

## Experiential learning outside the comfort zone: Taking medical students to downtown Durban

N Prose,<sup>1</sup> MD; P Diab,<sup>2</sup> MB ChB, MFamMed; M Matthews,<sup>3</sup> MB ChB, DOH

<sup>1</sup> Department of Pediatrics and Dermatology, Duke University Medical Center, Durham, North Carolina, USA

<sup>2</sup> Department of Rural Health, School of Nursing & Public Health, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa

<sup>3</sup> School of Clinical Medicine, Nelson R Mandela School of Medicine, University of KwaZulu-Natal, Durban, South Africa

Corresponding author: P Diab (diabp@ukzn.ac.za)

**Introduction.** The ability to communicate across cultures requires a combination of knowledge, skills and attitude. Our current medical school curriculum includes innovative methods of teaching communicative knowledge and skills. Our aim is to encourage students to examine their attitudes toward patients from social groups and cultures other than their own and, ultimately, to interact with empathy in a multicultural society.

**Method.** An experiential learning technique where students were given various tasks intended to improve their attitude towards cross-cultural learning.

**Results.** A number of students expressed appreciation at being in a multicultural group, having a shared experience, and engaging in open and respectful discussion about similarities and differences.

**Conclusion.** Students need to be involved in activities that encourage them to examine their attitudes and develop respect for patients from cultures other than their own. We suggest ways in which learning experiences of this type can be integrated within the medical undergraduate programme.

AJHPE 2013;5(2):98-99. DOI:10.7196/AJHPE.256

The Nelson R Mandela School of Medicine in Durban was among the first South African tertiary institutions to educate black, Indian, and coloured students under apartheid. The student body remains culturally and racially diverse, and each student is called upon, almost daily, to provide care for patients from cultural and racial groups other than their own.

For this reason, teaching medical students to communicate effectively and empathically across cultures is one of the most important educational tasks. The literature on teaching cross-cultural communication suggests that educators must focus on three critical aspects: knowledge, skills and attitude.<sup>[1]</sup> The authors hypothesise that education about attitude (learning to recognise one's own subtle biases and to appreciate and respect members of other cultures) has been particularly difficult to integrate into the medical school curriculum. In this article, we report on an innovative educational intervention that we hope can serve as a model for highlighting the need for empathy and teaching medical students to be more curious about, and respectful of, patients from cultural backgrounds other than their own.

### Teaching and learning

Historically, the ability to communicate across cultures has been attributed to a combination of knowledge, skills and attitude.<sup>[1]</sup> Knowledge is critical for our students, as we know that basic information about the healthcare beliefs of patients in KwaZulu-Natal is fundamental. A good doctor understands something about the role of the traditional healer, and has some knowledge of the alternative and complementary therapies commonly in use. 'Good doctors' are also able to apply curiosity and enquire about practices with which they are not familiar. 'Checklists' of key issues relating to practices of certain cultural groups have been suggested, but tend to reinforce racial and ethnic stereotypes rather than promote cultural competency. The role of effective communication skills in increasing empathy is well documented,<sup>[3]</sup> and our medical school curriculum uses

small group learning with simulated patients to establish the essentials of doctor-patient communication. In addition, language skills play a large role in a region where approximately 80% of patients communicate primarily in *isiZulu*. Although many students may currently learn *isiZulu*, it is not to a standard where they can comfortably converse with patients. The literature on teaching attitude has focused on the process of developing curiosity, respect, humility and self-awareness.<sup>[2]</sup> In her landmark essay, Faith Fitzgerald commented on the importance of curiosity among health professionals:<sup>[4]</sup>

'What does curiosity have to do with the humanistic practice of medicine?' ... I believe that it is curiosity that converts strangers (the objects of analysis) into people we can empathize with. To participate in the feelings and ideas of one's patients — to empathize — one must be curious enough to know the patients: their characters, cultures, spiritual and physical responses, hopes, past, and social surrounds.'

In some medical schools, students are asked to write narratives or reflective portfolios about their clinical experiences and use these writings, along with small group discussions, to challenge their own stereotypes and beliefs about their patients and their families.<sup>[5]</sup>

Other programmes have been created in which students experience medical care from a patient's perspective; or immersion experiences, where students live in a community for a period as part of their training and are thereby exposed to the culture and language of their patients. Currently, teaching at medical school focuses mostly on knowledge and skills acquisition, with less emphasis on developing students' attitudes; although, within the new curriculum, issues such as doctors' social accountability and cultural competency are being addressed. The present report offers an example of how awareness of attitude may be incorporated as an important part of practice in the future.

## Methodology

Traditional learning focuses on rote or didactic teaching where there is a distinct teacher (the expert) and learners, whereas experiential learning focuses on the learner's experience and the subsequent reflection on that experience, which promotes deeper learning by students. We decided to intervene in a way that challenged students' acquired beliefs and value systems. With the help of colleagues who run a professional company that teaches cultural competency and self-awareness to executives, we arranged a tour of Durban's Warwick Triangle for a group of medical students. This area, a hub of economic and cultural diversity and situated a mere 10-minute drive from the 'ivory tower' of the university, provided the multicultural learning experience that was needed.<sup>[6]</sup>

The group included a diverse range of students from second- to final-year who volunteered for this experiential learning opportunity. Outside the *muthi* [*isiZulu* term for traditional remedy] market, each student and faculty member was given R10 (US\$1.40), asked to purchase a specific herbal remedy, and to find out its use. Each participant was additionally asked to seek advice about a specific health complaint, and to obtain some basic personal information about the vendor. On our return, we huddled in the parking garage, displayed our medications, and discussed them. We also discussed the feelings that were generated in each of us by this experience. 'I realised we tend to be a bit insular,' noted one student, 'Being at the *muthi* market helped us to know ourselves as doctors and humans.'

We ended the day with a tour of the Juma Masjid mosque, the largest in the southern hemisphere. We talked about the significance of Ramadaan, and the two Muslim students in our group took the lead in explaining their beliefs and rituals. In discussion afterwards, both Hindu and Christian students commented on the previously unimagined similarities of Islam to their own belief systems. Unfortunately, time constraints prevented a visit to the Durban Hindu Temple and Emmanuel Cathedral, all located in the same area.



Photo by Lunga Memela.

## Results and reflection

Several days later, the students and faculty who participated in the tour reconvened at the medical school and reflected on the tour experience. A number of students expressed appreciation at being in a multicultural group, having a shared experience, and engaging in an open and respectful discussion about similarities and differences. To the astonishment of some, a number of black students felt as surprised and 'out of place' in the *muthi* market as did their white and Indian counterparts.

The overall impact on the students appeared to be very powerful. One student summarised her experience by saying:

'We're going to be serving society. We haven't really understood who we are serving. What is our country about? Who are we amongst? How can we help?'

Another student reflected:

'We are so used to being in a cocoon in medical school. When we step into someone else's world, it opens a different channel.'

Surely we were seeing glimpses of a 'curiosity that converts strangers into people we can empathise with.'

## Conclusion

The current curriculum focuses mainly on teaching students communication skills and knowledge of the *isiZulu* language. More emphasis is required on developing attitudes of curiosity and respect by engaging in meaningful discussion with diverse people. By forming connections across cultures based on mutual respect, students can be made aware that people of other cultural groups have something important to teach them, if they only take the time to learn. An experience that takes students out of their 'comfort zone' seems to be particularly useful. Ingrained beliefs and values are challenged, and students are encouraged to look at their own belief systems, and reflect on the ways in which their beliefs may influence them as doctors. We hope that experiences that foster cultural competency by engendering curiosity and respect can be integrated into the medical curriculum in a number of ways. Our ability to create true transformation in medicine depends on creating opportunities such as these. As one student reflected, 'There are so many things that unite us.'

**Acknowledgements.** The authors express their gratitude to administrative staff from UKZN Medical School for facilitating this experience through the consent of the Dean of the Medical School. They also wish to thank Soweto Style Experience for providing the facilitators and funding for the tour. Dr Neil Prose's visit to South Africa was sponsored by a Fulbright Specialist Grant.

## References

1. Betancourt JR. Cross-cultural medical education: Conceptual approaches and frameworks for evaluation. *Acad Med* 2003;78(6):56-569.
2. Jenks AC. From 'Lists of Traits' to 'Open-Mindedness': Emerging issues in cultural competence education. *Cult Med Psychiatry* 2011;35(2):209-235.
3. Winefield HR, Chur-Hansen A. Evaluating the outcome of communication skill training for entry-level medical students: Does knowledge of empathy increase? *Med Educ* 2000;34(2):90-94.
4. Fitzgerald F. Curiosity. *Ann Intern Med* 1999;130(1):70-72.
5. DasGupta S, Charon R. Personal illness narratives: Using reflective writing to increase empathy. *Acad Med* 2004;79(4):351-356.
6. Dobson R, Skinner C, Nicholson J. Working in Warwick: Including Street Traders in Urban Plans. Durban, South Africa: School of Development Studies, University of KwaZulu-Natal, 2009:136.