Education in Medicine for a Multicultural, Multilingual Post-apartheid South Africa

Introduction

In South Africa public health policy has changed drastically since 1994. Now the emphasis is on primary health care for those who were previously so ill-served by the state. They are mainly, but not entirely, the rural poor. Tertiary care in academic hospitals continues, but with far less state funding than before 1994. Doctors are needed for the new primary health care medical services. Their training requires them to know much about their patients in the public service, whose cultural background usually differs from the doctors'. Also medical students are being recruited who are now more representative of the population as a whole. But in contrast to these patients and students, the teachers in medical faculties in general continue to be mainly white. Thus both the interactions between these three groups (students, their teachers and patients) and a desire to optimise the ultimate product (an equitable health service) all present problems which are extremely challenging and often unique to South Africa. Some of these problems reflect situations present in other countries, for example when education is conducted in a language other than a student's home language and when cultural beliefs and practice of a patient and student or doctor differ.

Of the current 94 medical faculties in Africa today, just 31 existed before 1970, so the increasing necessity for medical education was recognised only in the last few decades. Although there were universities in Africa in the middle ages, current university models in this continent are mainly based on those of the UK and France (van Niekerk: 1997a). But because of the diversity of backgrounds between medical students and the patients, whom they must meet and serve, new directions in medical education are evolving.

South Africa's legacy of apartheid still has a great influence on all aspects of its education system. H. F. Verwoerd, a principal architect of apartheid, described it in his statement of 1954 saying, "[t]here is no place for the Bantu in the European community above certain sorts of labour. Within his own community all doors are open." (Dekker and van Schalkwyk)

Some relevant problems to be considered

The problems of multicultural education are well known and doubtlessly will be described by other speakers in this colloquium. But preparing medical students to provide services to patients with a different system of beliefs from their own, adds further multicultural interactions. I shall consider the following.

There are eleven official languages in South Africa. Nine are indigenous African languages and two of European origin (English and Afrikaans). Students' backgrounds now reflect this variety of language. Some of these languages are mutually intelligible. The students' cultural and linguistic backgrounds often may differ from those of their patients. The composition of the student body has changed very much faster in the last decade than that of their teachers. Hence there are cultural and language differences between teachers and students. Additional factors, resulting from apartheid's legacy, affect attitudes towards use of languages. Methods for selecting students often fail to recognise relevant potential. Teachers' understanding of patients is often from a eurocentric viewpoint, which is frequently much too narrow.

Language

Use of Afrikaans for instruction can be perceived of as a means of slowing increase in numbers of black students. Minister of Education Bengu has warned the University of Stellenbosch that "its language policy and 'identity' need urgent review." Although President Mandela received an honorary degree at the University of Stellenbosch and said in 1997 that "there is place for an Afrikaans medium University in South Africa,"

this was later modified by him in his statement that "a language (Afrikaans or any other) must not be used to resist transformation and pursue divisive agendas" (Anon: 1998a 32-33). Such advice has clearly been heeded in medicine at least, since now about 50% of lectures at the Medical Faculty at Stellenbosch are given in English (private communication, J. Lochner, Nov. 98).

Students learn faster using their mother tongue, but in medicine all relevant material often cannot be translated into an African mother tongue, sometimes because of limitations in ideas and vocabulary (Owino). Also ex-colonial languages do offer a wider window onto the world. The few dictionaries which exist for African languages are often inadequate. Political manipulation of language is an added complication and in South Africa one legacy of apartheid has been to associate mother tongue instruction with inferior education. (It was formerly used as a tool to divide and rule.) (Westcott). So there is strong resistance to those who wish to use indigenous languages for tertiary education in South Africa and none of the usual antagonism towards ex-colonial languages found elsewhere in Africa (McGregor and McGregor). The Freedom Charter states: "All people have equal rights to use of their own language" and there is similar ANC policy: "None should be denied access to economic and political life because of the language they speak." These are admirable democratic sentiments, which also try to avoid the situation elsewhere in Anglophone Africa, where former colonial power has, in general, been transferred only to the English speaking elite, not to the masses (McGregor and McGregor).

Medical education encourages use of English for reasons of practicality and historical perception, even though this may be interpreted as maintaining the old order. One must be aware that use of English as a foreign language for instruction can bring about "cultural arrogance and isolation" (Anon: 1993 3-5), but curricular changes can also shield against this. It is generally agreed that in South Africa English should be used for medical education, except in those faculties using Afrikaans. Study of English as a foreign language in medical education shows that there is strong correlation between scores in English and basic science scores, (Hassan et al. 272-82) for both are associated with rote learning, while

less correlation exists between scores in English and clinical subjects, which require more integration of information and problem solving (Hassan et al. 272-82). However a more recent report shows that English scores do correlate with results of problem based learning (Mpofuo et al. 479-85). This leads directly to a need for communication skills to be taught (Swadi 270-74). Such a change in curriculum is in effect recognised by the Department of Education in a recent policy document which asserts, "there is no contradiction in a multicultural society between a core of common cultural traits, beliefs, practices, etc. and particular sectional or communal cultures. Indeed the relationship between the two can and should be mutually reinforcing" (Anon: 1997). This is exemplified by the benefits of cross-cultural interactions between medical educators, medical students and their patients.

Multicultural education

What is a culture? It is the design for living of a particular group expressed in their observable (things made, cooked, worn, behaviour, etc.) and their non observable (values, attitudes, beliefs, etc.) (Allen 325-28). So multicultural education includes the usual aims of education, plus a respect for these manifestations of cultural diversity and the promotion of individuality (Gorski). Thus it should promote awareness of one's own culture, reinforcing a sense of identity and pride. It should not prevent social integration, whereby one culture adopts features from another. At least four models to provide multicultural education in the health care field have been described (McGee).

Cultural concepts can be integrated with other content to pervade the whole curriculum. Usually this is impractical. Specific units can be added as required with the resulting dangers of superficiality and tokenism. Another model involves providing an extra course with an anthropological background by "educationally prepared teachers." This is often adopted in the USA, for example as a separate initiatory "Black Studies" course. Finally an interdisciplinary approach includes cultural components from teachers of anthropology and social science.

Difficulties with all these approaches can be readily appreciated, so a combination is probably the optimal solution, its exact nature depending on the availability of time and personnel. In these theoretical considerations it must be emphasised that specific knowledge is *less important* than establishing the concept of respect for self and others (Jeffcoate 192-200). At the University of Cape Town (UCT) Medical Faculty a general strategy for curricular policy is being drawn up. So far there has been scant attention paid to multiculturalism. A proposal will be made to include aspects of the above approach little by little, with repeated reinforcement throughout the undergraduate medical course.

The universities and other educational institutions in South Africa should encourage multiethnic awareness and facilitate intergroup contacts. This has clearly come about in many other situations in South Africa since 1994. Three stages can be recognised in improving cross-cultural skills (Nobin). Firstly a healthy attitude to one's own group must be developed, also tolerating strong criticism of the group's unacceptable aspects, if any. The next aim is comfortable functioning with one's own group and one other. (This is often evident with Muslims, so called Coloureds and urbanised Blacks.) Finally a personality with multiple social integration will allow optimal functioning in present South Africa society. In the medical school such an approach will prepare students to understand patients from all parts of South African society. A specific three-year pilot programme in the USA to accomplish this has been described. It increases self-awareness of cultural influences on doctors, improves recognition of cultural influences on patients and facilitates multicultural communications with patients in clinical settings (Cullhane-Pera et al. 719-23). Its success will encourage others.

Learning Methods

Fairy stories are not confined to bedtime tales for children. Allegations that learning patterns of whites differ from those of others have been extensively studied in the USA. A mega study by a panel representing different disciplines concluded: "[n]o evidence supported the controversial theory that African Americans shared different learning styles from

Caucasians" (Gordon). Further educational similarities have been reported. In all ethnic groups underachievers were found to experience similar learning difficulties (Dunn and Griggs) and gifted adolescents have comparable learning styles (Milgram et al.). Although it is probable these findings are relevant to the learning situation in South Africa, there are *other* cultural differences between various groups in South Africa today, of which medical educators must be aware. (I am indebted to T. Xiphu for the following points concerning African culture.)

In the classroom praise for an individual is not always viewed positively by the group and co-operation among students is more highly valued than competition. (Incidentally this latter characteristic is also true for many women (Lynch and Hanson)). Respect for elders will often reduce lively discussion or any questioning of teachers' material. (In the last few years in my classes at the University of Cape Town I have found this to be less and less applicable.) Often a global or holistic attitude is preferred to a direct analytical study. The story telling approach with its spiralling away from, and return to, the main theme is favoured over the linear route. (Here the relevance of the African oral tradition is clear.)

Other such beliefs and practices are even more directly relevant to medical education.

- Hallucinations may be considered a gift in Africans, for they can reflect greater contact with spirits than is possible for most persons.
- Illness may result from witchcraft, breaking a cultural taboo, spirit intrusions, etc.. (These are associations very rarely considered in a eurocentric medical setting.)

The Medical Curriculum

With such cultural diversity and the state's post-apartheid medical policy, it is crucial that multicultural aspects of medical education be considered. (Some believe that the feminist standpoint is equally as important as that of multiculturalism, but this is not the place for such discussion.) An Indian approach in several established medical schools is

to run two simultaneous curriculum tracks, the one traditional, the other innovative (Paul 769-76). The much smaller number of South African medical schools will not permit this luxury. An enterprising integration of appropriate psychology and obstetrics at the University of the Witwatersrand has resulted in a greater awareness of cross-cultural difficulties in women's needs during birth. In contrast at UCT the emphasis so far has been on primary health care, with a stated goal of patient care being appropriate to community needs. For this reason a new course on health and society has been recently introduced for first year students. In contrast to slow progress in some universities, the introduction of traditional medicine and healers into the nation's formal medical structures is taking place (Folb 1538-39). Such action is not confined to the developing world, for in the UK there is now a move afoot, involving Prince Charles, to extend the teaching of complementary medicine (including acupuncture) beyond the University of Newcastle, a pioneering institution in this respect. (Anon: 1998b).

Communication and Multiculturism in the Medical Education Curriculum

Worldwide, medical education curricula are being submerged in facts, with insufficient attention to the interaction between health care and social behavioural science (McLeod and McCullogh 1367-73). In the USA cross-cultural training is not solely a classroom process but practical experience is considered essential, whether to learn the drawbacks of working with translators (Douglas and Lenahan 372-75), or to appreciate the crucial nature of setting up a partnership with any community, for which health care is to be provided (Nora et al., 144-47). When such interactions are sought, cross-cultural sensitivity training is essential. In 1994 in the USA only 19 of that nation's 126 medical schools were reported as offering such training and only at a further 33 medical schools was there any planning to implement this. Such a move must urgently be considered for inclusion into South African curricula.

But perceptions across the divide of cultural differences can depend on the side of the perceiver. In Canada, both doctors and patients

recognised that both language and attitudes to modern medical technology were barriers to communication between the two groups. But doctors alone also perceived that patients' traditional beliefs constituted another high barrier. Yet other barriers were felt only by patients (e.g. doctors' racial discriminatory attitudes) (Chugh et al. 83-91). These findings have clear implications for the evolving South African medical curriculum. Preliminary results of concentrating on patient centredness, admittedly involving interpreters, in the Ga Rankura Hospital of MEDUNSA are very encouraging in providing greater patients' understanding. This was the first such report from a developing country (Henbest and Fehrsen 311-17). Analogous results have been reported from Lesotho, in particular for understanding the physical symptoms associated with major depressive illness, panic disorder and generalised anxiety disorder (Hollifield et al. 179-88). Subsequent work by the World Health Organisation in five centres representing five different cultures has confirmed these findings (Isaac et al. 88-93). A deeper knowledge of both patients' beliefs and the value of their cultures can use this understanding as resources in producing more effective health promotion, treatment of disease (Rothschild 293-319) and patient care in general (Shapiro and Lenahan 249-55).

Communication skills are independent of other personal characteristics. This has been confirmed in a study of Australian medical students who have very diverse backgrounds and variable skills in English (Chur-Hansen et al. 259-63). So if all in a class of South African medical students have excellent English language fluency, this should not be a reason for reducing the teaching of communication skills. When such instruction is included in a medical course its positive effect has been confirmed by evaluation one year after graduation (Marvel et al 441-42). These are apparently "scientific" results of investigations into medical students' communication with patients from different cultural backgrounds. Before too much weight is given to them, a further equally "scientific" observation should be described: 519 Australian medical students were assessed for their communication skills by two groups. One group comprised academic teachers, "trained in communication skills" who graded the same interviews as did the second group. The latter graders were "specifically trained 'standardised' (non medical) role playing patients." There was so little agreement between their two perspectives

that the study's author rightly drew attention to it as a "cause for concern" (Cooper and Mira 419-21). So appropriate communication skills must be taught and then evaluated as being effective for those most concerned, the patients.

Pilot studies have also begun in South Africa medical schools. At the University of the Transkei (UNITRA), every student must spend a 4-week period in a rural health care centre where relevant community based learning is directed by local GPs and UNITRA staff (Buga 414-18). Its effectiveness remains to be evaluated. Such community based work will only be effective if there is sufficient cross-cultural sensitivity.

Medical School Teachers

Often backgrounds of medical school teachers and state hospital patients differ markedly, with the former usually white and most of these teachers having been trained before there was any general consciousness of issues of gender, cross-culturalism and race (Morey and Kitaro). The reasons for this are principally due to medical teachers' slow turnover rate and the higher income in a non-academic setting, which attracts the younger graduates. University Teachers often have "greater difficulties in establishing rapport with students who differ significantly from themselves in culture, language, race, gender, socio-economic status and other salient variables. Sensing this lack of communication and rapport, students may feel less adequate and perform less well" (Hilliard 65-69). So when transformation of curriculum and teaching methods is considered for South African medical education, the limitations of the teachers must not be forgotten, at least until such time as they more closely represent the range of cultural background of their students. Difference in language background between teachers and students can lead to misjudgement of student capabilities. (Hilliard 65-69). So it is in everyone's interest (students, teachers and patients) that the modifications outlined here, to the medical curriculum and teaching methods, be instituted to overcome the present barriers resulting from South Africa's multiculturalism and multilingualism.

South Africa's unique history can provide valuable material, unknown elsewhere, for medical education. Medical ethics are an important part of medical education but little on this subject has so far been taught in South Africa. This point is also strongly made in the recent Truth and Reconciliation Commission (TRC) final report (Anon 1998c). It stated that the medical schools "were generally complicit in committing human rights abuses by helping to create and perpetuate the racist environment in which health professionals were trained." A new undergraduate course at UCT on medical ethics presented material on the shameful medical complicity in apartheid abuses. It included visits to a police station, prison and a psychiatric facility. Torture survivors and doctors who took principled ethical stands also participated. There were clear improvements in relevant knowledge of the students and other "less tangible attitudinal benefits" (London and McCarthy 257-62). The partial catharsis resulting from the TRC's final report will benefit future medical doctors if a relevant ethical examination of the past, forms part of their ethics teaching. It can also aid in breaking cultural barriers existing between constituent groups in the same medical class.

Medical Student Selection

More black students are being sought for all South Africa medical schools (Anon: 1998a 32-33) with a final aim to have a student population representing that of the country as a whole, considering gender and ethnic groups (van Niekerk: 1998). This has not yet been attained. The needed changes in faculty and student bodies are particularly slow in coming to the Afrikaans medium universities. This has been unfavourably commented upon for Stellenbosch, where the proportion of black students in February 1998 was 3%. Equivalent percentages for the University of Pretoria and the Rand Afrikaans University are 5% and 22% full time (Anon: 1998a 32-33). Afrikaans language bridging courses exist, but at the University of Stellenbosch they have been described as a "farce" (Anon: 1998a 32-33) by a lecturer there. It is likely that more strenuous attempts to improve matters will be forced on that university. A shift to more equitable student proportions is encouraged by government aid to universities, for the Higher Education Act of 1998 will reduce funds for

universities which do not accommodate poor black students and whose ethnic group proportions do not tend towards those of South Africa as a whole (Anon: 1998a 32-33).

All higher education must involve competition, even if only for the selection procedures (Morey et al.). In South African medical faculties academic ability is an important criterion for entry and a points system is employed. Usually comprehensive results are used for school leavers. However 20-30% of points are awarded for non academic factors (e.g. leadership, community involvement, communication skills, etc.). It is very difficult to find sufficient suitable black students, for their matriculation results are an unreliable indicator of success at the university, especially for maths and science (van Niekerk: 1998). Recent work from the UK draws similar conclusions about such predictions for British students (Richardson et al. 294-97). In South Africa this of course reflects the generally poor teaching of these subjects in schools with mainly black pupils. Thus there remains great uncertainty in identifying potential excellence in poorly prepared black students (van Niekerk: 1997b 1539-40).

Financial difficulties for black students present another great problem. At UCT about 50% of over-offers are made to blacks for places in medical schools, but even so targets are not attained, in part because of competition from other faculties (van Niekerk: 1997b 1539-40) and universities. A central clearing house for such applications would appear to be very desirable.

The experience of the UCT changing its medical student body shows increasing numbers of Africans (from zero before 1986) and a simultaneous decrease in numbers of whites. There was a sudden increase in African student numbers in 1995 (up to about 90, from about 50), but this was not sustained.

South Africa's medical faculties have all the problems associated with any multicultural, multilinguistic society, but some additional unique features; notably the nation's eleven official languages and a persisting legacy from apartheid. Change is required and change is coming, perhaps

too slowly in some Afrikaans medium universities. Information for instruction is usually unavailable in the student's African home language, so all the well known difficulties of English as a (second) language of instruction are manifested. Students and teachers are mainly from different cultural backgrounds. Their patients often have yet another home culture. While a student body more representative of the nation is gradually evolving, similar desired changes in the faculty members are appearing, but much, much more slowly. Procedures are underway, and planned, to achieve these ends. The cultural gaps between medical students and their patients require different bridges. These include a better preparation in language and, most important of all, cultural sensitivity training. Can this lead to true cross-cultural understanding between doctors and their patients? This is probably possible, if one considers the results of such programmes elsewhere and the goodwill at a personal level in South Africa between individuals of different backgrounds. Acceptance of demographic changes in student composition and acceptance of the need to understand others' beliefs and practices bode well, although so far such changes are grossly insufficient.

Conclusions

English is becoming a unifying factor in medical education both for reasons stemming from apartheid's legacy and for practical considerations. The spectra of backgrounds of medical students and their teachers will become indistinguishable. There clearly remains a great need to teach cross-cultural sensitivity and understanding, for the widely diverse groups of patients in the public health service will surely continue. The identification of individual potential for excellence in applicants from different backgrounds remains a serious problem, as does apparent resistance to change in some Afrikaans medium universities. But the racist assertion that learning patterns differ between cultural groups has been put to rest. An intelligent application of results of much relevant work in other societies to South Africa's needs is already apparent. Curriculum changes are moving in the right direction to bridge the gaps resulting from multiculturalism, but much more remains to be done. Thus the multicultural aspects of South African society which today provide problems in

achieving equitable health care of the desired standard, can also provide an opportunity for increased mutual understanding between medical students and their patients, for their mutual benefit. *Je suis très optimiste.*

Sinclair Wynchank[1]

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