Research

An exploration into the awareness and perceptions of medical students of the psychosociocultural factors which influence the consultation: Implications for teaching and learning of health professionals

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Background. South African society is undergoing rapid changes, and includes people from different cultures, beliefs and social backgrounds. Research suggests that these contextual influences have an important bearing on how patients present and relate to healthcare providers. Medical students, too, have a life-world based on their own backgrounds and cultures, and may find relating to a patient with a different life-world challenging.
Objectives. To explore students' awareness and perceptions of how psychosociocultural factors in a multicultural society influence the consultation, and to suggest adaptations for teaching.
Methods. Focus group discussions were conducted with final-year medical students in the Family Medicine rotation. Some of the students had viewed a video of a consultation with an isiZulu-speaking patient, and completed a self-reflection learning task. Audio recordings were transcribed and analysed thematically.
Results. Exposure to patients in the clinical years had made students aware of the challenges of cultural diversity, although they felt under-prepared to deal with this. Students alluded to the influences of their own cultures, of cultural similarities as well as differences, the roles and behaviours of doctors and patients in cross-cultural consultations, the potential knowledge and experience gap that exists across cultures, and an awareness of the need for patient-centredness.
Conclusion. Students should be assisted to improve their cultural competence. Recommendations are made for using various methods, including critical incidents and visual learning to provide opportunities for reflexive practice and transformative learning. Educators must be equipped to address learning objectives relating to cultural competence.

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South Africa (SA), like many countries in the modern world, is a rapidly changing society that represents individuals from a multitude of different cultures, beliefs and social backgrounds. Research suggests that these contextual influences have a profound effect on how patients present to healthcare providers.[1] Such a healthcare environment is complex for young health professions students, who have a life-world based on their own backgrounds and cultures, and may find relating to a patient with a different life-world challenging. (The concept of a life-world derives from the German term *lebenswelt* and refers to the individual and social influences on an individual's life that result in the subjective manner in which the world is viewed through each individual's eyes.)

As educators, we stress the concept of transformative learning and teach students that they should have a patient-centred approach to the consultation, in which they take into account the patient's ideas, beliefs, concerns and expectations,[2] but provide little context for students to enable them to negotiate problems of this nature. As such, they may find unfamiliar situations personally challenging or difficult to manage in the clinical environment, in which the context is determined largely by the community or patient's cultural views and behaviours that determine language, thoughts, communication, actions, customs, beliefs and values. The ability to operate effectively within this environment is referred to as cultural competence and is defined by the USA's Centers for Disease Control and Prevention (CDC) as 'a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations'. SA's situation is somewhat unique, as most international literature on cultural competence originates from countries in which there are ethnic minority groups from different cultures. A recent study at this medical school showed that at least a third of undergraduates come from cultural and ethnic groups[3] that differ from the dominant groups in the communities they serve.

Many different methods have been suggested for sensitising students to cultural differences. The checklist method of stereotyping cultures and providing a list of characteristics that should be expected has been shown not to be very useful, especially in dynamic societies.[4] Another method of making students culturally aware is that of immersion into a host culture.[5,6] This may be effective, for example, for an emigrant learning a foreign language, but has tremendous logistical and safety implications when incorporated into an undergraduate curriculum, particularly with the large numbers necessary to increase throughput of medical students.[7] Cultural tourism has been criticised for the way in which it places societies 'on show', with observers viewing the culture from an outsider's point of view. It has, however, been shown to be extremely useful in raising awareness of cultural issues.[8]

Theory

Transformative learning theory, an adult learning theory, was used as a theoretical framework for the study. The original work in this field involved Mezirow's[9] notion of a 'disorientating dilemma' or life crisis, which resulted

in perspective transformation. The theory involves learners transforming their perspectives by making meaning of their experiences through critically analysing underlying premises and previously held beliefs. It is useful in cross-cultural contexts as, in this manner, individuals learn to change their frames of reference as they critically reflect on their assumptions and beliefs and consciously make plans that bring about new ways of defining and negotiating their worlds.[10]

Objectives

The main objective of this article was to explore medical students' awareness and perceptions of how behavioural, social and cultural factors in SA's multicultural society influence the consultation and consequently their practice as future medical practitioners. The article highlights some of the frequently encountered complex cross-cultural situations that SA doctors face and, finally, recommends how teaching and learning can be adapted to address this in the current curriculum.

Specific objectives are: (*i*) to identify and describe emergent themes and attempt to understand their implications for the teaching and learning of health professions students; and (*ii*) to make recommendations for future practice that will promote transformative learning and perspective change.

Methods
Study setting
The study comprised health professions educational research using a qualitative approach. It was conducted at the hospital sites where students were doing their rotations, teaching platforms that serve the Nelson R Mandela School of Medicine of the University of KwaZulu-Natal, Durban, SA.

Participants, sampling and data collection methods
A group of 40 final-year medical students in their Family Medicine rotation was identified in July 2013. As part of this module, students lived and worked in groups of four at rural district hospitals where they were immersed in a host culture that was sometimes unfamiliar. Prior to their departure, students received a lecture and tutorials on communication skills. This lecture was enhanced to include elements of cross-cultural learning (Group 1). A subset of this group was then shown a video that highlighted a clinical scenario in which a culturally sensitive

topic was introduced (Group 2). A further subset was shown the video and given a self-reflection questionnaire to complete (Group 3).

Having had these teaching and learning opportunities, three groups of students were interviewed in focus group discussions (FGDs) towards the end of their module. These were mixed groups in terms of first language, ethnicity and religion, and there were no exclusion criteria. A broad interview schedule was used to gather information on the students' experience of culture in the consultation and of cross-cultural teaching and learning. The FGDs were conducted at a pre-arranged time at the hospital sites. They were led by a research assistant from the School of Nursing and Public Health, and attended by the researchers.

Data analysis
Audio recordings of the FGDs were transcribed and analysed using inductive coding and thematic analysis.[11] The students' responses to the self-reflection questionnaire were also included in the thematic analysis. For trustworthiness, the researchers analysed the transcripts separately, discussing and comparing emergent themes, and selected representative quotations and incidents referred to by the students. Comments were referenced as being extracted from one of the three FGDs, with no specific reference to individual students due to ethical constraints.

Ethics and consent
Ethics clearance for the study was granted by the University Humanities and Social Sciences Research Ethics Committee (HSS/0312/013). Necessary permissions were obtained from gate-keepers, and students gave individual consent. In the interviews, students were assured of anonymity and were not identified by name. They were informed that all contributions were voluntary, that the interviewers would not participate in assessment, and that there would be no negative consequences from participation in the focus groups.

Results
While students had been sensitised to cross-cultural issues by the teaching exposures, across the three groups of students there were no differences in responses from those who had been exposed to the video or self-reflection questionnaire. In addition, the students' rural experience had presented opportunities for learning experiences.

Table 1 summarises the various themes and subthemes as the findings of this study.

Table 1. Results of study: summary of themes and subthemes

Themes	Subthemes
Interactions and relationships	With self
	With other students
	With doctors
	With patients
Awareness of cultural diversity	Similarities
	Differences
Gaps	Knowledge
	Experience

Interactions and relationships
Certain students indicated an awareness of their own cultural influences that had the potential to influence their clinical interactions. Some spoke on matters of relevance in their own religions and cultures, and shared with the group the influence that these may have on their practice of medicine:

'You have to understand religious views also, you cannot have guys and girls together. Like for us we are not allowed to go out with boys.' (comment by a Muslim student, FGD3)

'... not someone who is pulling towards the East and you are pulling West.' (FGD1)

Some participants had noted or discussed behaviours in health professionals that they considered inappropriate:

'They were complaining about the doctors at [...] Hospital. They were telling me that they hope that I do not become a doctor like that and like, we cannot even greet!' (FGD2)

'In the rural areas your stethoscope is way too powerful!' (FGD3)

'Your patients will take for granted that you look the part, I mean you are black.' (FGD1)

Students had been exposed to the concept of patient-centredness, and this was an important theme, with many referring to the importance of incorporating the patient's perspective:

'... all that stuff to show that you actually care about the patient as a whole and that actually shows the patient that you do not take them as a disease but as a person.' (FGD 1)

'... that patient centredness, for each patient it will not work out the same, you have to work out something that is right.' (FGD3)

Awareness of cultural diversity

Certain students mentioned the need for cultural sensitivity in multicultural environments, and went on to note that there were, in fact, some previously unrecognised similarities among cultures:

'So if you are going to be judgemental and putting your religion and culture there on the table, it will not work because we are all different.' (FGD3)

'There are actually a lot more similarities than differences.'(FGD1)

Gaps

Some students described incidents in which behaviours demonstrated insufficient knowledge of cultural practices:

'... I know my granny would be like, I saw this white girl and she said this ... and there is also that thing that probably she does not understand me. She does not know what 'ukugcabha' [the use of scarification to treat symptoms] is, so I cannot explain what that is so let's just leave it there. She says I should take these pills. I will just take them home and that is it and I will continue what needs to be done.' (FGD2)

'The patient kept saying to the consultant, he was calling her "mama," not in a bad way, because he is respecting her. And then the consultant got offended and said "No, I am not your mom, I am your doctor!" For me, that was like OK, but the patient is trying to be respectful, not that he is saying you are old or something ... that is how we are taught, especially in blacks ... .' (FGD1)

'... we are not sensitised to each other's cultures at all.' (FGD1)

Specific anecdotes

Various participants recounted incidents that they found significant, provoking rich discussions in the groups. Some examples are included for illustrative purposes.

Interesting discussions around aspects of African culture included content about *isintu* (traditional rituals); cultural beliefs such as *thwasa* (calling to be a *sangoma* or traditional healer); and the use of various types of *muthi* (traditional medicines), including herbal enemas and a therapeutic intervention called *isithlambezo* (traditional medicine used to induce labour). Others referred to the abovementioned *ukugcaba* and the importance of *iziphandla* (a wrist bracelet of animal skin mainly used in rural communities).[12] Some students spoke of how their lack of awareness of or misperceptions about some or all of these practices made their understanding of the patient's perspective more difficult (various FGDs).

Discussions also arose about other cultures, with the following brief narrative about Muslim culture included for illustrative purposes. This anecdote is an example of how easily cross-cultural misunderstandings may arise:

'... during an interview seeing this Muslim patient, there was this young lady ... you could only see her eyes and there was a black registrar and she was not looking at him. Eventually he asked, "What is wrong? Why are you not looking at me? Is there something wrong with your eyes maybe?" and she said, "No, this is how we are taught to; we do not look at the men in the eyes when we are speaking to them".' (FGD 1)

Discussion

This objective of this article is to explore the awareness and perceptions of medical students of the psychosociocultural factors that influence the consultation. It describes emergent themes and mentions incidents in multicultural environments that were significant to students.

In analysing the comments, it was noted that the responses reflected different individual levels of self-awareness and ability to cope with challenges. Some students had considered the influence of their own cultures on their behaviours and interactions with colleagues, other health professionals and patients, and perceived to varying degrees that these differences had an important influence on successful communication. The study showed that many students experienced difficulty when dealing with cross-cultural contexts, and several students recognised knowledge gaps that exacerbated the problem.

The impact of introspection was demonstrated by some students who showed greater self-awareness than others and had considered the influence of their personal, cultural and religious views. Some participants realised that other people they encountered, either as colleagues or patients, also had similar innate factors or personal views that affected the consultation. Some had noted negative role-modelling and lack of cultural sensitivity in more senior health professionals they had encountered in clinical rotations.

Exposure to patients from various cultures, particularly in the rural setting, had raised awareness of the challenges of cultural diversity, with several participants expressing the opinion that they felt under-prepared to deal with this. Some made reference to insufficient exposure to information about the cultures of others, and expressed a need to engage with issues related to patients' life-worlds and cultures to improve their own knowledge. Several students narrated incidents that they considered important, and spoke of the difficulties they anticipated for their future practice as healthcare practitioners.

Implications for teaching and learning

To improve teaching and learning, it is imperative that students in the health professions are equipped to deal with cultural diversity in a culturally competent manner. Students need to gain an understanding of one another's life-worlds. They need to develop appropriate attitudes and have the knowledge and skills to deal with challenges in multicultural professional environments.

The roles and responsibilities of the educator in health professions education in fostering transformative learning thus cannot be overemphasised, as learners should be assisted to become aware and critical of long-held assumptions. Perspective change can be achieved through an accumulation of transformations over a period of time, assisting students to redefine problems and improve their ability to respond to their patients' cultural influences on health.[10] As mentioned above, many methods of teaching cultural competence have been used with varying degrees of success in other contexts.

To understand another culture, one has to be self-aware and have a good appreciation of the influence of one's own culture relative to that of others in practice – a realisation that may only occur after a certain degree of self-reflection and self-examination.[13] By reflecting upon past experiences and narrating experiences to others, rather than adopting a stereotypical approach, learners may begin to understand the complex factors that influence how a patient behaves when confronted with illness.[14] Experiences such as those described by the students in the form of 'difficult' consultations or challenging experiences occur throughout a professional career, including in the undergraduate phase, and may be used as critical incidents to promote self-awareness and awareness of the influence of psychosociocultural factors that affect their patients.

Students in the FGDs were enthusiastic about sharing challenging experiences. We noted that the opportunities for sharing of the students' narratives and discussions in the focus groups proved to be a fertile ground for new conversations between students themselves and the researchers about the challenges encountered in multicultural populations. Because of this, it is the opinion of the authors that these learning spaces in the rural attachment should be supported to provide students with opportunities for deep reflective practice and transformative learning. We propose that gaps in knowledge and experience could be filled by maximising opportunities in existing structured teaching times in communication teaching and clinical rotations within the context of routine, everyday intercultural encounters, to reflect on their cultural significance and implications in context. They could also be addressed in a structured manner in cultural seminars or when teaching a language. Opportunities exist for students to use engagement in deep reflection by journaling their experiences: how this has changed their insights and perspective, and what they have learnt. This would assist in creating the 'change agents' who are socially responsive and relevant to the populations they serve as healthcare professionals.[15]

The authors have previously suggested the use of critical incident reflection and of video technology in the teaching and learning of communication to medical students.[14,16] As competition for teaching time already exists in the medical curriculum, it is suggested that further innovative methods be used to make this cultural learning generally available. Thus, the university's Visual Learning Project, a repository of videos, could be used as a teaching platform for recorded scenarios illustrating appropriately selected cross-cultural consultations (with inputs from subject experts) to be critical incidents for discussion. These would allow students to improve their knowledge and reflect on challenges, while raising cultural awareness and contributing to cultural competence. Additional functionality of the video software allows learners to conduct online discussions, and educators to provide feedback on the content as necessary. While students have long been taught the importance of a 'patient-centred' approach (which the study shows to have been assimilated), it is suggested that educators raise awareness of the person in an individual context, thus highlighting the concept of 'person-centredness', to assist in developing an empathic approach.[17] This locates the person in a somewhat more complex psychosociocultural context as opposed to a pure illness context, and may help to develop culturally competent healthcare practitioners who are sensitive to their patients' perspectives in a deeper fashion, and therefore more equipped to respond appropriately.

As specific recommendations to promote cultural competence in students, the authors suggest the following:

- Specifying the understanding of psychosociocultural influences in the consultation in learning objectives from early in the curriculum to raise awareness.
- Developing self-awareness in students by encouraging them to analyse how their own life-worlds affect their views.
- Filling knowledge and experience gaps about culturally sensitive problems.
- Specifying topics and critical teaching points for educators, with the implications for practice being the value of student involvement in material selection and the use of a task-based approach.

- Providing positive role-modelling and increasing the diversity in teaching staff to make it representative of the demographics of the province.
- Including cultural competence as a learning outcome and assessing it specifically as a competence in clinical assessments.

Study limitations

The study was conducted using only three FDGs and self-reflection questionnaires. Only final-year students were asked to participate, as the study was done after they had been exposed to the rural attachment of the final year. While this is the case, the results showed strong emergent themes that are generative in nature, and support the necessity for a response in terms of the introduction of innovative methods for the teaching and learning of cultural competence.

This study highlighted the importance of developing reflexivity and cultural awareness at undergraduate level. However, the maintenance of this awareness after qualification is beyond the scope of the study. This study also does also not highlight the behavioural change that may/may not result from experience and/or exposure.

Novelty and significance of the work

Although a great deal of research is being done internationally in cultural competence, there is a lack of literature on cultural competence in medical students in the SA context. This article provides new and important insights into local healthcare contexts and can assist in making recommendations for teaching and learning, as well as contributing to the body of knowledge internationally on facilitating multicultural competence.

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