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Cultural Competence among Healthcare Professional Educators: A Mixed-Methods Study

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Abstract: As cultural diversity gains global prominence, healthcare professional educators (HPEs) are expected to exhibit a high level of cultural competence in education. Responding to this necessity requires the establishment of healthcare education that is oriented toward sustainability. This study aimed to investigate HPEs' perceptions of cultural competence at the Qatar University-Health Cluster (QU-HC). A convergent mixed-methods design was applied. The quantitative phase involved 118 HPEs at QU-HC responding to the Multicultural Teaching Competency Scale (MTCS). The qualitative phase included 3 focus groups (FGs) with 22 HPEs guided by Campinha-Bacote's (1999) model of cultural competence. Thematic analysis was applied to analyze FGs data. Seventy-one educators responded to the MTCS (response rate was 60.2%), and twenty-two educators attended the FGs. HPEs demonstrated a moderate level of cultural awareness (total MTCS mean = 57 $\pm$ 7.8). The FGs revealed that the HPEs exhibited awareness and responsive teaching, but individual and institutional factors needed improvement. This study expands upon the existing literature concerning the cultural diversity impacts on the teaching and learning aspects of health profession programs, specifically within the Middle East context. It is recommended that health professional programs intensify the cultural orientation provided to educators, reanalyze the curricular content to serve diverse patients, and explore innovative approaches that embrace cultural diversity and sustainability.

Keywords: cultural diversity; cultural competence; sustainability; healthcare professional educators; healthcare professional students; convergent mixed method

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1. Introduction

Cultural competence is "the ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)" [1]. Cultural competence promotes the questioning of one's own preconceptions and prejudices, as well as other cultural humility and anti-oppressive principles such as respecting differences, minimizing power disparities, forming alliances, and learning from patients [2]. Campinha-Bacote (1999), in her conceptual model of cultural competence, "The Process of Cultural Competence in the Delivery of Healthcare Services", suggested five constructs of cultural competency that could be used to develop and implement culturally responsive healthcare services: cultural awareness; cultural knowledge; cultural skill; cultural encounter; and cultural desire [2]. In this model, there is an interdependence and an intersection between the constructs; the stronger the intersection, the greater the integration of cultural competence constructs in the healthcare provided to people from diverse races, ethnicities, genders, religions, and countries of origin [2].

Cultural competence is widely recognized as a way of minimizing health inequities in the medical and public health field. Healthcare inequities are systematic disparities due to discrimination, bias, and prejudice faced by different groups in attaining optimal health

resulting in inequitable and preventable differences in health outcomes [3,4]. One of the causes of healthcare inequities is differences based on social groups (e.g., race, religion, and culture) [5]. In the clinical literature, differences in referrals and in treatment practices by providers have been linked to patients' cultural, racial, or ethnic backgrounds [6].

Several scholars view cultural competence as a practical tool providing healthcare providers and educators with crucial skills for dealing with various individuals, groups, and communities in today's complicated world [7]. The World Health Organization (WHO) underscores the importance of cultural awareness in fostering the growth of adaptive, equitable, and sustainable healthcare systems, as well as in driving overall enhancements in various aspects of public health and welfare [8]. This reflects the necessity for formally and informally developing health professionals, and strengthening their ability to serve diverse populations through the implementation of well-planned cultural competence training curricula as a means of decreasing health disparities and improving patients' quality and sustainability of care [9]. The notion of sustainability, in particular, is progressively occupying a larger role within the domain of medical education, encompassing every level and across all healthcare disciplines. This is evident in the commitment to educating healthcare professionals who possess not only scientific expertise but also cultural proficiency, enabling them to effectively cater to local healthcare needs. Furthermore, it involves upholding the present and future healthcare standards by navigating the challenges posed by social, environmental, and financial factors. A Cochrane review on cultural competence education has prompted the need for further research to assess how cultural competence education interventions for healthcare professionals influence healthcare institutions, as these factors are likely to impact adoption and sustainability [10]. Healthcare educational institutions have recognized the significance of incorporating cultural competence into their curricula, thereby equipping students with the knowledge and skills to provide culturally competent and sustainable care. For example, Levi (2009) claimed that the preparation for international student nursing experiences requires incorporating a chance for students to introspect about their personal values and perspectives on cultural differences. Additionally, nursing programs should strive to enhance the communities they engage with, extending their impact beyond the immediate clinical care delivery. This can be achieved by either reinforcing existing resources or committing to a lasting and sustainable service initiative [11].

The State of Qatar is considered to be one of the most culturally diverse nations [12], with data suggesting that 88.4% of the population is comprised of a mix of immigrants from 94 nationalities with almost 190 different spoken languages [13]. Qatar provides an attractive destination for individuals to immigrate, live, and work in [14], because of a high gross national income [15] and one of the best healthcare systems in the world; being second in the MENA region and 39th out of 167 countries according to 2021 Legatum Prosperity Index [16]. Cultural diversity is a prominent feature in the Qatar workforce, particularly in the healthcare sector. This diversity is challenging for the healthcare system, which aims to provide excellent care for all citizens and residents [17]. Moreover, the Qatar National Vision 2030 indicated an expected tension between moving towards socio-economic development whilst preserving the Arab–Islamic tradition in Qatar [18].

Cultural diversity is a core value at QU, prompted by a growing realization of the opportunities associated with a multireligious and multicultural environment in enhancing student and faculty teaching and learning experiences [19]. The Health Cluster (HC) at QU, established in 2017, is one of the largest academic HCs in the country, which includes four colleges; the College of Pharmacy (CPH), the College of Medicine (CMED), the College of Health Sciences (CHS), and the College of Dental Medicine (CDM). It aims to prepare competent graduates capable of shaping the future of healthcare in Qatar through high-quality interdisciplinary programs. Health profession programs at Qatar University Health Cluster (QU-HC) are taught and assessed in English. QU-HC colleges are accredited by international accreditation bodies such as the Canadian Council for Accreditation of

Pharmacy Programs, the National Accreditation Agency for Clinical Laboratory Sciences, and the Accreditation Council for Education in Nutrition and Dietetics.

The educational workforce at QU-HC as well as the healthcare professionals, who are actively involved in the experiential training of students as clinical preceptors, originate from a variety of countries and cultures [20]. There were concerns in the late twentieth century regarding aligning health profession education with the needs of a culturally evolving and diverse patient population [21]. Therefore, in 2009 Weil Cornell Medical College in Qatar (WCM-Q) established the Center for Cultural Competence in Health Care in order to provide healthcare providers and educators with strategies to deal with cultural diversity and to achieve cultural competence [22]. Moreover, in an effort to understand students' perspectives on cultural competence, a mixed-methods study was conducted in CPH at QU which explored pharmacy students' perceptions of cultural competence [13].

This current study was conducted to explore cultural competence in health profession education in light of the multicultural nature of Qatar's population, healthcare professionals, and educator workforce. Hence, this study aimed to investigate the healthcare professional educators' (HPEs) perceptions of the cultural competence at QU-HC and the influence of cultural diversity of HPEs and students on teaching and learning processes.

2. Materials and Methods

2.1. Study Design and Setting

A convergent mixed-methods design was utilized [23], where quantitative and qualitative data were collected and analyzed separately but simultaneously in a parallel manner (i.e., quantitative data: October 2019–January 2020 and qualitative data: November–December 2019). Later, the two types of data were integrated and interpreted to gain an in-depth understanding of the topic [24]. The integration of data was performed at the reporting level through the contiguous narrative approach, and both sets of data were summarized, compared, and contrasted, an approach commonly applied in health-related literature [24,25]. This study was conducted in the HC at QU. In the quantitative phase, a validated self-reported questionnaire, the Multicultural Teaching Competency Scale (MTCS) [26], was adopted and administered among HPEs at QU-HC. The qualitative phase was conducted to illuminate, verify, and contradict the quantitative phase through the conduction of FGs with HPEs and was guided by Campinha-Bacote's (1999) model of cultural competence [2]. Table 1 demonstrates the five constructs of the model.

Table 1. Campinha-Bacote's (1999) conceptual model of cultural competence: "The process of cultural competence in the delivery of healthcare services".

Construct	Definition
Cultural awareness	A self-examination and in-depth exploration of biases and stereotypes about culturally diverse groups.
Cultural knowledge	A process of acquiring education and learning about culturally diverse groups.
Cultural skill	Involves the ability to collect culturally relevant information and perform a cultural assessment to meet the needs of diverse clients.
Cultural encounter	A process of direct engagement in cross-cultural interactions with clients from culturally diverse backgrounds.
Cultural desire	A motivation to want to learn and engage in the process of culturally competent care.

2.2. Study Population and Eligibility Criteria

All faculty members (faculty and teaching assistants) in the three colleges of HC at QU were eligible (i.e., CPH, CMED, and CHS). Educators from the Dental College and the Physiotherapy Program were not included in this study because they were newly established (in 2019 and 2018, respectively) and the multicultural interaction between

educators and students was not established. Administrative staff who were not involved in the teaching process were also not included.

2.3. Quantitative Phase

2.3.1. Sample

All professors, lecturers, and teaching assistants from the three HC colleges constituted the eligible population (n = 118). The total population sampling approach was followed because the population was relatively small, and this attempt was made to maximize the number of responses.

2.3.2. Data Collection Instrument

An extensive review of the literature was conducted to select the most suitable method to assess the perception of educators' teaching experience in a multicultural educational environment. The Multicultural Teaching Competency Scale (MTCS), developed by Spanierman et al., (2011), was selected because it covered most aspects related to the study objectives [26]. The MTCS is a validated, 16-item, 6-point Likert-type scale, ranging from 1 (strongly disagree) to 6 (strongly agree) originally intended to measure the multicultural competencies of teachers in primary and secondary classrooms. The scale has two sections: (a) multicultural teaching skill (MTS) (10-item) and (b) multicultural teaching knowledge (MTK) (6-item). The MTCS has been used previously to assess educators' self-efficacy and biases when teaching diverse populations [27]. The MTCS is considered a significant resource for integrating culturally responsive strategies for health discipline educators [28].

In Qatar, cultural diversity is demonstrated, and is defined in this paper, by the various nationalities and their associated cultural values and not through race and ethnicity variations. Therefore, the terms "races" and "ethnic group" were replaced with "cultural group" and "nationalities" in the majority of items. In addition, the original tool was a six-point Likert scale; however, an agreement was reached by the research team to reduce it to a five-point scale (1 = Strongly Disagree, 2 = Disagree, 3 = Neither Agree nor Disagree, 4 = Agree, 5 = Strongly Agree) so there is a midpoint value that provides neutrality and prevents forced-choice or anticipated difficulties in defining points of view with multiple choices [29]. Permission was granted from the developer of the original scale to use it in this study. The final survey version was composed of three sections: (1) demographic, professional characteristics, and involvement in multicultural activities (eight items); (2) MTS (ten items: minimum score = 10–maximum score = 50); and (3) MTK (six items: minimum score = 6–maximum score = 30). A higher score indicates a higher level of multicultural teaching competence among educators. Because of the absence of a reference point in the initial scale, a consensus among the research team was reached prior to the conduction of the study by discussing the different approaches to score categorization. A consensus was reached on considering the total MTCS score between 59 and 80 as high, 37–58 as moderate, and 16–36 as low. For MTS, a score between 37 and 50 is considered as high, 23–36 as moderate, and 10–22 as low. Whereas for MTK, a score between 23 and 30 is considered as high, 15–22 as moderate, and 6–14 as low.

2.3.3. Data Collection Procedure

The names and contact details of all HPEs were obtained through the administration at the three colleges. An online email invitation to participate in this study along with a SurveyMonkey® link to the self-reported survey was sent to all the HPEs (n = 118). The survey was open from October 2019 to January 2020. To improve the response rate, three reminder emails were sent to the participants, requesting those who had not yet responded to complete the survey. Participation in the survey was voluntary, no identifiable information was gathered, and participants were assured of anonymity and their right to abstain from answering any questions that they preferred not to answer.

2.3.4. Data Analysis

SPSS (IBM SPSS® Statistics; version 25, Armonk, NY, USA) was used for analyzing the quantitative data. The distribution of data was tested and showed normality. Descriptive analyses, including frequencies (%) and mean ± SD were employed to summarize the responses. The MTCS scores were presented as means ± SD. To test for significant differences between demographic subgroups in terms of MTCS scores, independent *t*-tests, and a one-way ANOVA were used. The level of statistical significance was set a priori at $p < 0.05$.

2.4. Qualitative Phase

2.4.1. Sample and Sampling Technique

A purposive sampling of educators from the same population used in the quantitative phase was conducted. This involved selecting educators from diverse genders, age groups, nationalities, and cultural backgrounds. Three FGs were conducted, one for each health college. During this phase, an invitation email was sent to 39 HPEs at the 3 colleges (n: CPH = 14, CMED = 11, and CHS = 14) to participate in the FG meetings. Information about the study objectives, a participant information leaflet, and a consent form were all provided in the email. The email was sent at least one week before the FGs scheduled date. Willingness to participate in the FGs was confirmed via email.

2.4.2. Data Collection Instrument

The literature review and the expert opinions of the research team guided the conceptualization of a topic guide of eight questions with probes. Campinha-Bacote's conceptual model of cultural competence can be used either to guide data collection and/or analysis [30]. The research team decided to use it only for guiding data analysis to allow flexibility in data generation. While the MTCS focused only on skill and knowledge aspects of cultural competence, the topic guide was developed to address other complementary aspects of cultural competence in the specific context that align and assist in understanding the research topic, such as cultural diversity among educators and students, cultural awareness, cultural encounter situations, skills to deal with cultural diversity, multicultural teaching strategies, and learning processes. The topic guide for health professional educators' FG is presented in Appendix A.

2.4.3. Data Collection Procedure

All FGs were conducted by one facilitator to ensure data collection consistency. Before the FG sessions, participants were informed about the voluntary nature of participation, the participant's right to withdraw at any time without any penalty, and the absence of risks and costs associated with this study. Participants were asked to disclose their understanding of the topic and procedure and to sign the consent forms before the commencement of the session. The FGs were conducted in the respective colleges between November and December 2019. All were conducted in English, recorded, and transcribed verbatim. Confidentiality and anonymity were ensured by using alphanumerical codes, with "Ph", "Med", and "HS" assigned to the pharmacy, medicine, and health sciences educators, respectively, and by maintaining all research documents in a password-protected laptop.

2.4.4. Data Analysis

The qualitative data were analyzed using the thematic analysis approach through NVIVO® software (version 11). Two independent investigators conducted the qualitative analysis to ensure the credibility and dependability of the results. A deductive thematic approach was applied and was guided by the constructs of Campinha-Bacote's (1999) conceptual model of cultural competence; as such, each of the five constructs was used to form the coding framework [2]. The use of this conceptual model to guide data analysis in qualitative studies aimed at exploring cultural competence is common [31]. Consensus

between the two investigators, or the involvement of a third investigator, was sought whenever inconsistencies in data analyses and interpretation occurred.

3. Results

3.1. Quantitative Phase

Seventy-one educators responded (the response rate was 60.2%); however, the usable rate was 81.7% (n = 58 of 71), after removing respondents who filled the demographic section only. The demographic characteristics of educators who participated in this study are presented in Table 2. The majority of HPEs were male (33 (57.9%)), with the majority (19 (33.3%)) being ≥50 years of age. HPEs were predominantly from Canada (10 (18.2%)), the UK (7 (12.7%)), the US (5 (9.1%)), and Palestine (5 (9.1%)).

Table 2. Demographics and professional characteristics of educators.

Demographics and Professional Characteristics	**Frequency N (%)**
Age in years	N = 57 (Missing = 1)
20–29	4 (7.0)
30–39	17 (29.8)
40–49	17 (29.8)
≥50	19 (33.3)
Gender	N = 57 (Missing = 1)
Male	33 (57.9)
Female	24 (42.1)
Nationality	N = 55 (Missing = 3)
Qatar	2 (3.6)
Palestine	5 (9.1)
Sudan	2 (3.6)
Lebanon	3 (5.5)
India	2 (3.6)
Canada	10 (18.2)
United Kingdom	7 (12.7)
United States	5 (9.1)
Australia	2 (3.6)
Ghana	2 (3.6)
Other: (Egypt, Jordan, Netherlands, Ukraine, Sweden, Germany, Ireland, Greece, Maldives, Nigeria, Tunisian, Iraq, Pakistan, Bangladesh, Danish)	15 (27.3)
Years of teaching experience	N = 57 (Missing = 1)
<1	0 (0.0)
1–5	12 (21.1)
6–10	15 (26.3)
11–15	8 (14.0)
>15	22 (38.6)
Health college	N = 56 (Missing = 2)
College of Pharmacy	26 (46.4)
College of Medicine	15 (26.8)
College of Health Sciences	15 (26.8)
Level of teaching	N = 57 (Missing = 1)

Table 2. *Cont.*

Demographics and Professional Characteristics	Frequency N (%)
Undergraduate Graduate Both	21 (36.8) 2 (3.5) 34 (59.6)
Number of times for being involved in multicultural activities	N = 58 (Missing = 0)
0 1–5 6–10 >10	24 (41.4) 21 (36.2) 7 (12.1) 6 (10.3)

The total mean MTCS score for the HPE participants was moderate (57.0 ± 7.8) (Table 3). The mean scores for the MTS and MTK were also moderate (35.9 ± 5.1 and 20.9 ± 4.3, respectively). No statistically significant difference was observed in MTCS scores when analyzed against subgroups of selected participants' demographic and professional characteristics (i.e., gender and health colleges) (Table 4).

Table 3. The healthcare professional educators' Multicultural Teaching Competency Scale total scores.

Item	Number of Participants	Mean ± SD	Min–Max
Total Score of Multicultural Teaching Competency Scale	52 (Missing 6)	57.0 ± 7.8	39–77
Total Score of Multicultural Teaching Competency Scale-Skills	52 (Missing 6)	35.9 ± 5.1	19–48
Total Score of Multicultural Teaching Competency Scale-Knowledge	53 (Missing 5)	20.9 ± 4.3	9–30

Table 4. Multicultural Teaching Competency Scale scores among participants' subgroups.

Item	Subgroup	Number of Participants	Mean ± SD	*p*-Value	Total	Missing
Gender					51	7
Total Score of MTCS	Male Female	30 21	57.2 ± 9.0 56.5 ± 6.1	0.78		
Total Score of MTCS-Skills	Male Female	30 21	35.1 ± 5.6 36.6 ± 4.1	0.32		
Total Score of MTCS-Knowledge	Male Female	31 21	21.6 ± 4.9 20.0 ± 3.0	0.17		
Health College					50	8
Total Score of MTCS	College of Pharmacy College of Medicine College of Health Sciences	23 14 13	55.3 ± 8.2 59.9 ± 8.3 57.1 ± 5.9	0.22		
Total Score of MTCS-Skills	College of Pharmacy College of Medicine College of Health Sciences	23 14 13	34.7 ± 5.8 36.9 ± 4.5 36.8 ± 4.2	0.35		
Total Score of MTCS-Knowledge	College of Pharmacy College of Medicine College of Health Sciences	24 14 13	20.0 ± 4.3 23.0 ± 4.8 20.3 ± 3.2	0.10		

Abbreviation: MTCS, Multicultural Teaching Competency Scale.

The participants' responses to the MTCS are presented in Table 5. The MTS section of this study investigated the HPEs' integration of multicultural competence into their practice. HPEs' agreement (i.e., agree and strongly agree) with the integration of multicultural competence into their practice ranged from 35.7 to 83.7%, and their disagreement (i.e., disagree and strongly disagree) ranged from 3.6 to 35.7%. The majority of the HPEs agreed most strongly with the items "I establish strong, supportive relationships with students from diverse cultures", and "I often promote diversity by the behaviors I exhibit" (83.7% and 76.4%, respectively). The HPEs demonstrated equal agreement and disagreement (35.7% for both) concerning the item "I plan events/activities to increase students' knowledge of experiences of cultural groups". It is worth noting that more than a quarter of the participants neither agreed nor disagreed with integrating multicultural competence into practice in most of the items (7/10 items). The MTK section explored the HPEs' knowledge of multicultural teaching issues. HPEs' agreement (i.e., agree and strongly agree) to understanding multicultural teaching issues ranged from 42.6 to 82.8% and their disagreement (i.e., disagree and strongly disagree) ranged from 8.6 to 31.5%. The highest agreement (82.8%) was observed in relation to the item "I understand the various communication styles among different cultural groups or religious groups or nationalities of students in my classroom". Notably, a sizable percentage of the HPEs demonstrated disagreement with the item "'I am knowledgeable about the various community resources within Qatar that I teach". Neutral agreement to understanding multicultural teaching issues was demonstrated by more than a quarter of the HPEs in three out of six items.

Table 5. The healthcare professional educators' responses to the Multicultural Teaching Competency Scale (N = 58).

Item	Strongly Disagree	Disagree	Neither Disagree nor Agree	Agree	Strongly Agree	Total	Missing
	N (%)	N (%)	N (%)	N (%)	N (%)	N	N
Multicultural Teaching Skill							
1. I plan many activities to value diverse cultural practices in my classroom.	3 (5.2)	1 (1.7)	15 (25.9)	26 (44.8)	13 (22.4)	58	0
2. I consult regularly with other faculty members or administrators or students to help me understand multicultural issues related to instruction.	2 (3.4)	10 (17.2)	21 (36.2)	21 (36.2)	4 (6.9)	58	0
3. I often include examples of the experiences and perspectives of racial and ethnic groups during my lectures.	2 (3.6)	9 (16.1)	14 (25.0)	24 (42.9)	7 (12.5)	56	2
4. I plan events/activities to increase students' knowledge about the cultural experiences of cultural groups.	1 (1.8)	19 (33.9)	16 (28.6)	16 (28.6)	4 (7.1)	56	2
5. My curricula integrate examples and/or applications from diverse cultures.	3 (5.5)	6 (10.9)	14 (25.5)	24 (43.6)	8 (14.5)	55	3
6. I make changes within the general classroom environment so students from diverse cultures will have an equal opportunity for success.	1 (1.9)	5 (9.3)	15 (27.8)	22 (40.7)	11 (20.4)	54	4
7. * I rarely examine the instructional materials I use in the classroom for cultural bias.	1 (1.9)	29 (53.7)	14 (25.9)	4 (7.4)	6 (11.1)	54	4
8. I integrate the cultural values and lifestyles of diverse cultures into my teaching.	0 (0)	3 (5.5)	11 (20.0)	34 (61.8)	7 (12.7)	55	3
9. I often promote diversity by the behaviors I exhibit.	0 (0)	2 (3.6)	11 (20.0)	32 (58.2)	10 (18.2)	55	3
10. I establish strong, supportive relationships with students from diverse cultures.	0 (0)	2 (3.6)	7 (12.7)	25 (45.5)	21 (38.2)	55	3

Table 5. *Cont.*

Item	Strongly Disagree	Disagree	Neither Disagree nor Agree	Agree	Strongly Agree	Total	Missing
	N (%)	N (%)	N (%)	N (%)	N (%)	N	N
Multicultural Teaching Knowledge							
11. I understand the various communication styles among different cultural groups or religious groups or nationalities of students in my classroom.	3 (5.2)	2 (3.4)	5 (8.6)	33 (56.9)	15 (25.9)	58	0
12. I have a clear understanding of culturally responsive pedagogy.	0 (0)	11 (19.3)	13 (22.8)	26 (45.6)	7 (12.3)	57	1
13. I have adequate knowledge about the concept of multicultural teaching competence.	1 (1.8)	10 (17.5)	17 (29.8)	21 (36.8)	8 (14.0)	57	1
14. I am knowledgeable of how historical experiences of various cultural groups may affect students learning.	1 (1.8)	11 (20.0)	12 (21.8)	21 (38.2)	10 (18.2)	55	3
15. I am knowledgeable about the particular teaching strategies that take into consideration students from diverse cultures.	0 (0)	11 (20.0)	16 (29.1)	20 (36.4)	8 (14.5)	55	3
16. I am knowledgeable about the various community resources within Qatar that I teach.	4 (7.4)	13 (24.1)	14 (25.9)	18 (33.3)	5 (9.3)	54	4

* Indicates a reverse-scored item.

3.2. Qualitative Phase

Nine educators from the CPH, ten from the CMED, and three from the CHS attended the FGs. The themes and subthemes identified through thematic analysis are summarized in Table 6.

Table 6. Themes and subthemes generated from the focus groups.

Themes	Sub-Themes
Theme 1: Cultural Awareness	Educators' perception of diversity in health colleges
	Different levels of cultural awareness
	Perception, attitudes, and biases of educators towards their own and other cultures
Theme 2: Cultural knowledge	Sources of cultural knowledge enhancement
	Knowledge of the cultural impact on student behaviors
Theme 3: Cultural skill	Teaching culturally diverse students
	Incorporating cultural competence concepts in health professions education
Theme 4: Cultural encounter	Female–male interactions
	Language difference
	Cross-cultural challenges
Theme 5: Cultural desire	Self-motivation of educators to learn about the local culture
	Desire for cultural adaptation

3.2.1. Cultural Awareness

This theme addressed the perception of educators regarding the extent of cultural diversity among students and educators' communities. It also examined educators' perceptions of their cultural awareness and their attitudes toward groups from different cultures. This theme included three subthemes, as follows:

Educators' perception of diversity in health colleges. The participants' view on the nature and extent of cultural diversity in health colleges was quite varied. Several educators

indicated that student groups are generally homogenous, mostly Arab and Muslim groups, with no major cultural differences among them. For example, a participant said:

> "I think that QU students are not diverse enough as compared to the US, where I came from, where you can find different cultures, religions, backgrounds, and races." Med-2

On the other hand, several other educators argued that cultural differences can be observed even among students with similar identities. A participant from CPH said the following:

> "We see several diversities between students, even within the same country: some outspoken females, and some conservative females. I guess it all gets back to the culture they were raised in." Ph-3

Generally, there was an agreement among participants that cultural diversity is a common feature observed among HPEs, which exceeds that of students and educators in other institutions.

Different levels of cultural awareness. The level of recognition of the Qatari cultural features and the existence of cultural diversity in Qatar varied among participants. Several educators expressed cultural awareness of the similarities and differences between their own cultures and cultures in the academic environment and wider Qatari society. For instance, one participant said the following:

> "My country has a population of more than 30 million. So, I studied with Muslims, and I have Muslim friends. I am aware of the culture. When I came here, I did not need to make any adjustments." Med-6

Lack of awareness and familiarity with other cultural habits existed among educators, where extreme and unpredictable cultural differences between the educators and the local Qatari culture were observed by few participants, especially non-Arab educators. One educator described his experience as follows:

> "When I first came here, it was a double shock to me; first because people are from the Arab region, and second, because all BSc students are females." Ph-4

Perception, attitudes, and biases of educators towards their own and other cultures. Generally, positive attitudes towards various cultural backgrounds, beliefs, values, and ideas were evident from the FG discussions. Educators tend to appreciate and respect differences in academic environments and society. For example, one participant mentioned the following:

> "In our college, there is no discrimination. Faculty members and students respect each other, their views, and their backgrounds. I think the 'Potluck' is one of the examples by which we celebrate the diverse cultures that we have in the college." Ph-8

HPEs demonstrated an awareness of potential stereotypes, biases, and judgmental attitudes that might exist among students or society towards specific cultural-related behaviors. One participant from the CHS said the following:

> "We touch on some controversial issues in our classes. I was giving a lecture about smoking and explaining that there is a cultural "non-health" dynamic to women who smoke and that in our Arab culture, smoking is 'Eib' [i.e., non-moral]. I said, 'The truth is that we judge women who smoke in public differently." HS-3

Nevertheless, concerns were raised about the challenges that educators or students might face when trying to balance their own cultural values and teaching or learning under the ethical code of QU. One participant mentioned the following:

> "It is challenging to demonstrate your own culture and feel included, respected and accepted when you have to adhere to the university's ethical framework" HS-3

3.2.2. Cultural Knowledge

This theme explored how educators perceive their knowledge of diverse cultures, backgrounds, and beliefs and how cultural diversity influences the way they learn about and understand the behaviors of students and people. This theme generated two subthemes:

Sources of cultural knowledge enhancement. Educators indicated using several sources to develop their knowledge about Qatari culture and other cultures in their work environment. Few participants referred to self-learning initiatives to help with learning about cultures, while other participants indicated that their lived experiences and immersion into a culturally diverse environment enhanced their knowledge about various cultures. One HPE made the following comment:

> "Diversity among students is an advantage to the faculty members. . . because we get exposed to different cultures, . . . and we learn how to deal with each one of them." HS-1

Knowledge of the cultural impact on student behaviors. Several HPEs were aware of the influence that cultural attributes and beliefs can have on a student's academic and non-academic behaviors. An educator said the following:

> "When students were young, they were going to Arabic schools where they have to memorize the Qur'an, and I think when they go to high school, the culture of learning is rote memorization, and they bring that to university." Ph-1

Additionally, the educators recognized that although interaction and communication between students from diverse cultures are beneficial, they also acknowledged their understanding of students' preference to gather with students from similar cultures as this enhances their sense of belonging. A participant mentioned the following:

> "I notice that students from the same country or culture tend to group together. That is very normal and does not stop the bridging process between groups, because people like to speak their own language and share cultural examples and so on." HS-3

3.2.3. Cultural Skill

This theme investigated the impact of HPEs' knowledge of cultural awareness and their ability to teach and interact with students from diverse cultures as well as on their performance in culturally sensitive situations. The theme also emphasized the cultural skills demonstrated by educators to meet the educational needs of all students. This theme included the three following subthemes:

Teaching culturally diverse students. Educators' teaching practice was influenced and reinforced by their teaching experiences in culturally diverse environments. One participant commented on her teaching experience, as follows:

> "Thinking back to my first year versus my fifth year here, and how I approach conversations with students. Over time, I understood that there are certain sensitivities that you can't talk about and things that you wouldn't talk about." Ph-7

Incorporating cultural competence concepts in health professions education. Evidence of incorporating theoretical and practical concepts of cultural competence in health profession curricula was reported. Participants shared examples of various teaching, training, and evaluation strategies that they utilized. One educator said the following:

> "Cultural competence is already covered a lot in the college, starting from the first year and even during the Structured Multi-Skill Assessment (SMSA) and the Objective Structured Clinical Examination (OSCE)." Ph-9

Areas of potential improvements recommended by the HPEs concerning the inclusion of cultural competence in health professions curricula included the incorporation of evidence-based, effective, culture-related content and the utilization of learning resources and content that is suited to the local culture to ensure cultural inclusivity.

> "I would love to have effective proven tools or strategies that I can implement or integrate into the curriculum to teach cultural competence." HS-2

Concerning HPEs' conduct in culturally sensitive situations, there was a variation in how they performed. Few educators preferred the avoidance of any culturally sensitive or controversial topics, and others restricted and refined their teaching strategies to standard scientific approaches. Moreover, applying instruction strategies that facilitate the academic achievement and personal development of all students was a key skill among HPEs. Furthermore, it was evident that the academic and non-academic environments in the HC encouraged the participation of all students without discrimination based on culture, language, religion, belief, or behavior. Together, these enhanced the equity and inclusivity at QU-HC. One participant described this inclusiveness as follows:

> "Whether the student is a liberal or a conservative student, I treat them equally. They interact with me similarly. One comment that I received in my course evaluation was: 'Dr. X does not discriminate between us'." Ph-4

3.2.4. Cultural Encounter

This theme explored how HPEs perceive their direct engagements in cross-cultural interactions. It also demonstrated the educators' attempts to promote purposeful interactions to refine beliefs and enhance cultural competencies. Three subthemes emerged under this theme:

Female–male interactions. Living in a Muslim-conservative society and teaching in QU where education is generally gender-segregated, HPEs highlighted the differences observed in the perception of students about communicating with the other gender. One educator from the CPH said the following:

> "Sometimes you see students in malls and despite spending 6 years teaching, some students will say hi, but others will pass without saying anything. So, we as instructors should not take that offensively. We should understand the culture from which the student may come; she may not be used to talking with a male instructor in public." Ph-3

However, with the introduction of a mixed-gender education in CMED, educators gave their insights on the interaction among students as follows:

> "Sensitivity of female students being taught by males is lessened when they are taught in a mixed-gender environment. Rarely, students are intimidated by the opposite gender. . . . My recommendation is to expand the mixed-gender education among health colleges as it has been successful in mimicking their future professional work experience." Med-3

Language difference. Some educators emphasized the importance of taking language differences into consideration while communicating in a multicultural setting. The educators also appreciated how language-based activities can be associated with a sense of exclusion among students. One participant elaborated:

> "As an Arabic speaker, I tend sometimes to mention some words in Arabic. So, I clarify at the beginning if there are any non-Arabic speakers because they could take it as an insult. So, I would rather explore the diversity of students before interacting with them." Ph-6

Moreover, educators indicated that the language of health profession curricula is one of the barriers to teaching and training students how to apply culturally competent care to diverse patients. Several participants suggested implementing strategies to strike a balance between the English scientific language adopted from the West, the Arabic language of the Qataris, and the other languages of the dominant cultures in Qatar. For example

> "The main challenge here in medicine is that the curriculum is in English. When students go to clinical rotations, and you ask them to explain the problem in Arabic, they cannot." Med-1

Cross-cultural challenges. The challenge associated with interactions with different cultures was perceived differently among participants. A group of educators argued that the absence of cross-cultural challenges in the health professional academic environment was due to student homogeneity. However, another group of participants pointed out that diversity in cultural and religious backgrounds can create difficulties in communication and/or unintentional disrespectful incidents. One participant said the following:

> "I came from a different religious background. At some points, especially in 'Ramadan', I tend to forget certain things that I need to respect, especially when I am surrounded by culturally diverse people. I had a lot of experiences where I kind of unintentionally disrespected, then I noticed and adjusted that to avoid these incidences." Ph-3

3.2.5. Cultural Desire

This theme evaluated the level of motivation among HPEs to be engaged in the process of cultural competence and the development of cultural awareness, knowledge, and skills. Two subthemes emerged from this theme:

Self-motivation of educators to learn about the local culture. A strong commitment to learning from and about other cultures to ensure optimal adherence to the local cultural values in an academic setting was indicated in participants' discourses. Participants described different approaches to seeking cultural guidance, as follows:

> "You can seek advice. For example, I teach anatomy. When I first started, I went and asked my chair, 'Is there any taboo in my lectures regarding what I am going to say and put in my slides?'" Med-9

It was shown that the participants appreciated the significance of having a cultural orientation, and the efforts by QU and the health programs to improve the adherence to the code of ethics and conduct by all faculty members, staff, and students. However, some participants showed interest in learning more than what is provided to improve their cultural encounters and experiences in a multicultural environment.

The desire for cultural adaptation. Participants indicated their willingness and desire not only to learn about different cultures but also to adapt to society. One participant said the following:

> "I think we make some changes in ourselves to fit in this culture. This indicates the flexibility that we have in our personalities that we can always survive with the demands and conditions that we are working in without being limited or threatened." Med-1

3.3. Data Integration

A summary of integrated quantitative and qualitative data is illustrated in Table 7.

Table 7. Integration of qualitative and quantitative findings *.

Quantitative Phase				Qualitative Phase		
MTSC Domains	**Mean ± SD**	**Item**	**Agreement vs. Non-Agreement (%)**	**Theme**	**Subtheme**	**Quote**
Multicultural Teaching Competency Scale-Skills	35.9 ± 5.1	I consult regularly with other faculty members or administrators or students to help me understand multicultural issues related to instruction	43.1% vs. 20.6%	Cultural desire	Self-motivation of educators to learn about the local culture.	"You can seek advice. For example, I teach anatomy. When I first started, I went and asked my chair, 'Is there any taboo in my lectures regarding what I am going to say and put in my slides?' I take advice from the right place." Med-9"
		My curricula integrate examples and/or applications from diverse cultures.	58.1% vs. 16.4%	Cultural skill	Incorporating cultural competence concepts in health professions education.	"I think that cultural competence is such a real concept to teach students. I always tell my students that one of life's greatest talents is to be able to put yourself in someone else's shoes and think about what they are hearing and how are they hearing it." HS-3
		I make changes within the general classroom environment so students from diverse cultures will have an equal opportunity for success.	61.1% vs. 11.2%	Cultural skill	Incorporating cultural competence concepts in health professions education.	"The mix situation here in CMD makes some changes in the structure of the session, for example, if they will work on teams, I always mix the group male and female work together and they find the body language to protect their private zone but also to interact with others." Med-1
		I often include examples of the experiences and perspectives of racial and ethnic groups during my lectures.	55.4% vs. 19.7%	Cultural skill	Incorporating cultural competence concepts in health professions education.	"Most of the textbooks and materials that we get are from the US or the West. I think that instructors have the responsibility to supplement the lecture with more examples and cases from other cultures, races and cities." HS-2
		I establish strong, supportive relationships with students from diverse cultures	83.7% vs. 3.6%	Cultural awareness	Perception, attitudes, and biases of educators towards their own and other cultures.	"In our college, there is no discrimination. Faculty members and students respect each other. They respect different views and backgrounds." Ph-8
		I often promote diversity by the behaviors I exhibit.	76.4% vs. 3.6%	Cultural awareness	Perception, attitudes, and biases of educators towards their own and other cultures.	"I think the 'Potluck' is one of the examples by which we celebrate the diverse cultures that we have in the college." Ph-8

Table 7. *Cont.*

Quantitative Phase				Qualitative Phase		
MTSC Domains	**Mean ± SD**	**Item**	**Agreement vs. Non-Agreement (%)**	**Theme**	**Subtheme**	**Quote**
Multicultural Teaching Competency Scale-Knowledge	20.9 ± 4.3	I understand the various communication styles among different cultural groups or religious groups or nationalities of students in my classroom.	82.8% vs. 8.6%	Cultural encounter	Female–male interactions.	"Qatar is small, and sometimes you see students in malls. Despite spending 6 years teaching, some students will say hi, but others will pass without saying anything. So, we as instructors should not take that offensively. We should understand the culture student may come from, she may not be used to talking with a male instructor in public." Ph-3
			82.8% vs. 8.6%	Cultural awareness	Educators' perception of diversity in health colleges.	"During activities we do, I feel that students present themselves based on their cultures and their beliefs. We see several diversities between students, even within the same country; some outspoken females, and some conservative females. I guess it all gets back to the culture they were raised in." Ph-3
		I am knowledgeable of how historical experiences of various cultural groups may affect students learning.	56.4% vs. 21.8%	Cultural knowledge	Cultural impact on student behaviors.	"I do notice that students from the same country or the same culture tend to group. This especially happens among undergraduates more than among graduates. That is very normal and does not stop the bridging process between groups, because people like to speak their language and share cultural examples and so on." HS-3
		I have a clear understanding of culturally responsive pedagogy.	57.9% vs. 19.3%	Cultural skill	Teaching culturally diverse students.	"Homogeneity of students makes it easy for us as faculty members because you are not necessarily going to be on your toes, concerned about being politically correct in every statement and attitude. You will not be worried about insulting anyone. My experience with students here is easier than that with truly diverse students in the USA." Med-2
		I have adequate knowledge about the concept of multicultural teaching competence.	50.8% vs. 19.3%			
		I am knowledgeable about the particular teaching strategies that take into consideration students from diverse cultures	50.9% vs. 20.0%			

* Mapping between quantitative and qualitative data is based on the meaning of the specific item in the MTCS and the quotes.

4. Discussion

This study adds to the current literature on how cultural diversity in the educational environment influences teaching and learning in health profession programs, particularly in the Middle East context. Cultural diversity among the HPEs at QU has been clearly demonstrated in this study and reflects the broader multi-culturalism in Qatar [13,20]. It is worth noting that the diversity observed in the HPEs in terms of belonging to different age groups, genders, and various nationalities across four continents (i.e., Asia, Africa, Europe, and the Americas) exceeded the diversity observed in the student group who are mainly female, Arab students, with a minority originating from non-Arab countries (e.g., from India, Pakistan, and the USA). However, a previous study conducted among pharmacy students at QU, demonstrated the existence of diversity even among students who originate from Muslim and Arabic nationalities [13].

The integration of quantitative and qualitative results illustrated that the HPEs possess a moderate level of cultural competence as indicated by their mean MTCS scores and by their discourse about their attitudes and behaviors in multicultural settings. In the absence of studies that used the MTCS tool in the healthcare professional education context, the findings were compared with studies conducted in the educational context in general. The qualitative data provided evidence of overall awareness and comfort with cultural diversity and the adoption of culturally responsive teaching among educators. However, it also sheds light on some personal and organizational aspects that need further enhancement with regard to multi-cultural teaching competencies, such as the demonstration of unintentional disrespect of the local culture, and the necessity of curricula adaptation to suit the needs of diverse patient populations.

This study identified a moderate level of knowledge among HPEs about cultural differences, socio-historical realities, culturally responsive pedagogy, and instructional strategies as demonstrated by the FG discussions and by the MTK mean score (20.9). One of the common findings between the quantitative and qualitative data is that the HPEs were knowledgeable of how cultural backgrounds, beliefs, and values can influence their behaviors. For example, participants' high agreement with item 14 in the MTCS aligns with FG findings of how students' historical Islamic culture of studying (e.g., memorizing the Holy Qur'an) and being raised in a conservative environment influenced their interaction and communication styles and behaviors in the academic setting. FG discussion revealed that one of the most evident sources through which the HPEs developed their cultural knowledge was learning from the experience and cultural encounters approach. Teaching experience in a multicultural environment was correlated with the adequacy of cultural knowledge among nursing faculty in California [32].

Although the quantitative phase of the current study showed that HPEs demonstrated culturally sensitive teaching skills and were able to facilitate the academic achievement of students from different backgrounds, values, and beliefs, the qualitative phase disclosed incidences of unintentional disrespect that occurred when a lack of knowledge of specific cultural norms exists. Popovich et al., (2018) also argued that pharmacy educators at the University of Illinois might unintentionally demonstrate micro-aggressive and discriminatory behaviors towards culturally diverse students, which the students might perceive as an insult [33]. It is worth noting that the discriminatory and aggressive behaviors of educators toward students of specific cultures necessitate the development of interventions to eliminate conscious and unconscious biases by educational institutions [34].

Implementing culturally responsive teaching and communication strategies that promote diversity and ensure positive relationships and equity among students was illustrated among the HPEs, which comply with the QU standards. This aligns with Burn's (2020) study which argued that around 50% of the nursing faculty in California include cultural competence topics in their course content [32]. Burns (2020) suggested that a faculty's ignorance of the inclusion of cultural competence content could be the result of their lack of knowledge of the significance of actively teaching students about cultural values, beliefs, and practices [32]. Furthermore, high agreement with items 6 and 9 in this study, and HPEs'

FG discourse about making changes within the general classroom environment to adapt students to diverse cultures and promoting diversity through the behaviors they exhibit provided evidence for HPEs' cultural skills. Davis (2003) suggested that promoting diversity, inclusiveness, and equity is very important because it influences student–educator relationships and ultimately students' motivation [35].

The results of this study shed light on the importance of developing evidence-based cultural competence educational curricula for health profession educational programs, to better prepare health professional students for real-world practice. While FG discussions revealed that the majority of the educators in this study agreed on the availability of cultural competence-related content in health professional curricula and demonstrated an understanding of the significance of teaching this content, item 4 in the MTCS illustrated that the majority of them do not plan for activities that increase the cultural knowledge and experience of cultural groups. In that regard, Shaya and Gbarayor (2006) proposed that cultural competence content should reflect the realities of evidence-based health inequalities and should focus on delivering culturally responsive healthcare services to meet the health needs of different patient groups [36].

FG discussions of the current study showed that HPEs in health colleges demonstrated different points of view concerning the cultural sensitivity of mixed-gender education, taking into consideration that mixed-gender education does not exist in other undergraduate programs at QU or in most governmental educational institutions in Qatar [37]. With the existence of supporting evidence for gender-segregated education in the non-health professions education context [38,39], further investigation of the effectiveness of mixed-gender education in health professional programs compared to gender-segregated education, is recommended. Interestingly, Weber et al., (2011) suggested that a significant number of patients who attended Hamad General Hospital in Qatar preferred to be treated by physicians of their own gender [40]. Hence, an investigation of the local societal impact of mixed-gender education in CMED at QU, as well as the CMED students' perception of mixed-gender education, before expanding the mixed-gender education to other colleges is recommended.

FG discussions also indicated that although HPEs were mindful of the language difference aspect in teaching and general communication with students and with each other, they stressed that health profession education programs in Qatar may not prepare students for providing language-appropriate care for Arabic and non-English speaking patients. Despite the availability of language interpretation services in governmental hospitals, several studies propose a curricular restructure to introduce students to health terminology for the dominant languages in the country [13,41]. Providing language-appropriate care resulted in improving patient satisfaction in Qatar [40], and in reducing medication errors in the USA [42].

Strengths and Limitations

The utilization of a mixed-method approach resulted in rich and detailed results about the cultural competence of HPEs at QU. The participants were culturally diverse, which facilitated the emergence of stronger views on the topic of cultural competence and diversity. Nevertheless, the findings of this study should be interpreted with caution because of the relatively small sample of participants and the lack of validity and reliability assessments of the adapted questionnaire. Yet, the results of the quantitative phase were supported and integrated with results from the qualitative phase, which enhanced the credibility of the findings. In addition, this study is the first to utilize the MTCS in the health profession education context, which necessitated a discussion and comparison of the study findings with studies conducted in non-health-related contexts or to studies that utilized other cultural competence tools. However, no significant differences in results and conclusions were demonstrated through the discussion and comparison.

5. Conclusions

The qualitative and quantitative data of this study showed that HPEs in QU demonstrate cognizance and comfort with cultural diversity and the adoption of culturally responsive teaching. However, some personal and organizational factors warrant further improvement. As this is the first study to investigate multicultural teaching competence among HPEs at a uniquely diverse population at QU-HC, it adds valuable insights to the current literature on how cultural diversity in the educational environment influences teaching and learning in health profession programs, particularly in the Middle East context, and calls for considering new innovations that reflect the opportunities in cultural diversity and sustainability. This study also provides a basis for future research on educators' strategies for the use of cultural moments to develop students' cultural competence.

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Appendix A A Topic Guide for Health Professional Educators' Focus Groups

Q1: What do you think about cultural diversity among faculty members and students in your college?

- Degree of diversity
- Diversity and learning styles
- Challenges vs. opportunities

Q2: From your experience, how well do faculty members in your college demonstrate cultural competence?

Q3: How do you perceive the cultural awareness of faculty members?

- Recognition of own and others' values and beliefs
- Biases and prejudices about others' culture
- How do you learn about others

Q4: Could you please describe a situation in which you have encountered any cultural diversity unawareness from a faculty member or a student in the learning environment?

Q5: Could you please describe your perception of the strategy you adopt to dealing with cultural diversity in general and in learning environment?

- Teaching skills in a multicultural setting

- Equity, students' inclusiveness, individual differences

Q6: What aspects of the academic program in your college promote addressing cultural competence?

Q7: In your opinion, what is needed from your college to help you improving your cultural competence?

Q8: Do you have additional comments or questions or suggestions about cultural diversity or awareness? Dealing with students or faculty of diverse cultures?

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