I Would Teach it, But I Don't Know How: Faculty Perceptions of Cultural Competency in the Health Sciences, a Case Study Analysis

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This paper presents results from a survey of faculty perceptions of cultural competency training at "Health Sciences University," a small, private university in a major city in the Northeastern United States. We found high levels of support among faculty for cultural competency training for students in bench and health sciences broadly, though data suggests that faculty are unsure how to effectively teach cultural competency and how to evaluate its effectiveness. Placing this data alongside literature exploring the lack of diversity and a "chilly climate" in STEM and health science disciplines for marginalized groups, we argue for 1) a need to improve and expand cultural competency training already in place for students and provide faculty with the knowledge and skills to teach it, and 2) using cultural competency as a tool for addressing the lack of diversity and the "culture of no culture" that pervades STEM and health science disciplines.

Keywords: cultural competency, STEM, diversity, faculty, students

Health Sciences University (a pseudonym) is a small private university located in a large and diverse metropolitan city in the Northeastern United States. With approximately 2,700 students, HSU is an undergraduate-focused institution that provides training at the bachelor's and graduate level in pharmacy, occupational and physical therapy, among others. As a renowned science-focused institution, we are well poised to examine issues of diversity in both STEM and health sciences fields. In 2014, a President's Commission on Diversity was charged with how to implement a "best practices" model of diversity and inclusion across campus in accordance with the University's mission. An interdisciplinary faculty, staff, and student committee was created to formulate a set of priorities around issues of diversity on campus. Several subcommittee groups were formed to investigate priority areas. One priority area identified was cultural competency. The cultural competency subcommittee members (who are the authors of this paper) developed a short survey for faculty members regarding their perceptions about cultural competency at our institution.[1]

We were pleased to find high levels of support among the faculty for cultural competency training for students in bench and health sciences broadly, as well as support for providing this training at our institution in particular. Disagreement arose only when faculty were

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asked to evaluate whether we, as an institution, were currently providing such training to students, the quality of that training, and who should be responsible for providing cultural competency instruction. While our results are not generalizable, we believe they provide important metrics for further research, and raise compelling questions about the role of cultural competency in broader discussions of diversity and inclusion in higher education, particularly for STEM and Health Science programs.

Background

Diverse Workforces and Patients

Cultural competency, at its core, is concerned with addressing the reality of our increasingly diverse world; specifically, the increasing diversity of the professional workforce and the populations served by health professionals. According to the U.S. Department of Commerce, people of color will account for 90 percent of the population increase in the United States from 1995 to 2050 (1999:2). Those promoting diversity in health services argue,

> [i]ncreasing the racial and ethnic diversity of the health care workforce is essential for the adequate provision of culturally competent care to our nation's burgeoning minority communities. A diverse health care workforce will help to expand healthcare access for the underserved, foster research in neglected areas of societal need, and enrich the pool of managers and policymakers to meet the needs of a diverse populace (Cohen, Gabriel, and Terrell 2002:91; see also Sullivan Commission 2004).

Similar arguments have been made for other marginalized identities including women, LGBT people, immigrants, and people with disabilities whose voices have become increasingly prominent in moving cultural competency agendas forward in our nation (American

Academy of Pediatrics, American Academy of Family Physicians, and American College of Physicians-American Society of Internal Medicine 2002; Anderson et al. 2003; Mayer et al. 2008).

Despite growing diversity in the country at large and within higher education, STEM and health science professions have remained largely resistant to diversification. Even after "decades of federally- and non-federally-sponsored programs, few educational initiatives have met this need, resulting in large disparities in science education and workforce diversity," (Winkleby et al. 2009:536). Racial minorities currently make up less than five percent of the STEM based workforce. While Asian-Americans are overrepresented as scientists and engineers, people from historically underrepresented groups (African-Americans, Latinos, American Indians, Alaskan Natives) continue to be underrepresented in STEM careers (National Science Foundation and National Center for Science and Engineering Statistics 2013). Further, women made up only 28 percent of science and engineering workers in 2010 (National Science Board 2014). There is also an emerging interest in documenting the experiences of LGBT people and people with disabilities in STEM and health professions. As such, the National Science Foundation has funded research addressing LGBT inclusion and ableness, in addition to research concerning women and people of color in STEM (National Science Foundation 2016; Ernst 2016).

For many years, scholars and practitioners have sought to increase the number of women and people of color in STEM fields by addressing various aspects of educational and professional pipelines (Leslie, McClure, and Oaxaca 1998), including bridge programs, mentoring, and career counseling (Tsui 2007). Academic research on educational and professional pipeline interventions are now giving way to an emerging interest in what are called professional climate studies.

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The Chilly Climate of STEM

Despite decades of interventions focused on STEM pipelines, the "stereotype of the white male scientist still exists in the public imagination" (Yoder and Mattheis 2016:4) and the underrepresentation of women and people of color reinforces this perception. Additionally, success in STEM fields is often related to adopting what are conceived to be masculine qualities, such as rationality, logical thinking, and manual dexterity. These "[i]mplicit and explicit messages about the masculine nature of math and science" (Shapiro and Sax, quoted in Yoder and Mattheis 2016:4) can contribute to a "chilly climate" for women, people of color, LGBT people, and others who do not conform to the heterosexual, white male scientist image.

In 1982, The Association of American Colleges described a widespread "chilly climate" for women in higher education, describing it as an environment that is "inhospitable to women in higher education classrooms resulting from both deliberate and unconscious discrimination by professors, fellow students, and by past socialization in K-12 education" (Wagner III and Dassopolous 2009:243). Over the last 35 years, there has been a thawing for women and other marginalized groups in higher education, but scholars note that STEM fields are lagging behind and the climate remains relatively inhospitable (Bilmoria and Stewart 2009; Cech and Waidzunas 2011; Patridge, Barthelemy, and Rankin 2014; Yoder and Mattheis 2016).

Further perpetuating a chilly climate, Faulkner (2000) argues that there is a technical/social dualism pervasive in STEM disciplines. Moreover, there is an "ideological separation between 'technical' activities and skills (such as design, science, and math-related activities) and 'social' tasks and skills (such as management, communication with other employees and clients, etc.)" (Cech and Waidzunas 2011:4). This technical/social dualism is then mapped on to gender, race, and sexuality: Men, white, and heterosexual people fall on the technical side of the binary, while women, people of color, and LGBT workers are relegated to the social, and are therefore perceived as ill-equipped for 'real' science (ibid). Cech and Waidunas (2011) have argued that this technical/social dualism creates a need for 'passing' or 'covering' strategies whereby a person "conceal[s] and downplay[s] cultural markers" associated with stigmatized identities (p.10). The authors further note that a chilly climate carries some very serious effects including social and academic isolation for minority students and professionals, the burden of identity work, and great concern about future job security. It is important to note here that the temperature is not uniformly frigid and there are important differences within sub-disciplines as well as across STEM and health science fields (Cech and Waidzunas 2011). However, there is still much room for improvement in STEM before the climate is deemed fully supportive and inclusive of women, people of color, and LGBT individuals (National Science Board 2014, National Science Foundation 2013, Sullivan Commission 2004).

Cultural Competency and Health Care

Practitioners and researchers are acutely aware of the need to address health disparities by understanding the health needs of under-served and minority populations (Musolino et al. 2009). According to some critics, however, many health systems have focused primarily on patient biases that contribute to health disparities, rather than practitioner biases. That is, they have targeted patients' 'culture' as the culprit for health inequities. For example, when patients do not access care or take medications as directed, cultural reasons are often sought, which may lead researchers and policy makers to overlook other salient variables such as gender, nationality, migration status, and social class (Sobo 2009). This does not mean that culture specific information is not important to health care, but using checklists of decontextualized knowledge,

i.e., beliefs, practices, diet, holidays, etc., rarely leads to culturally competent care. Indeed, this "cookbook approach" often leads to stereotyping and inflexible approaches to care (Fitzgerald 2000:186), while the cultural biases of biomedicine remain unexamined. Some have termed this proclivity as biomedicine's "culture of no culture" where medical knowledge is viewed as "real" knowledge, whereas patient knowledge is perceived to be "cultural" (Taylor 2003).

Therefore, anthropologists suggest that increasing the diversity among those who enter STEM and the health professions might help to unmask the culture within this culture of no culture. Educational institutions are part of the dominant sociocultural order and reflect its patterns of thought and social action (Taylor 2003). These patterns are less likely to appear obligatory and natural, and are more likely to become visible as "cultural" to people who are not from the dominant segments of society (Guarnaccia and Rodriguez 1996; Taylor 2003). Finally, health science curricula could potentially challenge the tendency to assume that "real" and "cultural" are mutually exclusive terms. Practitioners' medical knowledge is no less cultural for being real, just as patients' lived experiences and perspectives are no less real for being cultural (Taylor 2003).

Methodology

After reviewing multiple cultural competency definitions (Martin and Vaughn 2007; National Center for Cultural Competence 2016; SAMHSA 2016), we defined cultural competency as an "ability to successfully navigate cross-cultural differences in order to accomplish practical goals" (*Diversity Officer Magazine* 2011). We included this definition of cultural competency in the introduction to the survey for faculty reference. Our goals for this survey were not to judge or meddle in faculty affairs, but simply to assess 1) whether faculty believed cultural competency education to be important for future healthcare and science professionals, 2) whether faculty believed the HSU curriculum currently provided cultural competency training to our students, 3) what faculty thought was being done well with regard to cultural competency training at HSU, and 4) what faculty thought could be improved about cultural competency training at HSU.

Using Qualtrics survey software, we designed a thirteen-question web-based survey to assess faculty perceptions of cultural competency in the HSU curriculum. The survey also asked for basic demographic information such as faculty rank, college and department, gender, race/ethnicity, sexual orientation, (dis)ability, and citizenship status. Responses were solicited through the faculty email listserv. Because this listserv does not include adjunct faculty, one committee member compiled a list of adjunct faculty emails which were also added to the email solicitation. Michelle volunteered to send the email soliciting responses on behalf of the sub-committee. Since Michelle is a tenured member of the faculty she was able to access the faculty listserv for easy distribution of the survey link. She then followed up with reminder emails to all faculty members, including adjuncts, approximately every three weeks following the initial email announcement. Additionally, Michelle announced the survey at College Council meetings and all sub-committee members promoted the survey in face-to-face interactions with individual faculty. The survey was open for approximately one month.

Andrew analyzed the quantitative data from the survey with univariate and bivariate measures. Bivariate measures allowed us to breakdown responses by college, providing a better understanding of differences and similarities across disciplines. Michelle analyzed the qualitative responses, identifying major themes regarding faculty attitudes about cultural competency (Ryan and Bernard 2003). There were approximately 194 responses to our open-ended questions. These responses ranged from very short, i.e., "don't know" to longer discussions usually in response to the question,

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"Why do you feel HSU should be providing cultural competency training to students?" To identify themes in the data, Michelle followed Bogdan and Biklen's (1982) advice and read over all open-ended responses twice looking to find the commonly occurring themes. Some of the obvious themes in a corpus of data are those themes that occur and reoccur (Bogdan and Taylor 1975), and indeed, certain themes reoccurred quite frequently in the data, thus, the authors noted the frequency with which each theme was presented and hand coded representative quotes with particular themes (Ryan and Bernard 2003).

Results

Sample Demographics

One hundred and one faculty members responded to the survey, representing all four Colleges at HSU and all but one academic department. According to the University Factbook there were 191 full-time faculty employed by the University for the 2013-2014 academic year, the most recent data available at the time of the survey. Our survey therefore had a response rate of approximately 47 percent for full-time faculty. Of our 101 respondents, 21 percent were full professors, 34 percent associate professors, 30 percent assistant professors, 10 percent instructors, and 6 percent adjunct faculty members. Our sample roughly mirrors the distribution of all full-time faculty by rank, though under-represents Assistant Professors (47 percent of full-time faculty) and over-represents Instructors (3 percent of full-time faculty). Sixteen out of 26 (62 percent) faculty members from Health Sciences, 26 of 55 (47 percent) faculty from Pharmacy, 15 of 21 (71 percent) faculty from Health Care Policy, and 44 of 85 (52 percent) faculty members from Arts and Sciences responded to the survey.

Seventy-five respondents elected to fill out demographic information at the end of the survey (summarized in Table 1 below). In our sample, 44 percent (n=33) identified as men, 56 percent (n=42) identified as women, and no one identified as genderqueer or transgender, though those options were provided on the survey. Eighty-five percent (n=63) of respondents identified their race or ethnicity as White,[2] 5 percent (n=4) as Asian or Asian American, 4 percent each (n=3) as Black or African American and Southeast Asian or Indian Subcontinent, 3 percent (n=2) as Latino or Hispanic. 3 percent (n=2) of respondents identified as lesbian, gay, bisexual, or queer; while 7 percent (n=5) identified as having a physical, cognitive, or emotional disability. 95 percent (n=71) are United States citizens, while 5 percent (n=4) are permanent residents of the U.S. No respondents identified as foreign nationals.

Importance of Cultural Competency

There was overwhelming support for cultural competency and cultural competency training in our sample. One hundred percent (n=98) of respondents to the question agreed that "training students in cultural competency is important for healthcare and science professions," and close to that number agreed that HSU should provide cultural competency training to our students.

Qualitative responses to the question "Why do you feel [HSU] should be providing cultural competency training to students?" centered on six major themes that appeared most frequently in the data. Cultural competency is: 1) necessary for good healthcare practice, expected of professionals who work with diverse patients and colleagues; 2) important because we live in a multicultural society; 3) part of being a global citizen; 4) expected of professionals who work

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[2] This includes one "Other, please specify" response of Irish-American.

with diverse patients and colleagues necessary for good healthcare practice; 5) a necessary professional skill. See Table 2 below for exemplary responses for each theme.

Table 1. Demographic Results

	n	%
Gender Identity		
Man	33	44
Woman	42	56
Transgender	0	0
Genderqueer	0	0
	75	100
Race or Ethnicity		
White or Caucasian	62	84
Black or African American	3	4
African or Afro-Caribbean	0	0
American Indian or Alaska Native	0	0
Southeast Asian or Indian subcontinent	3	4
Asian or Asian American	4	5
Native Hawaiian or Other Pacific Islander	0	0
Middle Eastern or Arab	0	0
Latino or Hispanic	2	3
Other, please specify	1	1
	75	100
Identify as LGBQ?		
Yes	2	3
No	73	97
	75	100
Identify as having a disability?		
Yes	5	7
No	70	93
	75	100
Citizenship		
U.S. Citizen	71	95
U.S. Permanent Resident	4	5
Foreign National	0	0
	75	100

Table 2. Why do you feel [HSU] should be providing cultural competency training to students?

Theme: Cultural Competency is…	Exemplary Quote
Necessary for good healthcare practice	*All students are in careers that may require interaction with members of the community that are from a different culture and awareness of the cultural context is important in healthcare related issues.*
Important because we live in a multicultural society	*The U.S. is an increasingly multicultural country.*
Part of being a global citizen	*The world has shrunk, and understanding diversity in culture both locally and globally is essential to higher education.*
Expected of professionals who work with diverse patients and colleagues	*To work with people from different cultures and backgrounds as well as professionals from different fields.*
Necessary professional skill	*Cultural competency is a crucial skill for students entering the workforce and especially for those who will be working with the public through health care. Students need to be ready to serve a diverse population in a respectful manner.*

Responsibility for Cultural Competency Training

In contrast to near unanimous support for cultural competency training, respondents differed on who they felt should be responsible for such training. Out of 81 respondents to the question, 75 percent believed faculty should be responsible for cultural competency training. There was also support for academic department or program staff (35 percent), Student Affairs staff (40 percent), students and student groups (33 percent), and outside professionals (43 percent) providing training.[3] Though the faculty was clearly the preferred constituency for providing this training, there is clear support for other groups to provide cultural competency training.

Responses to where responsibility for cultural competency training should be housed in the University speak to a wider sense of responsibility across campus for educating our students on issues of cultural competency. Forty eight percent of respondents (n=84) believe responsibility for cultural competency training should lie in individual academic programs and departments, 38 percent believe it should lie with College Dean's Offices, 32 percent in University-level administrative units, such as the Provost's Office, and 23 percent in Student Affairs. A small number of respondents (12 percent) indicated "Other" for this question. When asked to specify, they indicated areas such as inter-professional education (IPE), in each academic course, and through multidisciplinary working groups.

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[3] Respondents could select more than one option, so totals may be greater than 100%.

Cultural Competency Work at Health Sciences University

Just over half (56 percent, n=89) of respondents believed that their academic department or program was currently providing cultural competency training to their students. While it is heartening that many faculty members feel their department is already providing cultural competency training, there is still a sizeable minority that does not see cultural competency work happening in their home departments. When we break the responses down by College (summarized in Table 3), we see a slightly more complicated story: Health Sciences faculty respondents all agree that their College provides cultural competency training. A majority (62 percent) of Pharmacy faculty say that their College provides cultural competency training, though just over a third (35 percent) say it does not. Many Healthcare Policy and Arts and Sciences faculty (57 percent and 62 percent, respectively) believe their College does *not* currently provide cultural competency training, though a sizeable minority of both faculties say they do (43 percent and 38 percent, respectively).

Based on these results, it seems clear that the Health Sciences are providing some cultural competency training to their students. Though we have a relatively small sample from each College, the unanimous response to this question by Health Sciences faculty increases our confidence in the result. For the other three Colleges, we should exercise some caution in

determining whether they are providing cultural competency training based on this measure alone. Additionally, when asked about the quality of training each College provides, the results were even more ambivalent (see Table 4 for results). Healthcare Policy faculty disagreed most on the quality of their programs, with marks from "very good" to "poor," a wider range than any responses from the other three Colleges. Health Sciences faculty were the most positive

Table 3. Does your College Provide Cultural Competency Training, by College

		Is your academic department or program providing cultural competency training to students?		
		Yes	No	Total
Health Policy	n	6	8	14
	%	42.86%	57.14%	100.00%
Arts and Sciences	n	14	23	37
	%	37.84%	62.16%	100.00%
Pharmacy	n	15	8	23
	%	65.22%	34.78%	100.00%
Health Sciences	n	15	0	15
	%	100.00%	0.00%	100.00%
Total	n	50	39	89
	%	56.18%	43.82%	100.00%

In which college do you teach?

about their cultural competency training for students, with 73 percent of Health Sciences faculty rating their programs as "good" or "very good." Pharmacy faculty were the most consistent in their ratings, with 70 percent rating their programs as "fair." Arts and Sciences faculty generally believed that their program offerings had room for improvement. Thirty-six percent of Arts & Sciences faculty rated their programs as "fair" while 45 percent of Arts & Sciences faculty feel their programs are "good".

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Table 4. Quality of Cultural Competency Training, by College

			Very Bad	Bad	Poor	Neutral	Fair	Good	Very Good	Total
			8 What is the quality of the cultural competency training provided by your academic department or program?							
In which college do you teach?	Health Policy	n	0	0	1	1	1	0	2	5
		%	0.00%	0.00%	20.00%	20.00%	20.00%	0.00%	40.00%	100.00%
	Arts and Sciences	n	0	0	0	1	4	5	40	11
		%	0.00%	0.00%	0.00%	9.09%	36.36%	45.45%	9.09%	100.00%
	Pharmacy	n	0	0	0	1	9	3	0	13
		%	0.00%	0.00%	0.00%	7.69%	69.23%	23.08%	0.00%	100.00%
	Health Sciences	n	0	0	0	1	3	9	2	15
		%	0.00%	0.00%	0.00%	6.67%	20.00%	60.00%	13.33%	100.00%
	Total	n	0	0	1	4	17	7	5	44
		%	0.00%	0.00%	2.27%	9.09%	38.64%	38.64%	11.36%	100.00%

Of those respondents who believe they teach cultural competency, we asked them where that teaching takes place: 59 percent address cultural competency in courses they teach, 50 percent address cultural competency informally with students in classes or office hours, 40 percent address cultural competency with individual students they advise, 26 percent engage cultural competency as part of co-curricular or professional development opportunities, 19 percent address these issues with students in research labs, and 18 percent address cultural competency as student organization advisors. However, one-fifth (21 percent) of all respondents say they do not provide any cultural competency training to students.

Respondents provided a list of 35 courses in which they address cultural competency issues. Of these 35, 18 were listed in Arts and Sciences, 8 in Health Sciences, 6 in Healthcare Policy, and 3 in Pharmacy, which is HSU's largest major. This is likely not an exhaustive list of courses that address cultural competency issues at the University, both due to the non-representative sample and the possibility that faculty decided not to provide specific courses for fear of compromising their anonymity.

Discussion

Overall, the data from this survey suggest that faculty are in support of providing cultural competency training to HSU students; they see such training as an important aspect of successful healthcare practice and a pillar of professionalism. The two most prominent reasons cited by the faculty–quality healthcare provision and professionalism–mirror findings from a 2013 survey of employers commissioned by the Association of American Colleges and Universities (AAC&U). AAC&U (2013) found that intercultural skills were one of the top three points of consideration in hiring decisions (along with ethics and a capacity for professional development). The support of both faculty and employers is a persuasive argument for the implementation and expansion of cultural competency training opportunities for STEM and health science students.

The faculty also appear to believe that they, as faculty members, should be responsible for training students in cultural competency, though there is also a strong push for cultural competency work across the university in both student and academic affairs. Following the belief that faculty should oversee cultural

competency training, there was generalized support for cultural competency training programs to be housed in academic units—at the department, College, or administrative levels. Again, there appears to be support for a multidisciplinary model of cultural competency training that would require institutional buy-in from multiple offices across campus.

Despite strong support for faculty and academic departments providing cultural competency training, there is less agreement on whether we are currently providing such training to students and whether the training we do provide is high quality. When we asked faculty what could be improved about the current offerings, few faculty felt equipped to offer such suggestions, often citing a lack of knowledge themselves about cultural competency practices, or at least a lack of knowledge in how to teach it. This suggests that one possible barrier to providing cultural competency training to our students is not a lack of will or desire among faculty, but a belief that faculty lack the knowledge or skills to teach it. If this is the case, if faculty want to take responsibility for cultural competency training as the data suggest, then *how can we prepare faculty with the skills and knowledge to effectively teach cultural competency to students in a meaningful, intentional way?*

The data collected here suggests the cultural competency training opportunities currently offered at Health Sciences University are neither pervasive nor systematic. The non-representative sample is partially responsible for this, but should not cause us to discount these findings completely. On the one hand, from this sample we gathered names of more than 35 courses in which faculty claim to address cultural competency, and would likely find many more if we had received responses from the entire faculty. On the other hand, 35 courses out of the hundreds offered at the University is still a relatively small piece of the overall offerings. Additionally, this data does not provide us with information about how many students are taking these courses, particularly for courses which are designated as electives. Unless a great many of these courses are required in all departments, it is quite possible that students complete their academic program requirements in good standing without ever encountering cultural competency training. This data also suggests that a fair portion of cultural competency training for students takes place in more informal settings such as advising sessions and with student organization advisors, rather than in the classroom. This is not to say that classroom settings should be the only or even primary venue for cultural competency work, but that relying too heavily on these informal venues increases the possibility that cultural competency training will remain largely unsystematic. *Further research is required to better understand which courses at the University cover cultural competency, which are required and which are elective, and how pervasive cultural competency topics and skills are across the curriculum.*

Limitations

Because the sample is not statistically representative, nor is it a full census, the results cannot be extrapolated beyond the sample to the entire faculty, nor to STEM and health sciences departments more broadly. Additionally, given the small community of faculty at Health Sciences University, and the often very specialized work performed by faculty in both teaching and research capacities, we acknowledge that there is some chance that individual faculty responses would be identifiable. This incomplete anonymity may have discouraged some faculty from providing fully candid answers (as possibly indicated by one respondent who filled in their department as "is this optional?") and may have discouraged other faculty from responding to the survey at all, which should also be considered when evaluating our results.

The data also do not account for differences in faculty perceptions about what the minimum

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amount of time or depth that is required for a course to count as addressing cultural competency. Nor do they speak to whether students recognize when cultural competency is being addressed. To address such issues, *we need to both systematically survey students about their perceptions of cultural competency training at HSU and to research and disseminate information regarding best practices in cultural competency training for faculty.*

Conclusion and Recommendations

The results of our survey on faculty perceptions of cultural competency training at Health Sciences University are somewhat mixed, but we believe the data are hopeful. These data are a clear statement about the importance of cultural competency training for future scientists and healthcare professionals. There is already strong commitment among our respondents to improving and expanding cultural competency training for our students, even if many are uncertain as to how this might be done. We also know that many faculty at Health Sciences University already provide some level of cultural competency training to students in classes, as advisors, and as researchers.

We draw two main conclusions from our data: 1) we need to improve and expand cultural competency training already in place for students and provide faculty with the knowledge and skills to teach it, and 2) the overall support of cultural competency among faculty may prove an effective tool for addressing the lack of diversity and the "culture of no culture" that pervades STEM and health science disciplines. While this survey and its findings have not brought forth any immediate changes, the authors are confident that under the university's new leadership, increasing campus diversity remains an important priority for the next round of strategic planning and new initiatives.

Perhaps the most striking finding from our survey of faculty was the overwhelming support of cultural competency training for students

coupled with a general uncertainty of how to implement such training (as well as how to evaluate these programs). It is beyond the scope of this paper to provide a robust overview of cultural competency training methods; however, we find Kripalani et al.'s "A Prescription for Cultural Competence in Medical Education" (2006) to be a useful guide. The authors suggest a three-fold approach to cultural competency work addressing students' knowledge, attitudes, and skills. Their suggestions for success speak not only to the need to make cultural competency instruction explicit (and therefore something faculty might also need to be taught), but also to intervening in the culture of science that seems so resistant to identity politics approaches to diversity by making cultural competency part of "a real science" (Kripalani et al. 2006:1118).

A focus on skills, and not just knowledge or attitudes, might allow diversity proponents to bridge the technical/social dualism by framing cultural competency as a technical skill, rather than a social nicety. Once cultural competency is reframed as a technical issue, it may be easier to expand the spaces in which such skills are necessary and valued to include the classroom, laboratory, and professional workplace. Addressing issues of diversity in these spaces may also be reframed as necessary to remain competitive with other schools or companies, as some literature suggests addressing diversity can have positive effects on the retention of diverse faculty, students, and employees (Patridge et al. 2014; Cech and Waidzunas 2011). We acknowledge that this approach will not satisfy everyone and we risk being accused of using a hair dryer to try to melt a glacier; however, we believe our data present cultural competency as a broadly appealing invitation to address diversity and inequality in STEM and the health sciences.

What is also clear from this data is that there are key areas in need of more research so universities may better support faculty who engage in cultural competency work with students. Based on the results of our survey, we suggested the following as initial points of

intervention at Health Sciences University and suggestions for work on cultural competency at other universities:

1. Explore theoretical frameworks and best practices for teaching cultural competency, particularly in the sciences and healthcare (see Beach et al. 2005; Kai et al. 1999; and Truong, Yin, and Priest 2014 as a starting point), and make these resources available to faculty in a variety of formats including written reports, workshops, interdisciplinary skill shares, and experiential learning opportunities.

2. Conduct a systematic assessment of the University's curriculum to determine where cultural competency is addressed and in what way; including, but not limited to, whether courses are required or elective, the depth and breadth of material covered, and whether material is informational or experiential.

3. Assess student perceptions of cultural competency and how cultural competency is currently addressed in the curriculum; including, but not limited to, the frequency, effectiveness, and importance placed on cultural competency in coursework and other program requirements.

We understand that these recommendations are not small undertakings, but believe that each would yield fruitful results to better understand, improve, and expand cultural competency training at the university-level and better prepare students for the rigors of a competitive, fast-paced, multicultural workforce and world.

Andrew J. Young *is a PhD candidate in Sociology at Temple University. His academic work centers on gender and sexuality in culture, specifically how queer and transgender identities are experienced, represented, and negotiated in popular culture, sports, and organizations. He is currently working on his dissertation:* Who Can Tell Our Story? The Lambda Literary Awards and the Development of a Transgender Literature. *AJ also has more than a decade of experience in higher education administration.*

Michelle Ramírez *is a medical anthropologist and an Associate Professor of Anthropology. Her teaching and research has been primarily focused on gender and sexuality in Mexico and the United States. Her current research examines the intersections of ethnicity, gender, and migration among U.S. Latina Pentecostals.*

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