studies include development of cultural competence and diversity awareness teaching skills for healthcare faculty, skills training for facilitating classroom conversations on race and racism, and practical implications of the skills training in a professional setting.
REFERENCES


doi:10.1097/ACM.0b013e31815c6753


APPENDIX A

EMAIL INVITATION TO PARTICIPATE IN THE STUDY

Dear Colleagues,
You are being invited to participate in a research study administered by Christina Gunther, MA, Director of the Health Science at Sacred Heart University. The purpose of this study is to learn how I can provide the most effective in-service workshops on cultural competence for faculty teaching in the Health Science Program. Participation in this study is voluntary and there are no penalties if you do not wish to participate. Your performance evaluation will in no way be affected by your participation and the only identifying information on the data will be removed by an alternate facilitator before I view it. If you decide to participate, you may withdraw from the study at any time.

If you decide to participate, you will receive an emailed link to the Intercultural Development Inventory (IDI). Clicking this link serves as your implied consent to participate in this study. A series of three workshops will be presented followed by an additional IDI survey and reflection questions via Survey Monkey.

Potential risks to the participants are minimal. Minor adverse reactions to the survey questions, workshop curricula, and focus group interview may include discomfort with some of the questions and the potential answers. Benefits of participation include potential growth in cultural competence skills. You may skip any questions which you do not wish to answer. The IDI survey should take approximately 30 minutes on average to complete (both times). The workshops will be conducted over three sequential Fridays. Each workshop will be three hours long. The focus group interview will take approximately one hour.

If you have any questions about this research study, please feel free to discuss with Prof. Christina Gunther at guntherc@sacredheart.edu (203) 371-7948. If you have any questions about your rights as a research subject, please call Dr. June-Anne Greeley, Chair of the Institutional Review Board at Sacred Heart University at (203) 371-7713 or XXX University of South Carolina.

Thank you very much for your time and consideration.

Sincerely,
APPENDIX B

RESEARCH PROCEDURE TIMELINE

This action research study will take approximately two to three months to complete once Institutional Review Board (IRB) approval is granted. The time period includes the sending of the IDI pretest, workshop series, the IDI posttest and follow-up qualitative questions, coding, analysis, and writing of the results. Table B1 provides the timeline for the process.

Table B.1 *Timeline of data collection, analysis, and interpretation of results.*

<table>
<thead>
<tr>
<th>Date</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 1, 2020</td>
<td>Send the IDI pretest.</td>
</tr>
<tr>
<td>July 10, 2020</td>
<td>Conduct inservice workshops.</td>
</tr>
<tr>
<td>July 17, 2020</td>
<td></td>
</tr>
<tr>
<td>July 24, 2020</td>
<td></td>
</tr>
<tr>
<td>August 1, 2020</td>
<td>Send the IDI posttest and qualitative questions via Survey Monkey.</td>
</tr>
<tr>
<td>August, 10 2020</td>
<td>Download qualitative data collection and critical memoir question data.</td>
</tr>
<tr>
<td>August 10 - 20, 2020</td>
<td>Code qualitative data. Conduct two-tailed T-Tests of quantitative data using SPSS.</td>
</tr>
<tr>
<td>August 21-Sept 20, 2020</td>
<td>Write up results of the data collection.</td>
</tr>
</tbody>
</table>
APPENDIX C

INSERVICE WORKSHOP TEACHING PLANS

Pre-workshop homework
- Dimensions of Diversity Activity – what has influenced you? (Cultural Programming Worksheet) (Appendices B & C)
- Intercultural Development Inventory pre-test

Workshop 1

Lesson Topic:  Cultural Competence and Diversity in Healthcare
Instructional Objectives: Faculty will be able to…

1. Define critical terms - cultural competence/diversity/race/stereotypes/unconscious bias/power/privilege/identity construction
2. Identify personal biases
3. Recognize own position in terms of power and privilege through critical consciousness.
4. Identify the value of cultural competence/diversity awareness in the healthcare environment and healthcare classroom

Introduction (10 min.):

“We don’t see the world the way it is. We see the world the way we are” -Anais Nin

It is difficult to have a discussion about human diversity without including the concept of culture. Culture is a construct of diversity. It is the totality of values, beliefs, and behaviors common to a large group of people. Human diversity means differences among people. The definition of cultural competence that we will use comes from the Forum on Education Abroad (2016). “The ability to relate and communicate effectively when individuals involved in the interaction do not share the same culture, ethnicity, language, or other common experiences.” This is critical in the field of healthcare because health outcomes suffer when providers are not culturally competent (Capell, Dean & Veenstra, 2008; Paez Allen, Carson & Cooper, 2008; Rajaram & Bockrath, 2014).

Yet how can practitioners and policy makers be expected to be culturally competent when they are not exposed to pedagogy instructed by culturally competent faculty? As faculty, we must become culturally competent and diversity aware before we can expect
our students to be so. Over the next three workshops, our focus will be on developing our own cultural competence and recognizing our place of privilege and power as members of the white community. It will then be our goal to learn how to teach our mostly white students to be culturally competent/diversity aware and recognize their own position within this context.

Research has suggested that we cannot expect students to gain cultural competence or diversity awareness without specific, guided pedagogy facilitated by educators or mentors (Vande Berg, Paige & Lou, 2012). Along with this pedagogy must come the notions of power, privilege and social justice and our own understanding of our place within those paradigms.

Instructional Procedures (20 min.):

PowerPoint instructional presentation with information including:

- Definitions of critical terms
- Importance in Healthcare and healthcare classroom
- Affirming or reframing mindset – identifying implicit biases (implicit attitudes) – Stereotype construction
- Unpacking the knapsack - privilege

Reflect on discussion with entire group (10 minutes).

PPTs on unpacking the knapsack (10 minutes).

Activity in Zoom breakout rooms: Extending the knapsack (15 minutes)

Closure/Summary Review (10 min.):

From Gorski:

- “We tend to require less evidence, and less accurate evidence, to convince us of the legitimacy of a stereotype about out-groups than in-groups” (Biernat, 2003; Macrae, Milne, & Bodenhausen, 1994; Van Rooy et al., 2003)
- We view our own social and cultural identity groups as diverse while we imagine “the other,” people belonging to a social or cultural identity group with which we are less familiar as “monolithic” (Clark, 1985; Hurst, 2007; Meiser & Hewstone, 2004).
- We attribute more positive characteristics to our in-groups than to our out-groups (DiDonato, Ullrich, & Krueger, 2011; Hewstone, Rubin, & Willis, 2002).
- This occurs because we know our in-groups better than we know our out-groups. For example, “when people find themselves in contexts with which they are not familiar, their decision-making cognition defaults to intuition and stereotyped beliefs. Meanwhile, they suppress their abilities, which they might demonstrate in
more familiar contexts, to draw on “a deliberate, controlled reasoning process” (De Neys & Vanderpeutte, 2011, p. 432).

Materials/Equipment/Media:

Dimensions of Diversity Sheet (Appendix A)
Cultural Programming Worksheet (Appendix B)

**Homework**
Complete module on the social construction of race. Then choose two of the following to listen, watch, and/or read. Answer the two reflection questions on Blackboard (answers are anonymous). Small group discussions will be held at the next workshop about the homework.

**Podcasts:**
How to Break Free from Limiting Beliefs - https://medium.com/personal-growth/how-to-be-free-unlock-your-beliefs-58bc2f7133c4

**Articles:**
Walking While Black (Garnette Cadogan) – https://lithub.com/walking-while-black/?fbclid=IwAR00nbDnPcoE7BJOUZgQL8nxFckVR0vsDWdC9hUXtERwmxmhuRw7HVSDwTI

**Videos:**
Interview about I’m Still Here - https://www.stitcher.com/podcast/defininggrace/art-of-the-sermon/e/54526347
Interview about White Awake - https://www.youtube.com/watch?v=DNkE5kNnIDQ
Introduction to Culturally Relevant Pedagogy - https://www.youtube.com/watch?v=nGTVjJuRaZ8
Paul Gorski on deficit ideology and poverty - https://www.youtube.com/watch?v=AJ2YQeZy4Hk
Wise’s video (part 9) of The Hidden Curriculum of Privilege - https://www.youtube.com/watch?v=1t_93NESRPs

**Workshop 2**
Lesson Topic: Cultural Competence and Diversity in Healthcare
Instructional Objectives: Faculty will be able to…
4. Identify ways in which structural racism contributes to inequity in healthcare.
5. Reflect upon barriers that limit equity, and how those barriers may be better managed.
6. Identify complicity in structurally racist systems.

Introduction (10 min.):
In workshop two, we will move from self-focused, reflective learning to understanding how the healthcare industry is based on white privilege and stereotypes in the U.S. We will reflect on how our identified biases and stereotypes may contribute to pedagogical practice that contributes to culturally incompetent healthcare providers. Ways in which these practices can be interrupted will be addressed.

Race is a social construct based on power and hierarchy. We live in a society entrenched in this structure. We all know that there is no biological connection to race, but many people don’t. Most of us categorize people on site using our implicit biases and stereotypes.

Example
Sickle cell anemia was first described in 1910 and was labeled a “black” disease. People were preoccupied with an imagined racial hierarchy, with whites on top. The disease was cited as evidence that people of African descent were inferior.

Today, scientists understand the sickle cell is an adaptation to malaria, not evidence of inferiority. Scientists also know that the trait is common outside Africa across the “malaria belt” — the Arabian Peninsula, India and parts of the Mediterranean Basin. And people historically considered white can, in fact, carry it. In the Greek town of Orchomenos, the gene is more prevalent than it is among African-Americans.

Ignorance about the above information may result in subpar medical care for some patients. For example, California’s universal blood disorder screening program has identified thousands of nonblack children with the sickle cell trait and scores with the disease — patients who might have been missed if providers are stuck on sickle cell being an African American disease which many still are (NY Times).

Instructional Procedures (30 min.):
PowerPoint instructional presentation with information including:

- Barriers many individuals face in healthcare like bias, prejudice, culture and racial disparities.
- Cultural competence training improves knowledge, attitudes and skills in healthcare providers with recognition of unconscious bias, power and privilege.
- Race and Medicaid = unequal access to care for more people of color.
- Cultural competence has a positive impact on patient satisfaction and adherence to instructions.

Activity in Zoom breakout rooms (12 minutes):
Sorting people - www.pbs.org/race
Ten Things Everyone Should Know about Race

Race is a modern idea. Ancient societies, like the Greeks, did not divide people according to physical differences, but according to religion, status, class or even language. The English word "race" turns up for the first time in a 1508 poem by William Dunbar referring to a line of kings.

Race has no genetic basis. Not one characteristic, trait or even gene distinguishes all the members of one so-called race from all the members of another so-called race.

Skin color really is only skin deep. The genes for skin color have nothing to do with genes for hair form, eye shape, blood type, musical talent, athletic ability or forms of intelligence. Knowing someone’s skin color doesn’t necessarily tell you anything else about them.

Most variation is within, not between, “races.” Of the small amount of total human variation, 85% exists within any local population. About 94% can be found within any continent. That means, for example, that two random Koreans may be as genetically different as a Korean and an Italian.

Slavery predates race. Throughout much of human history, societies have enslaved others, often as a result of conquest or debt, but not because of physical characteristics or a belief in natural inferiority. Due to a unique set of historical circumstances, North America has the first slave system where all slaves shared a common appearance and ancestry.

Race and freedom were born together. The U.S. was founded on the principle that "All men are created equal," but the country’s early economy was based largely on slavery. The new idea of race helped explain why some people could be denied the rights and freedoms that others took for granted.

Race justified social inequalities as natural. The “common sense” belief in white superiority justified anti-democratic action and policies like slavery, the extermination of American Indians, the exclusion of Asian immigrants, the taking of Mexican lands, and the institutionalization of racial practices within American government, laws, and society.

Race isn’t biological, but racism is still real. Race is a powerful social idea that gives people different access to opportunities and resources. The government and social institutions of the United States have created advantages that disproportionately channel wealth, power and resources to white people.

Colorblindness will not end racism. Pretending race doesn’t exist is not the same as creating equality.

(From Race: The Power of Illusion Discussion Guide)
Assessment/Evaluation (10 minutes):
Reflection (formative assessment)
Describe and discuss a racial barrier either in access to healthcare or healthcare outcomes. How can you contribute to the disruption of the system? Answer in chat.

Closure/Summary Review (10 min.):
Cultural competence is a critical skill in education and the healthcare arena. The skill is beneficial to all fields of learning and all professions, but critically important in healthcare in order to have equity in health outcomes. Access to healthcare is subject to systemic racism through poverty and the Medicaid system.

Homework:
Take an implicit association test at implicit.harvard.edu. Choose either the race or skin color tests for workshop purposes, however, take as many others as you’d like. They are free!

Workshop 3

Lesson Topic: Cultural Competence and Diversity in Healthcare
Instructional Objectives: Faculty will be able to…

1. Add cultural competence/diversity training to curricula.
2. Develop teaching strategies and tools to help students achieve the ability to be culturally competent/diversity aware healthcare providers.
3. Facilitate difficult discussions with students.

Introduction (10 min.):

This workshop will be the culmination of self-reflection and healthcare industry identification of race and class biases. Ways in which students can develop multicultural perspectives and interrupt the deleterious effects of racial and class status determinants of health will be assessed. A brainstorming session will be included to develop the pedagogical and classroom tools necessary to engage students in learning to adopt a multicultural perspective of patients and healthcare as well as the necessary insight into race and class and ways to counterbalance their effects on the lack of equity in health.

Instructional Procedures (40 min.):
PowerPoint instructional presentation with information including:
How white faculty can best teach white students about race, power, privilege and diversity
Critical consciousness (Freire, 1973; Ladson-Billings, 2009).
Critical race theory and pedagogy (Ladson-Billings & Tate, 1995; Lynn, Jennings, & Hughes, 2013).
Normalization of whiteness; white people listening to other white people; obligations as white people. (Ferber, 2015)
Checking for Understanding – breakout rooms in Zoom (20 min):

Closure/Summary Review (10 min.):

Course content/curriculum must meet students where they are. Becoming culturally competent/diversity aware is a developmental, lifelong process. Step one depends on where you fall on the framework of cultural programming. Faculty must focus on integrating multicultural approaches to healthcare and how race and class affect health status and health equity into course content.

Ideas for integrating healthcare content with diversity and equity include: Socratic Seminar as identified by Koss and Williams (2018) (reading *All American Boys*)
(Review brainstorming ideas generated during workshop)

Articles for handout:


Assessment/Evaluation:

One week after last workshop - Intercultural Development Inventory post-test with debrief (summative assessment).

Qualitative questions in surveymonkey.com (all answers are anonymous):

1. What were the key take-aways for you from this workshop series?
2. Do you believe the workshops have made you more aware of race and racism? In what ways?
3. In what ways, if any, do you have a new view of your biases, power, and privilege (or lack thereof)?
4. Will you apply anything you learned in the workshop series to your course curricula? If yes, briefly describe.
Figure D.1. Dimensions of Diversity Wheel.
APPENDIX E

INFLUENCES OF DIVERSITY

Culture and diversity serve as a roadmap for both perceiving and interacting with the world.
What has influenced you? Fill-out the chart below based on the Dimensions of Diversity chart.

Figure E.1: Influences of diversity
APPENDIX F

GROUP REPORT INFORMATION – INTERCULTURAL DEVELOPMENT INVENTORY

The IDI also generates group, subgroup, and organizational intercultural competence profiles (click here for a sample group profile report). When used to assess a group’s intercultural competence, interviews or focus groups can be conducted to identify cross-cultural goals and challenges, providing valuable information regarding how the group’s IDI profile translates into interculturally competent strategies across diverse groups (IDI, 2020, para. 6).

APPENDIX G

WORKSHOP MIDPOINT REFLECTION QUESTION PROTOCOL

1. How truly open are you to those from different cultural, socioeconomic or racial backgrounds?

2. What experiences have you had that may influence how you view "others"? Please describe.

3. Do you engage in active reflection of your interactions with those from diverse backgrounds within your practice or classrooms? Explain.

4. Are you able to be flexible in responding to others' needs, seeking to understand those needs from their cultural/diverse perspective? Does your position of power and privilege influence your response to them?
APPENDIX H

POST-WORKSHOP QUALITATIVE PROTOCOL

1. Prior to the workshop series, did you think about power and privilege, unconscious bias, and/or stereotype representations? Please describe.

2. Did you uncover any unconscious bias during the workshop?

3. If you uncovered unconscious bias, will you work to disrupt it? How?

3. What were/are your thoughts before and after the workshops about power and privilege between the majority group in U.S. culture and minoritized groups in U.S. culture, particularly of Blacks and African Americans? Please describe.

4. Were you aware of the prevalence of unconscious bias in the healthcare system and healthcare practitioners before the workshops?

5. Will you work toward eliminating health inequities in minoritized patient populations through awareness of unconscious bias, stereotype representations, power and privilege? How?

6. Will you teach your students to be aware of unconscious bias, stereotype representations, power and privilege and how they affect patient populations? Please describe.

7. Do you have any other comments or suggestions?

The answers will be compared to similar open-ended question answers collected during the workshop series to validate this part of the data collection process (Creswell & Creswell, 2018).
APPENDIX I

FOCUS GROUP PROTOCOL

1. What are your overall thoughts about the workshop material?

2. What did you learn?

3. Will you teach your students what you learned?
APPENDIX J

ACTION GUIDE LEVEL 2 RESOURCES


Serwer, A. (2020, May 8). The coronavirus was an emergency until Trump found out who was dying. *The Atlantic*, 8.


APPENDIX K

ACTION GUIDE LEVEL 4 RESOURCES


