How to better teach and evaluate Diversity Education in the National Health Service and Health Educational Institutions in the United Kingdom

Thesis Submitted for the degree of Doctor of Philosophy to the University of Leicester

by

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ABSTRACT

HOW TO BETTER TEACH AND EVALUATE DIVERSITY EDUCATION IN THE NATIONAL HEALTH SERVICE AND HEALTH EDUCATIONAL INSTITUTIONS IN THE UNITED KINGDOM

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Background and Context

Despite the frequent inclusion of the term 'diversity' in health educational policy, ambiguity remains in its usage and implementation. A paucity of high quality research exists on how to best teach and evaluate diversity education in healthcare settings. This PhD aims to first gather the perspectives of key stakeholders on how we can better teach and evaluate diversity education. Secondly, develop an evaluation tool that can be used to measure its effectiveness, thereby providing theoretically informed evidence to guide curriculum development and evaluation.

Methods

This PhD has a mixed method design in which a participatory research approach (PRA) was utilised, involving the collaboration of 8 organisations. A total of 94 key-stakeholders across the UK took part in 8 participatory workshops. Using template analysis, a reconstructed relationship-centred care (RCC) model was developed. Based on this model a situational judgment test (SJT) was constructed. This allowed multi-dimensional factors related to diversity to be evaluated. A total of 208 participants participated in the piloting of the SJT, which involved a rigorous process of writing, refining and retesting scenarios.

Findings

The findings revealed that diversity education should be focused on the nuances and dynamics of clinical relationships. In particular, the relationship considered the most important to examine with respect to diversity education was the 'practitioner-self' relationship. The SJT offered a robust evaluation tool and the scenarios can be tailored to different contexts, further developed and refined for future use.

Discussion and Conclusion

The findings provided clarity on how diversity education can be better theoretically informed. The reconstructed RCC model situates diversity within a wider context that should be considered for achieving high quality patient centred care and improving professional practice. In addition, the SJT offers a tangible resource for healthcare educators to begin to evaluate the effectiveness of their diversity education.

ACKNOWLEDGMENTS

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ABBREVIATIONS

BPS   British Psychological Society

DH   Department of Health

GMC   General Medical Council

IPE   Inter-Professional Education

LPM   Learning Partnership Model

NHS   National Health Service

NMC   Nursing Midwifery Council

PCC   Patient-centred care

PRA   Participatory Research Approach

RCC   Relationship-centred care

SJT   Situational Judgement Test

UK   United Kingdom

USA   United States of America

NOTATIONS

The following notations are used in the quotations of the respondents in the findings.

".." Represents the opening and closing of the quote

// Represents a pause

[ ] With text within these brackets has been inserted by the author to explain the meaning made by the respondent.

... Between sentences indicates the quite has been shortened and linked to appropriate relevant sentences.

Quotations from the literature are indented and non-italicised.

Single quotation marks convey terms used by medical educationalists and lay people but imply that there is inconsistent usage.

Single quotation marks plus italics show concepts developed within the analytical framework by the author; for example, 'reconstructed relationship-centred care model'.

DECLARATION

I certify that this thesis represents original research carried out by me with the help of those persons outlined in the acknowledgements. It does not contain material previously submitted for a degree or diploma in any university and, to the best of my knowledge and belief, does not contain any material published by any other person, except where due reference is made in the text.

Riya Elizabeth George
APPROVED WORD EXTENSION: 100,000

INTRODUCTION

This introductory chapter describes the principles and issues that will be comprehensively explored, evaluated and discussed in this thesis. This chapter aims to provide an overview of the definition of diversity education, an outline of why diversity education is important and describe key challenges associated with the development, delivery and evaluation of diversity education. The aim and objectives of the thesis will then be addressed, with the accompanying chapter number indicating where each objective will be achieved.

WHAT IS DIVERSITY EDUCATION?

Diversity education aims to equip health professionals with the knowledge, skills and attitudinal responses to provide effective healthcare to diverse patient populations. Achieving consensus on the definition of diversity has proved challenging. In its broadest sense, any difference can be regarded as diversity (Napier et al, 2014). To understand diversity, the term culture must first be clarified. Definitions of 'culture' are complex, nuanced and varied depending upon the context and discipline (Curcio et al, 2012). Culture is a highly-debated concept, with no single, agreed definition. The definitions of diversity and culture will be comprehensively explored in this thesis, but one definition of culture defined by the UK organisation 'Diversity in Medicine and Health' (DIMAH) is presented below to aid in the explanation of the term diversity.

> *"Culture is a socially transmitted pattern of shared meanings by which people communicate, perpetuate and develop their knowledge and attitudes about life. An individual's cultural identity may be based on heritage as well as individual circumstances and personal choice and is a dynamic entity." (DIMAH, 2014; Accessible via: www.dimah.co.uk)*

As humans, we exist as 'cultural beings'. The meanings we attach to health and illness are weaved from our own individual prism of beliefs, values and experiences, creating a unique fabric for each of us that colours how we define, perceive and react to a given situation (Bhugra & Bhui, 2001). The manner and variation upon which shared meanings of culture are internalised, understood and practised in individuals gives rise to diversity in populations and creates differences in the understandings of health and illness (Dogra et al, 2015). Diversity is a concept that acknowledges differences in

systems of shared cultures and values. Although values, beliefs and practices can be shared in a 'culture', 'diversity' recognises the heterogeneity among single cultures and identifies characteristics that are autonomous and distinct.

Whilst diversity education varies considerably across healthcare disciplines and settings, in a generalised sense the curriculum broadly includes either one or a combination of three educational dimensions; namely the acquisition of knowledge regarding different cultural groups, secondly the encouragement of self-awareness of one's own diversity and culture and reflection upon personal assumptions, biases and preconceived ideas and lastly the development of skills notably in improving communication in cross-cultural settings (Betancourt et al, 2007; Shen et al, 2015). .

WHY IS DIVERSITY EDUCATION IMPORTANT?

The demographic landscape of the UK population continues to change, (Census, 2011) leading to questions about how the prevailing health-system can meet the needs of an increasingly diverse population. The rapid growth of culturally diverse communities, each with their own health profiles and cultural norms, presents complex challenges for health professionals and policy makers in terms of achieving equitable care, which is responsive to the diverse needs of patients. It is a basic and fundamental human right to be cared for in an equitable way. Evidence supporting the positive benefits of providing individualised, patient-centred care is irrefutable in demonstrating improved health outcomes, better patient satisfaction, enhanced patient experience and an increased likelihood of patients adhering to medical advice and treatment (Bauman et al, 2003). Diversity education explicitly aims to acknowledge, value and respond to patient differences. It is underpinned by healthcare values that aim to eliminate health inequalities particularly in Black and ethnic minority communities, improve health outcomes in marginalised and under-served populations and enhance the patient-doctor clinical experience (Dogra et al, 2009). Evidence has shown the influence of diversity and culture on the accessibility, appropriateness, acceptability and quality of healthcare service provision (Bhui et al, 2007; Qureshi et al, 2008). Consistent research indicates that a failure to acknowledge, understand and manage cultural variations in patients impedes effective communication and the development of a therapeutic relationship, contributing to disparities in care and lower rates of patient satisfaction, particularly among Black and ethnic-minority groups. (Napier et al., 2014)

Diversity education is mandatory for all NHS health professionals (Department of Health, 2012) and a variety of healthcare professional bodies including the General Medical Council (GMC, 1993; 2003; 2009), the Nursing Midwifery Council (NMC, 2000; 2005; 2010) and the British Psychological Society (BPS, 1994; 2008; 2015) encourage and even mandate the inclusion of diversity education in the undergraduate health curriculum. These various healthcare policies and institutional requirements hold transparent expectations that issues of diversity should be addressed. UK healthcare institutions aim to ensure services are equitable, responsive to diverse needs of patients, culturally inclusive and operate in a discrimination free environment. Political drivers have been the key reason, particularly in the NHS as to why diversity education is considered important. The NHS and UK health educational institutions also an organisational duty to ensure diversity legislation is complied with.

OVERVIEW OF THE CHALLENGES IN DIVERSITY EDUCATION

Beyond broad agreements, exactly how to apply and teach diversity education has become something of a conundrum. There are questions about how, when, where and why diversity education should take place. Despite the frequent inclusion of the term 'diversity' in health policy and institutional guidelines, considerable ambiguity has evolved in its definition and use across settings. This lack of consensus encompasses not only the definition of diversity education, but also its core elements, best practices and measures to assess effectiveness. Consequently, health educational institutions adopt different ways of developing and delivering diversity education, resulting in fragmented and variable approaches often lacking in a theoretical underpinning (Dogra et al, 2005; Bentley et al, 2008; George et al, 2015).

The literature demonstrates inconsistencies in the usage, understanding and implementation of the terms 'diversity', 'culture' and 'cultural competence.' Diversity education is a term synonymously interchanged with a range of labels such as, 'cultural awareness', 'cultural competence' and 'equality and inclusion'. The assortment of vocabulary for these types of educational teaching reveals the lack of consensus as to what the correct terminology is and the evidence base for these types of teachings. The use of these terms varies across healthcare contexts nationally and internationally, with 'diversity' being used more in the UK, whereas 'culture' and 'ethnicity' frequently applied across Europe and 'cultural competence' remains a prominent term used in the

USA. The considerable variation and lack of conceptual clarity of these terms results in different diversity educations with differing intentions and educational objectives.

Diversity is a term often accompanied with the concept of 'equality'. Equality is a widely-acknowledged notion in healthcare policy, with on-going debates as to how to better articulate this term. Even though the concept of 'equality' stems from a political arena, its primary concern is 'social justice' and how certain organisational structures create social and cultural barriers (Campbell, 1976). It aims to ensure fairness in the distribution of health-care services and practice, and in simple terms, refers to 'treating all individuals the same' (Bogg, 2010; pp.2). Changes in equality legalisation including discrimination acts have resulted in new terms and content for diversity education. The Equality Act (2010) represents a streamlined approach to factors relating to diversity, and collectively sought to incorporate all equality legislation under a single Act. The overarching purpose of the Equality Act (2010) is to "*achieve harmonisation, simplification and modernisation of equality law.*" The Act defined nine 'protected characteristics', namely 1) age, 2) disability, 3) gender, 4) marriage and civil partnership, 5) pregnancy and maternity 6) race including issues of culture and ethnicity, 7) religion, 8) sex and 9) sexual orientation.

As equality legislation changed and became broader in scope; acknowledging a variety of differences other than the popular focus on race and ethnicity, the concept of 'diversity' originated and new ways of conceptualising 'equality' began. It is widely acknowledged the 'one size fits all approach' is not appropriate for most clinical groups and especially those that are diverse in many ways. Many authors in the field have acknowledged that diversity education is driven by political motives as opposed to clinical and educational need, resulting in diversity education being perceived as merely a legal 'tick-box' requirement (Dogra et al, 2015; Betancourt, 2008).

Various theoretical frameworks to achieve diversity education have been applied in the healthcare curriculum. Granting the authors describe their "*theoretical models or frameworks*", the literature describing diversity education infrequently refers to a clear theoretical position. Recent reviews on diversity education illustrate the lack of conceptual clarity and rigour in identifying a sound, evidence-based theoretical framework upon which to base diversity education. Different educational philosophies and theoretical frameworks view diversity very differently, again leading to programmes with very different intentions (Dogra et al, 2014). The distinctions between these

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theoretical models is somewhat blurred, resulting in terms such as 'cultural competence' and 'cultural sensitivity' being used interchangeably and synonymously.

Current diversity education in the NHS and other health educational institutions is widely variable in content, duration, delivery and assessment (Bentley et al, 2008; Dogra et al, 2011; George et al, 2015). The evidence-base for diversity education in healthcare settings is limited. Price et al (2005) conducted a systematic review of the methodological rigour of studies exploring different types of diversity education for health professionals, and found studies were of a low to moderate quality and therefore of small value upon which the development and implementation of future work in this field might be based (Beach et al, 2005; Betancourt et al, 2008). In addition, the quality of the literature in this field does not appear to be consistently improving over time in the UK. Although an increasing number of professional guidelines encourage and even mandate diversity education, these efforts have not been standardised or carried out in a consistent manner.

Evaluation is an integral part of determining the effectiveness of education and training programs (Stufflebean & Shinkfield, 1985). Diversity education is subject to little or no evaluation and assessment beyond subjective measures (i.e. feedback forms or self-reported questionnaires) and rarely includes evaluating the long-term effects of the teaching on patient outcomes. There remains a paucity of validated evaluation tools to measure diversity education, particularly within UK NHS settings (Beach et al, 2005: Betancourt et al, 2005; Harris-Haywood et al, 2014). Despite the number of health organisations endorsing a variety of diversity education, there is limited evidence to indicate whether the impact of the education is known or even being measured (Beach et al, 2004; Anderson et al, 2003).

The heterogeneity of curriculum and educational designs makes evaluation a complex task. There are no two studies that could evaluate the exact same training experience (Price et al, 2008; Truong et al, 2014). The lack of uniformity in educational designs and measurement of outcomes makes it challenging to identify specific types of knowledge, attitudes and skills which are impacted by diversity education. In addition there are limited studies that compare different types of diversity education in terms of evaluating their effectiveness in improving professional practice and patient health outcomes (Gozu et al, 2007; Green et al, 2007; Grant et al, 2013; Hanssmann et al, 2010). Diversity educational programs which have undergone evaluations of some sort,

have indicated mixed findings in terms of their effectiveness, a large majority being conducted in the U.S.A (Beach et al., 2005). Despite conceptual and methodological limitations, the evaluation data available has suggested significant improvements in skills, knowledge, behaviour and attitudes after training (Beach et al, 2005; Kardong-Edgren et al, 2005; Anderson et al, 2003). However there remains a need for validated evaluation tools and evidence suggesting an association with an improvement in professional practice and health outcomes.

AIM AND OBJECTIVES OF THE THESIS

The main aim of this thesis is to support curriculum development and evaluation of diversity education within the NHS and health educational institutions by gathering the perspectives of key-stakeholders (namely mental-health patients, NHS health professionals and medical educators') on how to better teach and evaluate this subject and to develop an evaluation tool that can be used to measure the effectiveness of diversity education. This thesis has the following 13 core objectives outlined below which are achieved in the chapters listed next to them.

1. To provide a critical overview of theoretical frameworks used in diversity education in healthcare settings, to identify areas of conceptual similarity and difference. (Chapter 1)
2. To provide an overview of the institutional requirements and expected healthcare policy outcomes concerning diversity education and explore its relationship to the development of different theoretical frameworks. (Chapter 1)
3. To review core educational theories pertinent to health educational institutions and their application and relevance to diversity education and understanding of one's cultural identity. (Chapter 2)
4. To identify and critically appraise the most widely cited measures and tools to evaluate diversity education, exploring the underlying assumptions and conceptual issues that these measures embody. (Chapter 3)
5. To provide an overview reviewing the application of theoretical frameworks in diversity education in practice across specified healthcare disciplines, nationally and internationally. (Chapter 4)
6. To explore the connection between diversity education and other healthcare concepts, specifically professionalism, patient-centred care and intercultural communication. (Chapter 5)

7. To identify key stakeholders' (specifically mental-health patients, NHS Leads, healthcare professionals and medical educators) understanding of the terms 'diversity', 'culture' and 'cultural competence.' (Chapter 6, 7 and 8)

8. To identify key stakeholders' (specifically mental-health patients, NHS Leads, healthcare professionals and medical educators) conceptualisation of patients' expectations of the knowledge, skills and attitudes of healthcare professionals they deem 'culturally competent.' (Chapter 6,7 and 8)

9. To identify key stakeholders' (specifically mental-health patients, NHS Leads, healthcare professionals and medical educators) viewpoints on current diversity education in the NHS and within medicine and how this might be improved. (Chapter 6,7 and 8)

10. To identify key stakeholders' (specifically mental-health patients, NHS Leads, healthcare professionals and medical educators) perspectives on how diversity education might be evaluated and what an evaluation tool for diversity training should be seeking to measure. (Chapter 6,7 and 8)

11. To establish a sound educational theoretical framework from the qualitative findings on the perspectives of key stakeholders' on how to better teach and evaluate diversity education, which could be used to achieve the institutional requirements and healthcare expectations concerning diversity. (Chapter 9)

12. To develop, pilot and validate an evaluation tool for diversity education that can be used to measure the effectiveness of diversity education in the NHS and healthcare educational institutions. (Chapter 10 and 11)

13. To provide key recommendations and implications for practice, policy and research for supporting curriculum development and evaluation of diversity education. (Chapter 12).

CHAPTER 1: OVERVIEW OF THEORETICAL FRAMEWORKS ON DIVERSITY EDUCATION

This chapter considers and evaluates the different theoretical frameworks for teaching diversity education, highlighting the conceptual similarities and differences between them. This chapter provides an overview of landmark theoretical frameworks and studies that have contributed to the vocabulary of education in diversity and culture. Key theoretical frameworks and educational practices that foster intercultural learning are discussed within phases of decades, starting from the 1980s to 1990s, 1990s to 2000 and 2000 to 2010, except for a few pertinent theoretical frameworks prior to the 1980s included to set the stage for subsequent exploration. This chapter aims to demonstrate the evolving understanding of cultural complexity in the way educators conceptualise frameworks. This is then discussed in parallel with the changing institutional requirements and healthcare expectations of diversity education, considering how these political drivers have influenced the way cultural complexity and diversity is understood.

1.1 EARLY CONCEPTUALISATIONS OF CULTURAL COMPETENCE

Early educational healthcare endeavours on issues of culture and diversity proceeded within the remit of cultural competence training initiatives. The concept of cultural competence first appeared in social work (Lewin, 1946, Gallegos, 1982) and counselling psychology (Sue et al, 1982; Perdson & Marsell, 1982) with reported training initiatives such as 'cultural sensitivity' being developed as early as 1946 (Lewin, 1946). The literature demonstrates several iterations and descriptions of cultural competence as described by different authors each striving to describe the concept; such as 'cultural sensitivity' (Lewin, 1946), 'cultural literacy' (Howell, 1982), 'intercultural sensitivity' (Bennett, 1986), 'ethnic competence' (Gallegos, 1982), with a large majority of authors eventually converging on the term cultural competence (Sue et al, 1980; Cross et al, 1989; 2001; Howell, 1982; Campinha-Bacote, 2003; Lum 2005; Weaver, 2005).

As a culture is used to define different interpretations and meanings of health and illness, it also defines healthcare values, practices and delivery of service provision. The increase in ethnic disparities in healthcare and the growing cultural diversity of the

patient population challenges healthcare professions to recognise culture and diversity to deliver 'culturally competent care.' The concept of cultural competence became prominent in healthcare as increasing numbers of studies conveyed significant disparities in health outcomes among minority ethnic groups. In response, it appeared that historically the notion of cultural competence training developed out of efforts to bridge the cultural divide between predominantly 'White' biomedical cultural perspectives and Black, and ethnic minority perspectives (Betancourt et al, 2003; Campinha-Bacote, 2002). The training became largely targeted towards minority groups and those whose health beliefs were in opposition to Western biomedical practice.

Early healthcare training followed the premise that particular races and ethnicities had certain cultural beliefs and attitudes that impacted the delivery of healthcare services. Cultural competence models *"emphasised a notion that clinicians and trainers need to develop 'cultural expertise' in particular cultures to be effective providers"* (Curcio et al, 2012; pp.42). Based on this early conceptualisation, learners were expected to formulate levels of knowledge about specific cultures i.e. their history, traditions and core beliefs as they directly impacted care provision. There was also the expectation that learners would develop skills based upon this generalised acquired knowledge; including cross-cultural communication skills, understanding patients' perspectives and the development of culturally sensitive treatment plans. This model of 'cultural expertise' also referred to as 'cultural competence' was reflected in definitions of culture which favoured group-based distinctions, categorising clusters of individuals based on factors such as religion, race or ethnicity (Bhui et al, 2012).

Smedley et al (2003) comprehensively reviewed the literature and stated that cultural competence training emerged primarily from three over-arching factors; first, for the issues mentioned in the earlier paragraph, highlighting the necessity to prepare healthcare professionals to meet the needs of a growing culturally diverse population (Welch, 1998). Secondly many authors hypothesised that cultural competence training could improve provider-patient communication, as exploration into the aetiology of ethnic disparities revealed that many cultural issues arose in clinical communication (Berne, 1961; Beveridge, 1942; Heron, 1976). Thirdly in response to statutory and institutional requirements both encouraging and mandating the need for training in cultural competence (GMC, 1993; 2003; 2009; DoH, 2000; 2005; 2015; Pew Health Professions Commissions, 1995; 2004).

In critically exploring the second factor, a minority of theoretical frameworks did not conform to the philosophy behind the cultural competence/cultural expertise model, disputing that a mastery of cultural knowledge fosters effective intercultural learning about 'others' and instead emphasised the importance of communication and self-exploratory discussions. For example, Lewin's model on cultural sensitivity (1946) proposed the following four learning objectives to achieving competence in cross-cultural settings: 1.) Developing interpersonal skills, 2.) Exploring the source of prejudice within one's self, 3.) Learning how to alter attitudes and 4.) Developing an understanding of one's own attitudes and values. Lewin, a social scientist, conducted research on intergroup relations and resolving conflict, with a focus on the problems of minority or disadvantaged groups. Lewin believed that the key to resolving intercultural and social conflicts was to facilitate self-exploratory learning that enabled individuals to understand and restructure their perceptions of the world.

Harrison and Hopkins (1967) contradicted the didactic approach towards healthcare professionals developing 'cultural expertise' and recommended that experiential methods were superior for five core reasons; 1) The didactic approach assumes passive rather than active learning and that cultural knowledge can be decanted into sets of specific information which may be incongruent to how cultural issues are presented in practice. 2.) It construes cultural issues as well-defined problems that can be easily identified and rationalised, whereas Harrison and Hopkins highlighted that cultural issues may be challenging to identify and rest on the practitioner to recognise them. 3.) It presents the challenges in intercultural relations as rational and unemotional, whereas many cross-cultural issues may be strongly associated with personal beliefs and emotions, thereby encouraging professionals to develop the 'emotional muscles' necessary to effectively address intercultural relations. 4.) Didactic/lecture based teaching on culture conforms to what Trifonovitch (1977) terms "*paper orientation*" whereas Harrison and Hopkins (1967) claim that intercultural relations requires interpersonal skills or a "*people orientation*." 5.) Finally lecture based teaching emphasises written communication as opposed to verbal communication, highlighting the elements of communication that are non-verbal or oral.

Similarly, Hall (1959; 1966) provided a set of conceptual tools on culture that facilitated the development of cross-cultural training as a field. Hall argued that cross-cultural misunderstandings resulted from distortions in communicating among people. Hall proposed that any aspect of culture could be studied at three levels; formal, informal

and technical. Formal refers to behaviours or values that are habitual within the work environment, that create cultural 'norms' and aspects of culture that are characterised as either right or wrong. Informal refers to behaviours and values that may vary in different contexts and in different people. These aspects of culture are instilled by modelling the behaviour of other professionals, and are therefore by nature implicit, flexible and variable across different individuals in a work culture. Conversely technical aspects of culture are explicit, usually in the form of 'codes of practice' or expectations of professionalism.

These few examples are in stark contrast to the notion of 'cultural expertise/cultural competence' in that they acknowledge culture more broadly, recognising the definition of culture as complex, nuanced and varied depending upon the context and discipline. They also illustrate aspects of culture that not only resides within the patient but also the healthcare professional and the organisation. As opposed to advocating the impetus of developing knowledge, these examples highlight the importance of developing one's skills and attitudes. We see that even within the earliest foundations of cultural competence training discrepancies arise about how this topic should be understood, theoretically framed and delivered. To date these struggles are still relevant in establishing a consistent national curriculum for diversity education.

1.2   THEORETICAL FRAMEWORKS DURING 1980S TO 1990S

The theoretical frameworks during the 1980s to the1990s showcase the evolving maturity of the notion of cultural expertise/ cultural competence, however aspects of communication and self-exploration remain interwoven in the narrative around how cultural competence is achieved. Howell's model of cultural competence (1982) was one of the earliest theoretical frameworks in the 1980s. It defines a developmental four stage approach of consciousness and competence that individuals progress through in becoming culturally competent. These stages are unconscious incompetence, conscious incompetence, unconscious competence and conscious competence. These developmental stages involve a transition from being unaware of cultural differences and cross-cultural miscommunications to gaining a conscious awareness of the challenges in cross-cultural interactions and the necessity of skills in communication to help them understand how to effectively converse across cultures.

This model was influential in illustrating the need for staged learning in the development of cultural competence, which was later inherited by the frameworks

developed by other authors (Bennett, 1986; Campinha-Bacote, 2000; Byram, 2008). However, individuals or teachers can wrongly assume different stages of competence or may be unable to correctly identify which stage is appropriate to their unmet needs. The structure of this theoretical framework suggests that achieving cultural competence is a linear process, failing to consider that individuals may regress back to previous stages or advance forward to the latter stages and that some may not transition through all stages. Also, little description is provided about how these transitions occur, the antecedents of change and how the experiences of transitioning may vary in individuals.

The LEARN model (Berlin and Fowkes, 1983) was developed shortly after Howell's model and contrasted in that it did not propose a developmental approach to achieving cultural competence nor did it necessarily advocate the importance of cultural knowledge; rather it suggested that improved communication is a central component of cross-cultural clinical interactions. The LEARN model encourages the ethos of patient-centred care by proposing the following components: a.) *L*isten with sympathy and understanding to the patient's perception of the problem b.) *E*xplain your perceptions of the problem and strategy for treatment c.) *A*cknowledge and discuss the differences and similarities between these perceptions d.) *R*ecommend treatment whilst remembering the patient's cultural parameters and e.) *N*egotiate treatment. Berlin and Fowkes (1983) emphasise that cultural issues may vary according to context, in that the perceptions of the provider-patient relationship may result in different expectations from both parties. Comparable to the frameworks mentioned prior to the 1980s, the learning goals are in the form of communication and competence. Berlin and Fowkes (1983) assert that attaining information on all cultures may be unrealistic and impractical, whereas equipping healthcare professionals with the skills to elicit, discuss, share and negotiate cultural understandings is more valuable. However, the model does not explicitly address how these cultural understandings can fluctuate among providers and how the culture of the healthcare provider can interplay in the understanding of the patient's culture.

Bennett's (1986) model of 'intercultural sensitivity' succeeded Howell's (1982) developmental approach and offered a new way of conceptualising what he defined as 'intercultural sensitivity'. Bennett proposed a developmental continuum of key stages of personal growth where an individual progresses from 'ethno-centrism' which describes the judgment of another's culture by one's own standards to 'ethno-relativism', which

acknowledges the cultural differences between oneself and others and integrates these into one's own standards. Bennett's framework suggests that as individuals increase their capacity for intercultural sensitivity and maturity, they are better able to understand the complexities of intercultural relations and dynamics, thereby assisting them to act in ways that are culturally sensitive and contextually appropriate. The first three stages are defence, denial and minimisation which mark the central hallmark of the notion of 'ethnocentrism', characterising a lack of awareness or ignorance to any cultural variations that are different to one's own. The progression towards the latter three stages, which are acceptance, adaptation and integration, encompasses a development of cognitive maturity to allow one to view other cultural perspectives as equally valid. As with the Howell's model, criticisms were raised in terms of the sequential progression through the proposed stages, however many authors acknowledge that this model represents a considerable refinement of non-sequential frameworks and assists educators in developing sessions of increasing complexity and thought to foster intercultural learning (Hoopes, 1981; Paige & Martin, 1983). However, it remains dependent on how participants identify their 'starting point' and how to facilitate their subjective experiences towards the concluding stages. This model is limited in its ability to identify the specific needs of an individual or group. Gudykunst and Hammer (1983) attempted to resolve this by suggesting a sequence of three stages of cultural competence training; perspective training, interactional training and context specific training. Although this may improve the development of training in terms of format and delivery, it remains inadequate in identifying the participants' developmental experience.

The theoretical frameworks in this phase attempt to operationalise the stages in which cultural competence is developed, however they are abstract in their descriptions of the types of educational strategies and materials to achieve the proposed stage of development. Minimal information is provided on how these theoretical frameworks are translated into the educational curriculum, how the needs assessments of an individual are identified and how the evaluation of outcomes for each stage are made. In contrast to the frameworks and theories prior to the 1980s these frameworks are fuller in description and emphasise the interactional nature of cultural factors between oneself and others, and how one begins to become aware and accommodative to different perspectives. Whilst dissemination of cultural knowledge will be utilised in these teaching approaches, similar learning goals in communication are also included as well as developing self-awareness of cultural differences within oneself and others.

1.3 THEORETICAL FRAMEWORKS DURING THE 1990S TO 2000S

The theoretical frameworks in this decade during the1990s to 2000 illustrate a clearer tapestry of the distinct fusions between the cultural expertise/cultural competence model focused on the attainment of specific cultural knowledge and the emerging frameworks eliciting the importance of communication, self-awareness, context and cultural interactions. A plethora of theoretical frameworks were developed during this decade and the most frequently cited models will be critically evaluated and compared.

Transcultural nursing emerged in 1991 (Leininger, 1991) as a formal area of research, study and practice that was centred on culturally based care, beliefs, values and practices. Leininger's 'theory of culture care diversity and universality' (Leininger, 1960; 1981) advanced the body of theory on transcultural nursing. This theory acknowledges the cultural dynamics that influence the nurse to client relationship, with the goal of providing 'culturally congruent holistic care.' Leininger explains that through creative partnership between the nurse and the client uniting professional expertise with patient expertise, culturally congruent care can be achieved. Care modalities are re-patterned towards the specific cultural needs of the patient and require co-participation and working together. Leininger states transcultural nursing is *"directed towards holistic, congruent (appropriate) and beneficial healthcare"* for individuals, families, communities and institutions (Leininger, 1991, pp.56). Leininger defines 'culturally congruent care' as providing *"care that is meaningful and fits with cultural beliefs and life ways"* (Leininger, 1991; pp.44). On a practical level this involves a synergy between an 'emic' approach; meaning to utilise local cultural knowledge in a significant way that is compatible with an 'etic' approach which largely refers to professionals' expertise and knowledge (Leininger, 2001).

This model echoes the principles of cultural competence in how culture is defined and understood. Transcultural nursing and Leininger's theories are still largely influential in the practice of nursing today. Leininger's model emphasised care as well as culture and consciously addresses the fact that culture affects the nurse-client relationship. Although it does not specify the skills or attributes necessary to elicit culturally relevant information from the patient nor does it stipulate how to mobilise the patient and nurse to work cooperatively to achieve culturally congruent care. Also, the model appears to pay an unbalanced attention to the cultural aspects of the patient as opposed to the healthcare professional. These criticisms were raised by other authors, including the

lack of significance of the influence of the provider's cultural background in their understanding of the patient's cultural needs (Duffy, 2001; Beach et al, 2004). Duffy (2001; pp.2) argued that *"greater critical self-reflection and acknowledgement of self"* should be included.

Cultural competence models were increasingly gaining several negative criticisms of their assumptions that a healthcare professional can learn or know enough about particular cultural groups and develop a full understanding of cultures different from their own. Criticisms were made over the disregard for the inherent complexity of culture and diversity and the assumption that one could become 'culturally competent' by simply learning generalised facts on certain cultural groups. In contrast to other theoretical frameworks aligning with the cultural competence model, the notion of transcultural nursing attempts to acknowledge the interactional nature between the culture of the patient and the nurse and the need to actively work in partnership, sharing and exchanging expertise to achieve care that is congruent to their cultural needs.

Cultural sensitivity (Stafford, 1997) begins to advance the notion of 'cultural competence' and proceeds by accepting an awareness of the fact that there are cultural differences and similarities between individuals and those cultural differences are of equal value. Stafford (1997; pp.78) defines cultural sensitivity as *"being aware that cultural differences and similarities exist and have an effect on values, learning and behaviour."* Elements of Bennett's (1986) model of intercultural sensitivity are included in Stafford's notion of cultural sensitivity. Stafford outlines many steps to achieving cultural sensitivity, specifically 'cultural awareness'; investing time in reflecting upon one's own biases and prejudices and identifying one's cultural norms. Second learning about cultural knowledge; demonstrating a willingness to acquire knowledge about cultures and particular practices, beliefs and traditions. In contrast to Bennett's intercultural sensitivity model, it does not advocate a staged developmental continuum to achieving cultural competence and appears closely compatible with the notions on transcultural nursing.

Cultural safety (Polaschek, 1998) developed as a subsidiary model of transcultural nursing which specifically addresses nursing practices towards different ethnicities, in particular the needs of indigenous minority communities. The term 'safety' has not been mentioned previously in theoretical frameworks concerning culture. Safety implies

pre-defined standards which should be met, and contrary to the name it is not confined to the theory of cultural practices. It sheds light on the status of certain groups and how they are perceived and treated in society. Polaschek (1998; pp.8) defines culturally unsafe care to include any *"practices which diminish, demean or disempower the cultural identity and well-being of an individual."* Conversely culturally safe practices entail *"actions which recognise, respect and nurture the unique cultural identity and safely meet their needs, expectations and rights."* Cultural safety is specifically contrasted by its advocates with transcultural nursing. It argues that no healthcare interaction is ever simply objective. Rather a health professional operates from her/his own cultural mind set which influences how she/he relates to those she/he cares for. Also, every particular healthcare interaction is to some extent influenced by the cultural context in which it occurs.

This model is unique in that it explicitly draws attention to the clinical relevance and safety of acknowledging cultural factors and failure to acknowledge this may result in misunderstandings, misinterpretations, incorrect diagnoses, poorer quality of care and unsuitable care plans. There is a greater emphasis on the healthcare professional's as well as the patient's culture and the importance of context. This model also encourages professionals to recognise harmful or negative attitudes and stereotypes that may impede the delivery of high quality care. Nonetheless it is developed specifically for indigenous populations, and although it may allude to the diversity within specific ethnic groups it appears to assume that attitudes and practices may be culturally similar. Like other theoretical frameworks mentioned, it is abstract in nature and detached from devising the framework for an educationally sound model.

Cultural humility (Tervalon & Murray-Garcia, 1998) is a theoretical model which challenges the concept of learning finite bodies of knowledge about cultural groups which are typically expected in cultural competence models. They conceptualise three key principles to achieving cultural humility; 1.) Life-long learning and critical self-reflection which highlights that each individual is a complex, multi-dimensional human being and their identity is rooted within that complexity. 2.) Recognition of and challenge to the power imbalances that exist in provider-patient relationships, encouraging a sense of respectful partnerships and a term they coined as developing 'respectful curiosity' meaning to actively seek culturally relevant information from those they are conversing with. This principle strives to achieve a sense of equity and

equality in healthcare relationships. 3.) Institutional accountability; addressing the necessity for institutions to model the principles of cultural humility.

Cultural humility focuses on 'self-humility' rather than achieving a state of cultural knowledge or awareness. It proposes that 'self-humility' allows professionals to engage in a lifelong commitment towards self-learning, evaluation, reflection and critique and to better understand the power dynamics involved in the practitioner and patient relationship. It echoes the principles and practices of patient-centred care and challenges professionals to grasp the importance of learning with and from patients. In comparison to models of cultural competence, cultural humility is a philosophy and an approach to practice and continual professional development, not a subject to be mastered or be well-acquainted with. The principles of cultural humility can be used to help healthcare professionals and institutions to navigate through different intercultural relations and to understand the needs of the community they serve. This model also draws greater reference to the association between culture and identity and wider organisational aspects.

Cultural sensitivity begins to dilute the static parameters of cultural competence models in encouraging a more thoughtful consideration of culture and diversity; however, it does not emphasise the necessity of self-learning, reflection or growth as expressed in the cultural humility framework. Both cultural competence and cultural sensitivity pay little attention to the need for professional self-development as a foundation for improving clinical relationships with patients. An isolated increase in cultural knowledge and sensitivity without consequent change in a professional's attitude and behaviour is of questionable value when trying to improve the way professionals acknowledge and respond to culture and diversity. Supporting this, existing evidence documenting a lack of 'cultural competence' in clinical practice mostly reflects not the lack of cultural knowledge but rather the need for change in the practitioner's attitude and self-awareness towards diversity (Todd et al, 1994; Javitt et al; 1991; Kai, 2004). The cultural humility model has gained prominence in a variety of different disciplines and international settings and is still widely used in health educational institutions today (Betancourt et al, 2003, 2007; Kumas-Tan, 2007; Lotin et al, 2013; Price et al, 2015; Gozu et al, 2007 & Stanhope et al, 2005). In addition, the cultural humility approach highlighted the need to define educational and training outcomes consistent with its principles and proposed philosophy.

The theoretical frameworks during the 1990s to 2000 were influential in the adoption of new terms associated with culture namely safety, humility and identity and began to resonate more closely with the principles and practices of patient-centred care. However, frameworks and elements of the cultural expertise/cultural competence model remain diffused within the concepts of newer frameworks. The theoretical frameworks in this decade demonstrate a divergence from cultural competence models and assert new ways of achieving competence and high quality care in cross-cultural settings.

1.4 THEORETICAL FRAMEWORKS DURING THE 2000S TO 2010S

The theoretical frameworks during 2000s to the 2010s demonstrate a greater departure from the notions of culture associated with models of cultural competence to a broader conceptualisation of culture and notably the introduction of the term 'diversity'. Theoretical frameworks and elements of cultural competence remain permeated within other frameworks, however newer conceptualisations of cultural competence depict the evolving maturity and changing understanding of cultural complexity from prior decades.

Cross-cultural efficacy (Nunez, 2000) was one of the first theoretical frameworks to be developed in this phase as a preferable alternative to cultural competence. This framework asserts that neither the caregiver's nor the patient's culture offers a preferred view. Nunez (2000) describes clinical encounters as a 'tri-cultural' interaction, where the culture of the patient, healthcare provider and the organisation co-exist. Nunez actively recognises the shared, multi-dimensional dynamics involved in clinical practice, allowing for a broad appreciation of different cultural factors at play rather than a fact-based approach. Nunez contradicts the usefulness and validity of traditional notions of cultural competence in their application of sets of pre-defined cultural knowledge about a patient implying that they are somehow different from the norm. Cross-cultural efficacy provides an educational framework where individuals transition from ethno-centrism to ethno-relativism through facilitation of cross-cultural interactions. It consciously addresses the dynamics of the doctor-patient interaction (negotiation, affirmation and translation of communication) as well as for instance ethnic and religious differences and emphasises the importance of students learning to see their own culture and the impact of their own behaviour on others whose culture

differs and recognise the impact of the patient's own behaviour on them (Nunez 2000; 2003).

To date Nunez's (2000) framework of cross-cultural efficacy represents considerable enhancement in framing theories on culture within a more educationally sound model. Little description is provided around the format and nature of the learning objectives and how educational outcomes will be assessed. The Intercultural Approach and Diversity developed by De Rosa (2001) is like the cross-cultural efficacy framework in nature, although one could argue it is less broad in focus and regresses back to the theoretical framework of cultural sensitivity (Stafford, 1997) except with a greater focus on facilitating cultural exploration within the healthcare professional compared to the patient. It attempts to help people develop sensitivity to the cultural roots of their own behaviour, as well as an awareness of the richness and variety of values and assumptions of people of other cultures. This approach recognises ignorance, cultural misunderstandings and value clashes as key challenges of intercultural relations and that increased cultural awareness, knowledge and tolerance are the solution. De Rosa (2001) states the *"focus is on finding ways for people to work cooperatively despite differing perspectives."* Different parts of this model resonate with a variety of theoretical frameworks mentioned throughout the decades such as the LEARN model, transcultural nursing and cultural sensitivity. However, again ambiguity remains on how this theoretical framework can be translated into an educational setting.

Cultural sensibility (Dogra et al, 2004) adopts a social constructivist approach and conceptualises culture as an internally constructed sense of self which is dynamic, fluid and multi-dimensional and gives rise to diversity among individuals. 'Sensibility' is defined as the openness to emotional impressions, susceptibility and sensitiveness and relates to an individual's moral standards (Thompson, 1995). Cultural sensibility is thus a contextualised model, and claims that individuals bring their own meanings and stories to different contexts, which are subject to continuous change. This approach is different from cultural competence and cultural sensitivity in that there is no notion of acquiring cultural knowledge about particular groups or simply being aware of cultural differences, rather it focuses on encouraging professionals to understand their own perspectives and sense of self and how this affects their perceptions of others. As in the cultural humility framework, it begins first with the professionals understanding themselves in-order to help them make sense of their relationships with others. Cultural

sensibility is concerned with the acquisition of principles based on patient-centred care and changing professional attitudes.

Using Weber's (1971) construct of ideal types, systematic analytical distinctions can be made between the cultural competence (also known as cultural expertise) model and the cultural sensibility model (Dogra, 2004). The rigour of the ideal types methods explicitly allows comparisons to be made between four dimensions, namely educational philosophy, educational process, educational content and the educational and clinical outcomes. Given the assortment and lack of conceptual clarity between the theoretical frameworks on diversity, using the ideal types allows systematic analytical distinctions to be made. Dogra (2004) categorised distinct characteristics unique to the 'cultural expertise' model (also referred to as the cultural competence model) and 'cultural sensibility'. The cultural sensibility model is unique in that it is one of the few models where the approach is framed within a sound educational background. This dissipates the ambiguity present with other theoretical frameworks on how to translate this theoretical framework into an educational curriculum and materials. In comparison to other theoretical frameworks cultural sensibility is fuller in description, transparent in its educational stance and closely reflects the cultural humility model. However, it does not explicitly address the necessity of communication or interpersonal skills in cross-cultural interactions. Although it does acknowledge the significance of context, it pays little attention to the interactional cultural dynamics involved in clinical interactions. In comparison with the cultural humility model, both the cross-cultural efficacy and cultural sensibility models place less emphasis on the importance of the relationship between practitioners and their colleagues and the organisational/institutional factors influencing their professional identity and perception of self.

The intercultural maturity model (King & Baxter-Magolda, 2005) was developed shortly after the cultural sensibility model and attracted attention particularly within educational and social science settings. This model adopts a constructive development approach (Kegan, 1994; Piaget, 1950), meaning it refers to an individual's ability to internalise, interpret and make sense of an experience, and thereby their ability to construct meaning. It is also developmental in accounting for the growth of increased capacity in one's ability to construct meaning in a more adaptive and complex way over time. The intercultural maturity model is a multi-dimensional framework, which portrays initial, intermediate, and mature levels of intercultural maturity in three dimensions: cognitive, intrapersonal, and interpersonal. King and Baxter-Magolda (2005;pp.22) highlight that

> *"demonstrating one's intercultural skills requires several types of expertise, including complex understanding of cultural differences (cognitive dimension), capacity to accept and not feel threatened by cultural differences (intrapersonal dimension), and capacity to function interdependently with diverse others (interpersonal dimension)".*

This model resonates with developmental approaches such as Bennett's (1986) intercultural sensitivity and social constructivist frameworks such as cultural sensibility; recognising that achieving competence in cross-cultural settings is not an endpoint but a developmental process that adopts a continual cyclic practice, internalisation of external expertise and construction and reconstruction of meaning. The intercultural maturity model conveys how one makes meaning of cultural differences within oneself and how one relates to and interacts with others. As with its predecessors, this model also emphasises the importance of continual self-reflection, awareness, critique and evaluation of one's understanding of one's personal culture and cultural differences in others. It illustrates a greater emphasis on the nuances present in intercultural relations such as power, privilege and oppression which affect the construction of knowledge, images of self and interactions with others.

The construction of models mentioned particularly in the latter decades arguably relies on educators to have a sophisticated understanding of intercultural issues, suggesting that they too must engage in the reflective process embedded in these models. Although very little emphasis is made in regards to the necessity of faculty development for educators teaching and delivering training in culture and diversity. The theoretical frameworks in this decade show a transparent divergence from cultural competence models and a knowledge based approach to one about changing attitudes and developing skills.

1.5   SUMMARY OF CONCEPTUAL SIMILARITIES AND DIFFERENCES

Throughout the decades, the theoretical frameworks show a clear convergence to developing one's self understanding, reflection or intercultural maturity to facilitate a better understanding of cultural differences and the complexity of others. Some models consciously acknowledge the interactional nature of cultural factors between oneself and others, emphasising the importance of communication, interpersonal skills and context. Elements of the cultural competence/cultural expertise model remain

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throughout the decades and are incorporated within parts of other frameworks. This chapter attempted to disentangle the different theoretical frameworks, however establishing the distinct differences between the different cross-cultural models is some-what blurred, and arguably a prime reason why many of these terms are used interchangeably with one another. There is inevitably some borrowing and cross fertilisation as understanding grows and models and frameworks develop. However, despite the many names, and many different perspectives they all aim to improve the quality of healthcare for patients. Only a minority of theoretical frameworks throughout the decades have been developed from an educational stance, the educational philosophies, content or evaluative outcomes behind many are unclear or absent.

The conceptualisation of culture can be seen to expand throughout the decades with theoretical frameworks increasingly acknowledging the breadth, depth, complexity and variability in how culture can be defined and understood. Cultural competence has been defined in many ways by different authors and the features of the definition have evolved over time. The different theoretical frameworks suggest an assortment of ways that lead to a more pluralistic way of thinking about cultural differences than was originally proposed in cultural competence models. The literature demonstrates vast inconsistencies in how culture is conceptualised, interpreted and theoretically framed. Consistent common themes that have arisen throughout the frameworks are communication, self-reflection and awareness, interaction and context. The theoretical frameworks are different in their degree of emphasis on the development of self and how this is achieved, the association and acknowledgement of culture and its relation to one's identity, organisational and institutional cultural factors, the nuances of intercultural relations and the use of and description of educational philosophies and approaches.

1.6 INSTITUTIONAL REQUIREMENTS AND HEALTHCARE EXPECTATIONS

Statutory requirements and institutional guidelines on diversity education are one of the prime drivers for implementing this type of education (Smedley et al., 2003). Throughout these decades there have been changing institutional requirements and healthcare expectations of cultural competence, as largely defined in this current decade as diversity education, which are summarised in Appendix 1. Healthcare institutions are responsible for defining the knowledge, skills and attitudes health

professionals should possess, to work effectively across cultures (Salas & Cannon-Bowers, 2001).

The institutional requirements and expected learning outcomes concerning diversity predominantly originated during the 1990s to 2000s, followed by an influx of policy requirements during the 2000s to 2010. The implementation of the Equality Act (2010) represented a monumental pinnacle in propelling further expected outcomes and institutional requirements that arguably married the concepts of equality and diversity together, although the relationship between these two concepts prior to this and at present is at times unclear and imbalanced.

1.6.1. Early origins of institutional requirements concerning diversity

Changes in equality legalisation have greatly influenced changes in the institutional requirements and healthcare expectations concerning diversity education. Prior to the 1990s, several pieces of legislation covering discrimination came into force, for example the Sex Discrimination Act (1975) and the Race Relations Act (1976). These legislations rendered unlawful differences in practice between sexes and on the grounds of race to be an act of discrimination. Specifically, the Race Relations Act (1975) established the Commission for Racial Equality to ensure legislative requirements were complied with. The first cohort of equality legislation (including those mentioned above) was centred on the concept of 'formal equality', meaning 'likes must be treated alike' (Hepple, 2010; pp.2) and referred to the need for identical clinical practices and heath provision to all individuals irrespective of their diversity, though this was disproportionally emphasised in relation to race and gender.

The promotion of issues of race has had a substantial history in policy recommendations prior to the 1990s which have had significant implications in healthcare policies regarding diversity. For example, the Public Inquiry into the Brixton riots outlined in the Scarman Report published in the 1980s suggested that a potential strategy for improving the quality of policing diverse communities would involve the recruitment of officers from minority ethnic backgrounds. Recognition of this suggestion was visibly replicated in a variety of NHS healthcare policies (DHSS, 1988; NAHA, 1988; NHSME, 1993), which first recognised the importance of diversity in terms of recruitment of minority ethnic health professionals. For example, the Department of Health and Social Security Health Report (1988; pp.32) states "*NHS institutions should actively recruit health professionals from minority ethnic communities to reflect the*

population in which they serve." However, these recommendations were arguably neglected in various public sectors including the NHS till the MacPherson Report (1999), a decade later, highlighting the issue of institutional racism in public sectors. The history of addressing issues of diversity in this time arguably equated to addressing issues of race. Despite its lengthy history, very little effort had been given to defining the concept of diversity and what this means for those who are responsible for implementing diversity polices in practice.

1.6.2. Changing institutional requirements and healthcare expectations

As increasing evidence regarding issues of race and discrimination appeared, new understandings on institutional diversity and equality requirements emerged. It was noted that the NHS has a numerically well represented population of minority ethnic health professionals, however they were largely confined to the lower hierarchical ranks in the NHS (Bhavani, 1994; Owens, 1994; Beishon et al, 1995). An influx of ample evidence suggested discrimination and issues of diversity play a role in the promotion and access of equal opportunities in minority populations (Esmail et al, 1993; Iganski et al, 1998; Mason, 2000). The initial response to addressing diversity through numerical representation of minority ethnic staff represented a starting point, however it was recognised that issues of equality need to be addressed simultaneously with issues of diversity.

Concerns had been raised that existing healthcare provision frequently falls short of meeting the needs of minority ethnic communities (Ahmad, 1993; Smaje, 1995). To rectify this, healthcare policies began to make explicit reference to the importance of healthcare services catering for the needs of ethnic minority populations (Department of Health, 1992; Balarajan & Raleigh, 1993, NHS Ethnic Health Unit, 1996; Department of Health, 1997). These changes in healthcare policies led to calls for training in cultural competence to reduce the disparities in care. This also led to the concept formally known as 'segregational needs-led diversity' (Iganski and Johns, 1994), which describes the initiation of discrete healthcare services or ethnic-specific health services to provide specific care unique to the cultural and diverse needs of those minority communities. Whilst these initiatives began to sprout, these were firmly rejected as they were seen to be divisive, preventing integration and further marginalising communities, and was financially impractical (Health Authority, 1995). At the same time critiques of these healthcare policies raised concerns that attention was being diverted

away from other diversity aspects such as socio-economic disadvantage, health literacy and institutional racism in reducing healthcare inequalities.

In 1993 the General Medical Council, a major medical governing body, published the first version of Tomorrow's Doctors', which has a significant influence on the curricula in the large majority of UK medical schools. Within this document broad educational outcomes referring to the expected standards of knowledge, attitudes and skills concerning diversity are outlined. Outcome 6 is presented below, which defines both an attitudinal and skills objective:

> *Outcome 6: Relationships with patients*
>
> i.   *Respect patients regardless of their lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age or social or economic status.*
>
> ii.   *Communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds or their disabilities.*

The first attitudinal objective provides little additional guidance as to how this can be achieved. Also, the term 'regardless' before all the diversity factors are listed denotes a deviation from adopting a patient-centred, individualised approach to care and implies a 'one size fits all approach' is preferred. The outcome below this emphasises the importance of communication across cultural settings, which is a recurring theme included in the theoretical frameworks on diversity education. This document was later revised in 2002, however the expected attributes of doctors concerning diversity are arguably closely consistent to legalisation on equal opportunities. The rationale for why these outcomes have been included is not described, however this may be attributable to increasing concerns regarding issues of racial discrimination in the NHS (Ahmad, 1993; Smaje, 1995).

Gradually, a growing transition towards the concept of 'substantive equality' was reflected in legislation. Substantive equality describes the need for practical adjustments within public bodies to cater for the diverse needs of individuals, ensuring equality is achievable. Substantive equality is most notably practised in reference to

disability. In principle 2 of the Disability Discrimination Act (1995;n.p.) it states "*equal treatment, as an aspect of equality, is not equivalent to identical treatment.*" It clearly highlights an expectation for disabled people not to be treated the same as non-disabled individuals; there is a recognition and acceptance of the unique needs of individuals with disability.

Equality legislation gradually became broader in scope, discrimination acts such as the earlier Race Relations Acts (1965; 1968; 1976) were incorporated and later amended by the Race Relations Amendment Act (2000) which explicitly included a statutory duty on all public bodies to promote race equality. This was the case with many of the previous discrimination acts which were further revised and amended during the decade of the 2000s such as the Sex Discrimination Act (2002) and the Disability Discrimination Act (2005). Although an increasing number of healthcare policies and legislative requirements explicitly referred to the importance of tackling race equality and discrimination in healthcare, continued research demonstrates discrimination, harassment and exclusion are pervasive experiences of Black and minority ethnic NHS staff and disparities in care continue to exist in Black and minority ethnic patient populations.

The Vital Connections: An Equality Framework for the NHS (2000) was the first healthcare policy document to mandate diversity training for all NHS Boards in an attempt to tackle racial harassment. Again, little description or institutional guidelines are provided in regards to how the diversity training should be developed, delivered and evaluated. Consequently, many of the diversity training sessions in the NHS are politically driven, providing knowledge regarding equality legislation as opposed to utilising theoretical frameworks on diversity education. Following the David Bennett inquiry (2003) which concluded that the death of David Bennett was due to institutional racism within NHS mental-health services, a large action plan defined as Delivering Race Equality (2005) was formulated. This proposed a five-year strategy aimed at creating more appropriate and responsive services, fostering community engagement and improved monitoring of ethnicity and race. Throughout the years, a consistent theme of focusing on race is present in all institutional requirements and healthcare expectations concerning diversity and closely resemble equality legislation, with little description regarding the clinical and educational need for addressing issues of diversity. However, in the latter part of this decade, institutional requirements and healthcare expectations concerning diversity place a greater emphasis on personal

attributes such as openness and sensitivity to diverse view points and adopting attitudes and behaviours conducive to collaborative team working.

The Equality Act (2010) streamlined all previous discrimination Acts and attempted to codify the numerous array of Acts and regulations which formed the foundation of anti-discrimination laws in the UK. It provides a single Act which draws attention to a variety of differences and aims to strengthen the protection of individuals. As equality legislation changed and became broader in scope; acknowledging a variety of differences other than race and ethnicity, the concept of 'diversity' originated and new ways of conceptualising 'equality' began. 'Diversity' became a favourable concept as it broadened the notion of 'cultural competence' and articulated it in a manner that does not minimise racial inequalities but draws focus on the health needs of the entire population.

Principle 13 of the Equality Act (2010;n.p.) states "*to achieve full and effective equality it may be necessary to require public and private sector organisations to provide reasonable accommodation for different capabilities of individuals related to one or more prohibited grounds.*" Hepple (2010) distinguishes these requirements into two broad categories; a) reactive meaning requirements that are elicited when the practice, provision or criterion disadvantages a disabled individual. Second, b) anticipatory which entails predetermined, proactive steps to ensure service availability, appropriateness and access (Hepple, 2010). The requirements are distinct in that they cater towards providing individual solutions to individual problems. Arguably, actions towards diversity issues in healthcare depict both reactive and anticipatory approaches.

In 2011, the UK National Institute for Health Research announced that NHS or university partnerships for research grants would only be permissible if academic departments held at least a Silver Athena Swan Award, thereby recognising its policies to promote gender equality. Studies from a variety of educational and health contexts have demonstrated that mandated policy interventions to promote diversity which have legal and financial implications result in better outcomes than non-mandated policies (Priest et al, 2015). Early findings from academic institutions suggest an increase in leadership roles for women and in applications since Athena Swan (HEE, 2015).

In recognition of the limited progress of the Delivering Race Equality Standard (2005), the NHS Equality and Diversity Council has implemented a mandatory Workforce Race Equality Standard (2015). This requires NHS organisations to actively collect and

collate data on nine indicators of workforce equality for BME staff, including representation at higher employment levels in the NHS. Organisations that fail to achieve progress on these defined metrics will be classed in breach of their NHS standard contract. Arguably diversity education, particularly within the NHS, is still perceived as addressing issues of 'colour' and not 'diversity' (Abrams et al, 2009; Bhui et al, 2008; Bhugra et al, 2015). Despite acknowledging a range of differences, the training has not been displaced from its original intention in combating issues of race in healthcare. Unlike other generic healthcare training, diversity training is laden with issues of sensitivity, 'political correctness' and entrenched in the history of tackling racial inequalities (Bennet et al, 2007). The diffusion of diversity characteristics under one paradigm of diversity education has many challenging whether this approach is down playing core issues that remain unaddressed (Esmail, 2012; Sheikh, 2001). Some argue that current diversity training may be normalising and perpetuating issues of diversity as opposed to effectively addressing them.

Healthcare policies gradually began to realise that training in cultural competence and diversity in isolation does not improve diversity. Wider organisational processes, policies and structures must be considered. The institutional requirements and expected healthcare outcomes concerning diversity from 2010 onwards explicitly recognise the importance of self-awareness and reflection on the impact of one's own behaviour on others. Training in strategies to reduce conscious and unconscious bias, stereotypes and discriminatory behaviours is mandatory in different health educational institutions. The importance of communication continues to recur throughout healthcare policy outcomes during this time period, with a greater emphasis on acknowledging contextual and interactional factors.

CONCLUSION

The overview of theoretical frameworks and institutional requirements in diversity education depict a growing departure from the notion of cultural competence/cultural expertise models to frameworks which emphasise the importance of self-awareness, reflection on one's own culture and diversity, communication, cultural interactions and wider organisational factors. The breadth of diversity thinking and its application to diversity education has arguably grown exponentially under the changes of equality legislation. Institutional requirements and healthcare expectations closely reflect equality legislation, although greater progression towards encouraging self-awareness in diversity education is seen throughout the years. The institutional requirements and

healthcare expectations appear to invest little or no energy in defining the concepts of diversity, culture and cultural competence clearly and even less in its operationalization. Both the theoretical frameworks on diversity education and institutional requirements demonstrate a move beyond the acquisition of cultural knowledge/cultural expertise to the development of self-awareness, practical personal skills in communication and interpersonal team-working across differences.

CHAPTER 2: APPLYING EDUCATIONAL THEORIES IN DIVERSITY EDUCATION

This chapter begins by providing an overview of educational learning theories relevant to health settings. These theories are then discussed in relation to their relevance and application to the teaching of diversity education. This chapter is designed to showcase the deficiency of application of educational theories in the teaching of diversity resulting in common criticisms of being undertheorised, fragmented and biased towards the trainers' perspectives. Throughout the chapter the increasing focus on the development of one's self is exemplified in the changing learning outcomes, new learning theories and expectations of diversity education. This chapter also considers appropriate educational theories to critically evaluate and reflect upon one's self.

2.1 EXAMINING EDUCATIONAL THEORIES

The literature demonstrates a multitude of educational theories explaining the different ways in which adults learn (Taylor et al, 2013; Merriam et al, 2007). An educational or learning theory can be defined as a *"coherent framework of integrated constructs and principles that describe, explain or predict how people learn"* (Braungart et al, 2007: pp.2). The process of becoming a proficient healthcare professional demands the acquisition of knowledge, skills, values and continual professional development. Learning typically entails the acquisition of knowledge, attitudes and skills and a large majority of educational theories account for learning in these three dimensions. Educational theories hold a broadly social constructivist view, considering learning as a process of continual reconstruction of new knowledge with existing knowledge (Vygotsky, 1997). Authors have noted several conceptual similarities between theories of adult learning and have often categorised them under broad themes which will be discussed further on in the chapter. First, an overview of the early conceptualisations of historical aspects of adult learning theories are reviewed to provide a platform for subsequent discussion.

2.2 EARLY HISTORICAL ASPECTS OF ADULT LEARNING THEORIES

One of the earliest documented learning theories was noted by John Locke (Locke, 1690) who considered the mind as a 'tabula-rasa' meaning a 'blank slate' upon which all acquired knowledge was derived from one's experiences. This notion considers the mind devoid of knowledge at birth and claims only by external experiences is knowledge impressed upon the mind. This was a pervasive view in the seventeenth century, however these ideas were revised and refined throughout the eighteenth and nineteenth centuries until the early twentieth century when Edward Thorndike (Thorndike,1911) proposed his 'laws', most notably the 'law of effect' and the 'law of exercise'. The former describing the prerequisite of a positive effect on an individual for learning to occur and the latter stating that repetition strengthens learning.

This notion was further developed by behaviourists (Skinner, 1954) who claimed with supporting evidence that some forms of learning are demonstrated by a simple stimulus-response paradigm, meaning the use of an appropriate reward could elicit the correct response to a given stimulus. Skinner described three integral elements that strengthened learning: firstly frequency, specifically referring to the number of times a stimulus is presented which leads to a habitual response, like Thorndike's (1911) law of exercise. Secondly contiguity, meaning the time delay between the response and the reward, and thirdly, contingency referring to the substantiated association between the stimulus and the reward regardless of differences in time between the two. Questioning the work of Skinner, Chomsky (1975) claimed that the experiments conducted by behaviourists did not account for nor explain the acquisition of higher order skills such as learning a new language or mathematical calculations, which are substantially developed and modified by new experience.

Social constructivists, most notably Vygotsky (1978), became a strong emerging voice illustrating the importance of the social environment and the way that the learning community supports learning. A fundamental notion in social constructivism is the 'zone of proximal development' which claims that a learner can only acquire new knowledge if it can be effectively linked with existing knowledge. These ideas were further developed and were influential in social learning theories such as Bandura (1977). They were also used by Wenger in the theories surrounding 'communities of practice' and the concept of learning communities (Wenger, 1998). Piaget was influential in highlighting the different types of knowledge that could be acquired at different stages

in a child's life (Piaget, 1952). This was prominent in the work of William Perry (1999) exploring the shift in college students from 'dualism' meaning a binominal response to how a teacher presents information as either right or wrong to 'multiplicity' which asserts that truth is dependent on context and the teacher is not always necessarily right or wrong. These theories are merely a small sample of educational thoughts and notions on how learning can occur, but they have formed the foundation of early historical aspects of educational theories which continue to be revised and expanded upon.

2.3 CATEGORIES OF ADULT LEARNING THEORIES

The increasing body of literature on educational theories resulted in many educationalists suggesting that adults learn in a different manner to children. The term 'andragogy' was defined as adult education and refers to any form of adult learning. Pedagogy can be classed as the child equivalent. However, it also broadly describes the discipline of the theory and practice of education. Knowles et al. (2005) distinguished adult learning from child learning, asserting that they are differently motivated in several respects such as the learner's 'self-concept', the need to know, the role of the learner's experiences, readiness to learn, orientation to learn and motivation. For the purposes of this chapter, broad categories of educational theories and concepts are presented in accordance with Taylor's (2013) groupings, specifically covering educational theories which will then be later discussed in relation to diversity education.

2.3.1 Instrumental learning theories

These theories focus on the individual experience which largely concerns behaviourist and cognitive learning theories. The behaviourists' laws of learning were identified through experimentation with animals, however these lessons have been extrapolated to humans. These theories of learning argue that behaviour can be learned and that an individual can be trained appropriately to produce specific behaviours. Behaviourist learning theories consider learning to be an outcome of a connection made between the stimulus conditions in the environment and the consequent individual responses to these stimuli. The learning process is therefore conceptualised as relatively simple. Behaviourist theories depict the learner as a passive recipient of external stimuli, and define learning as changes in behaviour. Behaviourists introduced several concepts

that explained learning, such as frequency, recency (Watson, 1950) and positive reinforcement (Skinner, 1971). Modifications in an individual's attitude is achieved by altering conditions in the environment and reinforcing positive behaviours once they occur.

Cognitive learning theories depart from behaviourist theories in that they focus on psychological and mental processes of the mind and not one's behaviour. These theories illustrate the individual differences in perception of information and the processing of information (Piaget, 1952; Bruner, 1966; Ausubel, 1968; Gagne et al, 1992). Cognitive learning theories cover a broad range of theories which attempt to explain the differing mental processes, such as perception, reasoning and problem solving, which form the foundation of cognitive processes that are influential in learning. They also acknowledge the internal and external environmental factors that play a role in the development of mental representations and how individuals perceive and react to changing environments. Cognitive learning theories dispute the early conceptualisation of the mind as a 'blank slate' (Locke, 1690) and recognise the internal dynamics of learning. Unlike behaviourists, cognitive learning theories regard rewards as not necessary for learning, and place a greater emphasis on the learner's goals and expectations. By recognising an individual's cognition (i.e. perception, memory and ways of processing) and meta-cognition, meaning an understanding of an individual's way of learning, one can better formulate how to initiate learning situations.

Bandura's (1969) social cognitive learning theory agrees in one respect with the behaviourist learning theory, however it asserts in addition that behaviour is learned from the environment through observational learning, formally known as 'modelling' of behaviour. This practice of modelling another's behaviour involves a cognitive process of identification that is driven by the desire to behave in the same as way as the person the imitator is modelling. Piaget (1960) proposed a theory of cognitive development, describing a process of progressive reorganisation of mental processes and environmental experiences, primarily in children. This theory refers to a process of accommodation where learners revise aspects of their existing mental worldviews, known as 'schemas' based on the process of meaning-making of their experiences to accommodate new knowledge. Piaget defined education as embodying two integral components, namely the 'growing individual' and 'social, intellectual and moral values' (Smith et al, 2007) which are instilled by teachers and educators. Piaget recognised both the need to internalise and interpret external information into understanding and

the necessity for social interactions, but placed a greater emphasis on the learner's own reasoning, which he referred as one's 'active mind' (Piaget, 1960) and different developmental stages. Piaget (1960) stressed that educational pedagogy should be congruent to the stage of development of the learner.

Experiential learning theories emphasise the central role that experience plays in the learning process. The term 'experiential' is used to differentiate themes of experiential learning from cognitive learning theories which emphasise internal, cognitive dynamics of thinking and behavioural learning theories which disregard the influence of subjective experiences in the learning process. Experiential learning theories describe the process of learning from experience and explore distinctions between how individuals learn in unique ways and react to individual perceptions of experience. These theories describe the process of 'individual transformation', and views knowledge as bound to the person from whom knowledge is constructed. Experiential learning theorists included David Kolb (1984), who developed the learning style inventory to assess individual learning styles, which led to further developments regarding different personality types. Kolb (1984) also developed the four-stage model of experiential learning which is further discussed under reflective learning theories. John Dewey, another experiential theorist, highlighted the relation between the processes of actual experience and education (Dewey, 1902) and suggested active engagement and interaction with external experiences assisted learners in establishing applied versus abstract knowledge. Dewey asserted the importance of direct personal experience in enriching the learner's understanding and argued that educational systems must allow for the interests and experiences of the students as well as the subject matter. Educational material must be presented in a way that allows learners to relate information to their personal experiences. These theories have made educators responsible for facilitating sessions that capitalise on and organise individual learner experiences. This is especially highlighted in Bruner's (1966) theory of discovery learning and Piaget's theory (1952) of cognitive development. Critiques of experiential learning claim that these themes are limited in their acknowledgment of the social context (Hart, 1992), with a higher emphasis placed on individual knowledge. However, in health educational settings experiential theories are ideal for practising skills in a specific context (i.e. clinical skills) or focusing on developing certain competencies (e.g. clinical communication).

2.3.2   Humanistic learning theories

These theories are designed to promote individual development with the goal of assisting individuals to achieve self-actualisation and become self-directed and intrinsically motivated. These approaches have been influential in eliciting a learner-centred approach to education. Humanistic theories are most reflective in self-directed learning (Kaufman et al, 2000) which facilitates autonomy and individual freedom in planning, conducting and evaluating one's own learning. Self-directed learning is an accumulation of educational theoretical approaches and requires the opportunity for learners to develop and practise skills that facilitate learning. It requires the learner to critically reflect and evaluate the learning experience. However, concerns have been raised regarding the extent to which self-directed learning is achievable and the individual variations that may exist in how learners approach and plan learning and whether directed self-learning is more appropriate in different developmental stages (Norman, 1999; Hoban et al, 2005). Like instrumental learning theories, these theories are limited in acknowledging the social context of learning and appear to under-estimate the value of other forms of learning, such as collaborative learning.

Self-authorship theory (Kegan 1995; Magolda, 2008), like self-directed learning, is an assortment of educational theoretical perspectives, and has been defined as a humanistic, constructive-developmental educational perspective on a learner's journey of development (Kegan & Magolda, 2008; Sanders & Jackson, 2015). The constructive perspective acknowledges that learning is an active process of construction and reconstruction, where meaning making is formulated and refined. The developmental aspect recognises that this process of construction occurs over time (Magolda, 1999). This is especially applicable to a healthcare curriculum such as medicine, dentistry or nursing, where there is a substantial period of learning to facilitate self-authorship. The self-authorship theory was based on several research studies of leaners during late adolescence and early adulthood (Kegan, 1995; Magolda, 2005). It concentrates on the essential development of cognitive maturity, an integrated identity and mature relationships. Parts of the theory are consistent with transformative learning theories which are discussed later, as it situates learning within the experiences of the learner and attempts to challenge and question the learners' world view allowing them to take responsibility for their attitudes and behaviours.

The self-authorship theory is unique in that it pays due regard to the intrinsic aspects of healthcare curricula to ensure learners develop both professionally and personally, with the transparent intention of supporting their development as future healthcare professionals (Magolda, 2008). It describes various phases in a person's journey of development, focusing on the critical period of development between late adolescence and early adulthood where leaners begin to fully construct their own worldview accompanied by knowledge, beliefs and values that have been internalised and made sense of. The stimulus to the self-authoring process occurs intermittently through 'cross-roads' (Kegan, 2000), sometimes referred to as 'proactive experiences' (Belenkey et al, 1986; Perry, 1999) which challenge learners' existing worldview, encouraging reflection on their current frames of reference. These cross-roads could be likened to the process of assimilating into a different culture or experiencing a recent bereavement (Barber et al, 2013).

Based on extensive research (Magolda, 2008: Kegan, 1999), self-authorship was defined as three interrelated dimensions; cognitive, intrapersonal and interpersonal. The cognitive dimension revolves around the question 'how do I know?' This dimension describes the process of cognitive maturity where learners shift from regarding knowledge as absolute to a more contested state. This is closely consistent with the notion of dualism and multiplicity (Perry, 1999) which will be explored later. This shift in the perception of knowledge involves learners making sense of competing perspectives and enables them to take personal responsibility for their decision making and actions. The second dimension, intrapersonal, considers the question 'who am I? This involves the development of a clear sense of the learner's integrated identity and their belief and value system independent of the views of others. This dimension includes personal and professional parts of one's identify such as cultural affiliation. The final dimension reflects upon the question 'how do I want to construct relationships with others?' This stage concentrates on the mutual aspects of relationships and an appreciation of diversity (Magolda, 2005; 2008). The primary aim in this stage is to develop mature relationships with acceptance and tolerance of diversity in others.

2.3.3   Transformative learning theories

Transformative learning theories are largely developed by Mezirow (1990; 1995) and describe the social process of how learners interpret and reinterpret the meaning of their experience. Mezirow (2000) comprehensively defined transformative learning as:

> *"the process by which we transform our taken for granted frames of reference (meaning perspectives, habits of mind and mind-sets) to make them more inclusive, discriminating, open, emotionally capable of change and reflective so that they may generate beliefs and opinions that will prove true or justified to guide action" (Mezirow, 2000; pp.5)*

Like Dewey's (1938) conceptualisation of theories of learning, Mezirow (1995) emphasises the importance of acknowledging the learner's existing experiences to allow them to participate in constructive discourse with others and encourage educational experiences to maximise the use of students' prior experiences to transform understanding of the educational matter.

These theories embody three key dimensions of transformation; 1.) Psychological, referring to changes in the understanding of the self, 2.) Cognitive or convictional, describing adaptations and revisions to one's attitudes or belief systems and 3.) Behavioural, referring to changes in practice and habits (Mezirow, 1978; 1990; 1995). Transformative theories are designed to explore the use of critical reflection, awareness and evaluation to challenge the learner's attitudes, beliefs and assumptions (Mezirow, 1978; 1990; 1995). An integral element of transformative theories is the change in the learner's existing frame of reference through processes such as critical reflection or the 'disorientating dilemma' (Mezirow, 1995) which describes triggers that enable one to question or re-evaluate their existing assumptions. These shifts in understanding and meaning-making are similarly referred to as 'cross-road' experiences in the self-authorship theory (Mezirow, 1997). These types of theories exemplify how learners construe, validate and restructure their meanings of both internal and external experiences. Mezirow (1990) also identified different forms of reflection in the transformation of meanings, structures, context, process and premise. Critical reflection also involves the active examination of the context and the interplay of personal, professional and social factors.

Transformative learning approaches consider the process of transformation in the development of meaningful learning and assert that learning connections are made between new knowledge and existing knowledge (Regan-Smith et al, 1994). Norman and Schmidt (1992) proposed three elements which further defined these learning connections: these include elaboration, refinement and restructuring. Elaboration describes the process of formulating precise linkages between new and existing knowledge. Refinement describes the method of filtration in sifting through all elements of new knowledge and retaining those elements which are meaningful. Lastly, restructuring involves the development of schemes or representations of theory, formally known as schemata (Piaget, 1960) which allow one to develop expertise in certain aspects of knowledge (Norman et al, 2006).

Guided discovery learning strategies form part of the remit of transformative learning theories. Part of the challenge in healthcare curricula is bridging the divide between theory and practice, and ensuring learning in theory can be applied and its relevance understood in practice. In a structured learning environment, the presentation of new knowledge to existing knowledge is relatively straightforward. However, in practice or when learners are faced in new social environments, the application and relevance of new knowledge may appear distant from their existing knowledge. Johari's Window (Luft and Ingham, 1995) describes the different variants associated with ambiguous and new learning situations. Luft and Ingham (1995) depicts four compartments that are either known or not known to self and known or not known to others. They assert that learning involves guided discovery through discussion with others, meaning that discussion between individuals elicits and amplifies one's level of practical knowledge. It also suggests that some aspects of learning will remain unknown to the self if we do not discuss them with others. Luft and Ingham (1995) claim diverse learning groups are more likely to learn unfamiliar knowledge about themselves and others than non-diverse learning groups. One of the four compartments of Johari's Window is 'unknown unknowns' suggesting there will always be areas where new knowledge is yet to be established, but through guided learning teachers can assist learners into these areas with the appropriate use of teaching materials, resources and interaction with others, particularly patients.

Taylor and Hamdy (2013) developed a multi-theory educational model which defines five stages of learning, the first of which involves transformative learning. These stages are dissonance, refinement, organisation, feedback and consolidation. The first stage,

dissonance, describes the learner's experience of challenge, discomfort and unfamiliarity. These challenges can be internal and driven by the learner, or external and presented by the teacher. The aim in this stage is to identify a base line of the learner's current knowledge, skills and attitudes and to recognise what is unknown and where personal development and learning is needed. The teacher's role is to provide a learning context that is conducive to the student working through this dissonance and which will assist the student in identifying his or her learning needs. Ideally this stage concludes with the learner reflecting upon their learning needs. The other subsequent stages involve a process of constructing new knowledge with existing knowledge, where the learner begins to refine new information, organise new knowledge in relation to existing knowledge and restructure ideas to create new schemata. The feedback stage involves the learner articulating their new knowledge with others to gauge feedback which will either reinforce their new knowledge or require them to re-evaluate their new theories. The consolidation phase closely mirrors Schon's (1983) notion of 'reflection on action' which requires the learner to reflect upon the learning process and identify what they have learnt and areas for further development.

2.3.4   Social theories of learning

Social theories of learning have an integral focus on context and community (Choi & Hannafin, 1995; Durning & Artino, 2011). A stream of situated cognition theories claim learning and thinking are social activities, and that thinking is influenced by the way in which learning occurs (Wilson, 1993). Vygotsky (1986) conceptualised learning as a social and cultural rather than an individual process (Kozulin et al, 2005). Vygotsky acknowledged the social and cultural environment as a starting point to understanding learning. These notions led to the well-recognised concepts of 'inner speech' and the 'zone of proximal development'. The former describes the connection between internal thought and spoken language which Vygotsky claims is developed during social interaction. The latter describes the metaphorical space between what is known and what is not known and the additional potential for learning (Ardichvilli, 2001; Kozulin et al, 2005).

Perry (1999) noticed significant changes in student's learning styles based on the changes in their social learning environment. Perry claimed that as students' progress from undergraduate to postgraduate teaching their approach to learning shifts from 'dualism' to 'multiplicity'. This shift reflects a greater consideration of the social context:

dualism denotes an approach where students hold an expectation that the teacher will identify aspects of learning that are right and wrong. Conversely multiplicity recognises that truth is dependent on context and that teachers will bring different perspectives based on their background and experiences and that their colleagues and the social environment are valuable resources for learning. This shift has been found to be associated with greater confidence in dealing with uncertainty and unfamiliar contexts (Belenky et al, 1997; Maudsley, 2005). Studies have shown that medical students do not typically conform to the progression from dualism to multiplicity and authors suggest this may be due to the adoption of more strategic learning styles that are consistent with the demands of assessment or from messages students receive from the hidden curriculum, referring to learning they receive from members in the profession which can be taken as either right or wrong regardless of context (Maudsley, 2005; Land et al, 2008; Meyer et al, 2010).

Wenger (1998) proposed the theory of 'community of practice' which argues that the whole community plays a role in helping students overcome states of liminality (i.e. the feeling of discomfort or unfamiliarity) and engage them in the process of becoming part of a new professional team and assuming a professional identity. This is particularly applicable in the healthcare professions. Lave and Wenger (1998) state that learning, meaning and identity are inextricably connected with one-another. Communities of practice refers to groups of individuals who collectively engage in collaborative and shared learning experience i.e. healthcare professionals. It does not assume learning is intentional but can arise as an incidental outcome of professional interactions. Wenger and Lave (2005) clarified three distinguishing characteristics of 'communities of practice'. First 'domain'; communities of practice are identifiable by an identity that embodies a shared domain of interest where collective competence is valued and interdisciplinary learning is a continual practice. Second, 'community', this primarily concerns the interactions between professional members and the building of relationships that enables them to learn from each-other. It is these interactions and relationships that define a community of practice regardless of whether professionals have the same job title or occupation. Lastly, 'practice', which clarifies that a community of practice is not merely a group of interested individuals but rather individuals that develop a shared repertoire of resources, meaning the development of shared experiences, stories and insight. Again, this resonates with the definition of community and emphasises the importance of sustained interactions and relationships. Wenger's

(1998) theory of 'community of practice' exemplifies the principles of social learning theories.

In considering how the social context can facilitate learning, educators can provide many advance organisers (Ausubel, 1968) such as scaffolding, models and metaphors. Educational social theorists have often described the concept of 'liminality' (Land et al, 2008; Meyers et al, 2010) which describes the sense of ambiguity and discomfort when a learner is unfamiliar with the rules or context of a social situation. Scaffolding, a type of advance organiser, describes structural components that guide learners through new materials and knowledge. It acts as a stable point of reference in introducing new ideas and explaining how different ideas link together and form a bigger picture. Scaffolding can be easily described in terms of programme organisers such as readings lists, syllabus, lists of intended learning outcomes and an induction when students are introduced into a new learning environment.

Learning outcomes are essential in orientating the learner towards the key objectives of the learning experience. Learning outcomes can be further exemplified using Bloom's taxonomy (Bloom et al, 1956; 2011) and Miller's pyramid (1990) which are frequently used in health educational institutions. Bloom's taxonomy (Bloom et al, 1956), which was later revised by several authors including Anderson (Anderson & Krathwohl, 2001), defines six processes of learning: knowledge, comprehension, application, analysis, synthesis and evaluating. Miller's pyramid (1990) is a simplification of Bloom's taxonomy and defines four stages, namely knowledge ('knows'), competence ('knows how'), performance ('shows how') and action ('does'). This pyramid is frequently used as a guide in the planning and assessing of health curricula, particularly in medical education. Although knowledge represents the foundation of Miller's pyramid, it is not the whole pyramid itself, with the end point being action – 'does', outlining the necessity for a learner to be able to apply their knowledge and skills in practice.

In addition to learning outcomes, a variety of social and transformative learning theories have demonstrated an array of different learning styles and preferences. Educationalists continue to debate whether learning styles are static or malleable and the extent to which they are shaped by the social learning environment (Coffield et al, 2004). Newble and colleagues (Newble & Clarke, 1986; Newble & Entwistle, 1986) differentiate between surface learning and deep learning and how these different types of learning are adopted based on the social context and influenced by external drivers

such as assessment. Surface learning, as the name suggests, merely attempts to broadly cover facts or aspects of learning. However deep learning, for example learning about interacting with patients or how to manage challenging medical consultations, requires a deeper understanding of how various aspects of learning interact and are applied. Healthcare curricula, particularly in medical education, are assessment driven (Biggs et al, 2001; Taylor & Hamdy, 2013), where the type of learning employed is dependent on the type of assessment. For example, if the assessment necessitates merely a recall of facts, surface learning is more likely to be employed, however if the assessment requires a demonstration of critical thought, analysis and reasoning, deeper learning will be adopted.

2.3.5 Motivational and reflective theories of learning

Adult learning theories place an emphasis on motivation and reflection. Self-determination theory (Ryan & Deci, 2000; Cate et al, 2011; Kusurkar & Cate, 2013) is an example of a motivational model. This theory places intrinsic motivation at the centre and claims three basic needs must be fulfilled; autonomy, competence and 'relatedness' meaning a sense of belonging. The degree to which autonomy, competence and relatedness is supported and amplified within a social and cultural context has a profound impact on an individual's motivation. The self-determination theory also draws attention to the impact of the social and cultural factors on one's sense of initiative, stating that the socio-cultural environment can either foster or hinder the development of individual motivation. Certain models emphasis the expectancy of success as a prerequisite for one's motivation. The expectancy theory (Weiner, 1992) claims the motivation to learn equals the expectancy of success multiplied by the value of success. Whereas the chain of response model (Cross, 1981) lists three internal motivating factors that encourage learning: self-evaluation, attitude of the learner about education and the importance of goals and expectations. They also include an outline of the main barriers to motivation to learn, which are life events, transitions and opportunities for other learning. This appears to contradict notions such as 'cross-roads' (Magolda, 2005) and 'disorientating dilemmas' (Mezirow, 1997) outlined in humanistic and transformative learning theories that assert these experiences can encourage meaning-making and initiate personal insights, although does not specify how this affects the motivation of the learner to continue learning.

Reflective learning (Schőn, 1983; 1987) has become increasingly important in health educational institutions and more widely in society (Archer, 2012). The continual practise of reflection and feedback aids in developing students' autonomous learning. Kolb's (1984) experiential learning model demonstrates a cyclic process of reflection and action, where the learner reflects upon a concrete experience from which they are able create abstract thoughts and generalisations, which they then apply in practice creating new implications of knowledge and experience. Kolb's experiential learning model depicts four quadrants of learning styles; 1.) Activists who feel and do, 2.) Reflectors who feel and watch, 3.) Theorists who watch and think and 4.) Pragmatists who think and do.

Schon's (1983) theories on reflection arguably extend the quadrant of 'pragmatists' as defined by Kolb (1984) and specifically advocate two types of reflection; 'reflection *in* action' and 'reflection *on* action'. The former describes the process of reflection where we interpret what we see with what we already know and reflect upon the difference. Mirroring the experiential learning model described by Kolb (1984), reflection in action enables us to construct abstract notions and concepts of new knowledge which we then reflect on in regards to existing knowledge. This then leads us to proposed tests of our knowledge through discussion or experimentation. The latter concept 'reflection *on* action' refers to reflecting on the process of the learning experience and how learning of new knowledge has been formulated.

2.4 RELEVANCE AND APPLICATION OF EDUCATIONAL THEORIES TO DIVERSITY EDUCATION

Diversity education has largely stemmed from training as opposed to educational contexts, and despite the wealth of knowledge concerning theories of learning, there has been a deficiency in the application of educational theories in diversity education (Betancourt et al, 2009; Dogra et al, 2015). The term diversity is used in reference to both training and education across healthcare disciplines and within the NHS, with little regard to the distinction between the two terms. In a broad sense, training implies imparting a specific skill or attaining specific knowledge necessary for performing a task. Education refers to the process and theory of systematic learning. The literature surrounding diversity demonstrates these terms are closely intertwined and frequently used interchangeably. However, these concepts differ in their nature and orientation: training is primarily based on practical application whereas education is founded on

theoretical orientation. Whilst training may lead to an improvement in performance and productivity, education aids in developing one's sense of judgement and reasoning. This is an important distinction, as much of diversity education has been grounded in the context of training (Chirico, 2002; Dogra, 2004) with a large emphasis on developing 'cultural competence' as opposed to principles of educational theories.

2.4.1   Competence-based approach

As outlined in Chapter 1, early educational interventions on issues of diversity and culture proceeded under the notion of acquiring 'cultural competence' in healthcare. The term 'competence' can be defined as a *"state or quality of being adequately or well qualified in knowledge or skills in a particular area"* (Kumagai et al, 2009; pp.2). Typically, competencies in education are categorised into learning outcomes that comprise knowledge, attitudes and skills. Consequently, cultural competence has been defined in the same way to allow for educational processes to adequately address each domain. However, models of cultural competence/cultural expertise have been approached in a way that limits its educational goals to largely the domain of knowledge, implying that the development of cultural knowledge translates to competence in cross-cultural settings. Behaviourist learning theories have been influential in competency-based curricula and training programs (Thorndike, 1911; Skinner, 1954). Applying these theories results in task orientated educational materials, which typically leads to standardisation of outcomes. However, concerns raised in these approaches suggest uncertainty regarding how and with which methodology these outcomes can be defined, measured and evaluated. These concerns are echoed in the literature concerning models of cultural competence, suggesting that achieving cultural competence is like that of clinical competence. Cultural competence is viewed as a static outcome, providing an inconsistent message that achieving competence in cross-cultural settings requires only surface-learning strategies to recall facts and lists of knowledge.

The notion of personal development is an ill-defined concept, however it can be considered as *"an individual's journey to becoming a fully-functioning person"* (Rogers & Frieberg, 1994;pp.9). Research indicates that the critical period of personal development occurs between late adolescence and early adulthood (approximately ages 18 to 25) which represents the large majority of students entering different healthcare curricula such as medicine and nursing (Levinson, 1997). Understanding

the importance of the developmental journey of healthcare students will aid in informing educators on how best to provide a curriculum that can offer appropriate educational experiences to facilitate diversity teaching (Dorsey et al, 2006). Models such as the Cultural Competence Continuum (Cross et al, 2001) and the Cultural Competence Framework (Howell, 1982) place the development of cultural competence within a linear, developmental scale, suggesting that competence is predicated on action. Novice undergraduate healthcare students with little or no action or behaviour in their professional roles will be more likely to be inaccurately placed given their developmental stage. Considering the developmental stage of the learner as addressed in educational theories by Piaget (1960) and Vygotsky (1970) has rarely been acknowledged in diversity education, but may assist in assessing the appropriate stage of cultural competence in accordance with the student's learning needs. The major difference, which is significant if taken in the context of developing cultural competence, is that, unlike Piaget's (1936) developmental stages in children, Perry's (1990) learners are conscious of, and indeed have a degree of control over their movement from dualism to multiplicity. In comparison to Piaget (1936) where emphasis is placed on developing cognitive maturity, Perry (1990) is concerned with changes in the learners' philosophical assumptions, which can be examined, revised and affirmed during the shift from dualism to multiplicity. This suggests that given the right learning environment it may be possible for learners to achieve multiplicity in an active and predetermined way, which is vital if students are to develop the ability to demonstrate an understanding of multiple cultural viewpoints. The current trend for competence-based health education, particularly in regards to diversity education, fails to address the essential growth and the developmental aspects of the learner (Frank et al, 2010).

2.4.2   Changing attitudes

The review of institutional requirements and healthcare expectations relating to diversity in Chapter 1 showed a large majority referred to educational outcomes concerning attitudes. For example, the Medical Students Professional Values and Fitness to Practice (GMC, 2009;pp.08) document in outcome 16 states that medical students should not "*unfairly discriminate against patients by allowing their personal views to affect adversely their professional relationship or the treatment they provide.*" Similarly, the Clinical Leadership Competency Framework (NHS Leadership Academy, 2011;pp.7) asserts under the heading *"self-awareness"* that all NHS healthcare professionals must *"identify their own emotions and prejudices and understand how*

these can affect their judgment and behaviour." Cognitive learning theories rarely allude to issues regarding attitudes and how one formulates and changes specific attitudes. The literature suggests there has been little use of these theories in diversity education. The self-authorship theory recognises the importance of cognitive maturity in stimulating intellectual growth and critical questioning of one's knowledge, beliefs and values (Lipman, 2003). However, the process of intellectual growth actively involves critical reflection, self-evaluation and an ongoing practice of meaning-making of one's worldview and the external messages received (King & Kitchener, 1994). This suggests that the use of transformative learning theories is strongly applicable to facilitating the learning outcomes of diversity education. The concepts of 'disorientating dilemmas' in transformative learning theories (Mezirow, 1997) or 'cross-road experiences' in humanistic learning theories such as self-authorship (Magolda, 2008) may be applied in diversity education to encourage shifts in one's attitude. Among outcomes linked to the self-authorship dimensions, the interpersonal (relationship) dimension has this example: "*increasing appreciation of different beliefs, values and attributes between individuals and groups, with greater awareness of cultural competence, team working and social accountability*" (Sanders & Jackson, 2015; pp. 527). This closely mirrors the tables shown in chapter 1 outlining institutional requirements and healthcare expectations in relation to diversity education.

Many educational theories are limited in the practical application of theory, particularly in relation to diversity education (Magolda, 2009). However, the self-authorship theory is grounded in observations from educational practice and can be applied using the Learning Partnership Model (LPM) for higher education (Magolda and King, 2004). This model asserts that three interrelated aspects are necessary for implementing the self-authorship theory. These are 1.) Knowledge is complex and contextual and learners must be exposed to situations where multiple interpretations of a single experience can be applied. This facilitates the cognitive dimension encouraging intellectual growth and maturity, 2.) The self is central to knowledge construction which correlates to the interpersonal dimension, where learners must hold a willingness to challenge and question their worldview from both an individual and external perspective, and 3.) Authority and expertise are shared in interactions which connect to the interpersonal domain, so learners appreciate that effective learning is a mutual and collaborative process. The two primary conditions of this model are support and challenge. Constructing educational contexts that allow learners to constructively challenge their worldviews within a supportive relationship and environment, facilitates the process of

self-authorship. By offering a mixture of 'cross-road' experiences through simulated scenarios and skilful reflective questioning and supportive conditions the process of self-authorship is enabled. This is closely consistent with good practice guidelines on how diversity education should be taught, namely creating a safe learning environment where an open dialogue about diversity issues can be elicited and constructive discourse can occur (Dogra et al, 2009; Dogra et al, 2015).

2.4.3 Role modelling and faculty development

Research suggests Bandura's social cognitive learning theory applies to diversity education, as how diversity issues are perceived and effectively managed can be dependent on how these attitudes and behaviours are modelled in other healthcare professionals. Various authors have acknowledged that much of diversity education occurs in the hidden or informal curriculum (Turbes et al, 2002; Green et al, 2007). Diversity learning through observation and modelling may occur informally without educators or students necessarily being aware of this, which can have both positive and negative effects. The presentation of diversity issues unintentionally in clinical scenarios, for example exploring tuberculosis in Asians (Kai et al, 2005) and diabetes in South Asians (Qureshi et al, 2008), may reinforce stereotypes and imply that diversity issues are only applicable to certain patient populations. Additionally, qualitative research studies have demonstrated that negative attitudes towards diversity issues from senior staff are noted and can be perceived as appropriate behaviours and responses by younger healthcare students (Moira et al, 2004; Palgrit et al, 2008; John, 2002). These unhelpful examples of modelling diversity issues provide inconsistent messages that undermine formal diversity teaching that is consistent with institutional requirements.

Educating faculty on diversity issues is essential as they serve as role models, and poor modelling in professionals in practice can detract from positive formal teaching of diversity education in earlier years (Hausmann et al, 2007). The LPM used to practically apply the principles of the self-authorship theory offers a framework for faculty development (Wildman, 2004) and emphasises the importance of role modelling by the educator to demonstrate how multiple diverse perspectives can be considered and critically evaluated (Barber et al, 2014; Magolda & King, 2008). Applying the use of the LPM in diversity education may help educators to become consciously aware of their attitudes and behaviours. In addition, Wenger's (2005) theory of 'communities of

practice' may assist in illustrating the interplay of diversity and cultural issues in different healthcare interactions.

The use of reflective learning theories in healthcare curricula, particularly in relation to diversity education, is increasing. The skill of reflection and the importance of developing *"reflective practitioners"* (GMC, 2003; 2009; NHS KFS, 2009; NWC, 2004, 2015; BPS, 2015, 2017) is widely acknowledged across health educational institutions. Theoretical frameworks in diversity education, particularly those that depart from the cultural competence/cultural expertise model such as cultural humility (Tervalon & Murray-Garcia, 1999) and cultural sensibility (Dogra, 2004) explicitly encourage continual self-reflection. Additionally, newer versions of cultural competence, such as the intercultural competence model (Byram, 2008) and the cultural competence framework (Seelman et al, 2009), emphasise the importance of embedding reflective practice in teaching on culture, with cultural competence being a 'recurring focal point' (Seelman et al, 2009; pp.45). The opportunities for reflective practice in reference to diversity education may be enhanced by a specific focus on self-authorship, as the purpose of reflection can often be unclear to both students and educators (Sanders et al, 2014).

Any successful implementation of strategies designed to promote diversity education relies on educators also having a sophisticated understanding of diversity and reflecting upon what diversity and culture means to them on an individual level (King and Baxter-Magolda, 2005). The cultural humility (Tervalon and Murray-Garcia, 1999), cultural sensibility (Dogra, 2004) and intercultural maturity (King and Baxter, 2007) models suggest educators must engage in reflective processes outlined in different reflective theories such as Kolb's experiential learning model or Schon's theories of reflection. In terms of 'reflection on action', Freire (1970) claimed a prerequisite to learning involves a willingness to be challenged regarding one's worldview and to be comfortable with ambiguity. This is particularly applicable to diversity education as learning about diversity can arguably involve being challenged about one's personal world view and assumptions, which learners are likely to find uncomfortable (Kai et al, 2004). Notions described in transformative learning theories such as the 'disorientating dilemma' (Mezirow, 1978) and the shift from dualism to multiplicity (Perry, 1990) may assist in changing or re-evaluating one's attitudes and world views. Transformative learning theories are explicitly applied in the cultural sensibility model (Dogra, 2004), which is one of the few models based on educational principles.

2.4.4   Communication skills

The development of communication skills is a recurring skills outcome in relation to diversity education (GMC, 1993; 2003; 2009, NHS KSF, 2004; 2005, NMC, 2000; 2007) and covers a wide range of diversity issues. Institutional requirements and healthcare expectations are more specific in their requirements on how diversity issues should be addressed in communication. Despite limited literature, available research suggests sessions on clinical communication and diversity frequently employ experiential learning techniques such as role play and the use of simulated patients to allow students to practise how to response to diversity issues in a simulated environment (Joe et al, 2015, Turner & Dogra, 2015). These sessions typically involve communicating with a patient with limited English or working with interpreters (Hargie et al, 2010; McEvoy et al, 2014), and have been formally added to existing communication health curricula. A variety of experiential learning such as video-taping, incorporating standardised patients and role play have been used to develop prospective health professionals' skills in diversity (Harris et al, 2004; Rosen et al, 2002), by fostering a supportive, non-judgmental approach, working in partnership and respecting differences in worldview. These skills are identical to those required for effective patient-centred care (Nelson-Jones, 2013). Reflections on video examples of patients from diverse backgrounds have been shown to improve students' development of a patient-based framework for approaching cultural contexts of all patients (Carrillo et al, 1999; Green et al, 2001; Betancourt et al, 2003). In addition, cultural and linguistic differences in communication are formally assessed using Observed Structured Clinical Exams (OSCE). Medical schools are frequently utilising 'cultural OSCEs' (Dogra & Wass, 2006; Altshuler & Kachur, 2001; Robins et al, 2001; Rosen et al, 2004; Miller et al, 2007) to assess diversity issues.

CONCLUSION

In parallel to the evolution of theoretical frameworks in diversity education, so too have educational theories developed more emphasis on self-awareness and personal development. Responding to the healthcare expectations and institutional requirements of the 21st century requires a holistic educational curriculum that facilitates personal development for all learners, particularly in relation to diversity issues. This chapter illustrates the rich heritage of educational theories and explores their relevance and application to diversity education. The utilisation of educational theories in diversity education is limited to date, although there are prime opportunities to apply the use of

these theories in developing appropriate curricula to achieve the expected outcomes associated with diversity education.

Chapter 3: Evaluating Cultural Competence Training in Healthcare Institutions

Despite the limited theoretical progression towards the use of the term 'diversity' in healthcare educational trainings in relation to cultural issues, the majority of the literature on the evaluations of these trainings is centred on the concept of 'cultural competence' (Price et al, 2015; Shen, 2016; Lotin et al, 2013). Therefore, this chapter uses the term 'cultural competence' as opposed to 'diversity', though in some cases authors use these terms interchangeably. The reasons for embracing the term 'cultural competence' are varied; however, its frequent use is historically rooted in the fact that it has been a central tenet in the discussions of racial and ethnic inequalities in healthcare (Malet, 2013; Meghani et al, 2009). Cultural competence models have arisen primarily in response to increasing evidence of ethnic and racial disparities in healthcare. The sources of these disparities are complex and multi-factorial and have been described as 'pervasive' (2003, 2004), 'prevalent' (2006), 'persistent' (2008) and worryingly 'not improving' (2010) and 'not changing' (2012, 2015). Education and training initiatives around cultural competence are not sufficient alone to address these significant health disparities, however they remain an integral component for addressing cultural issues and ethnic disparities in healthcare (Betancourt, 2003).

Cultural competence poses inherent challenges in its evaluation and measurement largely due to the fact that its meaning is so varied, broad, nuanced and complex (Suzuki, McRae and Short, 2001). As healthcare institutions and educational bodies continue to develop and implement trainings around 'cultural competence' or 'diversity', questions of how to evaluate these initiatives frequently arise. This chapter aims to critically identify and explore the challenges and philosophical issues related to the measures used to evaluate 'cultural competence'. In addition, the most widely used measures and tools to evaluate 'cultural competence' will be explored to examine the conceptual issues and underlying assumptions on what constitutes 'culturally competent' practice and what understandings of 'cultural competence' these measures embody. Finally, this chapter reviews common theoretical and practical issues involved in evaluating these trainings and the new insights and recommendations for future research.

3.1 Cultural competence

A plethora of health educational policies consistently demonstrate the expectation that healthcare providers can work effectively with an increasingly diverse population and have often implicitly inferred that their capacity to do this will depend on their acquisition of 'cultural competence' (Department of Health, 2012, GMC, 2009). Cultural competence or diversity training has become a widespread practice in an active attempt to improve the knowledge, skills and attitudes of health professionals in serving culturally diverse populations (Bhui et al, 2007). The basic challenge of measuring any construct like cultural competence is to reliably and precisely capture its meaning and constituent components in a feasible and practical way (Fall, 2002).

There are important differences among the definitions of the term 'cultural competence' and there remains no single accepted conceptual framework for organising this construct's multifaceted components (Kumas-Tas, 2007; Gozu et al, 2007; Stanhope et al 2005). Even the so called 'simple' definitions of cultural competence are challenging to operationalise and translate in terms of identifiable, observable and measurable behaviours or attributes (Suzuki et al, 2001). Burchum (2002) identified six common attributes of cultural competence that are identified in the literature, namely cultural awareness, cultural knowledge, cultural skill, cultural sensitivity, cultural interactions and cultural understandings. Greater critical examination revealed that four of these six attributes, sensitivity, awareness, knowledge and skills, constitute the typical domains or subscales among existing evaluative measures for cultural competence.

Research on the evaluation of cultural competence can be traced back to the early 1990s. Researchers showed a preference for the development of psychometrically valid measures of cultural competence, with the majority of these being self-reported measures (Gozu et al, 2007). Typically, these measures would conform to three domains: knowledge, attitudes and skills. Knowledge would depict the need for healthcare professionals to be educated about different practices, beliefs and traditions of cultural groups and differing world views. Attitudes would attempt to convey an understanding that one's beliefs and values are shaped by culture and that different cultural groups will hold unique attitudes to health and illness. Finally, skills, which generally focused on communication, described the need for culturally appropriate and cross-cultural communication skills to be able to build effective relationships with patients (Betancourt, 2003).

3.2 HIDDEN ASSUMPTIONS IN EXISTING MEASURES

Evaluation can be defined as *"the act of judgement of the worth of…"* (Collins, 1994;n.p.). It is fundamentally an endeavour to ascertain the value, merit and worth of an intervention or training, therefore it is a value laden activity (SenGupta, 2004). Goldie (2006) distinguishes assessment from evaluation by describing assessment as primarily concerned with the measurement of student performance. Evaluation is referred to as the "*process of obtaining information about a course or programme of teaching for subsequent judgment and decision making*" (Newble & Cannon, 1994;pp.1). The role of cultural competence evaluation is to ensure training is in fact improving or equipping professionals with the knowledge, attitudes and skills to effectively serve diverse populations. Therefore, the development and quality of evaluation methods and tools is an integral part of the overall strategy to reduce racial and ethnic healthcare inequalities.

Kumas-Tan (2007) reviewed fifty-four methods commonly used to evaluate cultural competence, and a critical analysis of the ten most widely used measures has been outlined in Table 3.1. Kumas-Tan (2007) defined six underlying assumptions about culture that these measures exemplified. These were 1.) Culture is a matter of ethnicity and race, 2.) Culture is possessed by the 'other' and the 'other' has the problem, 3.) The problem of cultural incompetence lies in practitioners' lack of familiarity with the 'other', 4.) The problem of cultural incompetence lies in practitioners' discriminatory attitudes towards the 'other', 5.) Cross-cultural healthcare is about White practitioners working with patients from ethnic and racial minority groups and 6.) Cultural competence is about being confident in oneself and comfortable with others. Interestingly, most these assumptions are consistent with the notion of 'ethnocentrism' or 'cultural expertise' (Dogra, 2004). These notions perceive culture as an external characteristic and applicable to those of a non-White race, and advocates the need for White individuals to acquire a body of knowledge of the different cultural practices, attitudes and beliefs of non-White groups to develop 'cultural expertise' (proficiency in cultural knowledge). These assumptions are critically explored in relation to the common challenges identified in existing measures used to evaluate cultural competence.

3.2.1 Definitional ambiguities

Commonly cited measures outlined in Table 3.1 and additional frequently used evaluation tools shown in Appendix 3.1 appear to conceptualise culture and cultural competence as notions only pertinent to issues of race and ethnicity. Most cultural competence measures disproportionately emphasise issues of race and ethnicity in comparison to other individual differences. Examples of different measures outlined in Table 3.1 are explicit in solely focusing on measuring the competence of individuals in their relations with non-White racial and ethnic groups (Kumas-Tas et al, 2007). Despite the array of other patient differences that can affect healthcare interactions, race and ethnicity remain the most frequently discussed differences to the near exclusion of other differences. This may reflect a larger conceptual problem about defining cultural competence and its parameters and echoes current debates about how 'diversity' is a better term to capture all differences that can affect healthcare interactions. Whilst the 'Multicultural Awareness, Knowledge and Skills Survey' (MAKSS-CE-RE, Kim et al, 2003) and the 'Quick Discrimination Index' (QDI, Ponterotto et al, 1995) adopt a broader concern for diversity, there is clearly a predominant focus on ethnic and racial differences. The MAKSS-CE-RE tool, consisting of thirty-three items, only includes seven items on issues other than race and ethnicity and similarly the QDI devotes only seven out of thirty items to the measurement of sexist attitudes, with the remainder centred on race and ethnicity. Culture is conceptualised in a manner consistent with the notion of ethnocentrism and 'cultural expertise' is understood to refer to ethnic and racial differences.

As knowledge and research advances to reveal the multiple axes where inequality and oppression lie, this has led to the broadening of cultural competence training in tackling issues beyond race (Razack, 1999; Rothman, 2008; William, 2006). Yet arguably the training is still perceived as addressing issues of colour and not diversity (Abrams et al, 2009; Bhui et al, 2008; Bhugra et al, 2015). Despite acknowledging a range of differences, the training has not been displaced from its original intention in combating racial inequalities in healthcare. Recent reviews have shown that cultural competence trainings and even those referred to as diversity trainings are often still based on this premise, with the focus of their teaching purely on those of a non-White race. (George et al, 2015; Bentley et al, 2008) This further perpetuates the perception that issues of culture and diversity are only relevant to those of a non-White race. Culture is a topic rarely explored in relation to the White race, with individuals of a White race appearing

to be not acknowledged as a cultural group (Bennet et al, 2007; Pfeffer, 1998; George et al, 2015). However, literature concerning diversity education, particularly theoretical frameworks which depart from cultural competence models, acknowledges any difference as diversity and emphasises the importance of acknowledging a range of factors that contribute to the development of one's identity, other than race and ethnicity (Tervalon & Murray-Garcia, 1999; Nunez, 2000; Dogra, 2004).

Many cultural competence evaluation tools and measures rely heavily on the three domains of knowledge, attitude and skills. However, there is still much dispute as to whether these domains can fully and reliably capture the complexity of diversity and cultural issues and all aspects of cultural competence. For example, the widely used 'Multi-cultural Counselling Inventory' (MCI, Sodowsky et al, 1994) identified an additional domain, *'relationships'*, highlighting the increasing cultural issues that arise in healthcare interactions, for example a new item is *"ambiguity and stress often result from multicultural situations because people are not sure what to expect from each-other*." The 'Multicultural Counselling Knowledge and Awareness Scale' (MCKAS, Ponterotto et al, 2002) later revised the tool, combining the knowledge and skills into one factor based on psychometric testing. The awareness dimension of this tool continued to demonstrate poor reliability, which may indicate a lack of clarity about what this dimension is actually measuring. Sodowsky et al (1994) defines awareness as a two-stage process, whereby one first becomes aware of one's own culture and how this informs one's personality and behaviour. The second stage is then to reflect upon and understand how this influences one's interactions with patients. Although this awareness dimension has been further revised and defined, to capture this on a measurement scale raises serious challenges. Arguably the process of attaining this level of awareness is unique to all and dependent on one's experiences and cultural background.

3.2.2   'Us versus them': practitioners versus patients

Measures in Table 3.1 also compartmentalise ethnic and racial groups as 'others' creating an 'us versus them' posturing. For example, the 'Multicultural Counselling Knowledge and Awareness Scale' (MCKAS) includes the following item *"I have an understanding of the role culture and racism play in the development of identity and worldviews among minority groups.'* Similarly, the other existing measures fail to acknowledge or examine the culture of dominant groups and how they influence their

interactions with non-dominant groups. In examples where measurements have recognised the culture of the dominant group they portray a similar skewed conceptualisation. For example, the 'Inventory for Assessing the Process of Cultural Competence among Health Professionals' (IAPCC-R, Campina-Bacote, 2007) expects health professionals to disagree with the following statement; "*it is more important to conduct a cultural assessment on ethnically diverse clients than with other clients.*" The item like the one quoted displays an ethnocentric view and constructs a narrow concept of culture that only applies to minority groups, whilst the term cultural competence implies that the dominant group needs to relate correctly to the minority groups, similarly implying the presence of those who are ethnically diverse and those who are not. Although these measures consistently portray ethnocentrism and 'cultural expertise' they do little to address the issues except merely acknowledge their presence.

Issues of culture and diversity are a daily practice which all healthcare professionals face, as their patients, colleagues and peers present varied perspectives, expectations, values and behaviours regarding issues of health, disease and well-being. Eisenberg (1979) demonstrated that cultural and social differences between the patient and the physician can influence both the communication and clinical decision making. The cultural differences between the patient and the practitioner are often unarticulated and unexplored. Despite the evidence that cultural differences can contribute to issues of miscommunication, patient and provider dissatisfaction, poor compliance and adherence and poorer health outcomes, it is rarely explicitly acknowledged that the culture of the provider is as important and influential as the culture of patient (Betancourt, 2003; Nunez, 2000).

On examining the 'awareness' or 'attitude' scale of many of these existing measures we see that they commonly attempt to ascertain the presence and degree of discriminatory biases, pre-conceived ideas/stereotypes and attitudes. Statements such as *"I think that clients who do not discuss intimate aspects of their lives are being resistant and defensive"* or *"I believe that all clients should maintain direct eye contact during counselling"* taken from the MCKAS are intended to identify the presence of ethnocentric prejudice. In contrast the CCAI is unique among the measures in Table 3.1 as it reflects more of an ethno-relativist, 'cultural sensibility' ideology and includes a 'flexibility/openness' subscale with examples such as *"people who know me would describe me as a person who is intolerant of others' differences"* to test for the

presence of discriminatory attitudes. These items imply an understanding that if an individual eliminates any discriminatory or ethnocentric attitudes then issues of race and ethnicity would no longer be a problem. Some of the instruments are clear in suggesting the 'correct attitude' is one of comfort with or celebration of diversity (CCCI-R, MCKAS, IAPCC-R, QDI, CCSAQ, MCI and CCAI). The underlying assumption of cultural incompetence as the result of individual discriminatory attitudes denies the larger structural and institutional issues and the systemic realities of ethnocentrism and inequalities. However, this depth of understanding and the issues outside the remit of an individual's actions are not evaluated in these measures.

Another assumption that Kumas-Tan (2007) raises is that many of these measures assume the respondents are of a White race and the recipients of care are from a non-White race and fails to account for interactions that are vice versa. Again, this corresponds to the assumption that issues of culture and cultural competence only arise with ethnic or racial minorities. A clear example taken from the CCSAQ (Mason, 2007) is *"do you attend cultural or racial group holidays or functions within communities of colour?"* which suggests the respondents are White. Examining how individuals of a non-White race would answer these items and what this indicates about their level of cultural competence remains to be further explored. Additionally, these items imply the experiences of the dominant culture are homogenous as are the experiences of the ethnic minority groups. The assumption that the White race may be more comfortable with diversity than ethnic minority groups does not appear to be explicitly recognised. Additionally, the assumption that ethnic minority groups can hold attitudes that are discriminatory, biased and prejudiced towards the dominant group is also not acknowledged. This argument is supported by Ponterotto (1995) who found that for all factors in the QDI except *"affective attitudes regarding racial diversity"* that African and Latino Americans scored higher than White Americans, indicating that the presence of discriminatory attitudes is present in those of a non-White race.

The Shen et al (2015) review illustrates that existing evaluative measures only measure the healthcare professionals' cultural competence; patient and health outcomes are rarely addressed (Balcazar et al, 2009; Capell et al, 2007). Many authors argue that without acknowledging the patient outcomes, care that is deemed culturally competent cannot be validated (Capell et al, 2007). Many authors have identified that there is limited research examining the expectations of culturally competent practitioners by patients. Healthcare educational institutions and researchers call for an

integration of patient perspectives in their conceptualisation of cultural competence. Fall (2002) echoes the same concern about the lack of patient input and claims that it is inappropriate to base a judgement on a provider's level of cultural competence without the valued input from the patient or care recipient.

3.2.3 Cultural misunderstandings as the source of racial inequalities

Research has shown a wide range of contributing factors to racial inequalities in healthcare which vary from socio-economic causes to cultural issues (Nazroo, 2013; Williams et al, 2005). It appears that the fundamental problem may originate from the notion that cultural misunderstandings are understood as a primary source of racial disparities in healthcare (Hsing-Yu Yang, 2015; Adams et al, 2015; Bhugra et al, 2000). The literature reflects an ethos that the source of cultural misunderstandings stems from those of a White race and not those of a non-White race. It also implies that non-White patients are meaningfully (i.e. contrasting beliefs, expectations and preferences) different from their White health professionals, and arguably that racial differences are a source of dissimilar cultural health beliefs and practices (LaVeist et al, 2002; Saha et al, 2011; Megahani, 2009). Yet, it fails to consider the situation vice versa; that cultural misunderstandings can stem from those of non-White race and even amongst patients and health professionals of the same race (Van-Ryn & Burke, 2000; Chen et al, 2005; LaVeist & Neru-jeter, 2002; Malet & Hamilton, 2006). There is often an unquestioned assumption that individuals of the same race share similar values, life experiences and cultural beliefs. However, racial discordance does not necessarily imply cultural differences. In addition, this assumption that race concordance between the patient and the provider leads to better quality of care, has not been thoroughly tested. Research yields mixed support for the idea that non-White patients prefer the same race provider and that patient satisfaction improves in racially concordant pairs (Sacks, 2013). It is unclear whether the lack of cultural understanding is the source for racial inequalities or is it our inability to *adapt* to different patients' cultural and diverse needs?

The training content of many current diversity trainings often relays a one-way process where individuals adopting foreign or non-Western practices need to be accounted for and known as different. In addition, current evaluation measures imply health professionals assuming foreign practices that are different to the UK health culture need to integrate and conform. Minimal research has explored the sequential

processes needed in adapting to these differences and the challenges and impact this has on health professionals (Sheikh, 2001; Esmail et al, 1995). UK education and training often holds an implicit assumption that professionals with different cultural backgrounds (often those of a non-White background) to the West will adapt to the UK culture. However, what is problematic, is the expectation that the adjustment rests solely on practitioners or patients who are considered foreign and not those from a UK White British culture (Hunt, 2007). In addition, open discussions of which cultural differences should be accommodated by those working in the NHS are minimal. How individuals of a White race perceive and adapt to cultural differences is rarely discussed, documented or evaluated. Efforts to promote a health system that is truly receptive and responsive to diversity arguably needs input from those of both a White and non-White race.

3.3 DEFICIENCY IN INSTITUTIONAL GUIDELINES

Beach et al (2004) concluded that the heterogeneity of evaluation strategies, curriculum content and teaching methods made comparisons of the trainings impossible and made it difficult to determine the impact of the training on set outcomes. With little institutional or standard guidelines for the development, design and evaluation of these trainings, variability in the trainings is inevitable. Sagar (2012) conducted a comprehensive comparison of six well known transcultural or cultural competence theoretical frameworks and concluded *"there is a paucity of literature applying those models*." Despite the multitude of theoretical frameworks for cultural competence and diversity, little research has compared the efficacy of each framework/model in achieving the desired outcomes of cultural competence or diversity. Shen (2015) claims that the flawed practical application of these different theoretical models/frameworks may be attributable to the fact that many of these frameworks are abstract and broad in focus with little guidance on how to translate them into specific, precise and clearly defined educational content and concepts (Fawcett, 2005). In addition, the paucity of valid and reliable evaluation tools to evaluate their models makes it more challenging to apply these models in practice. Many of the theoretical frameworks for cultural competence and or diversity are not empirically tested (Shen et al, 2015).

Given the lack of institutional guidelines, many organisations develop their own ad-hoc assessment/evaluation tools that are theoretically uninformed and often not tested for

their validity and reliability. From the review of commonly used measures and evaluation tools for cultural competence in Table 3.1 and Appendix 3.1, the most widely used theoretical frameworks for understanding cultural competence appear to be the Sue et al (1992) model for cultural competence developed in the context of counselling psychology. As shown in Table 3.1, Sue et al's (1992) model has formed the basis for most standardised psychometric measures of cultural competence to date. This defines three broad domains of cultural competence: knowledge, beliefs and attitudes and skills. It was later revised to include a more specific area of cultural competence i.e. culture-specific knowledge. Several of the most established measures of cultural competence are heavily based on and influenced by Sue's original model and generally support the three-dimensional framework. However recent studies have shown that existing measures are being revised to include new dimensions. For example Sodowsky (1994) argued for greater consideration of cross-cultural relationships and greater considerations of power, authority, and leadership dimensions.

3.4   ASSUMPTIONS ON HOW TO DEVELOP CULTURAL COMPETENCE

As well as constructing the notion of ethnic and racial groups as the other or the problem, existing measures listed in Table 3.1 assume that cross cultural understanding and connection can be attained by acquiring specialised knowledge. This is consistent with theoretical frameworks under the model of 'cultural expertise' dictate that healthcare professionals must acquire a finite mastery of cultural knowledge to be culturally competent. Most models are based on the knowledge-skills-attitudes model of cultural competence or have subscales which measure the cultural knowledge-cultural skills and cultural awareness. Although these measures and training initiatives are persistent in their attempt to evaluate and teach these three broad domains, many solely measure cultural knowledge. Authors (Dogra et al, 2004; Bennet et al, 2008) have criticised the idea that knowledge alone is the key indicator of cultural competence. The reliance on self-reported quantitative measures without the addition of more complex measures to capture the complexity of culture and cultural competence allows only short term surface level change to be measured. Evaluating the impact of the training on long term professional development and how knowledge is used to improve patient outcomes is left unexamined. These measures could demonstrate a change in knowledge from training and educational initiatives, but how and whether this knowledge was applied and had an impact on patient and service outcomes remains unclear. The problem is that often these quantitative measures are

the sole evaluative indicators as to how effective the training initiatives are. Despite knowledge being only one part of cultural competence, it is often used as the prime indicator to evaluate the effectiveness of the training.

Another important assumption that Kumas-Tan (2007) raises is that often these measures imply that exposure to or communication with ethnically diverse groups leads to increased awareness. The skills domain of cultural competence is often seen as equivalent to communication, leading to experiences of different cultural exposure. For example, the MCI measures the exposure healthcare professionals and students have to cultural experiences; *"extensive life experiences with minority individuals"* is an example of one item. These implied assumptions fail to account for the *quality* of an individual's cultural experiences, and assume that all cultural experiences are inherently positive and promote increased awareness. This is often the assumption held by cultural immersion training programs where an individual is intentionally immersed in a different culture to gain an increased awareness and insight into how that culture manifests itself. However, research shows that many cultural experiences are not necessarily positive, nor do they foster increased insight, conversely, they can be occasions of ambiguity, uncertainty and discomfort. Supporting this notion, one study using the MCI found that both the extent of rehabilitation counsellors' multicultural experiences and the percentage of minority clients on their caseloads were inversely correlated with the quality of their cross-cultural relationships.

In examining the rating format of the most commonly cited measures of cultural competence, we see that they appear to rely to some extent on respondents' self-ratings of their own confidence or comfort through the commonly used Likert scales. A variety of evidence shows that increased confidence or comfort with issues of culture and diversity may not necessarily be a measure of increased competence. Also, there are inconsistencies in what is defined as comfort and what is defined as tolerance. Some studies have shown that learners/healthcare professionals who receive cultural/diversity training may feel less confidence or comfort than those who receive no training (Alpers, 1996). In addition, parallel findings for the IAPCC-R have found that 1.) Confidence and comfort may not be valid indicators of cultural competence and 2.) Higher levels of confidence and comfort may be indicative of lower insight and awareness.

The measure that is unique among the others listed in the ten most frequently cited tools is the 'Cross-Cultural Adaptability Scale' (Kelley and Meyers, 1992) as it does not depend on the ethnocentrism/cultural expertise perspective but on an ethnorelativist/cultural sensibility perspective. This measure focuses on components of intercultural effectiveness, outlining several desired attributes that are necessary for one's ability to form *meaningful relationships*. These included, open-mindedness to new ideas and experiences, intercultural empathy, perception and understanding of difference and being non-judgemental. These domains are in stark contrast to the typical knowledge, attitudes and skills model and reflect the attributes listed under theoretical frameworks consistent with the cultural sensibility model. Kelly and Meyers (1992) developed this tool to specifically assist trainees in developing self-understanding about their cross-cultural ability and for trainees to connect theoretical awareness to practical application. This tool can be used simultaneously as an evaluation measure and an educational resource, arguably showing greater promise of achieving the outcomes of the evaluation measure. Kelly and Meyer (1992) condensed the desired attributes into four distinct subscales: 1.) Emotional resilience: outlines the need for humility and self-confidence in dealing with the stress of 'cultural shock', 2.) Flexibility and openness: describes the capacity to be broad-minded, curious, respectful and flexible in cross-cultural encounters, 3.) Perceptual ability: entails an individual's capacity for empathy which aids in their understanding of others' experiences across cultures and finally 4.) Personal autonomy: refers to the ability to retain a sense of self when encountering different cultures. This measure makes a greater reference to issues surrounding 'cultural identity', 'cross-cultural interactions' and the ability and attributes needed to form meaningful relationships across cultures.

The examination of evaluation tools listed in Table 3.1 and Appendix 3.1 raises the broader issue of whether cultural competence measures intentionally constrict their focus on issues of race and ethnicity. Most the measures are explicit in their focus on the competence of White individuals in their health relations with non-White individuals. Those measures that go beyond the concerns of race and ethnicity only devote a small number of items to measuring other social health inequalities and needs of marginalised groups. This limitation is rooted within the larger historical and conceptual issues relating to how the concept of cultural competence arose and the lack of consensus over what cultural competence is concerned with.

3.5 SOCIAL DESIRABILITY AND METHODOLOGICAL QUALITY

The reliance on self-reported measures to evaluate cultural competence consistently raises the issue of social desirability as one of the core challenges in this field (Price et al, 2015; Shen, 2016; Lotin et al, 2013). Multiple studies have shown that respondents may over or underestimate their cultural competence and may be inclined to report what they anticipate to be their cultural competence rather than their actual behaviours and attitudes. In addition, it may be challenging for participants to assess their cultural competence without a clear understanding of how these terms are defined and understood in practice. The widespread use of self-reported measures of cultural competence and diversity makes them easily susceptible to social desirability effects. The current literature identifies that many evaluative measures of cultural competence are self-administered and based on individuals' perceptions (Loftin et al, 2013) and rarely offer any objective measure of culturally competent care from a patient's perspective.

The common reliance on pre and post psychometric evaluation measures only provides evidence of short term changes. Examining the long-term impact of the training in terms of professional development and patient outcomes has rarely been attempted. In addition, being able to attribute any change in the pre/post test scores solely to training may discard pertinent variables such as personal experiences and meaningful relationships that may contribute to one's development of cultural competence. Therefore, causal interpretations cannot be made. Evidence suggests that learners would be more inclined to identify socially appropriate or safe answers as opposed to more politically charged or loaded responses. Their responses may not truly capture their beliefs or predict their clinical behaviours (Ponterotto et al, 2000; 2008).

Betancourt (2003) suggests that capturing their behaviour in real time via videotaping or audiotaping would be the optimal, gold standard approach. In addition, knowledge or fact based evaluation fails to evaluate the complexity of cultural issues and appears incompatible with the ability to capture the fluidity of culture and diversity. Another important issue that Betancourt (2003) raises is attention to how this training and its associated evaluation methods are perceived. There is much evidence to suggest that learners perceive cross-cultural education negatively and are resistant to discussing their personal attitudes to culture and diversity. Acknowledging how this training is

perceived as well as received is important in the context of evaluation. Betancourt (2003) advocates the use of multiple, mixed methods for evaluating cross-cultural education, highlighting the use of newer techniques focusing on qualitative assessment through structured interviews or focus groups. Other techniques (outlined in Appendix 3.2) such as reflective essays, objective structured clinical examinations (OSCEs) or the use of videotaped/audiotaped clinical encounters are valuable to explore in relation to the assessment and evaluation of these training initiatives.

In addition, little research has been conducted to explore the quality of evidence upon which future developments in this area might be based. Price et al (2005) concluded that the quality of evidence upon which trainings to improve cultural competence of practitioners are based is generally poor. Also, the quality of the literature does not appear to be improving consistently over time (Price et al, 2015; Lotin et al, 2013). Many of the existing measures used raise the question of reliability of these instruments. Common criticisms note that many of these measures were developed without the valued input of patients and were normed for a predominantly White, middle-class and educated population.

Another challenge that is consistently raised is in reference to 'utility'; existing measures of self-reported psychometric questionnaires can be lengthy and not entirely relevant to those of different healthcare professions. Many of the evaluation tools and measures for cultural competence were developed in the context of counselling psychology and used internationally, and questions of transferability of these tools into the UK context still need further exploration. Additionally, the NHS now requires all healthcare professionals to undergo diversity/cultural competence training, therefore it is important to ensure that evaluation instruments are broad enough to apply to all healthcare professionals.

One of the most disconcerting challenges that is consistently raised is the question of the validity of existing measures. It has been argued that many existing measures over-simplify the concepts of culture and cultural competence as a means to conform to the narrow domains of measurement scales. Although many measures are based on the typical attitude-knowledge-skills model of cultural competence there remains continual dispute about the meaning of cultural competence and its constituent components.

3.6　FUTURE DIRECTIONS

Evaluating cultural competence or diversity training is complex and challenging to measure objectively. Much research is still needed to establish compelling and comprehensive evaluation methods for cultural competence and diversity trainings. The current use and preference for self-reported measures may be attributable to the fact that they are cost-effective, readily available and easily administrated. This chapter outlined core underlying assumptions, conceptual issues and understandings that must be taken into account when assessing the validity, reliability and usefulness of existing measures and in the development of new methods. Collectively these assumptions and underlying understandings found in existing measures are consistent with the notions of the ethnocentrism and cultural expertise model. They constitute a conceptualisation of culture and cultural competence as belonging to issues of race and ethnicity and are only applicable to those of a non-White race. Even when concerns beyond race and ethnicity are raised, these differences imply those that are distinct from the White race group, including issues of non-British and non-Western traditions. Existing measures depict an image of arming those of a White race with specialised knowledge about those of a non-White race in order to bridge cultural differences and become culturally competent.

Future research on the evaluation of these training issues needs to actively explore the other perspectives of culture and cultural competence, ideally those of a White and non-White race. In moving forward in our efforts to better understand, teach and practise diversity teaching it is essential to attain conceptual clarity on the terms culture, diversity and cultural competence to ensure evaluation tools are clear and transparent in what these terms actually mean and how to effectively measure them. We need to reconsider the definition of culture and diversity in this century and how it can be practically applied in evaluation tools. Wear (2003) concludes that *"what has come to be known in medical education as cultural competency is theoretically truncated and may actually work against what educators hope to achieve."* This concern is echoed by many authors advocating a move away from ethnocentric/cultural expertise approaches to more diversity and ethnorelativism/cultural sensibility perspectives. Evidence suggests that more qualitative methods should be used to inform the overall conceptualisation of these terms cultural competence and diversity, especially patient perspectives.

Collectively the authors from the Kumas-Tas review suggested the following recommendations to consider in the development of new evaluation tools in this field; 1.) Expand what it is that we measure when evaluating cultural competence, 2.) Measure constructs above and beyond cultural competence in a traditional sense, 3.) Develop more theoretically informed measures of effective practice across cultures and 4.) Explore alternative methods for evaluating cultural competence, namely qualitative and mixed methods. Given that institutional and healthcare educational policies are emphasising a wider range of desired attributes, aptitudes and skills beyond the typical knowledge and attitudes in relation to diversity, more research is needed to explore whether these different constructs are best measured separately, whether multiple methods should be used or whether new instruments can expand the conceptualisation of diversity and cultural competence.

Fall (2002) similarly echoes the need for further research on the evaluation of cultural competence, highlighting three areas: 1.) How to best understand and measure the perceptions of patients and healthcare professionals in appropriate care encounters and relationships, 2.) How to best understand, measure and influence the attitudes and behaviours of practitioners and 3.) How to best understand, measure and assess the organisational and social factors influencing cultural competence. The translation of learning experiences to actual changes in clinical practice remains uninvestigated. Further research is needed to confirm the theoretical dimensions of cultural competence empirically to shed greater light on how to define this term and effectively measure its constituent components. Fall (2002) defines the major challenges of the evaluation of cultural competence measures in three dimensions: 1.) Failure to define what cultural competence means, 2.) Failure to consider patient perspectives in the design of evaluation measures and 3.) Failure to test the reliability, validity and psychometric properties of the measure.

CONCLUSION

Despite widespread consensus on the need to introduce cultural competence/cultural diversity trainings, much more development and research on how to effectively evaluate these types of training is needed. The presence of strong evaluation tools may help clarify definitional ambiguities that exist in the terms cultural competence, culture and diversity and therefore clarify outcomes for trainers and educators. Evaluation measures for cultural competence training must account for the current challenges and underlying assumptions of existing measures and show a greater

overall understanding of the conceptual issues involved in measuring cultural competence.

TABLE 3.1: THE TEN MOST FREQUENTLY CITED CULTURAL COMPETENCE MEASURES

Measurement Tool	Development & Theoretical Framework	Psychometric Properties	Format	Relationship to ethnocentrism/cultural expertise or ethnorelativist/cultural sensibility
Multicultural Counselling Inventory (MC1) (Sodowsky, Taffe, Gutkin and Wise, 1994)	-Theoretical framework: Sue et al's (1982) attitudes-knowledge-skills model of cultural competence -Developed in 1994 for use in counselling psychology	-Good face and content validity -Acceptable criterion validity -Unknown test-re-test stability -Moderate relationship among subscales -Four factor model only accounts for 36% of variance	-40 items -Four-point Likert scale (very inaccurate to very accurate) -One general multicultural competency factor and four specific factors: 1.) Multi-cultural counselling skills, 2.) Multi-cultural awareness, 3.) Multi-cultural counselling *relationships* and 4.) Multi-counselling knowledge	-Consistent with an ethno-centric, 'cultural expertise' approach
Cultural Self-Efficacy Scale (Bernal and Froman, 1987)	-Theoretical framework: Leininger's (1991) model for transcultural nursing & Social Learning Theory (Bandura Self-Efficacy, 1977, 1997) & Transcultural Assessment Model and Theory (Giger and Davidhizer) -Developed in 1987 for use in nursing, then revised in 1993	-Good reliability and validity -Content and Construct Validity -High internal consistency -Cronbach's alpha. 97 overall with subscales ranging from 85. To 98.	-26 items -Five point Likert scale (very little confidence to quite a lot of confidence) -Three sections: 1.) Knowledge of cultural concepts, 2.) Knowledge of cultural patterns and 3.) Skills in performing transcultural nursing functions	-Consistent with an ethno-centric, 'cultural expertise' approach (found to not link with a specific over-arching theoretical framework) -Designed to test perceived sense of self efficacy in caring for diverse patients (Black, Hispanic and Asian) -The cultural specificity of this instrument has been found to limit its use for assessment of nurses caring for individuals

				from cultures other than those addressed by the instrument.
Inventory for Assessing the Process of Cultural Competence Among Health Professionals (IAPCC and IAPCC-R) (Campinha-Bacote, 1999, 2003)	-Theoretical framework: Campinha-Bacote's (1991) model of cultural competence -Developed in 1998 for use in nursing, medicine and pharmacy and revised in 2003	-Good internal consistency and reliability -Reliability of original version reported as a limitation. -Content validity determined by 5 national healthcare experts in fields of transcultural nursing and construct validity determined by known groups techniques	-25 items -Four point Likert scale (very aware to not very aware; strongly agree to strongly disagree; very knowledgeable to not knowledgeable; very comfortable to not comfortable; very involved to not involved) -Five subscales: cultural awareness, cultural knowledge, cultural skill, cultural encounter and cultural desire	-Consistent with an ethno-centric, 'cultural expertise' approach -Designed to measure level of cultural competence in healthcare providers
Cross-Cultural Adaptability Inventory (CCA1) (Kelley & Meyers, 1995)	-Theoretical framework: Tervalon and Murray Garcia's (1998) cultural humility model -Developed in 1987 intended for general use and then revised in 1992	Conflicting reports -Kelley & Meyers report excellent reliability, face validity and construct validity; questionable predictive validity -Davis and Finney report four factor structure not replicable and cross-cultural adaptability not measurable by these items and or this structure	-50 items -Six point Likert scale (definitely not true to definitely true) -Four subscales: 1.) Emotional resilience, 2.) Flexibility/openness. 3.) Perceptual acuity and 4.) Personal autonomy -Focuses on the components of intercultural effectiveness stating a number of desired attributes that lead to *meaningful relationships*	-Consistent with an ethnorelativist, 'cultural sensibility' approach

Quick Discrimination Index (QDI) (Ponterotto, 1995)	-Theoretical framework: Colour blind model and Multicultural model -Developed in 1995 for use in counselling psychology and intended for general use	-Good internal consistency of scale and subscales -Stable over 15 weeks test-retest period -Promising face, content, construct- and criterion related validity	-30 items -Five point Likert scale (strongly disagree to strongly agree) -Three subscales: general (cognitive) attitudes about racial diversity, affective attitudes about racial diversity and general attitudes regarding women's equity issues.	-Consistent with an ethnocentric, 'cultural expertise' approach
Culture attitude scale or ethnic attitude scale (CAS/EAS) (Bonaparte et al, 1979; Rooda et al, 1993)	-Theoretical framework: Leininger's (1991) model around transcultural nursing -Developed in 1979 for use in nursing and revised in 1993	-Poor reliability	-20 items for each of the two vignettes (re: Anglo and African American patients; additional vignettes may be added) -Five point Likert scale (strongly agree to strongly disagree) -Three factors: Nursing care-patient *interactions*, cultural health beliefs and cultural health attitudes and beliefs	-Consistent with an ethnocentric, 'cultural expertise' approach
Multicultural Awareness, Knowledge and Skills Survey (MAKSS and MAKSS-CE-R) (D'Andrea et al, 1991)	-Theoretical framework: Sue et al's (1982) attitudes-knowledge-skills model of cultural competence -Developed in 1991 for use in counselling	-Adequate reliability -Acceptable support for construct- and criterion related validity of scale and subscales -Content and construct validity	-33 items -Four point Likert Scale (very limited to very aware; very limited to very good; strongly disagree to strongly agree) -Three subscales: awareness-revised,	-Consistent with an ethnocentric, 'cultural expertise' approach

	psychology and revised in 2003	-The MAKSS-CE-R only accounts for one third of the variance that original MAKSS had accounted for (29.08%)	knowledge-revised and skills-revised. -Aware of one's own attitude to racial/ethnic populations, skills to communication cross-culturally and knowledge about racial/ethnic populations	
Cultural Competence Self-Assessment Questionnaire (CCSAQ) (Mason, 2007)	Theoretical framework: Cross et al's (1988, 1989, Ponterotto, 1988) model of cultural competence. This is based on five stages: cultural destructiveness, cultural incapacity, cultural blindness cultural pre-competence and cultural proficiency -Developed in 2007 for use in child and adolescent mental-health	-Acceptable reliability, except for personal involvement subscale -Validity supported by literature and expert review	-Two versions; one for direct service providers, the other for administrators -The former consists of 79 items -Four point Likert scale (various) -Five subscales: knowledge of community, personal involvement resources and linkages; staffing, service delivery and practice, organisational policies and procedures and reaching out to communities.	-Cross et al (1989) model emphasised three critical elements of cultural competence: 1.*) Self-awareness*, 2.) Culture specific knowledge and 3.) Skills in promoting effective socio-cultural *interactions* by an individual. This reflects a combination of the 'cultural expertise' and the 'cultural sensibility' approach.
Cross-Cultural Counselling Inventory (CCCI and CCCI-R) (LaFromboise et al, 1991)	-Theoretical framework: Sue et al's (1982) attitudes-knowledge-skills model of cultural competence -Developed in 1983 for use in counselling	-Questionable test-retest and interrater reliability -Factor structure remains in question	-20 items -Six point Likert scale (strongly disagree to strongly agree) scored by an observer -Three factors: cross-cultural counselling skills, socio-political awareness and cultural sensitivity	-Consistent with an ethnocentric, 'cultural expertise' approach

	psychology and revised in 1991			
Multicultural Counselling Knowledge and Awareness Scale, formerly the Multicultural Counselling Awareness Scale-form B (MCKAS) (Ponterotto et al , 2002)	-Theoretical framework: Sue et al's (1982) attitudes-knowledge-skills model of cultural competence -Developed in 1991 for counselling psychology and revised in 2002	-Moderate, convergent validity with MCI -Questionable criterion validity -Two factor model only accounts for 32% of variance -Results are preliminary and the MCKAS should not be used for any individual evaluative purposes	-32 items -Seven point Likert scale (not at all true to totally true) -Two subscales: knowledge and awareness	-Consistent with an ethnocentric, 'cultural expertise' approach

CHAPTER 4: THE APPLICATION OF DIVERSITY EDUCATION IN HEALTHCARE SETTINGS

The preceding chapters have demonstrated the wide variability in the definitions, understandings and approaches to teaching diversity education. This variability is similarly reflected in the application of diversity education in healthcare settings differs depending upon discipline and context. This chapter presents an overview of diversity education in different healthcare fields including medicine, nursing, social work and psychology and the NHS, identifying early contributions and the differences in how diversity education is applied across disciplines. It also considers the application of diversity education in different international settings, recognising commonalities in the challenges of teaching and evaluating diversity education.

4.1. DIVERSITY EDUCATION IN MEDICINE

Early contributions to the conceptualisation of cultural competence (CC), as it is understood in medicine originated from the work of Arthur Kleinman (1981). Kleinman introduced the 'explanatory model of health and illness' to recognise and validate the expectations and experiences of health and illness based on cultural beliefs (Kleinman, 1981; 2006). In contrast to the prevailing practice of identifying illness and disease from biomedical perspective, Kleinman highlighted the complexity of an individual's experience of health and disease. The explanatory model illustrates the role culture plays from both a provider and client perspective and has been influential in providing medicine with an avenue towards understanding cultural competency (Fisher-Borne, 2015). The term 'cultural diversity' and 'diversity and equality' is frequently used in reference to diversity education in UK medical schools (Dogra et al, 2005; Bentley et al, 2008; Dogra et al, 2009; 2015). Conversely in the US, the term cultural competence is popularly preferred (Hobgood et al, 2006; Lie et al, 2011; Beach et al, 2005).

Diversity education has considerably advanced in the last two decades in medicine, however progression has been slow and recurring challenges continue to prevail, namely conceptual clarity, lack of institutional guidelines and agreement on best teaching practices, limited faculty development, variability in teaching and a paucity of valid assessment and evaluation tools. Dogra et al (2005) cross-sectional survey showed 72% of UK medical reported some sort of cultural diversity teaching, however

this was widely variable in content, design, delivery and evaluation. Commonly used teaching methods included small group-based teaching, discussions, lectures, problem-based learning, community placements and workshops and assessment methods tended to be either short answer questions or assignments. Bentley (2008) cross-sectional survey reported an increase to 77%, with UK medical schools reporting the highest provision of diversity education in comparison to other healthcare disciplines. Teaching methods employed were small groups (75%) or lectures (62%) and reasons for establishing cultural diversity programs were noted as either 1.) Improve workplace communication, 2.) Patient care, especially for ethnic minority populations and 3.) Comply with formal requirements and institutional expectations. However, the same challenges found from Dogra et al (2005) cross-sectional survey were stated, including a lack of institutional guidelines, fragmented provision and primarily being concerned with diversity issues in ethnic minority communities. Dolhun et al (2001) survey of 19 US medical schools found there was no consensus in what constituents the core components of diversity education and what teaching methods should be employed. Similar results were found by two other surveys that reviewed cultural diversity education in Canadian medical schools (Azad et al, 2002; Flores et al, 2000), stating the teaching was inadequate, unsystematic and fragmented and recommended the development of more specific courses.

Gustafson et al (2010) reviewed cultural diversity teaching in English Canadian undergraduate medical schools and found they either adopted the cultural competence or the critical cultural approach (also known as cultural safety), however there was no convincing evidence to suggest which approach was better in eliminating healthcare disparities. All 14 medical schools claimed to provide cultural diversity education, however were widely variable in how they defined culture, the place of cultural diversity in the curriculum and how the teaching was expected to shape medical practice. In contrast to UK medical schools Gustafson et al (2010) found many of these programmes encouraged students to learn about diversity issues beyond the boundaries of race and ethnicity and considered a wide range of social determinants of health. Cultural immersion programs involving community care access centres and placements in inner-city clinics for marginalised and under-served communities were frequently employed in US medical schools. The literature review also concluded cultural diversity teaching was inadequate and limited in the use of assessment measures. These conclusions closely reflect a previous review of cultural competence education in US medical schools conducted by Betancourt et al (2003) which similarly

stated a deficiency of validated assessment methods, demonstrating that progress in this area has been relatively slow. Betancourt et al (2003) proposed a three-legged stool model of evaluating attitudes, knowledge and skills and recommended using a variety of assessment methods with the criterion standard for evaluating attitudes being video-taped/ audio-taped real clinical encounters. Dogra et al (2009) paper exploring the current status of cultural diversity teaching in UK, US and Canadian medical schools demonstrated the same recurrent challenges of lack of assessment methods, insufficient faculty development, deficiency of institutional guidelines and variability in teaching methods were applicable to all three international settings.

4.2. DIVERSITY EDUCATION IN NURSING

Since the early 1990s the field of nursing has explored diversity and cultural issues. The National League for Nursing published a curriculum guide in 1917 which explicitly included teaching on social inequalities (DeSantis & Lipson, 2007). In the 1950s Madeline Leininger introduced and pioneered the field of transcultural nursing which was influential in setting the foundational concepts of cultural competency (Leininger, 1991). The notion of transcultural nursing suggested nurses should aim to provide culturally specific and congruent care that actively acknowledges patients' cultural beliefs, customs and values. In 1983, the National League for Nursing expanded upon the teaching of health inequalities to include issues of ethnicity and race (De Santis & Lipson, 2007). This movement was reflected internationally, in 1992 the American Academy of Nursing's Expert Panel on Culturally Competent Care was introduced and defined culturally competent care as "*sensitive to issues related to culture, race, gender and sexual orientation*" (American Academy of Nursing, 1992; pp.278). In 2007, this same panel introduced new recommendations on cultural competency as a strategy to eliminating healthcare disparities to 'advance clarity and understanding' on the importance of culture in the nursing profession (Giger et al, 2007; pp.96). In 2008, the American Association of Colleges of Nursing mandated the inclusion of cultural competency in nursing programs in the publication titled *'The Essentials of Baccalaureate Nursing Education'* (Calvillo et al, 2009); this highlights that nursing programs should include learning objectives related to increasing the awareness of one's personal culture, developing skills in assessing and communicating with individuals from other cultures and assessment of cross-cultural variations.

Lofin et al (2013) integrative review of measures of cultural competence in nurses in the US demonstrated wide variability in how cultural competence is conceptualised and assessed and evaluated, with the large majority of measures being 'culture general', meaning there was no distinctions about which cultural groups or variations were important to acknowledge (Lofin et al; pp.8). Ryan et al (2000) conducted a survey of 610 National League for Nursing-approved U.S. baccalaureate and graduate programs (36% response rate) and found 89 of 205 schools had formal undergraduate courses in CC and 27 of 103 had graduate program courses. Similarly, to the field of medicine, Ryan et al (2000) survey findings concluded that although transcultural nursing concepts are *"incorporated in most curricula, wide variation exists as to the content, depth and level of integration"* (Ryan et al, 2000; pp.300). Lipson et al (2009) later reviewed current approaches to integrating elements of CC in nursing education in the US and similarly found wide variability in approaches, making it challenging to compare and contrast the effectiveness of programs. The review demonstrated that there has been little formal evaluation of the effectiveness of teaching CC, inconsistencies in the approaches used to teach CC and where CC is integrated in the curriculum. Limited faculty preparation was consistently raised with many schools reporting only one to two faculty members responsible for the CC curriculum. Lipson et al (2009) recommended five types of curriculum input to incorporate CC, these included 1.) Speciality focus, 2.) Required courses, 3.) Models, 4.) Immersion experiences and 5.) Distance learning or simulation. The need for culturally competent healthcare has been consistently reported in international nursing literature, including Australia, Canada, Israel, Sweden and South Africa (Jeffreys, 2010), with the same challenges in teaching and evaluating diversity education being raised.

4.3. DIVERSITY EDUCATION IN SOCIAL WORK & PSYCHOLOGY

Cultural competency was first formally introduced by Sue et al (1982), however terms related to culture emerged in the literature from 1980s onwards. These included ethnic competency, cross-cultural social work and process orientated approach to people of colour (Devore & Schlesinger, 1981; Green, 1995; Lum, 1986). Lum (1999) introduced culturally competent practice which emphasised the need for multi-cultural counselling competencies. Similar to other healthcare settings, many of the theories from this period focused on issues of race and ethnicity. To date, the social worker Terry Cross continues to pioneer the field of cultural competence (Cross et al, 1989). Cross et al (1989) definition of cultural competence is the most widely cited definition to date

(Truong et al, 2014); *"a set of attributes, skills, behaviours and policies enabling individuals and organisations to establish effective interpersonal and working relationships that supersede cultural differences"* (Cross et al, 1989; pp.3). Cross et al (1989) was influential in expanding the definition of cultural competence to include organisational factors such as institutional guidelines and frameworks (Fong & Furato, 2001).

In psychology, the body of work develop by Derald Sue and colleagues set the foundation for cultural competency counselling in mental-health settings (Sue et al, 1982; Sue, 2001; Sue, Arredondo & McDavis, 1992). Sue et al (1982) developed a core set of multicultural counselling guidelines which have been recognised by six divisions of the American Counselling Association and two divisions of the American Psychological Associations (Suh, 2004). These guidelines include cross-cultural language skills, awareness of diversity and providing care across difference (Sue, 2001). Joseph Ponterotto also significantly contributed to multicultural counselling and psychology. In particular, Ponterotto challenged the current approaches used to explore ethnicity and race and highlighted the disregard for the influence of the practitioner's culture, leading to the development of the comprehensive theory of multicultural personality (Ponterotto et al, 2011; Ponterotto, 2010; Ponterotto & Mallinckrodt, 2007).

4.4. Diversity education in National Health Service

As part of exercising practices of the Equality Act (2010), NHS educational and training programs have been developed with the intent of improving health professionals' knowledge, skills and attitudinal responses to practice effectively in culturally diverse settings. Diversity education in the NHS largely stems from training as opposed to educational contexts, although the terms training and education are used interchangeable without a sense of distinction. These diversity teachings aim to provide a foundation of information around the legal and professional obligations of healthcare providers to ensure services are equitable, respective and responsive to diversity and healthcare practice operates in a discrimination free environment. Similar to other healthcare settings, term diversity is synonymously interchanged with a range of labels such as 'inclusivity and diversity', 'cultural awareness' or 'cultural competence'. A generic sequence often adopted in diversity sessions in the NHS involves the acquisition of basic knowledge of cultural differences, increasing cultural awareness

through providing information on cultural groups, examining cultural attitudes through group discussion and outlining the core characteristics of the Equality Act (2010). The delivery of this type of training is mandatory for all UK NHS Trusts, and in particular, attendance is mandatory for all mental-health professionals (Department of Health, 2007; Health, 2010; Royal College of Psychiatrists, 2009).

Diversity education particularly in the NHS has been politically as opposed to clinically and educationally driven. The term diversity is frequently presented as a pair with the term equality in the NHS. Little to no formal reviews of diversity educational programs or trainings have been conducted in the NHS. An small scale MSc study (George, 2014) conducted prior to this research study provides an overview of key characteristics and challenges faced by diversity educators/ trainers in the NHS, this is shown in Table 4.1. Similar challenges outlined in other healthcare settings arise, namely the lack of formal assessment and evaluation, variable in content, design and delivery, deficiency of institutional guidelines and poor faculty development and preparation. A great amount of uncertainty exists in the development, content, delivery and evaluation of diversity educational programs. The research base for diversity education in the NHS is severely under-developed. Whilst the notion of diversity has gained considerable momentum in the last few decades politically in the NHS, it appears that these sessions are largely assumption based and theorised in an aspirational manner about the hopes diversity teaching can bring in reducing health inequalities, without quantifiable evidence to prove its effectiveness on improving professional practice and patient outcomes.

CONCLUSION

The application of diversity education in healthcare settings remains widely variable, fragmented and under-theorised on a national and international setting. The assortment of vocabulary and approaches towards teaching diversity education reveals the lack of consensus as to what the correct terminology is and the evidence-base for these types of teaching in reducing health inequalities. The heterogeneity in program designs, curriculum content and evaluation methods internationally, further exacerbates the problem in identifying a unifying conceptual framework or set of principles that can be used in the diversity education.

TABLE 4.1: SUMMARY OF FINDINGS; ENGAGEMENT WITH KEY STAKEHOLDERS' ON THEIR PERSPECTIVES ON UK NHS DIVERSITY IN LONDON NHS TRUSTS

Training Format & Content	Assessment and Evaluation	Limitations of the training	Recommendations
-A 1 hour training on equality and diversity every 2 years for all NHS employees in the designated NHS Trust -Content of the training is determined according to staff and patient complaints about clinical care given and received and analysis of patient experiences through feedback forms. Training material from other NHS Trusts is also incorporated in the training content -Attendance not mandatory	-Informal feedback forms are given to trainee attendees; most common feedback received is duration of the training is too short, cultural issues were simplified, training content was politically driven and not all the right individuals attended the training -No rigorous assessment and evaluation of the training is conducted	-No financial /administrative resources are provided by the NHS Trust to conduct rigorous evaluations of the training -Vast amount of 'uncertainty' in the content, delivery and evaluation of the terminology -Lack of training and supervision for trainers and training co-ordinators -Ensuring the right people attend the training is challenging, generally a poor attendance of the training was recorded -The lack of specificity in the language used in the training content	-Greater emphasis needs to be placed on addressing institutionalised racism within the NHS through training -Recommended research i.e. a literature review on the core barriers to implementing cultural diversity training within the NHS
-A 1 hour training on equality and diversity every 2 years for all NHS employees within the NHS Trust -Content of the training was developed by health professionals with service-users and was used in over 20 NHS Trusts. Training material addressed the most common patient issues and cultural issues presenting in mental-health -Attendance not mandatory	-Informal feedback discussion of the trainings revealed: trainers felt uncomfortable discussing issues of racism and sexuality and limited time to discuss issues in depth i.e. challenge stereotypes	-No financial /administrative resources are provided by the NHS Trust to conduct rigorous evaluations of the training -Lack of comfort around discussion of sensitive issues such as culture, racism etc.	-The importance of targeting the training towards the needs of the majority and minority populations -Training needs to address issues (interethnic tensions) not in only in relation to healthcare providers and patients but between staff -Equality and diversity training requires a different approach to other clinical training, and therefore should not be conducted in the same manner -Training material and evaluations of training should be published

			-Encouragement of service-user involvement in trainings
-A 1-2 hour training on cultural competence was provided at the request of NHS Trust (date and location of the training varied) -Training material was developed by within the company and through research -Attendance not mandatory	-Feedback forms were used to evaluate the training; most common feedback received is the duration of the training is too short and training content was politically rather than clinically driven.	-NHS Trusts did not make it mandatory to evaluate the training; no financial/administrative resources to evaluate the training -Lack of consistency in the different types of trainings in terms of how they are conducted, the content, core definitions and evaluation methods -Scope of the training is confined to practitioners interested in the cultural diversity field; "pockets of individual efforts" -No tool of measurement that can warrant the training to be evaluated adequately, especially in assessing long-term changes -Challenges in measuring attitudinal dimensions of the training -Lack of clinical relevance in the training -Misperception of the training only addressing the legal requirements of the NHS -Lack of support and supervision for the trainers	-Encouragement of 'White' leaders within the field of equality and diversity -Training should be targeted towards addressing the needs of the minority and majority populations
-A 1 hour e-learning package offered by the NHS to health professionals -Content material was politically driven, generic and broad -Attendance not mandatory	-Occasionally the training is evaluated by self-reported feedback forms -The lack of evaluation of training reduced the credibility of the training; health professionals were not aware if the training was beneficial for practice and clinical outcomes	-NHS Trusts did not make it mandatory to evaluate the training: no financial/administrative resources to evaluate the training -Poor attendance of the training -Misperception of the training being 'less important' in comparison to other clinical demands -Training is not entirely specific to mental-health and lacked clinical relevance	-Encouragement of service-user involvement -Higher level of collaboration with equality and diversity leads across the UK

		-Lack of evidence-base information to demonstrate the training was beneficial to improving professional practice and patient outcomes -Lack of information as to how to deal with resistance (i.e. defensive behaviours) towards the training and the delivery of training regarding sensitive issues	
-A 1 hour e-learning package offered by the NHS to health professionals -Content material was politically driven, generic and broad -Training was not mandatory to attend	-No formal assessment and evaluation of training is conducted -Lack of support and supervision for trainers -Small teams in the equality and diversity unit in NHS Trusts		
-Initial base line training incorporates 'Diversity in the workplace' -A 1 hour e-learning package: 'cultural diversity' -Content of the training consisted purely of case studies -Training is mandatory	-No formal assessment and evaluation of the training is conducted	-Lack of service-user involvement in the training -Poor attendance of the training -Lack of supervision and support for trainers and training facilitators	-Classroom sessions as opposed to e-learning packages are more suitable for delivery of this kind of training -Training content needs to be adequate for training time available
-A 1 hour e-learning package offered by the NHS to health professionals -Content material was politically driven, generic and broad -Attendance not mandatory	No formal assessment and evaluation of training is conducted	-Lack of financial and time constraints in the development and delivery of the training -Lack of evidence-based to demonstrate the impact the training had on improving professional practice and patient outcomes	-Encouragement of service-users in the training

-A 1 hour e-learning package offered by the NHS to health professional -Developed specific cultural competence training from his own research and studies -Content material was politically driven, generic and broad -Attendance not mandatory	No formal assessment and evaluation of training is conducted	-Lack of financial and time constraints in the development and delivery of the training -Lack of consistency and continuity of training across NHS boards -Lack of research interest in the field of equality and diversity training	-Higher level of collaboration with equality and diversity leads across the UK -Higher emphasis on teaching institutional racism in the training content -Higher level of organisational support is needed for equality and diversity training
-An e-learning package on equality and diversity ranging from 30 minutes to 3 hour sessions -The e-learning package is focused on employment issues, legal acts, forms of discrimination and tries to be as broad as possible -Attendance is mandatory	-The training is evaluated in assessing the changes in the PEDIC survey which records all aspects of patient experience and clinical audit data covering race and spirituality care needs of patients -No feedback on the e-learning package is conducted -Evaluations is usually measured in an "anecdotal manner" and informal feedback discussions which are generally positive, however suggest more time is needed for this training	-Lack of discussion, service-user involvement in e-learning training -Lack of clinical audit data on race, cultural and spiritual issues -Financial and time constraints -Lack of feedback from e-learning training packages	-Encouragement of service-user involvement, to enable the training to be more powerful and influential -Suggested co-facilitation of the training with service-users
-Content of the training was developed in line with the 'vague recommendations' from the Trust and the trainer's knowledge, research and clinical practice and experiences -Attendance not mandatory	-No formal evaluation of the training is conducted, general feedback forms were given which indicated positive comments about the training but unanimously commented on the limited time constraints and suggested the training should be longer	-Vague and unclear recommendations for the development, content and delivery of training by the NHS Trusts -Lack of external and formal support for equality and diversity training -Financial and time constraints -Lack of formal evaluations of the training -Lack of guidance as to how to deal with resistance from the participants of the training	-Development of best practice guidelines for the development and delivery of the training -Assessing whether the training is beneficial for improving patient outcomes

-Content of the training is as broad as possible and aims to be patient-centred and individualised -Conducts a race awareness training which is 1 day a week for 9 weeks where the content draws on the expertise of leading academics and speakers -Training development is heavily reliant on the trainer, however is assessed by a NHS panel for quality assurance, this is conduced quarterly -Face to face and e-learning package currently exist which are fact-based describing work force figures -The equality and diversity training is mandatory	-No assessment measures for the training, given the complexity and challenges involved in evaluating the training -Assessing the impact of the training on improving patient outcomes remains elusive -The content of the training is developed from patient and professional complaint forms and PEDICT data which outlines patient's experiences of care and staff attitudes -Voluntary electronic feedback forms can be filled out as a form of evaluation	-Absence of assessing whether the training is impacting the needs of professionals and patients, lack of assessment measures -Lack of consistency in equality and diversity training across the UK	-Encouragement of 'White' leaders within the equality and diversity/ cultural diversity field to gain more equal inclusion -Encouragement of interactive, face-to-face sessions for training to allow discussions and voice the concerns of professionals -Suggested the development of team-training with a clear clinical focus, service-user involvement throughout the training and content should be dependent upon patients and professional needs -The training content needs to have a higher focus on tensions between interethnic staff, conflict resolutions and forms of discrimination
-The equality and diversity training is conducted every 3 years in the format of both an e-learning and face-to-face training, this is a mandatory training -Conducts 900 trainings a year for on average 25 – 30 health professionals -Equality and diversity training is also conducted as an induction training -The content of the training covers all aspects of the Equality Act, and issues highlighted in patient complaints, current issues in the media, patient experience data and staff complaints. It also includes '9 protective factors', case notes and examples of inequality	-No formal methods of assessment and evaluation are conducted, although general feedback forms are given -Feedback forms for the online, e-learning package are not given, however during the face-to face sessions forms are voluntarily given, and they received generally positive feedback about the training	-Limited number of individuals on the equality and diversity team -Limitations of on-line training because of lack of discussions and concerns about the content -Financial and time constraints in the development and delivery of the training -Lack of guidance and support in training the trainers and dealing with resistance and uncomfortable discussions around the trainings	-Encouragement of face-to-face trainings -Development of assessment and evaluations methods to access the impact of the training in reducing health inequalities

-Specialist training is also conducted on a range of topics i.e. intercultural faith, institutional racism and unconscious bias -The content of the training is also developed from examples of other Trusts and formal training companies			
-Conducts equality and diversity training specific to mental-health -Conducts a range of trainings which vary according to location on mental-health and raising cultural awareness	No formal methods of assessment and evaluation are conducted, although general feedback forms are given -Feedback forms for the online, e-learning package are not given, however during the face-to face sessions forms are voluntarily given, and they received generally positive feedback about the training	-The absence of a consistent frame of reference or practice guidelines regarding the content, delivery, assessment and evaluation of the training -Assessment and evaluation measures that can be used to determine the short and long-term impact of the training on healthcare professionals' practice and improving patient outcomes -Lack of financial resources, organisational support and time constraints -Lack of specific data on equality and diversity issues	-Conduct a participatory workshop with other equality and diversity leads to develop good practice guidelines about the development and delivery of training -Regular or annual meetings with equality and diversity leads across the NHS Trusts to discuss, collaborate, update and improve the training -Encouragement of service-user involvement in the training but guidance on how to manage the challenges with using patients in the discussion of sensitive issues
- The Equality and Diversity training delivered includes a 3-hour session as part of the induction which is given to 60 health professionals per month, there is also an e-learning package program on equality and diversity -The Equality and Diversity Team is made of up of 1 person -The content and training materials are developed by the Strategic Lead, a range of sources from other Trusts are used, and information from patient and staff complaints form the majority of case	-Voluntary feedback forms are given to participants -No long-term evaluation and assessment measures are conducted on the training -No assessment and evaluation on assessing the improving on patient outcomes in conjunction with the training -Proxy measures i.e. number of complaints are used to assess the impact of the training	-Limited perception of the training being a 'tick-box' approach to legislation and 'politically correct.' -Professional isolation in the equality and diversity team, lack of supervision and support for trainers and service-user involvement in the training -Ineffectiveness of e-learning packages in changing individual's behaviours and attitudes -Lack of assessment and evaluation methods in the training	-Service-user involvement in the training -Encouragement of interactional, face to face, discussion training -Supervision, guidance and support for trainers -A higher level of data monitoring around equality and diversity issues to use in training material and content of the training

studies included in the content of the training	-The feedback forms generally reveal positive comments	-Lack of 'White' equality and diversity professionals	
-Content of the training is developed from his knowledge, experiences and own research -Attendance is not mandatory	-The training undergoes frequent revalidation, peer observation and evaluation reports however is not assessed in relation to improvement in patient outcomes. There is no formal NHS process for evaluation of the training.	-Lack of a shared dialogue, given the vast amount of different cultural groups within the London NHS Trust, patients often perceived the training as 'Western, culturally inappropriate', he felt it was not catered to address their existing belief systems	-Encouragement of a cultural multidisciplinary team for development and delivery of the training - Higher emphasis on spiritual and cultural needs training in more ethnically diverse areas

CHAPTER 5: LINKING DIVERSITY EDUCATION TO DIFFERENT HEALTHCARE CONCEPTS

The concepts of professionalism, intercultural communication and patient-centred care appear to be linked in theory and practice to diversity education. These healthcare concepts are separate fields in healthcare curricula with distinct terminologies, trajectories and fields of practice, competing for limited resources in healthcare training and education. Healthcare professionals increasingly practise in multi-cultural, diverse environments, challenging existing shared agreements in how we define professionalism, not least the perception of professional behaviours and attitudes (Hodges et al, 2009) and fosters an environment where intercultural encounters are common.

This chapter critically reviews the concepts of professionalism, intercultural communication and patient-centred care, providing arguments explicating the potential links between them and diversity education. The chapter illustrates points of convergence as well as contention among the different concepts, and attempts to depict the fluidity and dynamic nature of diversity issues in relation to these concepts, particularly in regards to one's identity and perceptions and experiences of intercultural relations.

5.1. PROFESSIONALISM

Healthcare professions are underpinned by a set of professional values, attitudes, behaviours and cultural norms that are shared within a profession (Cruess & Cruess, 2008; Sanders et al, 2014). Collectively these implied or explicitly defined attributes constitute what health professionals consider as 'professionalism'. Similar to diversity education, the elusive nature of the definition of professionalism has resulted in wide variation in how this concept is understood, taught and assessed (Jha et al, 2007; Hodges et al, 2011). Despite numerous attempts to define professionalism, none have been standardised or reached universal consensus (Birden et al, 2014). The variations in the precise dimensions of professionalism as exemplified in the literature, may be attributable to the semantic challenges in labelling such a broad and complex construct. The literature broadly demonstrates a tendency to categorise professionalism within one of two categories; 1.) An ethos (referring to a *"value-*

orientated ideologically based construct" (Baldwin, 2006; pp.103) or 2.) A set of attributes to be mastered (Van Mook et al, 2009). The latter is arguably simpler to translate into methods of teaching and assessment. However, a mixture of attributes better portrays a holistic conception of professionalism and the complex, contextual nature of desirable attributes in healthcare (Goldie, 2012).

Like diversity, professionalism can mean different things to different people in different contexts. Early conceptualisations of professionalism largely focused on construing the notion as a competency, or an attribute that can be taught, measured and assessed (Bhawuk & Brislin, 1992; Bennet, 1993; Ambrozy et al, 1997). Reviews attempting to define the dimensions of professionalism in existing measures outlined four common categories; namely 1.) Adherence to ethical practice, 2.) Effective interactions with patients and service users, 3.) Effective interactions with staff and 4.) Reliability and commitment to improve (Coulehan, 2005; Jha et al, 2007; Swick, 2007; Wagner et al, 2007). These four characteristics strongly illustrate a behavioural focus, with little reference to professional attitudes and values (DeWitt Baldwin, 2006). Though some argue that professional behaviours are an expression of professional attitudes, with the two being intrinsically linked. (Jha et al, 2010). Conversely, recent reviews suggest professionalism is not akin to imparting a technical skill or behaviour, but rather a continued process of shaping an individual's moral identity, formally defined as embarking on a *"personal transformation"* (Huddle, 2005; pp.890; Barker, 2016). This closely reflects the evolution of understanding around the complexity of cultural and diversity issues and the progression from a competency based training approach focusing on attaining cultural competence to emphasising the necessity for self-development and awareness of one's own diversity and how this influences their practice.

Whilst early literature has been based on observable behaviours of professionalism, including the contextual framing of those behaviours, recent literature relates professionalism closely to the concept of 'professional identity', meaning the perception of oneself as a professional. Some theories of professional identity consider professional behaviour as the performative element of professional identity, despite it being explicitly prescribed (Bennet, 1989). Newer definitions of professionalism appear to embody the notion of professional identity more closely, and either interpret the concept as either a holistic construct, describing an all-encompassing overall way of being (Hofstead, 1989; 2011) or consistent with the outcomes of good clinical care,

depicting specific values and attitudes which constitute this competence (Dorman et al, 2007). Alternatively, professionalism is transparently defined as an expression of self, outlining the fundamental qualities of a good health professional, strongly referring to an individual's personal moral and ethical code of practice. Many of these qualities have been referred by educators as intrinsic to the individual (Gaar, 2016).

Institutional guidelines and healthcare expectations relating to professionalism are often entwined with issues of diversity and in reference to the expected behaviours and attitudes in intercultural relations suggest not necessarily a shift in values and behaviours but rather a need to be sensitive and respectful of differences that can exist in patients, colleagues and peers. For example, the NHS Knowledge Skills Frameworks states in following expectations, *"allows others to express their views even when different from one's own and does not discriminate or offer a poor service because of others' different viewpoints"* (NHS KSF, 2011; pp.108). Cultural and diversity influences are rarely questioned and are often taken for granted as the *"way we do things around here"* (Jha et al, 2007; pp.3), yet institutional guidelines on both professionalism and diversity education emphasise the importance of being actively aware of these influences and how they affect the way we think, act and relate to others. Various notions have been proposed in regards to how to appropriately, respond to and manage cultural differences whilst ensuring professionalism; 1.) *"Reflecting honestly on one's own culture, attitudes, beliefs and prejudices about 'others', which includes all aspects of diversity"*, 2.) *"Asking about individual's cultural preferences and treating them as individuals not representative of a group"*, and 3.) *"Being prepared to engage with others in a two-way dialogue where knowledge is shared"* (Thistlethwaite et al, 2008). Again, these recommendations are closely similar to those of diversity education and resemble the principles of patient-centred care.

5.1.1 Professional Identity

All health professionals undergo a process of personal transformation from a layperson to a professional, arguably taking on (McKimm & Wilson, 2008) cultural norms, values and practices associated with the profession, which may result in the suppression or dilution of other personal values and norms. The concept of professionalism in healthcare is largely acknowledged as a complex multi-dimensional social construct, (Jha et al, 2015; Stern, 2006; Martimiankis et al, 2009: Ho et al, 2011) permeable to changing societal expectations and arguably culturally constructed and defined.

Professional identity has been explored in several different theoretical frameworks including the 'Personality and Social Structure Perspective' (House, 1977), 'Social Identity Theory' (Jenkins, 1996) and the 'Personal Identity' Model (Cote and Levine, 2002). Various theories exploring professional identity have typically categorised identity into two forms; 1.) Social identity and 2.) Professional identity, where both forms undergo a process of professional socialisation (George et al, 2015) which describes the process of *"becoming, being and belonging"* (Mannion et al, 2015; pp.7) into a professional. Literature surrounding the concept of professionals' social identity exemplifies that is it intrinsically connected to the emotions and values of one's *"self-hood"*, which describes the state of one's individuality (Mannion et al, 2015; Tee, 2013).

Professionalism can be defined as a *"culturally constructed mediated contract between the professional and society"* (Cruess, 2010; pp.4), and much has been written regarding the influence of the social environment on one's professional identity. The notion of professionalism fundamentally informs and influences our relationships and interactions with our social environment. Expectations of professional attitudes and behaviours and existing prototypes of how health professionals should behave, are socially constructed notions influenced by those who engage in the healthcare system (Goldie, 2012; Barker, 2016). Jenkins (2008;pp.4) defines institutions as *"embodying patterns of behaviours that are habitually established over time as 'the way things are done' within hierarchical settings."* Well established health educational institutions such as medical and nursing are grounded in traditions and customs that Bourdieu called (1990) the 'field's doxa' meaning the implicit, taken for granted presumptions, habits and patterns of ways of doing things.

For new professionals, their expectations of professionalism are measured against existing schemata present in their new environment. Mannion (2015) suggests this may explain why some doctors are not informally accepted into professional groups, not based on their skill or expertise but rather general attributes such as race, age or gender depicting their social identity. Historically the traditional prototype of a doctor served to exclude women, individuals with disabilities and ethnic minorities (Sinclair, 1997; Becker, 1961), whereas in our current healthcare system seeing an *"Asian doctor is the norm"* (Kai et al, 1999; pp.45; Palgrit, 2003). Accounts such as '*Boys in White'* (Becker, 1961) describes the process of professional socialisation for middle-class, male medical students and demonstrates that those belonging to the medical profession were alike in general attributes concerning their social identity as well

professional aspects relating to their future roles as a doctor. Conversely '*Making Doctors'* (Sinclair, 1997) strongly emphasises the nuances of the professional socialisation period in UK medical schools, stating if an individual has either acquired or learnt (or unlearnt) to behave according to expected standards this permits acceptance into the professional group.

5.1.2. Hidden Curriculum and Role Modelling

The prior conceptualisation of professional identity as a single and distinct entity has shifted to a dynamic conception of multiple identities situated in different clinical and social situations (Shotler & Gerger, 1994; Gergen & Davis, 1985; Eisenberg, 1979). Research has shown that the way different health students develop their professional identity and subsequent multiple identities has profound implications for their future well-being and clinical relationships (Monrouxe, 2009; Shen et al, 2016). The development of professional identity is therefore relational, multiple, dynamic and situated. Research has shown that informal teaching through role modelling, tacit behaviour and the 'invisible pedagogy' (which includes diversity issues) has significant implications for students' professional development. Students learn the art of being a professional through observing the social role and behaviours of the peers and professionals they interact and relate with.

A review of best available evidence regarding the teaching of professionalism in medical education demonstrates that professionalism is most effectively learned though clinical interactions in the course of their education and role modelling (Birden et al, 2014). Formal didactic approaches such as lectures and presentations were found to be the least effective (Shapiro & Rucker, 2003; Shapiro et al, 2006). Qualitative research has revealed that despite health students displaying attributes congruent to the inherent qualities as defined by professionalism, such as probity, compassion and empathy, on entering health educational institutions, these decline by the time students exit health educational institutions such as medicine (Hatem & Ferrara, 2001; Lemp & Seale, 2004; Nogueira-Martins et al, 2006). Collectively these studies recommended consistent competent role modelling throughout health education, with students having time dedicated to debriefing and critical reflection on their experiences with trusted members of staff (Stephenson et al, 2006). A mixture of qualitative and quantitative research suggests students' experiences of the hidden curriculum often negate their conceptualisations of professionalism (Zink et al, 2009;

Van De Camp et al, 2004). A few studies based in the USA exploring health students understanding of professionalism, through reflective portfolios and essays, suggested continual experience of positive role models in clinical practice heavily influenced what students classified as professional attitudes and behaviours (Lemppe & Seale, 2004; Weissman et al, 2006).

Health care students will develop concrete patterns of behaviour and ways of interacting that characterise their day to day contact with their peers, teachers and medical professionals. The importance of exposure and participation in different clinical relationships cannot be overestimated in contributing to the development of a professional's identity and their ways of interacting and relating with others (Caspi & Roberts, 2001). Professionals are subjected to unofficial rules, habitual practices and attitudes which are subsequently reproduced and reinforced in day to day interactions (De Montingy, 1995). In this way professional cultures are transmitted and social roles passed down (Giddens, 1984). How the relationships among practitioners contribute to the sense of self and response to diversity issues is less well emphasised in frameworks on diversity education than are relationships to the institution.

It is likely that proponents of the development of professional identity and understanding of oneself would embrace additional features of diversity education. Diversity education expresses the need for professionals and students to develop a critical consciousness that facilitates questioning and respectful curiosity which is particularly important when working with diversity issues. Exploring and understanding one's own biases and prejudices should also be part of professional development.

5.1.3. Intercultural Relations

Modern healthcare is now considered 'global' (GMC, 2014), with greater emphasis being placed on developing *'global health practitioners'* (McKimm & McLean, 2011; pp.626; McKimm & Wilkinson, 2015; GMC, 2011; NMC, 2009). Authors have argued that there is a need to develop health professionals as 'global citizens' (McKimm & McLean, 2011), able to constructively question and accommodate multiple cultural perspectives that may arise in their interactions with patients, colleagues and peers. This ensures that health professionals are not only aware of different perceptions of professionalism, but assists their development of reflexivity in terms of embracing difference and ambiguity and accepting varying perceptions of professional attitudes

and behaviours. The World Federation of Medical Education (WFME, 2003) attempted to develop global standards for medical professionalism, however this remains an unfulfilled aspiration. Whilst the notion of 'global health practitioners' has not been formally mentioned in diversity education, theoretical frameworks concerning diversity, particularly those which depart from cultural competence/cultural expertise models appear to be closely striving for the same outcome. However, for this to be realised changes in health professionals' attitudes must be established, arguably health professionals must be comfortable with their own as well as others cultural norms, values and practices. Different authors in the field of professionalism suggest establishing cultural awareness an integral component in the subject, though openly acknowledge this is an area many health professionals struggle with (McKimm & Wilkinson, 2015; Jha et al, 2015; Gibbs et al, 2016), particularly those from different cultures.

Recent research strongly suggests variations in the consensus of attitudes, beliefs and behaviours which are believed to constitute professionalism (Hofstead, 2001; Chandratilake et al, 2012; Goldie, 2012), as well as which attributes are deemed more important than others (Schmidt et al, 2004: Bennett & Bennett, 2009). For example, Ho et al (2014), in a study exploring the perceptions of professionalism among Chinese medical students, showed a strong convergence on attributes of morality. Conversely Bensing et al's (2014) research investigating the notions of professionalism in western doctors indicated a shift towards business-like task orientated attributes. Al-Eraky et al (2014) identified *"Four-Gates"* of medical professionals from studies exploring health professionals' understanding of professionalism in Arab countries. The four gates were defined as dealing with self, dealing with tasks, dealing with others and dealing with God. These variations become more pronounced and poignant in regards to palliative care and mental-health, in which differences in cross-cultural understanding, communication and professional practice among healthcare professionals greatly vary among practitioners (Kagawa-Smith & Blackhall, 2001).

Research demonstrates that many students as well as healthcare professionals struggle with this transition as it can involve a recalibration of their social and professional identities (Jha et al, 2000; Lu, 2006; Hammer et al, 2003). International students and overseas health professionals acquire a double shift in acculturating into a new profession as well as a new society, resulting in their individual social identity and professional identity undergoing change and refinement. The General Medical Council states that *"Black and minority ethnic doctors and doctors who gained their primary medical qualification outside the UK often have higher than average likelihood of receiving a sanction or warning in (their) fitness to practice procedures"* (GMC, 2014; pp.06). Research demonstrates this is largely related to issues of professionalism, lack of insight and communication issues rather than clinical competence (GMC, 2014; Esmail, 2010). Different models exploring the process of professional socialisation across cultures and how new professionals assimilate and adapt to professional environments is outlined below. Different theories concerning professional identity and professional group identity are also examined.

5.1.3.1 Assimilation and adaptation

The Intercultural Development Continuum (Hammer et al, 2003; Bennett & Bennett, 2004) and the concept of 'Cultural Fit' (O'Reilly et al, 1991; Lu, 2006) have been used to explore the concept of professionalism as a social-cultural construct. The Intercultural Development Continuum is a revised by-product of the Intercultural Sensitivity Model (Bennet, 1993) outlined in Chapter 1, which has been used to describe individual variations in the experiences of and reactions to cultural differences. This revised model similarly depicts a developmental continuum beginning from a phase of ethnocentrism (defined as the evaluation of other cultures according to the standard of one's own culture) and concluding in the state of ethno relativism (meaning the ability to accommodate and value multiple cultural perspectives that may conflict with one's own). However, it differs in that the endpoint of the model involves the constructing of an intercultural identity. This concept of intercultural identity refers to the creation a new identity that has assimilated aspects of the professional within their social or personal identity.

The notion of Cultural Fit (Lu, 2006) acknowledges the variations in how social norms concerning professionalism are manifested in individuals. It contends that an individual's cultural fit into a new profession has meaningful implications on their well-

being. If an individual can positively align their personal culture with the shared values and norms of the profession, this ensures a positive effect on their well-being. Conversely if an individual's personal culture is in discord with the social culture, these cross-cultural interactions can be stressful and confrontational, creating negative repercussions in one's psychosocial adjustment and well-being. With increasing diversity within the healthcare system, it is likely that health professionals will experience assimilation into new cultural environments where their personal values may be different from their professional values. Bhawuk and Brislin (1992) comprehensively explored how health professionals culturally align to new professional environments, stating that

> *"to be effective in another culture, people must be interested in other cultures, be sensitive enough to notice cultural differences, and then also be willing to modify their behaviour as an indication of respect to the people of other cultures" (Bhawuk and Brislin, 1992; pp. 416).*

This suggests the onus is on the individual to culturally assimilate into the new profession they have chosen, accepting the potential challenges they may face. Arguably this requires critical self-reflection and evaluation of one's own values and beliefs and their compatibility with professional values, with little questioning concerning one's willingness to assimilate and how tolerant one might be or one's current stage in the intercultural sensitivity model (Bennett, 1993).

Becher and Trowler's (2001) concepts of 'tribes and territories' in healthcare and medical practice, referring to the distinguishing features of *"being and behaving"* (Becher & Trowler, 2001: pp.840) among different professional groups. Individuals belonging to specific professional groups are classed as 'tribes' and their belonging is implicitly associated with a 'territory', that might be in the form of a collective body of knowledge or a physical space. This can contribute to 'othering' of individuals and an 'us versus them' posturing. A lack of knowledge concerning 'tribes' and 'territories' or differences in power or status can lead to 'tribal warfare' which can be characteristic of miscommunications, misunderstandings or conflicts between professionals, which can affect both team-working and patient care (Croft et al, 2015). This relates to the concept of in-groups and out-groups and professional shared identity within teams (Tee et al, 2013). Tee et al (2013) research on professionalism and professional grouping suggests members of an in-group can turn against each other if they are deemed

dissimilar to other members, in terms of general and professional attributes. Additionally, if an in-group is perceived as under threat, defensive behaviours can emerge, for example blaming others or covering up a colleague's mistakes (Bristol Inquiry, Department of Health, 2001; Roland et al, 2011). Tee et al (2013) acknowledge that group professional identity is not homogenous with further layers of in-groups and out-groups within larger groupings. A shared professional identity may be insufficient to overcome out-group formations, with blame for service failing being more likely to be placed on members of the out-group than the in-group (Cruess et al, 2000) and result in problems in team-working and communication. This situation becomes further complicated for international healthcare graduates (Esmail et al, 2000; Blackhall, 2001) who can be positioned as an out-group in both a professional and social context. Many authors propose that definitions of professionalism should be closely situated to the cultural, local and professional contexts.

5.1.4. Teaching professionalism and its relation to diversity education

Best teaching models for professionalism have included effective role modelling (Brownell & Cote, 2001; Baernstein 2009), early clinical interactions (Goldie et al, 2007), critical reflection (Hatem & Ferrara, 2001) and acknowledging the hidden curriculum (Nogueira-Martins et al, 2006). In addition to the factors above, many educators advocate the importance of a safe and supportive environment where learners can honestly share their perspectives and observations (Jones et al, 2004; Neher et al, 1992; Hatem, 2003). These requirements closely match those outlined for best practice regarding diversity education. Attitudinal learning is fundamental to professional development, and arguably less amenable to didactic approaches to learning (Howe, 2002; pp.353). Other authors propose transformative learning to facilitate a higher level of consciousness and awareness of one's sense of professionalism (Kumangi et al, 2008; Weicha & Markuns, 2008).

A thematic analysis of literature describing how professionalism should be taught (based on the highest citation count and collective views), identified six core themes which have been used as the foundation of professionalism (Birden, 2014). These are 1.) Modelling of institutional values, 2.) Moral development, 3.) Best teaching methods, including critical and guided reflection and role-modelling, 4.) Active selection of students with well-developed humanistic traits, thereby making them more susceptible to assimilating professional traits. 5.) Adopting the use of experiential and

transformative learning techniques and 6.) Embedding professionalism throughout the curriculum. Just as in diversity education, research has noted insufficient faculty development in the area of professionalism (Lewn et al, 2007), with clinical educators receiving little or no training in professional attitudes. The hidden curriculum in healthcare has been found to undermine formal teaching in professionalism, providing students with inconsistent messages. In particular, qualitative studies noted students' transparent understanding that desirable professional attitudes and behaviours could be *"legitimately side stepped when the pressures of the job come to bear in the real world"* (Stephenson et al, 2006; pp. 1076). Authors have openly criticised the teaching of professionalism in health educational institutions as *"too little, too soon, too late, too distant and too countercultural"* (Coulehan & Williams, 2013; pp.14). Research illustrates mixed responses from students on formal professionalism teaching. Gorden (2013) observed students' frequent perception of professionalism teaching as an active attempt to *"force all students into straightjackets of political correctness"* (Gorden, 2003); pp. 342), which agrees with the qualitative findings of student perceptions of diversity education. The qualitative quotes included descriptions of students providing examples of how professional behaviours and attitudes could be mastered for assessment purposes without necessarily internalising and practising them outside the assessment arena. In response to the findings, Gorden (2003) recommended a developmental staged approach to embedding professionalism within medical education, encouraging dedicated time for critical reflection and appropriate observation in clinical practice. This is consistent with the Dornan et al (2007) recommendations of learning professionalism through *"participation in practice."*

Other studies have demonstrated themes relating to professionalism that are not necessarily taught, but are given prominence by students, for example seniority, obedience and team allegiance (Gingsberg et al, 2013). Gingsberg (2013) frequently reported students' low perception of their status in healthcare, expressing an imperative to conform and not challenge, otherwise one may be classified as a difficult student. Although this study is specific to medical students, various healthcare reports exemplify the resistance to and fear of challenging professionals for unprofessional behaviours (Francis Report, 2003; Bennett Inquiry, 2007; Bristol Inquiry, 2011).

The literature demonstrates a strong emphasis on the collective view that professionalism is most effectively learned through clinical interactions. Role modelling and mentoring are frequently identified as essential components of formal delivery

methods for professional education (Ambrozy et al, 1997; Kenny et al, 2003; Couletian, 2004; Cohen, 2007; Lown et al, 2007). Observed behaviours in practice are more likely to influence students' professional personas than behaviours that are formally taught. Given the critical period of development where students are positioned, they are impressionable and vulnerable to influence by modelled behaviour that may be inconsistent and feel unable to challenge inappropriate behaviours due to the power difference in relationships (Brainard & Brislen, 2007). Some authors have proposed a greater emphasis on a patient-centred curriculum in early years of health training to initiate organisational shifts, in an attempt to combat the negative effects of the hidden curriculum (Christianson et al, 2007).

Ensuring the study of professionalism has consistent pedagogical space for students to understand and synergise developing their multiple professional identities is an integral component of both diversity and medical education as a whole. Identities are developed during all types of interactions. Role models and mentors play an important part in demonstrating role appropriate behaviours and attitudes to diversity. Demonstrating a capacity for self-reflection and critical thinking are essential in understanding one's self. Opportunities to interact and develop relationships with different members involved in clinical settings and being able to experiment with provisional identities will aid in helping students develop an appropriate professional identity that support the principles of diversity education.

5.2. INTERCULTURAL COMMUNICATION

Much of diversity issues and education has focused on problems arising in communication. The discipline of intercultural communication situates the theory of communication within specific contexts where more than one culture coexists. Whilst the term is used interchangeably with cross-cultural communication, the intention is broadly the same, namely understanding communication across different cultures. The literature reflects a tendency to view cultural differences as a source of misunderstandings, with a large emphasis placed on managing as opposed to appreciating cultural differences (Barker, 2016). However, meaningful intercultural communication can be built on difference as well as similarity (Xu, 2013; Sussman, 2000). Notably Witteborn (2003) stated *"the difference-as-problem approach reflects a worldview that linguistic and cultural differences can be reduced to a communication problem"* (Witteborn, 2003; pp.380).

Communication is a recurring theme in many theoretical frameworks concerning diversity education. Wohl (1989) states all interactions in healthcare are intercultural, as at the simplest level the patient and practitioner do not typically use the same terminology or have the same expectations and preferences. Models of intercultural communication tend to present culture as simultaneously existing as a socially shared, external reality and an individual, internal reality (Berry, 2009; Byram, 2008; Kim, 2007), with many asserting that one's culture becomes pronounced in intercultural encounters when it is challenged (Navas et al, 2007; Sussman, 2000; Samovar et al, 2010). Specifically, theories of intercultural communication focus on the development and influence of one's cultural identity.

5.2.1. Intercultural communication competence

In recent years 'intercultural communication competence' has become a favoured concept (Barker, 2016; Perry, 2011; Ulrey & Amason, 2001) in healthcare. Intercultural communication competence describes theories which outline how cultural differences can stimulate dissimilar interpretations and expectations, which creates an ambiguity about how to communicate effectively (Lusting & Koester, 2006). The difference between intercultural communication competence and intercultural communication is somewhat blurred.

Intercultural communication competence can be categorised into cognitive, affective, behavioural and value-based attributes. A common example of the attributes depicting intercultural communication competence is presented by Chen (2010) as intercultural awareness, sensitivity, and adroitness, meaning skills. The cognitive component refers to the communicator's perception of and accurate interpretation of verbal and nonverbal cues, which include an insider knowledge of the social interactional norms, values and beliefs. This dimension can often be categorised as intercultural awareness (Chen, 2013; Cheng & Young, 2012). The affective component describes the ability to appreciate, empathise, respect and respond appropriately to cultural experiences and be accepting of cultural differences. This is closely similar to the desirable attitudes for facilitating patient-centred care and those ensuring effective responses to diversity issues. Some authors have classified the attributes under the affective remit as intercultural sensitivity (Chen & Starosta, 2000). Measurements of intercultural communication competence operationalise the construct as open-mindedness, engagement, interaction and attentiveness, similarly supporting notions of patient-

centred care (Chen, 2013; Portalla & Chen, 2010). The behavioural component outlines the ability to communicate according to cultural and social norms, and includes attributes such as interaction flexibility and management and identity maintenance. These are closely similar to the dimensions of different theoretical frameworks concerning diversity education such as the LEARN model (Berlin and Fowkes, 1989), intercultural competence (Byram, 2008) and cross-cultural efficacy (Nunez, 2000).

The interrelationships between the different dimensions of intercultural communication competence models are yet to be explored. Arguably, an effective communicator should acquire both intercultural awareness and intercultural sensitivity, and an inter-culturally aware communicator cannot be effective without intercultural sensitivity. In addition, authors note that variables such as willingness to communicate (Holopainen & Bjorkman, 2005) and language fluency (Kim, 2001; Witteborn, 2003) need greater examination in relation to intercultural communication. Although the defined attributes of intercultural communication are specified to varying degrees in the literature, the exact process of developing intercultural communication competence in specific contexts remains elusive and confined to studies where differences in cultural contexts are in stark contrast as opposed to examining within group cultural differences. Similar challenges exist in theoretical frameworks related to diversity education, that specify many dimensions which constitute cultural competence or effective responses towards diversity issues, yet fail to explore the interrelationships between these dimensions and assumptions that they may all occur simultaneously (Howell, 1989; Bennet, 1993; Stanton, 1997).

Intercultural communication competence may be acquired and experienced differently by individuals from different cultures, further suggesting that whilst measures of intercultural communication competence may be transferable across cultures, individual interpretations may not. A comparison of findings evaluating different models and theories of intercultural communication competence, identified that achieving relational closeness and commonality was a strong indicator of increased intercultural communication competence (Spitzberg & Changnon, 2009). Perceptions of identity and perceived similarity to or difference from others varied substantially, which may be attributable to differences in attitude towards diversity, re-emphasising that cultural differences may not necessarily create intercultural communication barriers (Kim, 2001; Xu, 2013). The experience of cultural difference is arguably dependent on how an

individual conceptualises that difference, which agrees with the principles of the intercultural sensitivity model (Bennett, 1993).

Intercultural communication competence theories and, more broadly, theories of intercultural communication, acknowledge culture as the backdrop for all intercultural relations at both an individual and social level. Research exploring the individual variations within intercultural communication clearly identifies that the process of acculturation and engaging in intercultural relations does not occur in a vacuum, but rather involves a constant intermingling of cultural factors and nuances from both parties present in the encounter (Navas et al, 2007; Barker, 2015). Though multiple frameworks and conceptualisations of intercultural communication exist, research demonstrates these frameworks are not transferable across cultures, as some aspects of communication have been regarded as culture-general and others culture-specific, though much of this is context dependent, with different patterns of intercultural communication emerging based on the encounter (Hsu, 2010; McCroskey et al, 1990; Hostead, 2010). This raises the question as to whether different theoretical frameworks are transferable across settings. Research on intercultural communication has been influential in conceptualising culture as a dynamic and evolving entity.

Various socio-linguists and communication theorists state that intercultural communication and intercultural relations result in changes to both parties involved in the encounter, recommending that key features of both culture and the nature of their relationship in terms of compatibility, respect and equality be examined (Berry, 2009; Casmir, 1999). Some theorists state that cross-cultural differences should be examined in relation to those engaging in intercultural communication (Witteborn et al, 2003), with many suggesting the need to validate models of intercultural communication competence in specific cultural contexts. Some theoretical frameworks concerning diversity education often assume that culture is exclusively applicable to patients, disregarding that healthcare professionals are cultural beings too. Similarly, theoretical frameworks on diversity education are typically not validated in different cultural contexts, despite the frameworks being used internationally and being assumed to be transferable across settings.

Research comparing cross-cultural communication patterns in different healthcare contexts is limited. However, Hsu (2010), on reviewing papers exploring cross-cultural communicative practices, identified five communication traits that have been compared

across cultures; 1.) Comprehensive apprehensive, 2.) Willingness to communicate, 3.) Self-perceived communication competence, 4.) Argumentativeness and 5.) Self-disclosure. Conceptually, the traits comprehensive apprehensive and willingness to communicate have similar meanings, and refer to one's ability to initiate communication with others that are perceived to be culturally different (Mc Croskey et a, 1999). Self-perceived communication describes one's subjective assessment of interpersonal and group based communication. This trait has been found to vary cross-culturally in individuals from different cultures (Swenson et al, 1998) and also amongst individuals within the same culture (Gudykunst, 2003; Yoo et al, 2006), which supports many of the assumptions held by different theoretical frameworks relating to diversity education. Argumentativeness refers to the predisposition to avoid or disengage from cross-cultural relations. This has also been found to vary cross-culturally in individuals from different cultures (Infante & Rancer, 1993), but more so amongst individuals within the same culture (Moore & Barker, 2012), which disputes the notion that individuals from the same culture/ race have the same values and perspectives. Self-disclosure describes the variations in comfort and ease of communication in cross-cultural settings (Wheeles, 1978) and this has been found to be dependent on individuals' tolerance of difference.

5.2.2. Cultural identity and intercultural relations

Surprisingly various concepts of cultural identity exist in the field of intercultural communication, drawing upon wider literature in an attempt to better articulate this concept. Earliest conceptualisations of cultural identity can be traced to Erikson (1950; 1968) who claimed cultural identity is a fusion of one's individual and group identity. In contrast De Vos articulates cultural identity (1990) as the basis *for "self-defining in-groups"* (De Vos, 1990; pp.204). The conceptions of cultural identity in intercultural communication has progressed from a narrow focus on issues of race and ethnicity to a more pluralistic perspective acknowledging multiple variables present in intercultural relations. Arguably this mirrors the theoretical progression and conceptualisation of culture in diversity education.

Kim's (1999; 2006; 2007) extensive research on intercultural communication identified four interconnected positions relating to the nature of the different dialogues in and reactions to intercultural experiences. Intercultural relations could be classified on a continuum of four profound ideologies; assimilation, integration, pluralism and

separatism. Assimilation represents one end of the spectrum and defines the notion of expected conformity and is consistent with the saying *"when in Rome do as Romans do"* (Gorden, 1964; pp.2). It describes a process of adaptation or acquiring the social, cultural and psychological characteristics of a group an individual is situated among. On the contrary, pluralism depicts the other end of the spectrum and denotes the reproduction of a group based identity within a different context. It refers to contexts where two or more cultural groups (based on differing identities) co-exist, where each group actively works to maintain their unique cultural identity, for example Chinatown in Central London. Straddled between assimilation and pluralism is integration which represents the compromise, reconciliation, or middle point between these two ideological positions. It describes the modification of one's cultural identity to respect the culture of a different context. It seeks mutual accommodation and balance for diversity during a different context and mainstream culture. Outside this spectrum, representing a discursive extension of pluralism is the notion of separatism. This denotes the view of so called extremists and it opposes any kind of intercultural integration and holds a strong preference for maximum in-group-out-group distance, galvanising an 'us against them' stand-point. Kim (2007) asserts that these four ideological positions are not mutually exclusive, but rather each informs and defines, and is defined by the other.

Cultural identity is a term strongly emphasised in the literature concerning intercultural communication. Kim (2007) distilled the concept of cultural identity in relation to intercultural communication into five dimensions: 1.) An adaptive and evolving entity of an individual, 2.) A flexible and negotiable entity of an individual, 3.) A discrete social category and individual choice, 4.) A distinct and communal system of communicative practices and 5.) A discrete social category and a non-negotiable group right.

The first dimension of cultural identity is personified in the integrative communication theory of cross-cultural adaptation (Kim, 1988; 1995; 2001; 2005) which closely relates to the notion of assimilation. The integrative communication theory of cross-cultural adaptation characterises adaptation as a natural process of external individuals striving to achieve a reciprocal and functional relationship with their new internal environment. This process of adaptation arises from cumulative experiences of intercultural communication which result in a gradual transformation from one's original cultural identity to an 'intercultural identity' which exemplifies a transparent understanding of the self-other orientation and remains permeable to different group identities.

Cultural identity as a flexible and negotiable entity can be exemplified in the communication theory of cultural identity (Hecht et al, 2005) specifies four levels of 'identity frames' that provide the 'interpretive context' of a communication setting. These are identified as *personal*, describing individual characteristics, *enacted*, which highlights traits that emerge in social behaviour, *relational,* explaining the dynamics and nuances that arise in conversing with other individuals and lastly *communal*, referring to group assumptions and social norms. These identity frames portray different strategies in communicating across cultures. Little is mentioned in diversity education concerning the dynamics and nuances of intercultural relations.

In contrast theories that acknowledge cultural identity as a discrete social category and individual choice choose to identify with one or more categories based on an act of voluntary identification. For example, Rosenthal (1992; 1994), in his work exploring intercultural communication in minority adolescents, suggested that individuals present a clear commitment to one cultural identity that cultivates a sense of belonging, this uni-dimensional commitment is seen as essential in assuring one's well-being. Diversity education embodies the importance of individuality and choice. Newer theoretical frameworks on diversity education, do not typically view identity as a discrete social construct but rather a dynamic concept where different parts of one's identity intersect.

The fourth category of cultural identity as a distinct system of communal practices replicates the notions of culture from ethnographic research which conceptualises the term as a shared system of communicative practices that is unique to a group of individuals and persistent over time (Geertz, 1973; Philipsen, 1992; Coutu & Covarrubias, 2005). The interpretive theory of cultural communication (Philipsen et al, 1992; 1997) offers an ethnographic structure to illustrate the distinctive cultural features of communication applicable to different communities. An extensive corpus of communication theories within this perspective has provided a body of knowledge identifying conversational patterns and communicative practices unique to a cultural community. Although not explicitly stated, this may have encouraged models of cultural competence/cultural expertise in diversity education that theorised culture in a manner that defined categories of specific factors applicable to certain cultural groups. These distinctive communicative practices convey a pluralistic 'us and them' stance, and is largely silent on individual variations that may exist.

The last dimension perceives cultural identity as a discreet and non-negotiable social category and a group right which describes an unwillingness and discomfort towards engaging in intercultural communication and adapting to new cultural environments. Young (1996) offers a solution to this notion with the concept of 'true intercultural communication' stating that *"effective intercultural communication is based on a joint interest, a common interest, so that one is eager to give and the other to take."* (Young, 1996; pp.183).

5.3 PATIENT-CENTRED CARE

Patient-centred care (PCC) describes an approach to how healthcare providers and patients should interact, relate and communicate with each other. Originally coined by Balint (1969), it describes the need for each patient to be *"understood as a unique human being."* Similar to diversity education, the concept of patient-centred care differs in different theoretical frameworks, with some describing it as a style of interaction and communication with patients and others defining it as a more comprehensive approach to patient care and delivering health services (Mead & Bower, 2000; 1995). Many different terms have emerged from patient-centred care including 'patient-centred interviewing', 'patient-centred communication' and 'patient-centred accesses' which many would argue are broad and vague, since no particular content is specified. The Institute of Medicine (2001) defines patient-centred care as *"providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions."* Again, similar to diversity education, lack of a clear definition of patient-centred care is a well-recognised issue, despite the term being used widely. Whilst conceptual clarity and a shared definition of patient-centred care is challenging to achieve as the concept is individualised, there are similarities in the components which encompass the idea (Hobbs, 2009; Kitsou et al, 2013; Pelzang, 2010). These include six key elements; establishing a therapeutic relationship, shared power and responsibility, understanding the patient as an individual, empowering the patient, trust and respect and finally communication.

Proponents of patient-centeredness consider diversity education as merely one aspect of patient-centred care, whereas proponents of diversity education often assert the converse. Diversity education is underpinned by principles of patient-centred care and shared decision making. Like diversity education, patient-centred care shares many of the same challenges in terms of establishing a consistent definition, identifying best

practices and uncertainty over measures to assess effectiveness. Although healthcare policy frequently uses the term patient-centred, there is little consensus on what patient-centred care is and how it is achieved (Cegala, 2009).

The number of different ways patient-centred care has been construed has made patient-centeredness to be the antithesis of the biomedical illness orientated model, which continues to dominate medical education. This has led to a greater focus on the bio-psychosocial model and considering the patient as a 'whole person'. However, the term bio-psychosocial, that is used to describe an integrated approach to healthcare, implies that human experience consists of three separate dimensions – biological, psychological and social, as opposed to one reality that the patient experiences, which diversity education attempts to illustrate. Many argue that patient-centred care is situated on a continuum with doctor-centeredness at the opposite end. This approach to care requires a change in the traditional role of a doctor as a medical expert and primary decision maker to one that supports patient autonomy, choice and expertise in healthcare decisions. A therapeutic relationship forms the context in which patient-centred care is achieved. It is situated and actualised through a dynamic relationship among individuals, others who are important and all relevant providers. This interactional exchange and collaboration informs all aspects of clinical decision making. Many of the characteristics of patient-centred care can be endorsed as traits of diversity education. Although patient-centred care has not been directly responsive to addressing racial health inequalities, it does suggest the theoretical potential for reducing such disparities as it focuses on addressing the need for individualised, tailored care, accounting for factors beyond their disease. Diversity education has the capacity to enhance patient-centred care and improve the quality of care for all patients.

Patient-centred care emerged as an approach to finding and exploring common ground between the doctor and the patient, and understanding the patient's unique experience of illness. This shifts the focus of healthcare provision from the preferences and values of the doctor to the preferences and values of the patient. Diversity education builds upon the principles of patient-centred care, highlighting the importance of also acknowledging the patient's and the professional's social and cultural background that is brought into the dynamics of the doctor-patient relationship. Furthermore, it encouraged the professional to first understand oneself to help them better understand

how diversity and culture affects the patient's experience and understanding of health and illness.

Before a therapeutic relationship can develop, a professional must adopt an attitude and identity that is conducive to these principles and practices in terms of working in partnership with their patients. However, in comparison to principles of diversity education, patient-centred care makes little reference to the need for professional development and self-learning before patient-centred care can be achieved. In addition, implementing patient-centred care practices includes the need for significant core changes in the norms and expectations of the organisational culture. The organisational infrastructure and culture dictates what can be realistically implemented in practice. Ensuring that the organisation is receptive to patient-centred principles and approaches is the vessel for supporting professional behaviours and attitudes that are conducive to patient-centred care. Yet the relationship between practitioners and the organisation and its impact in facilitating patient-centred care is less acknowledged. Attention to the patient's social and cultural context is less emphasised in patient-centred care than in diversity education.

Renzaho et al (2013) conducted a systematic review of cultural competence (CC) programs that incorporated patient-centred care (PCC) and concluded that these programs increased practitioners' knowledge, awareness and cultural sensitivity when dealing with culturally diverse patients. However, there is limited research to indicate whether the increase in practitioner's knowledge is translated into improved patient health outcomes. Renzaho et al (2013) identified common similarities between the principles of PCC and CC, in that both notions principally signify a shift from a 'one size fits all' approach in healthcare to an individual, tailored care plan. PCC advocates the importance of attending to the individual needs of the patient, and accounting for the specific circumstances of the patients, including the diversity variables. However successful delivery of PCC is arguably dependent on the practitioners' CC, in recognising and valuing the diversity of the patient and to work in partnership, communicating effectively verbally and non-verbally. Several studies demonstrate the significance of CC in delivering PCC (Fernandez et al, 2004; Mazer et al, 2002), and given the increasing diversity in the patient and provider population, CC is an integral aspect of PCC. The principles of PCC and CC are complimentary in improving health care quality and outcomes. CC capitalises on the importance of acknowledging the patient's perspective in PCC whilst highlighting the cultural barriers which may exist

between the practitioner and the patient (Saha et al, 2008). The 13 studies included in the systematic review reported no significant findings in terms of patient health outcomes, most the studies primarily measured effectiveness in terms of practitioner knowledge, with no reference to patient outcomes. The connection between patient-centred care and diversity education warrants further research and study.

CONCLUSION

Very little literature has reviewed the intersections and relationships between these concepts in connection to diversity education, despite their inherent similarities (Banfield & Lackie, 2009; Purden, 2005). The chapter illustrates points of convergence as well as contention among the different concepts, and the fluidity and dynamic nature of diversity issues in relation to these concepts. Collectively these concepts highlight the significance of identity and the dynamics and nuances of intercultural relations. Despite the common perception that cultural differences are merely a communication problem, this chapter showed that cultural differences can have profound effects on one's identity and how one interacts with and relates to others. Cultural identity is a salient feature in professionalism, intercultural communication and patient-centred care as well as diversity education. Linking these three concepts together with diversity education may assist in helping health professionals practise in cross-cultural settings.

CHAPTER 6: QUALITATIVE METHODOLOGY – DEVELOPING PARTICIPATORY WORKSHOPS

A mixed method approach was adopted in this PhD. This chapter describes the qualitative methodology and the quantitative methodology is outlined in the latter chapters of the thesis. This chapter begins by revisiting the key issues raised in the literature review presented in chapters 1 to 5. This informs the foundations of the research aim and objectives which follow in this chapter. The qualitative research objectives are then described, accompanied by a justification of the chosen methods to achieve them. Stakeholder engagement in curriculum development, delivery and evaluation is increasingly being recognised as an integral part of quality improvement in health education. This qualitative phase of the research involved engaging a wide range of key stakeholders; referring to individuals with a unique perspective or expertise in the field of diversity education and those impacted by the diversity education of healthcare professionals i.e. patients.

The chapter initially broadly explores the benefits and challenges of involving patients and healthcare professionals in health education and then specifically involving mental-health patients, NHS leads and healthcare professionals and medical educators in diversity education. A participatory research approach was utilised and the justification for this is addressed in this chapter. Also described is the process of developing participatory workshops, recruitment and sampling of key stakeholders and ethical issues. The method of analysis chosen (i.e. template analysis) is explored, justifications are provided and a description of how themes were developed is presented. Issues of validity and reliability, the role of the researcher and limitations are also discussed.

6.1 LITERATURE REVIEW AND RESEARCH AIMS

6.1.1 Issues raised in the literature review

The literature review demonstrates the evolving understanding of the complexity of cultural and diversity issues in healthcare. Over the years, theoretical frameworks on diversity education illustrate a gradual progression from knowledge based models as personified in cultural competence/cultural expertise frameworks to process-orientated models, emphasising self-development, a shift in attitudes and values and a particular

focus on the development of skills to effectively address intercultural relations. Despite the limited application of educational theories in diversity education, there are prime opportunities for these to be utilised, particularly in recent process-orientated models concerning self-development and attitudinal changes. Evaluation of diversity education remains under-explored and existing measures reflect inherent conceptual issues and definitional ambiguities in the terms cultural competence, culture and diversity. Wide variation exists in the application of diversity education across healthcare educational institutions, with much of diversity education remaining fragmented, under-theorised and deficient in the use of evaluative measures. In addition, the literature review validates that this variability can be extrapolated across international settings. Whilst little literature has comprehensively explored the connection between diversity education and other healthcare concepts, the notions of professionalism, intercultural communication and patient-centred care appear intrinsically aligned to diversity education and a unified approach may situate diversity education within a wider framework (Saha et al, 2008; Kim et al, 2007; George et al, 2015).

6.1.2　Research aim and objectives

The main aim of the research is to support curriculum development and evaluation of diversity education within the NHS and health educational institutions. The following research objectives are outlined below. The term key stakeholders specifically refer to mental-health patients, NHS leads and healthcare professionals and medical educators:

1. To identify key stakeholders' understanding of the terms 'diversity', 'culture' and 'cultural competence.'
2. To identify key stakeholders' conceptualisation of patients' expectations of the knowledge, skills and attitudes of healthcare professionals they deem 'culturally competent.'
3. To identify key stakeholders' viewpoints on current diversity education in the NHS and within medicine and how this might be improved.
4. To identify key stakeholders' perspectives on how diversity education might be evaluated and what an evaluation tool for diversity training should be seeking to measure.
5. To establish a sound theoretical framework from the qualitative findings on the perspectives of key stakeholders for better teaching and evaluation of diversity

education, which could be used to achieve the institutional requirements and healthcare expectations concerning diversity.

6.2 INVOLVING KEY STAKEHOLDERS IN HEALTH EDUCATION

6.2.1 Benefits of involving key stakeholders

Involving key stakeholders during all stages of educational program design and development ensures that teaching is relevant to those concerned and increases the likelihood of early buy-in, successful implementation, and effective application in practice (Department of Health, 2012. Health Education England, 2014). Patient and public involvement (PPI) in health research and education has been found to improve the quality of educational teaching and learning (Health Education England, 2000; 2005). Patient involvement (also known as service-user involvement) is well established in certain areas of healthcare training and education in the UK, with notable initiatives in social education and mental-health. *"Putting patients at the heart of healthcare and learning"* permeates in several healthcare policy documents (General Medical Council, 2009; pp. 03). With new models of care centred on the patient, health professional training requires learning *from* and *with* the patients they are caring for. This allows both parties to approach clinical interactions as partnerships, a union of both the experiential knowledge of the patient and the medical expertise of the professional (Tuckett et al, 1985).

Utilising the expertise of patients in healthcare training and education provides experiences that enhance the educational learning that could not otherwise occur in the conventional biomedical model of the curriculum (Langton, 2003), in terms of providing personal insights and practical application of theory. There is strong evidence to suggest that patient involvement has short term benefits for all involved, where learners have reported positive outcomes such as perceived relevance, enhanced understanding of patient perspectives, communication skills and increased confidence when approaching patients (Jha et al, 2009). Similarly, educators have found that students have valuable learning experiences, are exposed first hand to patient issues and concerns and gain valuable patient interaction skills (Livingston & Cooper, 2004). Finally, studies reveal overwhelming benefits for patients with few or no negative effects (Morgan & Jones, 2009). Patient reports express a variety of therapeutic benefits including empowerment, increased self-esteem, greater insight into their

issues and a deeper understanding of the doctor-patient relationship (Walters et al, 2003).

Involving health professionals and gaining the perspectives of staff in health education, service provision and delivery is also a frequent practice. Research has shown that acknowledging health professionals' perspectives ensures training is appropriate to their needs and concerns, clinically relevant and contextualised (Health Education England, 2014). The NHS Staff Survey, implemented in 2003 gathers valuable information on staff experiences and daily practice. Thereby identifying areas of training deficiencies for staff and providing information to inform local improvements in staff experience and well-being. In addition, it provides an important measure of performance against the expected levels of competence, values and attitudes defined by the NHS Constitution. Similar surveys such as 'Healthcare Employee Engagement Survey', 'Provider and Staff Satisfaction Survey' (Institute for Healthcare Improvement, 2008) are also used as indicators of training needs and development.

6.2.2   Challenges of involving patients in diversity education

Patient or service user involvement in health professional education is widespread but piecemeal in nature, particularly in medical education and postgraduate training, where comprehensive involvement across the spectrum is uncommon. Many reports of patient involvement appear to be isolated educational occurrences within the broader curriculum (Spencer et al, 2011). Most published initiatives occur at an undergraduate level, with little or no research indicating its part in postgraduate education, especially NHS trainings. Only limited literature patient involvement in education is informed by theory (Katz e al, 2000; Rees et al, 2007) resulting in minimal evidence to suggest the role patients should play in training development and design. There remains a paucity of literature demonstrating examples of best practice; the defined purpose, role and degree of participation needed from patients.

Rarely is the patient's explicit role in education and training addressed in published literature. Manthorpe (2002) postulated four specific roles that patients typically entails; 1.) Personal anecdotal testimony; in which the patient as a trainer describes their personal story. This has been shown to be a powerful form of training, however frequently criticised for being unrepresentative of all patient experiences and often shown to evoke sympathy rather than debate. 2.) Co-trainers; where patients are explicitly acknowledged in providing their expertise alongside the professional trainer in

the delivery of training. 3.) Using the experience of the patient to cultivate a feeling of equality between participants and professionals, though there is uncertainty about how to effectively support individuals and challenge them when disclosing personal information. Finally, 4.) Para-professionals; this is a variant of co-training where the patients acts as a therapeutic agent (Hossack & Wall, 2005).

These typical forms of involvement, whilst common, have been criticised for being tokenistic and absence clear and measurable educational outcomes (Dogra et al, 2009). The literature demonstrates that patient involvement is frequently applied to augment clinical teaching, where most involvement in confined to training *delivery* as opposed to training *development*. Careful consideration is needed to ensure patient involvement in training is judicious rather than tokenistic. The traditional tokenistic nature of patient involvement raises concerns of 'representativeness.' Often a clear majority of individuals are categorised under the label 'patient or service user', however they are by no means homogenous. Diversity in patient populations is the norm. Different patients are bound to differ in their views, needs and concerns as do professionals, yet the literature appears ignores this issue. Concerns have arisen about how students can develop an understanding of difference and diversity in respect of service users' needs by merely having isolated examples of service user involvement in training (Williamson, 2007). Individual patients can express their own experiences but cannot necessarily speak for others. Therefore, patients with the same health conditions do not necessarily have equal needs, experiences and perspectives.

The degree of service user involvement can be categorised along a spectrum of engagement using different models, such as the 'Cambridge Framework' (Spencer et al, 2000), the 'Ladder of Involvement' (Tew et al, 2004) and the 'Spectrum of Engagement' (Towle et al, 2010). The most commonly used framework is the 'Ladder of Involvement' (Tew et al, 2004) which describes a range of involvement from 'little or no involvement' ("*They know best. We do as we're told.*") to a 'full partnership' ("*We're all on the same side. We all want to make a difference*"). This describes a gradual progression towards contributing to all aspects of training. The Ladder of Involvement was primarily developed in the context of mental-health education; however, it is theoretically applicable to a range of educational programmes and across the educational continuum. Internationally, research shows that many examples of patient involvement congregate at the first three levels of this model: level one – little or no involvement, level two – emerging involvement and level three – growing involvement,

with a few exceptions achieving level four; collaboration and level five; partnership (Spencer et al, 2011).

The vulnerability of patients, especially mental-health patients, creates inherent challenges and the literature suggests this may be attributable for the small degree of patient involvement (Livingston & Cooper, 2004). Accounts of health professional perspectives demonstrate concerns about the potential negative effects of service user involvement, such as emotional distress, conflict of interest over whether their views should be balanced, clarified or corrected and physical stamina (Gecht, 2000). In addition, health professionals can perceive patient involvement as threatening in terms a 'relinquishing of professional knowledge' (Walters et al, 2003; Foucault, 1982) and dominance of the patient perspective. Similarly, learners reported concerns over the patient's emotional well-being, with a few negative experiences documented with mental-health patients, which were associated with unbalanced views and perceived antagonistic attitudes (Morgan & Jones, 2009). However, the little research on this topic is inconclusive (Gecht, 2000).

A recurring theme in reviews of patient involvement is the absence of clear and measurable educational outcomes. Much of the current research is descriptive, lacks rigour and has been assessed as 'low quality' by the accepted criteria of the 'best evidence medical education' as defined by Cote and Turgeon (2005). Not only have learning outcomes not been studied, but the educational theory underpinning patient involvement is lacking (Towle et al, 2010). Little evidence exists on the effectiveness of patient involvement on long term learner experiences and ultimately changes in practice. Morgan and Jones (2009), using Kirkpatrick's four level model of evaluation, identified that most papers in reviews of patient involvement reported positive results at level one – learner perceptions. A small number illustrated evaluation data at level two – measured changes in attitudes, skills and knowledge, and finally only a mere handful suggested constructive changes in practitioner behaviour and patient outcomes. The methodological weaknesses and lack of specificity in these papers makes it challenging to define conclusively the benefit of service user involvement on a long-term basis. However, the majority of research conveys the clear, positive short term benefits of patient involvement for all parties.

The challenges of patient involvement are most notably addressed in the common criticisms of diversity education. Attempts at patient involvement have been criticised

for being tokenistic, stereotypical, unrepresentative and largely minimal and passive (George et al, 2015; Dogra et al, 2005). Whilst diversity education seeks to highlight patient differences and diversity, little research has suggested patient involvement in educational development and design. Many of the examples of patient involvement are confined to training delivery, particularly involvement in terms of 'sharing their story' and providing a personal testimony (Hunt et al, 2007). The perceived vulnerability and threatening nature (patients expressing conflicting or 'politically incorrect' views) of involving patients by educators is often a persuasive factor in validating the inappropriateness of patient involvement, especially with mental-health patients (Hoop et al, 2008).

Given that the foundation of diversity education is to represent and raise awareness of patient differences and diversity, there remains a lack of clarity and evidence on what patients would like diversity training to cover, and how diversity issues in patient care should be effectively managed. This information would be of value in ensuring diversity education is reflective of patient needs and concerns and is beneficial to the learner. In the absence of evidence of best practice for patient involvement generally, aside from in diversity NHS training, there are many possible approaches to developing and embedding involvement in training programmes and arguably no one right way (Spencer et al, 2011). There is a need for a research approach and method that is iterative and flexible in adopting and adapting its framework to ensure its appropriateness to the needs of the service user, the type of involvement required, the context and the research aims and objectives.

6.2.3   Challenges of involving health professionals in diversity education

Health educational policies actively require involvement from key stakeholders in healthcare research and education, but little is known about how NHS healthcare professionals are directly involved in the development of national training such as diversity education. Exploratory research prior to the development of this thesis reveals that diversity education design and development typically relies solely on the diversity trainers (also known as diversity leads). These individuals have often reported that they have little or no faculty support either in developing, delivering and evaluating diversity training or in constructively facilitating the challenging and contentious discussions elicited in diversity training. A review of diversity training in the NHS and different health educational institutions outlined in Chapters 1 to 5 demonstrates the diverse

epistemological interpretations and curriculum applications which are arguably indicative of and dependent on the trainers' backgrounds. Consistent challenges that are raised regarding this training are learner readiness and faculty development, teacher preparation, and possible resistance from both groups (Dogra et al, 2010; Dogra et al, 2009). Research has shown trainers commonly experience defensiveness, anger and denial when presenting diversity material (Abrams & Gibson, 2007; Stith-Williams, 2007). Little research has been published exploring the collective views of NHS leads and healthcare professionals involved in the development and delivery of diversity training and how training can be improved for both trainees and trainers.

Many of the papers published in the area of diversity education in the UK are based on expert opinion and are descriptive or qualitative studies, with little research unifying and comparing the perspectives and stances of medical educators in the field of diversity. Different research studies have demonstrated a disconnection between academics, policy-makers and healthcare organisations regarding how diversity education and training might be strategically and meaningfully implemented. Gaining the multiple perspectives in a single setting of medical educators who may adopt different educational theoretical frameworks for diversity may have a beneficial impact in assessing the conceptual similarities and differences in their intentions and elicit constructive discussions on how to collectively resolve the wide variability in diversity education.

6.3   PARTICIPATORY RESEARCH

6.3.1   Defining participatory research

Participatory research is a methodological approach or research style that has grown from a great deal of creative cross-fertilisation between different research doctrines such as action research, qualitative methodology, adult education and medical anthropology (Cornwall & Jewkes, 1995). A participatory research approach is tailored towards planning and conducting the research with those individuals whose experiences and perspectives are under study. Consequently, the research process develops out of a convergence of two perspectives; the researcher and the researched, in which both parties benefit from the research process (Bergold & Thomas, 2012).

Participatory approaches are not completely distinct from other social research styles; rather there are numerous points of convergence between participatory research and qualitative methodologies. Therefore, the boundaries of participatory research approaches and methods are often blurred, as the concepts of 'participation', 'participants' and 'participatory' have a range of different interpretations and applications. Cornwall and Jewkes (1995) provide clarity on the defining characteristics of a participatory approach; firstly, participatory approaches entail innovative adaptations of methods drawn from conventional research and their use in new contexts and new ways. Second, researchers become learners and facilitators, catalysts in a process which takes on its own momentum as participants (with their local knowledge and perspectives) come together to discuss and analyse. The striking difference between participatory and conventional methods lies not solely in the theories which inform these methodological frameworks or even in the methods they choose to use, "*but in who defines the research problems, and who generates, analyses, represents and acts on the information which is sought.*" (Cornwall & Jewkes, 1995; pp.6). Determining the answer to this 'who' question enables participatory approaches to actively involve members of the researched community and to have action, impact and contextual appropriateness.

6.3.2   Rationale for the use of participatory research

Research strategies are increasingly emphasising 'participation', with the processes of reflection, analysis and critique being carried out by the participants as well as the researcher. Nowadays research and research funders are recognising the importance and sense in involving service users in research. Cook (2012) pointed out that in the UK, public and patient involvement (PPI) is often explicitly required by funding bodies. Within this framework, the principle aim is not to change practice, but rather to produce knowledge in collaboration with members of the researched community. The popularity of the use of participatory methods has been motivated by pragmatism and concerns of equity. Where conventional health research methodologies tend to generate knowledge for understanding, which can be independent of its use in planning or implementation, participatory research focuses on *"knowledge for action."* This approach enables research to be conducted *with* service users and other key stakeholders as opposed to *on* service users or key stakeholders. Research has shown that adopting participatory research approaches maximises the involvement of different key stakeholders in a variety of aspects of training development and implementation (Macaulay et al, 1999).

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Several studies have demonstrated that participatory research approaches allow patients and healthcare professionals to feel empowered, valued, and able to draw new insights into training development (Beresford, 2005; Faulkneretal, 2002).

Participatory methodologies offer innovative ways to a learning approach which is both responsive to local priorities and committed to change. The diverse and original nature of participatory methodologies in their interpretation and use makes it challenging to describe rigid prescriptions of their role. Participatory research methods cannot be organised into a single methodological approach, as the strategies can be manifested in a variety of ways depending on the study itself. Therefore, this approach allows for flexibility in adopting and adapting methods that are congruent to the different key stakeholders' needs, local context, priorities and perspectives. This approach was used because it offered a flexible method, appropriate for the research aims and evidence has shown it maximises the involvement of a variety of key stakeholders in exploring different aspects of curriculum design, development, and evaluation.

6.3.3   Using a participatory workshop

A participatory workshop adopts the principles of a participatory research approach within the format of an extended group discussion with many participants. They are designed primarily for three purposes; exploratory scoping of a subject, to obtain clarity about the needs and objectives of a topic and to generate or develop ideas and stimulus (Bergold & Thomas, 2012). Participatory workshops are generally conducted to allow a more in-depth exploration of an issue that otherwise would have been challenging to achieve in a standard group discussion (i.e. focus group). It enables relevant groups of individuals to come together to exchange advice and opinions, extract their knowledge and identify, understand and challenge problems in a collaborative and creative environment. A mixture of small and large groups of participants can be sought collectively in a participatory workshop and a variety of data collection methods can be employed such as task activities, pictorial representations and workshop booklets.

Given the complexity and nuanced nature of diversity training, this method allows complex issues to be discussed in depth in a supportive environment and enables potential solutions to be discussed. Participatory workshops specifically seek dissenting views, contractions and an exploration of different perspectives. The aim is not to create a conflict-free space, but rather an environment where conflicts are

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revealed, discussed, and considered (Israel et al, 2001). Participants are active, not just reactive and participatory workshops have the potential to be more creative than focus groups and can generate more buy-in than individual interviews (Israel et al, 2010).

6.3.4 Consideration of alternative methods

Given that mental-health patients are vulnerable and can be challenging to involve in research, the typical method of focus groups or semi-structured interviews appeared ill-suited. Reports have shown they can be perceived as formal, rigid, threatening and intimidating for mental-health patients, although this may be dependent on the facilitator (Bergold & Thomas, 2012). Inevitably this may result in failing to engage them effectively in the research process and prevent the generation of new and creative ideas. Discussions and interactions typically elicited in a focus group organically evolve, with guidance by the facilitator through a series of open-ended questions. The facilitator plays an important role in ensuring the group discussions are focused on the topic, which can be challenging to achieve, especially if more contentious and sensitive topics are being discussed. Participatory workshops allow for discussions and interactions to develop organically, thereby capitalising on the diversity of perspectives among the participants, however they are structured around a specific task, ensuring direct responses to the research objectives are addressed. Additionally, the mixture of small group and larger group discussions allows for both a greater exploration of individual perspectives and self-reflection on personal viewpoints in a constructive manner.

Theoretical and empirical research has shown that in-depth interviews can lead to personal accounts of culturally incompetent care, discrimination and experiences of racism and prejudice, but fail to induce self-reflection on perspectives. (George et al; 2015). Participatory workshops and group discussions will allow participants to engage in an interaction which is complementary; sharing a common experience and argumentative, questioning, challenging and disagreeing with each other. It will also stimulate participants to analyse their views more intensely than in an individual interview. Also, given the complexity and nuanced nature of topics to be explored in relation to diversity education, it allows complex issues to be discussed in-depth in a supportive environment. A participatory workshop provides a supportive environment in which participants can share and co-construct knowledge and explore perspectives.

The format of a workshop allows many participants to be involved, is inclusive of differences and diversity and therefore bypasses the issue of patient involvement being unrepresentative. In addition, the format, tasks and activities designed in the workshop can be tailored to the needs of the group, in this case the different types of stakeholders, and the research objectives.

6.3.5   Developing participatory workshops: study design and session plan

The workshops were conducted and planned in collaboration with eight healthcare and mental-health service user organisations and held at their organisational sites. The participatory workshop was designed to obtain specific answers to the research objectives 1-4 through discussion on four tasks (see Table 6.1 for an outline of how the session plan was developed). These involved gaining participants' perspectives on how they understood key terminology in relation to diversity education, their expectations of the knowledge, skills and attitudes they anticipated from culturally competent practitioners, their views on current diversity education and how to improve it and their ideas on how to effectively evaluate the training.

The session structure and content was piloted on four occasions with healthcare professionals and patients and subsequently modified after feedback from supervisors and leads from collaborating organisations. Example changes to the session structure included; 1.) The wording of the questions were improved as some lacked clarity and were not easy to understand 2.) Decision to frame activities within the context of outcomes from health policy documents, to overcome the problem of participants struggling to answer general questions relating to their understanding of key terms such as diversity. 3.) Decision to use creative materials (i.e. flips charts and pictorial representations of concepts and terms) to allow participants to express their individual and group ideas visually, and workshop booklets to capture perspectives that individuals may not feel comfortable to share.

A variety of techniques (such as small and large group discussions, written feedback) were used to accommodate the diversity of participants and to enable maximum participation. Each participatory workshop lasted approximately 3-4 hours, with a break included. There were small group discussions and the groups then came together to compare their discussions with other groups in a larger discussion. Workshop booklets, flip charts and materials supplemented their discussions. Examples of these are shown

in Appendix 6.4 and Appendix 6.8. The different data collection methods allowed for a range of diverse data to be collected, as shown in Table 6.2. The different methods accommodated the diversity of key stakeholders attending the workshops, with some preferring small group discussions over larger group discussions and others more inclined to writing their reflections and comments coherently in the workshop booklets. Each workshop consisted of the same session format and comprised consistent data collection methods, which allowed the data from the different key stakeholders' groups to be compared.

6.3.6   Establishing the degree of participation

In practice, participatory research projects have been rarely able to follow the smooth pathway implied by theoretical writings. Briggs (1989) distinguishes four modes of participation: 1.) Contractual: people are contracted into the projects to take part in enquiries or experiments. 2.) Consultative: people are asked for their opinions and consulted by researchers before interventions are made. 3.) Collaborative: researchers and participants work together on projects designed, initiated and managed by the researcher and 4.) Collegiate: researchers and participants work together as colleagues with different skills to offer in a process of mutual learning, where participants share control over the process. Brigg's typology of participation demonstrates the extent to which participation can be classed, interpreted and conducted in research and the degrees to which participation can vary in the research process. Participatory workshops are theoretically situated at the collaborative or collegiate level of participation. However, scrutiny of research practice has often revealed that research studies rarely if ever reach this expectation. This project aimed to involve key stakeholders in a collaborative manner as defined by Brigg's typology throughout the research project.

6.4   ETHICAL ISSUES

Ethics approval was granted by the University of Leicester (see Appendix 6.10). The mental-health organisations and NHS health organisations that collaborated with this study provided a formal written document of their consent to participation, shown in Appendix 6.11 - 6.14. The key ethical issues concerning this study largely referred to mental-health patients (specifically for research objectives 1-4) and were addressed in the following ways:

1. **Appropriate recruitment of mental-health patients:**

Patients who had experienced or been in contact with UK mental-health services were invited to take part in a participatory workshop. Patients who were severely mentally unwell, or lacking mental capacity were not eligible to take part. Determining suitable participants for the workshops was done in consultation with the organisations and leaders of the service user groups, to ensure that participants who may have a detrimental effect on other participants or be uncomfortable in discussing the issues proposed in the workshop were excluded. Target patients were provided with a consent form and a detailed information leaflet (shown in Appendix 6.5 and Appendix 6.6) prior to the workshop, to ensure any questions or concerns were raised and discussed with the Chief Researcher in due time.

2. **Discussion of sensitive or contentious issues:**

Care was taken to ensure that the study design enabled such discussion within the targeted groups. Particular care was taken to ensure that the format was appropriate for mental-health patients. Techniques and group based activities adopted were presented in a non-intrusive and appropriate manner for patients. 'Ground rules or expectations' were set through discussion with the eligible participants at the beginning, for example to respect confidentiality, to listen to each other and respect each other's opinion. Advice and guidance from the patient organisations involved was continually sought as how to best conduct these participatory workshops. In addition, the researcher (myself) attended participatory workshops conducted with patients by the organisations to learn and observe good practice. The proposed workshops were also piloted twice with mental-health patients and once with NHS healthcare professionals to ensure appropriateness, relevance and clarity of the tasks and exercises.

3. **Consent and assurance of confidentiality:**

Mental-health patients were not recruited as participants if they were unable to give informed consent or if they were severely mentally unwell/lacking mental capacity/advised unsuitable by the organisation. Care was taken to ensure the information about the research was communicated in a way that is meaningful to the individuals concerned. An information leaflet detailed the study so that participants could give informed consent. Additional, at the start of the workshop, the information was verbally reiterated to remind participants that participation was entirely voluntary and what was to happen.

6.5 RECRUITMENT AND SAMPLING STRATEGY

For this study, the perspectives of mental-health patients, NHS leads and healthcare professionals and medical educators were sought. The justification for only choosing mental-health patients was to determine whether we could attain a focused set of findings for a specific patient group. Also, as diversity education was first made mandatory for mental-health professionals, equality and diversity issues have been undertaken for a longer period in this field, and particularly the impact of culture on mental-health is irrefutable (Bhui et al, 2007). NHS leads (specifically in diversity) and health professionals were recruited from a variety of backgrounds, levels of experience, occupation and areas of England, to ensure that a diverse range of perspectives were gathered in relation to diversity issues. Medical educators from UK medical institutions were selected based on those who were either involved or whose teaching role contributed to aspects of diversity education, and these were deemed an appropriate sample to ascertain perspectives specifically from an educationalist stance.

Potential mental-health patients were recruited by collaborating with five mental-health patient organisations which contacted potential participants through their newsletters, website, and word of mouth (i.e. through community development workers). A total of 94 key stakeholders (patients, NHS professionals and medical educators) were involved in this qualitative study. The demographics of the three sample groups are shown in the Tables 6.3, 6.4 and 6.5 below. More details are provided in Appendices 6.1, 6.2 and 6.3.

TABLE 6.3: SUMMARY OF DEMOGRAPHIC CHARACTERISTICS OF THE MENTAL-HEALTH PATIENT SAMPLE

Gender Groups		Age Groups		Ethnic Groups	
Male	19	21-30	3	African	6
Female	23	31-40	6	Caribbean	10
Total	**42**	41-50	9	Mixed	2
		51-60	17	Italian	2
		61-70+	7	Black British	7
				White British/Other	15

TABLE 6.4: SUMMARY OF NHS HEALTH PROFESSIONALS WORKSHOPS PARTICIPANTS

Ethnic Groups		Gender Groups	
Black	4	Male	23
Black and White	1	Female	22
British Asian	9		
Mauritian	1		
Mixed Race	2		
Other	1		
White British	25		
White Irish	1		
White Other	1		
Total	**45**		

TABLE 6.5: SUMMARY OF MEDICAL EDUCATORS WORKSHOPS PARTICIPANTS

Ethnic Groups		Gender Groups	
Bangladesh British	1	Male	3
British	2	Female	5
Chinese British	1		
Indian British	1		
Welsh British	1		
White British	2		
Total	**8**		

All groups were generally diverse. All identifying information of the participants has been removed to protect confidentiality. Three patient participatory workshops were conducted in London and Greater London at the collaborating sites with 42 diverse participants (Appendix 6.1). Four NHS healthcare professional workshops were conducted with 44 participants across four regions at the collaborating sites (Manchester, Bristol, London and Leicester; Appendix 6.2). One medical educators' participatory workshop was conducted in London with 8 participants and again these participants were from diverse backgrounds (Appendix 6.3).

6.6　ANALYSIS

6.6.1　Template analysis

Thematic analysis is a frequently utilised form of qualitative analysis, where themes (referring to collective categories) are identified, examined and recorded as pertinent patterns within the data. By definition it is not an approach itself, but rather a broad category of approaches used in qualitative analysis that strive to effectively identify themes and categorise those themes into meaningful structures that assist interpretations. There are multiple ways of conducting thematic analysis and these have been further developed in other disciplines such as Framework Analysis (Ritcher & Spencer, 1994) and Matrix Analysis (Miles & Huberman, 1994). Template analysis (King, 2004) is a style of thematic analysis, widely employed in organisational and management research (King & Horrocks, 2010). It utilises hierarchical coding and is designed to facilitate a relatively high degree of thematic structure whilst ensuring flexibility to adapt the thematic structure according to the needs and priorities of the particular study.

Central to this type of analysis is the use of a coding template, which prior to data analysis identifies salient themes in regards to the aims and objectives of the research project, forming an initial, tentative coding template. This coding template is then applied to further data, revised and refined. The approach of template analysis does not outline authoritative guidelines regarding the style and format of the coding template produced, rather it encourages the researcher to develop themes extensively, where the most relevant themes in relation to the research objectives are obtained.

6.6.2   Rationale for use of template analysis

The literature review in Chapters 1 to 5 demonstrates recurring and consistent challenges in diversity education, which led to the formulation of specific research objectives (namely 1 to 4) that are integral to improving areas of curriculum development and evaluation. The aim of the study was built on existing mainstream theory and literature. The selective and judicious application of a priori themes, meaning salient themes identified from the literature prior to the analytical process, allows important theoretical concepts and perspectives to inform the design of the research process. Studies convey diverse applications of a priori themes used to inform the research process (Brooks et al, 2015; King et al, 2013; McCluskey et al, 2011), which is particularly advantageous for research studies that have applied concerns which need to be incorporated into the analysis. This study specifically sought to identify ways to support curriculum development and evaluation of diversity education. The flexibility of template analysis ensures that a priori themes are equally subject to refinement and modification should they fail to effectively characterise the data.

The primary benefit of employing template analysis is the flexibility of the technique, as it can be adapted to the needs of a specific study and the study's philosophical underpinning. Given the complexity and dynamic nature of issues relevant to diversity education, numerous themes were likely to develop. Typical approaches to thematic analysis (Braun & Clark, 2006) conform to one or two levels of sub-themes. Template analysis permits flexible, hierarchical coding, commonly using four or more levels to capture the richest, detailed aspects of the data. Template analysis offers a highly flexible approach that can be readily modified for the needs of the study. Other methods of analysis such as grounded theory (Glaser & Strauss, 1967) or interpretative phenomenological analysis (Smith, 2010) appeared too prescriptive and procedural to reconcile the salient features of this study. Template analysis is also well-suited for larger qualitative sets of data than other methods, seeking across case rather than within case analysis, typically using groups of individuals as opposed to individual interviews (King, 2008).

Template analysis can sometimes be used interchangeably with Framework Analysis (Ritcher & Spencer, 1994) and both are referred to as 'codebook approaches' (Crabtree & Miller, 1992), which describes the construction of a coding template from a

mixture of a priori themes and engagement with the data which is then applied to the full data set. The key distinction between the two approaches is that template analysis places greater emphasis on providing guidance on the iterative process and development of a coding template. In addition, studies of Framework Analysis do not demonstrate the depth of coding shown in Template Analysis (Gale et al, 2013). Template analysis is well-suited for studies exploring complex phenomena such as diversity education which are likely to have varied, nuanced and multiple interpretations of a single phenomenon. Framework Analysis also asserts a greater importance of reducing the data through identifying patterns of *"mapping"* or *"charting"* (Ritcher & Spencer, 1994) which is not an essential part of template analysis, nor is it aligned to the aims of this research.

Template analysis has been utilised in prior qualitative studies which adopt a 'contextual constructivist' position (Madill et al, 2000; Gale et al, 2013), closely referring to a social constructivist position, which assumes there are multiple interpretations to be made of any phenomenon and these differ according to the specific social context. Template analysis allows both a bottom-up and top-down approach, using a combination of a priori themes whilst actively accommodating the organic development of new themes. In addition, similar studies exploring educational development and design with a social constructivist stance have effectively used template analysis (Taylor & Ussher, 2001; Budds et al, 2013). For all the reasons above, template analysis was deemed the most appropriate method of analysis for this study.

6.6.3 Development of themes

The development of themes was conducted in accordance with best practice guidelines for template analysis (King, 2012). These included the following core procedural stages, with relevance to this research study:

1. **Development of a coding template of a priori themes**

Prior to data analysis, a coding template was constructed, consisting of themes identified in advance of the analytical process which are formally defined as a priori themes. A priori themes are those that are particularly salient to the research objectives. The a priori themes and areas where data was most sought after are shown in Table 6.1. These themes were translated into relevant participatory workshop task questions that were to be explicitly covered during the participatory workshop. These a

priori themes are viewed as provisional and tentative and are subject to modification or deletion as the coding template is developed from the initial form to the final version (as shown in Figure 6.1).

2. Developing familiarity with the data

Gain familiarity with the initial sets of data to be analysed. The participatory workshops were not conducted simultaneously but rather over a period of six months according to the convenience and availability of the collaborative organisations. A reflective journal was used throughout the period, as recommended in thematic analysis. Initial themes emerging from the participatory workshop booklets and flip charts which were immediately obtained after the workshops were reviewed and discussed with research supervisors after each workshop. As the workshops were transcribed, preliminary coding of the data began, which again was discussed with the research supervisors.

3. Preliminary coding

All the workshops were transcribed verbatim and uploaded on Nvivo software for further analysis. As this study involved a large qualitative data set, requiring 512 hours of audio recording (this includes both small groups and larger group discussions) to be transcribed, a combination of by-hand analysis and qualitative analytical software was used, to retain contextual appropriateness and greater familiarity with the depth and breadth of the data. The process of template analysis began with preliminary coding of the audio and written data (i.e. the workshop booklets and information written on flip charts) which closely reflects the same process used in most thematic approaches. This involves making preliminary notes and highlighting areas in the text that may contribute to the researcher's understanding, which were subsequently reviewed during the period of data collection and analysis.

4. Developing meaningful themes and categories

The emerging themes for each participatory workshop were then organised into meaningful clusters which were then reviewed to define how the clusters relate to one another, within and between these groupings. This included hierarchical coding, where narrower themes were enmeshed within broader themes. Again, themes were identified and discussed with research supervisors to reach consensus on those relevant to the research aims. Participants were also involved in this and in doing so the rigour of the qualitative analysis was strengthened.

5. **Developing a coding template**

A coding template based on the preliminary thematic analysis was then developed for each participatory workshop. This was then compared with the coding template of a priori themes developed prior to the data analysis. This a priori coding template was modified and refined according to the new coding template. This was repeated for all participatory workshops.

6. **Modification and refinement of coding templates**

In the development and revision of the coding templates, incorporating new data that held potential relevance to prior templates and could be used to represent it became a continual practice. When new themes emerged that did not align to previous coding templates, modifications of the template were necessary. The exact process slightly varied with each new data set from the participatory workshop, but involved new themes being inserted, existing themes being redefined and in some circumstances themes were deleted if they appeared redundant.

7. **Comparison of coding templates**

This iterative process of experimenting with successive versions of coding templates, modifications and reconstructions continued until a rich and comprehensive representation of the researcher interpretation of the data was achieved and no further new themes emerged. Coding templates from different stakeholder groups were then compared to develop conceptual ideas beyond the different coding templates. These were then categorised in an attempt to identify a master coding template for the findings from all participatory workshops.

8. **Finalisation of master and coding templates**

The final coding template for each stakeholder group was then applied to the full data set for each respective participatory workshop. The master coding template was then applied to the full data set and continual engagement with the data set and further reflections and minor amendments were made. The finalisation of the master coding template was deemed sufficient when the data clearly addressed the research objectives and no new themes or patterns emerged.

6.7. PRACTICAL ISSUES

6.7.1. The role of the researcher and reflexivity

The researcher's role is a highly-debated issue particularly in qualitative research. A consistent component of qualitative research is the articulation of one's own world view, which includes the researcher's explicit acknowledgment of one's background, biases, experiences and assumptions. This practice of active awareness and acknowledgment of the researcher's role can be captured in the term 'reflexivity.' Reflexivity describes a two-stage process whereby the researcher reflects upon their role as a researcher and the research relationship which describes their influence on the participants and vice-versa, and the dynamics of interactive meaning-making between the two parties (Robson, 2002). This process of reflexivity includes considering the influence of the researcher's background and role in how the research question is formulated, selection of methodology, and the process of how data is collected, analysed and presented.

Robson (2002) defines three consistent components to consider when establishing the researcher's role, these include 1. How the researcher's own perspectives influence the research process. 2. How the researcher can be perceived by those involved in the research study and 3. How perceptions of the researcher influence the research process and interactions with those being researched. An overview of these three components will be outlined in this section.

Researcher's perspectives and perceptions of the researcher

Robson (2002) recommended researcher's to explicitly reflect and identify their personal experiences of the research process, including the influence of personal characteristics when undertaking the research. The researcher in this study possessed the following demographic and background characteristics; Christian, female, hetero-sexual, married, British nationality, South Indian origin, 26 years of age, educated in the UK and a psychologist by background. The researcher had conducted research in diversity at undergraduate and postgraduate level prior to the PhD. This aided in providing theoretical familiarity and understanding of the topic. These experiences coupled with teaching diversity sessions in different healthcare contexts, interactions/collaborations with different stakeholder groups, committee board membership on diversity groups and clinical practice in a mental-health/ palliative care

setting, captured the depth and nuances of different issues relating to diversity education. These experiences suggested diversity education was fragmented, under-theorised and widely variable in terms of design, delivery and evaluation, with little consensus on how diversity education is conceptualised and taught.

My name, Riya Elizabeth George, can suggest a White English origin, which a few of the collaborators prior to meeting me had inferred from my name. During conversations, it was interesting to find that some individuals assumed I may be of a mixed racial heritage or married to a White race individual based on the connotations of my surname. Christian (or perceived 'White' English names) are commonly adopted in individuals from a South Indian background, yet for those who are not aware of this commonality, it can be perceived as a novelty. This demonstrates that individual's responses might be modified by their experiences and assumptions of the researcher. As an individual of Indian origin, for some respondents I was automatically given credibility about acquiring expertise or valuable insight into diversity. Participants' responses and willingness to participate in the research may have been modified by their expectations and impression of the researcher. Participants may feel more or less comfortable to discuss diversity issues depending on their impression of the researcher and their assumptions of the researcher's diversity perspectives and values.

On two separate occasions when conducting the mental-health patient participatory workshops, on welcoming participants to the workshops, three individuals from a White race English background enquired whether it was appropriate for them to attend the workshop given they were from a White race. One individual passionately explained why the White race perspective is important in relation to diversity issues. For some participants, they deemed their eligibility to participate in the workshop based on their race/ethnicity. Similarly, when liaising and identifying gatekeepers during informal conversations, subtle remarks made by those of a non-White race implied an assumed understanding of diversity issues based on race concordance between myself and them, for example *"you know what I mean"* or *"they think in the same way as our culture."* These responses by patients and gatekeepers were indicative of how they understood the terms culture and diversity, which appeared equated with issues of race and ethnicity.

Being a British, Indian and Christian woman born in Kerala, India and raised in London, England, exploring and reflecting upon my cultural identity has become a habitual

practice. My individuality has been shaped by my values, social contexts, personal experiences and the on-going internal dialogue that continues to make sense of what I've experienced and what that means in relation to my identity. Growing up amongst different cultures and working in diverse and variable settings has made me aware of my own differences and how my individuality can resonate with people I may assume are different to me. I often found my identity rarely ever applied to the generalised cultural group characteristics of being an 'Indian or an Asian'. Being a Christian is the most pertinent part of my identity and often not a typical characteristic associated with being an 'Indian'. My values of openness, inclusivity and humility have influenced my understandings of culture and diversity as complex, broad and nuanced terms that are intrinsically connected with one's experiences, heritage and values.

In addition, Robson (2002) also suggests considering the gatekeepers interests and the social climate and context of the research. The social and political climate in which this research took place was highly receptive to diversity issues in healthcare. Two key NHS initiatives had been recently established; Refreshed NHS Equality Delivery System (EDS2, 2011) and the NHS Workforce Race Equality Standard (2015). The Equality and Diversity NHS Council were keen to garner stakeholder engagement. The EDS2 in particular demanded that organisations demonstrate active commitment towards addressing equality and diversity issues. In addition, the two biggest medical education organisations in the UK (Association of the Study of Medical Education, ASME) and internationally (An International Association for Medical Education, AMEE) hosted their 2016 and 2017 conferences with a primary focus on diversity. Whilst diversity education is susceptible to political motives, a growing emphasis was being placed on shifting the research in an educational context. This piece of research has a strong applied implication in producing research that supports curriculum development and evaluation of diversity education.

Reflections on the research process

Encouraging a variety of stakeholder engagement required developing good relationships, meetings with stakeholders were all arranged in person, which was positively received. An integral aspect of adopting a participatory research approach must entail developing good collaborative relationships with stakeholders and gatekeepers. The format of a participatory workshop encouraged a collaborative and creative environment, and for all participants to actively contribute their views. All

participants who were eligible and agreed to participate all attended, no participants declined. In addition, participants' positive responses at the participatory workshops significantly encouraged greater attendance at later participatory workshops which were oversubscribed. This combated my limitations as a relatively as a relatively junior researcher with little access to relevant stakeholders. Contrary to my own expectations, my age and relatively junior research experience did not hinder gathering a large amount of relevant and senior stakeholders. This may be attributable to feelings of hierarchy or perceived threat not being as present due to my age and junior level of experience. Some participants would often ask me for the 'right' answers, however I would reflect back the question to the group as a whole to encourage everyone to contribute their views. This was important in establishing that all perspectives and thoughts were valued and to encourage mutual respect for each other's views. Valuing a range of healthcare and sociological perspectives was important for engaging a diversity of stakeholder involvement, particularly those who were less inclined to get involved in diversity research. A personal approach of openness, valuing all contributions and inclusivity assisted in making participants and collaborators feel valued. For the purposes of engaging a variety of stakeholders, whenever possible the researcher would attend collaborator's events and networking opportunities to establish familiarity with recent initiatives and demonstrate genuine interest in their work.

After each participatory workshop as the researcher, I reflected on my thoughts, impressions and feelings through reflective journals and this was discussed regularly at research supervision. This was particularly useful for self-reflection and considering different and ulterior perspectives/ motives for my impressions. The supervision sessions were also helpful in assessing where improvements could be made to the participatory workshops and discussing emerging themes.

6.7.2. Study limitations: Issues of validity and reliability of the research

Contrary to statistical methods used in quantitative research to establish the validity and reliability of the findings, qualitative research incorporates methodological and design strategies to establish the 'trustworthiness' of the findings (Noble et al, 2015; pp.34). Reliability in qualitative research refers to the soundness of the research in relation to selection and appropriateness of the methodology and the integrity of the final conclusions (Nobel et al, 2015). Lincoln & Guba (1985; pp.330) used the term 'dependability' to closely correspond to the notion of 'reliability' in quantitative research.

This describes the methodological strategies used to enhance the dependability of quantitative research. Validity in qualitative research describes the *"conceptual and ontological clarity of the research question and the success of translating these into a relevant and meaningful epistemology"* (Mason, 1996; pp.148).

These methodological strategies include critical reflection on how personal characteristics and biases may have influenced the research process and the interpretation of the findings. This has been addressed above, and as mentioned through reflective journals and regular discussions with the supervisory team throughout the different phases of the research. Purposive sampling was employed in this research study, meaning a non-probability sample that is characterised by a deliberate effort to obtain a representative sample by selecting respondents with specific characteristics which are relevant in addressing the research aims and objectives. The limitations of a purposive sample include the subjective/ arbitrary nature of selecting participants, as it may reflect the researcher's personal stance more than a random sample.

A common limitation of qualitative research is the ability to generalise the findings, as to replicate the exact research process in wider populations is challenging to achieve. The structured format of the participatory workshop with set activities and tasks and large sample size attempts to reduce this limitation and make it easier to replicate. However, the extent to which these findings can be extrapolated to wider populations with the same degree of certainty as quantitative analysis is limited. Qualitative research is both time and labour intensive, making it prone for certain aspects to go unnoticed. Regular meetings and co-rating of the qualitative findings with supervisors was established to reduce this limitation. Thoughtful planning was adopted throughout this research to ensure high quality, comprehensive and accurate date was received.

To ensure a transparent and consistent interpretation of the findings, a meticulous record of the development of themes and templates were kept which are shown in the tables accompanying this chapter. Transparent were recorded verbatim and all responses were considered. In addition to the transcripts, the responses from the participatory workshop booklets and creative responses on flip charts were also considered. Utilising different methods of data collection was helpful in providing a comprehensive set of findings and for respondents who were more articulate in their written respondents as opposed to verbal discussions. The use of template analysis

resulted in the development of codes and themes to be a relatively mechanical task, making reliability higher in these qualitative circumstances. Reliability is more likely to be reduced when judgments are made about the data without full consideration about how these interpretations were made. To ensure respondent validation, collaborators and participants were invited to review and be engaged in the development of final themes and templates, this allowed a varied and adequate reflection of the findings of the research.

CONCLUSION

In summary, this chapter comprehensively outlines the benefits and challenges of stakeholder involvement, the qualitative research design and process and practical issues involved in this phase of the research. Participatory research approaches are well-suited to exploring diversity issues with a range of stakeholders. The method of using a participatory workshop offered a dynamic, collaborative and semi-structured environment to gain relevant information to support curriculum development and evaluation of diversity education.

TABLE 6.1: PARTICIPATORY WORKSHOP - DEVELOPMENT OF SESSION PLAN

Key Questions from Existing Research	Aims of the Research	Activity Questions
-Lack of conceptual clarity in the definition and use of the terms 'diversity', 'culture' and 'cultural competence'	-Clarity of terminology Key stakeholders' understanding of the terms 'diversity', 'culture' and 'cultural competence'	*Question 1:* NHS documents state that each patient's culture should be respected and accounted for in their care. How do you understand the term 'culture'? *Question 2:* NHS documents often state that health services must value diversity. How do you understand the term 'diversity'? *Question 3:* NHS documents state that health professionals should be trained to be 'culturally competent', they should be able to effectively manage the diverse and cultural needs of patients. How do you understand the term 'cultural competence'?
-Limited evidence of key stakeholders' (especially patients) perspectives on their expectations of 'culturally competent' practitioners	-Learning objectives Key stakeholders' expectations of the knowledge, skills and attitudes they expected from 'culturally competent' practitioners	*Question 4:* What is it that patients expect health professionals' skills in providing culturally competent care are able to do?
-Research shows that diversity training is under-developed, under-theorised and fragmented -Diversity trainings are lacking a theoretical underpinning	-Curriculum development and design Patient viewpoints on current diversity NHS training and how this might be improved	*Question 5:* What do you think of the current training material? *Question 6:* What kind of training do you think would actually improve the care health professionals give to patients from culturally diverse backgrounds?
-Uncertainty over how to assess and evaluate diversity training -Unclear whether the effectiveness of diversity training is known or even measured	-Assessment and evaluation Patient perspectives on how NHS diversity training might be effectively evaluated	*Question 7:* How can we measure the effectiveness of diversity training in improving professional practice and patient outcomes? *Question 8:* What should an evaluation tool for diversity training be seeking to measure?

TABLE 6.2: PARTICIPATORY WORKSHOP INFORMATION

Workshop Number	Date	Type of Workshop	Collaboration	Number of Participants
1	12.10.2015	Health Professional	NORTH ENGLAND REGION: Manchester Workshop NHS Employers, NHS England Equality Diversity Council & Health Education England	16
2	05.10.2015	Health Professional	SOUTH ENGLAND REGION: Bristol Workshop NHS Employers, NHS England Equality Diversity Council & Health Education England	8
3	28.09.2015	Health Professional	LONDON REGION: London Workshop NHS Employers, NHS England Equality Diversity Council & Health Education England	12
4	14.09.2015	Health Professional	EAST MIDLANDS REGION: Leicester Workshop NHS Employers, NHS England Equality Diversity Council & Health Education England	8
5	20.11.2015	Patient	MIND in Haringey and MIND in Westminster and Wandsworth	12
6	20.08.2015	Patient	Croydon Black and Minority Ethnic Forum	15
7	05.08.2015	Patient	Nubian Service Users Forum and Islington Well-Being Community	15
8	13.11.2015	Academic	Diversity in Medicine and Health (DIMAH)	8
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TABLE 6.6: METHODS OF DATA COLLECTION

Small group discussions	Larger group discussions	Workshop booklets	Flip charts and creative materials
-Activities were first discussed in small groups to allow participants to become comfortable and familiar with the setting of the participatory workshop and begin to develop relationships with members of their small group -Small groups were designed to create a supportive scaffold in which issues and activities could first be discussed on a more intimate, personal level before the larger group discussions	-Each activity was then discussed as a larger group, where all individual small groups contributed to the debate and discussion -The larger group discussions were designed to allow participants to reflect on each other's perspectives and engage in complementary and argumentative debate and generate new and creative ideas.	-Workshop booklets were created to complement the small and large group discussions, and allow those who preferred writing down their perspectives and comments to do so. -Workshop booklets allowed information to be collected on topics that participants felt uncomfortable or embarrassed to share in their small and larger group discussions, it also permitted more reflective and thoughtful information to be gathered specific to each question. -There was a section for additional comments and perspectives for participants who felt their views were not heard or included in the group discussions	-Flip charts and creative materials were used as an additional material resource to help in outlining group thoughts and perspectives and for those participants who were more inclined to a visual style of learning.

FIGURE 6.1: SUMMARY OF TEMPLATE DEVELOPMENT AND REVISIONS

Initial Template

Activity 1 Conceptual Clarity	Activity 2 Learning Objectives	Activity 3 Curriculum development and design	Activity 4 Assessment and Evaluation
-Understanding of 'culture' -Understanding of 'diversity'	-Expectation of culturally competent practitioners Knowledge Attitudes Skills	-Training improvements Content Design Format Delivery	-Evaluation methods -Aspects to evaluate

Second Template

Understanding of culture and diversity	Relationship-centred care	Patient-centred care	Improvements for diversity training
-Individual -Shared -Complexity	-Developing and maintaining relationships -Practitioner-self relationship • Personal and professional characteristics	-Understanding the nature and dynamics of patient-practitioner relationship -Individualised care -Acknowledges, values and respects patient differences in the patient and the practitioner	-Approach to training -Ensuring sustainability -Evaluation of training • Challenges in evaluation

Third Template

Conceptual Clarity	Relationship-centred care	Curriculum Design	Improvements for diversity training
-Individual -Shared -Complexity	-Developing and maintaining relationships -Practitioner-self relationship -Practitioner – patient relationship	-Centred on relationships -Development of inter-personal skills -Clinical communication -Centred on professional development	-Approach to training -Ensuring sustainability -Evaluation of training • Challenges in evaluation

Final template

Conceptual clarity on key terms	Relationship-centred care	Improvements for diversity training
-Different meanings to different people -Diversity as just another form of labelling -The political strings attached to diversity -Cultural competence aspirational not achievable	-Practitioner-patient relationship • Back to basics • Assuming not asking • Racial concordance as a way of creating better practitioner-patient relationship -Patient-centred and individualised care -Practitioner-self relationship	-Focusing on policies not patients -Interactive and contextualised -Credibility of the trainer and faculty development -Organisational commitment -Evaluation of training

CHAPTER 7: FINDINGS OF PARTICIPATORY WORKSHOPS

7.1. INTRODUCTION AND SUMMARY OF OVER-ARCHING THEMES

This chapter outlines the over-arching themes that emerged from the findings of the participatory workshops with three key stakeholder groups; namely mental-health patients, NHS healthcare professionals (including diversity leads and policy makers) and medical educators. Although the participatory workshops for each stakeholder group were conducted in isolation from each-other, the findings from all three stakeholder groups converged on the same three over-arching themes, which are shown in Table 7.1 below:

TABLE 7.1: OVER-ARCHING THEMES FROM PARTICIPATORY WORKSHOPS WITH THREE KEY STAKEHOLDER GROUPS

Conceptual clarity of key terminology	Relationship-centred care	Improvements for diversity education
-Culture -Diversity -Cultural competence	-Practitioner-self relationship -Practitioner-patient relationship -Practitioner-practitioner relationship -Practitioner-organisation relationship	-Development -Delivery -Assessment and evaluation

The findings will be presented according to the table above, drawing on relevant accounts and pertinent themes from all three stakeholder groups. The key aspects of the findings for all three stakeholder groups are also summarised in Tables 7.2 – 7.5. The first theme 'conceptual clarity of key terminology' describes how participants defined, understood and distinguished between the terms 'culture', 'diversity' and 'cultural competence'. The second theme termed 'relationship- centred care' represents the fundamental over-arching theme of the findings. The findings revealed that diversity education should be focused on the nuances and dynamics of clinical relationships, where the influence of both the patient and the professional are acknowledged and explored. In particular, the relationship considered the most important to examine with respect to diversity education was the 'practitioner-self' relationship. This requires health professionals to explore, unpack and reflect upon the meaning of diversity on an individual level and in relation to colleagues, peers and patients, to facilitate an appreciation and value for diversity in others. The participants' experiences and accounts of diversity education cohered across four relational dimensions:

1.) Practitioner-self relationship, 2.) Practitioner-patient relationship, 3.) Practitioner-practitioner relationship and 4.) Practitioner-organisation relationship. A reconstructed theoretical framework on 'relationship-centred care' was developed, outlining the additional dimension of the 'practitioner-self' relationship, which will be discussed in Chapter 9. The third theme exemplified 'improvements for diversity training', highlighting issues that warrant consideration in the development, delivery and evaluation of training.

7.2. THEME I: CONCEPTUAL CLARITY IN KEY TERMINOLOGY

The conceptual clarity of key terms in diversity education was critically explored in all stakeholder groups in an attempt to present the most broadly accepted views as clearly as possible. The vocabulary used by the different stakeholder groups presented different meanings and focus and provided a wider understanding of these terms in their relevance to the expectations of 'culturally competent' practitioners and how these terms are defined in different theoretical frameworks concerning diversity and cultural competence.

7.2.1 Defining culture

Culture was defined as both unique to an individual and associated with shared similarities and characteristics that are applicable to a group of individuals. Mental-health patients conceptualised culture in a fluid, broad and personal way. They defined culture as a self-constructed, self-subscribed concept that is subject to both individual and societal interpretations. Whilst they acknowledged culture as unique to an individual, a large majority of the mental-health patients largely associated the term with shared similarities and clusters of characteristics that are relevant to a group of individuals, which resonates with how medical educators perceived the term 'culture'. All stakeholder groups continually debated the challenges of matching culture as defined for an individual and culture as defined for a group. Medical educators further compartmentalised culture into *'self-determined culture'* and *'perceived culture of others',* describing the differences between how individuals define their own cultural identity and how others assume a different cultural identity of them.

> *"It's both an individual and a collective term, they don't always map on to each-other. You could be from one cultural background, but not necessarily practice those cultural norms and traits, but others may think you do." (NHS Diversity and Equality Manager).*

All three stakeholder groups highlighted the transparent connection between culture and one's identity. Many of the participants described in their personal experiences how an individual can embody multiple identities, and different aspects of their culture will become more or less salient depending on the context and the clinical relationships they participate in. Specifically, NHS policy makers emphasised that health professionals will have multiple identities, asserting different identities in different circumstances based on what is contextually appropriate for each clinical interaction, whether that be patients, colleagues, peers, or senior managers. Medical educators asserted the same, as expressed by one participant below:

> *"Our understanding of our values and identities guide our own behaviour and interaction with other people. In a specific interaction, which culture becomes relevant is dependent on the interaction. At work I'm a GP, but when my son was ill and taken to A&E I was concerned mother, the GP part of my identity was diluted." (Medical educator).*

All stakeholder groups stressed that identity formation is situated and develops within interactional relationships. Many NHS professionals and medical educators stated that one's professional identity is formulated through a dynamic process whereby individuals classify and identity themselves in relation to others, realising their own place as individuals and members of different professional groups.

> *"How we see ourselves, our different cultures often actually links up with other people around us in our community, how they behave, act, what they value. There will be certain things that will be driven by personal perspectives, but there will be some integral aspects especially in our professional identities that will be linked with other people, our connections with other people and how we relate to others." (Diversity Lead, Health Education England).*

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NHS health professionals were more likely to understand 'culture' in relation to institutional culture, describing how different NHS institutions embody a unique set of values, beliefs and practices that are specific to their context of work, and which act as a significant indicator in how they see themselves as professionals. Many participants described how organisational and institutional practices organically create a professional culture which in turn becomes inherited by health care professionals, where there is less personal choice concerning which aspects of the professional culture they can choose to practise.

> *"That part of your identity as a healthcare professional, which in itself is a culture because it has certain expectations on how you can act, practise and your values. With a patient, you have to act in a certain way, if you're with a NHS manger people will react differently." (NHS Clinical Commissioning Co-ordinator).*

NHS healthcare professionals were largely in agreement that acknowledging the organisational and institutional culture is integral to understanding one's professional identity and the conceptualisation of professionalism at an individual and organisational level.

The medical educators and NHS healthcare professionals frequently engaged in discussing the challenges in the co-existence of one's professional identity as a healthcare professional and one's personal identity and the disharmony that can arise between the two different cultures. Several mental-health patients described personal challenges in assimilating and adapting to different cultural contexts and the different ways individuals experience cultural changes. Similarly, NHS professionals and medical educators described their experiences of different reactions to intercultural relations such as discomfort, personal transformation and different adaptation styles. A few of the participants from different stakeholder groups expressed their opinion that individuals coming from a different cultural background to the British culture should be expected to conform to the values and practices of the British culture, as presented below:

> *"You're coming here, you merge with us, you culturally do what we do. Sometimes given the pressure we are under, we don't want to know what your culture is. I have worked for a long time in the East End estate in Hackney and in the 60s and 70s the different cultural backgrounds caused most of the friction not just with patients, it was more between staff, and it was just that lack of cultural understanding. They wanted different people to behave like the English. Fish and chips on Friday, whatever their culture was, there was a lot of unspoken hurt and disrespect."* (NHS healthcare professional).

These opinions were often challenged by participants with responses such as *"but what is British culture? Do we have the same understanding of what British culture is?"* (Mental-health patient). Other participants expressed the opposing belief asserting that individuals from different cultural backgrounds should be allowed to practise their different cultural traditions and customs, with participants recollecting the tendency for individuals of the same cultural groups to congregate in a specific area, constructing their own cultural norm.

> *"I've noticed the cultures are reproducing themselves, you can go into a place like Whitechapel and you think you're in Bangladesh, there is a security and safety for the Bangladeshi community there, because they can hold on to their identity, maintaining a culture from "back home." I then can walk a short distance and I feel like you're in a culture from another country, where's there's a strong Pakistani community."* (Mental-health patient advisor).

All stakeholder groups were active in their discussions on the fundamental challenge they each experienced to varying degrees on how to respond and adapt to 'difference' in its broadest sense. Participants described that differences in culture were accompanied by differences in values, norms, expectations, preferences and behaviours which created inevitable challenges in how to relate to and interact with patients, professionals and their peers. Participants recounted from their experiences that the introduction of new cultural groups can evoke feelings of threat, resentment and discomfort and create an 'us versus them' posturing; as exemplified in one participant's account:

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"There is a resentment that if you see another culture arising you think that means it's going to have to kill another culture or make it smaller, and sometimes you can either keep fighting for your own culture that you're comfortable with or gradually adjust to a new culture thinking there are better ways or you can just exist with a new culture and resent it. For example, I know many people in London are sad that the Cockney culture has just died out, you hear all different languages other than English nowadays." (NHS Diversity and Inclusion Lead).

Many of the participants from all stakeholder groups were active in questioning the uncritical assumption that one's personal cultural identity can co-exist with one's professional cultural identity, with some participants describing the internal struggles they experienced in integrating these two cultures. Other discussions were significant in revealing the variety of ways one can respond and manage different intercultural relations, suggesting little discussion occurs on how the multiple cultures that exist in healthcare function in synergy with one another. Collectively the findings showed that all stakeholder groups conceptualised culture as a dynamic, multiple, situated and relational concept. Participants largely discussed culture in association to issues that affected groups of individuals, however several participants acknowledged the heterogeneity that can exist amongst individuals within the same cultural group.

7.2.2 Defining diversity

All stakeholder groups generally understood the term diversity as implying 'individuality' in that it intentionally distinguishes 'differences' among people and conceptually appeared synonymous with the meaning and principles of person-centred care, in acknowledging the importance of recognising each patient as a person. The term 'diversity' was more strongly associated with individuality and choice. One mental-health patient expressed "*culture is part of you; diversity is a tool to recognise you.*" Various participants perceived diversity as a way of recognising individual differences despite the multiple cultural groups they were, as 'individuals', perceived to belong to. Several mental-health patients strongly described the sense of empowerment and choice diversity gave them by explicitly recognising their health needs and experiences as different and unique to them despite having the same disease or conditions as others.

> *"That's where diversity comes in. Because you have your own needs.*
> *Diversity makes you have <u>a choice</u>. In diversity, <u>you</u> choose what you*
> *want, you don't choose it for me." (Mental-health patient, BME Forum).*

Achieving conceptual clarity on the terms 'diversity' and 'culture' appeared challenging. Many of the participants conceptualised 'diversity' and 'culture' as inter-linked concepts and inseparable from each other. However, most participants were in agreement that diversity was perceived as a tool for explicitly recognising differences among patients. Diversity mostly focuses on differences among individuals, while culture mostly focuses on differences among groups. Conversely culture was recognised as a concept that could be both individually and group defined, however many participants understood culture as largely concerning shared similarities than differences. As with term culture, diversity was strongly associated with identity, in particular the multiple identities an individual may personify and how different cultural aspects may resonate with different aspects of one's identity, as one mental-health patient expressed:

> *"I am Greek up to a certain point, then I'm <u>me</u>. You can adopt aspects*
> *of other cultures; into your own, how you live your life. It's like pick and*
> *mix." (Mental-health patient, Mind).*

Both NHS health professionals and medical educators found it challenging to distinguish diversity from culture, often concluding that they were same, whereas the mental-health patient groups appeared more able to articulate that diversity is a concept that acknowledges differences within systems of shared cultures and values. Many mental-health patients claimed values, beliefs and practices can be shared in a 'culture' whereas diversity' recognises the heterogeneity within single cultures and identifies characteristics that are autonomous and unique to the individual. A few of the NHS leads made reference to the association of diversity with individual identity and acknowledged the multiple identities one may have, but stated healthcare professionals were unable to portray one's personal cultural identity or struggled with aligning one's professional identity with one's personal cultural identity.

> *"There are certain markers you can identify with as a healthcare professional, but it's how you as an individual experience those markers, how you change and develop and relate to others, how you move through them isn't it? Sometimes I feel like we in healthcare we all have to be the same, act the same, behave the same. They say diversity is celebrated, but it's really just tolerated." (NHS healthcare professional).*

All stakeholder groups expressed a dislike towards how the term diversity was currently being applied in clinical practice. Various participants recounted experiences where diversity was typically applied in a stereotypical fashion in the form of *'lists'* and *'facts'* about different cultures, thereby using diversity as a *'label'* with professionals failing to respond to differences amongst patients in their care. Many of the NHS Diversity trainers collectively described their struggles in attempting to educate professionals on the relevance of diversity to patient-centred care.

> *"They struggle because (pause), they just struggle, conceptually it's very hard, they find it hard for people to, and they always think, 'why are you looking for difference? Why you looking problems? Can't we just treat…?"* (NHS Equality and Diversity Training).

A few of the mental-health patients found it challenging to understand why professionals would ask diversity questions if not clinically relevant as it appeared to be merely an administrative task rather than a mechanism by which to better understand the patient as a person.

> *"It's not negative, but it's a label, they are going to write to you and ask which religion you are? What is your ethnicity? Stuff like that. And they're going to write that, what are they going to do with that though? Why does it have to be on a piece of paper? Why don't they just say 'nice to meet you, tell me about yourself, how can I help?"* (Mental-health patient advisor).

All groups acknowledged that race and ethnicity appeared disproportionally emphasised as individual differences in comparison to other facets that make a patient an individual. Many NHS health professionals suggested the term 'inclusion' over

diversity arguing that it was better suited in eliciting a consideration of all differences that individuals can represent. Equally medical educators described accounts of how students misunderstood the meaning of diversity and diversity education; perceiving it as teaching that promoted the dismantling and disregarding of patients' individual differences. This in turn suggested the adoption of a 'we treat everyone the same' approach that respects differences while failing to respond to or acknowledge them in patient care.

> *"Their understanding is to have a robotic approach to the human being. They say to us 'we treat the disease; the rest of it is irrelevant'. In the evaluation sheets they said "why are you teaching this stuff, this is common sense? We do not judge people." (Medical Educator).*

Many of the participants, including mental-health patients stressed the need to shift away from the 'tick box culture' that has emerged and been reinforced in the NHS healthcare system. Some participants asserted attention to diversity is a necessary condition for patient-centred care whereas others expressed diversity as sufficient condition for patient-centred care. However, when re-evaluating participants' accounts it appeared that diversity was both necessary and sufficient and therefore synonymous with patient-centred care.

> *"There needs to be a balance between not just seeing diversity as a label but looking at all of the patient's needs and how we can best acknowledge and manage their different clinical needs. If we're using this model of 'ticking the boxes' what does that make us? We lose our individuality, we lose our differences, and we lose care." (Medical Educator).*

All stakeholder groups, including mental-health patients suggested greater emphasised of diversity in relation to organisational factors and how different professionals relate to one another on a variety of levels. Several participants also mentioned the absence of conceptual clarity in health policies and institutions guidelines in how they defined and interpreted diversity and culture, with one mental-health patient stating "*they've 'decanted' culture and diversity into so many things; it's very difficult to know where they stand.*" Particularly various mental-health patients claimed there was a deficiency of transparency in the political stances of key terms in relation to diversity and many

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expressed the political strings attached to diversity made the concept detached from individual needs and choices. This may not be a lack of conceptual clarity but the failure to be explicit about the ways in which terms are used and implemented. The lack of institutional transparency on the definitions of diversity and culture was thoroughly discussed in the NHS healthcare professionals and medical educators' groups. Each of the NHS diversity trainers as well as the medical educators demonstrated different interpretations on the meanings of culture and diversity. Although there was some overlap in how these terms were defined, there was no consensus amongst participants.

As discussions and debates matured, many participants reflected on the relationship between diversity and the term 'equality'. Participants reported that terms 'diversity' and 'equality' were often presented in conjunction with each other. Characteristics that were defined as 'diverse' were seen as only those that were covered by the protected characteristics outlined in equality legislation, as further explained below.

> *"I do have a problem though with diversity, now that I'm thinking about it, because it can be so wide and vast, that it can protect everybody and protect nobody. So it's a word that covers everything and nothing, which means that you could be going through something and because it's something that's not seen as important or mundane, it's not dealt with. So the word becomes a word that's a 'catch all', but not dealt with all."* (Mental-health patient).

'Equality' as well as 'diversity' and 'culture' are terms consistently acknowledged in healthcare policy, with on-going debates as to how to better articulate these concepts. The discussions in the different stakeholder groups reflected these debates. Most participants in the three stakeholder groups asserted that the terms equality and diversity stem from two opposing platforms, the former originating from a legal standpoint and the latter stemming from a clinical and educational need, with many participants describing uncertainty about how to bridge these two platforms in a way that was legally comprehensive, clinically relevant and contextually appropriate. This was especially apparent in comparing the NHS healthcare professional group with the medical educators.

Overall the findings suggested 'diversity' was equated with the notion of 'individuality' and working from an approach that values diversity requires an active intention to understand the patient as an individual as well as understanding how you as an individual comprehend the term diversity. This aids in operationalizing a broad and complex term into specific and explicit ways on how individuals use and implement the term diversity.

7.2.3 Defining cultural competence

'Cultural competence' was a well-recognised term for most participants, and arguably the most challenging term to conceptualise. The terms culture, diversity and cultural competence are value laden concepts, likely to have different meanings and interpretations among individuals and be influenced by personal opinions and values. Initial discussions on defining cultural competence reflected a conceptual struggle on how best to operationalize this term in ways that are observable and measurable. Despite familiarity with the term cultural competence, many of them admitted to not considering what the term meant to them in relation to their role and also their expectations of what healthcare professionals who were deemed to be 'culturally competent' were able to do. For example:

> *"We couldn't define culture, how can we possibly define cultural competence? We've got experts here and not one of us could come up with a one sentence definition of culture, we may have been able to do lots of list of what culture is but can we agree on one definition? Do NHS health bodies know what this means? They don't know either! They've used the term, which has no relation to training. This hasn't been written with training in mind, it's been written with a political view of saying, 'look we're saying everybody needs to be culturally competent'. We're not giving you any guidelines about what that means, how that can be achieved, this is meaningless to most professionals." (NHS Diversity and Equality Lead).*

Medical educators in particular continually debated this concept. Dialogues initially began by trying to disaggregate cultural competence into a set of knowledge, attitudes and skills, but as discussions matured consensus was reached that cultural competence cannot be reduced to a fix set of knowledge, attitudes and skills. Rather it

should reside on a changing continuum of desirable attitudes and skills, which are conducive to professional self-development and interpersonal skills. Equally mental-health patients first began discussing cultural competence as the acquisition of knowledge of certain cultural groups, however found it perplexing to establish which cultural groups were most pertinent to learn about, concluding that cultural competence on the basis of knowledge of all cultural groups was impossible to achieve. Likewise, many NHS health professionals argued the notion of 'cultural competence' was an aspirational not achievable aim, in that it could not be defined in ways that were measurable and useful. In addition, as expressed in relation to diversity and culture, many NHS professionals stated political stances and the organisation's understanding on cultural competence lacked transparency and clinical meaning.

> *"A culturally competent environment is an aspiration. It's an aspiration and I don't think it's understood because it comes with a-lot of political small peep [referring to talking] baggage." (NHS Equality and Diversity Lead)*

A few of the medical educators concluded that competencies were perhaps *"limiting and basic"* with one individual questioning the usefulness of the term stating *"if competence is the lowest common denominator, the lowest level that you can achieve and just get by, shouldn't we be aiming for better than that?"* In addition, defining which competencies were considered at a basic level and by whom was another popular topic of discussion. There were many instances were cultural competence was strongly associated with traits that were measurable. Determining who was best and most appropriately suited in identifying when certain competences have been reached varied among participants, as exemplified below:

> *"We looked at that in terms of does cultural competence imply a fixed point that can be measured? If that's the case what is that point, how do you decide when that point has been reached and who decides when that point has been reached? We wondered whether that was the patient, whether that was the educator, or whether that was the professional." (Medical educator).*

Due to the definitional ambiguities, defining 'cultural competence' in ways that were measurable and useful appeared to some as an *"impossible task*.". When all

stakeholder groups were attempting to establish patients' expectation of 'culturally competent practitioners', their discussions cohered on the expectation that professionals would be proficient in the skills, values and attributes that underpin a good therapeutic *relationship* i.e. communication, trust, empathy and respect; which one can argue to be the very basics of healthcare competencies.

> *"They should be culturally competent to know what you need, what I need, and what somebody else's needs, understand and respond to differences. I'd just want to be treated like a human being with someone who cares for me, it's the relationship we want." (Mental-health patient).*

All participants' principal expectation was that professionals would have a reflective and comprehensive understanding of themselves, referred to in the findings as the '*practitioner-self relationship*.' Collectively participants from all stakeholder groups actively encouraged healthcare professionals' to first understand their own cultural identity before attempting to better understand how diversity and culture affects the patient's experience and understanding of health and illness. The complexity of culture and diversity can only be understood and appreciated in others when it has been first acknowledged in one's self. Seeing their own culture as more than just race and ethnicity was an essential step in enabling professionals to see patients as individuals.

> *"They would expect their doctor to be <u>self-aware</u> enough to realise when the interaction in the consultation is going wrong because of the differences between them and their patient. Professionals would have to be self-aware to have that realisation that you need to clarify, probe, explore something further when you realised you've made an assumption. Cultural competence is self-awareness. <u>You have to be aware of your own self</u>, <u>before you can respect other people's multiplicity</u>." (Medical educator).*

Self-awareness and introspection enabled professionals to understand the cultural differences that exist between them and others, further encouraging professionals to actively recognise and respond to different patient needs. These realities must be considered, experienced, developed and owned. Collectively participants agreed

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cultural competence cannot be pursued as a sole outcome nor achieved as a result of a single training event.

> *"When the board says they want all the staff to have cultural competency training, I think they think, that's ticked and now they know. Sometimes the staff come in, yesterday we learned how to do a stitching, and today we're going to learn cultural awareness. This is personal, development, it takes time." (NHS Equality and Diversity Lead).*

Medical educators and NHS healthcare professionals demonstrated the confusion between different terms associated with cultural competence. Distinguishing between the different terms such as cultural sensitivity, cultural humility and cultural sensibility, proved challenging for the participants resulting in them being used interchangeably with each-other. A few of the medical educators stated that despite the number of different labels they shared a common single intention in advocating patient-centred, individualised care.

> *"I very much <u>conflate</u> cultural awareness, cultural humility, sensibility and diversity, in the same way. I agree with others that cultural competence is too narrow a description, but I think what they we're trying to do was the same thing as what we're trying to do with diversity education, just encourage more individualised care." (Medical educator).*

Several of the medical educators as well as the NHS health professionals claimed cultural competence was equivalent to the term cultural humility. 'Respectful curiosity', a term coined in the cultural humility model, was deemed an essential attribute of being culturally competent. This in addition to self-awareness describes the need for professionals to be curious and interested in their patients in order to establish their individuality. An example given by one of the NHS healthcare professionals is similar *"another term for cultural competence is 'cultural humility which is not to try and know anything about anybody, but to assume you don't know and to be curious about the other person."* The preference for the term 'cultural humility' was frequently noted in the NHS healthcare professionals' groups. The mental-health patient groups also used the concept, though they did not formally define it as 'cultural humility', but rather they

described the approaches to practice in the cultural humility model notably *"self-humility"*, *"curiosity to learn about others"*, and regularly admitting when *"you don't know*."

Participants from the medical educators and health professional groups frequently reflected upon the misinterpretations and confusion their trainees and students often held about the notion of 'cultural competence', with many asserting that cultural competence or diversity education is about being *"blind to differences"* and treating everyone the same. Several mental-health patients expressed their concerns regarding the application of cultural competence in practice, claiming it is often incorrectly understood and healthcare professionals are unclear how to operationalise the term in clinical practice, as reported below:

> *"Because cultural competence is so broad and you could actually have preconceived ideas of the culture, when they go into the environment though and find out what this culture actually is, they could be totally different. So it's really how do you kind of tailor make it to that particular person? It's not just a broad kind of umbrella in practice, we need to define the attitudes and skills to becoming culturally competent."* (Mental-health patient).

Collectively all stakeholder groups highlighted the disproportionate emphasis towards race and ethnicity in relation to the term cultural competence. Overall the findings from all three stakeholder groups indicated that cultural competence is equated with the attitudes and skills that underpin a therapeutic relationship. In particular, the most significant relationship and the pre-requisite to becoming culturally competent is the 'practitioner-self' relationship, which echoes the importance of self-awareness, introspection and reflection on one's own culture and diversity. The findings exemplified the continual conceptual struggles in defining cultural competence in measurable ways and the lack of political transparency on how these terms are defined in healthcare policy. The findings also highlighted the blurred distinctions between different terms associated with cultural competence, although the large majority of participants appeared to favour the notion of 'cultural humility'.

7.3   THEME II: RELATIONSHIP-CENTRED CARE

The second overarching theme demonstrates with the importance of actively considering the dynamics and nuances of clinical relationships to foster a better understanding and respond to diversity issues. Collectively all stakeholder groups concluded that culture and diversity issues are situated in clinical relationships and come into play during interactions with one another. The findings from each stakeholder group collectively defined four dimensions of clinical relationships that are deemed essential to consider in relation to teaching and actualising the principles of diversity education.

Learning objectives developed by each stakeholder group could be categorised as either outcomes of professional self-development or inter-personal skills, which are summarised in Table 7.3. Both these outcomes fall within one or more of the following four relationship dimensions, namely practitioner-self, practitioner-patient, practitioner-practitioner and practitioner-organisation. These relationships, which will be described below, are built upon a large body of knowledge from existing literature relating to diversity education and the relationship-centred care model (Tresolini & Pew Fetzer Task Force, 1994). A new reconstructed theoretical framework on relationship-centred care was developed which will be discussed at length in Chapter 9. This reconstructed model can be used to theoretically inform the development, delivery and evaluation of diversity education in an array of healthcare settings and educational institutions.

Relationships provide the context for many exchanges and activities in healthcare. Within relationships professionals are able to engage and understand others, exchange information, arrive at concrete clinical decisions and provide care. None of these occur with solely one party, as clinical practice occurs in a shared environment. All of these activities are mediated by the quality of the manifold relationships with patients, professionals and the wider organisation. Collectively the findings illustrated that diversity education should be focused not just on clinical interactions but more specifically *relationships*. Many participants from the different stakeholder groups clearly differentiate between the notion of an interaction and a relationship. Several participants described an interaction as a situation or an occurrence in which two or more objects, events or individuals act upon one another to produce a new effect. Conversely the term relationship describes the way in which these two subjects interact and *affect* one another. All stakeholder groups emphasised that relationships are

associated with interpersonal interactions where there is a close and direct connection between people that embodies healthcare principles and values.

Relationships in healthcare were unanimously expressed as forming the core of practitioners' and patients' experiences and were suggested as the foundation of diversity education. Collectively as mentioned the findings demonstrated that issues come into play when two individuals or more are in relationship or interacting with one another, as shown in the example below:

> *"So there's something about the <u>relationship between the two people</u> isn't there? The person who's there and the person who's making that assessment and what background and what information they have to bring to the table if you like. In the relationship people will negotiate what kind of a culture becomes, or cultures become relevant in that <u>specific interaction</u>, and they may generate a certain, a new culture just because of that specific interaction that's relevant to both of them. It's the human connection that makes a difference." (NHS Head of Clinical Commissioning Group).*

7.3.1   Practitioner-self relationship

All of the stakeholder groups were in agreement that diversity education should be centred on the exploration of the practitioner-self relationship, which was consider the most important relationship in regards to diversity education. This describes the necessity for health professionals to explore, unpack and reflect upon the meaning of diversity on an individual level and in relation to colleagues, peers and patients, and to develop the capacity for self-reflection, critique and evaluation of their identity (identities).

> *"I think the professional who is so called 'culturally competent' is one who can look at themselves, and say this is where I am. And once you know where you are. Then and <u>only then</u> can you actually understand others and have good relationships with them." (Mental-health patient).*

Collectively the findings described the need for professionals to develop a continual practice of self-reflection, critique and evaluation to help them to understand their

professional self. As a mental-health patient stated *"you have re-educate yourself about yourself before educating others about themselves.*" Many participants drew attention to the multiple identities an individual can possess based on different parts of their cultural identity, further explaining that these identities reside in the different relationships professionals participate in with themselves, their patients, colleagues and the wider healthcare organisation. Different parts of one's identity can become more or less pertinent given the context and with whom one interacts. An example is shown below where one of the medical educators describes how the professional part of their identity becomes diluted when they are in the context of caring for their child. In this context their identity as a mother becomes more concentrated:

> *"We might both be women and that might be an important part of our individual cultures, our interpretation of what that means to us and our personal life will be different, the influence in any one particular situation will be different as well, so I'll often say to students, you know 'I'm a doctor' but when I go with my child to the GP 'I'm a mother.' And actually my identity is much more defined by <u>that</u> facet of myself than the doctor facet of myself. So the different identities are more or less important depending on the situation and it sort of, it feeds into <u>really treating everyone as an individual</u>." (Medical educator).*

In connection with acknowledging the multiple identities one can embody, many of the participants described the differences between how they perceived their own culture (termed self-determined culture) and how others might perceive their culture (describe as, culture as perceived by others) and the recursive relationship between the identity of an individual and the identity of different cultural groups they might belong to. Several participants discussed how a person's assumptions, biases and pre-conceived ideas about an individual's cultural belonging can hinder the understanding of a person's true individuality and create a distance from the other. Questioning and challenging one's assumptions and biases may minimise and potentially dissipate this perceived distance and therefore should be encouraged in diversity education.

"It's about how you identify yourself and about how other people identify you from what they <u>know</u> of you, which might be quite limited in the case of contact with the NHS services. It's about the short cuts that people use to interact and relate with you, because we all do make assumptions, biases and short cuts don't we. But do we challenge them?" (Medical educator).

However, many participants reflected upon how challenging and uncomfortable exploring the practitioner-self relationship can be, especially in relation to diversity issues, as it forces practitioners beyond their comfort zones. NHS healthcare professionals from a variety of backgrounds recounted a number of experiences where they struggled to initiate discussions on exploration one's self, with some trainers reporting that trainees would "*walk out of the sessions, they hated it, they saw it as pointless.*"

"And I think what gets into the way of that is that there are people that are not able to honestly look at themselves and that process might be <u>very painful</u>. A lot of people don't know who they are. And they won't accept that they have biases towards one or the other." (NHS Diversity Trainer).

Understanding oneself is the essential step in identifying and overcoming assumptions and biases, but it requires a willingness from the trainees and students to be comfortable with and open to exploring personal prejudices and stereotypes. All stakeholder groups acknowledged this is challenging. A few participants alluded to the type of learning environment that needed to be created to facilitate meaningful dialogues on diversity issues as summarised in Table 7.4. NHS healthcare professionals and medical educators in particular emphasised the necessity of creating a safe, trusting, exploratory and respectful learning environment.

"Diversity education is primarily about self-awareness of our own cultural lenses, our own culture, being aware of how important culture is in the way that we think, live, do everything, like what you said our personalities, and our thinking and then being able to realise when we make assumptions that are based on ideas of bias and stereotypes and prejudices, so diversity education starts with an understanding of one's own culture. It's being able to look outside, back into your-self. To challenge one's comfort zone but it has to be in a supportive and safe environment, otherwise it will never work." (NHS Diversity and Equality Policy Lead).

Another pre-requisite that was highlighted as necessary to constructively facilitate the exploration of the practitioner-self relationship was the need for educators to have an awareness of their own perspectives and sense of self in the context of different clinical relationships and roles. Many participants within the NHS health professionals' groups reported negative experiences of feeling under prepared and ill equipped to facilitate the kind of challenging and sensitive discussions that are inevitable in diversity education. Faculty development and the impetus on developing effective facilitation skills among educators was stressed in all stakeholder groups.

"I get really challenging conversations and I didn't have the background, I ended up in a mess, in a real mess with it. If you're a non-clinician, answering a clinical question, the principles might be the same but it's easy to make a mistake, and then you feel a bit of an idiot, and then you're not following through, because you just think, 'I am not getting this right." (Diversity and Equality Lead).

NHS health professionals, especially those that were trainers, were extremely keen for more institutional guidelines and examples of best practice for developing and delivering diversity trainings. Health professionals and medical educators alike identified the lack of consistency and standardisation of diversity education in the NHS and medicine, and the need for an evidence based overarching framework that can guide the development of diversity curriculum materials and integrate diversity throughout healthcare curriculum. All stakeholders agreed that without the adequate development and exploration of the practitioner-self relationship in educators and

professionals, the subsequent development of the other specified relationships will be challenging to achieve.

7.3.2 Practitioner-patient relationship

The relationship between the practitioner and the patient takes place within a transpersonal, co-learning human experience, and thereby acts as the medium through which patients' basic needs for connection and meaning are met. All stakeholder groups recognised the patient and the doctor as cultural beings, who bring their own unique background and cultural identity to clinical encounters, which influence the nature and meaning of their clinical relationships with each other.

> *"You want to feel like you have a personal relationship with the doctor. I think when you have been trained hopefully you've raised awareness and have a better understanding of how to care and support that patient. It's the relationship, the rapport, that's what we want." (Mental-health patient).*

In particular, many mental-health patients claimed cultural differences and diversity issues can hinder the formation of a therapeutic practitioner-patient relationship, resulting in both the patient and the professional feeling frustrated, not understood and dissatisfied. The relationship between the practitioner and the patient was seen as the vehicle for bridging cultural differences between parties and a platform from which learning from and with each other took place, as stated below.

> *"To make the training more like what happens in practice for both sides. There are two of us, and we depend on each-other, health professionals and patients. Understanding how to form relationships with different people? How co-effect and co-learning takes place between the health professional and patient? Cultural competence or diversity is not one-sided. It's not that, you learn or them learn, it's a two-way street." (Mental-health patient).*

However, many mental-health patients gave examples the NHS healthcare system being an incompatible environment towards the notion of relationship-centred care. The

lack of time, increasing pressures and modernisation have detracted from the patient-doctor relationship and diversity is perhaps viewed as "*additional, unwanted problems.*"

> *"You go and see the doctor, some doctors 'oh what's wrong with you?'*
> *'I've got the flu.' They just write something down straight away, they*
> *won't even look at you, they'll just write something down and done.*
> *Having a <u>relationship</u> with me, getting to <u>know</u> me, <u>asking</u> why I've*
> *been having so many flues? Not even considered." (Mental-health*
> *patient).*

The large majority of participants stated bridging cultural differences, developing connection, meaning and mutual understanding was applicable to both the patient and the healthcare professionals. However, for some health professionals these factors appeared to be a secondary concern compared to dealing with a patient's medical or disease related issues. As one mental-health patients expresses "*because if they don't understand diversity, it's difficult, because there is no push for developing a relationship.*"

> *"We want to develop good relationships with our patients, many of us*
> *I'm sure would agree with me that it leads to better health outcomes*
> *and patient satisfaction and satisfaction for me as the practitioner. The*
> *problem…we've built a healthcare system that doesn't allow us to form*
> *good relationships, spend time with our patients, tailor care to their*
> *needs. We've built a healthcare system, where they come in, we try*
> *and fix them as quickly as possible and then they're out and we try and*
> *fix the next patient." (NHS healthcare professional).*

When all stakeholder groups were devising learning objectives they cohered on valuing and developing skills of working in partnership, shared-decision making, holistic care, communication skills, empathy and attributes that again underpin a therapeutic relationship and closely resonate with the principles of patient-centred care. Several mental-health patients stated terms such as 'cultural competence' and 'cultural expertise' detracted from the basic interpersonal skills needed to effectively respond to diversity issues.

"They are writing all these things about what doctors should be trained in, but we <u>can't even get the simplest of things from them</u>, because of lack of this, cultural competence." (Mental-health patient).

Communication was increasingly reported as an integral aspect of diversity education and the practitioner-patient relationship by all stakeholder groups. Effective communication skills were repeatedly stressed as an essential tool to bridging cultural differences, understanding one another, facilitating respectful curiosity and developing and maintaining a caring and compassionate relationship with patients. A lack of good communication skills was often noted as further exacerbating diversity issues as differences were not recognised, understood or allowed for. Arguably, good communication skills need to underpin by an understanding of diversity.

"I was an in-patient and I think before they teach the staff to be culturally competent in talking to patients, they have to be competent in actually <u>talking</u> to patients. Because when I was in there, half of the staff never spoke to me, they just walked by me, they wouldn't communicate, they just walked up and down the room, and we just sat and watched the television." (Mental-health patient).

All stakeholder groups reported that health professionals were more inclined to make assumptions about patients' diversity issues as opposed to asking them. The reasons for this varied according to their individual experiences but ranged from fear of offence, the notion that professionals should already know about their patient's diversity needs and a superficial understanding of the complexity of cultural and diversity issues, for example:

"What's your culture? Ask me that now, and 'I don't know', you know 'I'm normal, I'm like' you know. So you need a <u>long</u> time to have that conversation, which is something that the front line staff don't have. And getting the information on the characteristics, this is a real challenge for people on the reception desks. 'I don't want to', I was shocked when I went to some, I can understand you not wanting to ask if a person's transgender or what their sexual orientation is, but the thing they were worried about most was religion, which to me, well that's my culture, my background, I've got no problem telling them what my religion is and I've got no problem asking you what yours is. That sort of shocked me actually." (NHS Diversity Policy Lead).

Many mental-health patients described experiences of how a professional's unquestioned assumptions governed their relationship with them and the care they provided. Many of the mental-health patients asserted that professionals making assumptions was a clear sign of 'cultural incompetence' and often found it bizarre how professionals could make assumptions about such personal aspects of their identity and background without asking. Interestingly, many of the mental-health patients often failed to reflect on how they would make assumptions about their providers and other patients.

Racial or ethnic concordance between the practitioner and patient was discussed in all stakeholder groups as a way of cultivating a better practitioner-patient relationship. A few participants expressed a strong preference for having racial concordance between the practitioner and patients to create a better relationship. A greater perceived cultural distance between the patient and the practitioner may exist if both parties were from different ethnic backgrounds. Racial or ethnic in concordance may affect the therapeutic relations and lead to the practitioner being unable to meet the diversity needs of the patient. For example, a NHS healthcare professional stated

"Well there's no point in talking about 'cultural competence', we can sit here forever, but when you look at the type of people they're employing in the mental-health system in the NHS, all the therapists are young...female....White...middle-class. You can give them this training for hours, they're not going understand." (NHS healthcare professional).

These findings exemplify that patients also bring assumptions and pre-conceived ideas into the clinical relationship as well as the practitioner. A few of the mental-health patients considered racial differences were a source of cultural differences. Yet they failed to consider that cultural differences can stem even amongst patients and professionals of the same race; which was mentioned by a few of the participants in response to these comments.

> *"Participant 1: No disrespect, who do you think you're going to see first? You're going to see an <u>Asian</u> doctor straight away. And you're expecting them to be culturally competent? It's not going to work is it? So what we're supposed to speak, know and learn about their language in a British country. We need to close the gap and see more West Indian doctors. (Mental-health patient).*
>
> *Participant 2: I've seen West Indian doctors and as a West Indian I don't think they understand me any better. The only way to understand me better is to ask me" (Mental-health patient).*

Seeing diversity issues as held in the context of a relationship was seen as a positive outcome as it draws attention to the reciprocal influence patients and professionals have on each-other and acknowledges both the practitioner and the patient, instead of one or the other. Many of the participants emphasised exploring the nuances and dynamics of clinical relations using experiential techniques such as role play and drama in a safe and supportive learning environment.

Overall the findings from all three stakeholder groups illustrated the necessity of individualise care where diversity issues were actively recognised and denoted the significance of equipping professionals with effective interpersonal skills to bridge any perceived cultural distance that may arise between a professional and a patient. In particular, many mental-health patients stated that allowing for their diversity made them feel cared for and happier with their care, as explained below.

"When the diversity of a person becomes the centre of the care, for me it's kind of a way of saying, <u>we exist</u>, you see <u>me</u> as me not as a patient. Even when we've been sectioned in hospital and given treatment and had our rights taken away, you remember to care for me." (Mental-health patient).

7.3.3   Practitioner-practitioner relationship

Developing and understanding a professional's sense of self is often influenced by other professionals and peers. Many participants from the NHS health professionals' and medical educators' groups described how observations of others and exposure to different clinical relationships assisted in the development one's professional identity and sense of self. Many participants, even mental-health patients highlighted the importance professional relationships amongst colleagues (termed the 'practitioner-practitioner' relationship) in supporting one another in understanding shared notions on professionalism and professional identity and encouraging each other to value diversity. As one medical educator stated:

"I think the other thing that diversity doesn't really cover is your colleagues', your peers' cultures as well as your patients. A lot of the things that happen in medicine are because of difficulties between professionals rather than just between patients and professionals, we need to be exploring that relationship too, some of my colleagues think diversity is just a waste of time." (Medical educator).

There were several discussions on the relationship between the professional culture and one's individual culture and how shared values and behaviours can develop that may or may not be supportive of both. NHS healthcare professionals and medical educators frequently described the challenges that occurred when their professional values were in conflict with their personal values. They often mentioned how their colleagues' reactions and responses to diversity issues played a role in how they reacted to diversity issues themselves. Examples are shown below:

> *"In the Francis report it was the professional culture that was the problem. The culture that is set up within a working profession rather than individual culture. But how much can we separate these two, a lot of the times the professional culture contaminates our individual culture, whereas the patients are only bringing in their individual culture."* (NHS Diversity and Inclusion Policy Lead)

> *"Professionals are living within two separate cultures, the workplace culture and yours and you're supposed to have respect for both those cultures at the same time, well which way do you go? What choice do you make?"* (Medical educator).

Again, the transparency in how institutional bodies define culture and diversity arose. Many of the participants claimed organisational understandings of these terms differed amongst professionals creating frustration and ambiguity amongst colleagues. As one participant says:

> *"NHS documents they interpret it differently, different people will have different views, just like us. So, we need to really look at the document, the authors of the document, what was their understanding of culture and diversity. Documents like this need some word to encapsulate everything, but why are they using these words? What do they actually want? I get mixed messages from my senior colleagues all the time."* (NHS healthcare professional).

Other issues that arose in the practitioner-practitioner dimension particularly from the mental-health patient groups was the necessity of staff support, self-care and team working. Mental-health patients greatly emphasised the importance of staff caring for themselves and their colleagues and for good relationships to begin amongst practitioners which subsequently fosters good relationships with patients. Many participants described the healthcare system as *"hostile", "unsupportive"* and *"deficient in care and compassion for everyone"*. Increasing pressure and time constraints resulted in professionals were deemed contributing factors to perceiving diversity issues as low on the agenda. Many participants stressed the importance of developing communities of care in healthcare systems and being aware of support systems and coping mechanisms.

"The way <u>colleagues treat each other</u> can impinge on the treatment that a patient is getting, if you're not agreeing with your colleagues or being asked to do something that you're not happy with or you're being told to do it in a way that is offensive, could have a knock effect on the way you treat patients, so those <u>interactions</u> are important for the professional in developing themselves too." (Mental-health patient).

Staff not feeling cared for or valued was noted as a potential reason why relationships were not seen as central in healthcare practice. Mental-health patients also raised concerns that the relationships between colleagues affects patient care and how diversity is responded to. Collectively the findings demonstrated the need for strong leadership and collective involvement towards addressing diversity issues. For example:

"Sometime I feel I'm fighting a lost battle with diversity, I can understand to be honest why staff don't' want to hear about diversity and equal opportunities, they have so much going on. Diversity responsibilities is just an add-on for many of us, most of my colleagues think this is an easy job, not much too it" (NHS diversity trainer).

7.3.4   Practitioner-organisation relationship

Many participants commented on the prominence of the organisational culture in shaping one's professional identity and professional relationships. Several participants particularly from the NHS health professional groups emphasised the collective resistance towards diversity issues, with a large number of participants from different NHS health professional groups stating a recurring theme describing the situation as a *"culture of compliance not commitment to diversity"*. This describes how participants considered diversity issues as something to be legally complied with rather than actively committed towards. Several participants from the NHS health professional groups described negative attitudes towards addressing diversity, for example:

"They <u>struggle</u> because (pause), they just struggle, conceptually it's very hard, they find it hard for people to, and they always think, '<u>why are you looking for difference? Why you looking problems? Can't we just treat…?</u>" (NHS Diversity and Inclusion Lead).

Recurring and negative experiences towards diversity education and training were reported by several of the NHS trainers, these ranged from perceiving diversity as clinically irrelevant, too sensitive to discuss, enforcing politically correctness and an uncertainty on how to approach diversity issues effectively. With some participants suggesting the organisational culture may be attributable to these negative perceptions. NHS trainers collectively strongly suggested the necessity to focus on differences other than race and ethnicity as it conveyed a persistent message that diversity was merely a 'race issue'. Organisational policies recently introduced tended to focus on issues of race, discrediting other differences that are equally important, as exemplified below:

> *"I think we need to embrace that it's not just an Indian thing, it's not just an African thing, and it's not just a Chinese thing. And I think one thing culture shouldn't do is link it to a defined race, but the organisation continues to. It shouldn't be a uniform, culture. I thought we might be going forward with the Equality Act, but in this field it's like you go one step forward and then three back and then one step forward and two back. There's no real collective commitment." (NHS Diversity and Equality Lead).*

In comparing the NHS health professional groups with the mental-health patient groups both stakeholders suggested the organisational culture needs reconstructing into a supportive culture where diversity issues are consistently and openly discussed, allowing health professionals time to self-reflect on one's practice and teams to self-reflective on their intercultural relations with each other and with patients. Whilst many participants suggested better leadership in diversity education, most participants stated diversity should be an issue applicable to all professionals, as shown below:

> *"We see diversity every day, not just with patients but with staff, it's all around us, its affect how we relate to each-other, you can have diversity leadership and champions but we need everyone involved in this, this is everyone's duty, not just the interested." (NHS Diversity Assistant Manager)*

Several participants from all stakeholder groups strongly emphasised the need to foster an organisational culture where developing and maintaining supportive and safe

relationships were possible. Several NHS health professionals described that diversity issues and complaints received were often associated with challenges in team working, where diversity issues would exacerbate team dynamics and challenge perceived norms within a team. They also consistently reported patient complaints applicable to the practitioner-patient relations were due to communication issues leading to misinterpretations and misunderstandings from both parties. Many of mental-health patients particularly emphasised the importance of creating an organisational culture that values inter-professional working and communication, particularly in regards to intercultural relations. Several participants emphasised the need to bring back basic principles of healthcare for patients and staff such as care, compassion and support, as shown below:

> *"We use to have an organisational culture where you felt the care not just for patients but between staff, now even I can see staff are over-worked, competing with one another, feeling threatened by one another, relationships are the vehicles for care, compassion and understanding to take place, the organisation stop fuelling it a long time ago. I'm pretty sure if we got those things right, diversity would come naturally." (Mental-health patient)*

Many of the medical educators described the necessity for change in the organisational culture of medical education with many suggesting a shift from *"assessment driven to excellence driven"* with an equal emphasis on clinical excellence, professional development and team working. Overall the findings suggested a change in the organisational culture was necessity to support and implement the diversity agenda in healthcare.

7.4 THEME III: IMPROVEMENTS FOR DIVERSITY EDUCATION

All stakeholder groups were active in making many suggestions for improvement in diversity training, specifically in terms of the development of training, how it is to be delivered and evaluated. These will be discussed below.

7.4.1 Development of diversity education

When reviewing examples of current NHS diversity training and discussing it in their groups, all stakeholder groups unanimously agreed that the patient aspect of the

training was absent. Diversity training particularly within the NHS had a tendency to focus on polices, legislation and discrimination but not patient care, with many participants suggesting diversity education was more susceptible to political motives than clinical education.

> *"I mean <u>all</u> of this is about discrimination, equality act, why isn't there anything on patient care? The patient part is missing and that's the <u>whole point</u>. There is nothing here about how to treat patients." (NHS healthcare professional).*

When exploring ideas about how to improve diversity education, involving patients in the development and delivery of the training was suggested as useful because relationship building skills could be further developed and enhanced. As one participant describes

> *"You need both the patient and the professional to be included in the training, for them to <u>learn from each-other</u>. You always learn from your patient because they are the centre of that care. We are the centre so everything has to be according to what we say, <u>because we know ourselves best</u>. They might be learning about theory, but when it comes to practice that's a different world, that's our world." (Mental-health patient).*

Involving patients would help professionals to reflect upon their relationships with patients and enable professionals and patients to reflect upon different intercultural relations and how to appropriately respond and recognise cultural differences. Some of the mental-health patients said "*you can learn much more from the patient than what you can from yourself, there are two sides of the coin, the professional and the patient.*" Involving patients may assist professionals in reflecting upon the practitioner-patient relationship and how they are different or similar to their patients. Several participants suggested the use of experiential techniques such as role play, guided reflection and interactive videos of consultations in developing effective diversity education. This would in turn change the learning environment of diversity training in placing relationship building and individual care at the centre.

Change in the learning approach was one of the biggest topics of discussion amongst the participants. Many participants, particularly the medical education group conveyed how diversity education was often perceived as an anomaly in the context of the medical model of care that is favoured in medical and health education. The medical model separates the physical and disease conditions from human experiences, relationships and socio-environmental conditions that may be viewed as secondary determinants and causes of disease. Many participants suggested the greater attention should be paid towards a holistic model of care, recognising that effective healthcare is based on patient-centred, team based and inter professional working. Several medical educators' described experiences of students or trainees misinterpreting diversity and cultural competence because the terms were situated in the context of the medical model. As described by one participant:

> *"Their understanding of cultural competence is to have a robotic approach to the human being. They say to us 'we treat the disease; the rest of it is irrelevant.'"* (Medical educator).

Many of the medical educators expressed that many of the students and trainees understood being culturally competent as adopting a 'colour blind' approach, whereby cultural differences and cultural groups are dismantled and disregarded, resulting in a failure to acknowledge one's self and patients, as *"culturally situated human beings that will have culturally based reactions and different perspectives and ways of doing and relating to things. (Medical educator)."* This notion is antagonistic to the patient-centred, individual approach that diversity education is about. It places a higher emphasis on disease and science rather than the patient. As one participant describes:

> *"This is even more of a problem because then that suggests there're not being patient-centred. Because then actually the bigger problem is that they see themselves as just 'medical experts' to just be dispensing of stuff, rather than people working in partnership with their patient. That's a dangerous game in terms of clinical outcomes; it's going to be detrimental if you're not taking the whole picture into account."* (Manager, Health Education England).

All stakeholder groups perceived culturally competent care as closely associated with a critical awareness of self and providing individual care, thereby actively recognising the

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entirety of the patient to fully understand their health needs. Understanding how the professional influences the relationship with their patient and vice versa is essential in understanding how diversity and culture affect both the professional and patient. In relationships, each is an observer of the other, each interprets and constructs a subjective world and these worlds are modified by the dialogue between them and the nature of their relationship. As one participant clearly expresses:

> *"So, I think it's largely because medical curriculums still suppose that in-order to be a doctor what your primary goal is to have <u>knowledge and skills</u>. And it frames people's understanding of what it means to be a doctor or what health is in terms of being a medical expert, whereas in a, at least in the UK context, where you've got chronic disease rather than acute disease, actually what works is having a partnership with the patient and understanding their individual needs, and <u>basically the curriculum doesn't value that partnership</u>. So, the basic core of medical training and more so diversity training should really be around <u>relationships</u> but it isn't, relationships are tacked on the edges."* (Medical educator).

Developing a shared understanding of meaning, exploring patient perspectives, acknowledging and responding to differences in the patient's preferences and expectations as well as the professionals occurs in the context of clinical relationships. Many of the participants discussed the strain students and professionals feel in adopting either a patient-centred or doctor-centred approach and suggested a relationship-centred approach was better suited in achieving the best for both the patient and the professional and is conducive to exploring dynamics and nuances of diversity issues in clinical encounters. Another topic that was frequently raised was the differences in value systems, describing how differences in culture and diversity often originated from a difference in values, with some participants suggesting to incorporating values in the development of diversity education.

7.4.2   Delivery of diversity education

Many participants were keen to shift the negative perception of diversity education from a sole focus on legal and political issues to a positive approach based on relationships and individual care. Many participants strongly suggested the use of clinical case

studies to assist in contextualising different clinical relationships and diversity issues in practice, encouraging professionals to evaluate multiple perspectives and different expectations. During the workshops participants collectively worked together in their groups to identity ideas to make diversity education interactive and contextualised, for example:

> *"I think what's lacking is clear examples of behaviour, of what is good behaviour and what is not acceptable behaviour in the workplace. Unless you can see something that says well this is great and this is really bad, it doesn't mean anything. It's just a list of words. If you say to someone do you discriminate, everyone would tell you 'no' they don't. But if you gave them two examples and said which one do you think is discriminatory and which one is not, you would be surprised to find that quite a few of them wouldn't understand that one was discriminatory. Or role play with patients, where the professional is the patient and the patient is the professional to make each other understand different perspectives" (NHS healthcare professional).*

Staff/ faculty development was an area of improvement noted by several participants in the different participatory workshops. Reflecting upon what diversity means to educators and this influences their approach to the development and delivery of diversity education. The NHS diversity trainers and medical educators shared their feelings about how their perspectives influenced how diversity training was designed and assessed.

> *"If I go into a teaching situation thinking of myself as a White middle aged male Caucasian and I'm working with a student who is male, Chinese, I don't know, twenty, might be gay, with a role player who is Afro-Caribbean. There, there's such a mix of cultures, how do I understand the cultures of both those people and the <u>interaction</u> that's happening between them?" (NHS Diversity trainer).*

The importance of time for educators to reflect upon their interactions and relationships with students and trainees as an assessor and facilitator in diversity issues was frequently stressed. Several mental-health patients suggested educators must have an

awareness of their own perspectives and sense of self in the context of different clinical relationships and roles.

> *"It makes me think there are really two different types of culture. The culture when it's a steady and then the culture when it comes into the relationship, the <u>interaction.</u> You may think I'm a medical student, but when it comes into the teaching session, and you're a facilitator you have a different view of what activities and what counts as a medical student which may be where there is a kind of a misalignment. Examining the different perspectives around clinical contexts, the dynamics, the relations, all the different directions." (Medical educator).*

Many medical educators and NHS diversity trainers described experiences feeling ill-prepared and uncomfortable in teaching diversity. Numerous participants highlighted the necessity for educators/ trainers to facilitate meaningful dialogues about diversity issues to effectively implement the diversity curriculum. Diversity education requires experienced skills in facilitating difficult and challenging discussions and contending with group dynamics. Some of the NHS trainers and medical educators from a White race questioned whether they were most suitable to teach diversity. This was similarly discussed in the mental-health patient groups who considered issues of representativeness of the trainer in being able to educate others on diversity issues, for example one mental-health patient expressed *"if it's a White facilitator, could she be able to deliver that training competently to these various diverse groups? And if not, why not?"* Some of the mental-health patients suggested that individuals of a non-White race were better suited to delivering the training. Others sensed individuals of a non-White race had more exposure to diversity issues and were more likely to consider their cultural identity without being prompted.

> *"Is a White person representative? It's not really a White problem?"* (Mental-health patient)

Many of the NHS trainers and medical educators expressed a lack of support from their colleagues and educational organisations in encouraging them to teach diversity, reporting experiences where professionals looked down upon them for teaching diversity, for example:

I've heard about that too, when people hear that I teach diversity, 'oh you don't do that do you?' And I get a real negative reaction from it, I've never had a positive reaction from people, 'oh that's fantastic you teach diversity', it's 'oh no' because it's linked to this idea of it's a problem subject and they think it's dreadful. (Medical educator).

Considering how diversity training is *perceived* as well as received may aid in understanding the reasons for student and professional resistance to the topic. Collectively the NHS professionals and medical educators adopted different theoretical frameworks to teach diversity, each with their own reasons for adopting them. However, the findings demonstrated consensus on the limitations of exiting theoretical frameworks in failing to acknowledge the reciprocal influence between the professional and the patient and the importance of relationships in diversity issues. They also suggested that many theoretical framework did not assert the importance of formal evaluations by an external examiner in addition to self-reported measures.

I think all these models and frameworks overlook the 'interactiveness' of the interaction, the different clinical relationships. The interaction is so dynamic that you cannot predict what's going to happen next until you get into the situation. And I think cultural models are missing the kind of the teaching of <u>understanding the dynamics around clinical relationships </u>and managing it. We really want our categorisation model. We really like it, we're quite fond of it. We like knowing that all Muslim people will act in this way and Jewish people will act in this way. Because it gives us something to hang our hat on. We need this to be more complex and evaluated properly (NHS healthcare professional, Health Education England.)

The importance of creating a safe learning environment was suggested by most of the participants as a pre-requisite for the delivery of diversity education. Creating a safe, trusting, exploratory and respectful learning environment is necessary to facilitate meaningful dialogue and discussions on diversity issues. Many of the NHS trainers and medical educators reported that students and trainees were apprehensive in asking questions about diversity issues for fear of offence or 'politically incorrectness'.

Apprehension in asking diversity questions was also reported amongst NHS trainers and medical educators' themselves, for example:

> *I think there's fear about it all. A fear of some of the students and <u>staff</u> that oh they're going to say something that's a bit controversial or offensive. So, one of our scenarios again is about somebody who comes to see you as a doctor and you think it's a man dressed as a woman. And they say what do you do about that? And they have this big debate about oh no, I wouldn't ask that. Why don't you just ask! (Laugh) If it's relevant, if it's at all relevant to what they're coming to see you about, otherwise you don't. But they get really worried don't they; I'm going to say the wrong thing. I'm going to offend them. (NHS Diversity Lead).*

Practising asking these kinds of questions in a safe learning environment could make both staff and students feel less apprehensive about enquiring about diversity issues in a real-life healthcare context. Many of the participants including mental-health patients expressed their concerns regarding the discord between teaching and practice. As one medical educator stated:

> *"There's a spilt in medical and health education full stop. A spilt between the ideal world that we're teaching and the one that students and professionals live in, we need to bring them closer." (Medical educator)*

Many of the participants argued for more practical based teaching of diversity issues, that actively helped the trainees contextualise, explore and critically think about these issues in practice and develop their critical-judgment and reasoning abilities. Most participants favoured the use of small groups, using simulated patients, working with students and trainees and making the training interactive and engaging. Collectively the findings demonstrated that diversity training be both attitudes and skills based, and should assist in developing health professionals' self-awareness, self-reflection, interpersonal-skills, critical thinking and professional development.

7.4.3   Evaluation of diversity education

All stakeholder collectively agreed that diversity training is primarily about measuring attitudes and skills. Although many participants reported uncertainty and concerns around how to measure attitudes in particular, with some saying "*it's just too difficult to do*" *(Medical educator).* However, many participants agreed it would be more effective to measure attitudes via measuring behaviour, as shown in this quote; *"attitudes are difficult; questions around validity and reliability come into it. But attitudes can be accessed through the behaviour" (Mental-health patient advisor).* Consensus was reached that an evaluation tool for diversity education should be contextualised, utilise clinical scenarios and appropriate for all health professionals. Several participants discussed the challenges of identifying which exact attributes should be assessed and which method was most appropriate, for example:

> *"What are we assessing in terms of behaviour? Is it just saying I understand how you feel, ticks the box of empathy? Or are you actually looking at the interaction, the relationship and the responses from the patient, tone of voice, picking up on cues, all this kind of fundamental stuff that allows people to achieve what we're supposed to be doing in the verbal interaction. There are methods we can borrow from other disciplines to help us assess attitudes <u>via</u> people's behaviours." (NHS healthcare professional).*

Several assessment/evaluation tools were discussed for diversity education, these included video-taping of consultations, OSCES and reflective journals. However, several participants were active in identifying the limitations of each tool, and concluded that multiple evaluative and assessment tools should be utilised. For example, when discussing OSCEs several medical educators' shared their concerns about the effectiveness of measuring patient-centred skills:

"Even our assessments in OSCEs are around standardisation. So, you're saying that we need to standardise everything, we need to make it as though that we are looking for sameness. We need to make it so that it's the same for every student and it's the same for every patient, when all of this is around, <u>well it's different for everybody</u>. If you're assessing something how do you make sure it's reliable? Well that's standardisation. But actually the <u>validity of doing diversity well would be to be responding to every person differently!</u>" (Medical educator).

Several participants from all stakeholders strongly demonstrated their concerns about the validity and effectiveness of using traditional methods such as questionnaires and feedback forms in measuring the complexity diversity issues. With many participants strongly advocating against the use questionnaires and to seek alternative methods to evaluate diversity education.

A few mental-health patients proposed asking health professionals to develop 'personal objectives' on diversity, outlining what they would change about their clinical practice from the training they've received. Other useful suggestions included peer-assessment, reflective and creative portfolios, examining complaint forms and changes in patient satisfaction levels. Many of the patients questioned the impact of the diversity education, claiming *"this is all done in writing but not practice, how they actually follow these procedures? Do they actually follow these procedures?"* Although participants were uncertain about how to measure the effectiveness of the diversity education, collectively participants emphasised the need for evaluation as an integral aspect of diversity education.

CONCLUSION

The findings for each stakeholder group are comprehensively summarised in Tables 7.2. – 7.5 and are closely similar to one-another in describing how diversity education can be better taught and evaluated. The findings conveyed the heterogeneity of understanding of the terms 'culture', 'diversity' and 'cultural competence', but there was consistency in what was expected of professionals who are competent to provide care for diverse patient needs. The findings provided clarity around how diversity education can be better theoretically informed and evaluated. Framing diversity teaching on 'relationships' with the 'practitioner-self' relationship at the centre holds promise for a theoretical model that could integrate diversity education throughout the medical and healthcare curriculum, this will be further discussed in the next chapter.

TABLE 7.2: CONCEPTUAL CLARITY ON KEY TERMINOLOGY

NHS health professionals	Mental-health patients	Medical Educators
Diversity & Individuality: -Preference for the term 'inclusion' over diversity as some participants argued that it was better suited in eliciting a welcoming ethos around the importance of valuing and involving every individual and their differences. -Participants expressed that diversity appeared synonymously with the principles of individual, person-centred care. **Culture & Identity:** -Conceptualised culture as belonging both to an individual and collectively to a group of individuals. Participants often associated the world culture to 'institutional culture' of the NHS. They expressed that different NHS trusts embody different cultures which defines their values, beliefs and practices. -Participants found it challenging to distinguish culture from diversity. **Equality:** -Participants expressed the frustration of 'equality' being a mis-interpreted term around 'treating individuals the same', they argued that equality describes the need to actively not treat people the same but equally. -Participants expressed that often equality is thought to only be applicable to the nine protected characteristics. Participants often described how trainees found it challenging to conceptualise 'equality' in relation to clinical practice but were able to define it in legal terms.	**Diversity & Individuality:** -Self-constructed, self-subscribed concept that is subject to individual interpretation. -Diversity was strongly associated with individuality in that in actively distinguishes 'differences in a person and is congruent with the principles of providing 'patient-centred care.' -Encouragement for 'diversity' to be broadly defined to enable the definition to resonate with every individual. -Diversity is a significant variable in identity formation. -Application of the term 'diversity' in practice appeared incongruent to how patients conceptualised the term. Patients expressed that diversity was often applied in the form of 'lists or facts' about different cultural groups, thereby being used as a 'label' with professionals failing to respond to differences in patients in their care. -Lack of transparency in the political stances in how diversity and culture are understood. Patients argued that diversity carried weighted political connotations and in practice was detached from individual needs and choices. **Culture & Identity:** -Self-constructed, self-subscribed concept that is subject to individual interpretation. -Culture was more associated with 'shared similarities' whereas diversity is more about 'differences.' -Encouragement for 'culture' to be broadly defined to enable the definition to resonate with every individual. -Culture is a significant variable in identity formation. -Misinterpretation of 'culture' being associated with issues of race and ethnicity. Race and ethnicity appeared disproportionately emphasised in comparison to other facets that made a patient an individual.	**Competence:** -Some participants viewed competence as a fixed measurable and generic set of traits, whereas others interpreted 'competence' as a set of attributes that are developmental, impermanent and context-dependent. **-Cultural competence & Self-awareness:** -Some participants began to delineate cultural competence into sets of knowledge, attitudes and skills. -Other participants argued that necessary attributes of 'cultural competence' could not be reduced to a fixed set of attitudes or behaviours. Participants argued that cultural competence resides on a changing continuum of knowledge, attitudes and skills, and in particular values. -Discussion around who and what level of competences defined 'cultural competence.' Participants tended to define 'competencies' that were measurable. -Participants agree that defining 'cultural competence' in ways that were measurable and useful appeared as some expressed an "impossible task." -All participants agreed that 'cultural competence' cannot be pursued as a sole outcome nor achieved as a result of a single training event. -Cultural competence values, attitudes, knowledge and skills cannot be imposed. These realities must be considered, experienced, developed and owned.

Cultural Competence & Self-awareness:	Cultural Competence & Self-awareness:	Culture & Identity:
-Participants argued that 'cultural competence' was impractical and impossible in terms of acquiring knowledge about all cultural groups. Some of the participants claimed that instead of 'cultural competence' the NHS should be aspiring to achieve 'cultural excellence' and or quality. -Participants were in agreement that cultural competence cannot be achieved in a single training or by e-learning. -Participants expressed that health organisations lacked conceptual clarity around the term 'cultural competence' and how it can be measured and achieved.	-Described the acquisition of knowledge of particular cultural groups. Patients voiced uncertainty about which cultural groups were most pertinent to learn about. -Patients argued that 'cultural competence' was impractical and impossible in terms of acquiring knowledge about all cultural groups. -Patients understood 'cultural competence' as developing attributes of compassion, open-mindedness, respect and trust that underpinned a therapeutic relationship.	-Characterised culture as associated with attributes such as gender, disability and characteristics that define 'groups' of people. Diversity and culture were defined as the same. -Participants agreed that culture and diversity form an integral aspect of an individual's identity which in turn defines their attitudes, values, and behaviour. -Participants drew attention to the multiple identities that individuals can possess and these multiple identities reside in the different relationships professionals have with themselves, their patients, colleagues and the wider healthcare organisation. Different identities a person possesses may hold more emphasise in defining them in comparison to others. -Participants differentiated culture as 'self-determined' culture and 'perceived culture by others' and described the recursive relationship between the identity of an individual and the identity of different cultural groups they might be perceived to belong to.

TABLE 7.3: LEARNING OBJECTIVES

NHS health professionals	Mental-health patients	Medical Educators

Professional Self-Development:
-To define and reflect upon what 'diversity' means to you and the context in which you work in.
-To critically explore and evaluate the 'practitioner-self' relationship.
-To develop skills and attributes for self-reflection and awareness of professional's clinical interactions with others.
-To develop the capacity for self-reflection and awareness among diversity trainers
 	
Interpersonal Skills:
   • **Patients**
-To develop and foster clinical communication skills that facilitate 'respectful curiosity.'
-To value and develop core attributes and skills that underpin a good therapeutic relationship.
-To develop and practice good clinical communication skills.
-To acknowledge the patient as a person and adopt a holistic approach to care.
   • **Colleagues**
-To encourage an open dialogue and discussion about the challenges culture and diversity can bring in clinical practice and healthcare provision.
-To understand and critically examine the dynamics and nuances involved in different clinical relationships professionals will participate in.
-To recognise and evaluate the influence of their colleagues in the development of their 'professional identity.'
	Professional Self-Development:
	-To explore the meaning of diversity at an individual level and in relation to colleagues, peers and patients.
	-To be able to define 'diversity' and 'culture' and reflect upon how these two concepts are similar and different to each-other.
	-To identity personal examples of prejudice and bias and strategies to challenge this effectively.
	-To be aware of personal assumptions and pre-conceived that may influence their consultation with patients and develop strategies and skills to challenge this.
	-To develop the capacity for self-reflection, critique and evaluation of their 'professional self'.
	
	Interpersonal Skills:
	   • **Patients**
	-To reflect upon the relevance and influence of diversity in healthcare and what the practitioner and patient brings to an encounter from different cultural perspectives.
	-To value the need for a partnership between the practitioner and the patient in all decisions of a patient's care.
	-To gain an understanding of the principles of patient-centred care and how to put these into practice.
	-To develop the skills and attributes that underpin a therapeutic relationship.
	-To value the expertise of the patient and utilise their knowledge in their care planning and decision making.
	-Facilitate 'respectful curiosity' about patients and being able to learn from the patient.
	-To develop and practice good clinical communication skills.
	-To acknowledge the patient as a person and adopt a holistic approach to care.
		Professional Self-Development:
		-To value and develop core attributes and skills that underpin a good therapeutic relationship.
		-Define 'cultural competence' and 'culture' and critically examine both concepts.
		-To reflect upon and be aware of what diversity means to the professional and how their culture and diversity influences their clinical relationships with patients, colleagues and carers.
		-To reflect and discuss the multiple identities professionals can embody and how these are different and similar from each-others.
		-To explore personal assumptions, biases and pre-conceived ideas that influence professional interactions with patients and professionals and identity strategies to challenge these.
		-To engage in a continual practice of self-reflection and self-awareness throughout their professional development.
		-To evaluate the compatibility between your personal and professional identities.
		
		Interpersonal Skills:
		   • **Patients**
		-To reflect upon the different expectations, preferences and views, patients will have and how to appropriately respond to these differences.
		-To be able to recognise and respond to cultural differences that exist between themselves and others.
		-To develop and foster clinical communication skills that facilitate 'respectful curiosity.'
		-To adopt and value the principles of patient-centred care.

| • **Organisation**
-To develop strategies and coping mechanisms to effectively deal with the uncertainty and instability of the NHS health culture.
-To understand and place mechanisms in place that allow the healthcare culture to embody the principles and practice of 'relationship-centred' care. | • **Colleagues**
-To be able to reflect upon and value the different perspectives that are present in a clinical encounter.
-Develop skills to facilitate and maintain meaning clinical relationships with patients and colleagues
-Critically examine the dynamic and nuances involved in different clinical relationships.
-To be able to engage in an open-dialogue with others about areas of clinical practice they feel uncomfortable or uncertain about and develop skills to support one-another.
• **Organisational**
-To be aware of personal and institutional support systems.
-To value the contribution of all healthcare professionals and create culture that supports and values every member. | • **Colleagues**
-To encourage an open dialogue and discussion about the challenges culture and diversity can bring in clinical practice and healthcare provision.
-To understand and critically examine the dynamics and nuances involved in different clinical relationships professionals will participate in.
-To recognise and evaluate the influence of their colleagues in the development of their 'professional identity.'
• **Organisation**
-To value and appreciate the cultural diversity of patients and health professionals.
-To critically evaluate how the identity of the health profession influences the identity of health professionals in positive and negative ways. |

TABLE 7.4: CURRICULUM DEVELOPMENT AND DESIGN

NHS health professionals	Mental-health patients	Medical Educators
Content: -Diversity education should be centred on the exploration of different clinical relationships, particularly the relationship between the 'practitioner-self' and the development of interpersonal skills. **Format & Delivery:** -Participants recommended face-to-face, interactive, practical sessions composed of small groups. -The majority of participants were in agreement that e-learning is not suitable for the exploration of diversity issues in healthcare. -Participants were uncertain around the usefulness of developing a standardised approach to diversity training as it may not adequately address the specific needs of the institution, the context or organisational needs. They suggested a framework that guides the remit that diversity training should focus on is better suited and this can be tailored to the local context and the organisation. -Training in diversity needs to be seen as one element on a wider framework that needs to be implemented to develop high quality relationships. -Strong recommendation for face-to-face training, some participants suggested that e-learning could be used supplementary just to provide information about legal requirements. E-learning was not a favoured approach to learning around diversity education.	**Content:** -Focus on developing good relationship building skills and reflection and awareness of their 'professional identity'. -Less emphasis on the political agenda and more attention towards providing patient-centred care. -Evaluation should be a continuous and integral aspect all of trainings. **Format & Delivery:** -Interactive and practical sessions with small groups exploring different clinical relationships through role play, video and using theatre and drama. -Strong preference for the use of genuine case studies to help contextualise different clinical relationships and healthcare problems in practice, allowing professionals to reflect upon the clinical relevance of diversity issues and how individuals impact and influence each-other. -Encourage patient involvement to exemplify and practice relationship-building skills and working in partnership with the patients. Patients may also help facilitate guided reflection for professionals. -Training should be personal, relational and experiential.	**Content:** -Diversity education should be centred on the exploration of different clinical relationships, particularly the relationship between the 'practitioner-self' and the development of interpersonal skills. -Developing skills and attributes that underpin a therapeutic relationship and how to bring cultural distances that may exist between them and others. -Continual practice of professional development, where professionals participate in exercise, activities to explore and evaluate their 'cultural identity.' -Participants were in agreement about the limitations of using existing theoretical frameworks as many felt they failed to acknowledge the reciprocal influence between the professional and the patient and the importance of relationships in diversity issues. **Format & Delivery:** -Creating a safe, trusting, exploratory and respectful learning environment needed to be present in order to facilitate meaning dialogue and discussions around diversity issues. -Encouragement of practical based teaching around diversity issues, that actively helped the trainees contextualise, explore and critically think about these issues in practice and reflect their judgment and reasoning abilities. All the participants favoured the use of case studies, using simulated patients, working with students and trainees, small group sessions and making the training interactive and engaging.

Faculty Development: -Lack of support and training for diversity trainers, many accounts reported of trainer feeling ill-equipped, under-prepared and lacking in experience of facilitation skills necessary to deliver diversity education. -Some participants recommended externally recruiting 'expert trainers' on specific diversity issues such a BME patient representation, transgender champion etc. to increase the credibility of the training. Some participants recommended more emphasis around leadership and having diversity champions throughout the organisation. **Duration:** -On-going, integral and continual part learning and professional development.	**Faculty Development:** -Participants actively discussed the representativeness of the trainer in being able to educator others around diversity issues were raised, with some participants suggesting that individuals of a non-White race were better suited to delivering the training. -Importance of educators being self-reflective and aware of what diversity means to them and their personal biases, assumptions and prejudices. -Importance of encouraging a culture amongst professionals for relationship building and to be role models for advocating and promoting the importance of diversity issues. **Duration:** -On-going training, integral and continual part of learning and development. -Participants criticised the use of 1 hour or 3 hour sessions on 'diversity' or 'cultural competence' questioning their usefulness and impact on improving professional practice and interpersonal skills.	**Faculty Development:** -Ensuring faculty and trainers are competent and comfortable to deliver such training and have clarity of why diversity training is clinically relevant is essential in order to facilitate a safe learning environment. -All the participants emphasised the need for educators to have an awareness of their own perspectives and sense of self in the context of different clinical relationships and roles. -Participants described a lack of support from colleagues and their educational organisations to teach diversity. Professionals reported negative experiences of professionals who 'looked down' upon them for teaching diversity. **Duration:** -On-going continual practice of professional development and self-awareness/ reflection. -Diversity education should be integrated throughout the medical curriculum.

TABLE 7.5: ASSESSMENT AND EVALUATION

NHS health professionals	Mental-health patients	Medical Educators
Measuring Attitudes, Values and Skills: -Participants agreed that an evaluation tool for diversity training should be focused on measuring attitudes, behaviours and skills. -Some participants suggested the training should be measuring values and any changes to one's values however in both cases expressed great uncertainty around how to do this. **Proposed Evaluation Methods:** -Evaluate staff appraisals and feedback against trust values and diversity. -Make diversity part of the overall performance management i.e. set targets for performance around equality and diversity providing specific examples. -Gather follow-up feedback after the training session to identity if it helps them respond and manage diversity issues in their day to day practice. -Critically examining changes and feedback from service-user complaints. -Implement 'values-based' recruitment which involves accounting for 'respecting of diversity,' -Develop a psychometric before and after test to evaluate the effectiveness of the training that is based on clinical scenarios. -Develop a evaluation tool that allows individuals to discuss and reflect upon multiple perspectives within different clinical encounters.	**Uncertainty:** -Participants expressed great uncertainty in how to measure the effectiveness of diversity education. **Measuring Attitudes and Skills:** -Participants agreed that an evaluation tool for diversity training should be focused on measuring attitudes and skills. -Participants expressed concerns that traditional methods such as questionnaires and feedback forms are insufficient and ineffective to measure the complexity of attitudes, behaviours and skills of professionals in relation to diversity issues. **Proposed Evaluation Methods:** -Patients suggested asking professionals to develop *'personal objectives'* around diversity, outlining what they would change about their clinical practice from the training they've received. -Useful suggestions included peer-assessment, reflective and creative portfolios, examining complaint forms and changes in patient satisfaction levels. -Many patients strongly suggested not using questionnaires, but an evaluation tool that allows health professionals to critically reflect on the different perspectives present in clinical encounters.	**Uncertainty:** -All participants expressed uncertainty and concerns around how to measure attitudes, with many participants claiming it is too difficult to measure. **Measuring Attitudes and Skills:** -All participants agreed that an evaluation tool for diversity education should be focused on measuring attitudes and skills. All participants agreed that it would be more effective to measure one's attitude via their behaviour, and asserted interpersonal skills and communication skills must be measured. **Evaluation Methods:** -A number of assessment tools were discussed around how to evaluate diversity training, these included OSCES, reflective journals and examinations. However, for each assessment tool, participants were active in identifying the limitations for each tool, and concluded that multiple assessments were needed when assessing diversity training. However, participants collectively expressed a strong emphasis away from using questionnaires. -Participants also discussed the challenges of assessing diversity in actual practice and in the educational context. Participants explored the challenges involved in assessing an individual's actual behaviours in the clinical context and suggested developing an evaluation tool for diversity training that encouraged participants to contextualise clinical issues, and cultivate reasoning, critical thinking skills and allows them to question multiple perspectives present in different clinical encounters.

CHAPTER 8: DISCUSSION OF FINDINGS FROM PARTICIPATORY WORKSHOPS

This chapter discusses the first two over-arching themes outlined in Chapter 7 and their implications for how to better teach and evaluate diversity education. Improvements to the conceptualisation of key terms and the theoretical framing and evaluation of diversity education will be discussed in these first two themes. Collectively the findings led to the development of a reconstructed RCC model which explores how diversity education can be better theoretically informed and evaluated. This reconstructed theoretical model incorporates the findings of the participatory workshops and demonstrates how they can be operationalised within a sound educational model, outlined in Chapter 9. The findings of the participatory workshops also led to the development of a SJT as a potential evaluation tool for diversity education: this process is outlined in Chapters 10 and 11.

8.1 DISCUSSION OF THEME I: CONCEPTUAL CLARITY OF KEY TERMS

Overall, the findings showed the many meanings the terms 'culture', 'diversity' and 'cultural competence' can have on an individual and institutional level. The discussions showed that the lack of conceptual clarity of these terms stems from the fact that they are not discrete concepts but derived from a cross fertilisation of meanings that are socially and individually constructed. The findings indicated common and transparent distinctions between the terms, however how they were applied and understood in practice appeared incongruent to how they were defined.

8.1.1 Defining culture

Collectively the findings showed that all stakeholder groups conceptualised culture as a dynamic, multiple, situated and relational concept. All participants largely discussed culture in association with issues that affected groups of individuals, though several participants acknowledged the heterogeneity that can exist amongst individuals within the same cultural group. Traditionally culture has been narrowly limited to a unidimensional concept often discussed in relation to issues of race and ethnicity that are shared by a group of individuals (Cross et al, 1989; Sue et al, 1999), as exemplified in early conceptualisation of cultural competence models. The findings are indicative of supporting definitions of culture that view the term as an individually and socially

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constructed phenomenon that is ever evolving and varied depending on context. This is compatible with how frameworks such as cultural humility (Tervalon and Murray-Garcia, 1998), cross-cultural efficacy (Nunez, 2000) and cultural sensibility (Dogra, 2004) conceptualise culture. These theoretical frameworks represent a distinct departure from traditional cultural competence models which define culture as a one dimensional, external characteristic applicable to certain groups of individuals that conform to specific factors that depict how they act and behave. These definitions of culture tend to disproportionally emphasise issues of race and ethnicity in comparison to other characteristics that might be pertinent to one's culture. All participants emphasised the inaccurate understanding of culture as a term only applying to issues of race and ethnicity, and encouraged a shift from this misperception to one that acknowledges the depth and complexity of issues denoted by the term culture. Participants acknowledged that shared characteristics such as sexuality, heritage, values and gender contribute to one's culture, and strongly emphasised these characteristics apart from race and ethnicity. All stakeholder groups also considered culture across personal, organisational and institutional levels as opposed to simply a characteristic of a group of individuals. Existing definitions of culture vary in their focus either on individual aspects, group based distinctions (Howell. 192; Leininger, 1991), organisational factors (Cross et al, 1989) and systematic issues (Fong & Furuto, 2001). Recent definitions of culture reflect a more expansive definition, with the length of the definition ever increasing. Despite the challenges in initial discussions attempting to define culture, all stakeholder groups appeared to reach a consensus that culture was a term best suited to describing shared characteristics applicable to a group of individuals. Conversely terms such as diversity or individuality were better used for describing one's individual culture, specifically characteristics that are unique and autonomous among one's shared characteristics with others.

In all stakeholder groups culture was strongly associated with identity. All participants understood individuals as having fluid and intersecting identities with a wide variation both between and within different groups. Multiple accounts from the stakeholder groups demonstrated the multitude of different parts that comprise one's identity, saying that these parts become more or less pertinent depending on the context and with whom they interact. These findings are strongly consistent with the notion of 'intersectionality', a term coined by Kimberle Crenshaw (1989) to describe the multiple components of one's social identities (i.e. gender, social class, race etc.) and how they overlap or intersect one another. As in the findings of the workshops, the concept of

intersectionality draws attention to the relationship between different social categories of one's identity. Minow (1997; pp.38) defines intersectionality as the way in which any particular individual's identity stands at the cross-roads of multiple groups. Participants from the different stakeholder groups described the different parts of their identity and how they intersect each other, but contrary to the traditional notion of intersectionality they placed more emphasis on the context and the interaction between individuals in defining how the intersections in one's identity were formed and maintained.

The large majority of participants described one's identity as situated within multiple interactions. This echoes later revised and critiqued versions of intersectionality as Collins et al (2015; pp.4) asserts that different aspects of one's identity are not *"unitary, mutually exclusive entities but rather a reciprocally constructed phenomenon"* The majority of participants suggested individual identity should not be perceived different parts additive upon one another or as the prescribed protected characteristics as outlined in the Equality Act (2010), but rather infused, with certain parts becoming more salient depending upon the encounter and context. This has been noted by a few authors who have critiqued the notion of intersectionality (Anderson et al, 1992; West & Fenstermaker, 1995; Mc Call, 2005). For example, Anderson et al (1992) highlighted the significance of *"interlocking categories of experiences"*, describing how one experiences the intersection of one's identities in different interactions. McKenna (1978; pp.42) made prior note of this, explaining how different social identities intersect with each other, either to *"abrade, inflame, amplify, twist, negate, dampen or complement each other."* Some authors have attempted to create models which distil one's different and overlapping identities using Venn diagrams (Yuval-Davis, 1989; Walby; 1986; Valentine,2007), demonstrating that one's cultural identity cannot be reduced to fixed social categories, but should be seen as emergent, fluid and inter-connected. Many participants stressed how cultural groups are defined, stating that although there are shared characteristics among groups of individuals these generalisations should not be assumed as absolute but dependent on context and interactions.

In relation to issues concerning cultural identity, all stakeholder groups debated the challenges of matching culture as defined for an individual and culture as defined for a group. This issue resonates with concerns expressed by authors stating that although diversity education typically insists on the awareness and recognition of cultural diversity within and between different groups of individuals, attention needs to be paid

to the context in which this training is received, perceived and put into practice (Kai et al, 2000; Fuller et al, 2001; Dogra et al, 2007). In particular, the manner in which cultural information regarding groups of individuals is presented has been criticised as stereotypical, reductionist and fixed, stipulating a discord between how culture is defined for a group of individuals and how it is defined for an individual. Participants in the different stakeholder groups related countless experiences of how other's assumptions about their culture were incongruent to how they defined their identity, highlighting the importance of continually questioning cultural information and for cultural information to be presented as both an individual and shared notion. Supporting this research, studies stemming from the Social Identity Theory (Tajfel & Turner, 1979) and Self-Categorisation Theory (Turner, Hogg, Oakes, Reicher & Wetherall, 1987) have documented the plethora of negative outcomes that arise from solely focusing on social/cultural categorisation including prejudice, stereotyping, out-group homogeneity and in-group favouritism (Brewer & Brown, 1998).

The NHS healthcare professional groups in comparison to the other stakeholder groups were more likely to associate culture with institutional or organisational culture. NHS healthcare professionals tried to articulate the meaning of 'organisational culture' in all groups, and included responses that were predominantly negative descriptions, for example *"unstable, tick-box, mandatory, hierarchical and power."* The NHS healthcare professional groups strongly emphasised their concerns with the current NHS culture, suggesting a change in culture is most needed in organisational culture. These concerns are repeated in recent strategic health policy documents for the NHS (Kennedy, 2001: Francis, 2013; CQC: 2015). The verdict from the well publicised Mid Staffordshire NHS Foundation Trust report (2010) which investigated the causes of hundreds of preventable deaths, concluded that no specific person or groups of individuals could be held accountable, but rather it was the *"culture"* of the NHS that was responsible (Napier et al, 2014). The findings from the NHS healthcare professional groups described the different institutional NHS cultures that can exist, although unwritten contributions conveyed local behaviours, or *"patterns of behaviours"* both positive and negative that developed in different NHS trusts leading to social cohesion within different groups of individuals and social conflict between others. There were similar findings in the medical educators' groups, who collectively asserted that these locally defined patterns of behaviour are based on inherited, written or unwritten social agreements and assumptions.

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Definitions of organisational culture are ubiquitous (Scott, 2003; Denison et al, 1996; Schein, 1985) and in their simplest form can be defined as 'mini-societies' (Allaire, 1984). Alvesson (1985) attempted to disaggregate the plethora of definitions by identifying their different intentions. The findings of the participatory workshops on organisational culture are closely similar with four of the different areas identified by Alvesson (1985), namely 'exchange regulation' describing a form of control used to shape shared views with a view to reducing transaction costs, 'compass' which states a shared value system that provides guidance and direction, 'non-order' described as the inherent ambiguity, uncertainty, contradiction and confusion of organisational life and 'blinders', the deep aspects that provide an unconscious guide to behaviour. Collectively the findings of the participatory workshops showed that organisational culture is both overtly and covertly expressed and largely associated with values which are often unrecognised and unarticulated. Particularly NHS healthcare professionals and medical educators emphasised that organisational culture is influential in shaping one's professional and personal identity. This is compatible with definitions of organisational culture that highlight the importance of values, beliefs, assumptions and patterns of behaviour, however many definitions fail to assert the influence of organisational culture on one's individual identity. The findings also showed the need for transparency in how culture is understood and defined in healthcare policy documents, which is consistent with previous recommendations for improving diversity education (Bhui et al, 2007; Dogra et al, 2007).

All stakeholder groups questioned the uncritical assumption that one's personal cultural identity can coexist with one's professional cultural identity, with some participants describing the internal struggles they experienced in integrating these two cultural identities. Several participants from the NHS health professional and medical educator groups described how their professional identity is formed through a dynamic process whereby individuals classify and identity themselves in relation to others, realising their own place as individuals and members of different professional groups. They conclude that identity formation is situated and develops within different clinical relationships. The prior conceptualisation of professional identity as a single and distinct entity has shifted to a dynamic conception of multiple identities situated in different clinical and social situations (Shotler & Gerger, 1994; Gergen & Davis, 1985; Eisenberg, 1979), which is supported by the findings of this research. Frost et al (2013) reviewed papers exploring the discourses between standardisation (describing the importance of uniformity, consistencies and commonalities among healthcare professionals) and

diversity (emphasising one's unique, personal and multiple social identity) in one's professional identity construction. They concluded that constructing one's professional identity becomes challenging primarily due to the increasing diversity among healthcare professionals. To effectively address this, faculty and trainers must first invest in acknowledging that these tensions between standardisation and diversity arise and adopt a social constructivist understanding of identity. These conclusions are endorsed by the findings from the participatory workshops.

Other discussions were significant in revealing the variety of ways one can respond to and manage different intercultural relations, suggesting little discussion occurs on how the multiple cultures that exist in healthcare function in harmony with one another. The different accounts of adaptation to cultural differences from the workshop findings can be supported by existing theories of assimilation, integrationism, pluralism and separatism as mentioned in the preceding chapters (Kim, 2007). The findings also illustrate how different individuals defined cultural differences and similarities; these were often expressed in terms of what they perceived as shared or conflicting values in their identity. This contradicts previous research which asserts cultural differences are depicted by a difference in behaviours, customs or traditions, which is notably referred to in cultural competence models (Leininger, 1991; Bennett, 1986; Howell et al, 1987). The workshop findings indicate that cultural differences are internally identified, based on one's values, more than external, observable patterns of behaviour. This appears to support the similarity attraction paradigm (Byrne, 1971) which asserts that individuals are attracted to others who share similar attitudes or values as opposed to those who hold different attitudes or values. However further research has found this is dependent on context, with certain situations encouraging an attraction to dissimilarity, especially in the cases of interpersonal attraction (Singh and Ho, 2000). Further empirical research exploring how individuals define and respond to cultural differences and similarities could be used in influence the pedagogical approach to diversity education.

8.1.2. Defining diversity

Overall, the workshop findings suggested that the term 'diversity' was equated with the notion of individuality, and an approach that values diversity requires an active intention to understand the patient as an individual as well as understanding how you as an individual comprehend the term diversity. This aids in operationalising a broad and complex term such as diversity into specific and explicit ways of using and

implementing the term diversity. The way in which diversity was conceptualised in the workshops is consistent with theoretical frameworks that are contradictory to the traditional cultural competence models such as cultural humility (Tervalon & Murray-Garcia, 1998), cross-cultural efficacy (Nunez, 2000) and cultural sensibility (Dogra, 2004). This is like the workshop findings on conceptualising culture. Diversity was conceptualised in a way that agreed with how participants understood the term 'individual culture' but with the large majority of participants preferring the term diversity as it closely equated to individual differences, whereas culture was more closely associated with shared similarities among groups of individuals.

Many participants noted that even though they may belong to or inherit multiple shared cultural identities, this does not imply that they subscribe to the patterns of behaviour as defined by the group nor understand group members on an individual level. Whilst cultural groups can have overtly expressed patterns of behaviour, how these are internalised and practised among individuals within that group will vary and be dependent on context. Most participants preferred the term 'diversity' for this variation. This similarly supports research on social constructivist theories of identity (Frost et al, 2013; Tajfel & Turner, 1979; Turner et al, 1987). Different participants highlighted that these differences are often not questioned until they are in conflict or vary substantially from other values an individual may agree with. As with culture, all participants recognised diversity as a dynamic concept which is both overtly and covertly expressed. Likewise, all participants strongly associated diversity with identity, however with more emphasis on how the unique intersections within and between their multiple shared identities form and the identification of characteristics that are different from their shared cultures with others.

The vast majority of mental-health patients in particular positively commented on the term 'diversity' as offering them a sense of choice and empowerment. Collectively the findings demonstrated that the notion of diversity appears compatible with that of patient-centred care in advocating the importance of acknowledging the patient as a person, customised care and attention to the whole person and their needs (Morgan et al, 2012). The word 'patient' is interchangeably used with 'person', 'client' and 'resident' and this was apparent in the findings. As with diversity education, although person centred care is frequently used in the literature, ambiguity remains in its meaning and how its principles are translated into practice. Patient-centred care shares many of the same challenges as diversity education in terms of establishing a consistent definition,

identifying best practice and uncertainty over measures to assess effectiveness. All stakeholder groups emphasised, particularly in the mental-health patient groups, the importance of acknowledging both the patient's diversity and the healthcare professional's diversity. This is reflected in the transition from positivist approaches (i.e. learning about others) in cross-cultural education to social constructivist approaches (i.e. learning about self) in recognising that both the patient and the healthcare provider bring unique socially constructed cultural perspectives to the clinical relationship (Bennett; 2003; Dogra et al 2014). The findings collectively encouraged healthcare professionals to explore their own cultural identity in helping them understand the different cultural identities that exist in their patients. A more recent review by Mead and Bower (2000) on the empirical literature of patient-centred care proposed a conceptual framework that outlined the following key dimensions; patient as a person, sharing power and responsibility, therapeutic alliance and 'doctor as a person'. Whilst the dimension 'doctor as a person' is included to emphasise the dimension of the doctor in acknowledging the influence of his/her attitude, personality and cultural background on the doctor-patient relationship, it is unclear how this is acknowledged and in what way it affects the clinical relationship.

Overall the workshop findings demonstrated that diversity was a favoured term as it broadened the concept of culture that was held in traditional cultural competence models, and was articulated in a way that did not minimise racial inequalities but drew attention to other dimensions of difference. However, many participants expressed concerns over the expansive definition of diversity and how it was applied in practice. The dispersal of information under one paradigm of 'diversity' or 'diversity training' has many people questioning whether this approach is down playing core issues that remain unaddressed (Esmail, 2012; Sheikh, 2001). Some authors argue that current diversity training may be normalising and perpetuating issues of diversity as opposed to effectively addressing them. With the topic of race remaining the so called 'elephant in the room', with individuals, more notably those of White race, feeling fearful of discussing this issue (Nazroo, 2013; Williams et al, 2005).

The workshop findings demonstrated that how diversity was applied in practice appeared incongruent to how participants defined the term. Many participants reported diversity still being associated with issues of race and ethnicity, with healthcare professionals unsure on how to ask appropriate diversity questions and subsequently how to respond effectively to the information given. This is consistent with the concerns

raised by other authors, emphasising that whilst diversity training has broadened to allow for a range of differences, the training has not been displaced from its original intention of combating racism in healthcare (Hall, 2014; Malet, 2013). Arguably the training is still perceived as addressing issues of 'colour' and not 'diversity' (Abrams et al, 2009; Bhui et al, 2008; Bhugra et al, 2015). Recent reviews have shown that cultural diversity trainings are often still based on this premise, with the focus of their teaching purely on those of a non-White race. (George et al, 2015; Bennett et al, 2007) This further perpetuates the perception that issues of culture and diversity are only relevant to those of a non-White race. Diversity or culture is a topic rarely explored in relation to the White race, with individuals of a White race appearing to be not acknowledged as a cultural group (Van Soest, 2000; Pfeffer, 1992; George et al, 2015). These concerns were echoed in the workshop findings, and demonstrated the need for further research in exploring how the principles of diversity education can be translated into tangible outcomes in practice and the importance of measuring the effectiveness of these outcomes.

8.1.3   Defining cultural competence

Definitional ambiguities in the term 'cultural competence' was clearly evident amongst all the participants' responses. Associating the word 'competence' with 'culture' triggered discussions on the interpretation of what being competent in culture actually means. The two terms appeared at opposite ends of a spectrum, with competence perceived as a term that is fixed, measurable and specific and culture as a concept that is fluid, nuanced and evolving; there was obscurity about how these two different notions become one concept. This agrees with existing research where many leading authors in the field struggle to precisely define the term cultural competence in a way that allows it to be operationalised in practice and teaching (Kleinman et al, 2006). In its simplest form competence is defined as *"having ability"* (Webster, 1971) and depicts one's ability to carry out a set of tasks or role adequately or effectively. Typically, competence is described using a set of statements outlining several abilities needed to perform a role effectively in a variety of specified situations (Azzopardi et al, 2016; Burg et al, 1982). A large majority of the participants attempted to define cultural competence in the same way as clinical competence is conceptualised, and disaggregated cultural competence into knowledge, attitudes and skills.

The workshop findings demonstrated concerns about the utility of the term cultural competence. As discussions matured participants agreed that cultural competence cannot be reduced to a set of fixed attributes and traits but rather can only be achieved by a healthcare professional having a critical awareness and understanding of themselves. This is consistent with the common criticisms of the term cultural competence (Garran et al, 2013; Whaley; 2008; Fisher-Borne; 2016). Many criticised the emphasis on cultural knowledge for its impracticality, reductionist approach and its potential for over generalisation and stereotyping. All participants highlighted the in correct assumption that acquiring 'cultural expertise' or 'cultural knowledge' translates to competent practice. Cross et al (1989) definition of cultural competence is one of the most widely cited and notably does not refer to the acquisition of cultural knowledge as shown; *"cultural competence is a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations"*. Similarly, recent definitions of cultural competence such as Betancourt, Green and Carrillo (2002) are devoid of an explicit emphasis on the acquisition of cultural knowledge in one's pursuit of becoming culturally competent. Current definitions of cultural competence are more abstract in nature, and typically do not outline measurable constructs or defined lists of knowledge, attitudes and skills for achieving cultural competence (Boyle & Springer, 2001; Bryan, 2008). Some definitions of cultural competence remain focused on the acquisition of knowledge to allow for measurable outcomes (Solomon, 1976; Green, 1982; Saha, 2008). Others are more nuanced, reflecting the way theoretical models that depart from traditional cultural competence models conceptualise competence in cross-cultural settings, and emphasise the development of critical awareness and reflection.

Participants from all stakeholder groups criticised the failure of current understandings of cultural competence to explicitly acknowledge the complexity of clinical interactions in healthcare and the interplay of cultural and diversity issues in healthcare relationships. Many participants raised the erroneous assumption of cultural competence as a static characteristic of the practitioner, arguing that greater emphasis should be placed on considering the dynamics and nuances of clinical relationships and wider issues pertinent to the organisational structure in achieving cultural competence. When all the participants were attempting to establish their expectation of culturally competent practitioners, their discussions cohered on the expectation that professionals would be proficient in the skills, values and attributes that underpin a

good therapeutic relationship i.e. communication, trust, empathy and respect; which one can argue to be the very basis of healthcare competencies. Many participants stated that cultural competence is an ongoing process. Again, this is similar to theoretical frameworks that represent a departure from traditional cultural competence models where understanding one's self takes precedence over gaining knowledge and expertise about others.

Contrary to many theoretical frameworks on cultural competence or diversity, the findings from all stakeholder groups strongly advocate the importance of the dynamics and nuances of clinical relationships in being able to understand and respond to cultural diversity issues. The participants concluded that culture and diversity issues are situated in clinical relationships and come into play during interactions with one another. As mentioned above, becoming culturally competent (or competent in cross-cultural interactions and relationships as many participants preferred to say), one must acquire critical awareness and reflection. This notion is consistent with a recent term frequently cited in cultural competence literature titled 'critical consciousness' (Kumagai et al, 2009; Azzopardi et al, 2016). As the term, cultural competence becomes more controversial and criticisms are raised (Tervalon et al, 1998; Wear, 2003; Saha, 2006) authors are advocating the development of an orientation defined as 'critical consciousness' of the self, others and the world. Critical consciousness has conceptual roots in research concerning the critical theories of Frankfurt and Freire (1993) and posits that one's practice of self-awareness and reflection does not exist in isolation but rather in relationship to others in the world. Authors describe the development of critical consciousness as the reflective awareness of difference in power and privilege and the inequalities that are embedded in social relationships. This development of critical consciousness leads to cognitive and affective changes, engaged discourse, collaborative problem solving and 're-humanisation of human relationships' (Hurtado, 2005; Kumagai, 2007; 2008). Akin to the theoretical framework on cultural humility, the acknowledgement of power and privilege in clinical relationships is mentioned. Whilst the notion of critical consciousness closely reflects the workshop findings, if fails to situate the concept in an educational theoretical framework that can be used to teach diversity education. In addition, authors are unsure how this concept differs from the notion of critical thinking (Fraser, 2001; Burbules, 1999). Theories of social identity may be more compatible with the workshop findings as they similarly describe the internal experience of how we see ourselves in relation to others, as well as the different ways one can categorise, position and align

oneself with others (Miller & Garren, 2008). This echoes the workshop findings of how culture and diversity have been understood and conceptualised.

The workshop findings also demonstrated the confusion between interrelated terms associated with cultural competence, namely cultural sensitivity, cultural humility and cultural sensibility. Overall the findings strongly conveyed a preference for the term cultural humility over cultural competence and other associated terms. Cultural humility describes a process of *"committing to an on-going relationship with patients, communities and colleagues that requires humility as individuals continually engage in reflection and self-critique"* (Tervalon & Murray-Garcia, 1998;pp.118). Many authors have used cultural humility as an antithesis to cultural competence, and cultural humility is one of the most widely cited theoretical frameworks used in cultural diversity education across a variety of disciplines and internationally (Fisher-Borne, 2015; Garren, 2013; Betancourt et al, 2007; Gregg et al, 2006; Jani et al, 2011; Furlong et al, 2011). Both cultural competence and cultural humility are similar in the intention to address healthcare disparities but differ greatly in their approach.

Cultural humility (Tervalon & Murray-Garcia, 1998) is one of the very few theoretical frameworks that explicitly recognises the nuances that exist in clinical relationships, specifically power and privilege differences and wider aspects of cultural competence, namely organisational and institutional influences. Whilst cultural humility provides a theoretical revisioning of traditional cultural competence models and appears favourable in the literature, it is less developed than current cultural competence models and deficient in educational underpinnings. However, the model holds strong promise for health outcomes as documented by the array of medical literature reporting improved patient outcomes and practitioner-client relationships from adopting a cultural humility framework (for example, Alsharif, 2012; Chang et al, 2012; Juarez et al, 2006; Ross, 2010).

8.2 DISCUSSION OF THEME II: RELATIONSHIP-CENTRED CARE

The centrality of relationships in healthcare practice and in relation to diversity teaching was a recurring theme in the workshops. Overall the findings from all three stakeholder groups situated diversity issues in different clinical relationships, describing the interplay of diversity issues during interactions with one another. The findings emphasised the importance of actively considering the dynamics and nuances of clinical relationships in being able to better understand and respond to cultural diversity

issues. The importance of good relationships in healthcare is consistently documented throughout healthcare literature, with evidence based research demonstrating that good healthcare relationships can lead to better patient outcomes, patient/provider satisfaction, increased compliance and adherence to medical advice, effective team building and positive attitudes. Although the focus on relationships has not been explicitly addressed in different theoretical frameworks, increasing research on diversity issues demonstrates the significance of unpacking relationships and clinical interactions. Participants highlighted the popular tendency to either focus on patient-centred care or professional development, but multiple accounts drew attention to the reciprocal and meaningful influence the patient and the professional had on each other. The findings illustrate that each is an observer of the other; each interprets and constructs a subjective world and these worlds are modified by the dialogue between them and the nature of their relationship. This is consistent with social constructivist perspectives in acknowledging the importance of context and how meanings are constructed and reconstructed based on our external experiences with others.

Based on the workshop findings, diversity education would be better situated in the context of relationship-centred care, where the nuances of clinical interactions and the influence of both the professional and patient are actively acknowledged and explored. The practitioner-self relationship is especially important.

8.2.1 Practitioner-self relationship

When participants were attempting to establish their expectation of culturally competent practitioners, overall the discussions cohered on the expectation that professionals would be proficient in the skills, values and attributes that underpin a good therapeutic relationship i.e. communication, trust, empathy and respect, which one can argue to be the very basics of healthcare competencies. All participants' principal expectation was that professionals would have a better understanding of themselves, referred to in the workshop findings as the 'practitioner-self relationship'. Participants actively encouraged professionals to first understand themselves to help better understand how diversity and culture affects the patient's experience and their understanding of health and illness. This is consistent with theoretical frameworks for professional development which echo the need for professionals to first understand their own professional identity, as this characterises their ways of interacting with and relating to others.

While the focus on relationships has not been explicitly addressed in different theoretical frameworks for culture and diversity and debates on this topic, the importance of continual reflection and self-awareness is addressed in prominent frameworks that depart from the traditional cultural competence models, such as cultural humility, cross-cultural efficacy and cultural sensibility. These frameworks advocate that the starting point for understanding and recognising the complexity of what diversity brings to clinical settings resides with first understanding oneself. Engaging in professional development allows individuals to reflect upon what diversity and culture means to them and how it applies to the context in which they work. The findings of this study are unique in that, unlike traditional theoretical models associated with diversity such as 'cultural competence' and 'cultural awareness', which prescribe the necessity to develop cultural knowledge about different cultural groups, they return to the fundamental principles of care and compassion. The significance of relationships in which differences between the patient and professional are valued, acknowledged and acted upon is explicitly transparent in the findings. Many of the participants agreed that isolated increases in cultural knowledge and sensitivity without consequent change in a professional's attitude and how they relate to different patients is of questionable value when trying to improve the way professionals acknowledge and respond to diversity. This is consistent with criticisms of traditional cultural competence models that claim that acquiring cultural knowledge and facts about different cultural groups translates into competence in cross-cultural settings. The workshop findings support the departure from traditional cultural competence models focused on attaining knowledge, to models which advocate a change in attitudes and the development of interpersonal skills. The findings clearly showed that the aim of diversity education is not to learn about others but to learn about oneself, in order to facilitate a better understanding of others in how they are similar to or different from oneself. This level of self-awareness accompanied by interpersonal skills and attributes conducive to developing a good relationship will lead to competence in intercultural settings.

Although the findings suggested the emphasis on the practitioner-self relationship, particularly in relation to diversity education, participants from all stakeholder groups expressed their concerns with the challenges healthcare professionals face in practising self-awareness and reflection on their own culture and diversity. This has been defined in the literature as the "*anthropological paradox*" (Needham, 1972; Walzer, 1994) which describes the difficulty in being able to actively define and recognise one's own culture and to objectively critique the subjective nature of one's

practices and assumptions. This difficulty may account for why culture for the large majority remains a vague concept, especially for those individuals whose cultural practices and norms are less explicitly defined. The workshop findings highlighted the significant challenges experienced by diversity educators and trainers in facilitating discussions about one's own assumptions, practices and biases. Many reported an unwillingness of trainees to participate, uncertainty on how to constructively facilitate discussions of sensitive issues and negative attitudes towards the relevance of reflection and self-awareness. Similarly, research has shown that trainers commonly experience defensiveness, anger and denial when presenting diversity material (Abrams & Gibson, 2007; Stith-Williams, 2007). The issue is not that these reactions arise, as arguably these responses are part of a normal process when exploring topics outside one's comfort zone. Rather, training models may not be designed in a way that mobilises learners to shift from defensive responses to a more refined critique. Diversity awareness, values, attitudes, knowledge and skills cannot be imposed. These realities must be considered, experienced, developed and owned. Further consideration may be needed on whether traditional didactic methods of teaching diversity education are appropriate for the training content, which requires experience and skills in facilitating difficult and challenging discussions and contending with group dynamics. The complexity and sensitivity of the diversity training requires a greater understanding of how to create a supportive environment in which to frame and deliver this teaching that will allow participants to constructively explore their own culture, biases and assumptions.

8.2.2   Practitioner-patient relationship

The workshop findings demonstrated the significance of the practitioner-patient relationship as a medium where the basic needs of both the practitioner and patient for connection, meaning and understanding are met. Participants from all stakeholder groups reported that cultural and diversity issues were significant variables in impeding the development of a good therapeutic relationship. This was described as creating a cultural distance. The practitioner-patient (sometimes referred to as the 'doctor-patient' relationship) is the most widely explored type of relationship in healthcare and fundamental to patient care. In reference to the wider literature the notion of 'cultural distance' closely matches the well-known sociological idea of 'social distance' which is categorised into four dimensions, which are cultural, normative, interactive and personal (Kadushin, 1962). Kadushin states that social distance can have both

advantages and disadvantages in maintaining stable interactions where both closeness and understanding and objectivity and detachment are essential to the practitioner-patient relationship. Conversely the findings from the participatory workshops from both the patient and the healthcare professional groups suggests there is a greater need for closeness and understanding in healthcare relationships both in general and particularly in intercultural relations.

Kadushin defines 'cultural distance' as the 'degree of value sameness that exists between two persons or statuses' (Kadushin, 1962; pp.98). This definition emphasises that it is the difference in values that creates a cultural distance, which was also noted in the workshops. Social scientists such as Kadushin, Talcott and Parsons (1951) examined the complexity of social distance in its origins and manifestations. Simmel (1960) identified a difference between perceived feelings of social distance which represent individual attitudes and those which denote norms about interactions between statuses. Interestingly, the workshop findings concerning cultural distance appear to derive from a perceived difference in individual attitudes and values. Issues concerning differences in status were mentioned among the NHS healthcare professionals especially regarding relationships between professionals. Whereas issues concerning power and privilege in the practitioner-patient relationship are explicitly addressed in the cultural humility model, they were only slightly alluded to by the participants in this qualitative study. The concept of social distance became the foundation for the Bogardus social distance attitude scale (Bogardus, 1923; Selitz et al, 1993) which operationalised the notion of social distance into a concrete continuum attempting to measure one's attitude and willingness to endorse certain cultural attitudes or prescriptions about role relations. The Bogardus social distance scale has been used in evaluation tools to measure the effectiveness of diversity training such as the CDET (Curcio et al, 2004).

A few of the participants from each stakeholder group questioned whether ethnic or racial concordance between the practitioner and the patient could help in facilitating shared meanings and better relationships, thereby limiting this perceived cultural distance between two parties. A few participants attributed cultural differences and cultural distance to racial or ethnic differences between the practitioner and the patient. The inequalities in healthcare between White and non-White groups are extensively and frequently documented (Bhui & Bhugra, 2000; Fiscella et al, 2000). Research has shown a wide range of contributing factors to racial inequalities in healthcare which

vary from socio-economic reasons to cultural issues (Nazroo, 2013; Williams et al, 2005). It appears the fundamental problem may be that that cultural misunderstandings are a primary source for racial disparities in healthcare (Hsing-Yu Yang, 2015; Adams et al, 2015; Bhugra et al, 2000).

The literature reflects an ethos that cultural misunderstandings stem from those of a White race and not those of a non-White race. It also implies that non-White patients are different from their White health professionals, and arguably that racial differences are a source of dissimilar cultural health beliefs and practices (LaVeist et al, 2002; Saha et al, 2011; Megahani, 2009). Yet, it fails to consider the situation vice versa; that cultural misunderstandings can stem from those of non-White race and even amongst patients and health professionals of the same race (Ryn & Burke, 2000; Chen et al, 2005; LaVeist & Neru-jeter, 2002; Malet & Hamilton, 2006). There is often an unquestioned assumption that individuals of the same race share similar values, life experiences and cultural beliefs. However, racial discordance does not necessarily imply cultural differences. In addition, this assumption that race concordance between the patient and the provider leads to better quality of care has not been thoroughly tested. Research does not show consistent support for the idea that non-White patients prefer the same race provider and that patient satisfaction improves in racially concordant pairs (Sacks, 2013). It is unclear whether the lack of cultural similarities or our inability to recognise, adapt and relate to different patients' cultural and diverse needs is the source offer racial inequalities.

The workshop findings from all stakeholder groups suggested that the perceived cultural distance between the practitioner and the patient may be present with individuals from the same cultural background and a discordance in race or ethnicity may not be the only source of cultural differences. All stakeholder groups stressed the importance of interpersonal skills, in particular clinical communication, for bridging any cultural distance between the practitioner and the patient. Similarly, the importance of communication has been noted in several theoretical frameworks for diversity education such as the LEARN model (Berlin & Fowkes, 1986). Mental-health patients in particular emphasised the importance of eliciting 'respectful curiosity' from the practitioner and asking, not assuming, the patient's cultural or other needs. As in the cultural humility model, 'respectful curiosity' was seen as a constituent component of demonstrating humility in a clinical setting. For a relationship to be therapeutic, the professional and patient need to acquire a shared understanding of the meaning of the

illness, which is arguably through communication and the use of the practitioner's interpersonal skills. Many of the participants said healthcare professionals fall short in facilitating this shared understanding of meaning. Research exploring patient perspectives in clinical consultations suggests that many healthcare professionals have a limited capacity to 'sense meaning', especially at an affective, cultural and spiritual level (Frank, 1991; Hawkins, 1993; Prince, 1994). As differences in culture between two individuals become greater, the practitioner may be increasingly unable to sense meaning and develop rapport and may become increasingly distant and detached from the patient's cultural identity and experience. Further research is needed to explore why a cultural distance may occur between two individuals and how communication and interpersonal skills can be adapted to bridge this divide.

8.2.3   Practitioner-practitioner relationship

Overall the workshop findings drew attention to the relationships between practitioners and their colleagues in shaping one's professional identity and influencing one's expression of personal identity. The mental-health patient groups emphasised the importance of practitioners supporting each other and working as a team, as failure to do this has implications for patient care. The relationships between practitioners in contributing to the understanding of one's sense of self and depicting how one defines and responds to diversity issues is rare in or absent from most theoretical frameworks concerning diversity education. Issues concerning wider institutional and organisational factors are mentioned in a few of the theoretical frameworks relating to diversity education. Healthcare professionals are subjected to unofficial rules, habitual practices and attitudes which are subsequently reproduced and reinforced in day to day interactions (De Montingy, 1995). In this way, professional identities and cultures are transmitted and social roles passed down (Giddens, 1984). This is consistent with the Social Identity Theory (Jenkins, 1996) and the Personality and Social Structure Perspective (House, 1997).

Understanding one's self is an integral part of diversity education and these findings suggest that greater attention is needed in exploring how different clinical relationships, in particular relationships between practitioners, shape one's professional identity and ways of relating and interacting with others. However, all stakeholder groups said that the current culture of healthcare is not conducive to or centred on developing and maintaining good relationships. Compared with the vast array of literature on the

practitioner-patient relationship and its influence on patient outcomes, the quality of the relationships between practitioners is relatively unstudied. There remains a paucity of evaluative measures for determining the effect of quality of relationships amongst staff and with colleagues and also wider organisational relations.

Similar to the issues raised in the practitioner-patient relationship, the importance of communication and care between colleagues was strongly emphasised. All stakeholder groups reported that poor communication between colleagues further exacerbated diversity issues and a lack of care and compassion between staff created further cultural distance between different groups of professionals, fostering an 'us versus them' posturing. Recent health reports in the UK and internationally suggest that medical errors are never solely a result of individual incompetence, but rather are attributable to poor organisational systems (Safran et al, 2005). This will be discussed further in the 'practitioner-organisation' section below. Also, recent health reports have highlighted that medical errors and health disparities in care are largely a result of poor communication among healthcare teams (Baggs et al, 1992; Donchin et al, 1995; Sexton et al, 2000; Helmreich, 2000; Leonard, 2004). As concerns about patient safety increasingly arise, the significance of relationships among practitioners will be increasingly important. However further research is needed on how diversity amongst practitioners affects team-working and the individual's professional identity.

The benefits of collaborative team-work are well-documented in the literature. Also, better patient health outcomes have been associated with highly integrated and collaborative care teams (Gitell et al, 2000), which the mental-health patients emphasised in the workshop findings. Specifically, Gitell et al (2000) found better 'relational coordination' amongst care teams was significantly associated with better patient outcomes. Relational coordination is defined as frequent, timely, accurate communication along with shared goals, shared knowledge, mutual respect and problem solving. Likewise, Shortell et al (2008) found that team culture was significantly associated with better outcomes of care. Shortell also asserted the importance of open communication among professionals as well as care and compassion for each other. All stakeholder groups emphasised the way in which healthcare professionals respond to diversity is often mirrored in how they see other professionals respond to diversity issues, even if this might seem contradictory to one's own personal or professional identity.

8.2.4. Practitioner-organisational relationship

The lack of organisational commitment to and involvement in diversity issues was apparent in all the stakeholder groups. According to a recent review of cultural competence trainings in UK healthcare settings (George et al, 2015), lack of institutional commitment was given as a primary reason for the inconsistencies in how diversity training is understood, applied and implemented in practice. This systematic review re-emphasised the lack of coherent and consistent leadership in diversity, describing leadership in this area as "*pockets of individual efforts*". Sadly, recent reviews and articles in diversity education strongly support this claim. This relational dimension closely influences the practitioner-practitioner relationship, where the lack of institutional support for diversity failed to encourage professionals to actively respond and value diversity issues. Many participants, in particular those in the NHS healthcare professional groups, said that leaders and heads of department disengaged from openly discussing diversity issues or failed to address diversity issues unless it was specifically part of their role. Again, this is consistent with recent reviews concerning diversity education: a greater level of leadership is needed to implement the principles of diversity education in practice. Also, as similarly mentioned repeatedly in the literature, more transparency is needed in healthcare policy documents on how leaders and policy makers define the terms diversity, culture and cultural competence.

The workshop findings also highlighted the inability of the current healthcare system as an environment to foster the development and maintenance of good relationships. Factors such as power, hierarchy, competing threats, lack of support, financial and time constraints play a role in impeding the quality of different clinical relationships. Participants from all stakeholder groups expressed their strong desire to form meaningful relationships with patients, colleagues and peers but continually demonstrated the challenges in doing so given the current healthcare environment. Medical educators in particular said that the challenge in implementing diversity education is that the focus on medical education remains anchored in the biomedical model rather than the patient experience and developing a professional's sense of self (Smith et al, 2014). Traditionally medical education has favoured the biomedical perspective which in turn has constructed an objective world of abstractions of disease that is detached from the subjective world of patients. Many medical educators actively acknowledged this and expressed their concern that an assessment driven medical education culture will continue to move the emphasis away from the importance of

professional development and understanding the patient experience, which in turn devalues the importance of diversity education. A change in the educational approach first requires healthcare professionals to acknowledge and value their capacity to be reflective, meaning to make explicit their own sense of professional identity, reflecting on their own interpretation of health and illness and the impact of diversity, which in turn will help them become more open to the different ways patients respond to and experience illness.

The workshop findings provided clarity about how diversity education can be better theoretically informed. Framing diversity teaching around 'relationships' with the 'practitioner-self' relationship at the centre holds promise of a theoretical model that could integrate diversity education throughout the medical curriculum and provides distinction and clarity in relation to other frameworks for culture and diversity which are often misinterpreted and interchanged with one another. It situates diversity education within a broader framework demonstrating the relevance of diversity in relation to all aspects of clinical practice.

CONCLUSION

Efforts to enhance patient-centeredness without the professional understanding him or herself, and the impact of the professionals' relationships with their colleagues and the organisation has the potential to exacerbate existing disparities in care and result in a lower quality of care for all patients. Reframing diversity education in the model of relationship-centred care ensures a framework that can be easily embedded in NHS and health educational institutions and ensure health services are aligned to meeting the needs of all patients. Relationship-centred care advances the principles of its predecessor patient-centred care and is arguably better suited to theoretically inform diversity education.

CHAPTER 9: RECONSTRUCTED RELATIONSHIP-CENTRED CARE MODEL

The aim of this chapter is to describe the development of the reconstructed relationship-centred care (RCC) theoretical model, which emerged from the findings of the participatory workshops outlined in the preceding chapters. The reconstructed RCC represents the theoretical contribution of this thesis, and the chapter describes how this framework can be situated within an educational stance.

Weber's construct of ideal types (Giddens, 1971; Morrison, 1995) is used to demonstrate and distinguish the theoretical progression from cultural competence to the reconstructed RCC model and to situate this new model within a sound educational framework. The rigour of the ideal types method explicitly allows comparisons between the educational philosophy, educational process, educational content and the educational and clinical outcomes to be made. Given the assortment of and lack of conceptual clarity between different theoretical frameworks on diversity, using the ideal types demonstrates organised analytical distinctions. The reconstructed RCC model formed the basis upon which an evaluation tool (SJT) was built, which is outlined in the next two chapters.

9.1. FINDINGS OF THE PARTICIPATORY WORKSHOPS

The findings from the participatory workshops demonstrated a discernible pattern of common themes for how diversity education can be better taught and evaluated. Overall the findings of the participatory workshops from all three stakeholder groups converged on the importance of relationships in healthcare, in particular the strong emphasis on the practitioner-self relationship. In addition, the different stakeholder group findings cohered across three other relational dimensions, namely the practitioner-patient, practitioner-practitioner and the practitioner-organisation.

The findings of the participatory workshops provided supporting evidence for the theoretical progression away from knowledge-based cultural competence models to process orientated models, emphasising self-development and awareness. However, in comparison to the array of theoretical frameworks used in diversity education, the findings were most closely consistent with the relationship-centred care framework (Tresolini & Pew Fetzer Task Force, 1994) which has not been applied in diversity

education. A reconstructed RCC model was developed both to include the extra practitioner-self dimension and to refine the original three dimensions in the light of the workshop findings.

9.2. RELATIONSHIP-CENTRED CARE FRAMEWORK

9.2.1. Historical origins of the relationship-centred care framework

The term 'relationship-centred care' (RCC) was first introduced in the Pew Fetzer Task Force Report (1994) on Health Professions Education. Its conception has evolved from the history of power present in the doctor-patient relationship. The blooming biomedical era of the late 1960s to 1970s was increasingly based on principles of scientific study, resulting in medical decision making becoming a professional prerogative, distant from the involvement and the lived experience of the patient. Although the term was not formally used, this era of healthcare and the power dynamics in the doctor-patient relationship could be characterised as 'doctor-centred care'.

The 1970s onwards exemplified a strong movement away from the reductionist perspective of biomedical science towards a participatory process recognising and valuing the lived experience of the patient, thereby shifting the focus from cure to care. New integrative disciplines such as family medicine, child and adolescent mental-health and general internal medicine challenged the unilateral authority of the doctor and the resulting depersonalisation of care associated with the biomedical stance. A new medical paradigm was proposed to facilitate an integrative, holistic approach to care, titled the 'bio-psychosocial model' (Engel, 1977). This represented both a philosophy of clinical care and a practical clinical guide, and showed the need to understand different aspects of the patient's subjective experience. This trend from doctor-centred care to the bio-psychosocial model can be characterised more clearly with the term 'patient-centred care' (McWhinney, 1989).

The notion of patient-centred care signified the importance of patients being active participants in the decision-making process of their care. The evolving polemics of power in the doctor-patient relationship was the context in which the Pew-Fetzer Task Force (1994) was developed. The report reflects this debate and suggests the process of care could neither be successfully understood from a doctor-centred nor a patient-centred perspective alone, but rather requires attention to the relationship between the

doctor and the patient, leading to the term 'relationship-centred care' (Pew-Fetzer Task Force, 1994). This notion acknowledged the personhood of the doctor (referring to the doctor as an individual) as equally important to the person-hood of the patient in depicting how well they work together. The personal dynamics and nuances of the relationship were distinct from attributes solely focusing on the patient or the doctor.

9.2.2. Description of the existing framework of relationship-centred care

Relationship-centred care (Tresolini and Pew Fetzer Task Force, 1994) is a clinical philosophy that provides a values foundation on the fundamentals of being a professional. It highlights the role of a health professional and how it is founded upon meaningful relationships with patients, other professionals and the wider health community. The RCC framework explicitly defines three dimensions of relationships in healthcare, namely the relationship between the practitioner and the patient, the practitioner and the community and the practitioner with other practitioners, i.e. the relationship between colleagues, shown in Table 9.1. The importance of self-awareness and reflection in influencing how these different relationships are manifested is also emphasised. Therefore, the notion of RCC advocates a clinical approach based on shared decision making, collaboration and partnership in every clinical relationship. This framework holds communication, relational dynamics and the attitudes and behaviours towards developing partnerships as integral in determining the success of different clinical relationships.

Each dimension of relationship-centred care is a unique product of its participants and its context and is interrelated with the other dimensions. Within each relational dimension, these are then categorised into different sections which stipulate a set of knowledge, skills and values. The practitioner-patient defines this relational is the medium through which connection and meaning between the practitioner and the patient are established. The existing RCC framework outlines various components to positively foster a therapeutic practitioner-patient relationship, which includes practising from a caring, healing ethic and perspective that seeks to preserve the dignity and integrity of the patient and patient's family. The practitioner-practitioner relationship advocates the importance of establishing an effective and empathetic community of practitioners within and across disciplines. This dimension highlights the importance of team work, shared values, helping others learn and develop and working beyond issues of specialism, hierarchy and privilege. RCC states these relationships are

beneficial for the needs of the practitioners and patients and promotes the professional development and maturation of practitioners. The last dimension titled the practitioner-community relationship acknowledges that individuals belong to multiple communities as a result of exposure to different cultures and work contexts. Components include developing a sense of community responsibility and recognising and acting in accordance with the values, norms, social and health concerns of the community.

Beach et al (2006) expanded upon the ideas of RCC and articulated four core principles of the RCC framework. These were; 1.) *"Relationships in healthcare ought to include the personhood of the participants."* This principle acknowledges the individuality of people in healthcare relationships and the explicit need to recognise both the patient and the clinician as unique individuals with their own set of experiences, values and preferences. 2.) *"Affect and emotion are important components of relationships in healthcare."* Affect and emotion are influential variables in the development, maintenance and termination of healthcare relationships. Empathy is of clinical benefit to relationships as it helps the patient to experience and express their emotions and enables clinicians to understand how to meet the patient's needs and improve the experience of their care. 3.) *"All healthcare relationships occur in the context of reciprocal influence."* This describes how healthcare actions occur in relation to one another in time, space and content, and are not isolated occurrences. Relationships provide a context for interactional exchanges. The aim in a clinical relationship is not to create a friendship between unequals in which the professional is considered the expert, but to create a partnership in which both parties learn, exchange and develop each other's character and assist in attaining the best care for the patient. This partnership acknowledges that both the clinician and patient benefit from the relationship. Finally, 4.) *"Relationship-centred care has a moral foundation."* RCC embodies the notion that developing and maintaining genuine relationships is morally valuable. Genuine relationships foster the ability for a clinician to truly serve the patient.

Arguably the principles of RCC and patient-centred care are not entirely mutually exclusive. RCC emulates and expands upon the principles of patient-centred care by re-establishing the influence and perspectives of the practitioner and introducing the explicit attention on the relationship itself. Soklaridis et al (2016) identified that most articles differentiated RCC from patient-centred care in the following five ways: 1.) RCC explicitly focuses on how practitioners relate to the patient, 2.) RCC acknowledges relationships as therapeutic and the medium of care, 3.) The practitioner and patient

influence and bring important aspects to the relationship, 4.) RCC emphasises the necessity of the practitioner being present for themselves and others and 5.) RCC recognises the influence of relationships on the quality, course and outcomes of care (Wyner et al, 2014). Additionally, practising RCC has been frequently cited as a reason for improving PCC (Engel et al, 2012; Sprague, 2009), with several articles demonstrating positive outcomes for both patients and practitioners (Dobie, 2007; Madigan, 2001; Manning-Walsh et al, 2004).

9.3. LIMITATIONS OF THE RELATIONSHIP-CENTRED CARE FRAMEWORK

When examining the existing RCC framework there appears to be a duplication of attributes in the different relational dimensions, notably in issues pertaining to the importance of self and principles of patient-centred care. Whilst RCC values self-awareness and emphasises the capacity for practitioners to be reflective and critical, it does not explicitly define the importance of the practitioner's own self-relationship as a separate dimension to the framework. The characteristics of self-awareness and self-growth are situated with the practitioner-patient relationship. Within the other dimensional relationships there is an assumption that clinicians are aware of their own reactions, emotions and biases in clinical relationships and can monitor their behaviour in light of this self-awareness. Diversity education and the findings of the participatory workshops show that professionals frequently fail to acknowledge their own, often ill-defined and multi-dimensional identity and culture and how this impacts their clinical relationships. The importance of the practitioner-self relationship as the foundation for subsequent development within the other specified relationships is neither explored nor addressed.

Notably the RCC framework refers to the importance of respect and affirmation of cultural diversity in the practitioner-practitioner and practitioner-community relationships, but not in the practitioner-patient relationship. There is little indication of how cultural and diversity issues affect these two relationships and not the practitioner-patient relationship. This contrasts with the majority of literature on diversity issues, which emphasise the presence of cultural and diversity issues in the practitioner-patient relationship. In its current form with little to no description of the impact of diversity issues on different clinical relationships, it appears ill-suited to be applied in diversity issues. In addition, the stipulated knowledge, skills and values in each relational dimension appear blurred and overlapping, making it challenging to distinguish the

different identities professionals will participate in and the necessary knowledge, skills and values that facilitate these different clinical relationships.

Another limitation identified which resonates with the large majority of theoretical frameworks in diversity education is the lack of educational underpinning and the translation of this abstract framework into objective and structured teaching materials and assessments. Little to no description is provided on the types of educational theories used to inform the RCC framework and teaching of its principles.

9.4. PREVIOUS PROPOSALS OF REVISIONS TO THE RELATIONSHIP-CENTRED CARE FRAMEWORK

Critiques and revisions of the relationship-centred care framework (Tresolini et al, 1994) are relatively limited in the literature, with new proposals only emerging more than a decade after the framework was introduced (Suchman, 2005; Safran et al, 2005; Beach et al, 2006). Different proposed revisions and expanding of the RCC framework has included the role of organisational culture, with Soklardis et al (2016) and colleagues suggesting three new sub-categories to the practitioner-organisational relationship; namely practitioner-education, practitioner-profession and practitioner-practice. New proposed models of relationship-centred organisations (Safron et al, 2005) and relationship-centred administration (Suchman et al, 2011) have been developed. Other widely cited new revisions include the complex response processing of relating (CRPR, Suchman, 2005) and the addition of a technology component to RCC (Suchman et al, 2011). The recent revision of the biopsychosocial model (Carrio et al, 2004) upon which the notion of RCC was founded has influenced these new proposals. A brief description of a few different previous proposals that include a reference towards diversity and exploration of self are next described to showcase the different directions the RCC framework can be expanded upon. They also highlight the potential scope for including the importance of recognising and valuing diversity in the RCC framework.

Suchman (2005) theory of CRPR argues that the existing RCC model fails to account for the unpredictability of clinical interactions and focuses on the relational outcomes as opposed to the relational processes. CRPR classifies human interactions as unpredictable, where patterns of relating and meaning are continuously re-enacted and recreated, formally defined as 'self-organising' patterns. CRPR states that diversity

creates further complexity in the emergence of self-organising patterns and suggests differences should be approached with curiosity as opposed to fear and defensiveness. This is consistent with the notion of 'respectful curiosity' formally introduced in the cultural humility framework (Trevalon & Murray-Garcia, 1998) and resonates with theoretical frameworks which depart from the traditional notion of cultural competence. CRPR offers an approach to encouraging practitioners to participate more mindfully in the relational process and how diversity can result in different patterns of self-organisation. Like many theoretical frameworks used in diversity education, CRPR is abstract in description, making it challenging to translate into educational teaching material. Whilst diversity is acknowledged as a contributing factor in influencing the patterns of relating and meaning in clinical relationships, few examples are included on how diversity can alter or distort normal patterns of self-organisation in both positive and negative ways.

Safron et al (2005) introduced the notion of relationship-centred organisations and highlighted the disproportionate emphasis in the study of the practitioner-patient relationship in comparison to other relationships posited by the RCC model. Safron et al identified seven relationship characteristics that constituted the core components of the relationship-centred organisations, one of which includes diversity. However again fails to describe how diversity can foster or inhibit high team functioning and organisational practices. It also is devoid of considering how this proposed framework can be applied in an educational setting. The biopsychosocial model (Engel, 1977) underpins the development of the RCC framework. However, the term biopsychosocial implies that the human experience consists of three separate dimensions – biological, psychological and social, as opposed to one reality that the patient experiences. It also fails to address the importance of relationships in healthcare, particularly in reference to reflection and awareness of one-self.

Carrio et al (2004) proposed a revised version for a bio-psychosocial orientated clinical practice that comprised seven constituent components. These are 1.) Self-awareness of the practitioner, 2.) Active cultivation of trust, 3.) An emotional style characterised by empathetic curiosity, 4.) Self-calibration as a way to reduce bias, 5.) Educating the emotions to assist with diagnosis and forming therapeutic relationships, 6.) Utilising informed intuition and 7.) Communicating clinical evidence to foster dialogue as opposed to using it as purely a scientific approach. Notably, many of these constituent components are closely similar to those outlined in theoretical frameworks which depart

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from the traditional cultural competence and ethno-centrism perspective. These revised components echo the impetus of diversity related educational outcomes of fostering self-awareness, reducing bias and developing skills in communication. However further research is needed to explore how this revised approach can be applied in healthcare settings. The current RCC framework has not been significantly changed by previous proposals of revisions or reframing, nor have these proposals assisted in situating the RCC framework within an educational stance.

9.5. RECONSTRUCTING THE RELATIONSHIP-CENTRED CARE FRAMEWORK

9.5.1. Process of reconstructing the relationship-centred care framework

The route for developing the reconstructed RCC model was an iterative process. The development of the reconstructed RCC model occurred in the stages outlined below.

1. A comparison of the templates developed from each of the three key stakeholder groups were critically examined for areas of conceptual overlap and difference. The four relational dimensions were consistent throughout. A summary of this process is shown in Appendices 9.1– 9.3.
2. This tentative over-arching template from the findings of all three stakeholder groups (shown in Appendix 9.4) was then reviewed in the light of the existing RCC framework.
3. The process of reconstruction then proceeded by firstly accommodating the extra dimension of the 'practitioner-self' relationship which was the prerequisite for optimising the quality and nature of the other relational dimensions. The other three existing relational dimensions were reconstructed in light of the findings of the participatory workshops. This is shown in Appendices 9.5, 9.6 and in Table 9.2.
4. The reconstructed RCC model developed in stage 3 was then reviewed in conjunction with different proposed revisions of the RCC framework to assess areas of conceptual similarity or difference.
5. The reconstructed RCC model was then revised to substantiate the model within a coherent educational stance, explicitly defining the educational philosophy, process, content and outcomes. This educational reframing and demonstrating the theoretical progression from cultural competence to the

reconstructed RCC model was presented in a format consistent with how the two ideal types of cultural expertise and cultural sensibility were presented (Dogra, 2004), shown in Table 9.3. Given the limited application of educational theories and evidence based guidelines in theoretical frameworks on diversity education, reconstructing the RCC framework within an educational stance was essential.

9.5.2. Description of reconstructed relationship centred care model

The reconstructed RCC model represents a transformed perspective on how diversity education should be theoretically framed. The reconstructed RCC model defines four dimensions of clinical relationships that are integral in healthcare practice and the understanding of diversity issues, namely the practitioner-self, practitioner-patient, practitioner-practitioner and practitioner-organisation relationships (shown in Table 9.2). Each relational dimension is further categorised into sub-sections, and within these sub-sections stipulated sets of attributes are defined.

The attributes outlined in the reconstructed RCC model are intended to be illustrative rather than comprehensive, as many positively associated attitudes, skills, behaviours and values can be incorporated. Each sub-section of the relational dimension is not static, many new attributes can be nested within higher-order concepts and values, behaviours, knowledge and skills will continue to change as these are interactional processes, arguably dependent on context. Another important aspect is that is impractical to dictate how much of a given attitude or value is optimal in practice. The optimal level or intensity of the attitude, value or behaviour will depend on the circumstances and context (Suchman, 2005; 2011). Listing concrete attributes for each relational dimension would also disregard the 'art form' of healthcare practice.

The first and most important relationship which fosters positive relationships with others is the practitioner-self relationship. The reconstructed RCC framework argues that understanding oneself and what diversity means on an individual level facilitates a better understanding and value for diversity in others. This is particularly important for educators teaching diversity, and faculty development is included as the first sub-category of this dimension. Other sub-categories include identity, self-growth and development and culture and diversity. This relationship is arguably the most challenging to explore as it involves identifying and overcoming personal assumptions and biases. The second dimension is the practitioner-patient relationship which

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expands upon the principles of PCC by placing an equal emphasis on the practitioner as well as the patient and highlights the knowledge, skills and values that underpin a therapeutic relationship. This dimension includes the sub-categories of approach to practice, developing and maintaining relationships and the patient's experience of health and illness and the multiple contributions to health and illness within the community. The third dimension tilted the practitioner-practitioner relationship acknowledges the significance of relationships between colleagues in depicting one's sense of professionalism and appropriate responses towards diversity issues. It touches upon themes such as role-modelling, professionalism and team and community building. The final dimension is the practitioner-organisation relationship, which draws attention to the organisational culture, workforce learning and development, leadership and effective community based care. Clinical communication is integral to all healthcare relationships as it is the medium through which connection and meaning are established.

9.5.3. Educational reframing and exploring theoretical progression using ideal types

RCC closely represents an ideology rather than a sound educational theoretical framework. Weber's ideal types provides educational organisers to establish the reconstructed RCC model within an educational model and to distinguish the theoretical progression from cultural competence to the reconstructed RCC model (shown in Table 9.3.) The comparison between the cultural competence/cultural expertise model and cultural sensibility model was established using Weber's construct of ideal types (Giddens, 1971; Morrison, 1995) on several characteristics. These characteristics were grouped into four categories pertinent to curriculum development, delivery and evaluation. These were educational philosophy, educational process, educational outcomes and educational and clinical outcomes. The cultural competence/ cultural expertise and the cultural sensibility model (Dogra, 2004) have contributed in creating the ground work for models such as the reconstructed RCC model to be developed.

Table 9.3 demonstrates the systematic analytical distinctions between the cultural competence and cultural sensibility model in relation to the reconstructed RCC model and how each model builds on present approaches to teaching diversity education. The text highlighted in blue is used to indicate areas of conceptual similarity between the

models and the text highlighted in red illustrates areas of conceptual difference between the models. As shown in Table 9.3, the educational philosophy (which informs all stages of curriculum development, design and evaluation) behind the cultural sensibility model and the reconstructed RCC model is closely similar, however expanded upon in areas to showcase the relational and collaborative dynamics between individuals, and the need to focus first on exploration of self before others. The educational process depicts the way in which the educational philosophy is translated into practice. The primary difference in the educational process between the reconstructed RCC model and the cultural sensibility model is the learning process requires the acquisition of principles (attitudes and values driven) and skills resulting in other categories of the educational process/ content to differ. The learning outcomes are expanded upon in the reconstructed RCC model, to include developing a proficiency in the skills and attributes that underpin a good relationship, notably self-reflection, clinical communication and interpersonal skills. Educational theories such as self-authorship theory and the LPM (Kegan, 1995; Magolda, 2008) can be used as pedagogic approaches to maximise self and co-operative learning. The most apparent difference between the cultural sensibility and the reconstructed RCC model is in terms of educational outcomes. The reconstructed RCC model explicitly requires both teacher and student-self assessment. To meet the suggested educational outcomes a range of assessment methods are employed such as objective structured clinical examinations (OSCEs), reflective portfolios and pre and post questionnaires. The reconstructed RCC model shows promise for better theoretically informing and evaluating diversity education, however warrants further study, to understand what educational approaches lead to the adoption of a reconstructed RCC outlook or how RCC behaviours are best developed and fostered.

9.6 RATIONALE FOR A MIXED METHOD DESIGN

By definition, a mixed method design describes the mixing or integration of qualitative and quantitative designs in the research process for the purpose of adequately addressing the research aim and objectives in a single study (Tashakkori & Teddie, 2003; Creswell, 2005). A plethora of mixed method research designs exist, from not mixed (i.e. mono-method mixed design) to partially mixed to fully mixed (Creswell, 1994; Onwuegbuzie & Johnson, 2004). This research study employs a mono-method mixed design, meaning the exclusive use of either qualitative or quantitative designs in a single research study. When a research study combines the qualitative and

quantitative techniques to any degree it can no longer be classified as utilising a mono-method mixed design. In this study, the first phase (outlined in Chapters 6-9) of the research entails qualitative research methods and the second phase (outlined in this Chapter 10 and 11) involves using quantitative research methods. Thus, the qualitative and quantitative research phase are conducted sequentially. `

By employing a mono-method mixed design, it provides a comprehensive set of research findings that adequately address the research objectives. It provides a depth and breadth of understanding, whilst off-setting the inherent limitations of using each approach separately. The qualitative phase of this research was significant in informing the quantitative phase of the research. It was necessary to first establish and gain clarification and consensus on key aspects of curriculum development, design and evaluation for diversity education in order to inform the development of the evaluation tool. The sequential mono-method mixed design also allows the qualitative findings to be built upon the in the quantitative phase, allowing a more context specific evaluation tool to be built. Chapters 10 and 11 describe the development of a SJT based on the reconstructed RCC model which emerged from the qualitative findings of the participatory workshops.

CONCLUSION

The practice of healthcare is a dynamic, inter-personal process, where different relationships affect others. Understanding the four dimensions of the reconstructed RCC model creates a more integrated and comprehensive view of healthcare. Presenting the reconstructed RCC model using Weber's ideal types establishes it as an educational model and makes transparent the position and perspectives of the authors. It also demonstrates the theoretical progression and evolution of understanding on how diversity education can be better taught and evaluated. The reconstructed RCC model has the potential to improve professional practice and care for all patients, thereby reducing healthcare disparities which are based on diversity issues (i.e. ethnicity or disability). It provides a paradigm that moves beyond the concept of patient-centred care by focusing on all relationships that are integral to high quality care and delivery and the importance of diversity in healthcare settings.

TABLE 9.1: RELATIONSHIP-CENTRED CARE FRAMEWORK (TRESOLINI & PEW FETZER TASK FORCE, 1994)

DIMENSION ONE	DIMENSION TWO	DIMENSION THREE
PATIENT- PRACTITIONER RELATIONSHIP	**PRACTITIONER-COMMUNITY RELATIONSHIP**	**PRACTITIONER-PRACTITIONER RELATIONSHIP**
SELF-AWARENESS AND SELF-GROWTH **Knowledge** Knowledge of self **Skills** Reflection of self and work **Values** Importance of self-awareness, self-care and self-growth	THE MEANING OF COMMUNITY **Knowledge** Various models of community Myths and misperceptions about community Perspectives from the social sciences, humanities and systems theory Dynamic change: demographic, political and industrial **Skills** Learn continuously Participate actively in community development and dialogue **Values** Respect for the integrity of the community Respect for cultural diversity	SELF AWARENESS **Knowledge** Knowledge of self **Skills** Reflect on self and needs Learn continuously **Values** Importance of self-awareness
PATIENT'S EXPERIENCE OF HEALTH AND ILLNESS **Knowledge** Role of family, culture, community in the individuals development Multiple components of health Multiple threats and contributors to health as dimensions of one reality **Skills** Recognising patient's life story and its meaning View health and illness as part of human development **Values**	MULITPLE CONTRIBUTORS TO HEALTH AND ILLNES WITHING THE COMMUNITY **Knowledge** History of community, land use migration, occupations and their effect on health Physical, social and occupational environments and their effects on health External and internal forces influencing the overall health of the community **Skills** Critically assess the relationship of health care providers to community health	TRADITIONS OF KNOWLEDGE IN THE HEALTH PROFESSIONALS **Knowledge** Healing approaches of various professions Healing approaches across cultures Historical power inequalities across professions **Skills** Derive meaning from other's work Learn from experience within healing community **Values** Affirmation and value of diversity

Appreciation of the patient as a whole person Appreciation of the patient's life story and the meaning of the health-illness condition	Assess community and environmental-health Assess implications of community policy affecting health **Values** Affirmation of relevance of all determinants of health Affirmation of the value of health policy in community services Recognition of the presence of values that are destructive to health	
DEVELOPING AND MAINTAINING RELATIONSHPS WITH PATIENTS **Knowledge** Understanding of threats to the integrity of the relationship (e.g. power inequalities) Understanding of potential for conflict and abuse **Skills** Attend fully to the patient Accept and respond to distress in patient and self **Values** Respect for patient's dignity, uniqueness and integrity (mind-body-spirit unity) Respect for self determination Respect for person's own power and self-healing processes	DEVELOPING AND MAINTAINING RELATIONSHPS WITH THE COMMUNITY **Knowledge** History of practitioner-community relationships Isolation of the healthcare community from the community at large **Skills** Communicate ideas Listen openly Empower others Learn Facilitate the learning of others Participate appropriately in community development and activism **Values** Importance of being open-minded Honesty regarding the limits of health science Responsibility to contribute health expertise	TEAM AND COMMUNITY BUILDING **Knowledge** Perspectives on team-building from the social sciences **Skills** Communicate effectively Listen openly Learn co-operatively **Values** Affirmation of mission Affirmation of diversity
COMMUNICATION CLEARLY AND EFFECTIVELY **Knowledge** Elements of effective communication **Skills** Listen	EFFECTIVE COMMUNITY-BASED CARE **Knowledge** Various types of care, both formal and informal Effects of institutional scale on care Positive effects of continuity of care	WORKING DYNAMICS OF GROUPS, TEAMS AND ORGANISATIONS **Knowledge** Perspectives on team dynamics from the social sciences **Skills**

	Skills	Share responsibility responsibly
Impart information	Work as a member of a team or healing community	Collaborate with others
Learn	Implement change strategies	Work co-operatively
Facilitate the learning of others	Collaborate with other individuals and organisations	Resolve conflicts
Promote and accept patient's emotions		
Values	**Values**	**Values**
Importance of being open and non-judgmental	Respect for community leadership -Commitment to work for change	Openness to others' ideas
		Humility
		Mutual trust, empathy and support
		Capacity for grace

TABLE 9.2: FINAL RECONSTRUCTED RCC MODEL (TEMPLATE 3)

DIMENSION ONE	DIMESION TWO	DIMENSION THREE	DIMENSION FOUR
PRACTITIONER- SELF	**PRACTITIONER- PATIENT**	**PRACTITIONER-PRACTITIONER**	**PRACTITITIONER – ORGANISATION**
CLINICL COMMUNICATION			
FACULTY DEVELOPMENT	**APPROACH TO PRACTICE**	**PROFESSIONALISM**	**LEADERSHIP**
KNOWLEDGE -Knowledge of the influence of an educator's background, bias and assumptions on curriculum development, design and evaluation. SKILLS -Capacity for critical self-awareness and reflection. VALUES -Learning and professional development -Value for equality, diversity and fairness in the development and evaluation of education materials -Understanding the differences in values among different professionals, patients and careers	KNOWLEDGE -Knowledge of patient's background, needs and concerns -Knowledge of the patient's culture SKILLS -Self-awareness and reflection -Working in partnership -Collaborative involvement -Shared decision making -Patient-centred interviewing VALUES -Patient-centred care -Importance of individualised care and tailoring healthcare services to the patient -Respect for patient's dignity, uniqueness and integrity (mind-body-spirit unity) -Respect for self determination -Respect for person's own power and self-healing processes	KNOWLEDGE -Knowledge of professional values, ethics and codes of practice SKILLS -Exhibits and maintains professional relationships -Maintaining professional boundaries -Demonstrates respectful curiosity VALUES -Delivering high quality care and ensuring patient safety -Respect for cultural diversity -Sincerity and collaborative working	KNOWLEDGE -Knowledge of leadership, hierarchy and power relations within the organisational context SKILLS -Cultivates a healthcare system reflecting patient and professional values -Inspires and motivates professionals for excellence -Communicates powerfully and prolifically consistent messages and guidance -Builds strong organisational relationships -Champions and adapts to change VALUES -Importance of positive role models -Respect for community leadership -Commitment to work for change -Values and respects diversity

IDENTITY	DEVELOPING AND MAINTAINING A RELATIONSHIP	ROLE MODELLING	WORKFORCE LEARNING AND DEVELOPMENT
KNOWLEDGE -Knowledge of one's personal and professional identity -Knowledge of health expectations on one's professional identity **SKILLS** -Capacity for critical self-awareness and reflection of the multiple identities one can possess and how these different identities intersect and interact with one another. -Reflection of self and one's own professional practice -Self-awareness -Critical thinking and reflection **VALUES** -Importance of authenticity	**KNOWLEDGE** -Understanding of threats to the integrity of the relationship (e.g. power inequalities) **SKILLS** -Engagement and building rapport -Listening -Open-mindedness -Respecting the patient -Curiosity -Adaptation -Assurance and warmth -Flexibility -Learning from each other -Approachability -Non-judgemental -Empathy -Attends fully to the patient -Accept and respond to distress in patient and self -Self-awareness and reflection -Ability to communicate across different cultures and backgrounds -Facilitate the learning of others -Promote and accept patient's emotions **VALUES** -Importance of developing and maintaining authentic and genuine relationships -Demonstrating care and compassion -Maintaining the dignity and respect of the patient and self -Importance of being open and non-judgmental	**KNOWLEDGE** -Knowledge of the impact of the hidden curriculum and the influence of role-modelling on learners **SKILLS** -Ability to share responsibility -Collaborate with others -Work co-operatively -Resolve conflicts -Balance and manage different professional perspectives **VALUES** -Openness to others' ideas -Humility -Mutual trust, empathy and support	**KNOWLEDGE** -Discipline of continual development and up-dating knowledge and skills with the changing context -Organisational understanding of healthcare values **SKILLS** -Adaptive to change -Ability to deal with uncertainty -Commitment -Supporting staff development and growth -Organisational assessment of staff needs -Listen openly -Empower others -Facilitate the learning of others **VALUES** -Importance of organisational development and growth -Ensuring training is reflective of the changing training needs for professionals and patient concerns -Importance of staff morale and support -Importance of collaboration and co-operation -Importance of evaluation of healthcare training and its effectiveness in improving professional practice and patient outcomes -Importance of a supportive and open learning environment

SELF-GROWTH AND DEVELOPMENT	PATIENT'S EXPERIENCE OF HEALTH AND ILLNESS	TEAM AND COMMUNITY BUILDING	ORGANISATIONAL CULTURE
KNOWLEDGE -Knowledge of areas for further development and growth -Knowledge of areas within and outside one's comfort zones SKILLS -Ability to identify areas for self-improvement and growth -Reflection and awareness of self needs -Ability to develop critical thinking skills -Emotional intelligence VALUES -Importance of self-care -Importance of personal and professional development -Value for continuous learning and development	KNOWLEDGE -Role of family, culture, community in the individuals development -Multiple components of health -Multiple threats and contributors to health as dimensions of one reality SKILLS -Recognising patient's life story and its meaning -Ability to view health and illness as part of human development VALUES -Appreciation of the patient as a whole person -Appreciation of the patient's life story and the meaning of the health-illness condition -Respect for differences in the patient experience	KNOWLEDGE -Knowledge of inter-disciplinary team working SKILLS -Trust -Mutual respect -Mutual learning -Constructive challenging -Support and commitment -Open dialogue -Participate actively in community development and dialogue -Derive meaning from other's work -Learn co-operatively -Communicate effectively VALUES -Importance of creating a supportive environment -Affirmation of diversity -Value and respect of differences in expertise and perspectives -Importance of being open-minded -Responsibility to contribute health expertise	KNOWLEDGE -Knowledge of the organisational structure -Knowledge of organisational resources, constraints and pressures -History of practitioner-community relationships SKILLS -Dealing with the instability and the changing nature of the organisational culture VALUES -Importance of creating a relationship-centred and clinically driven organisational culture -Importance of the organisational culture reflecting health care values

CULTURE & DIVERSITY	MULITPLE CONTRIBUTORS TO HEALTH AND ILLNES WITHIN THE COMMUNITY		EFFECTIVE COMMUNITY-BASED CARE
KNOWLEDGE -Knowledge of cultural self -Knowledge of other cultural identities -Knowledge of one's culture and diversity impacts the interactions with different professional relationships -Knowledge of personal biases, stereotypes and prejudices that may impact clinical care SKILLS -Ability to deal with uncertainty -Ability to engage and empathise with those of a different cultural background -Clinical communication: respectful curiosity and confidence in asking sensitive questions -Capacity for self-awareness and reflections VALUES -Value for differences in perspectives -Respect for diversity and culture	KNOWLEDGE -Physical, social and occupational environments and their effects on health -External and internal forces influencing the overall health of the community SKILLS -Critically assess the relationship of health care providers to community health -Assess community and environmental-health -Assess implications of community policy affecting health VALUES -Affirmation of relevance of all determinants of health -Affirmation of the value of health policy in community services -Recognition of the presence of values that are destructive to health		KNOWLEDGE -Various types of care, both formal and informal -Effects of institutional culture on quality and delivery care -Positive effects of continuity of care SKILLS -Ability to work as a member of a team or healing community -Ability to implement change strategies -Ability to collaborate with other individuals and organisations VALUES -Respect for community leadership -Commitment to work for change -Value and respect for different health professionals and different health disciplines

TABLE 9.3: THEORETICAL PROGRESSION FROM CULTURAL COMPETENCE TO RECONSTRUCTED RELATIONSHIP-CENTRED CARE MODEL (ADAPTED DOGRA, 2004; GEORGE, 2017)

	CULTURAL COMPETENCE	CULTURAL SENSIBILITY	RE-CONSTRUCTED RELATIONSHIP-CENTRED CARE
EDUCATIONAL PHILOSOPHY			
Philosophy	-Biomedical model	-Social constructivist	-Holistic model -Social constructivist -Reconstructed relationship-centred care model 1.) Practitioner-self relationship 2.) Practitioner-patient relationship 3.) Practitioner-practitioner relationship 4.) Practitioner-organisation relationship
Epistemology (i.e. the theory of knowledge)	-Knowledge exists independently	-Knowledge is contextual to one's environment. Knowledge can be contextually and socially derived and changed.	-Knowledge can be contextually and socially derived and changed
Categorisation of knowledge	-Knowledge can be categorised and learnt	-Knowledge does not need to be categorised	-Knowledge can be categorised and un-categorised, but is dependent on context
Use of categorisation	-Categorisation is useful	-Categorisation may be unhelpful	-Categorisation may be helpful and unhelpful depending on the context
Ontology (the nature of being)	-Positivist view of science	-Social constructivist	-Social constructivist
Conception of reality	-Objective reality to be revealed or discovered -Structuralist -Modern	-No single objective reality to be discovered -The reality of a person can only be understood by communication with that person. Encourages students to develop a 'respectful curiosity' and ask about their patients rather assuming their characteristics based on their external characteristics i.e. skin colour, age etc.	-No single objective reality to be discovered -The reality of a person can only be understood by communication with that person. Encourages students to develop a 'respectful curiosity' and ask about their patients rather assuming their characteristics based on their external characteristics i.e. skin colour, age etc.

		-Individuals must learn from each-other in-order for realities to be understood. -Non-Structuralist -Postmodern	-Individuals must learn about themselves first and then about others. Learning with and from each-other enables for realities to be understood. -Non-Structuralist -Postmodern
Analytical perspective	-Reductionist: the notion of culture can be reduced to a set of characteristics and behaviours that are applicable to only a certain group of individuals. -People are treated as members of a group.	-Holistic: recognises the diversity and individuality in each person. -People are treated as individuals	-Holistic: recognises the diversity and individuality in each person. -People are treated as individuals -Relational: the interplay of cultural and diversity factors between the practitioner and who they interact with (i.e. the patient, colleagues and peers)
Historical connection	-Cultural competency training was a strategy in alleviating/ eliminating the health inequalities that existed in ethnic and racial groups. -Rooted in the historical context of minority disadvantage and White domination.	-Acknowledges the historical context of culture being rooted in issues of race and racism but does not allow it to dominate or deviate from the philosophy that individuals must learn from one-another.	-Acknowledges the historical context of culture being rooted in issues of race and racism but does not allow it to dominate or deviate from the philosophy that individuals must learn about themselves in order to facilitate a better understanding and curiosity to learn about others. -Individuals learn from one-another.
Politics of institutions	-Improve cultural competence of health professionals which in turn improves the access to care, in particularly ethnic minority populations.	-Proposes that competence as a static concept does not encompass the dynamic nature of clinical relationships	-Proposes that competence as a static concept does not encompass the dynamic nature of clinical relationships -Improves the patient and practitioner's experience in healthcare service, provision and delivery, leading to high quality care for all patients and effective working relationships amongst practitioners.
Relation to inequalities	-Attempts to change and reduce healthcare inequalities by facilitating cultural competency trainings.	-Acknowledges inequalities but as such does not directly attempt to change them	-Attempts to change and reduce healthcare inequalities and improve healthcare service and delivery for all patients and practitioners
Role of the teacher	-Teacher sets the agenda	-Teacher introduces the agenda	-Teacher and the student introduce and facilitate the agenda
Role of the learner	-Primarily as receiver	-Student contributes to the dialog and receives information	-Student is active partner in the learning process as the teacher. The student learns from and with the teacher.

			-Student contributes to the dialogue and receives information as does the teacher.
Conception of culture	-Culture is an externally recognised characteristic and that individuals are static in their cultural belongings. -Culture is seen as one-dimensional -Race and ethnicity are disproportionally emphasised in comparison to other aspects of culture.	-Culture is an internally constructed sense of self that is in a constant state of on-going dialogue. -Culture is seen as multi-dimensional and dynamic -Race and ethnicity are just one aspect of culture. There is no hierarchy about which of an individual's characteristics has most significance for them.	-Culture is an individual and shared experience. -Culture is an internally constructed sense of sense that is in a constant state of on-going dialogue. -Culture is seen as multi-dimensional and dynamic -Culture is also an externally constructed shared experience (i.e. social traditions, practices and norms) that may be willingly or un-willingly inherited in one's construction of their sense of self. -An individual will define which characteristics are most significant to them, this may differ to how others define which characteristics may be significant to them.
Conception of difference/ diversity	-Differences between individuals are generalised. -Different cultural groups are projected as homogeneous.	-Sensitive to differences.	-Acknowledges individual differences and is sensitive to differences that may exist in cultural groups. -Asserts that different cultural groups are homogeneous in some characteristics and heterogeneous in other characteristics.
Identity formation	-Individuals are shaped by their social world.	-Individuals construct and accomplish their own social world.	-Individuals embody and participate in multiple identities and these identities become more or less pertinent based on the context and the interaction they participate in. -An understanding of others' identity formation is best facilitated by first having an understanding of one's own identity formation. --Individuals construct and accomplish their own social world.

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			-External social environment and the relationships they participate in plays a role in the formation of one's identity. -Faculty development is an integral component of the 'practitioner-self' relationship when this framework is applied in the context of education. Faculty members must reflect on their own identity formation before attempting to explore students' identify formation.
Conception of individual identity	-An individual is defined by their culture	-An individual defines their culture	-An individual defines their culture, which differs depending on context and the relationships they participate in.
Individual's relationship with society	-In defining culture, relationship is between groups.	-In defining culture, relationship is between an individual and others. -Dialogue about culture takes place between individuals. -Individuals bring their own meanings and histories to different contexts. Personal meanings may change dependent on the context.	-In defining culture, relationship is between an individual and themselves and also with others. -Dialogue about culture takes place within an individual and between individuals. -Individuals bring their own meanings and histories to different contexts. Personal meanings may change dependent on the context.
EDUCATIONAL PROCESS			
Learning process	-Acquisition of knowledge (knowledge driven)	-Acquisition of principles (attitudes-driven)	-Acquisition of principles (attitudes and values driven) and skills
Learning outcomes	-Presented as the acquisition of facts and largely uses the cognitive approach to learning. This approach is dichotomous implying that there is a wrong or right perspective. -Command of a body of information and facts	-Key outcome is to equip students with principles and concepts of cultural sensibility which then in turn becomes a transferable skills -Command of mode of respectful questioning ('skilled questioning')	-Key outcome is to help students explore the 'practitioner-self' relationship in order to then facilitate a better understanding of other relationships they will participant in with their patients, colleagues and peers. -Develop a proficiency in the skills and attributes that underpin a good relationship, notably self-reflection, clinical communication and interpersonal skills.
Expression of learning goals	-In terms of skill and competence	-In terms of attitude and self-reflection	-In terms of attitudes and skills -Students develop a mode of self-awareness and reflection about his or hers

		-Students develop a mode of self-awareness and reflection about his or hers own actions and understanding	own actions and understanding in order to better facilitate their understanding of others -Students develop clinical communication and interpersonal skills
Content	-Certain: there is a certainty of outcomes which creates feelings of comfortable and confident of what they have learnt but does not challenge them personally. -Dichotomous: Right or wrong	-Acknowledges uncertainty and aids learners being 'comfortable with areas they find uncomfortable'. -Gray areas: not always a right and wrong answer	-Exploratory and participatory: encourages students to explore areas of certainty and uncertainty within themselves and with others -Acknowledges that truth is dependent on context and there is not always a right and wrong answer
Cultural focus	-Majority Whites must consider the needs of minorities	-No focus on particular groups, all individuals must consider the needs of others	-Focus on the individual's culture and it's similarities and difference to others -No focus on particular cultural groups
Pedagogic approach	-Didactic	-Directed self-learning	-Directed self-learning and self-directed learning -Co-operative learning – experiential and situated learning, peer assisted learning and role modelling
Role of experts	-There are those who are experts on understanding cultural perspectives of certain groups	-No one individual has ownership of expertise of others with respect to identification of cultural belonging	-An individual is an expert on their own cultural identity and is a continual learner of others' cultural identity.
EDUCATIONAL CONTENT			
Curriculum type (as relating to Bernstein, 1973)	-Collection type	-Integrated type	-Integrated type
Nature of content	-Parochial: Originates from the dominant White perspective and how this group understands minorities with little consideration vice-versa. In some respects there is a consideration of considering one's own views but this does not predominate. -Specific: Educational content is presented in the form of facts and lists about characteristics that are pertinent to different groups of people.	-Global: Students understanding of culture is linked to their own meaning of culture and cultural belonging, and this must be understood first. -Non-specific: it places equal responsibility on all to learn about others including those they may believe are similar to themselves and it challenges students to consider their own attitudes.	-Global: Students understanding of culture is linked to their own meaning of culture and cultural belonging, and this must be understood first. -Relational: Students understanding of their own cultural identity is facilitated and reflected upon in discussion with others. Students develop an understanding of how their cultural identity is unique and similar and or different to others.

			-Experiential: Educational content in terms of developing the skills and attributes that underpin a good relationship are experiential, through role plays, working with simulated patients, and situated learning through observation of different clinical interactions and healthcare relationships in placements and self-reflection through peer-learning and clinical supervision.
Organisation of content	-To meet the demands of local need	-To maximise student self-learning	-To maximise student self-learning and co-operative learning from others
Curriculum	-Fact acquisition to gain a body of knowledge	-Self-reflection and awareness of students	-Self-reflection and awareness of students ('practitioner-self relationship) and of their relationships with others (practitioner-patient/ practitioner & organisation) -Skills-based, particularly in clinical communication and interpersonal skills
Teaching focus	-Groups; treats people as groups -Move service-centred	-Individuals: views individuals as potentially parts of different groups in different contexts -More patient-centred	-Individuals and groups: exploration of the relationship with one's self and with others. -Patient and service centred
Focus of content	-Students learn about others	-Students learn about themselves and about others	-Students learn about themselves in order to facilitate a better understanding and curiosity about others.
EDUCATIONAL OUTCOMES			
What purpose does the assessment serve?	-Demonstrates knowledge of other cultures	-Demonstrates some understanding of self and the ability to evaluate their own learning	-Demonstrates some understanding of self in relation to others and the ability to evaluate their own learning -Demonstrates a proficiency in clinical communication and inter-personal skills
What methods are used?	-Paper and pencil tests ranging from multiple choice questions and short answers to long essays	-Reflective journals, project work (usually experimentally based) -Emphasis is that students take responsibility for their own learning.	-Objective clinical structured examinations (OCSEs), situational judgement tests (SJTs), reflective portfolios and pre and post questionnaires.
Results of assessment	-Norm-referenced (i.e. students ranked against peers)	-Not norm-referenced	-Both norm-referenced and not norm-referenced

Who leads the assessment process?	-Teacher assessment	-Student self-assessment	-Both teacher assessment and student-self assessment
Outcomes in clinical practice	-Practical in that the learner has facts about other cultures	-Practical in that the learner has a method of inquiry to be aware that others may have different perspectives -More critical and self-reflective -Greater capacity for dialogue: developing capacity to engage in dialogue with others and withhold judgement. -Learning is on-going.	-Practical in that the learner has a method of inquiry to be aware of their cultural identity and perspectives and that others may have different perspectives -More critical and self-reflective, with a particular focus on the 'practitioner-self' relationship. -Enhancement in clinical communication and interpersonal skills. Greater capacity for dialogue: developing capacity to engage in dialogue with others and withhold judgement. -Learning is continual, relational and exploratory.
Applicability	-Learning can only be used for cultural issues	-Learning can apply to any context in which differences exist between the doctor and patient	-Learning can apply to any context in which differences exist between the doctor and their patients, colleagues and peers.
Patient-centeredness	-Doctor has position of expertise	-Doctor and patient are active partners in care -Perceives patients as individuals with expertise in their own lives. -The 'doctor as a person' dimension acknowledges that doctors bring their own perspectives which may play a part in decision-making as 'objective issues' do.	-Relationship-centred care -Acknowledges the cultural identity of both the patient and the practitioner and how they each bring their own perspectives to a clinical encounter -Acknowledges the wider influences of relationships with other colleagues and the organisation and how this impacts the delivery of patient-centred care
Definition of a successful course	-Students learn competence regarding other cultures and exceptional if students then learn about themselves	-Course is only successful if students learn about themselves, because this is necessary before they can relate to other perspectives.	-Course is only successful if students learn about themselves, because this is necessary before they can relate to other perspectives. -Demonstrates a proficiency and or enhancement in their clinical communication and interpersonal skills.

CHAPTER 10: DEVELOPING A SITUATIONAL JUDGEMENT TEST TO EVALUATE DIVERSITY EDUCATION

10.1 INTRODUCTION

Traditionally diversity and or cultural competence education has primarily used self-reported measures to evaluate cultural knowledge, attitudes and skills to demonstrate the effectiveness of training initiatives. This approach has been consistently questioned, particularly with reference to the emphasis on measuring cultural knowledge as being primarily indicative of health professionals' ability to effectively respond to and manage cultural diversity issues in practice (Price et al, 2015: Shen, 2015). In Chapter 3, the limitations and challenges of using existing measures were critically explored. This highlighted the inability of current methods to capture the complexity of cultural and diversity issues and failure to measure the impact of training or perception of 'culturally competent care' on patient/health outcomes. Additionally, there is little evidence to suggest that an increase in 'cultural knowledge' predicts a higher level of competence in cross-cultural settings (Dogra et al, 2014; George et al, 2015). Such evidence, coupled with the increasing focus on and change in expected learning outcomes on attributes outside the remit of 'cultural knowledge, attitudes and skills' illustrates the need for a re-design and re-development of evaluation tools in the field of diversity/cultural competence.

This chapter aims to explore the challenges of evaluating professional and non-academic attributes, review the pertinent findings on evaluation from the participatory workshops and establish the justification for the decision to develop an SJT and the practical aspects involved in this process.

10.2 EVALUATING PROFESSIONAL AND NON-ACADEMIC ATTRIBUTES

There has been increasing emphasis in health educational institutions on evaluating professional and non-academic attributes that are integral to competent performance in clinical practice (Eva et al, 2009; Prideaux et al, 2011). Varied evidence has shown that academic attainment or solely focusing on increases in knowledge is a good predictor of early performance in health educational settings such as medicine and nursing (e.g.

Ferguson et al, 2002). However longitudinal research has shown that the predictive power of academic attainment or increases in knowledge declines as health professionals move into clinical practice and beyond (Ferguson et al, 2002; James et al, 2010; McManus et al, 2013). These findings are significant in that they convey the necessity for academic attainment and relevant clinical knowledge but highlight the insufficiency of knowledge alone in developing competent and reflective practitioners. Various reports in the UK highlight major concerns in the decline of non-academic and professional attributes such as care, empathy, interpersonal skills and respect (Cavendish, 2013; Francis Report, 2013; NHS England, 2015). These findings are consistent with and relevant to international research, suggesting the clear impact health professionals' values, attitudes and behaviours have on the quality of patient care and consequently on patient outcomes. Research on job analysis provides supporting evidence for the significance of non-academic attributes for successful performance in different healthcare roles. Patterson et al (2012) for example established that attributes of empathy, resilience, team involvement and integrity are essential for medical and dental students and in postgraduate medical training.

However, evaluating personal qualities, values and professionals' attributes in an effective and efficient way poses several challenges. Many methods for evaluating non-academic attributes have been found to have poor methodological rigour (Albanese et al, 2003). A large body of evidence suggests that common methods of evaluating non-academic attributes such as personality questionnaires, reflective answers, personal statements and references do not provide valid assessments of an individual's non-academic attributes (Ferguson et al, 2000; Poole et al; 2009; Kreiter & Axelson, 2013; Husbands et al, 2014; Patterson et al, 2016). This may be attributed to that fact that these methods are susceptible to 'coaching' (Rankin, 2013) and risk of 'faking'.

10.3 FINDINGS ON EVALUATION FROM THE PARTICIPATORY WORKSHOPS

These findings as well as the limitations and challenges of existing evaluation methods necessitate an evaluation tool that allows the complexity of cultural and diversity issues to be explored from multiple perspectives, and clarity in defining what cultural competence, culture and diversity actually mean and their constituent components. In addition, the evaluation tool should be clinically and contextually relevant and

applicable to a broad range of learners and be effective in measuring non-clinical/academic attributes in a fair, reliable and valid way.

The findings of the participatory workshops from the three key stakeholder groups cohered around the emerging reconstructed framework of 'relationship-centred care', shown in Table 9.2. In summary, the findings revealed that diversity education should be focused on the nuances and dynamics of clinical relationships, where the influence of both the patient and the professional are acknowledged and explored. In particular, the relationship considered the most important to examine with respect to diversity education was the '*practitioner-self' relationship*'. This requires health professionals to explore, unpack and reflect upon the meaning of diversity on an individual level and in relation to colleagues, peers and patients, to facilitate an appreciation of and value for diversity in others. This framework highlights the key attributes and skills that an evaluation tool should be seeking to measure.

Table 10.1 summarises the key findings each stakeholder group raised around evaluation. These findings showed that an evaluation tool for diversity education should be seeking to measure health professionals' attitudes, values and behaviours and whether they change or improve after the training. The findings contradicted the idea that isolated increases in cultural knowledge and sensitivity without consequent change in a professional's attitude and how they relate to different patients is of questionable value when trying to improve the way professionals acknowledge and respond to diversity. Participants desired an evaluation tool that made health professionals think about diversity issues from multiple perspectives, that was contextualised, clinically relevant, meaningful to every day practice and simple to administer and evaluate. All the participants collectively expressed concerns around the challenges of measuring attitudes and behaviours. Participants collectively highlighted that although questionnaires are often a practical and feasible option, they are prone to issues of bias and social desirability (participants select responses that are deemed to be socially approved) and are unable to fully capture the complexity of culture and diversity issues. These considerations, along with the attributes of evaluation required by the reconstructed RCC model and the findings summarised in Table 10.1, suggests that a SJT may be the most appropriate evaluation tool. This chapter describes an exploration of an approach to developing a robust SJT which shows much promise, but will need considerable development before it can be used in a routine way.

10.4 SITUATIONAL JUDGEMENT TESTS

Situational judgement tests (SJTs) are designed to evaluate an individual's reactions to or judgements of several hypothetical scenario-based questions that reflect situations they are likely to encounter in clinical practice (Patterson, 2016). These scenarios are developed based on a rigorous and detailed analysis of the pertinent attributes and traits of the desired role and are constructed collaboratively with a range of subject matter experts. This robust developmental aspect ensures the test is accurately able to evaluate the key attributes that are associated with competent performance. In contrast to the limitations of current methods used to evaluate non-academic professional attributes, SJTs are less susceptible to problems of 'faking', social desirability or 'coaching' (Patterson et al, 2013). In support of this claim, there is evidence that even where the effect of coaching can be seen, it does not influence the operational validity of the SJT (Stemig et al 2015). Systematic reviews of SJTs consistently demonstrate that they are a valid and reliable method for evaluating non-academic, professional attributes (Patterson, 2012; Patterson et al, 2016).

Situational judgement tests are classed as a *measurement methodology* (Chan et al, 1998) as opposed to a single style of evaluation or assessment. This is due to the variability in scenario content, response formats and approaches to scoring. Typically, candidates are presented with a likely scenario which is accompanied by a series of possible responses (known as 'items'), and are asked to identify the appropriateness or effectiveness of these responses. The response options are developed in the same detailed and rigorous fashion as the scenarios and a pre-defined scoring key is agreed by subject matter experts. Several scenarios are likely to be included in a SJT as this allows broad and complex constructs to be measured efficiently. SJTs are uniquely designed to correspond to the specific requirements for an assessment or evaluation. They have been used in a range of occupational contexts in both the public and private sector for the last 40 years (Patterson et al, 2016; Ployhart et al, 2003; Wyatt et al, 2010) and have been recently applied in health educational institutions such as medical schools and other healthcare training institutions.

SJTs have been derived from two core theoretical propositions. First, the behavioural consistency theory which argues that past behaviour is the best predictor of future behaviour and that ascertaining a sample of current behaviour will allow a prediction of future (i.e. in role) behaviour (Wernimont & Campbell, 1968; Motowidlo et al, 2006).

Secondly there is a growing consensus that SJTs measure pro-social Implicit Trait Policies (ITPs). This proposes that individuals make judgements about how and when to express certain traits or behaviours based on previous experiences or beliefs about the effectiveness of different traits/behaviours (i.e. the costs and benefits associated with demonstrating certain traits/behaviours). This theory is primarily related to choices about trait or behaviour expressions rather than the traits/behaviours themselves (Motowidlo et al, 2006) and how these choices of expressions are shaped and developed by different socialisation processes. SJTs therefore offer a promising tool for assessing or evaluating an individual's values as an element of personal choice in how to behave and act in practice.

SJTs can be used for selection, assessment, evaluation or developmental purposes. They are flexible and pliable in that they can be designed in a way that is tailored to the specific needs and attributes of a target role. In medical recruitment SJTs are now being commonly used to assess candidates' non-academic attributes as this provides a standardised and cost efficient method (Koczwara & Ashworth, 2013). In addition, SJTs can be easily transformed into OSCEs (objective structured clinical examinations) stations or shown in videos or used to complement structured interviews to assess a range of skills and attributes as defined by the role analysis. Several studies including high quality meta-analytic and longitudinal research has consistently demonstrated that SJTs are reliable and valid in many different healthcare and occupational settings (Sartania et al, 2014; Lievens & Patterson, 2011).

10.5 DEVELOPMENT OF A SITUATIONAL JUDGEMENT TEST

SJTs designed for selection, assessment, evaluation or developmental purposes should follow best practices outlined in Patterson et al (2016) review to ensure psychometric quality. In our case these involve a rigorous role analysis based on qualitative research to ascertain the key attributes and competencies associated with competent 'cross-cultural' performance. Test specification should then be developed in collaboration with key stakeholders, followed by a rigorous process of development and re-design of items, piloting and a thorough review of appropriate response formats, scoring and test constructions (Motowidlo et al, 1990). Each process in the development of a SJT to evaluate diversity/cultural competence education is outlined below and shown in relevant tables in the appendices.

10.5.1 Role analysis and test specification

The first stage in designing an SJT is to conduct and establish a role analysis and test specification. Typically, a role analysis includes conducting interviews with key stakeholders, however in the context of this study the vast amount of qualitative findings from the participatory workshops provided the ideal platform of essential information on what an evaluation tool for diversity education should be seeking to measure. It outlined the desired attributes and skills of a 'competent' professional in cross-cultural settings and clarified the meaning of 'cultural competence' and its constituent components highlighted in Table 9.2. Qualitative research used for exploring the role analysis involves identifying and collecting several 'critical incidents'; these are salient or challenging situations that reflect every day scenarios health professionals are likely to come across in the target role. A total of 90 critical incidents were identified and translated into scenario based questions and responses that conformed to the dimensions of the reconstructed relationship-centred care model. An example of this known as 'developing a test specification' is shown in Table 10.2. Identifying 'critical incidents' from the qualitative findings ensures cases reflect every-day scenarios, grounded in evidence and ensure the content of the scenarios is relevant to the particular role (Lievens et al, 2006). Other criteria in the test specification such as the types of items, response instructions, response format, scoring and length of the test was tentatively proposed but rigorously explored and refined during the piloting of the SJT.

10.5.2 Item development and initial Phase I pilot reviews

SJT scenarios and responses are best developed in collaboration and in a participatory manner with key stakeholders i.e. those who have an expertise in diversity issues and are familiar with the target role (Patterson et al, 2016). This process of item development is essential to ensure SJT scenarios and responses (items) are based on realistic, appropriate and plausible scenarios. The different critical incidents that have been translated into role-related scenarios can be used to pilot with different key stakeholders. An outline of the piloting process for this part of the research project is shown in Table 10.3. The piloting process was categorised into three phases; the first phase involved the item development and input from three key stakeholder groups (mental-health patients, NHS diversity leads and medical educators in the field of diversity). The second phase involved piloting the example SJT on small and then

subsequently larger groups of NHS health professionals who attended the diversity training. Finally, the third phase involved piloting the SJT on groups of non-NHS health professionals (finance & investment bankers and mathematicians) as a control group to establish whether their responses differed from that of NHS health professionals. As mentioned the first phase of the pilot involved gathering the input of key stakeholders in the development of scenarios. Participants were told in advance that the purpose of these pilot sessions was to gain their valuable feedback on the appearance, clarity, relevance and fairness (content validity) of scenarios as well to identify appropriate responses. Specific areas were also provided for participants to note down any suggestions for improvement or general comments. An example of the feedback received is shown in Table 10.4.

10.5.3 Response format and scoring

Response instructions, format and scoring take on various forms depending on how the SJT is being used. Response instructions are typically grouped in two categories: 1.) Knowledge-based (i.e. what is the best option) or 2.) Behavioural tendency (what would you be most likely to do). Within these two categories, a variety of response formats can be used such as *ranking* all the response options independently or ranking possible actions in order. Another format is that of *multiple choice* where candidates are asked to choose the best/worst response options. Other researchers have opted for *single response* formats where only one response is chosen (Motowidlo et al, 2009; Martin & Motowidlo, 2010). The type of response format depends on the role analysis and test specification and the context or level in the education and training that SJT is targeting.

SJTs are typically scored by comparing candidates' responses to a pre-determined scoring key, which outlines a specific numerical score for each response. This scoring system is defined and agreed upon by an in-depth review process collaboratively with key stakeholders or in-depth interviews with subject matter experts. This in-depth process was carried out throughout Phases I and II of the piloting. An example of how the scoring changed is shown in Table 10.5. Various types of scoring were tested as shown in Table 10.5, however the single best response was preferred by participants and simplest to analyse. Careful exploration of how responses were scored by different stakeholder groups was considered, in particular, identifying response sets where

almost all respondents choose the same item. Items as well as responses and scoring were continually explored, discussed and revised during the piloting process.

10.5.4 Test construction and Phase II pilot reviews

An example SJT was constructed for Phase II pilots, which involved piloting the test on a series of actual equality and diversity trainings to ensure that it is fair and measures what it is intended to measure (construct validity). Piloting the different versions also provided an opportunity to gain learners' reactions to the SJT (Patterson et al, 2011). The content and design of the SJT changed over the course of the pilot sessions, Table 10.6 shows how four example scenarios, their response sets and formats were developed over the pilots. Appendix 10.1 shows how the design of the complete test was developed over the pilots. Statistical tests such as a paired t-test, correlations and cross-tabulations were performed for the November, December, January and February pilot sessions and will be discussed further in the next chapter. A final development of an item bank of 12 scenarios was created at the end of all the piloting sessions, shown in Appendix 10.2. These cases can be further developed, piloted and re-designed in the future.

CONCLUSION

This chapter aimed to describe the methodology and practical steps involved in developing an SJT to evaluate diversity education. Developing an SJT requires a rigorous, structured and on-going approach that actively involves the input and expertise of multiple key stakeholders. SJTs offer a flexible and promising approach to evaluating diversity education. Although not traditionally used for diversity education, extending the application of these tests for evaluating these trainings may provide a beneficial resource for future researchers on measuring non-academic, professional attributes.

TABLE.10.1: KEY FINDINGS AROUND EVALUATION FROM PARTICIPATORY WORKSHOPS

NHS health professionals	Mental-health patients	Medical Educators
Measuring Attitudes, Values and Behaviours: -Participants agreed that an evaluation tool for diversity training should be focused on measuring attitudes and behaviours. -Some participants suggested the training should be measuring values and any changes to one's values however in both cases expressed great uncertainty around how to do this. Evaluation Methods: -Evaluate staff appraisals and feedback against trust values and diversity. -Make diversity part of the overall performance management i.e. set targets for performance around equality and diversity providing specific examples. -Gather follow-up feedback after the training session to identity if it help them respond and manage diversity issues in their day to day practice. -Critically examining changes and feedback from service user complaints. -Implement 'values-based' recruitment which involves accounting for 'respecting of diversity,' -Develop a psychometric before and after test to evaluate the effectiveness of the training.	Uncertainty: -Participants expressed great uncertainty in how to measure the effectiveness of diversity education. Measuring Attitudes and Behaviours: -Participants agreed that an evaluation tool for diversity training should be focused on measuring attitudes and behaviours. -Participants expressed concerns that traditional methods such as questionnaires and feedback forms in being able to measure the complexity of attitudes and behaviours of professionals in relation to diversity issues. Evaluation Methods: -Patients suggested asking professionals to develop 'personal objectives' around diversity, outlining what they would change about their clinical practice from the training they've received. -Useful suggestions included peer-assessment, reflective and creative portfolios, examining complaint forms and changes in patient satisfaction levels.	Uncertainty: -All participants expressed uncertainty and concerns around how to measure attitudes, with many participants claiming it is too difficult to measure. Measuring Attitudes and Behaviours: -All participants agreed that an evaluation tool for diversity education should be focused on measuring attitudes and behaviours. All participants agreed that it would be more effective to measure one's attitude via their behaviour. Evaluation Methods: -A number of assessment tools were discussed around how to evaluate diversity training, these included OSCES, reflective journals and examinations. However, for each assessment tool, participants were active in identifying the limitations for each tool, and concluded that multiple assessments were needed when assessing diversity training. -Participants also discussed the challenges of assessing diversity in actual practice and in the educational context. Participants explored the challenges involved in assessing an individual's actual behaviours in the clinical context and suggested developing an evaluation tool for diversity training that encouraged participants to contextualise clinical issues, and cultivate reasoning and critical thinking skills.

TABLE 10.2: DEVELOPING SCENARIOS FROM 'CRITICAL INCIDENTS' IDENTIFIED FROM PARTICIPATORY WORKSHOPS

PRACTITIONER-SELF RELATIONSHIP			
EXAMPLE SCENARIO 1	**EXAMPLE SCENARIO 2**	**EXAMPLE SCENARIO 3**	**EXAMPLE SCENARIO 4**
Scenario: You are a nurse working in the A&E department and seeing a patient who has revealed to you that he is homosexual, which makes you feel very uncomfortable as he begins to discuss his personal relationships with you during the clinical consultation.	Scenario: When working on the wards, your colleague notices that you are more empathetic and compassionate with the Asian patients than you are with the White patients. During your lunch-break together, she mentions this to you, and you explain to her that you are able to develop a better rapport with patients that are Asian as you are Asian yourself. Your colleague feels you should be trying to build rapport with all patients.	Scenario: You are one of the managers overseeing a hospice in West London, where due to a lack of funding a large proportion of the receptionists and support workers are volunteers. A disabled man has volunteered to be the receptionist for the in-patient ward, however you have found on a number of occasions that he cannot keep up with the pace of the ward and is more of a burden to the staff than a help. You feel it would be better to get someone who is not disabled to work as receptionist, however you are unsure how to express this to the person.	Scenario: Your work schedule has been increasingly demanding since you started as a support worker and there are areas in your life where further training would benefit you. However due to the under-staffing issues, taking time off for professional development training appears unlikely.

Scoring: Either *Choose the most appropriate actions to take in this situation or Choose ONE/TWO most appropriate actions you would take in this situation.*	Scoring: Either *Choose the most appropriate actions to take in this situation or Choose TWO most appropriate actions you would take in this situation.*	Scoring: *Choose ONE most appropriate action you would take.*	Scoring: Either *Choose TWO most appropriate actions to take in this situation or Rank in order the following actions in response to this situation (1=Most appropriate and 5=Least appropriate).*
Proposed Responses: **A.** Understand and reflect upon how your feeling of uncomfortableness may impact the clinical relationship you have with the patient **B.** Pretend to relate and empathise with the patient's discussions **C.** Ignore the remarks in hopes that the patient can sense your uncomfortableness **D.** Explain to the patient that you feel uncomfortable discussing this and would prefer to focus on assessing their individual needs **E.** Treat the patient the same as you would all other patients	Proposed Responses: **A.** Defend yourself, explaining that you are trying to build rapport with other patients, but you find it easier with Asian patients and there is nothing wrong with that. **B.** Agree with your colleague and self-reflect on why you feel you are unable to build the same rapport with White patients. **C.** Ask your colleague to focus on looking after her own patients rather than watching you. **D.** Feel that your colleague made a hurtful comment about your incompetence to practise, and choose to distance yourself from her. **E.** Make an extra effort to build rapport with White patients.	Proposed Responses: **A.** Ask your colleague to move this volunteer to another department, and explain they need help with serving the teas and coffees **B.** Ask your colleagues about their opinions of the new receptionist and if they feel his disability is hindering his work **C.** Spend some time self-reflecting on your own views of people with a disability and explore if they are negative or positive **D.** Explain to the receptionist that you feel he is better suited elsewhere where things are happening at a slower pace **E.** Ignore, as other staff and patients have not raised this issue with you.	Proposed Responses: **A.** Accept that there is no time to attend professional development training **B.** Speak to your supervisor and with their support ask the manager for special permission **C.** Use your annual leave to attend trainings that would help you in your practice **D.** Ask your colleague if she can look after the ward in your absence and go if she agrees **E.** Raise the issue with the Trust board as a problem to be addressed for all staff

PRACTITIONER-PATIENT RELATIONSHIP			
EXAMPLE SCENARIO 5	**EXAMPLE SCENARIO 6**	**EXAMPLE SCENARIO 7**	**EXAMPLE SCENARIO 8**

Scenario: You are a Black nurse working on a geriatric ward. A 70-year-old woman is in hospital after a fall. She is refusing to let you remove her stitches. She says she doesn't' want foreigners, who don't speak her language touching her, she wants a White nurse. What would you do this situation?
 	
Scoring: Either *Choose the most appropriate actions to take in this situation or Choose the ONE most appropriate action to take in this situation.*
Proposed Responses:
  A. Provide the patient with a White nurse as it would make the patient feel more comfortable
  B. Explain to the patient that her request is unacceptable and offensive and you will now remove the stitches
  C. Ignore the patient's remarks and continue as normal
  D. Report the incident as an issue of racism to the senior management team
  E. Explain to the patient that you do speak English and
	Scenario: You have been asked by a GP to see a young Chinese girl who has come in with her family. She is suffering from epilepsy. During the conversation, it becomes obvious that the parents do not see this as a problem. Their perception is that she is blessed by the Gods. How would you manage this situation?
	
	Scoring: Either *Choose the most appropriate actions to take in this situation or Choose the ONE most appropriate action to take in this situation.*
	Proposed Responses:
	  A. Do not treat the patient because it is inappropriate to question their beliefs
	  B. Suggest to them to see a Chinese doctor as they would be more suitable and appropriate to assess the patient with her family
	  C. Explore the parents' beliefs and the young girl's, explaining the benefit of using of using western medicine and the consequences of not using it.
		Scenario: You are based in a GP surgery and have been asked to take a history from Chris Briggs. When he comes into the room to talk to you, you think he is a man dressed as a woman.
		
		Scoring: Either *Choose the most appropriate actions to take in this situation or Choose the ONE most appropriate action to take in this situation.*
		Proposed Responses:
		  A. Ignore and do not ask about the person's gender as you feel it is not clinically relevant
		  B. Continue with the consultation as normal
		  C. Ask about the patient's gender to clarify if they identify as a man or a woman
		  D. Only ask about the patient's gender if it is deemed clinically relevant
			Scenario: A number of elderly patients in the geriatric ward have made demands to have carers that were of the same ethnicity as them. They felt they would feel more comfortable and be better understood by someone who they perceived as of a similar background to them.
			
			Scoring: Either *Choose the most appropriate actions to take in this situation or Choose the ONE most appropriate action to take in this situation.*
			Proposed Responses:
			  A. Acknowledge that this request is part of meeting the patient's cultural diversity needs
			  B. Ignore the request as it is inappropriate and unacceptable for the patient to ask
			  C. Have a team meeting and ask the advice of a colleague who is of the same ethnic background
			  D. Explore the patient's concerns and understand why they think someone of

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are competent to remove her stitches	D. Discuss the case with your colleagues and act on their advice E. Report the incident as a safeguarding issue as you feel the parents are not acting in the best interests of the patient	E. Do not ask about the patient's gender as this may offend the patient	the same ethnicity is more likely to understand them E. Report the incident as an issue of racism

PRACTITIONER-PRACTITIONER RELATIONSHIP			
EXAMPLE SCENARIO 9	**EXAMPLE SCENARIO 10**	**EXAMPLE SCENARIO 11**	**EXAMPLE SCENARIO 12**
Scenario: During your lunch break you overhear a group of your colleagues who are talking loudly and making jokes about a particular colleague's accent and how the professionals and patients cannot understand what they are saying. The particular colleague they are talking about could easily be identified from the conversation and is also working near you and may over hear them.	Scenario: The new medicine department has informed clinical commissioning groups that certain medications have an alcohol content and therefore it is important to inform patients as they may not want to take certain medications. When speaking with a GP practice, they asked "well which religions can or can't have alcohol?" You then explained that someone's alcohol use may or may not be influenced by their religion, there may be other factors at play, and you therefore have to ask all patients. He then looked at you with surprise saying 'oh, but I thought it just saves time if we knew not to give this to the Muslim or Jewish patients.'	Scenario: Your colleague discloses to you that she is going through a very difficult separation and occasionally has suicidal thoughts. She is unable to share this with her family as culturally they would look down on her separation and not help her feel better.	Scenario: One of your colleagues who is from the same cultural background as you, confides in you that they have been finding work quite challenging and have grown increasingly dependent on alcohol. He asks you not to tell anyone. In your cultural background misusing alcohol is seen as a negative stigma.

Scoring: Either *Rank in order the following actions in response to this situation (1=Most appropriate and 5=Least appropriate) or select the two most appropriate answers:*	Scoring: *Choose the most appropriate actions to take in this situation*	Scoring: *Choose the THREE most appropriate actions to take in this situation or Choose the TWO most appropriate actions to take in this situation.*	Scoring: Either *Rank in order the following actions in response to this situation (1=Most appropriate, 5= Least appropriate) or Choose the ONE most appropriate action to take in this situation.*
Proposed Responses: A. Inform the group that the particular colleague is around and may overhear their conversation B. Ignore the situation as they should know better and you do not want to cause a scene C. Pretend the conversation does not occur as you already have no time to have a break D. Challenge the whole group so that they are aware that their behaviour is inappropriate E. Speak to the person who is speaking the loudest so he is aware that his behaviour is inappropriate	Proposed Responses: A. Provide your colleague with information about which religious groups are not allowed alcohol B. Explain to your colleague the harmful effects of stereotyping patients C. Explain to your colleague that all patients need to be ask as everybody is different and individual D. Ignore the issue as you know your colleague will act in a way that they think is best	Proposed Responses: A. Be a supportive colleague and do not report anything unless you feel it impacts her clinical work B. Reassure her and tell her that everything will be okay C. Offer a friendly ear if and when she wishes to talk further D. Suggests she talks to her family E. Suggests she attends counselling F. Find a colleague who is from the same cultural background as her and ask her to talk to her G. Ask a colleague to prescribe some anti-depressants H. Suggest she speaks with her supervisor	Proposed Responses: A. Agree with your colleague and not tell anyone B. Reassure your colleague and suggest that he speaks to his supervisor C. Tell the nurses on the ward what's been happening and to act like nothing is going on D. Make time to talk to one of your colleague's family members about your concerns E. Tell your colleague's supervisor without informing him.

PRACTITIONER-ORGANISATION RELATIONSHIP			
EXAMPLE SCENARIO 13	**EXAMPLE SCENARIO 14**	**EXAMPLE SCENARIO 15**	**EXAMPLE SCENARIO 16**
Scenario: You feel under-staffed and under-supported when working on the wards today. You are responsible for all new in-patients and the welfare of around 80 ward patients. Attempts to raise concerns with your manager have been unsuccessful.	Scenario: You are a new member of a team of hospital receptionists and are coming to the end of your first week. You are very concerned about the attitude of a particular receptionist towards patients and have heard negative feedback from other healthcare professionals. After five weeks, your manager calls you in for your appraisal and to gain your feedback about other staff members in your team.	Scenario: You are part of the human resources department and play a role in the recruitment of staff. You realise that your colleagues and senior Trust board members have a preference for mature candidates, who have more experience, with younger candidates never making it onto the shortlist.	Scenario: The Trust board wishes your team conducts a national screening service for cancer. They are delivering letters to all patients by post, asking them to come in for a free screening appointment on the following days. After conducting the service, you realise that patients with a disability are not coming in to be screened. You discuss this with your team leader and express your concerns that they may need to develop a screening service specifically designed for patients with disability, however your team leader claims there is no time or funding to do this.

Scoring: Either *Rank in order the following actions in response to this situation (1=Most appropriate and 5=Least appropriate) or Choose the TWO most appropriate actions to take in this situation.*	Scoring: *Choose the THREE most appropriate actions to take in this situation.*	Scoring: *Choose the most appropriate actions to take in this situation.*	Scoring: *Choose the most appropriate actions to take in this situation.*

Proposed Responses:
  A. Document each stage of your complaint carefully
  B. Carry on and do the best that you can
  C. Contac the medical director and if necessary the Trust Chairman to report the issue
  D. Write an article in your local newspaper raising concerns about patient safety
  E. Discuss with your colleagues further plans to change the circumstances
	Proposed Responses:
	  A. Indicate your concerns with your manager, providing specific examples
	  B. Discuss the issue about your colleague's attitude with other staff members
	  C. Talk to your colleague directly about their unacceptable attitude towards patients
	  D. Write a letter of complaint to the Trust board about the staff's behaviour
	  E. Continue with your job as normal ignoring your colleague's behaviour
		Proposed Responses:
		  A. Discuss your concerns with your supervisor and enquire about the criteria for recruiting new staff
		  B. Raise your concerns with your colleagues that they are discriminating against the age of potential candidates favouring those of an older age
		  C. Ignore and continue your role as usual
		  D. Create a new system where the candidates personal information i.e. age, gender or ethnicity are not recorded to avoid any kind of discrimination
		  E. Discuss the issue with your colleagues and help them self-reflect on how they are recruiting new staff
			Proposed Responses:
			  A. Assume that patients with a disability do not want to be screened for cancer
			  B. Accept that changes cannot be made and continue with your job as usual
			  C. Discuss with your team issues around equality of access and how they can tailor their screening service for patients with disability
			  D. Raise the issue with the Trust board about designing a screening process that targets all patients

TABLE 10.3: OUTLINE OF THE PILOTING PHASES

PHASE I PILOT (TOTAL N =45)			
May 2016 NHS Equality & Diversity Leads (n =10)	July 2016 Mental-health Patient Advisors & Mentors (n=10)	August 2016 Medical Educators in Diversity (n=7)	September 2016 NHS Equality & Diversity Training (n=18) Pre & Post SJT

PHASE II PILOT (TOTAL N =103)	
November 2016 NHS Equality & Diversity Training (n=23) Pre & Post STJ	December 2016 NHS Equality & Diversity Training (n=80) Pre & Post SJT

PHASE III PILOT (TOTAL N = 60)	
January 2017 Finance & Investment Bankers (n=50) Pre SJT	February 2017 Mathematics (n=10) Pre SJT

Total Participants: 208

TABLE 10.4: EXAMPLE PHASE I PILOTING – DEVELOPMENT OF ITEMS & FEEDBACK FROM KEY STAKEHOLDERS

PHASE I PILOTING			
EXAMPLE SCENARIO	**Example Mental-health Patient Feedback**	**Example Mental-health Patient Feedback**	**Example Mental-health Patient Feedback**
Scenario: You are based in a GP surgery and have been asked to take a history from Chris Briggs. When he comes into the room to talk to you, you think he is a man dressed as a woman. Scoring: Choose the most appropriate actions to take in this situation.	• Reasoning for proposed choice: "Cross-dressing is probably normal for them, not clinically relevant. If not clinically relevant there is no need to ask the patient about their gender." • "This will make the professionals think about these issues from different perspectives." • Suggested improvements: "Some questions were easier to understand than other, would use less responses, maybe 4."	• Reasoning for proposed choice: "If a person decides to dress like a lady that is a personal choice that is a freedom. The person should just be treated as an individual. A person's sexual or dress sense should not be an obstacle to receiving care, we need to be comfortable with differences."	• Reasoning for proposed choice: "To consider the patient's culture which includes their gender should be covered any way in part of his care? It is a good idea for a GP to know the patient their culture and language to build rapport." • "Interesting education resource for the training."

Proposed Responses:	Answers:	Answers:	Answers:
A. Ignore and do not ask about the person's gender as you feel it is not clinically relevant. B. Continue with the consultation as normal. C. Ask about the patient's gender to clarify if they identify as a man or a woman. D. Only ask about the patient's gender if it is deemed clinically relevant. E. Do not ask about the patient's gender as this may offend the patient.	A. Ignore and do not ask about the person's gender as you feel it is not clinically relevant. B. Continue with the consultation as normal. (✓) C. Ask about the patient's gender to clarify if they identify as a man or a woman. D. Only ask about the patient's gender if it is deemed clinically relevant. (✓) E. Do not ask about the patient's gender as this may offend the patient.	A. Ignore and do not ask about the person's gender as you feel it is not clinically relevant. B. Continue with the consultation as normal. (✓) C. Ask about the patient's gender to clarify if they identify as a man or a woman. D. Only ask about the patient's gender if it is deemed clinically relevant. E. Do not ask about the patient's gender as this may offend the patient.	A. Ignore and do not ask about the person's gender as you feel it is not clinically relevant. B. Continue with the consultation as normal. C. Ask about the patient's gender to clarify if they identify as a man or a woman. D. Only ask about the patient's gender if it is deemed clinically relevant. (✓) E. Do not ask about the patient's gender as this may offend the patient.

PHASE I PILOTING			
EXAMPLE SCENARIO	**Example Medical Educator Feedback**	**Example Medical Educator Feedback**	**Example NHS Health Professional Feedback**
Scenario: Rachel formally known as Richard is a transgender nurse staff and has made you, the care manager aware that a number of her colleagues are bullying her and are preventing her from using the female toilets. Rachel presents herself as female throughout her employment, yet many of the staff as well as occasionally patients feel uncomfortable with her using the female toilets. How would you respond to this situation? Scoring: Rank in order the following actions in responses to this situation between 5 and 0 (5 being the most appropriate and 0 being most inappropriate).	• Reasoning for proposed choice: Educate colleagues on gender equality and diversity to be able to see her perspective. • Include another option of 'explore reasons of colleagues' objections.' • "Reduce the number of options and make the format easier for the reader, the instructions could be presented as a picture scale. Overall a thought provoking tool."	• Reasoning for proposed choice: Explore colleagues concerns that are most important. Deliver training sessions and educate colleagues on transgender equality and diversity and allow others to reflect on 'other perspectives.' • Include another option of 'explore colleagues' reasons for objections.' • "Could easily use this as an educational resource as well as an evaluation tool."	• Reasoning for proposed choice: "These questions make me think, some of these actions are very 'Black & White' whereas I may use a combination of B & D to facilitate sessions." • Include another option of 'speak to HR or E&D leads and review all policies.'

Proposed Responses:	Answers:	Answers:	Answers:
A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff.	A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff. (0)	A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff. (0)	A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff. (0)
B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter.	B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter. (5)	B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter. (5)	B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter. (3)
C. Would not consider this a major issue of bullying.	C. Would not consider this a major issue of bullying. (0)	C. Would not consider this a major issue of bullying. (0)	C. Would not consider this a major issue of bullying. (0)
D. Reassure Rachel that she would discuss the issue with the staff team lead to ensure she does have access to the female toilets.	D. Reassure Rachel that she would discuss the issue with the staff team lead to ensure she does have access to the female toilets. (4)	D. Reassure Rachel that she would discuss the issue with the staff team lead to ensure she does have access to the female toilets. (4)	D. Reassure Rachel that she would discuss the issue with the staff team lead to ensure she does have access to the female toilets. (3)
E. Review 'Equality & Diversity' policy on managing transgender issues.	E. Review 'Equality & Diversity' policy on managing transgender issues. (3)	E. Review 'Equality & Diversity' policy on managing transgender issues. (3)	E. Review 'Equality & Diversity' policy on managing transgender issues. (5)
F. Suggest an option of using the unisex disabled toilets.	F. Suggest an option of using the unisex disabled toilets.(0)	F. Suggest an option of using the unisex disabled toilets.(0)	F. Suggest an option of using the unisex disabled toilets.(Unsure)

PHASE I PILOTING			
EXAMPLE SCENARIO	**Example NHS Health Professional Feedback**	**Example NHS Health Professional Feedback**	**Example NHS Health Professional Feedback**
Scenario: A new member of staff, Miriam has joined the care team and during her induction she reveals that she is Jewish and will need to finish work early on a Friday in the winter. This manager appears apprehensive after her request and says she will have to discuss this request with a senior manager. The manager laughs and says "don't we all want to finish early on a Friday?" She refuses her request on the grounds that Friday is one of the busiest days at the hospital and all staff need to be present to manage patient demands. How would you respond to this situation as a senior manager?	• Reasoning for proposed choice: "It is the fairest decision to allow the member of staff the time for their religious beliefs." • Suggested improvements: "Reduce the ranking to be 5-1. Thought-provoking tool."	• Reasoning for proposed choice: "First option should be to try help, and discuss with staff and mentors and seek further help." • "Good tool, definitely sparked up discussion. I would use this in my diversity training sessions."	• Reasoning for proposed choice: "As a manger I would need to balance what's feasible, practical and best for staff. It's difficult, these questions would be useful to put in our agendas." • "Please provide explanations of which is the right answer. Good tool."
Scoring: Rank in order the following actions in responses to this situation between 5 and 0 (5 being the most appropriate and 0 being most inappropriate). Please note ranks can be tied.	Answers: A. Acknowledge that Miriam has the right to request flexibility in working patterns on the grounds on her religious beliefs. (5) B. Refuse her request on the basis of increasingly patient demands and staff pressures on Fridays. (1) C. Discuss with the hospital team how this arrangement could potentially work for Miriam. (4) D. Refuse the request as you fear this may lead to other staff feeling they can work certain days and hours	Answers: A. Acknowledge that Miriam has the right to request flexibility in working patterns on the grounds on her religious beliefs. (5) B. Refuse her request on the basis of increasingly patient demands and staff pressures on Fridays. (1) C. Discuss with the hospital team how this arrangement could potentially work for Miriam. (4) D. Refuse the request as you fear this may lead to other staff feeling they can work certain days and hours	Answers: A. Acknowledge that Miriam has the right to request flexibility in working patterns on the grounds on her religious beliefs. (4) B. Refuse her request on the basis of increasingly patient demands and staff pressures on Fridays. (3) C. Discuss with the hospital team how this arrangement could potentially work for Miriam. (4) D. Refuse the request as you fear this may lead to other staff feeling they can work certain days and hours
Proposed Responses: A. Acknowledge that Miriam has the right to request flexibility in working patterns on the grounds on her religious beliefs.			

B. Refuse her request on the basis of increasingly patient demands and staff pressures on Fridays. C. Discuss with the hospital team how this arrangement could potentially work for Miriam. D. Refuse the request as you fear this may lead to other staff feeling they can work certain days and hours depending on their personal beliefs. E. Discuss with senior members the Trust's policy on religion and belief. F. Refuse her request as you feel this may lead to all staff with small children requesting to leave early to pick up their children.	depending on their personal beliefs. (0) E. Discuss with senior members the Trust's policy on religion and belief. (4) F. Refuse her request as you feel this may lead to all staff with small children requesting to leave early to pick up their children. (0)	depending on their personal beliefs. (0) E. Discuss with senior members the Trust's policy on religion and belief. (4) F. Refuse her request as you feel this may lead to all staff with small children requesting to leave early to pick up their children. (0)	depending on their personal beliefs. (0) E. Discuss with senior members the Trust's policy on religion and belief. (4) F. Refuse her request as you feel this may lead to all staff with small children requesting to leave early to pick up their children. (1)

TABLE 10.5: EXAMPLES OF DIFFERENT RESPONSE FORMAT AND CHANGES IN ITEM SCORING

MULTIPLE CHOICE FORMAT	RANKING RESPONSE FORMAT	BEST SINGLE RESPONSE FORMAT
Scenario: Rachel formally known as Richard is a transgender nurse staff and has made you, the care manager aware that a number of her colleagues are bullying her and are preventing her from using the female toilets. Rachel presents herself as female throughout her employment, yet many of the staff as well as occasionally patients feel uncomfortable with her using the female toilets. How would you respond to this situation?	Scenario: Rachel formally known as Richard is a transgender nurse staff and has made you, the care manager aware that a number of her colleagues are bullying her and are preventing her from using the female toilets. Rachel presents herself as female throughout her employment, yet many of the staff as well as occasionally patients feel uncomfortable with her using the female toilets.	Scenario: Rachel formerly known as Richard is a transgender staff nurse. She has made you aware as a colleague that she is being bullied by several colleagues and that she is being prevented from using the female toilets.
Scoring: Choose the MOST appropriate ACTIONS you would take in this situation.	Scoring: Please RANK in order from 1 to 5 (1 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario: Please note ranks can be tied.	Scoring: Choose the ONE most appropriate action to take in this situation.
Proposed Responses: A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff. B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter. C. Would not consider this a major issue of bullying. D. Reassure Rachel that she would discuss the issue with the staff team lead to ensure she does have access to the female toilets. E. Review 'Equality & Diversity' policy on managing transgender issues.	Proposed Responses: A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff. B. Explore Rachel's concerns and ask staff for their experiences and feedback on this matter. C. Would not consider this a major issue of bullying and suggest an option of using the unisex disabled toilets. D. Reassure Rachel that you would discuss the issue with the staff team lead to ensure she does have access to the female toilets. E. Review 'Equality & Diversity' policy on managing transgender issues.	Proposed Responses: A. Raise the issue in a team meeting in a way that everyone can safely and openly discuss the matter and resolve together. B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but highlight to all colleagues that bullying is not acceptable under any circumstances. C. Discuss with other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets. D. Reassure Rachel that you would discuss the issue with the staff team leader to

F. Suggest an option of using the unisex disabled toilets.
 	
Reasons for Item Scoring:
The three responses deemed the most appropriate are highlighted in red. These responses and scoring were explored in phase I pilot.
    A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff.
Justification: Although this provides a resolution to the problem, it does not attempt to actively engage and address Rachel and staff concerns and may further marginalise/stigmatise transgender members of staff.
    B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter.
Justification: This response takes into account both Rachel's and staff perspectives and experiences before making any actions.
    C. Would not consider this a major issue of bullying.
Justification: This response fails to recognise this issue as 'bullying'.
    D. Reassure Rachel that she would discuss the issue with the staff team lead to ensure she does have access to the female toilets.
Justification: This response attempts to address and resolve Rachel's concerns and legally this may appear to be a popular response as Rachel is protected. However it does not attempt to
	Reasons for Item Scoring:
	Responses were given a pre-defined score of the following. These scores were determined collaboratively by a range of stakeholder perspectives:
	(1=most inappropriate and 5=most appropriate)
	    A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff. (3)
	Justification: Although this provides a resolution to the problem, it does not attempt to actively engage and address Rachel and staff concerns and may further marginalise/stigmatise transgender members of staff.
	    B. Explore Rachel's concerns and ask staff for their experiences and feedback on this matter. (5)
	Justification: This response takes into account both Rachel's and staff perspectives and experiences before making any actions.
	    C. Would not consider this a major issue of bullying and suggest an option of using the unisex disabled toilets. (1)
	Justification: This response fails to recognise the issue as 'bullying' and although suggests the 'unisex' disabled toilets as an appropriate option, it does not actively explore or discuss Rachel's or staff concerns.
	    D. Reassure Rachel that you would discuss the issue with the staff team lead to ensure she does have access to the female toilets. (2)
		ensure she does have access to the female toilets.
		Reasons for Item Scoring:
		Responses were given a pre-defined score of the following. These scores were determined collaboratively by a range of stakeholder perspectives:
		1= most appropriate and 4=inappropriate
		    A. Raise the issue in a team meeting in a way that everyone can safely and openly discuss the matter and resolve together. (1)
		Justification: This response takes into account different perspectives and tries to lead to respect and understanding. It also highlights the issue of 'safety' and ensuring a supportive environment to discuss these sensitive issues.
		    B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but highlight to all colleagues that bullying is not acceptable under any circumstances. (2)
		Justification: This response is also appropriate in that it makes clear that bullying is not permitted and raises the issue but there may be no resolution.
		    C. Discuss with other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets.(4)
		Justification: This response is the least acceptable as it appears to favour one the side of colleagues and may make Rachel feel that her issues are being talked about. Using the unisex toilets may

gain the perspectives of other staff members and does not necessarily change the culture.

    E.   Review 'Equality & Diversity' policy on managing transgender issues.

Justification: This response highlights the importance of healthcare professionals being educating and aware of policies and guidelines around 'equality and diversity' on managing transgender issues. Although it does not actively seek staff perspectives.

    F.   Suggest an option of using the unisex disabled toilets.

Justification: This option does provide a practical resolution to the issue, although it does not explore Rachel's and staff concerns to prevent this from happening again.

Justification: This response attempts to address and resolve Rachel's concerns and legally this may appear to be a popular response as Rachel is protected. However it does not attempt to gain the perspectives of other staff members and does not necessarily change the culture.

    E.   Review 'Equality & Diversity' policy on managing transgender issues.(4)

Justification: This response highlights the importance of healthcare professionals being educating and aware of policies and guidelines around 'equality and diversity' on managing transgender issues. Although it does not actively seek staff perspectives.

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leave the issue unresolved, although may not in itself be inappropriate.

    D.   Reassure Rachel that you would discuss the issue with the staff team leader to ensure she does have access to the female toilets. (3)

Justification: This response attempts to address and resolve Rachel's concerns and legally this may appear to be a popular response as Rachel is protected. However it does not attempt to gain the perspectives of other staff members and does not necessarily change the culture.

TABLE 10.6: EXAMPLES OF CHANGES TO FINAL CHOSEN SCENARIOS FOR THE SITUATIONAL JUDGEMENT TEST OVER PILOTING SESSIONS

SCENARIO 1			
Phase I Pilot: Sessions 1-3 Scenario: Rachel formally known as Richard is a transgender nurse staff and has made you, the care manager aware that a number of her colleagues are bullying her and are preventing her from using the female toilets. Rachel presents herself as female throughout her employment, yet many of the staff as well as occasionally patients feel uncomfortable with her using the female toilets. How would you respond to this situation?	Phase II Pilot: Session 4 Scenario: Rachel formally known as Richard is a transgender nurse staff and has made you, the care manager aware that a number of her colleagues are bullying her and are preventing her from using the female toilets. Rachel presents herself as female throughout her employment, yet many of the staff as well as occasionally patients feel uncomfortable with her using the female toilets.	Phase II Pilot: Session 5 Scenario: Rachel formerly known as Richard is a transgender staff nurse. She has made you aware as a colleague that she is being bullied by several colleagues and that she is being prevented from using the female toilets.	Phase II Pilot: Session 6 Scenario: Rachel formerly known as Richard is a transgender staff nurse. She has made you aware as a colleague that she is being bullied by several colleagues and that she is being prevented from using the female toilets.
Please RANK in order from 0 to 5 (0 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario. Please note ranks can be tied: A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff. B. Explore Rachel's concerns and ask other staff for their	*Please RANK in order from 1 to 5 (1 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario:* A. Discuss with the Trust Board the need to provide separate toilets specifically for transgender members of staff. B. Explore Rachel's concerns and ask staff for their experiences and feedback on this matter.	*Choose the ONE most appropriate action you would take:* A. Write to your service manager asking them to make the trust board aware of the need to provide separate toilets specifically for transgender members of staff. B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but highlight to all colleagues that bullying is not	*Choose the ONE most appropriate action you would take:* A. Raise the issue in a team meeting in a way that everyone can safely and openly discuss the matter and resolve together. B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but highlight to all colleagues that bullying is not acceptable under any circumstances.

experiences and feedback on this matter. C. Would not consider this a major issue of bullying. D. Reassure Rachel that she would discuss the issue with the staff team lead to ensure she does have access to the female toilets. E. Review 'Equality & Diversity' policy on managing transgender issues. F. Suggest an option of using the unisex disabled toilets.	C. Would not consider this a major issue of bullying and suggest an option of using the unisex disabled toilets. D. Reassure Rachel that you would discuss the issue with the staff team lead to ensure she does have access to the female toilets. E. Review 'Equality & Diversity' policy on managing transgender issues.	acceptable under any circumstances. C. Discuss with the other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets. D. Reassure Rachel that you would discuss the issue with the staff team leader to ensure she does have access to the female toilets.	C. Discuss with other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets. D. Reassure Rachel that you would discuss the issue with the staff team leader to ensure she does have access to the female toilets.

SCENARIO 2

Phase I Pilot: Sessions 1-3	Phase II Pilot: Session 4	Phase II Pilot: Session 5	Phase II Pilot: Session 6

Phase I Pilot: Sessions 1-3
Scenario: Your colleague comes to you on their break and is very frustrated about one patient that took up most of their morning as they were unable to understand what was written on their medication packets and prescription. She says to you "they should really learn English if they are coming to this country, or at least try." How would you respond to this situation?

Please RANK in order from 0 to 5 (0 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario. Please note ranks can be tied:

  A. Agree with your colleague as you know from experience health professionals do not have enough time.
  B. Discuss with your colleague their comment and why they feel this way.
  C. Explain to your colleague that as health professionals we are here to care for all patients with different needs and concerns.

Phase II Pilot: Session 4
Scenario: Your colleague comes to you on their break and is very frustrated about one patient that took up most of their morning as they were unable to understand what was written on their medication packets and prescription. She says to you "they should really learn English if they are coming to this country, or at least try."

Please RANK in order from 1 to 5 (1 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario:

  A. Agree with your colleague as you know from experience health professionals do not have enough time.
  B. Discuss with your colleague their comment and why they feel this way and suggest an interpreter.
  C. Explain to your colleague that as health professionals we are here to care for all patients with different needs and concerns.

Phase II Pilot: Session 5
Scenario: Your colleague comes to you on their lunch break and is very frustrated about a patient that took up most of her morning as they were unable to understand what was written on their medication packets. She says, "they should really learn English if they are coming to this country, or at least try shouldn't they?"

Choose the ONE most appropriate action you would take:

  A. Sympathise with your colleague's frustration and point out that an interpreter should be called (if available) if there are difficulties.
  B. Explain to your colleague that their comment may be seen as racist and is therefore inappropriate.
  C. Explain to your colleague that as health professionals we are here to care for all patients with different needs and concerns and suggest an interpreter.

Phase II Pilot: Session 6
Scenario: Your colleague comes to you on their lunch break and is very frustrated about a patient that took up most of her morning as they were unable to understand what was written on their medication packets. She says, "they should really learn English if they are coming to this country or at least try shouldn't they?"

Choose the ONE most appropriate action you would take:

  A. Point out that an interpreter should be called (if available) if there are difficulties.
  B. Explain to your colleague that their comment may be seen as racist and is therefore inappropriate.
  C. Explain to your colleague that as health professionals we are here to care for all patients with different needs and concerns and suggest an interpreter.
  D. Sympathise with your colleague's comment and raise this issue in a team meeting.

D. Offer to help with some of your colleague's workload for the afternoon. E. Provide the details for interpreters that can come and help the patient. F. Ignore the comment and try to change the topic of the conversation.	D. Ignore the comment and try to change the topic of the conversation.	D. Sympathise with your colleague's comment and take no further action.	

SCENARIO 3

Phase I Pilot: Sessions 1-3	Phase II Pilot: Session 4	Phase II Pilot: Session 5	Phase II Pilot: Session 6
Scenario: As you arrive on the ward you hear a patient in a side room make a sarcastic remark about a staff member who is a wheelchair user, saying "are you able to move around in that chair as much as the others?" You hear the staff member talk back to the patient in a rude and offensive manner. The tone and language used are unpleasant and you know the patient is elderly and suffering from dementia. How would you respond to this situation?	Scenario: An elderly patient who is suffering from dementia makes a sarcastic remark about a staff member who is a wheelchair user, saying "are you able to move around in that chair as much as the others?" You hear the staff member talk back to the patient in a rude and offensive manner.	Scenario: You hear a patient who has dementia say, "Are you able to move around in that chair as much as the others?" to a colleague who is a wheelchair user. Your colleague responds in a rude and offensive manner.	Scenario: You hear a patient who has dementia say, "are you able to move around in that chair as much as the others?", to a colleague who is a wheelchair user. Your colleague responds in a rude and offensive manner.
Please RANK in order from 0 to 5 (0 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario. Please note ranks can be tied:	*Please RANK in order from 1 to 5 (1 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario:*	*Choose ONE most appropriate action you would take:*	*Choose ONE most appropriate action you would take:*
A. Knock on the door and intervene in the situation, asking the nurse to leave the patient immediately.	A. Knock on the door and intervene in the situation, asking the nurse to leave the patient immediately.	A. Intervene in the situation, asking your colleague to leave the patient immediately.	A. Intervene in the situation, asking your colleague to leave the patient immediately.
B. Discuss the issue with a senior nurse in the first instance and follow their advice.	B. Discuss with the patient their sarcastic remark and how it was perceived to the staff member.	B. Say to the patient that the Trust's Equality and Diversity stance makes their comment un-acceptable.	B. Say to the patient that the Trust's Equality and Diversity stance makes their comment un-acceptable.
C. Discuss with the patient their sarcastic remark and how it was perceived to the staff member.	C. Discuss with the staff member how they perceived their own behaviour.	C. Discuss with your colleague that you witnessed unprofessional behaviour and that whilst it may be understandable, it is not acceptable.	C. Discuss with your colleague that you witnessed unprofessional behaviour and that whilst it may be understandable, it is not acceptable.
	D. Explain to the staff member that their behaviour is	D. Ignore the situation as you feel it is none of your	D. Ignore the situation as you feel it is none of your

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D. Discuss with the staff member how they perceived their own behaviour. E. Ignore the situation as you feel it is none of your business and carry on with your work as usual. F. Intervene in the situation once the nurse is away from the patient. G. Explain to the patient their sarcastic remark is rude and offensive. H. Explain to the staff member that their behaviour is inappropriate and unacceptable.	inappropriate and unacceptable. E. Ignore the situation as you feel it is none of your business and carry on with your work as usual.	business and carry on with your work as usual.	business and carry on with your work as usual.

SCENARIO 4

Phase I Pilot: Sessions 1-3	Phase II Pilot: Session 4	Phase II Pilot: Session 5	Phase II Pilot: Session 6
Scenario: A new member of staff, Miriam has joined the care team and during her induction she reveals that she is Jewish and will need to finish work early on a Friday in the winter. This manager appears apprehensive after her request and says she will have to discuss this request with a senior manager. The manager laughs and says "don't we all want to finish early on a Friday?" She refuses her request on the grounds that Friday is one of the busiest days at the hospital and all staff need to be present to manage patient demands. How would you respond to this situation as a senior manager?	Scenario: A new member of staff, Miriam has joined the care team and during her induction she reveals that she is Jewish and will need to finish work early on a Friday in the winter. She refuses her request on the grounds that Friday is one of the busiest days at the hospital and all staff need to be present to manage patient demands. How would you respond to this situation as a senior manager?	Scenario: A new member of staff, Miriam, reveals during her induction that she is Jewish and will need to finish work early on a Friday in the winter. She has not mentioned this earlier when specifically asked if there were any special circumstances. The manager appears apprehensive after her request and says she will have to discuss the request with a Senior Manager. The Senior Manager laughs and says, "Don't we all want to finish early on a Friday?" If you were the Senior Manager, what would you do in this case?	Scenario: A new member of staff, Miriam, reveals during her induction that she is Jewish and will need to finish work early on a Friday in the winter. She has not mentioned this earlier when specifically asked if there were any special circumstances. The manager appears apprehensive after her request and says she will have to discuss the request with a Senior Manager. The Senior Manager laughs and says "don't we all want to finish early on a Friday?" If you were the Senior Manager, what would you do in this case?
Please RANK in order from 0 to 5 (0 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario. Please note ranks can be tied: A. Acknowledge that Miriam has the right to request flexibility in working patterns on the grounds on her religious beliefs. B. Refuse her request on the basis of increasingly patient demands and staff pressures on Fridays.	*Please RANK in order from 1 to 5 (1 being the most inappropriate and 5 being the most appropriate) the following responses to this scenario:* A. Acknowledge that Miriam has the right to request flexibility in working patterns on the grounds on her religious beliefs. B. Refuse her request on the basis of increasingly patient demands and staff pressures on Fridays.	*Choose ONE most appropriate action you would take:* A. Acknowledge that Miriam has the right to request flexibility in her working hours and is entitled to finish early on Fridays. B. Refuse her request on the basis of increasing patient demands and staff pressures on Friday. C. Accept Miriam's request and discuss with the hospital	*Choose ONE most appropriate action you would take:* A. Acknowledge that Miriam has the right to request flexibility in her working hours and is entitled to finish early on Fridays. B. Grant her request as it is made on religious grounds. C. Discuss the request with the team, how this arrangement could potentially work for Miriam.

C. Discuss with the hospital team how this arrangement could potentially work for Miriam. D. Refuse the request as you fear this may lead to other staff feeling they can work certain days and hours depending on their personal beliefs. E. Discuss with senior members the Trust's policy on religion and belief. F. Refuse her request as you feel this may lead to all staff with small children requesting to leave early to pick up their children.	C. Discuss with the hospital team how this arrangement could potentially work for Miriam. D. Refuse the request as you fear this may lead to other staff feeling they can work certain days and hours depending on their personal beliefs. E. Refuse her request as you feel this may lead to all staff with small children requesting to leave early to pick up their children.	team how this arrangement could potentially work for Miriam. D. Explain to Miriam that the contract of employment that she signed made the working hours clear, and that it would not be fair to her other colleagues to make special arrangements for her.	D. Explain to Miriam that the contract of employment that she signed made the working hours clear and that it would not be fair to her other colleagues to make special arrangements for her.

CHAPTER 11: DEVELOPING A SITUATIONAL JUDGEMENT TEST - FINDINGS AND DISCUSSION

11.1 INTRODUCTION & FINDINGS

The findings of the pilot sessions for Phase I, II and III are discussed in this chapter as well as the implications of the findings both for future improvements to diversity training, and further refinement and development of the SJT. The findings will also illustrate the necessity for an iterative and rigorous piloting process in the development of a SJT (summarised in Figure 11.1 shown below) to aid and refine scenario and item development, response format and scoring methods.

FIGURE 11.1: SUMMARY OF PILOT PHASES

Phase I Pilot: Key Stakeholder Input & Expertise
Refinement of Scenario and Item Development, Response Format and Scoring and Test Construction

Session (PI.)1.	Session (PI.)2.	Session (PI.)3.
NHS Leads in Diversity Review 24 scenarios (Practitioner-Practitioner & Practitioner- Organisation Dimensions)	Medical Educators Review 24 scenarios (Practitioner-Self & Practitioner – Patient Dimensions)	Mental-health Patients Review 24 scenarios (Practitioner-Self & Practitioner – Patient Dimensions)

Session (PI.)4.

Development of Pre and Post SJT
Pre SJT = 10 scenarios
Post SJT = 10 scenarios (5 scenarios were the same as the Pre SJT)
Small NHS Diversity Training – Range of NHS health professionals (N=18)

Phase II Pilot: Pre and Post Test Development and Construction

Session (PII.)1.	Session (PII.)2.
Refinement of Pre and Post SJT Pre SJT = 6 scenarios Post SJT = 6 scenarios (same scenarios were the same as the Pre SJT) Small NHS Diversity Training – Range of NHS health professionals (N=23)	Refinement of Pre and Post SJT Pre SJT = 4 scenarios Post SJT = 4 scenarios (same scenarios were the same as the Pre SJT) Large NHS Diversity Training – Range of NHS health professionals (N=80)

Phase III Pilot: Comparison with Control Groups (Non-NHS groups)

Session (PIII.)1. Comparison of Findings Pre SJT from Session PII.2 (4 scenarios) Finance & Investment Bankers (Non-NHS groups) (N=50)	**Session (PIII.)2.** Comparison of Findings Pre SJT from Session PII.2 Mathematicians and Statisticians (Non-NHS groups) (N=10)
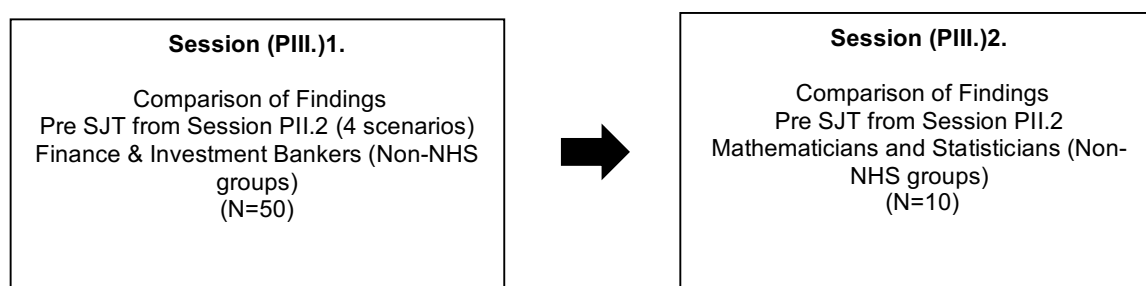
11.2 PHASE I PILOTS

Phase I involved three small pilot sessions (n=10 per session) with three key stakeholder groups (medical educators in the field of diversity, NHS diversity leads and mental-health patients). These were used to refine scenarios, items and test construction. A final fourth session involved the development of a pre and post SJT based on a selected number of scenarios that were thoroughly refined in accordance to the findings received from the previous three small pilot sessions. This fourth session was necessary to explore the challenges of response formats and scoring and also to assess participants' reactions and perspectives on the SJT. The sample used in the fourth session was representative of the typical NHS health professionals that this evaluation tool is intended for.

11.2.1 Scenario & Item Development

The initial three pilot sessions were one hour in duration, participants were asked to work in pairs to complete the pilot SJT, consisting of 4 example scenarios each with a list of items to rank in order of appropriateness. They were encouraged to discuss with their partner before making a response. The response sheets had an area for participants to document their responses to the following questions: a.) please explain your reasoning for choosing your appropriate actions, b.) please state any other comments or suggestions for improvement for this scenario and the proposed items and c.) Any other comments or suggestions for improvement for this scenario and the proposed items. In light of the responses from the first three sessions, a total of 20 scenarios were selected and used to develop a pre and post SJT that could be further piloted and refined.

Several matters were raised by participants from the pilot sessions in Phase I, these included:

- Positive reactions: the SJT was positively received by participants in terms of style, format, practicality and clinical relevance to real diversity issues that occur in healthcare.

- Format versatility: all three groups raised the different ways the SJT could be presented and used. Medical educators as well as NHS diversity leads suggested that the STJ can be used simultaneously as an educational resource and as an evaluation tool. The patient pilot group emphasised that the SJT could be converted into a video-based format and used as part of the e-learning package for diversity.

- Scenario refinement: illustrated common issues as to how to refine the scenarios, these included clearly stating the role (job description i.e. as a manager in this scenario) the participant plays in each scenario. All participants suggested that scenarios that allowed the respondents to answer from the perspective of their current role would elicit more authentic and plausible responses. Some participants suggested a blank response item where participants could provide a qualitative personalised response to the scenario.

- Specificity of scenarios: mixed responses were reported among the pilot groups in regards to whether the scenarios should be broad or specific in nature. Patients emphasised the need for broad scenarios in order for them to resonate and be applicable to a broad range of health professionals that attended the training. Conversely medical educators and NHS leads suggested more specific details to be included in the scenarios for example, patient information, details of the context and role of the respondent.

- Time constraints: all the pilot groups said the scenarios could be shortened and made more concise. All stakeholders proposed that items should be behavioural (action-driven) responses and that no more than four should be included given the time constraints.

11.2.2 Response Format and Scoring

After each of three initial Phase I sessions the frequencies with which each item was chosen as most or least appropriate were listed. In some cases, participants were almost unanimous in their choice, see example in Table 11.1. Such scenarios suggested that the list of items was too easy. All scenarios and their responses were collated and reviewed to assess whether certain items were unanimously chosen, or unanimously rejected. These items were subsequently refined to improve their ability to discriminate amongst respondents who are or are not able to effectively deal with diversity issues. These frequency tables were used, along with respondents' comments, to improve and refine items after each pilot session. Throughout the sessions in Phase I, each scenario and their corresponding items were revised and refined to make them more mutually exclusive yet plausible responses

During the Phase I pilot, participants were asked to either rank items (1= most appropriate/5= least appropriate) or choose the two/three most appropriate actions from the list of items. The fourth pilot session in Phase I aimed to develop a pre and post SJT to explore further issues around scoring. This pool of participants was representative of the typical NHS health professionals attending diversity training. The pilot sessions in Phase I revealed the following challenges in relation to scoring:

- Tied rankings: many participants opted for the use for tied ranking (identical responses for different items). These required calculations to be performed (establish the average rank) to make their responses comparable with others. Typically scoring should be based on the difference from the optimal ranking but with tied responses it is unclear how this should be calculated. Correlation between the participant's and the optimal ranking may be the best score, but this involves calculations which would be very time consuming and perhaps error prone in routine use.

- Omitted items: some participants omitted options from their ranking, and it is unclear how such responses should be scored. For these reasons, ranking was rejected from Pilot II onwards.

- Consistency in the number of items: As Phase I sessions involved the initial stages of item development, the scenarios requesting ranking all had different numbers of possible items therefore the same weights could not be applied when totalling the scores. The range of possible values/scores varied in accordance with the number of possible items for each scenario. It was deemed

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appropriate to have no more than 4 items per scenario. This offers some uniformity to the task presented to the participants and also means that a uniform scoring system can be used.

- Multiple choice scoring: scenarios that required participants to choose multiple most appropriate responses raised concerns, some participants failed to read the instructions, opting for ranking the items instead. Other participants responded by choosing only one option. Due to these reasons, it was deemed that the 'best single response' would be the most appropriate response format as this would be more manageable and enable the evaluation tool to be used on a routine basis. Also with the 'best single response' it is easier to score as it is given the value assigned by the agreed optimal ranking score.

- Single response format: some participants commented that it was confusing to be asked to respond in different ways to different scenarios, therefore a single response format needed to be established for future versions of the SJT.

11.2.3 Test Construction

In the fourth session, a pre and post version of the SJT was used. Ten scenarios each with 4 items were used. The post training version used 5 of the same scenarios used in the pre training version with the addition of 5 new scenarios. Feedback received from this session suggested that the same scenarios should be used in the pre and post versions and that no more than 6 scenarios should be used. Participants agreed that the optimal number of scenarios should be between 4 and 6 with 4 items per scenario. At all the pilots in Phase I, participants collectively reported issues around time constraints to complete the SJT.

Participants also highlighted in the feedback that different versions of the SJT could be developed to cater towards the different formats of diversity trainings across NHS trusts. For example, the longer 3 hour diversity training could use an STJ with a larger number of scenarios (perhaps 8 – 10) whereas the shorter 1 hour diversity training could use a SJT composed of a smaller number of scenarios (perhaps 4-6). Participants also suggested an e-version of the SJT could be used for the e-learning diversity training packages.

11.3 PHASE II PILOTS

There were two sessions in the Phase II pilots. The first session involved a diversity training for a small group of health professionals (n=23). In this case participants responded both before and after the training to 6 scenarios with 4 or 5 items for each scenario. The same 6 scenarios and items were used before and after training, but were presented in a different order after training. Participants were consistently positive about the STJ. The second session involved a diversity training for a larger group of health professionals (n=80). This time participants responded to only 4 scenarios, selected from the 6 used in the first session, but 4 items for each scenario were consistently used. The scenario items were refined after consideration of the feedback from the first session. The 4 scenarios chosen are shown in Table 11.2, and cover specific diversity issues such as disability, religion, language and sexual orientation. Once again participants responded before and after training, with the 4 scenarios presented in a different order after training.

11.3.1 Session 1 Results

A set of tentative scores from 1 to 5, most appropriate to least appropriate were used to establish pre and post training totals for comparison. The correlation between the pre and post totals is quite large (0.41), however not so large as to indicate no changes in participants responses after the training. A cross-tabulation of participants' responses for each scenario was performed (shown in Table 11.3) which indicates how participants changed their responses from pre to post.

The difference in mean total score from pre (9.95) to post (10.24) is quite small (0.29) and certainly not approaching significance (paired samples t-test = 0.44, df =20). Interestingly the findings conveyed that there were no consistent changes towards more appropriate responses after diversity trainings and the total scores tentatively indicate participants perform worse on the SJT after the training (although this is a small change).

The findings also suggest that good performance on one scenario concerning a specific diversity issue does not equate to good performance on another scenario concerning a different diversity issue. For example, of the 15 participants who chose the best response to the disability scenario after training, 10 chose one of the worst two responses to the health values scenario. However there are some positive correlations

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among the pre scores and among the post scores, which suggests there is some commonality present (Table 11.4 shows the pre training correlations). Given the sample size for session 1 is small, a larger sample size would provide a clearer picture of correlations among the scenarios.

Positive reactions to the SJT were reported by all participants, feedback around time constraints was also consistently reported. This led to the decision to use 4 scenarios for the second session. For uniformity in scoring and simplicity for participants all scenarios had 4 items for the final session. The scoring format from 1-5 that collectively arose from the findings of Phase I pilots was further reviewed and refined to 1-4, based on the findings on this session.

11.3.2   Session 2 Results

Session 2 involved a diversity training for a larger group of health professionals (n=80) and the same statistical tests performed in session 1 were also conducted for this set of data. Scenarios, items and scoring format were refined in accordance with the feedback and findings of session 1. The correlations between the pre and post totals is smaller than session 1 (0.165), indicating changes in participants' responses after the training.

A cross-tabulation of participants' responses for each scenario was performed (shown in Table 11.5) which indicates how participants changed their responses from pre to post. As in session 1, the findings of session 2 indicated no consistent changes towards more appropriate responses after diversity training. The difference in mean total scores from pre (7.08) to post (7.45) was small (0.37) and as in session 1 did not approach significance (paired samples t-test = 0.1537, df =75 because of some missing responses). Though the difference is small and not significant, it is in the wrong direction, suggesting that participants performed slightly worse on the SJT after the diversity training.

In addition, participants who performed well on one diversity issue did not consistently perform well in others. This is illustrated in Table 11.6, which shows that, of the 53 who gave the best response to the disability scenario, 14 (26%) gave one of the two worst responses to the transgender scenario. The same table shows that almost half of those who gave the best response to the transgender scenario gave one of the worst two responses to the disability scenario. However, there are some positive correlations

among the pre-scores and post scores (Table 11.7 shows the correlations among the post scores), which indicates that there is commonality present in what the scenarios are measuring. As in all the pilot sessions, participants received the SJT positively and this session reported no comments around time constraints.

11.4 PHASE III PILOTS

Pilot sessions in Phase III involved comparing the pilot sessions in Phase II with two non-NHS groups. Both non-NHS samples were samples of convenience and those who were easily accessible and did not receive any NHS diversity training and perhaps had less awareness about diversity issues. These two samples consisted of a group of participants in the field of finance and investment banking (n=50) and a group of mathematicians (n=10). The samples were combined and used as one whole comparison/control group. The non-NHS group was given the pre SJT test from Phase II session 2 and their responses were compared with the post scores of the NHS group in Phase II session 2. Similar to the pilot sessions on the NHS samples, the non-NHS sample positively received the SJT, indicating that the scenarios can be easily understood despite being tailored for a NHS context. This suggests that large scale validation testing should not be problem in the future.

The difference between the mean total score for the non-NHS groups (7.50) and the post NHS group (7.44) was very small (0.06) and did not approach significance, (independent t-test= 0.185, df =125).

11.5 DISCUSSION

11.5.1 Further development of SJT

This part of the PhD set out to develop an evaluation tool for NHS diversity training and the findings demonstrate significant progress in the development of an effective and plausible SJT. However, they also highlight substantial further development is needed to ensure this SJT is a valid and reliable tool. The scenarios and items developed so far are an ideal starting platform for further piloting, development and refinement. Further research is needed to test validity and reliability of all scenarios and corresponding items. Ideally a comparison between a larger sample of NHS health professionals (e.g. n>=500) and non-NHS individuals (i.e. those who have not undertaken diversity training and or are less aware of diversity issues) is needed to

establish whether the SJT can discriminate between such groups, before it can be used to evaluate diversity training. All the pilot sessions showed a lack of consistency in how participants can perform well (selecting the appropriate response) on one scenario concerning a specific diversity issue and worst on another scenario regarding another diversity issue. Ultimately a factor analysis would be desirable to explore the multiple dimensions of diversity awareness and judgments around how to most appropriately deal with diversity issues, again this requires a large sample technique.

11.5.2 What do the results tell us about the training?

The findings of the pilot sessions provide tentative support and resonate with the findings of the participatory workshops around the perceived limitations of diversity training. Key findings of the participatory workshops included the lack of conceptual clarity around core terminology, emphasis on the attributes and skills that establish a good *relationship* and the necessity of the practitioner's awareness of any diversity issues between themselves and others and how to effectively bridge any cultural distance that may exist in their healthcare relationships and or clinical interactions. Participants consistently reported the rigidity of diversity training in that it attempted to provide fixed answers to complex questions. Participants collectively suggested that diversity training should focus on exploring and discussing the *questions* around how to effectively deal with diversity issues rather than defining fixed *answers*. The findings revealed that what participants considered appropriate for dealing with one diversity issue may be inappropriate for dealing with another diversity issue, and that responding to diversity issues requires an active acknowledgement of the context and the individuals involved, an open dialogue and a safe and supportive environment to explore and discuss diversity issues.

The findings of the pilot sessions provide provisional support around the challenges NHS health professionals face in trying to discern the most appropriate response to take when dealing with different diversity issues, and their struggle appears not to be helped by the training. Supporting this all the pilot sessions in Phase II demonstrated NHS professionals performed worse after the training and the Phase III findings show that non-NHS groups are performing almost the same in comparison to NHS groups who received diversity training. This provides tentative support to the consistently reported limitations of diversity training that resonate in the findings of the participatory workshops and in the literature. This suggests diversity training needs to be interactive,

participatory and exploratory in helping professionals first understand the complexity of what diversity means to them in order to then be competent to explore and appreciate the complexity of diversity issues in others. This is consistent with the findings of the participatory workshops and the reconstructed RCC model.

The findings of the pilot sessions also suggest that one evaluation tool may not be sufficient to measure the effectiveness of diversity training and to capture the complexity of diversity issues. The use of a summative evaluation tool may be more practically feasible in the context of NHS diversity training, but using a combination of formative and summative assessment/evaluation tools may provide more useful, insightful information around how to improve diversity training and its long term impact on professional development and patient outcomes. A reliance on a single evaluation tool may fail to provide sufficient information on how to improve diversity training and which parts are not sufficient in meeting the needs of health professionals and the expectations outlined in health educational policies.

11.5.3 Using the scenarios as a training resource

Throughout all the pilot sessions, participants positively received the SJT, frequently expressing that it was "*thought-provoking*" and was very helpful in discussing diversity issues that were relevant to their clinical practice and the common diversity issues they encountered. All scenarios and proposed items were distilled from 'critical incidents/stories' expressed by participants in the discussions from the participatory workshops. Many participants contrasted these scenarios and the quality of the discussions elicited by them with the current diversity training content which they found was unhelpful, clinically irrelevant and devoid of open discussions. This suggests that some of the original scenarios (a bank of 90 scenarios) could be further developed as a training resource. This would aid the digression from the typical fixed blueprint of answers for dealing with diversity issues to an open and respectful discussion. As participants found the discussions most helpful from the pilot sessions, expressing that real diversity issues they encountered in practice were too varied and complex for fixed answers and also the most appropriate response to one diversity issue may not be applicable to another diversity issue in a different context.

The challenges expressed around diversity issues appear to reside within the practitioner, firstly recognising diversity issues within themselves and then in others, and how to demonstrate mutual respect, flexibility, tolerance and be comfortable in

initiating discussions that are uncomfortable and uncertain. This also raises an important emphasis on faculty development and the need for trainers in diversity to be comfortable in facilitating difficult and sensitive discussions. From the feedback received, using the scenarios as a training resource for both the trainers and trainees could potentially be a helpful starting point.

Some of the common limitations of SJTs include the restriction of responses to a single choice, particularly concerning diversity issues where different responses may be more likely and differ depending on context. Furthermore, response formats in certain SJTs may not provide an adequate range of responses, resulting in candidates feeling forced to select a response that is not necessarily comparable with their values and views. Whilst SJTs are well suited for assessing multiple constructs, it can be challenging to distil the separate constructs measured in one test. This is particularly relevant for diversity education. Developing different versions of SJTs (including shorter and longer versions) may be more useful and practical. Also, due to the multi-dimensional nature of SJTs, it can be challenging to assess their reliability using standardised measures.

CONCLUSION

This chapter highlights insightful findings and implications for future development of an SJT and evidence on how to improve and evaluate diversity training. The findings from the pilot sessions are consistent with those of participatory workshops and the reported limitations of diversity training in the literature. The tentative scenarios and items can be further developed and used as a practical training resource for diversity training and offer a tangible example of how to initiate open and constructive discussions around diversity issues.

The development of an SJT that can be used for routine evaluation of diversity training still needs considerable work, but in the process of bringing it to this level, important issues about the needs of the trainees, trainers and the shortcomings of the training were exposed.

TABLE 11.1: PHASE I PILOT – EXAMPLE OF EXPLORING RESPONSE FORMAT AND SCORING

		P1		P2		P3		P4	
SCENARIO 1		PRE	POST	PRE	POST	PRE	POST	PRE	POST
A Muslim female doctor claims that the organisational policy that all staff must be 'bare below the elbows' (hands and arms up to the elbow are exposed and free from clothing) is against her religious beliefs. Choose the one most appropriate action you would take.									
A	Respect that this is part of her religious beliefs and accept that she will not be abiding by the 'bare below the elbows' rule.								
B	Discuss the issue with the rest of the team and ask for advice from a senior member of the team		X	X	X	X	X	X	X
C	Explain to your colleague that all health professionals have to abide by healthcare rules and policies and that no adjustments can be made	X							
D	Allow your colleague to continue not abiding by the 'bare below the elbows' rule until any formal complaints are made								

TABLE 11.2: FINAL FOUR SCENARIOS AND ITEMS

Scenario 1:	Scenario 2:
Rachel formerly known as Richard is a transgender staff nurse. She has made you aware as a colleague that she is being bullied by several colleagues and that she is being prevented from using the female toilets. *Choose the ONE most appropriate action you would take:* A. Raise the issue in a team meeting in a way that everyone can safely and openly discuss the matter and resolve together. B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but highlight to all colleagues that bullying is not acceptable under any circumstances. C. Discuss with other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets. D. Reassure Rachel that you would discuss the issue with the staff team leader to ensure she does have access to the female toilets.	Your colleague comes to you on their lunch break and is very frustrated about a patient that took up most of her morning as they were unable to understand what was written on their medication packets. She says, "they should really learn English if they are coming to this country or at least try shouldn't try?" *Choose the ONE most appropriate action you would take:* A. Point out that an interpreter should be called (if available) if there are difficulties. B. Explain to your colleague that their comment may be seen as racist and is therefore inappropriate. C. Explain to your colleague that as health professionals we are here to care for all patients with different needs and concerns and suggest an interpreter. D. Sympathise with your colleague's comment and raise this issue in a team meeting.
Scenario 3:	**Scenario 4:**
You hear a patient who has dementia say, "are you able to move around in that chair as much as the others?", to a colleague who is a wheelchair user. Your colleague responds in a rude and offensive manner. *Choose ONE most appropriate action you would take:* A. Intervene in the situation, asking your colleague to leave the patient immediately. B. Say to the patient that the Trust's Equality and Diversity stance makes their comment un-acceptable. C. Discuss with your colleague that you witnessed unprofessional behaviour and that whilst it may be understandable, it is not acceptable. D. Ignore the situation as you feel it is none of your business and carry on with your work as usual.	A new member of staff, Miriam, reveals during her induction that she is Jewish and will need to finish work early on a Friday in the winter. She has not mentioned this earlier when specifically asked if there were any special circumstances. The manager appears apprehensive after her request and says she will have to discuss the request with a Senior Manager. The Senior Manager laughs and says "don't we all want to finish early on a Friday?" If you were the Senior Manager, what would you do in this case? *Choose ONE most appropriate action you would take:* A. Acknowledge that Miriam has the right to request flexibility in her working hours and is entitled to finish early on Fridays. B. Grant her request as it is made on religious grounds. C. Discuss the request with the team, how this arrangement could potentially work for Miriam. D. Explain to Miriam that the contract of employment that she signed made the working hours clear and that it would not be fair to her other colleagues to make special arrangements for her.

TABLE 11.3: PHASE II PILOT SESSION 1: CROSS TABULATION

Scenario 1: Religion and Health Policy

	After A	B	C	D	
Before A	1	2	2	0	5
B	2	8	2	0	12
C	1	1	4	0	6
D	0	0	0	0	0
	4	11	8	0	

Scenario 2: Health beliefs

	After A	B	C	D	
Before A	2	0	1	0	3
B	0	10	1	0	11
C	0	1	5	0	6
D	0	0	1	0	1
	2	11	8	0	

2 spoiled

Scenario 3: Sexual orientation

	After A	B	C	D	
Before A	0	0	1	0	1
B	0	11	1	3	15
C	0	1	1	0	2
D	0	2	1	2	5
	0	14	4	5	

Scenario 4: Language

	After A	B	C	D	
Before A	0	1	3	0	4
B	0	0	0	0	0
C	1	3	13	0	17
D	0	0	0	0	0
	1	4	16	0	

2 spoiled

Scenario 5: Disability

	After A	B	C	D	
Before A	1	0	2	0	3
B	1	2	2	0	5
C	0	4	11	0	15
D	0	0	0	0	0
	2	6	15	0	

Scenario 6: Religion and Service Delivery

	After A	B	C	D	
Before A	2	0	2	0	4
B	0	0	0	0	0
C	0	0	13	1	14
D	1	0	2	1	4
	3	0	17	2	

1 spoiled

TABLE 11.4: PHASE II PILOT I SESSION 1 PRE-TRAINING CORRELATIONS

	Religion & Health Policy	Values & Health Beliefs	Sexual Orientation	Language	Disability	Religion & Health Service Delivery
Religion & Health Policy	1	-.058	.123	-.185	.073	.045
Values & Health Beliefs	-.058	1	.333	.140	.011	.026
Sexual Orientation	.123	.333	1	.216	.552	.418
Language	-.185	.140	.216	1	.526	-.285
Disability	.073	.011	.552	.526	1	-.052
Religion & Health Service Delivery	.045	.026	.418	-.285	-.052	1

TABLE 11.5: PHASE II SESSION 2 CHANGES AFTER TRAINING

Transgender Pre, Transgender Post, Cross tabulation

		transgenderpost				Total
		1	2	3	4	
Transgenderpre	1	4	10	3	0	17
	2	3	24	5	0	32
	3	1	13	11	1	26
	4	1	1	0	1	3
Total		9	48	19	2	78

2 spoiled

Language Pre, Language Post, Cross tabulation

		languagerpost				Total
		1	2	3	4	
languagerpre	1	57	2	3	11	73
	3	2	1	1	0	4
	4	2	0	0	0	2
Total		61	3	4	11	79

1 spoiled

Disability Pre, Disability Post, Cross tabulation

		disabilitypost				Total
		1	2	3	4	
disabilityrpre	1	48	8	6	1	63
	2	3	4	1	0	8
	3	3	0	5	0	8
Total		54	12	12	1	79

1 spoiled

Religion Pre, Religion Post, Cross tabulation

		religionpost				Total
		1	2	3	4	
religionpre	1	1	5	1	0	7
	2	3	25	6	1	35
	3	0	24	8	1	33
	4	0	2	2	0	4
Total		4	56	17	2	79

1 spoiled

TABLE 11.6: PHASE II SESSION 2 POST TRAINING RESPONSES TO TRANSGENDER AND DISABILITY SCENARIOS

Transgender Post, Disability Post, Cross tabulation

		disabilitypost				Total
		1	2	3	4	
transgenderpost	1	4	1	4	0	9
	2	35	6	6	1	48
	3	13	4	1	0	18
	4	1	1	0	0	2
Total		53	12	11	1	77

3 spoiled

TABLE 11.7: PHASE II PILOT SESSION 2 PRE-TRAINING CORRELATIONS

	Sexual Orientation	Language	Disability	Religion & Health Service Delivery
Sexual Orientation	1	-.118	.042	.055
Language	-.118	1	-.163	.110
Disability	.042	.163	1	.204
Religion & Health Service	.055	.110	.204	1

CHAPTER 12: CONCLUSION AND IMPLICATIONS

This chapter begins by revisiting the main PhD research aim and providing an overview of the key findings. Based on the findings, implications for healthcare practice and policy, education and research are discussed. Specific recommendations to support curriculum development, design, delivery and evaluation of diversity education in health institutions are also outlined. This chapter is written in a concise and specific style as this was preferred and recommended by the collaborating organisations.

12.1 RESEARCH AIM AND FINDINGS

This thesis aimed to gather the perspectives of key-stakeholders (namely mental-health patients, NHS health professionals and medical educators') on how to better teach and evaluate diversity education and to develop an evaluation tool that can be used to measure the effectiveness of diversity education. The reconstructed RCC model provides clarity on how diversity education can be better theoretically informed and evaluated. It situates diversity education within a wider framework that should be considered for achieving high quality patient centred care and healthcare delivery. The new practitioner-self dimension is key to supporting and maintaining the personal growth necessary for increasing one's awareness of diversity in oneself and others and being attentive to the dynamics and nuances of their different healthcare relationships. Two areas are considered below: 1.) Reforming healthcare policy and practice and 2.) Reforming healthcare education and research with specific recommendations for how to better teach and evaluate diversity education.

12.1.1 Reforming healthcare policy and practice

Health professional bodies are ideally placed to provide consistent and coherent guidelines for the teaching and evaluation of diversity education and for ensuring that policy guidelines and expectations are adhered too. The findings of the participatory workshops provided conceptual clarity on the terms diversity, culture and equality and this can be more explicitly defined in policy. Race continues to dominate understandings of these terms in healthcare policy, yet the participatory workshops demonstrate that these terms have broad and complex meanings, all of which are intrinsically related to the exploration of oneself and one's relations with others.

Changing the perception of diversity education as a subject applicable to all requires active discussion and engagement, an evidence-based curriculum that highlights the clinical relevance of acknowledging cultural and diversity issues, institutional support and faculty development. As our population becomes increasingly diverse and culturally pluralistic, categorising individuals based on race will become problematic.

Health institutions should play a greater role in supporting diversity educators and creating safe spaces for individuals to gather together to discuss and share good practice. Networks for diversity educators should be formally established. Health educational bodies play a key role in forming core learning objectives and shifting the emphasis on diversity education from a political to an educational framework. This is particularly relevant in the NHS, where diversity education to date has been politically driven. NHS health professionals emphasised the importance of health bodies developing a repository of examples of good practice and teaching materials, showcasing the different ways diversity can be taught. Specific recommendations include:

- Rethinking the significance of relationships in healthcare and creating a healthcare culture that is conducive to developing and maintaining meaningful relationships with patients, professionals and the community.
- Creating a culture of change rather than compliance. Participants urged professionals and healthcare organisations to deviate from the 'culture of compliance' or also called 'tick-box' culture and strive for continual change and progression in the healthcare system.
- NHS organisations should place a greater emphasis on quality not targets, with some participants expressing "delivering quality leads to quality."
- The emphasis in diversity education should be on the improvement of professional practice and patient-centred care and not merely the generic acquisition of knowledge or skills that are centred on cultural differences, and this framework should be embedded within the organisation's systems and governance.

12.1.2 Reforming healthcare education and research

Further developments in diversity education must be educationally informed to assist in increasing the credibility of diversity education. The literature review demonstrates that whilst health educational institutions are aware of established educational theories, a competency based training approach has been commonly applied in diversity education, focusing on attaining knowledge and is often devoid of utilising educational theories. A wider, interdisciplinary constructive debate is needed on the development of educational models, particularly in the UK context. Further research using the method of participatory workshops and consulting a variety of stakeholders is ideal for this.

The reconstructed RCC model warrants further research and evaluation to verify the conceptual and pragmatic soundness of the revised model. In particular, the practitioner-self relationship needs further study. The reconstructed RCC framework proposes that the development of the practitioner-self relationship fosters optimal development in the practitioner's relationship with their patients, peers and the organisation. However further research exploring the other relational dimensions is needed to find out whether an increasing capacity in the practitioner-self relationship leads to better or worse relational functioning in the other dimensions. Embracing the reconstructed RCC model requires a transformation not just at an individual level but also at an institutional level, additional qualitative research into the barriers and perceived threats towards change would assist in understanding how to promote systems wide change.

Educational strategies that are common to the learning required in all four reconstructed RCC dimensions are firstly, opportunities for guided reflection which can encourage and support students' personal and professional awareness of themselves and how they impact others in different relationships. The apprenticeship model which reflects the principles of adult learning theory will help students develop an understanding of different clinical relationships in practice. The use of non-competitive, formative assessments will encourage individuals to develop a mastery of knowledge and skills rather than a sole focus on achieving high grades. This may reinforce the over-arching emphasis on personal and professional development and learning. It creates a non-threatening evaluation method that reinforces the importance of relationship-building. Faculty development should support teachers as role models and exemplars of relationship-centred care practice so that students can learn more

effectively. Small group discussions may be best to foster exploration and understanding of oneself in relation to others.

Relationship-centred care is reflected in a learner centred education. The caring relationship between the practitioner and the patient is modelled by the nurturing environment that students, faculty and practitioners themselves create through the quality of their relationships. Refocusing health education to include both the acquisition of technical knowledge and skills and the development of the capacity for self-reflection and understanding to enter into relationships for care requires attention to both the formal and the informal curriculum. The informal curriculum includes aspects of diversity, the organisational culture and the pedagogical space for exploring issues of professionalism and a professional's sense of self.

Designing curricula involves a number of factors, including defining the approach to teaching and the understanding and interpretation of educational issues. All these aspects are subject to the influence of the teacher's own perspectives about these issues. In order to adopt the principles of the reconstructed RCC model when designing curricula, educators must first have an awareness of their own perspectives and their sense of identity. Little research has explored the influence and impact of diversity educators' values, beliefs and perspectives on how diversity education is conceptualised and taught. Curriculum design is not value free or unbiased as educators' perspectives will have crafted its development, and understanding this is key to achieving good diversity education. This is an area of research that is needed in ensuring successful implementation of the practitioner-self principles in educators.

The relationship most explored in healthcare curricula is that between the practitioner and the patient. However, the reconstructed RCC model asserts the most important relationship is that between the practitioner and oneself. Educational reform is needed in redefining shared values around the importance of relationships, development of critical reflection and awareness, faculty development and curriculum development and evaluation. Although developing an entirely new curriculum is not necessary, but rather the reconstructed RCC model should be embedded throughout the existing curriculum and delivered by highly skilled and reflective educators.

Frankel et al (2011) proposed five recommendations for relationship centred care, these were:

- Make RCC a central competency in all healthcare interactions
- Develop a national curriculum framework
- Require performance metrics for professional development
- Partner with national healthcare organisations to disseminate a curriculum framework
- Preserve a face to face method (not e-learning) for delivering key elements of the curriculum

These recommendations also apply to the reconstructed RCC model, in addition to supporting educators in exploring their practitioner-self relationship and developing a mature and reflective understanding of their individual diversity and what that means in the context of their workplace and in relation to others. Research has shown trainers commonly experience defensiveness, anger and denial when presenting diversity material (Abrams and Gibson, 2007; Stith-Williams, 2007). The issue is not that these reactions arise, as these responses are part of a normative process. Rather, training models may not be designed in a way that mobilises learners to shift from defensive responses to a more refined critique. Further consideration may be needed in whether traditional didactic methods of teaching diversity education are appropriate for the training content, which requires experienced skills in facilitating difficult and challenging discussions and contending with group dynamics. The complexity and sensitivity of the training requires a greater understanding of how to create a supportive scaffold in which to frame and deliver this teaching.

Allocating protected time and space in clinical practice is essential for implementing the reconstructed RCC model and ensuring continual and sufficient exploration of the practitioner-self relationship. Practising the competencies outlined in the practitioner-self relationship such as self-awareness, reflection and self-growth involves being comfortable with uncertainty, accepting limitations, being collegial and actively asking for help (Madigan, 2001; Dogra et al, 2015). Miller's (2010) study on developing a relationship centred care model for primary care practice included sessions on mindfulness, heedful interrelating and trust. In addition, allocating time for regular clinical supervision, reflective practice sessions for health care teams and 360 degree appraisals will assist in supporting the implementation of the reconstructed RCC model. The reconstructed dimensions of the practitioner-practitioner and the practitioner-

organisation relationships rekindles the importance of team working, collaboration and cooperation and provides a prime opportunity to include inter-professional education (IPE). Other authors have emphasised the significance of IPE in supporting practitioners to foster a RCC approach to practice (Dix et al, 2008; Gaboury et al, 2011; Hebblewaite et al, 2013).

12.2 SPECIFIC RECOMMENDATIONS FOR IMPROVING DIVERSITY EDUCATION

Specific recommendations for implementing the reconstructed RCC model in diversity education include:

12.2.1 Curriculum development and design

- Diversity education should be centred on the exploration of different clinical relationships, particularly the practitioner-self relationship.
- Inclusion of specific learning objectives to achieve the outcomes of the reconstructed RCC model focusing on self-development and interpersonal skills, examples are shown in table 7.3.
- Further research comparing the different educational models to deliver diversity education, this would assist in providing educational clarity. Different models may be better suited to achieving certain learning objectives in comparison to others.

- Many of the challenges raised in the findings of this research around diversity education are similarly applicable to international contexts. The findings were neither specific to the context of mental-health or the NHS, and could therefore be applied in other health educational settings and internationally.

- Further research is needed to understand what educational approaches lead to the adoption of a relationship-centred care outlook or how relationship building behaviours are best developed and fostered. Determining whether and under what circumstances relationship-centred care leads to positive health outcomes is also important.

12.2.2 Curriculum delivery

- Encourage wider, inter-disciplinary discussion on diversity education to consider how diversity education can be integrated throughout the healthcare curriculum.
- Improved communication and collaboration between diversity leads in educational institutions.
- Establish support networks for faculty development and guidance on how to facilitate meaningful discussions on diversity issues.
- Diversity education should be integrated and a continuing part of professional's learning and self-development. Diversity education should be part of wider framework for promoting and delivery of high quality patient-centred care.
- Creating a safe space, a trusting, exploratory and respectful learning environment must first be established. Sessions should be face to face, interactive and participatory and composed of small groups.
- Sessions should be personal, relational and experiential. Collectively stakeholders recommended practical based teaching that helps trainees actively contextualise, explore and critically evaluate diversity issues in practice and reflect upon their judgement and reasoning abilities. Other recommendations included using simulated patients in communication skills, case studies, reflexive portfolios and problem-based learning.
- E-learning is not suitable for the exploration of diversity issues in healthcare.

12.2.3 Assessment and evaluation

- Stakeholders recommended that an evaluation tool for diversity education should allow individuals to reflect upon multiple perspectives within different encounters, focused on measuring attitudes and skills, particularly interpersonal and communication skills.
- Proposed evaluation methods for an individual and organisational level included a.) Staff and peer appraisals and feedback against NHS trust values and diversity, b.) Inclusion of diversity as part of overall performance and management i.e. set targets for diversity with specific examples, c.) Implement values-based recruitment, d.) Development of personal objectives after the session with long term follow up, e.) Objective structured clinical examinations (OSCEs) exploring aspects of professionalism and intercultural communication

related to diversity and f.) Examining complaint forms and changes in patient satisfaction levels.

- Many forms of evaluation were suggested and further research is needed to establish which methods are most effective. Although there is a desire to have a summative evaluation tool, the findings show this is not the only solution to evaluation and multiple methods should be employed. Collectively stakeholders emphasised a strong preference against using questionnaires.

- Further development of the SJT may provide a useful tool for the future.

CONCLUSION

Healthcare services continue to become more complex, diverse and specialised. Diversity awareness, values, attitudes, knowledge and skills cannot be imposed. These realities must be considered, experienced, developed and owned. This research identified consistent perspectives from a range of stakeholders on how diversity education can be better taught and evaluated. The nature of healthcare relationships affects the quality and delivery of healthcare and is a powerful medium of care. Soklardis et al (2016) notably concludes the 20 year old scoping document of RCC with the statement; *"how healthcare is delivered and received depends on how we define ourselves and others within a multitude of relationships and social circumstances."* (Soklardis et al, 2016, pp.137). The reconstructed RCC model holds promise for redesigning diversity education with greater clarity and relevance, and the SJT offers a starting point to exploring different options for evaluating diversity education.

APPENDICES

APPENDIX 1: OVERVIEW OF INSTITUTIONAL REQUIREMENTS CONCERNING DIVERSITY FROM THE 1990S TO 2015

General Medical Council (1993) – Tomorrow's Doctors	Outcome 4: Good clinical care Recognise personal and professional limits, and be willing to ask for help when necessary. Recognise the duty to protect patients by taking action if a colleague's health, performance or conduct is putting patients at risk. Outcome 6: Relationships with patients Respect patients regardless of their lifestyle, culture, beliefs, race, colour, gender, sexuality, disability, age or social or economic status. Communicate effectively with individuals regardless of their social, cultural or ethnic backgrounds or their disabilities. Outcome 7: Working with colleagues Be able to demonstrate effective team-working and leadership skills. Be willing to lead when faced with uncertainty and change. Outcome 35: Diversity and culture "They must understand a range of social and cultural values and differing views about healthcare and illness. They must be aware of issues such as alcohol and drug abuse, domestic violence and abuse of the vulnerable patient. They must recognise the need to make sure that they are not prejudiced by patient's life style, culture, beliefs, race, colour, gender, sexuality, age, social and economic status and mental or physical disability."
Making a Difference – Department of Health (1999)	2.34 Perhaps more than any of the health professions, nursing, midwifery and health visiting have embraced diversity, drawing recruits from a variety of social, ethnic and academic backgrounds and encompassing a wide range of roles within the sphere of professional practice. 3.7 And, crucially, access to training must support the NHS commitment to diversity. We need hospitals and practices that reflect the communities they serve.
The Vital Connection: An Equalities Framework for the NHS (2000)	"All NHS Boards should undertake training on managing equality and diversity" and "Leaders and Managers must be developed and trained to manage for equality and diversity."
Delivering Race Equality (2005)	More appropriate and responsive services - achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups, such as older people, asylum seekers and refugees, and children; Community engagement - delivered through healthier communities and by action to engage communities in planning services, supported by 500 new Community Development Workers; and

	Better information - from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental-health patients.
CRE Code of Practice (2005)	CRE Code of Practice (2005), whose provisions can be taken into account by Employment Tribunals specified that: "Staff responsible for shortlisting, interviewing and selecting should be given guidance or training on the effects which generalised assumptions and prejudices about race can have on selection decision" and should be "made aware of the possible misunderstandings that can occur between persons of different cultural background". Communication and comprehension difficulties. Differences in cultural background or behaviour.
NHS Leadership Qualities Framework (2006)	Political astuteness: "Understanding the climate and culture in their own organisation and in the wider health and social care environment." Delivering the service: "Taking a collaborative or facilitative approach in working in partnership with diverse groups." Empowering others: "Taking personal responsibility for ensuring that diversity is respected and that there is genuine equality of opportunity." Collaborative working: "Understanding and being sensitive to diverse view-points."
Medical Students: Professional Values and Fitness to Practice. General Medical Council (2009)	Outcome 16: Good clinical care: "Not unfairly discriminate against patients by allowing their personal views to affect adversely their professional relationship or the treatment they provide or arrange (this includes their views about a patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or belief, sex, sexual orientation and social or economic status.)" Outcome 46: Health and fitness to practice: Medical education and training should be able to accommodate people with a range of ambitions, different faiths and backgrounds, as well as those with health conditions and disabilities. Varied perspectives make valuable contributions to the profession and the population it serves."
General Medical Council: Tomorrow's Doctor (2009)	Outcome 10: Apply social science principles, method and knowledge to medical practice: C.) "apply theoretical framework or sociology to explain the varied responses of individuals, groups and societies to disease." D.) "explain sociological factors that contribute to illness, the course of the disease and the success of treatment, including issues relating to health inequalities, the link between occupation and health and the effects of poverty and affluence." Outcome 11: B.) "Assess how health behaviours and outcomes are affected by the diversity of patient population." Outcome 14: Diagnose and manage clinical presentations: A.) "Interpret findings from the history, physical examination and mental state examination, appreciating the importance of clinical, psychological, spiritual, religious, social and cultural factors."

Clinical Leadership Competency Framework (NHS Leadership Academy, 2011)	1.1. Self-awareness Recognise and articulate their own values and principles, understanding how these may differ from those of other individuals and groups. Identify their own emotions and prejudices and understand how these can affect their judgment and behaviour. 1.4. Acting with integrity Uphold personal and professional ethics and values, taking into account the values of the organisation and respecting the culture, beliefs and abilities of individuals. Communicate effectively with individuals, appreciating their social, cultural, religious and ethnic backgrounds and their age, gender and abilities. Values, respects and promotes equality and diversity
The NHS Knowledge & Skills Framework (NHS KSF) and the development review process (2011)	Level 1: Act in ways that support equality and value diversity: Act in accordance with legislation, policies, procedures and good practice. Allows others to express their views even when different from one's own. Does not discriminate or offer a poor service because of others' different viewpoints." Level 2: Support equality and value diversity: Challenges bias, prejudice and intolerance if appropriate or brings it to the attention of a manager. Aware of the impact of own behaviour on others. Level 3: Communication: Identifies the impact of contextual factors on communication. Adapts communication to take account of other's culture, background and preferred way of communicating." Level 4: Develop a culture that promotes equality and values diversity: Monitors and evaluates the extent to which legislation and polices are applied. Actively challenges unacceptable behaviour and discrimination. Positive Indictors: People feel confident in speaking up if they feel there is bias in a system or process of if they feel they have witnessed bias, prejudice or intolerance. Staff understand what diversity is and why it is important."
NHS Competency Framework for Equality & Diversity Leadership (2011)	Offers a holistic, comprehensive and evidence-based overview of the competencies required to support improved equality in health outcomes and workforce diversity across all our diverse communities. It outlines professional standards of practice for Equality & Diversity Leadership. To build capacity to respond to diverse and changing community needs: Requires building the organisation's internal capacity to identify and respond to diverse and changing community needs at a local, regional and national level. Creating and sustaining flexible organisation that can fulfil our commitment to personalised and patient-centred services and which reduces health inequalities within the local population.

Good Medical Practice General Medical Council (2013)	Outcome 15: "Adequately access the patient's conditions, taking account of their history (including the symptoms and psychological, spiritual, social and cultural factors), their views values and, where necessary, examine the patient."
Equality Delivery System 2 (EDS2, NHS England 2015)	EDS2 encourages a standardised, consistent, and more robust method of recording and evaluation of equality outcomes. EDS2 specifies eighteen outcomes upon which NHS organisations assess and grade themselves in relation to achieving core NHS equality objectives: Outcome 3.3: "Training and development opportunities are taken up and positively evaluated by all staff." Outcome 4.3: "Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination."
Workforce Race Equality Standard (WRES, NHS England 2015)	Commissioning strategy which requires NHS providers to demonstrate progress against a number of indicators of workforce equality. There are nine metrics; four metrics are specifically on workforce data and the other four are based on data derived from the national NHS Staff Survey indicators; aiming to highlight differences between the experiences and treatment of staff. Metric 4: "Relative likelihood of BME staff accessing training and CPD"; ensuring staff are aware of Trust policies and reporting of discriminatory practices.

APPENDIX 3.1: ADDITIONAL MEASURES FREQUENTLY CITED FOR CULTURAL COMPETENCE AND DIVERSITY

Measurement Tool	Development & Theoretical Framework	Psychometric Properties	Format	Relationship to ethnocentrism/cultural expertise or ethno relativist/cultural sensibility
Transcultural Self-Efficacy tool (TSET) (Jeffreys and Smodlaka, 1996, 1999)	Theoretical Framework: Leininger's (1991) model around transcultural nursing & Social Learning Theory (Bandura Self-Efficacy, 1977, 1997) -Developed in 1999 and experienced a number of revisions, 2012.	-Content validity by 6-member expert panel -Good Construct Validity -High internal consistency -Total alpha .97 and .98 with subscale alpha ranging from 90. to 98.	-83 items -10 point Likert Scale (1=not confident to 10=totally confident) -3 subscales: cognitive, practical and affective -Content Areas: 1.) Influences of cultural factors on nursing care 2.) Interviewing patients about different cultural backgrounds 3.) Knowledge of the self-practitioner in areas of *awareness*, acceptance, appreciation, recognition and advocacy for different cultures	-Consistent with an ethno-centric, 'cultural expertise' approach -Diagnostic tool designed to evaluate students perceived self-efficacy caring for diverse clients -Evidence to suggest TSET assesses the multi-dimensional aspects of transcultural self-efficacy
Cultural Awareness Scale (CAS) (Rew et al, 2003)	-Theoretical Framework: based on the Pathways Model and consistent with the Purnell Model of Cultural Competence -Developed in 2003 and revised and further tested by Krainovich-Miller (2008)	-Content validity determined by 7-member expert panel -Cronbach's alpha.82 for faculty and for students .91 on overall test	-36 items -7 point Likert type scale (strongly agree to strongly disagree) -5 subscales: general education experience, cognitive awareness, research issues behaviour, *comfort with interactions* and patient care issues.	-Consistent with an ethno-relativist, 'cultural sensibility' approach -Authors considered cultural awareness to be the minimal level of cultural competence

Cultural Competence Assessment (CCA) (Schim et al, 2003)	-Theoretical Framework: based on Cultural Competence Model of Schim and Miller (2003) -Developed in 2003 and underwent subsequent use/testing by Doorenbos et al (2005) and Starr and Wallace (2009)	-Content and face validity -Cronbach's alpha overall was .92 with subscales reliability of .93 and .75 -Good construct validity -Tested with hospice nurses, the psychometric properties were sound and support the CCA as an accurate instrument to measure provider cultural competence	-25 items -5 points Likert type scale (strongly agree to strongly disagree and no opinion) -Subscales: awareness and sensitivity, cultural diverse experiences and cultural competence behaviours	-Consistent with a combination of ethno-centrism/cultural expertise and ethno-relativist/cultural sensibility -Designed to measure cultural competence among hospice nurses and workers
Cultural Knowledge Scale (CKS) (Brathwaite et al, 2006)	-Theoretical Framework: based on the process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2002) -Developed in 2006 with no reported subsequent use or testing	-Moderate good reliability and validity -Cronbach's alpha of 0.71 to 0.96	-24 items -5 point Likert type scale (strongly agree to strongly disagree) -2 knowledge subscales: items taken from IAPCC-R and CSES -Four subscales: health seeking behaviours, perceptions of health and illness, response to health and illness and treatment of illness conditions.	-Consistent with an ethno-centric, 'cultural expertise' approach -Designed to evaluate effectiveness of cultural competence training provided by public health nurses.
Cultural Diversity Questionnaire for Nurse Educators (CDQNE) (Sealey et al, 2006)	-Theoretical Framework: based on the process of Cultural Competence in the Delivery of Healthcare Services (Campinha-Bacote, 2002) -Developed in 2006	-Content validity was determined by a panel of experts -No reports of reliability -No further psychometric properties were reported	-72 items -5 point Likert type scale (strongly agree to strongly disagree) -2 subscales measuring 5 constructs of desire, awareness, knowledge, skill and *encounters*,	-Consistent with an ethno-centric, 'cultural expertise' approach -Designed to measure cultural competence of nurse educators

			including items from the IAPCC-R.	
-Nurse Cultural Competence Scale (NCCS) (Perng and Watson, 2012)	-Theoretical Framework: based of the literature of Campinha-Bacote, Jeffreys and others -Developed in 2012 and further revised Perng and Watson.	-Face validity established -Cronbach's alpha for 4 scales ranged from 0.78 to 0.96.	-41 items -5 point Likert type scale (strongly agree to strongly disagree) -4 constructs: cultural awareness, knowledge, sensitivity and skill	-Consistent with an ethno-centric, 'cultural expertise' approach
Blueprint for Integration of Cultural Competence in the Curriculum Questionnaire (BICCQ) (Tulman & Watts, 2008)	-Theoretical Framework: Unknown -Developed in 2008 to measure students reports of components of content on cultural competence taught in undergraduate and graduate nursing programs	-No reports on validity -Reliability estimated by Cronbach's alpha ranged from .73 to .94 across factors and was .96 overall.	-31 items -Items were derived from TACCT (broad applicability to health professions disciplines/designed to examine all components of a curriculum.	-Appears consistent with the ethno-centrism/ethno-relativist
Eldercare Cultural Self-Efficacy Scale (ECSES) (Shellman, 2006)	-Theoretical Framework: Bandura's (1986) Self-efficacy theory: modified version of Bernal & Froman's (1987, 1993). -Developed for nursing education to examine students' confidence in caring for ethnically diverse elders.	-Good reliability and validity -Reliability estimated from Cronbach's alpha ranged from 0.82 to 0.95.	-28 items -Factor analysis revealed a four factor structure; 1.) Assessing for lifestyle and social patterns, 2.) Determining cultural health practices, 3.) Determining cultural beliefs and 4.) Dealing with grief and the losses associated with aging.	-Consistent with a combination of ethno-centrism/cultural expertise and ethno-relativist/cultural sensibility
Ethnic Competency	-Theoretical Framework: No reported.	-No reported evidence on validity	-23 items -5 Likert type scale (never to always, with a higher score	-No evidence or discussion of an over-arching conceptual framework or of specific

Skills Assessment Inventory (ECSAI) Napholz, 1999	-Originally designed for another discipline; used to examine self-report cultural competence of nursing students	-Reliability was estimated by a coefficient alpha .9444	indicating greater cultural competence)	concept areas measured by the questionnaire
Cultural Competency Instruments (CCI) (Kosoko-Lasaki et al, 2006)	-Theoretical Framework: No conceptual framework identified. -Designed to assess cultural knowledge and competence of clinical researchers, including nurse researchers.	-No reported evidence on validity and reliability -No psychometric testing was reported	-20 items -Multiple choice items -Instrument was designed in an effort to produce the specific outcome of increasing African Americans participants in research projects. The investigators identified an increasingly reluctance on the part of African Americans to participate on-going research studies.	-No evidence or discussion of a conceptual framework. -Pilot tested with a "small" group of clinical researchers and research nurses
Cross-Cultural Evaluation Tool (CCET) (Hughes and Hood, 2007)	-Theoretical Framework: Giger-Davidhizar Model of Transcultural Assessment -Designed to measure the cultural sensitivity of nursing students after educational activity	-Reliability estimated by Cronbach's alpha of 0.73 to 0.87. Significant alpha increases on post-test. -Subjected to factor analysis by PCA. Four factors accounting for 51.9% of variance for the concept cross-cultural interaction.	-20 items -Based on items from an unpublished by presentation by Freeman (1993). -5 Likert type rating scale assessing behaviours with a range from always exhibited to never demonstrated	-Consistent with an ethno-centric, 'cultural expertise' approach
Modified Cultural Competency Self-assessment	Theoretical Framework: Not reported	-Content Validity -High internal consistency	-50 items -4/5 Likert Scale and True or False	-No evidence or discussion of an over-arching conceptual framework

			-Three Subscales: 1.) Attitudinal Statements regarding race, culture and social issues 2.) Accessibility issues to healthcare in the United States and 3.) *Self-awareness* and knowledge of different cultures	-Appears consistent with the ethnocentrism/cultural expertise model
Questionnaire (MCCSAQ) (Godkin and Savageau, 2001)				
Multi-cultural Assessment Questionnaire (MAQ) (Culhane-Pera et al, 1997; Crandall et al, 2003)	Theoretical Framework: Not reported	-High internal consistency -Limited reports regarding validity and reliability	-16 items -Three Subscales: 1.) Cultural Knowledge, 2.) Cultural Skills and 3.) Cultural Attitudes	-No evidence or discussion of an over-arching conceptual framework -Appears consistent with the ethnocentrism/cultural expertise model
Socio-cultural Attitudes in Medicine Inventory (SAMI) (Tang et al, 2002)	-Theoretical Framework: Not reported -Developed to measure attitudes towards socio-cultural issues in medicine and patient care.	-Moderate internal consistency -Limited reports regarding validity and reliability	-26 items -5 point Likert Scale -Two Subscales: 1.) Socio-cultural knowledge, attitudes and behaviours And 2.) Socio-cultural factors influence on clinical care	-No evidence or discussion of an over-arching conceptual framework -Appears consistent with the ethnocentrism/cultural expertise model

Evaluation Method	Description	Evidence of Use	Strengths and Limitations
Objective Structured Clinical Exams (OSCEs)	-A way to assess clinical and communication practices by setting up a series of stations to assess a range of skills. Simulated patients are used to create a clinically real situation.	-Boursicot et al (2007) established that with blue printing of OSCEs, training of examiners and simulated patients and a large number of stations it is possible to assess a range of skills. -Atshuler and Kachur (2001) and Rosen et al (2004) suggested using Culture Competency OSCES to develop skills through practice and feedback. -Betancourt (2003) agreed that student's attitudes could be assessed as part of certain stations in the OSCEs. -Miller & Green (2007) provided a detailed reflection on a cultural competence OSCE station	-Covers a broader range of competencies like problem solving, communication skills, decision-making and patient management abilities. -Versatility and a broad scope of assessment. All students get examined using predetermined criteria for the same or similar clinical scenario or tasks, with marks written down against those criteria thus enabling recall, teaching audit and determination of standards. -Criticised for using unreal subjects, though actual patients can be used according to need. -OSCE is more difficult to organise and requires more materials and human resources.

Reflective Portfolios	-Aids in developing 'reflective practitioners' who value life-long learning. -The value of reflection has been acknowledged and the skill of reflection is now taught in most health educational institutions. -Can take on different forms e.g. journals of observations or experiences, signed debrief of case presentations, learning experiences, or short written pieces.	-Seeleman et al (2009) emphasised in their cultural competence framework the importance of embedding reflective practice with cultural competency as a "recurring focal point." -Moon (2006) claims reflective portfolios are flawed and claims essay writing would be better.	-Portfolios have been adapted to serve simultaneously as vehicles for learning and as demonstrations of learning. -Portfolios is longitudinal and developmental; the reflection is often regarded by both faculty and students as the most beneficial part of the process from an educational perspective. -Extremely labour and time-intensive, both to compile and to review -Susceptible to 'faking', social desirability and coaching
Written Assignments: Multiple Choice Questions	-Wide range of written assessments including multiple choice questions and short answer questions, essays or reports and reflective portfolios.	-Limited role in assessing diversity issues because using these as assessment tools can reinforce this view that diversity education is merely about simply acquiring a body of relevant knowledge (Kai et al, 2001).	-Effective for assessing knowledge and academic attainment -Cost effective, easy to administer and assess.

APPENDIX 6.1: DEMOGRAPHIC CHARACTERISTICS OF THE MENTAL-HEALTH PATIENT SAMPLE (PSEUDONYMS USED)

WORKSHOP ONE

Participant No	Name	Gender	Age	Ethnicity
1	Sophie Wells	F	55	White British
2	John Smith	M	43	Black British
3	Fred Smart	M	60	Black British
4	Anne Jones	F	57	White Other
5	George Lipton	M	68	Ghanaian
6	Isaac Abraham	M	59	African
7	Larry Day	M	58	Jamaican
8	Bob Dilan	M	42	White British
9	Elizabeth Graves	F	51	Black British Caribbean
10	Cathy Green	F	43	Black British
11	Steven Olive	M	42	Black British
12	Terry Charleston	M	58	West Indian
13	Davina Acorn	F	40	White American
14	Dorothy Davis	F	53	Black British
15	Adrian Mc-Jager	M	45	Black British

WORKSHOP TWO

Participant No	Name	Gender	Age	Ethnicity
1	Sasha Chan	F	35	White and Chinese
2	Jeremiah Jones	M	39	White
3	Tim Mathews	M	50+	White
4	Adam Sevens	M	39	White
5	Lydia Henderson	F	60+	Afro-Caribbean
6	Beth Fernando	F	70+	Afro-Caribbean
7	Cathy Rivera	F	60	African
8	Mark Johnson	M	51	British Black
9	Sarah Volk	F	61	Black Caribbean
10	Heather Mills	F	74	Black Caribbean
11	Celine Mayor	F	55	Black Caribbean British
12	Mary Lucas	F	55	Black Caribbean British
13	Sonali Khan	F	63	Indian Caribbean
14	Nikita Bayes	F	26	Black African
15	Samuel Isaac	F	30	Black British Jamaican

WORKSHOP THREE

Participant No	Name	Gender	Age	Ethnicity
1	Peter Clark	M	52	British Born Cypriot
2	Maria Davis	F	68	White English
3	Garry Mc Jones	M	53	White British
4	Patricia Mann	F	44	Italian
5	David Pope	M	48	East African
6	Sheila Days	F	55	Mixed
7	Sherry Sanders	F	50	Mauritian
8	Gabby Noel	F	28	British
9	Ezra Jacobs	M	51	Welsh
10	Margaret Barrett	F	39	British
11	Andrew Kindley	M	45	British
12	Antony Jones	M	38	Italian

APPENDIX 6.2: DEMOGRAPHICS OF CHARACTERISTICS OF THE NHS LEADS AND HEALTHCARE PROFESSIONALS'

SAMPLE

Participant No.	Role	Organisation	Ethnicity	Gender
1	Interim Manager for Equality & Diversity	Birmingham Cross City CCG	White British	F
2	Senior Human Resource Manager	Coventry and Warwickshire Partnership	White British	F
3	Equality and Engagement Manager	South Staffs & Shropshire NHS Foundation Trust	Indian	F
4	Equality and Diversity Lead	Dudley and Walsall Mental-health Trust	Indian	M
5	Equality and Diversity Lead	North East London Foundation Trust	White British	M
6	Learning and Development Manager	Barnet, Enfield and Haringey Mental-health Trust	Other	F
7	Head of Equality and Engagement	East Kent Hospital University NHS Foundation Trust	White British	M
8	Equality and Engagement Lead	Health Education England	South East Asian	M
9	Cultural and Spirituality Trainer	East London Foundation Trust	White British	M
10	Equality and Diversity Manager	North East London Foundation Trust	Indian	F
11	Education Development and Commissioning Manager	Health Education England	Indian	F
12	Equalities and Engagement Manager	Norfolk and Suffolk NHS Foundation Trust	Black Other	M
13	Equality and Human Rights Lead	Arden and Gem Commissioning Support Unit	White British	M
14	Organisational Development Consultant	Royal Free Hospital NHS Trust	White British	F
15	Equality and Diversity Officer	Cambridgeshire & Peterborough NHS Foundation Trust	Indian	F
16	Associate Director Inclusion	Barts Health NHS Trust	Black	F
17	Team Manager	Avon & Wiltshire Mental-health NHS Partnership	Black African	M
18	Human Resources Manager	North Devon Healthcare Trust	White British	F
19	General Manager, The Care Forum	Health Watch	White British	F
20	Human Rights, Equality and Inclusion Lead	Royal Cornwall Hospital NHS Trust	White British	F
21	Equalities and Human Resource Project Manager	Arden and Gem Commissioning Support Unit	White British	M
22	Equality and Diversity Advisor	Avon & Wiltshire Mental-health NHS Partnership	Mixed Race	M

23	Head of Equality and Organisational Development	Barnet, Enfield and Haringey Mental-health Trust	African	M
24	Equality and Diversity Project Co-ordinator	NHS England	White Other	M
25	Equality and Diversity Lead	Blackpool Fylde & Wyre Hospital NHS Foundation	White British	F
26	Equality and Diversity Manager	Countess of Chester Hospital NHS Foundation Trust	White Irish	M
27	Equality and Human Rights Advisor	Mersey Care NHS Trust	White British	M
28	Equality and Diversity Manager	Stockport NHS Trust	White British	M
29	Indigo You Company Director	Indigo You Company	White British	M
30	Equality Consultant	Greater Manchester Commissioning Support Unit	British Asian	F
31	Equality and Diversity Manager	Central Manchester CCG	British Caucasian	F
32	Chair	Nottingham Equality and Engagement Network	White British	F
33	Learning and Development Manager	North West Ambulance Service NHS Trust	White British	F
34	Equality and Diversity Co-ordinator	Cheshire Wirral Partnership NHS Trust	White British	M
35	Business Information Officer	NHS England	White British	F
36	Equality and Diversity Manager	The Royal Liverpool Hospital	White British	F
37	Equality and Diversity Lead	Bolton NHS Foundation Trust	Mixed Race	M
38	Equalities Lead	CWP Health Promotion Partnership Project	White British	F
39	Equality and Diversity Manager	Central Manchester University Hospital	Asian British	F
40	Head of Patient Advisory	Health Education England	Black and White	M
41	Equality and Diversity Manager	North East London Foundation Trust	White British	M
42	Equality and Diversity Manager	North East London Foundation Trust	White British	M
43	Equality and Diversity Manager	North East London Foundation Trust	White British	M
44	Equality and Diversity Manager	North East London Foundation Trust	Indian	F
45	Equality and Diversity Manager	North East London Foundation Trust	Mauritian	M

APPENDIX 6.3: DEMOGRAPHICS OF CHARACTERISTICS OF THE MEDICAL EDUCATORS' SAMPLE

Participant No	Organisation	Ethnicity	Gender
1	University of Birmingham	White British	M
2	University of Sheffield	Indian British	F
3	University of Manchester	Bangladesh British	M
4	University of Manchester	British	F
5	University of Bedfordshire	British	F
6	King's College London	Chinese British	M
7	Bart's and London, Queen Mary	Welsh British	F
8	St George's Medical School	White British	F

Appendix 6.4: Examples of workshop booklet

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ADDITIONAL COMMENTS

Activity 1: Part 1
Questions:

1.) NHS documents state that each patient's culture should be respected and accounted for in their care. How do you understand the term 'culture'?

2.) NHS documents often state that health services must value diversity. How do you understand the term 'diversity'?

Activity 1: Part 2
Questions:

1.) NHS documents state that health professionals should be trained to be 'cultural competent', they should be able to effectively manage the diverse and cultural needs of patients. How do you understand the term 'cultural competence?'

2.) What is it that patients expect health-professionals skilled in providing culturally competent care are able to do?

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Activity 2
Questions:

1.) What do you think of the current NHS training material?

2.) What kind of training do you think would actually improve the care health-professionals' give to patients from culturally diverse backgrounds?

Activity 3
Questions:

1.) What should an evaluation tool for Equality & Diversity training be seeking to measure?

2.) How can we measure the effectiveness of Equality & Diversity training in improving professional practice and patient outcomes?

APPENDIX 6.5: EXAMPLE OF CONSENT FORM

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PARTICIPANT CONSENT FORM

Title of the Project: Examining the perspectives of key stakeholders on 'Equality and Diversity' training in UK NHS Trusts; a qualitative study

Name of the Researcher: Riya Elizabeth George, University of Leicester

Contact Details of the Researcher: reg18@leicester.ac.uk

Purpose of Data Collection: PhD Research Project
-Understanding Equality & Diversity trainers and health professionals' perspectives

Please initial all boxes

1. I confirm that I have read and understand the 'Information Leaflet' for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason ☐

3. I consent to the use of audio-recording of the participatory workshop for the above study. I understand that my data will be collected and managed in accordance with good practice guidelines and the Data Protection Act (1998) ☐

4. I understand that my data produced in this study is to be held confidential and only by the Researcher. My data produced in this study will be used for research purposes only ☐

5. I understand that my data will remain anonymous. Any information that may give away my identity will not be used nor shared. Every effort will be made to protect the anonymity of my data ☐

I have read and understood all of the consent statements above and agree to take part in the above study

Signature:

Date:

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Frequently asked questions:

How long will the project take?
The duration of the PhD Research Project is from May 2014 to May 2018. The participatory workshops and completion of the study will take place between May 2015 to May 2016. The workshops will take approximately 2 – 3 hours. The piloting and validation phase of the research project will take place between May 2016 to May 2017. Completing the questionnaire will take approximately 5 – 10 minutes.

Why have I been invited?
For the participatory workshops, you have been asked to take part because of your experience and expertise in the field of 'Equality & Diversity' UK NHS training and education. Patients from a mental health background have been asked to gain patient perspectives on equality, diversity and cultural issues in mental health.

For the piloting and validation of the questionnaire, you have been asked to take part as you are attending an 'Equality & Diversity' training at the selected London-based NHS Trust chosen to pilot the questionnaire.

What will the participants be asked to do?
During the participatory workshops, participants will be asked questions around the meanings of key terms such as 'equality', 'diversity' and 'cultural competence', and what they perceived should be the purpose, learning objectives and methods to evaluate 'Equality & Diversity' training.

During the piloting and validation of the questionnaire, participants will be asked to complete a questionnaire before and after receiving the training. The questionnaire will take approximately 5 – 10 minutes to complete.

Are there any risks for the participant?
No. Participation in the research study is entirely voluntary. Participants are free to withdraw from the study at any time without reason.

How will my data be used?
Data will be collected and managed in accordance with good practice guidelines and the Data Protection Act (1998). The data will only be accessible to the researcher and their supervisors. All data will remain confidential and any information that could identify the participant will be anonymous. Participatory workshops will be audio recorded.

What happens to the results of the research study?
The data collected will be solely used for research purposes only. The overall findings will be submitted for publication in a scientific journal and or presented at scientific conferences. Findings from the participatory workshops and responses from the questionnaires will be carefully examined in accordance with the research aims.

Is this research project Ethical Approved?
Ethical approval for the following PhD Research Project has been granted by the University of Leicester Ethics Committee. Ethical approval granted via the University of Leicester complies with recognised ethical standards; ensuring the dignity, rights, safety and well-being of the participant are a primary concern. This project has also been directly considered with the selected NHS London-based Trust via the Equality and Diversity Officers and has received confirmation of their approval to conduct the piloting phase of the project among healthcare professionals attending the training.

Who can I ask if you have any questions or concerns?
Riya Elizabeth George will be the Chief Researcher for his project and will be personally carrying out the research. Any questions or concerns can be emailed to Riya on reg18@leicester.ac.uk

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Evaluating the effectiveness of 'Equality & Diversity' UK NHS training: developing a tool to identify change and cost-efficiency

Information Leaflet

University of Leicester

Invitation to Participate

This is an invitation to take part in a PhD research project aimed at evaluating the effectiveness of 'Equality and Diversity' UK NHS training, through the development of a valid and reliable evaluation tool.

This information leaflet tells you about the project, why is it being conduct, and how it is going to benefit 'Equality and Diversity' UK NHS training for health professionals and patients. It also provides answers to some frequently asked questions about participating in this kind of study.

We hope you will read the information sheet carefully so that you understand why your participation in this study is important and what it will entail.

Many thanks for your consideration.

What is this project about?

The aim of the Research Project is to develop, pilot and validate a psychometric evaluation tool (a pre and post questionnaire) that can be used to measure the effectiveness of 'Equality and Diversity' training in UK NHS mental-health settings. The psychometric questionnaire is designed to explore and measure changes in a healthcare professional's knowledge, attitudes and skills before and after receiving the training. The answers of the questionnaire will be used to provide a baseline measure of the effectiveness of 'Equality and Diversity' training.

The questionnaire will be piloted at a London-based NHS mental health Trust among healthcare professionals the questionnaire is intended for. A series of participatory workshops with three key stakeholder groups: 1.) Healthcare professionals in the field of Equality and Diversity training, 2.) Academics in the field of Equality and Diversity training and education and 3.) Mental-health patients, will be conducted to explore the perspectives of these individuals towards Equality and Diversity training, and also to gain their input and advice in the development of a valid and reliable evaluation tool. The participatory workshops will be conducted prior to the piloting of questionnaire in a London-based NHS Trust. This is to ensure the findings from all the participatory workshops will form the foundation upon which the final version of the tool will be built on; in terms of content and design.

Why is this project important?

Whilst the NHS delivers Equality and Diversity training to all healthcare professionals, currently there are no suitable, validated tools that exist to measure whether or not the training brings about changes in knowledge, attitudes or skills. The development of a valid and reliable evaluation tool will help by:

- Identifying training models which deliver change, highlight improvements and are cost-efficient
- Offers systematic, specific and measurable evidence to improve and inform training programs
- Serves as a resource for health-professionals involved in the development and evaluation of the training
- Provides a valuable opportunity to ask patients and professionals directly about what constitutes as 'culturally appropriate care' from their perspective and gain their input in the development of an evaluation tool
- Findings from the participatory workshops should illustrate good practice guidelines and promote the sharing of good practice
- Acts as a resource for improving the quality of the training for the benefit of the health professional and patient care, in a transparent and measurable way

University of Leicester

What is 'Equality & Diversity' UK NHS training?

As part of adopting the practices of the Equality Act (2010) and in response to the increase in cultural diversity in the healthcare population, educational and training programs have been developed with the intent of improving health professionals' knowledge, skills and attitudes to practice effectively in culturally diverse settings.

The training aims to provide a foundation of information around the legal and professional obligations of healthcare providers to ensure services are equitable, respective and responsive to diversity and healthcare practice operates in a discrimination free environment.

The delivery of this type of training is mandatory for all UK NHS Trusts, and in particular, attendance is mandatory for all mental health professionals.

Evaluating the effectiveness of 'Equality & Diversity' UK NHS training

Riya Elizabeth George
The Greenwood Institute of Child Health
Westcotes House
Westcotes Drive
Leicester
LE3 0QU

Project Leader:	Riya Elizabeth George PhD Researcher
Project Supervision:	Professor Nisha Dogra Dr Michelle O'Reilly

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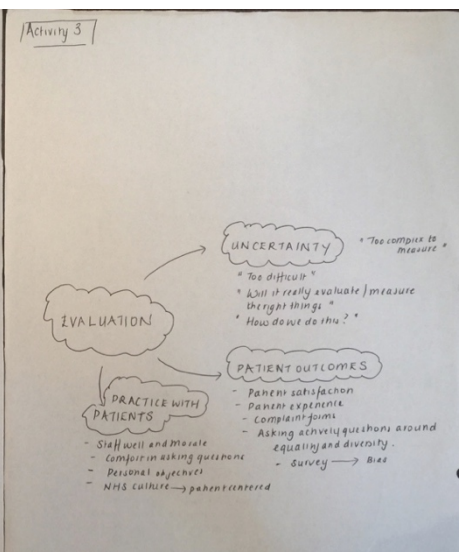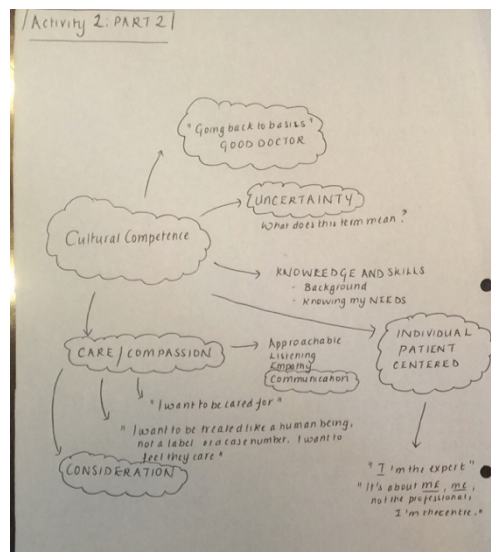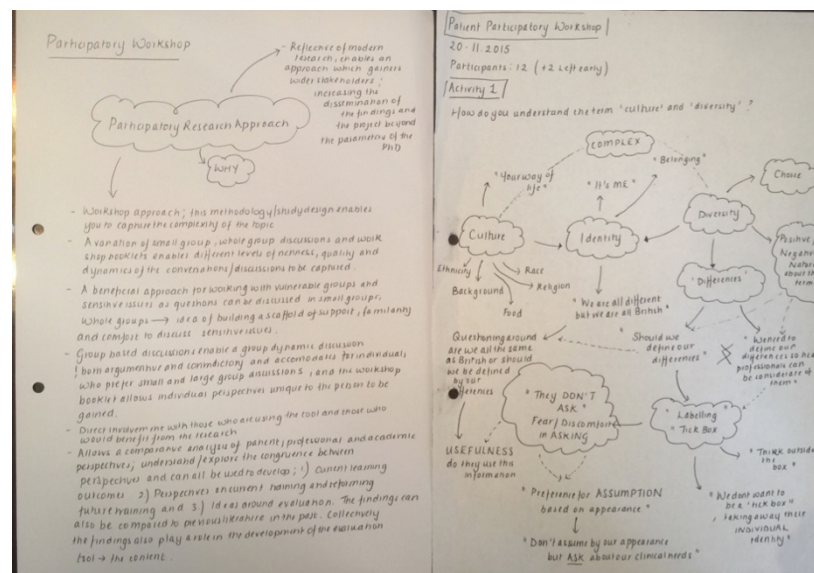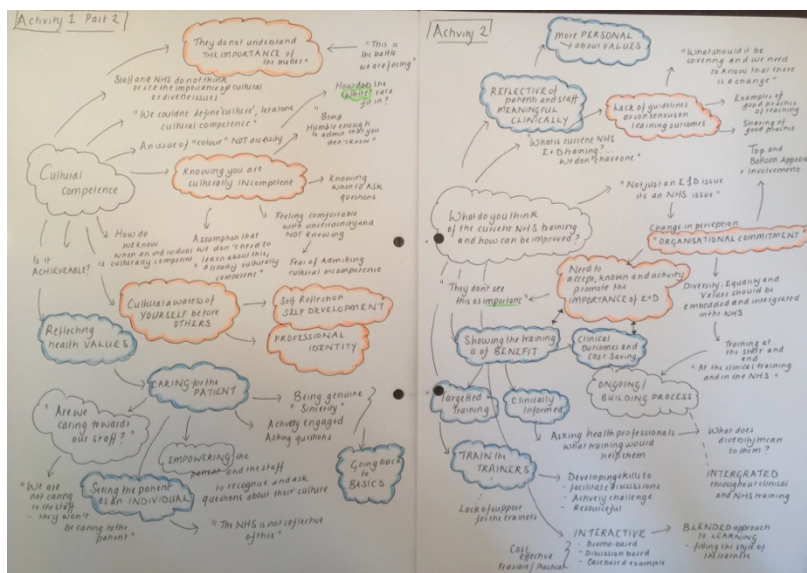
APPENDIX 6.8: EXAMPLES OF DATA COLLECTED USING DIFFERENT DATA COLLECTION METHODS

Analysis of Participatory Workshop Booklets

<u>Patient Workshop 2 (20.08.2015): Croydon BME Forum</u>

Relationship building elements →
- Communication
- Listening
- Understanding
- Engagement
- Building rapport ('connection')
- Care and compassion
- Asking
- Curiosity

Approach to practice →
- Patient-centred care
- Working in *partnership*
- Learning from each-other
- Multi-disciplinary

Characteristics of being a professional →

Practitioner-Self →
- Self development
- Self awareness
- Self reflection
- Self care

- Willingness to learn
- Open-mindedness
- Professionalism
- Adaptation
- Respect
- Cultural expressions
- Empathetic
- Caring
- Drive for 'quality of care'
- Non-judgemental
- Valuing 'differences'
- 'Being a good professional'

Improvements for diversity training →
- Interactive
- Real life case scenarios
- Patient involvement
- Practical 'hands on'
- Role play
- Face to face training

Challenges and uncertainty →
- Credibility of the trainer
- Impossible to teach by training
- The amount of cultural knowledge to teacher

You as a person

Understanding of culture and diversity

Identity

-Values   -Uniqueness
-Beliefs   -Differences
-Individualism

                          Respect/

Shared

-Collective identity
-Shared
-Groups of people

Multi-faceted

-Complex   -Impossible to manage and
                    support
-Conceptual flexibility   -Choice
-Fluid   -Changing

Evaluating diversity training

Measurement

-Personal objectives   -Patient satisfaction
-Pre and post questionnaires   -Long term
benefits

Challenges

-Social desirability
-Identifying the best practice of training
-Reviewing complaints

Patient Workshop 3 (20.11.2015): London MIND

Elements of cultural competence →
- Empathy   - Genuine interest   - Fairness
- Insight   - Assertiveness   - 'Making you feel at home'
- Humility   - Clinical communication
- Non-judgemental   - Asking

Relationship-building →
- Patient-centred care
- Learning from each other
- Strengthening and not weakening
- Awareness of what's important to the patient
- Staff morale and care
- Supporting the patient and professional
- Open dialogue
- Bridging 'cultural gaps'

Understanding of culture and diversity → **Individual**

- Values   - Way of life   - Difference   - Multi-dimensional
- Acceptance   - Origin   - Needs   - 'Norms for you'
- Respect   - Heritage   - Uniqueness
- You as a 'person'   - 'To know and learn about me'

Improvements in diversity training →
- Simpler   - Professional incentives
- Easier   - Access to peer support
- Practical 'hand's on'   - Patient involvement (co-facilitate)
- Interactive   - Regular/on-going

Ensuring sustainability →
- Accountability of change
- Leadership and change
- Establishing who is implementing the training
- Training is one part of a bigger strategy
- Integrated evaluation in different sectors
- Diversity of workforce
- Changing the perception of the training to 'positive'

Evaluation of diversity training →
- Measuring trainee experience and competency
- Impact in practice/application of knowledge
- Questionnaire
- Exploring complaints

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APPENDIX 6.10: ETHICS APPROVAL LETTER FROM THE UNIVERSITY OF LEICESTER

University of Leicester Ethics Review Sign Off Document

University of Leicester

To: **Riya Elizabeth George**

Subject: Ethical Application Ref: **reg18–6c33**

(Please quote this ref on all correspondence)

01/05/2015 18:02:58

Psychology

Project Title: **Evaluating the effectiveness of 'Equality and Diversity' UK NHS training: the development and validation of a psychometric evaluation tool**

Thank you for submitting your application which has been considered.

This study has been given ethical approval, subject to any conditions quoted in the attached notes.

Any significant departure from the programme of research as outlined in the application for research ethics approval (such as changes in methodological approach, large delays in commencement of research, additional forms of data collection or major expansions in sample size) must be reported to your Departmental Research Ethics Officer.

Approval is given on the understanding that the University Research Ethics Code of Practice and other research ethics guidelines and protocols will be compiled with

APPENDIX 6.11: EXAMPLE OF NHS TRUST FORMAL ACCEPTANCE LETTER TO COLLABORATE

North East London **NHS**

NHS Foundation Trust

Riya Elizabeth George
Greenwood Institute of Child Health
University of Leicester
Westcotes House
Westcotes Drive
Leicester
LE3 0QU

Equality and Diversity Department
North East London NHS Foundation Trust
Goodmayes Hospital
157 Barley Lane
Ilford
IG3 8XJ

Tel: 0300 555 1201

Email: harjit.bansal@nelft.nhs.uk

Date: 31st March 2015
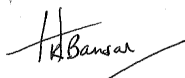
Dear Riya

Re: Ethical Approval PhD Research Project

Thank you for your letter dated 12.03.2015, regarding the PhD Research Project and its ethical approval.

I am writing to confirm that I am satisfied that the appropriate arrangements are being made for this project and that the necessary approval is being sought. Michael and I will therefore be happy to proceed once the University of Leicester has granted ethical approval and are in agreement with the prospect of conducting this research project in Year 2016.

Yours Sincerely,

Harjit. K. Bansal
Manager of Equality and Diversity

www.nelft.nhs.uk

Chair: Jane Atkinson
Chief executive: John Brouder

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APPENDIX 6.12: EXAMPLE OF MENTAL HEALTH PATIENT ORGANISATION FORMAL ACCEPTANCE LETTER TO COLLABORATE

hillside clubhouse

1 May 2015

To whom it may concern
Greenwood Institute of Child Health
University of Leicester
Westcotes House
Westcotes Drive
LEICESTER
LE3 0QU

Dear Sir/Madam

Re: APROVAL FOR PARTICIPATION

I write that we consent and approve to our staff member, Susan Fajana-Thomas, and our orgainsation participating in the following project being undertaken by Riya George:

'Evaluating the effectiveness of UK NHS 'Equality and Diversity' training: the development and validation of a psychometric evaluation tool'

This is subject to us having sight of, consenting to and approving any input prior to any publication.

Yours faithfully

Graeme Jones
EXECUTIVE DIRECTOR

APPENDIX 6.13: EXAMPLE OF MENTAL HEALTH PATIENT ORGANISATION FORMAL ACCEPTANCE LETTER TO COLLABORATE

Croydon BME Forum

Palmcroy House, 387 London Road, Croydon CRO 3PB | 020 8684 3719 | risq@bmeforum.org

www.bmeforum.org

Risq Animasaun

Palmcroy House

387 London Road

Croydon

CR0 3PB

Date: 28th April 2015

To whom it may concern

Re: Ethical Approval PhD Research Project
'Evaluating the effectiveness of UK NHS 'Equality and Diversity' training: the development and validation of a psychometric evaluation tool'

My name is Risq Animasaun, BME Mental Health Community Development worker from Croydon BME forum. I have had several meetings and consultations with the chief researcher of the project, Riya Elizabeth George.

I can confirm that Croydon BME Forum is happy to proceed in collaborating with the PhD Research Project once the University of Leicester has granted ethical approval.

I have been informed and updated on what the project will entail; involve conducting a series of participatory workshops with non-NHS patients to ascertain their perspectives around equality and diversity issues in mental healthcare and to gain their input in the development of a valid and reliable evaluation tool.

Riya has continued to update us on the progress of the PhD Research Project and the progress of the project from its inception. As a result, I have identified and ensured a suitable venue and time for the proposed participatory workshop. Presently I have contacted our service users, advertised the location, venue and time of the workshop to our service users.

Regards,

Risq Animasaun

Pat Dugard
15 Rose Street
Tay-port
DD6 9DF
01382 553750
28 November 2016

To whom it may concern,

I am a statistician and an honorary research fellow in the University of Dundee (http://www.dundee.ac.uk/psychology/staff/a-zmenu/d/). I have been working (as a third supervisor) with Riya George and Nisha Dogra on the Situational Judgement Test which will be part of Riya's PhD thesis. I believe it would strengthen the evaluation tool to pilot the situational judgement test on a group of non-health professionals. I am hoping to assist with piloting this tool with volunteer participants who are mathematicians or IT/Computing students at the University of Dundee. All participants who may volunteer will be adults.

Yours Sincerely

Pat Dugard

Initial Template

Activity 1 - Conceptual Clarity	Activity 2 - Learning Objectives	Activity 3 - Curriculum development and design	Activity 4 - Assessment and Evaluation
-Understanding of 'culture' -Understanding of 'diversity'	-Expectation of cultural competent practitioners: Knowledge, Attitudes, Skills	-Training improvements Content, Design, Format, Delivery	-Evaluation methods -Aspects to evaluate

Second Template

Understanding of culture and diversity	Relationship-centred care	Patient-centred care	Improvements for diversity training
-Individual -Shared -Complexity	-Developing and maintaining relationships -Practitioner-self relationship Personal and professional characteristics	-Understanding the nature and dynamics of patient-practitioner relationship -Individualised care -Acknowledges, values and respects patient differences in the patient and the practitioner	-Approach to training -Ensuring sustainability -Evaluation of training Challenges in evaluation

Third Template

Conceptual Clarity	Relationship-centred care	Curriculum Design	Improvements for diversity training
-Individual -Shared -Complexity	-Developing and maintaining relationships -Practitioner-self relationship -Practitioner – patient relationship	-Centred on relationships -Development of inter-personal skills -Clinical communication -Centred on professional development	-Approach to training -Ensuring sustainability -Evaluation of training • Challenges in evaluation

Final template

Conceptual clarity on key terms	Relationship-centred care	Improvements for diversity training

-Different meanings to different people
-Diversity as just another form of labelling
-The political strings attached to diversity
-Cultural competence aspirational not achievable
	-Practitioner-patient relationship
	   • Back to basics
	   • Assuming not asking
	   • Racial concordance as a way of creating better practitioner-patient relationship
	-Patient-centred and individualised care
	-Practitioner-self relationship
		-Focusing on policies not patients
		-Interactive and contextualised
		-Credibility of the trainer and faculty development
		-Organisational commitment
		-Evaluation of training

Initial Template

Activity 1 Conceptual Clarity	Activity 2 Learning Objectives	Activity 3 Curriculum development and design	Activity 4 Assessment and Evaluation
-Understanding of 'culture' -Understanding of 'diversity'	-Expectation of cultural competent practitioners Knowledge Attitudes Skills	-Training improvements Content Design Format Delivery	-Evaluation methods -Aspects to evaluate

Second Template

Practitioner-practitioner relationship	Practitioner-self relationship	Patient Expectations of 'Cultural Competence'	Improvements for Diversity training
-Shared values and practices -Professional culture -Different professional relationships -Collective approach to practice	-Characteristics of the professional -Personal practice -Self-awareness and reflection -Cultural identity and perceived culture -Assumptions, prejudices and biases -Multiple identities	-Defining cultural competence • Knowledge, attitudes and skills -Understanding of culture -Understanding of diversity -Policy documents interpretations	-Learning environment • Medical model culture • Student resistance -Evaluation and assessment • Measuring attitudes and mentality • Uncertainty over methods and effectiveness -Content and quality

Third Template

Conceptual Clarity	Relationship-centred care	Curriculum Design	Improvements for diversity training
-Defining cultural competence -Defining culture -Defining diversity	-Practitioner-self relationship -Practitioner-practitioner relationship	-Content and quality -Learning environment -Educators perspective and faculty development	-Medical education culture -Evaluation of training • Challenges in evaluation

Final template

Deconstructing cultural competence	Relationships in healthcare	Improvements for diversity training

-Defining cultural competence
-Patient expectations of CC
-CC begins with understanding one's self
-Confusion and misinterpretation
	-Practitioner-self relationship
	    • Self-determined culture and perceived culture
	    • Relationships as perceived by the individual
	-Practitioner-practitioner relationship
	    • Identity of the profession and the identity of the professional
		-Learning approach and environment
		-Creating a safe learning environment
		-Assessment driven
		-Educator's perspective and faculty development

Initial Template

Activity 1 Conceptual Clarity	Activity 2 Learning Objectives	Activity 3 Curriculum development and design	Activity 4 Assessment and Evaluation
-Understanding of 'culture' -Understanding of 'diversity'	-Expectation of cultural competent practitioners Knowledge, Attitudes, Skills	-Training improvements in Content, Design, Format Delivery	-Evaluation methods -Aspects to evaluate

Second Template

Conceptual Clarity	Clinical Interactions	Improvements in diversity education	Evaluation of training
-Culture and diversity Individual concept Group concept Unified concepts	-Approach to practice Relationship-building Clinical Communication -Patient expectations of 'cultural competence' Self-awareness and introspection	-Practitioner-self transformation -Organisational challenges -Training design & development Translation of training into practice -Learning environment	-Challenges and uncertainty -Ensuring sustainability -Ideas for evaluative methods

Third Template

Understanding of culture and diversity	Approach to Practice	Improvement of the education	Ensuring Change
-Individual -Shared -Unified concepts	-Relationship-building elements • Understanding clinical interactions -Practitioner-self relationship • Knowledge, awareness and comfort zone of self • Personal and professional characteristics -Patient-centred care Curiosity in communication	-Approach to training Values-based training -Guidance and examples of best practice -Faculty development	-Organisational Commitment -Desire for evaluation Change in attitudes and behaviours Change in the organisation -Practitioner-practitioner relationship

Final template

Conceptual clarity of key terms	Relationships in healthcare	Improvements for diversity education
-Defining culture and diversity Individual and shared -Defining cultural competence Practitioner-self relationship	-Practitioner-self relationship -Practitioner-patient relationship -Practitioner-practitioner relationship -Practitioner-organisation relationship	-Guidance and examples of best practice -Evaluation measures -Faculty and workforce development

APPENDIX 9.4: SUMMARY PROCESS OF DEVELOPING THE RECONSTRUCTED RCC MODEL

Over-arching template from stakeholder group 1: mental-health patients

Conceptual clarity on key terms	Relationship-centred care	Improvements for diversity training
-Different meanings to different people -Diversity as just another form of labelling -The political strings attached to diversity -Cultural competence aspirational not achievable	-Practitioner-patient relationship • Back to basics • Assuming not asking • Racial concordance as a way of creating better practitioner-patient relationship -Patient-centred and individualised care -Practitioner-self relationship	-Focusing on policies not patients -Interactive and contextualised -Credibility of the trainer and faculty development -Organisational commitment -Evaluation of training

Over-arching template from stakeholder group 2: medical educators

Deconstructing cultural competence	Relationships in healthcare	Improvements for diversity training
-Defining cultural competence -Patient expectations of cultural competence -CC begins with understanding one's self -Confusion and misinterpretation	-Practitioner-self relationship • Self-determined culture and perceived culture • Perceived relationships from one's self view -Practitioner-practitioner relationship • Identity of the profession and the identity of the professional	-Learning approach and environment -Creating a safe learning environment -Assessment driven -Educator's perspective and faculty development

Over-arching template from stakeholder group 3: NHS healthcare professionals

Conceptual clarity of key terms	Relationships in healthcare	Improvements for diversity education
-Defining culture and diversity, Individual and shared -Defining cultural competence, Practitioner-self relationship	-Practitioner-self relationship -Practitioner-patient relationship -Practitioner-practitioner relationship -Practitioner-organisation relationship	-Guidance and examples of best practice -Evaluation measures -Faculty and workforce development

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Master template from findings of all three stakeholder groups

Conceptual clarity of key terms	Relationship-centred care	Improvements for diversity education
-Defining Culture, Diversity and Cultural Competence	-Practitioner-self relationship -Practitioner-patient relationship -Practitioner-practitioner relationship -Practitioner-organisation relationship	-Development -Delivery -Evaluation and Assessment

APPENDIX 9.5: INITIAL TEMPLATE 1 DEVELOPMENTS OF THE RECONSTRUCTED RCC MODEL

DIMESION ONE	DIMENSION TWO	DIMENSION THREE	DIMENSION FOUR
PRACTITIONER- PATIENT	PRACTITIONER-ORGANISATION	PRACTITITIONER – PRACTITIONER	PRACTITIONER- SELF
APPROACH TO PRACTICE	ORGANISATIONAL CULTURE	PROFESSIONALISM	IDENTITY
KNOWLEDGE -Knowledge of patient's background, needs and concerns -Knowledge of the patient's culture SKILLS -Working in partnership -Collaborative involvement -Shared decision making -Patient-centred interviewing VALUES -Adoption of the principles and values of patient-centred and holistic care -Importance of individualised care and tailoring healthcare services to the patient -Respect for patient's dignity, uniqueness and integrity (mind-body-spirit unity) -Respect for self determination -Respect for person's own power and self-healing processes	KNOWLEDGE -Knowledge of the organisational structure -Knowledge of organisational resources, constraints and pressures -History of practitioner-community relationships SKILLS -Dealing with the instability and changing nature of the organisational culture VALUES -Importance of creating a patient-centred and clinically driven organisational culture -Importance of the organisational culture reflecting health care values	KNOWLEDGE -Knowledge of professional values, ethics and codes of practice SKILLS -Exhibits and maintains professional relationships -Maintaining professional boundaries -Respectful curiosity -Sincerity VALUES -Delivering high quality care and ensuring patient safety -Respect for cultural diversity	KNOWLEDGE -Knowledge of personal self; 'doctor as a person' -Knowledge of professional self and the expectations of healthcare practice -Knowledge of personal and professional values SKILLS -Reflection of self and one's own professional practice -Self-awareness -Critical thinking and reflection VALUES -Identifying personal and professional values and how they impact on their own clinical practice -Importance of self-awareness and reflection -Importance of authenticity

DEVELOPING AND MAINTAINING A RELATIONSHIP	WORKFORCE LEARNING AND DEVELOPMENT	TEAM AND COMMUNITY BUILDING	SELF-GROWTH AND DEVELOPMENT
KNOWLEDGE -Understanding of threats to the integrity of the relationship (e.g. power inequalities) -Understanding of potential for conflict and abuse SKILLS -Engagement and building rapport -Listening -Open-mindedness -Respecting the patient -Curiosity -Adaptation -Assurance and warmth -Flexibility -Learning from each other -Approachability -Non-judgemental -Empathy -Attend fully to the patient -Accept and respond to distress in patient and self VALUES -Importance of developing and maintaining authentic and genuine relationships -Demonstrating care and compassion -Maintaining the dignity and respect of the patient	KNOWLEDGE -Discipline of continual development and up-dating knowledge and skills with the changing context -Organisational understanding of healthcare values SKILLS -Adaptive to change -Commitment -Supporting staff development and growth -Organisational assessment of staff needs -Listen openly -Empower others -Facilitate the learning of others VALUES -Importance of organisational development and growth -Ensuring training is reflective of the changing training needs for professionals and patient concerns -Importance of staff morale and support -Importance of collaboration and co-operation -Importance of evaluation of healthcare training and its effectiveness in improving professional practice and patient outcomes -Importance of a supportive and open learning environment	KNOWLEDGE -Knowledge of inter-disciplinary team working SKILLS -Trust -Mutual respect -Mutual learning -Constructive challenging -Support -Open dialogue commitment -Participate actively in community development and dialogue -Derive meaning from other's work -Learn co-operatively -Communicate effectively VALUES -Importance of creating a supportive environment -Affirmation of diversity -Value and respect of differences -Importance of being open-minded -Responsibility to contribute health expertise -Affirmation of mission	KNOWLEDGE -Discipline of continual development and up-dating knowledge and skills with the changing context -Knowledge of areas within and outside one's comfort zones SKILLS -Continuous learning and development -Identify areas for self-improvement and growth -Reflection and awareness of self needs -Ability to develop critical thinking skills -Emotional intelligence VALUES -Importance of self-care -Importance of personal and professional development

CLINICAL COMMUNICATION	LEADERSHIP	WORKING DYNAMICS OF GROUPS, TEAMS AND ORGANISATIONS	CULTURAL DIVERSITY
KNOWLEDGE -Elements of effective communication SKILLS -Engagement and building rapport -Patient-centred interviewing -Ability to communicate across different cultures and backgrounds -Sensitivity - Listen -Impart information -Learn -Facilitate the learning of others -Promote and accept patient's emotions VALUES -Importance of being open and non-judgmental	KNOWLEDGE -Knowledge of leadership, hierarchy and power relations within the organisational context SKILLS -Cultivates a healthcare system reflecting patient and professional values -Inspires and motivates professionals -Communicates powerfully and prolifically -Builds strong organisational relationships -Champions and adapts to change VALUES -Importance of positive role models -Respect for community leadership -Commitment to work for change -Values and respects diversity	KNOWLEDGE -Historical power inequalities across professions SKILLS -Share responsibility responsibly -Collaborate with others -Work co-operatively -Resolve conflicts -Balance and manage different professional perspectives, including the patient VALUES -Openness to others' ideas -Humility -Mutual trust, empathy and support	KNOWLEDGE -Knowledge of cultural self -Knowledge of other cultural identities -Knowledge of how culture and diversity impacts different professional relationships -Knowledge of personal biases, stereotypes and prejudices that may impact clinical care SKILLS -Dealing with uncertainty and uncomfortable clinical situations -Ability to engage and empathise with those of a different cultural background -Respectful curiosity -Confidence in asking sensitive questions VALUES -Understanding the differences in values among different professionals, patients and careers -Value and respect for diversity and culture
PATIENT'S EXPERIENCE OF HEALTH AND ILLNESS	**EFFECTIVE COMMUNITY-BASED CARE**		
KNOWLEDGE -Role of family, culture, community in the individual's development -Multiple components of health -Multiple threats and contributors to health as dimensions of one reality SKILLS -Recognising patient's life story and its meaning	KNOWLEDGE -Various types of care, both formal and informal -Effects of institutional scale on care -Positive effects of continuity of care SKILLS -Work as a member of a team or healing community -Implement change strategies		

-View health and illness as part of human development **VALUES** -Appreciation of the patient as a whole person -Appreciation of the patient's life story and the meaning of the health-illness condition	-Collaborate with other individuals and organisations **VALUES** -Respect for community leadership -Commitment to work for change		
MULITPLE CONTRIBUTORS TO HEALTH AND ILLNES WITHIN THE COMMUNITY			
KNOWLEDGE -Physical, social and occupational environments and their effects on health -External and internal forces influencing the overall health of the community **SKILLS** -Critically assess the relationship of health care providers to community health -Assess community and environmental-health -Assess implications of community policy affecting health **VALUES** -Affirmation of relevance of all determinants of health -Affirmation of the value of health policy in community services -Recognition of the presence of values that are destructive to health			

APPENDIX 9.6: FURTHER TEMPLATE 2 DEVELOPMENTS OF THE RECONSTRUCTED RCC MODEL

DIMENSION ONE	DIMESION TWO	DIMENSION THREE	DIMENSION FOUR
PRACTITIONER- SELF	**PRACTITIONER- PATIENT**	**PRACTITIONER-ORGANISATION**	**PRACTITIONER – PRACTITIONER**
IDENTITY	**APPROACH TO PRACTICE**	**ORGANISATIONAL CULTURE**	**PROFESSIONALISM**
KNOWLEDGE -Knowledge of personal self; 'doctor as a person' -Knowledge of professional self and the expectations of healthcare practice -Knowledge of personal and professional values SKILLS -Reflection of self and one's own professional practice -Self-awareness -Critical thinking and reflection VALUES -Identifying personal and professional values and how they impact on their own clinical practice -Importance of self-awareness and reflection -Importance of authenticity	KNOWLEDGE -Knowledge of patient's background, needs and concerns -Knowledge of the patient's culture SKILLS -Working in partnership -Collaborative involvement -Shared decision making -Patient-centred interviewing VALUES -Adoption of the principles and values of patient-centred and holistic care -Importance of individualised care and tailoring healthcare services to the patient -Respect for patient's dignity, uniqueness and integrity (mind-body-spirit unity) -Respect for self determination -Respect for person's own power and self-healing processes	KNOWLEDGE -Knowledge of the organisational structure -Knowledge of organisational resources, constraints and pressures -History of practitioner-community relationships SKILLS -Dealing with the instability and changing nature of the organisational culture VALUES -Importance of creating a patient-centred and clinically driven organisational culture -Importance of the organisational culture reflecting health care values	KNOWLEDGE -Knowledge of professional values, ethics and codes of practice SKILLS -Exhibits and maintains professional relationships -Maintaining professional boundaries -Respectful curiosity -Sincerity VALUES -Delivering high quality care and ensuring patient safety -Respect for cultural diversity

SELF-GROWTH AND DEVELOPMENT	DEVELOPING AND MAINTAINING A RELATIONSHIP	WORKFORCE LEARNING AND DEVELOPMENT	TEAM AND COMMUNITY BUILDING
KNOWLEDGE -Discipline of continual development and up-dating knowledge and skills with the changing context -Knowledge of areas within and outside one's comfort zones SKILLS -Continuous learning and development -Identify areas for self-improvement and growth -Reflection and awareness of self needs -Ability to develop critical thinking skills -Emotional intelligence VALUES -Importance of self-care -Importance of personal and professional development	KNOWLEDGE -Understanding of threats to the integrity of the relationship (e.g. power inequalities) -Understanding of potential for conflict and abuse SKILLS -Engagement and building rapport -Listening -Open-mindedness -Respecting the patient -Curiosity -Adaptation -Assurance and warmth -Flexibility -Learning from each other -Approachability -Non-judgemental -Empathy -Attend fully to the patient -Accept and respond to distress in patient and self VALUES -Importance of developing and maintaining authentic and genuine relationships -Demonstrating care and compassion -Maintaining the dignity and respect of the patient	KNOWLEDGE -Discipline of continual development and up-dating knowledge and skills with the changing context -Organisational understanding of healthcare values SKILLS -Adaptive to change -Commitment -Supporting staff development and growth -Organisational assessment of staff needs -Listen openly -Empower others -Facilitate the learning of others VALUES -Importance of organisational development and growth -Ensuring training is reflective of the changing training needs for professionals and patient concerns -Importance of staff morale and support -Importance of collaboration and co-operation -Importance of evaluation of healthcare training and its effectiveness in improving professional practice and patient outcomes -Importance of a supportive and open learning environment	KNOWLEDGE -Knowledge of inter-disciplinary team working SKILLS -Trust -Mutual respect -Mutual learning -Constructive challenging -Support -Open dialogue commitment -Participate actively in community development and dialogue -Derive meaning from other's work -Learn co-operatively -Communicate effectively VALUES -Importance of creating a supportive environment -Affirmation of diversity -Value and respect of differences -Importance of being open-minded -Responsibility to contribute health expertise -Affirmation of mission

CULTURAL DIVERSITY	CLINICAL COMMUNICATION	LEADERSHIP	WORKING DYNAMICS OF GROUPS, TEAMS AND ORGANISATIONS
KNOWLEDGE -Knowledge of cultural self -Knowledge of other cultural identities -Knowledge of how culture and diversity impacts different professional relationships -Knowledge of personal biases, stereotypes and prejudices that may impact clinical care SKILLS -Dealing with uncertainty and uncomfortable clinical situations -Ability to engage and empathise with those of a different cultural background -Respectful curiosity -Confidence in asking sensitive questions VALUES -Understanding the differences in values among different professionals, patients and careers -Value and respect for diversity and culture	KNOWLEDGE -Elements of effective communication SKILLS -Engagement and building rapport -Patient-centred interviewing -Ability to communicate across different cultures and backgrounds -Sensitivity - Listen -Impart information -Learn -Facilitate the learning of others -Promote and accept patient's emotions VALUES -Importance of being open and non-judgmental	KNOWLEDGE -Knowledge of leadership, hierarchy and power relations within the organisational context SKILLS -Cultivates a healthcare system reflecting patient and professional values -Inspires and motivates professionals -Communicates powerfully and **prolifically** **-Builds strong organisational relationships** **-Champions and adapts to change** VALUES -Importance of positive role models -Respect for community leadership -Commitment to work for change -Values and respects diversity	KNOWLEDGE -Historical power inequalities across professions SKILLS -Share responsibility responsibly -Collaborate with others -Work co-operatively -Resolve conflicts -Balance and manage different professional perspectives, including the patient VALUES -Openness to others' ideas -Humility -Mutual trust, empathy and support
	PATIENT'S EXPERIENCE OF HEALTH AND ILLNESS	EFFECTIVE COMMUNITY-BASED CARE	
	KNOWLEDGE -Role of family, culture, community in the individuals development -Multiple components of health -Multiple threats and contributors to health as dimensions of one reality	KNOWLEDGE -Various types of care, both formal and informal -Effects of institutional scale on care -Positive effects of continuity of care SKILLS	

	SKILLS -Recognising patient's life story and its meaning -View health and illness as part of human development VALUES -Appreciation of the patient as a whole person -Appreciation of the patient's life story and the meaning of the health-illness condition	-Work as a member of a team or healing community -Implement change strategies -Collaborate with other individuals and organisations VALUES -Respect for community leadership -Commitment to work for change	
	MULITPLE CONTRIBUTORS TO HEALTH AND ILLNES WITHIN THE COMMUNITY		
	KNOWLEDGE -Physical, social and occupational environments and their effects on health -External and internal forces influencing the overall health of the community SKILLS -Critically assess the relationship of health care providers to community health -Assess community and environmental-health -Assess implications of community policy affecting health VALUES -Affirmation of relevance of all determinants of health -Affirmation of the value of health policy in community services -Recognition of the presence of values that are destructive to health		

APPENDIX 10.1: EXAMPLES CHANGES TO THE DESIGN OF SITUATIONAL JUDGEMENT TEST (SJT) OVER PILOTING SESSIONS

University of Leicester

DIVERSITY TRAINING EVALUATION TOOL

PILOT 1
SITUATIONAL JUDGEMENT TEST

This 'Situational Judgement Test' (SJT) is a collection of scenario-based questions **designed to evaluate your judgement abilities in healthcare situations involving diversity issues.** You will be presented with a set of four hypothetical work-based scenarios and will be asked to rank in order the actions of those that are most appropriate in response to the scenario, **with 5 being the most appropriate and 0 being the most inappropriate. Ranks can be tied, meaning that different responses can be given the same ranking number,** if you deem them to be on the same level of appropriateness (for example responses A and B can both be given 5 if they are deemed to be the most appropriate actions).

You have been asked to review the following questions for clarity, relevance and fairness as well as to identify appropriate answers. Please note any suggestions for improvement or change in the boxes provided below each question. Please read each scenario based question carefully and try to answer every question as honestly as possible.

Job Title: _____
Ethnicity: _____
Age: _____
Gender: _____

Scenario 1

During your lunch break you overhear a group of your colleagues who are talking loudly and making jokes about a particular colleague's accent and how the professionals and patients cannot understand what they are saying. The particular colleague they are talking about could easily be identified from the conversation and is also working near you and may over hear them. How would you respond with this situation?

Rank in order the following actions in response to this situation between 5 and 0 (5=Most appropriate and 0=Most in-appropriate). Please note that ranks can be tied.

		Most Appropriate					Most In-appropriate
		5	4	3	2	1	0
A	Inform the group that the particular colleague is around and may overhear their conversation						
B	Ignore the situation as they should know better and you do not want to cause a scene						
C	Pretend the conversation does not occur as you already have no time to have a break						
D	Discuss with the whole group that their behaviour is inappropriate						
E	Speak to the person who is speaking the loudest so he is aware that his behaviour is inappropriate						

Please explain your reasoning for choosing your most appropriate actions?

Are there any other appropriate responses that should be included?

Additional comments and suggestions:

Diversity Training Evaluation Tool (DTET)

INSTRUCTIONS

As before you will be presented with a set of six hypothetical work-based scenarios, **these are the same as you did in the before questionnaire but you may have changed your mind about some of them.** Again you will be asked to **choose the most appropriate response** to the scenario. Please read each scenario based question carefully and avoid looking at your previous before questionnaire.

PLEASE CHOOSE THE MOST APPROPRIATE RESPONSE FOR EACH SCENARIO BY PLACING A TICK IN ONE OF THE BOXES AT THE SIDE.

Scenario 1

Rachel formally known as Richard is a transgender staff nurse and has made you, the care manager, aware that a number of her colleagues are bullying her and preventing her from using the female toilets. Rachel presents herself as a female throughout her employment, yet many of the staff as well as occasionally patients feel uncomfortable with her using the female toilets. How would you respond to this situation?

A   Discuss with the Trust Board the need to provide separate toilets specifically for transgender members for staff ☐

B   Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but make it clear that bullying is never acceptable ☐

C   Discuss with the other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets ☐

D   Reassure Rachel that you would discuss the issue with the staff team leader to ensure she does have access to the female toilets ☐

Scenario 2

As you arrive on the ward you hear a patient in a side room make a sarcastic remark about a staff member who is a wheelchair user saying 'are you able to move around in that chair as much as the other staff?' You hear the staff member talk back to the patient in a rude and offensive manner. The tone and language used are unpleasant and you know the patient is elderly and suffering from dementia. How would you respond to this situation?

A   Knock on the door and intervene in the situation, asking the nurse to leave the patient immediately ☐

B   Discuss with the patient their sarcastic remark and how it could have been perceived by the staff member ☐

C   Take the nurse aside after she has left the patient and point out that it is not appropriate to respond angrily to insults or provocation from a patient with dementia ☐

D   Ignore the situation as you feel it is none of your business and carry on with your work as usual ☐

Scenario 3

One of the senior nurses is a strict and very traditional Anglican believer and finds it challenging to deal with termination. She is very pro-life and has openly admitted to finding it difficult to bring herself to be compassionate towards any patient that opted for termination, whereas she is exceedingly compassionate with all other patients. How would you respond to this situation?

A   Report the nurse's discriminatory behaviour to senior members of the team ☐

B   Allow your colleague to express openly her cultural beliefs and offer a staff development training to help her manage and deal with these differences that she finds uncomfortable ☐

C   Discuss with your colleague that as health professionals we must treat all patients the same regardless of their beliefs and choices ☐

D   Explain to your colleague that her behaviour is unacceptable and could result in disciplinary action ☐

Diversity Training Evaluation Tool (DTET)

INSTRUCTIONS

As before you will be presented with a set of six hypothetical work-based scenarios, **these are the same as you did in the before questionnaire but you may have changed your mind about some of them.** Again you will be asked to **choose the most appropriate response** to the scenario. Please read each scenario based question carefully and avoid looking at your previous before questionnaire.

PLEASE CHOOSE THE MOST APPROPRIATE RESPONSE FOR EACH SCENARIO BY PLACING A TICK IN ONE OF THE BOXES AT THE SIDE.

Scenario 1

Rachel formally known as Richard is a transgender staff nurse and has made you, the care manager, aware that a number of her colleagues are bullying her and preventing her from using the female toilets. Rachel presents herself as a female throughout her employment, yet many of the staff as well as occasionally patients feel uncomfortable with her using the female toilets. How would you respond to this situation?

A   Discuss with the Trust Board the need to provide separate toilets specifically for transgender members for staff ☐

B   Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but make it clear that bullying is never acceptable ☐

C   Discuss with the other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets ☐

D   Reassure Rachel that you would discuss the issue with the staff team leader to ensure she does have access to the female toilets ☐

Scenario 2

As you arrive on the ward you hear a patient in a side room make a sarcastic remark about a staff member who is a wheelchair user saying 'are you able to move around in that chair as much as the other staff?' You hear the staff member talk back to the patient in a rude and offensive manner. The tone and language used are unpleasant and you know the patient is elderly and suffering from dementia. How would you respond to this situation?

A   Knock on the door and intervene in the situation, asking the nurse to leave the patient immediately ☐

B   Discuss with the patient their sarcastic remark and how it could have been perceived by the staff member ☐

C   Take the nurse aside after she has left the patient and point out that it is not appropriate to respond angrily to insults or provocation from a patient with dementia ☐

D   Ignore the situation as you feel it is none of your business and carry on with your work as usual ☐

Scenario 3

One of the senior nurses is a strict and very traditional Anglican believer and finds it challenging to deal with termination. She is very pro-life and has openly admitted to finding it difficult to bring herself to be compassionate towards any patient that opted for termination, whereas she is exceedingly compassionate with all other patients. How would you respond to this situation?

A   Report the nurse's discriminatory behaviour to senior members of the team ☐

B   Allow your colleague to express openly her cultural beliefs and offer a staff development training to help her manage and deal with these differences that she finds uncomfortable ☐

C   Discuss with your colleague that as health professionals we must treat all patients the same regardless of their beliefs and choices ☐

D   Explain to your colleague that her behaviour is unacceptable and could result in disciplinary action ☐

Diversity Training Evaluation Tool

This 'Situational Judgment Test' (SJT) is a collection of scenario-based questions that are designed to evaluate your judgement abilities in healthcare situations involving diversity issues. You will be presented with a set of four hypothetical work-based scenarios and will be asked to choose the single most appropriate response to the scenario. Please read each scenario-based question carefully and try to answer as honestly as possible.

Please choose the most appropriate response for each scenario by placing a TICK in ONE of the boxes at the side.

* Required

Scenario 1

Rachel formerly known as Richard is a transgender staff nurse. She has made you aware as a colleague that she is being bullied by several colleagues and that she is being prevented from using the female toilets.

Choose the one most appropriate action you would take *

○ A Raise the issue in a team meeting in a way that everyone can safely and openly discuss the matter and resolve together.

○ B Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but highlight to all colleagues that bullying is not

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APPENDIX 10.2: DEVELOPMENT OF AN ITEM BANK – 12 SCENARIO BASED QUESTIONS

SCENARIO 1	SCENARIO 2	SCENARIO 3	SCENARIO 4
Scenario: A Muslim female doctor claims that the organisational policy that all staff must be 'bare below the elbows' (hands and arms up to the elbow are exposed and free from clothing) is against her religious beliefs. *Choose the ONE most appropriate action you would take.*	Scenario: One of your colleagues is very pro-life and objects to terminations of pregnancy based on her religious views. She has admitted to finding it difficult to bring herself to be compassionate towards any patient that was having a termination. She is otherwise a very caring and compassionate professional. How would you help your colleague? *Choose the ONE most appropriate action you would take.*	Scenario: Rachel formerly known as Richard is a transgender staff nurse. She has made you aware as a colleague that she is being bullied by several colleagues and that she is being prevented from using the female toilets. *Choose the ONE most appropriate action you would take.*	Scenario: Your colleague comes to you on their lunch break and is very frustrated about a patient that took up most of her morning as they were unable to understand what was written on their medication packets. She says, "they should really learn English if they are coming to this country or at least try shouldn't try?" *Choose the ONE most appropriate action you would take.*
A. Respect that this is part of her religious beliefs and accept that she will not be abiding by the 'bare below the elbows' rule. B. Discuss the issue with the rest of the team and ask for advice from a senior member of the team. C. Explain to your colleague that all health professionals have to abide by healthcare rules and policies and that no adjustments can be made.	A. Suggest she refuses to care for patients who are considering terminations. B. Allow your colleague to express openly her cultural beliefs and suggest she attends appropriate training to help her manage and deal with the situation she is struggling with. C. Discuss with your colleague that as health professionals we must treat all patients the same regardless of their beliefs and choices.	A. Raise the issue in a team meeting in a way that everyone can safely and openly discuss the matter and resolve together. B. Explore Rachel's concerns and ask other staff for their experiences and feedback on this matter but highlight to all colleagues that bullying is not acceptable under any circumstances. C. Discuss with other staff their concerns and if legitimate ask Rachel to use the unisex disabled toilets.	A. Point out that an interpreter should be called (if available) if there are difficulties. B. Explain to your colleague that their comment may be seen as racist and is therefore inappropriate. C. Explain to your colleague that as health professionals we are here to care for all patients with different needs and concerns and suggest an interpreter. D. Sympathise with your colleague's comment and

D. Allow your colleague to continue not abiding by the 'bare below the elbow' rule until any formal complaints are made.	D. Explain to your colleague that if she is treating those considering terminations differently that her behaviour is unacceptable and could result in disciplinary action.	D. Reassure Rachel that you would discuss the issue with the staff team leader to ensure she does have access to the female toilets.	raise this issue in a team meeting.

SCENARIO 5	SCENARIO 6	SCENARIO 7	SCENARIO 8
Scenario: You hear a patient who has dementia say, "are you able to move around in that chair as much as the others?" to a colleague who is a wheelchair user. Your colleague responds in a rude and offensive manner. *Choose ONE most appropriate action you would take:*	Scenario: A new member of staff, Miriam, reveals during her induction that she is Jewish and will need to finish work early on a Friday in the winter. She has not mentioned this earlier when specifically asked if there were any special circumstances. The manager appears apprehensive after her request and says she will have to discuss the request with a Senior Manager. The Senior Manager laughs and says "don't we all want to finish early on a Friday?" If you were the Senior Manager, what would you do in this case? *Choose ONE most appropriate action you would take:*	Scenario: You are one of the panel members interviewing for new nurses. During the next interview the candidate enters the room and politely refuses your handshake when you initiated one. Instead she places her hand on her chest and smiles. You find this quite rude and awkward and your other panel members appear to be feeling the same way. You continue with the interview process, however you already now have a negative first impression of the candidate. How would you respond to this situation? *Choose ONE most appropriate action you would take:*	Scenario: You are a new member of a team of hospital receptionists and are coming to the end of your first week. You are very concerned about the attitude of a particular receptionist towards patients and have heard negative feedback from other healthcare professionals. After five weeks your manager calls you in for your appraisal and to gain your feedback about other staff members in your team. How would you respond to this situation? *Choose ONE most appropriate action you would take:*
A. Intervene in the situation, asking your colleague to leave the patient immediately. B. Say to the patient that the Trust's Equality and Diversity	A. Acknowledge that Miriam has the right to request flexibility in her working hours and is entitled to finish early on Fridays.	A. Accept that the candidate may have different cultural norms for greeting each-other.	A. Indicate your concerns with your manager, providing specific examples.

stance makes their comment un-acceptable. C. Discuss with your colleague that you witnessed unprofessional behaviour and that whilst it may be understandable, it is not acceptable. D. Ignore the situation as you feel it is none of your business and carry on with your work as usual.	B. Grant her request as it is made on religious grounds. C. Discuss the request with the team, how this arrangement could potentially work for Miriam. D. Explain to Miriam that the contract of employment that she signed made the working hours clear and that it would not be fair to her other colleagues to make special arrangements for her.	B. Discuss with the candidate why she did not shake hands. C. Ignore the incident and carry on with the interview process. D. Suspect that the candidate may find it difficult to build rapport with patients on the wards. E. Note this in the feedback given to each candidate after the interview.	B. Discuss the issue about your colleague's attitudes with other staff members. C. Discuss the issue with your colleague directly about the unacceptable attitude towards patients. D. Write a letter of complaint to the Trust board about the staff's behaviour. E. Continue with your job as normal ignoring your colleague's behaviour.

SCENARIO 9	SCENARIO 10	SCENARIO 11	SCENARIO 12
Scenario: During your trust induction training, the Chief Executive of the board states that as future health professionals you ensure 'equality in your practice and a respect for diversity.' What do you understand by this phrase? *Choose ONE most appropriate action you would take:*	Scenario: On collating and reviewing the statistics in-order to try and ascertain the kind of patients that are accessing services, you notice that on numerous occasions' patient information about their race, ethnicity, religion and sexuality are not completed. When asking staff about this, they say due to their lack of time, only questions that are 'clinically relevant' are asked and completed. How would you respond to this situation? *Choose ONE most appropriate action you would take:*	Scenario: You have given your team an important deadline to meet. One of your team members informs you that the deadline falls on an important religious festival e.g. Diwali. How would you respond to this situation? *Choose ONE most appropriate action you would take:*	Scenario: Upon reviewing local GP practices, you notice that a practice in Leicester appears to be referring Asian patients suffering from mental-health problems to the local 'Iman' (Muslim faith leader) whereas White patients who have mental-health problems were referred to NHS mental-health services. You and your team decide to investigate this further and speak to the GP at this practice. He explained that many Asian patients were part of the local Islamic community to which he also belongs and their mental-health problems were related to their spiritual beliefs. How would you respond to this situation? *Choose ONE most appropriate action you would take:*
A. Treating all patients the same despite their differences. B. Treating all patients differently accordingly to their healthcare needs. C. Treating all patients equally allowing for their differences.	A. Agree and accept that professionals do not have the time to ask these questions B. Discuss with professionals why all questions about the patients are important C. Disagree with the professionals as asking these questions only takes a few minutes.	A. Suggest that colleagues who are celebrating the religious festival work over-time in the weeks prior to the deadline. B. Discuss with you colleagues that the deadline cannot be shifted and they must continue as everyone else. C. Make a reasonable adjustment to excuse your	A. Report the incident as inappropriate professional practice and discriminatory behaviour. B. Discuss with the GP about his practice choice in order to help him understand that he is allowing his own religious beliefs and perspectives to influence the care he gives to his patients.

	D. Raise this issue with the Trust Board. E. Acknowledge that these questions are not as relevant as the medically related questions.	colleague who is celebrating the religious festival. D. Ask to see if the deadline can be changed. E. Ask the management team what should be done in this situation.	C. Talk to the Asian patients her referred, asking them how they felt when they referred to the 'Iman.' D. Explain to the GP that his approach to referral was unacceptable and inappropriate. E. Accept that Asian patients have unique cultural and religious needs which may require a different approach to care.

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