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Research Article

# “Talking and thinking”: Impact of a simulation on pharmacy undergraduates' beliefs and attitudes about living in poverty<sup>☆</sup>

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## Abstract

**Aims:** To evaluate the effect of participation in a simulation exercise, on Bachelor of Pharmacy (B.Pharm.) undergraduates' attitudes and beliefs toward those living in poverty. To explore the acceptability of the simulation to students and their perception of how it related to their future practice.

**Method:** Second-year B.Pharm. undergraduates participated in the Community Action Poverty Simulation (CAPS), designed to allow participants to experience aspects of what it is like to live in poverty. Students completed the Short Form of the Attitude Toward Poverty Scale (ATP-SF) anonymously one week prior- and post-participation to examine the effect of the simulation. A paired comparison of the ATP-SF score and its subscales was undertaken. Free-text questions examined students' opinions of the simulation, what they learned from participating and how it could be improved.

**Results:** In total, 76 pairs of complete questionnaires were analyzed. A trend toward improvement in attitudes toward those living in poverty was seen (change in ATP-SF total score,  $P = 0.07$ ). This appeared to be associated with changes in the structural perspective subscale (implying more attribution of poverty to societal structures) post-simulation ( $P < 0.01$ ). No statistically significant changes were seen on the other two subscales (“personal deficiencies” and “stigma”). Thematic analysis of free-text responses indicated that participating in the simulation challenged the veracity of some negative attitudes and beliefs about poverty, and increased understanding and empathy.

**Conclusion:** Participation in the simulation had some positive effects on student attitudes, empathy, and beliefs related to those of low socioeconomic status.

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**Keywords:** New Zealand; Education; Pharmacy; Evaluation studies as a topic; Community action poverty simulation; Attitude toward poverty scale

## Introduction

Socioeconomic status has consistently been shown, over time and between countries, to be an important determinant of health. Those of lower socioeconomic status within countries are more likely to have poorer health and a lower life expectancy than those of higher status.<sup>1–6</sup> The Decades of Disparity reports provide evidence of a relationship between inequalities in mortality and socioeconomic position for the New Zealand population.<sup>7–9</sup> These findings are congruent with the last three New Zealand Health Surveys

<sup>☆</sup>The Community Action Poverty Simulation (CAPS) was purchased by the School of Pharmacy, Faculty of Medical Health Sciences, University of Auckland from the Missouri Association for Community Action.

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(NZHS), which found differences between those living in areas of high and low socioeconomic deprivation, in terms of health behaviors and risk factors for poor health. Adults living in the most deprived quintile rated their health poorer and were more likely to self-report anxiety or depression than those living in the least deprived quintile.<sup>10–12</sup> This association between poor health and poverty was well illustrated in a recent phenomenological study describing the life of families living in poverty in Auckland, New Zealand.<sup>13</sup>

Patient satisfaction with, and adherence to, treatment have both been associated with the quality of patient–provider communication.<sup>14,15</sup> It has been demonstrated that health care provider acceptance of stereotypical views distorts the interpretation of information about individuals and thereby contributes to health disparities via attitudinal biases toward different groups.<sup>16</sup> Perceived discrimination has been shown to have a negative effect on both the physical and mental health of individuals, producing significantly heightened stress responses and to be related to participation in unhealthy, and non-participation in healthy behaviors.<sup>17,18</sup> Furthermore negative biases and attitudes of health care professionals have been shown to have a negative influence on interactions with patients, including unwarranted variation in the management of medical conditions.<sup>16,19</sup>

The recognition that health practitioners' attitudes and beliefs about patients, in this case those living with socioeconomic disadvantage, may influence both the delivery and outcomes of health care services argues for a recognition of and efforts being made to address these non-technical elements of professional practice. Cultural competence in health care has been proposed as a way of contributing to reducing health disparities and has been defined in many ways.<sup>20–24</sup> Kumagai and Lypson suggest that cultural competence requires a critical consciousness of oneself as an individual, other people and the world in general.<sup>25</sup> This involves acquisition of knowledge of societal problems and a willingness to address disparities via action. Indeed Reutter et al. suggest that health professionals have a duty to advocate for more equitable health and social policies.<sup>26</sup>

In addition to becoming aware of the root causes of inequities, including the distribution of power in health care, it is often proposed that a foundational stage of becoming culturally competent involves an evaluation of one's own biases and attitudes toward different cultural groups.<sup>27</sup> Attitudes and beliefs are considered important determinants of behavior.<sup>28</sup> Individuals tend to be positively biased toward the social groups to which they belong.<sup>29–31</sup> It has been suggested that some health professionals may misinterpret information given to them by patients, especially when there are communication barriers and stereotypical views are held by health professionals.<sup>32</sup> This effect may occur where there are differences between the sociodemographic statuses of patients and their doctors.<sup>32</sup>

Pharmacists play an important role in the provision of health care and advice to patients within the community.

Pharmacists in New Zealand work predominantly as part of the publicly funded health and disability system, providing access to over the counter (OTC), and prescribed medicines and other related health care advice. Unlike primary care physicians, no payment is required to visit a pharmacy, no appointment is required to access care, and many pharmacies are open for extended hours, making them better able to help those of low socioeconomic status who may have extended or unsociable working hours or other barriers to access. However, one study found that language, socioeconomic status, and culture were the main patient-related barriers to optimal patient–pharmacist communication.<sup>33</sup> In order to optimize medicines related outcomes, pharmacists must have a good understanding of the challenges faced by those with low socioeconomic status, be aware of appropriate health services, providers and strategies to provide assistance to overcome those barriers that may affect health outcomes, and apply this in a patient-centered model of care.<sup>33,34</sup>

The Pharmacy Council of New Zealand (PCNZ) is the regulatory authority for pharmacist licensure in New Zealand and includes cultural competence in its competence standards for the profession. PCNZ defines cultural competence as: “The ability to interact respectfully and effectively with persons from a background that is different to one's own.”<sup>35</sup> Of note, the Council goes on to recognize socioeconomic status explicitly in its expanded statement on what defines culture in this context, stating that: “Culture includes, but is not restricted to age, gender, sexual orientation, race, socioeconomic status (including occupation), religion, physical, mental or other impairments, ethnicity, and organizational culture.”<sup>35</sup>

The primary registerable qualification for pharmacists in New Zealand is the four-year Bachelor of Pharmacy (B.Pharm.). Schools of Pharmacy have an obligation to ensure that graduating students are appropriately primed about cultural competence, understand the scope of the term and its importance, and possess sufficient knowledge, skills, and appropriate attitudes to enable effective consolidation of this learning once in practice during their internship training year and beyond.

University enrollment data show that many of our B.Pharm. students have attended schools where there are few children from the lowest socioeconomic areas of New Zealand enrolled (unpublished data). Therefore, we noted that there may be value in introducing a learning activity that raises awareness, understanding, and empathy in students who may have no experience of living with low socioeconomic status. Such an activity should contribute to the development of cultural sensitivity and competence, at least with regard to poverty and health. The intervention chosen was a simulation exercise, the Community Action Poverty Simulation (CAPS). The simulation uses the affective and cognitive domains to sensitize students to the realities of life faced by those living on low incomes.<sup>36</sup> To date, the CAPS simulation has been used predominantly

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