

## INSTRUCTIONAL DESIGN AND ASSESSMENT

### Using Patient Case Video Vignettes to Improve Students' Understanding of Cross-cultural Communication

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**Objective.** To develop, implement, and assess whether simulated patient case videos improve students' understanding of and attitudes toward cross-cultural communication in health care.

**Design.** Third-year pharmacy students (N=159) in a health care communications course participated in a one-hour lecture and two-hour workshop on the topic of cross-cultural communication. Three simulated pharmacist-patient case vignettes highlighting cross-cultural communication barriers, the role of active listening, appropriate use of medical interpreters, and useful models to overcome communication barriers were viewed and discussed in groups of 20 students during the workshop.

**Assessment.** A pre-lecture and post-workshop assessed the effect on students' understanding of and attitudes toward cross-cultural communication. Understanding of cross-cultural communication concepts increased significantly, as did comfort level with providing cross-cultural care.

**Conclusion.** Use of simulated patient case videos in conjunction with an interactive workshop improved pharmacy students' understanding of and comfort level with cross-cultural communication skills and can be useful tools for cultural competency training in the curriculum.

**Keywords:** cross-cultural, communication skills, cultural competence, patient case videos

## INTRODUCTION

The racial and ethnic composition of the United States population is rapidly changing.<sup>1</sup> Non-Hispanic whites now make up the majority of the US population. However, according to the US Census Bureau, no individual racial or ethnic group will constitute a majority by the year 2060.<sup>1</sup> With the increase in a "majority-minority nation" or a "plurality" of racial and ethnic groups, it is inevitable that pharmacists will interact with people from a variety of ethnic and cultural backgrounds. Hence, it is imperative to prepare pharmacy graduates who are able to provide cross-cultural care, which requires the ability to communicate effectively with patients from diverse socio-cultural backgrounds.

Cultural competence is described as "the ability to provide care to patients with diverse values, beliefs and behaviors, and to tailor care delivery to patients' social, cultural, and linguistic needs."<sup>2</sup> While the constructs of cultural competency include awareness, knowledge, and skills, it also is essential to convert these constructs into

appropriate communication.<sup>3</sup> The quality of communication is an important component of developing cultural competence and providing comprehensive health care to a multicultural patient population. Effective communication has been linked to reducing health disparities and improving patient outcomes.<sup>4,5</sup> Health care providers who tailor their communication in a way that respects the culture, traditions, and beliefs of the patient produce greater levels of patient satisfaction and more collaborative patient-provider interaction.<sup>6</sup> Among practicing pharmacists, the incorporation of cultural competency and communication training programs has produced positive health outcomes and greater levels of patient engagement compared to usual care in a small number of randomized studies.<sup>7,8</sup>

The need to integrate cultural skills, attitudes, and knowledge to promote cross-cultural communication within the pharmacy curriculum is essential. Understanding the role that culture plays in communication also needs to be addressed and should be introduced in the initial stages of the health care professional's education.<sup>9</sup> This idea is reflected in the 2016 Accreditation Council for Pharmacy Education (ACPE) doctor of pharmacy degree program accreditation guidelines, which state that schools and colleges of pharmacy must guarantee that

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curricula prepare students to understand the “potential impact of cultural values, beliefs, and practices on patient care outcomes.”<sup>10</sup> This understanding requires students to develop cultural skills, which include awareness of cross-cultural communication. Addressing barriers in communication, which include lack of knowledge about cultural differences, fear and distrust of others, stereotyping groups of people, and poor non-verbal communication/active listening (eg, lack of eye contact, physical contact, posture, learning forward in conversation, etc.) can impact a pharmacist’s ability to provide culturally sensitive care.<sup>2</sup>

Gaining knowledge of various cross-cultural models/tools that exist to enhance effective communication can allow students to identify when they can be applied to pharmacy practice. For example, the LEARN model is used to build trust, and allow for the pharmacist to negotiate a care plan with the patient, while the SOLER model is used to promote active listening and establish an empathetic, respectful relationship with the patient.<sup>2</sup> Several pharmacy organizations have publicly acknowledged the growing need for enhanced cultural competency, which includes communication skills, but the translation of this need to curricular revision at colleges of pharmacy has not been fully realized.<sup>11</sup> Approximately 10 years ago, a survey distributed in the United States and Canada showed that 33 of the 49 responding colleges of pharmacy used didactic lectures as their most frequent delivery method of cultural communication, skills, and knowledge in their curriculums.<sup>12</sup>

One reason limiting curricular integration is the lack of standard methods for providing cross-cultural communications training.<sup>13</sup> Colleges of pharmacy typically embed cross-cultural communication education into various formats of general cultural competency training, including a dedicated semester-long elective course, a semester-long interdisciplinary course, a component of a pharmacy skills and application required course series, and a brief practicum within a required course.<sup>14-17</sup> In addition to traditional lecture, integrated class activities vary significantly among colleges, ranging from reflective writing to patient simulations.<sup>6,18</sup> Studies of these curricular interventions to increase pharmacy students’ exposure to cultural skills have shown improvements in several domains of cultural competence, ranging from cultural awareness to desire to achieve cultural competence, but none specific to cross-cultural communication skills.<sup>14,16</sup>

Patient case videos have been used in medical education to assist with the development of observational skills and clinical reasoning in a wide range of practice settings.<sup>19</sup> They incorporate a “real-life” scenario in which the learners can observe the actions of the video

actors, reflect on the strengths and weaknesses of the interaction, and project how they would behave and respond if facing a similar patient interaction. While video case vignettes have been studied more formally in medical trainees, studies specifically evaluating the use of patient case videos to teach pharmacy students are limited and non-existent when addressing cross-cultural communication skills to promote cultural competence. Thus, the primary objective of this study was to develop, implement, and assess whether simulated patient case videos, in conjunction with a workshop format, improved students’ understanding of and attitudes toward cross-cultural communication in health care.

## DESIGN

Approximately five contact hours have been devoted to cross-cultural communication training in the Midwestern University Chicago College of Pharmacy curriculum, with two didactic hours dedicated in the first professional year. During fall quarter of the third professional year, all pharmacy students were enrolled in a health care communications course and received an additional one hour of didactic lecture on cultural competency, followed by two hours of workshop application time. The lecture focused on cultural competence concepts related to communication in health care settings, and time was spent discussing strategies and techniques to deliver culturally competent care. The lecture objectives included listing common patient beliefs that impact pharmacy practice; recognizing barriers to cross-cultural communication; recognizing the importance of active listening to building patient trust; and recognizing and being prepared to utilize communication tools to overcome barriers. During the lecture, students were provided with engaging stories regarding cross-cultural encounters experienced by the lecturer and were asked to participate in case discussions.

The following week, a two-hour mandatory workshop took place and incorporated active learning, with the opportunity to apply concepts taught in the lecture. Given that cultural competence requires self-awareness about our own prejudices, biases, and attitudes, prior to attending the workshop, facilitators and students were asked to complete a cultural self-awareness questionnaire adapted from the Randall-David survey developed in 1989.<sup>19</sup> This questionnaire titled, “How do you relate to various groups of people in the society?” was used to help identify the individual’s biases and ability to provide cross-cultural care. The questionnaire asked individuals to rate the level of response toward 30 specific types of people. Levels of responses included “greet,” “accept,” “help,” “background,” and “advocate.”

At the beginning of workshop, students were asked to complete the second part of the questionnaire in which their responses were categorized into five main categories: “ethnic,” “social,” “religious,” “physically/mentally handicapped,” and “political.” A concentration of responses in any of the categories indicated a conflict (ie, narrow view) that could hinder one’s ability to render effective cross-cultural care. Questionnaires were not collected or graded as they were purely used for self-reflection and as an exercise of cultural awareness that allowed for discussion in workshop. Facilitators posed these two questions to each student to stimulate discussion about cultural differences and similarities: what are important aspects of your cultural background that others should consider in health care interactions and how can you approach learning more about patients with backgrounds that differ from yours?

The second part of the workshop consisted of facilitator-led group discussions in which students watched three simulated patient case videos (Table 1) depicting mock patient-pharmacist encounters. Each encounter took place in a different pharmacy practice setting (hospital, ambulatory care, or community). The videos were created using actors. Scripts were written by the investigators and were each approximately 5-7 minutes in length. Each video vignette integrated a variety of non-verbal and verbal cross-cultural communication barriers while portraying true-to-life clinical scenarios. It was essential to the development of the case scenarios to capture the broader definition of “culture,” which includes perception, world views, and beliefs, rather than simply the racial, religious, or ethnic perspectives of patient encounters. The students were expected to assess barriers in communication, use of active listening, the need for interpreters, and to recognize models for overcoming cross-cultural communication barriers presented in each video. Students were asked to watch each video twice as a group of 20 students, with the second time focusing on completing a Likert-type assessment of the non-verbal and verbal communication skills of the pharmacist in each video, utilizing the SOLER and LEARN models of effective cross cultural communication.<sup>20,21</sup> After each video, a facilitator-guided discussion took place to discuss the students’ reactions, barriers to communication present, and the students’ subjective ratings of verbal and non-verbal communication used in each clinical scenario.

## EVALUATION AND ASSESSMENT

This quasi-experimental study used a pre- and post-survey design. Students were invited to complete the paper-based survey before attending the cross-cultural communication lecture, and then again after completing

the mandatory workshop about application of cross-cultural communication models (Appendix). They were informed that participation in the study would not affect their scores in the course. The surveys assessed students’ understanding of cross-cultural communications skills and concepts and their attitudes on including additional cross-cultural activities in the curriculum. The survey instrument was comprised of three parts: student demographics (eg, age, gender, race/ethnicity, work experience); nine knowledge-based questions (multiple choice or true/false) to assess understanding cross-cultural communication barriers, the role of active listening, appropriate use of medical interpreters, and models that can be used to overcome communication barriers; and attitudes and perceived comfort with providing culturally competent care. All perception and attitudes were assessed on a Likert-type scale (1=strongly disagree to 5=strongly agree) and were based on pharmacy education accreditation standards language.

Data analysis was performed using IBM SPSS 22.0. The Wilcoxon matched-pair signed-rank test was used to analyze students’ comfort with providing cross-cultural care. Dependent-samples *T* tests and ANOVA were used to analyze continuous variables, and the Chi Square and the Wilcoxon Signed Rank tests were used to analyze non-parametric data. This study was approved the Midwestern University Institutional Review Board.

One hundred and fifty nine students completed both the pre- and post-surveys, resulting in an 80% response rate. Table 1 includes the demographics of the class, of which a majority were female (66%), from diverse backgrounds, and had a mean age of 25.6 years. When the knowledge domain of the survey was evaluated, there was an overall increase in students’ understanding of cross-cultural communication concepts (on a scale of nine, mean pre-quiz score=5.5 vs. mean post-quiz score=6.6,  $p<.05$ ). Figure 1 depicts the performance on each individual item of the nine-item multiple choice quiz. The greatest improvement in knowledge was related to the appropriate use of interpreters and awareness of which verbal models of cross-cultural communication can be used in practice. No difference in knowledge was detected between students of different gender, social class, or multilingual status. Regarding items related to student attitudes and comfort with providing cross-cultural care, there was a significant increase after the workshop ( $p=.002$ ). (Figure 2).

Overall, the workshop was well-received by students, based on open response comments. A majority of the respondents ( $n=48$ ) said watching the videos was more helpful/impactful than reading about them, because they showcased language barriers and how uncomfortable

Table 1. Description of Patient Case Video Vignettes Created and Used in the Cross-Cultural Communications Workshop

<b>Case Setting</b>	<b>Brief Description of Patient Scenario</b>	<b>Cross-cultural Barriers Presented in the Video</b>	<b>Student/Facilitator Discussion Points After Each Video</b>
Ambulatory Care Clinic	African American female recently diagnosed with hypertension; Patient lives in an inner-city, urban area and is of low socioeconomic status; Patient is willing to adhere to the medication regimen; Patient is willing to adhere to lifestyle changes, if the plan will work for her specific situation; Pharmacist is a busy, enthusiastic new graduate with desire to apply evidence-based medicine but lacks understanding of lower socioeconomic status of patient and displays poor non-verbal communication skills such as typing on keyboard and looking at computer while patient is talking.	Patient does not own a car and needs to use public transportation; Large grocery store not within walking distance from patient; Patient obtains most groceries from a “corner store,” or fast food restaurants because it’s within walking distance; Limited access and affordability of fresh fruits and vegetables and low fat protein choices; Limited ability to adhere to an exercise regimen of walking 30min/day most days a week due to lack of neighborhood safety.	Patient upset and overwhelmed about new diagnosis and is embarrassed; Pharmacist is a young, new graduate who is friendly and initially attempts to develop a rapport with the patient by expressing empathy; Pharmacist types on the computer and looks at the screen while the patient is talking; Pharmacist attempts to relate recommendations to the patient by starting out with, “Tell me what your diet is like?” However, criticizes what patient eats by saying, “I know that’s not good for you and you know that’s not good for you.” When patient explains it’s not safe to walk in her neighborhood, pharmacist asks if she would consider moving to a safer neighborhood; Diet/exercise plan is evidence-based but not relatable to the patient due to lifestyle and income limitations due to pharmacist lack of cultural knowledge; Patient becomes quiet and withdraw due to hurt feelings and “shaming” done by pharmacist; Pharmacist’s lack of active listening.
Acute Care (Hospital)	Hispanic male (limited English skills) with new diagnosis of atrial fibrillation; Pharmacist provides warfarin discharge counseling and uses family member as interpreter who inserts her own biases while translating and providing incorrect information; Patient would like to discuss the use of warfarin with his Shaman, (spiritual healer) and purchase the medication in Mexico, where he is more familiar and comfortable; Pharmacist efficiently completes warfarin counseling assuming patient will start the medication immediately;	Cultural implications of family decision making; Patient and patient’s family rely on Shaman for guidance regarding health care decisions and cannot begin treatment until it is discussed with the Shaman; Patient not only states desire to consult his Shaman but expresses concern regarding medication cost; Patient’s English is limited and family member serves as an interpreter.	Pharmacist does not understand the role of a Shaman and does not attempt to understand the patient’s view; Pharmacist disregards what the patient says and continues to provide warfarin counseling; Pharmacist exhibits negative nonverbal communication skills by folding her arms when the patient continues to express desire to get medication in Mexico; Using a family member as an interpreter can introduce bias.

*(Continued)*

Table 1. (Continued)

<b>Case Setting</b>	<b>Brief Description of Patient Scenario</b>	<b>Cross-cultural Barriers Presented in the Video</b>	<b>Student/Facilitator Discussion Points After Each Video</b>
	Pharmacist disregards patient's desire to check with Shaman prior to beginning medication.		Family introduced bias and important points were lost in translation; Limited negotiation: INR monitoring and taking medication in Mexico.
Community Pharmacy	A homosexual, widowed, visually impaired patient picking up new insulin pen prescription; Pharmacist is initially unaware that the patient is visually impaired and continues to properly counsel the patient on how to use his insulin pen; Pharmacist makes an assumption that the patient is a married, heterosexual male but stating, "Your wife can help you." Patient becomes emotional when the pharmacist makes the above statement; The pharmacist displays empathy and appropriately adjusts counseling technique once he realizes patient's disability.	Patient cannot see the demonstration and the pharmacist needs to develop a means of providing the proper education to the patient to ensure the safe and effective use of the insulin pen.	Having a visually impaired patient in this scenario reinforces that culture goes beyond race and ethnicity; Recognizing the specific needs of the visually impaired patient; Adjusting counseling technique to effectively interact with the patient; Non-verbal communication cues are ineffective in a visually impaired patient.

Students were asked to rate how well the pharmacist in each video communicated with the patient based on the SOLER and LEARN models of cross-cultural communication:

SOLER (model for non-verbal communication/active learning)

S = Squarely facing the patient

O = Open posture

L = Lean slightly toward patient

E = Eye contact (if culturally appropriate)

R = Relaxed while communicating

LEARN (model for verbal communication)

L = Listen with sympathy and understanding to the patient's perception of the problem

E = Explain your perceptions of the problem

A = Acknowledge and discuss the differences and similarities in plan

R = Recommend treatment

N = Negotiate and agree on a treatment plan

Table 2. Student Characteristics. N=159 (%)

Age, Mean (SD)	25.3 (2.9)
Female	105 (66.0)
Race	
Asian American	77 (48.4)
Caucasian	63 (39.6)
African American/Black	7 (4.4)
Latino/Hispanic	5 (3.1)
Other	7 (4.4)
Multilingual <sup>a</sup>	108 (67.9)
Have lived outside of US	43 (27)
Household	
Upper Class	2 (1.3)
Upper Middle Class	59 (37.1)
Lower Middle Class	51 (32.1)
Working Class	39 (24.5)
Lower Class	8 (5.0)
Pharmacy Work Experience	
Community/Retail Pharmacy	118 (74.2)
Independent Pharmacy	9 (5.7)
Institutional Hospital Pharmacy	5 (3.1)
Research-based/Laboratory	5 (3.1)
None	22 (13.8)

<sup>a</sup>53.2% (n=80) of respondents speak one language besides English fluently, spanning over 27 languages

a patient can feel during certain situations. Students commented that the videos taught them to be aware and respectful of cultural differences, while not making assumptions about beliefs. They expressed that after taking part in the

workshop, they had a better understanding of cross-cultural concepts. Interestingly, students felt that this experience helped them develop certain soft skills, such as empathy, and that they would feel more equipped to apply them during future patient interactions. Students also felt the videos provided good examples to connect with what was taught in lecture (cross-cultural concepts, use of empathy, etc.). Student suggestions included facilitating more role-playing scenarios during the session and providing the links to the videos for viewing after workshop. Additional feedback suggested more discussion regarding the correct and incorrect ways to handle each scenario to offer the students more specific guidance. Also, they expressed a desire to watch more videos and have more time to discuss racial/cultural differences in order to gain more cultural knowledge and better understand various barriers to care. A majority of the respondents to the post survey (n=141, 88.7%) felt more communication training was needed in the curriculum, either throughout elective courses (90.6%) or required courses (50.9%).

## DISCUSSION

The pharmacy education literature lacks examination of instructional methods and assessment of cultural communication skills within the construct of cultural competency training. The American College of Clinical Pharmacy (ACCP) white paper on this theme advocates a “model curriculum” to provide better consistency in

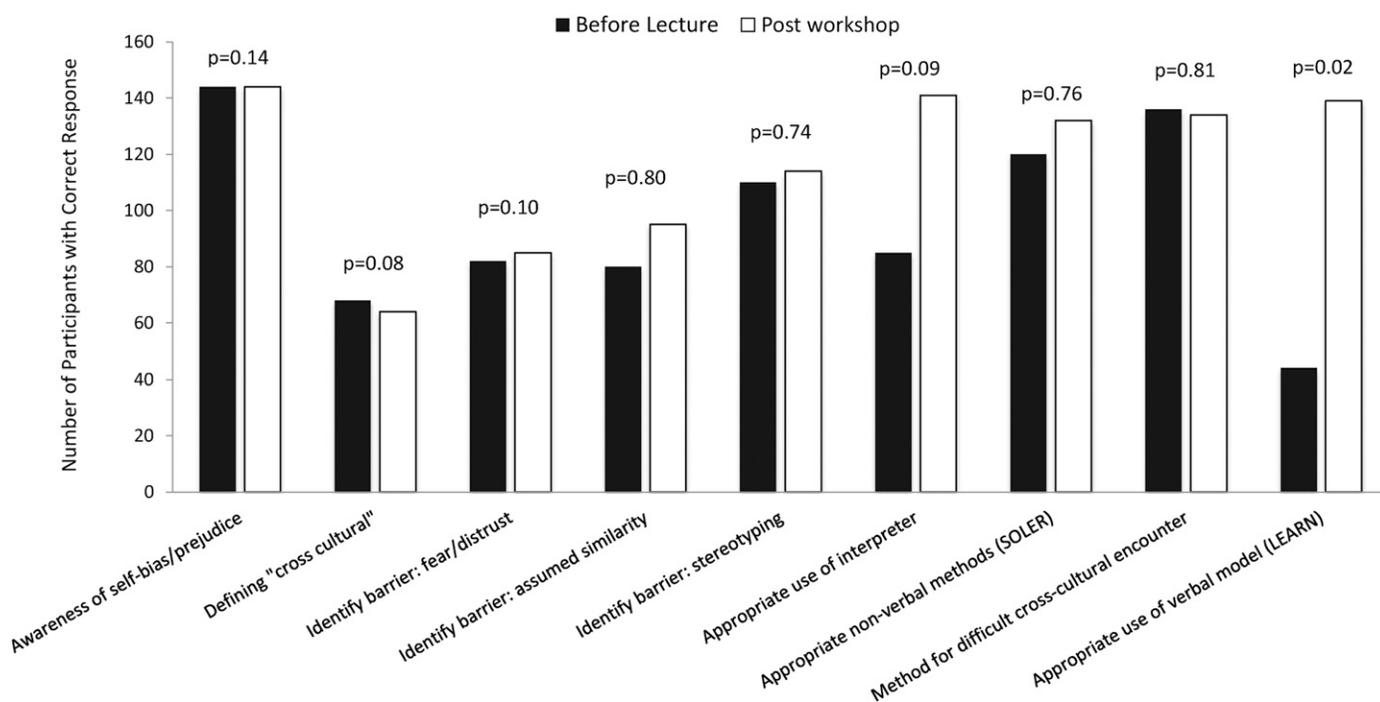


Figure 1. Pre- vs. Post-knowledge Assessment Scores.

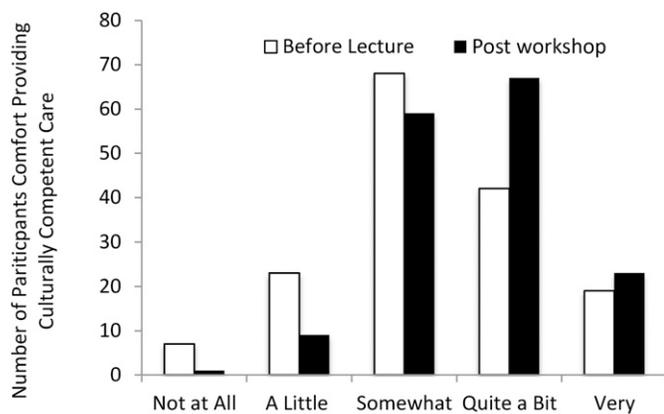


Figure 2. Pre- vs. Post-attitude Assessment: Students' Perception of Comfort Providing Culturally Competent Care ( $p = .002$ ).

cultural competency skills among practicing pharmacists and students.<sup>5,22</sup> This model curriculum would start with the same core learning objectives, but would be adapted by the individual college to meet the program-specific needs that it encounters. The proposed goals of the model curriculum include: develop awareness, knowledge and desire during the first and second year of the curriculum; develop cultural sensitivity, patient-centered focus and skills during the third year; and develop opportunities for clinical encounters with a diverse range of patients during the fourth year. Based on ACCP's recommendations, video vignettes seem appropriate during the third year of the pharmacy curriculum as demonstrated and examined in our study.

The pharmacy literature makes limited mention of the use of video-based case studies with discussion. It is also difficult to compare to the videos discussed in the literature as they were used in a broader context than those developed for our study.<sup>4,13</sup> Our video vignettes were designed to address concepts in cross-cultural communication to potentially improve student understanding of several communication models and contribute to students' awareness of the impact of communication barriers on culturally competent care. Students reported an increase in comfort and positive attitude toward providing culturally competent care after the video-based workshop. While student perceived comfort is important, the literature suggests that an increase in knowledge and awareness of differences better allows for acknowledgment of one's lack of skills to deal with cross-cultural barriers.<sup>23,24</sup> Although individually not all of the knowledge-based questions reached statistical significance, all but one demonstrated an increase in student learning after the workshop. It is possible that some questions were not robust enough to truly assess the knowledge of individual

concepts. An adjustment in these questions to reach a higher level of learning may better capture the impact of the videos on learning new ideas. Adding more videos and questions on each component of cross-cultural communication also could be added to the workshop and survey tool. Students seemed to better understand the proper use of an interpreter and the LEARN model after the workshop, which may have been due to a lack of exposure in their prior health care communications course in the curriculum. The use of the self-reflection questionnaire, which was not collected or assessed, was meant to address each students' level of cultural awareness and biases prior to watching the videos. This being said, it is not certain how much this first activity and discussion might have influenced the post-questionnaire results as some of the knowledge questions pertained to prejudices/biases and understanding the definition of "culture." The workshop incorporating the videos and discussions demonstrated an increase in immediate understanding of cross-cultural communication skills, as seen by pre- and post-quiz scores. This suggests that patient case video vignettes can be used as a simple and objective method to capture gaps in student understanding of cultural awareness and sensitivity. Furthermore, this is an example of an assessment of understanding that could be included as outcome data for students' demonstration of cultural awareness and sensitivity per ACPE standards.<sup>10</sup>

As previously stated, there were no differences in knowledge scores when compared by demographic characteristics, including socioeconomic status or self-identified race. The exception is that students who had not lived outside of the United States did statistically better on the pre-questionnaire than those who had lived outside of the United States. We hypothesize that those who grew up in the United States may have been exposed to more cultural competence content and experiences prior to attending pharmacy school, partially explaining their higher knowledge scores.

Instructors considering the use of patient case videos in a course should take into account the time commitment and labor in the development of video cases. The multi-step process includes choosing appropriate culturally relevant scenarios, creating scripts, recruiting actors who fit the demographics of the patient and pharmacist in each scenario, logistics of media resources, rehearsals, and film editing. Ideally, a database of such videos that can be shared across colleges of pharmacy would be beneficial as instructional methods. Additionally, such videos could include the role of other health care professionals and could augment interprofessional education, which is also included in educational accreditation bodies outside of pharmacy.

We solicited feedback from the workshop facilitators (N=6) after the workshop. The majority of indicated that the workshop incorporating the video vignettes was the most interactive workshop in the health care communications course. The videos encouraged students to share their personal experiences with cross-cultural encounters with less inhibition than previous workshop sessions in the course. While all the videos involved discussion, the video containing the most “cultural barriers” related to non-verbal and verbal communication was discussed the longest and in most detail by the students. Facilitators indicated that the most valuable points of this workshop were recognizing cultural biases and that asking questions is an effective method to promote cultural awareness. The videos were unique in that they highlighted the need for cultural awareness, knowledge, and skills in order to develop effective cross-cultural interactions. While the video-based workshop did not allow for students to practice use of the cross-cultural models, the students’ open-ended responses confirmed they must first be aware of barriers in communication and gain understanding of cross-cultural communication models in order to prevent failures in communication.

The majority of students (88.7%) in our study agreed that cross-cultural communication should be incorporated into more areas of the pharmacy curriculum. This finding somewhat contrasts with the results of a previous study on cultural competence content carried out among our college’s fourth-year students, where 67.5% of students thought they had enough cultural competence education.<sup>25</sup> The previous study was broader in scope and did not include an instructional design component, like the video vignettes we utilized, making a true comparison difficult.

The results of this study should be taken with the following limitations in mind. The study was conducted at one private school of pharmacy in the Midwestern region of the United States. The small sample size and unique demographic characteristics of our student body are not representative of the pharmacy student population across the country. Prior studies in cultural competence have been conducted in pharmacy colleges with varying degrees of cultural diversity in their student body, ranging from 22% to 85% of students classified as non-Hispanic white. Midwestern University Chicago College of Pharmacy’s third-year student body is 40% non-Hispanic white. The use of the videos is only one method in which cultural competence can be gained, and the results could have been influenced by knowledge, skills, and awareness gained outside of the pharmacy curriculum.

## SUMMARY

A two-hour cross-cultural communications workshop incorporating simulated patient case video vignettes

improved pharmacy students’ understanding of cross-cultural communication skills and comfort providing culturally competent care. This study demonstrated how videos can be added to lecture-based didactic teaching as a useful tool to teach cross-cultural skills within cultural competency training in the curriculum.

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Appendix. Patient Case Video Vignettes and Cross-Cultural Communication Questionnaire

**Instructions: Please check the response that most accurately reflects your perception/knowledge. If you have trouble understanding a question, answer to the best of your ability.**

Demographics (Pre-questionnaire only)

1. Age: \_\_\_years
2. Sex: Male\_\_\_ Female\_\_\_
3. Race/Ethnicity (Check all that apply)
  - a. African-American/Black
  - b. American Indian/Alaska Native
  - c. Asian American
  - d. Caucasian
  - e. Latino/Hispanic
  - f. Native Hawaiian/Other Pacific Islander
  - g. Other (specify)
4. Do you speak any other language(s)? Yes\_\_\_ No\_\_\_
  - a. If yes, please specify:\_\_\_\_\_
5. Have you ever lived in any countries outside the United States? Yes\_\_\_ No\_\_\_
  - a. If yes, please specify in which countries you lived and for how long?
    - i. Country(ies):\_\_\_\_\_
    - ii. Length of time:\_\_\_\_\_
6. Which of the following best describes the household where you grew up?
  - a. Upper class (Top-level executives, celebrities, heirs, Ivy League education common) \_\_\_\_\_
  - b. Upper middle class (Highly educated, often with graduate degrees, professionals & managers) \_\_\_\_\_
  - c. Lower middle class (Semi-professionals with some work autonomy; some college education) \_\_\_\_\_
  - d. Working class (Clerical, blue collar workers with often low job security; high school education) \_\_\_\_\_
  - e. Lower class (Those who occupy poorly paid positions or rely on government transfer; some high school education) \_\_\_\_\_
7. Pharmacy-related work experience (Select all that apply):
  - a. None \_\_\_\_\_
  - b. Community/Retail Pharmacy \_\_\_\_\_
  - f. Research-based/Laboratory \_\_\_\_\_
  - g. Pharmaceutical Industry \_\_\_\_\_

- c. Independent Pharmacy \_\_\_\_\_  
d. Institution/Hospital Pharmacy \_\_\_\_\_  
e. Ambulatory Care \_\_\_\_\_
- h. Academia \_\_\_\_\_  
i. Other (specify): \_\_\_\_\_

8. How comfortable are you providing culturally competent care? (Please circle the appropriate response)  
Not at all   A little   Somewhat   Quite a bit   Very

**Knowledge:** (Pre- and Post-questionnaire)

1. A pharmacist does NOT need to be fully aware of their own culture, biases, or communication style in order to practice in a culturally competent manner.
  - a. True
  - b. False
2. "Cross-racial" or "cross-ethnic" is another way to label "cross-cultural" interactions with patients. This statement is:
  - a. True
  - b. False
3. A young African American male wearing baggy clothes walks up to the pharmacy counter to pick up his prescription and only has cash to pay. The pharmacist assumes he is going to cause commotion because the prescription is not covered by any insurance and is expensive. Because she doesn't want to deal with him she makes the technician help him. Which cross-cultural barrier is being demonstrated in this case?
  - a. Assumed similarity
  - b. Nonverbal communication
  - c. Lack of cultural knowledge
  - d. Fear and distrust
4. A Muslim pharmacist is filling a prenatal vitamin for an Arab pregnant patient at the pharmacy. Upon counseling, she congratulates the patient and remarks, "Your husband must be very happy." The patient replies, "Actually my wife is very happy this round of IVF worked." Which cross-cultural barrier is being demonstrated in this case?
  - a. Assumed similarity
  - b. Stereotyping
  - c. Lack of cultural knowledge
  - d. Language barrier
5. An African-American nurse is caring for a middle-aged Latina woman several hours after the patient had undergone surgery. A Latino physician commented to the nurse that the patient appeared to be in a great deal of postoperative pain. The nurse immediately dismissed his perception, informing him that she took a course in cross-cultural medicine and recalled that, "Hispanic patients over express the pain they are feeling." Which cross-cultural barrier is being demonstrated in this case?
  - a. Assumed similarity
  - b. Stereotyping
  - c. Lack of cultural knowledge
  - d. Language barrier
6. Mr. Smith is brought into the hospital by his wife for severe breathing problems associated with his COPD. Upon admission, the medical team realizes that the patient is deaf and is unable to communicate with them. Mrs. Smith, who is not deaf tells the team that they communicate with each other using American Sign Language (ASL). One of the medical students on the team says he also know some basic ASL and offers to obtain information from the patient regarding the exacerbation. What is the best course of action for communicating with Mr. Smith?
  - a. Make a call for a hospital medical interpreter
  - b. Use the medical student as the interpreter
  - c. Use the patient's wife as the interpreter
7. Which of the following nonverbal method(s) during a counseling session allows the pharmacist to show respect an establish trust with their patient? (Select all that apply)
  - a. Use open posture

- b. Lean away from the patient
  - c. Maintain eye contact
  - d. Demonstrate authority
8. Which of the following is NOT a strategy that should be used by pharmacists in difficult cross-cultural communication interactions with patients?
- a. Provide examples
  - b. Simplify language
  - c. Rephrase instructions
  - d. Offer personal views
  - e. Honor preferences for names/titles
9. Which of the following is a mnemonic describing a model for overcoming cross-cultural communication barriers?
- a. ACCEPT
  - b. HONOR
  - c. LEARN
  - d. CLEAN
  - e. RACIAL

**Attitudes:** (Post-questionnaire only)

10. How comfortable are you providing culturally competent care after completing this workshop?  
(Please circle the appropriate response)  
Not at all   A little   Somewhat   Quite a bit   Very
11. Should the PharmD curriculum contain more cultural competence related communication training?  
Yes\_\_\_\_ No\_\_\_\_
12. Should the college offer a required course on cultural competency? Yes\_\_\_\_ No\_\_\_\_
13. Should the college offer an elective course on cultural competency? Yes\_\_\_\_ No\_\_\_\_

Please provide any comments related to this cross-cultural communication workshop below (eg, which video did you learn from the best, suggestions for improvement, areas you wish were covered more, etc.):

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Thank you very much!