How Can Experiential Learning Address Cultural Consciousness in Professional Healthcare Internship Programs?

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Abstract: According to recent surveys, the health gap between minority and non-minority populations in the United States has increased (Richards & Lowe, 2003). The Institute of Medicine has reported racial bias by health care providers is contributing to this disparity (Nelson, 2003). In 2008 the Joint Commission on Hospital Accreditation began a project to develop hospital accreditation standards for promoting, facilitating and advancing culturally competent care (Stein, 2009). In a discussion of what makes experiential learning an effective tool for developing multicultural counseling competencies, Arthur and Achenbach (2002) claimed "experiential learning encourages students to consider cultural contexts that influence their own behavior, attitudes and beliefs and to be reflective about the impact on their professional role" (p. 113). White's study (2008) examined effective community nutrition education from the perspective of African American nutrition educators. They commented on experiences working with dietetic interns in the field that contributed to developing cultural awareness for the student, and effective interventions in the community. “See it, feel it, touch it, eat it and understand how it relates to the larger world,” is the way educators characterized an effective approach teaching health and nutrition in the community.

Need For Cultural Consciousness for Health Care Professionals

In March 2002, the Institute of Medicine (IOM) Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care reported that the quality of care in this country is generally lower for people perceived as coming from communities of ethnic minority than that provided to the majority population (Nelson, 2003). Racial and ethnic disparities were associated with worse health outcomes (Betancourt, Maina, & Soni, 2005). The inequality was consistent with persistent racial and ethnic discrimination in many sectors of American life and “bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers” (Betancourt et al., 2005, p.341).

The recommendation of the Committee was the reduction of disparities “by reducing the variation around best practices, by placing incentives to improve quality and reduce errors, and by improving the quality of communication within the delivery system” (Nelson, 2003, p. S1380). Also recommended was an increase in the proportion of underrepresented minorities in the health care workforce.

Disparity In Health Care Practices Towards People Of Color

According to recent surveys, the health gap between minority and non-minority populations in the United States has increased (Richards & Lowe, 2003). For example, African Americans have the highest overall Coronary Heart Disease (CHD) mortality rate and the highest out of hospital coronary death rates of any ethnic group in the United States (Hall, 2003). Betancourt, Maina, and Soni (2005) described a national telephone survey conducted by the
Kaiser Family Foundation in 2000 which found that of almost 4,000 individuals surveyed, 36% of Latinos and 35% of African Americans (compared with 15% of whites) felt they were treated unfairly in the healthcare system in the past, based on their race and ethnicity. In contrast, physicians (mainly white) reported that the healthcare system “never” (14%) or “rarely” (55%) treats people unfairly based on race/ethnicity (Betancourt et al., 2005).

**Lack Of Diversity And Cultural Sensitivity Of Health Care Professionals**

In their research regarding culture, ethnicity and health care, Fox and Kleinman (1997) identified a failure of the medical profession to both address disadvantages experienced by poorer Americans, and to recognize the impact of cultural influences on disease.

Cohen and Northridge (2000) point to the structural roots of racial disparity: Nutrition, clothing, shelter and primary medical care cannot be reliably obtained with substandard income…Barriers to health resources are all but insurmountable where inferior education and compromised social networks limit dissemination and implementation. Racism and other forms of group oppression aggravate all of these situations and in themselves are sources of substantial, unrelenting stress. (p. 841)

Yancy, Kumanyika and Ponce (2004) published a review of interventions regarding obesity in communities of color. They claimed “There is a paucity of high-quality data on sustained chronic disease or obesity risk reduction from interventions targeting or including meaningful numbers of people of color or people from low-income backgrounds. This gap in the literature represents a major obstacle in developing effective policies and programs” (Yancey et al., p.9). The authors continued “It is sobering to note that as of 2001 (so few) participants have been studied to control obesity and reduce chronic disease risk among 100 million persons of color – more than one third of Americans….and data derived from ethnically inclusive studies are not widely disseminated” (Yancey et al., p. 9).

**Developing Cultural Consciousness In Health Care Programs**

In 2008 the Joint Commission on Hospital Accreditation began a project to develop hospital accreditation standards for promoting, facilitating and advancing culturally competent care (Stein, 2009). The Commission on Accreditation for Dietetics Education requires that dietetics programs integrate the study of culture into their curricula (Skipper, Young & Mitchell, 2008). In order for dietitians to work effectively with culturally diverse clients, they must practice in a culturally appropriate manner (Curry, 2000; Saracino & Michael, 1996; Wang & Tussing, 2004).

White (2008) conducted a series of interviews with African American nutrition educators to identify how dietetic programs could develop student cultural competency. The participants discussed needed changes in the educational process, including more multicultural education for dietetic students and exposure to the African American community. The women commented on the need for all dietetic students to be exposed to cultures and develop sensitivity.

Because food is very important, it is very private. It’s special to people, especially those who are in need, who don’t have a whole lot. Dietitians can’t understand the importance of food if you don’t have a lot. Like “why, if you are so poor or you are having health crisis or stress in your life, why are you turning to food. It’s going to make it worse”. I think if you can understand why they turn to food, you can deal with it better. (Lynn, LD, Nutritionist Community Program)
Utilizing Experiential Learning to Develop Cultural Consciousness

Stein (2009) reviewed a number of studies to find the best method of teaching cultural competency with medical students. She reported "it's the unplanned lessons that students appreciate most...the informal curriculum- which included knowledge-sharing made possible by student body diversity and cultural competence lessons presented in clinical situations ....... was preferred and deemed more worthwhile than the formal curriculum of reading assignments, lectures and standardized patient modules" (p. 1679).

According to Artherton (2004) adults learn by first by engaging in concrete experience, then reflecting upon it and making general conceptualizations about it, and finally by modifying and mirroring the first experience. Rogers (n.d.) identified experiential learning as equivalent to personal change and growth. Reggy-Mamo (2008) described her experiences utilizing an experiential approach to teach intercultural education. She designed a course providing direct experiences with cross-cultural communication issues and allowed for self-evaluation.

From these experiences they would practice applying these principles, models and strategies appropriately when relating to people of different cultures, worldviews, and value systems. As an instructor, my role was to facilitate learning by: (a) setting a positive climate for learning, (b) clarifying the purposes of the learning, (c) organizing and making available learning resources, (d) balancing intellectual and emotional components of learning, and (e) sharing feelings and thoughts with learners but not dominating (p. 113).

In a discussion of what makes experiential learning an effective tool for developing multicultural counseling competencies, Arthur and Achenbach (2002) claimed "experiential learning encourages students to consider cultural contexts that influence their own behavior, attitudes and beliefs and to be reflective about the impact on their professional role" (pg.4). They cautioned that experiential learning can also raise powerful feelings, including culture shock, and instructors must be conscious of providing positive ways for students to process these feelings (Arthur & Achenbach, 2002).

In 2000 Harris Davis and Haughton sought to create a model for cultural competency training in Dietetics. They identified self-awareness as the initial step towards achieving this goal (2000). Stein (2009) asked the question "Is it fair to expect health care professionals- and students in training- to become completely unbiased once they enter the industry or the classroom" (p. 1682). Even in the classroom, instructors and preceptors must be prepared to deal with backlash and reactions of students, including resistance, when their belief system is challenged. This may be particularly true for white students who may perceive discussions of racism as attacks on them (Stein, 2009).

Effective Community Health Teaching Experiences

White's study (2008) examined effective community nutrition education from the perspective of African American nutrition educators. Participants commented on experiences working with dietetic students in the field that contributed to developing cultural awareness for the students and effective interventions with people from the community.
“See it, feel it, touch it, eat it and understand how it relates to the larger world,” is how Lynn, Licensed Dietitian characterized the way educators needed to approach teaching nutrition in the community.

Despite the lack of formal education, some of the peer educators were the most effective in bringing their messages to people in the community. Ruth, peer educator, described her experience running a group for teen moms in a housing project, which is considered a difficult audience.

Yeah...it was challenging because the room was so small...and you had a room full of kids and a room full of mamas and a lot of times they don’t want to hear nothing about nutrition, ‘cause they’re busy talking about their personal problems. But you got to really just come in there with a bang. Be loud...you gotta get down with them...like we’re sitting here...I actually would just sit down with them and we’ll talk like a family instead of me standing up over them like I’m the one who knows everything. It took a while for them to actually warm up to me. The more you go back to them the more they warm up to you more and more. But it was really fun. When we did a label reading class...they really got into it...they couldn’t believe about the fat and the calories! I actually bring in real food products...so it was really good...it was fun. They like to be fed. I find that...when you’re feeding people they are more relaxed...they’re eating and talking.

Being able to communicate a message in clear, understandable terms was another theme discussed by the participants in being successful as community educators. Betty, Registered Dietitian, addressed this issue as follows:

There are levels of conversation you can have with people depending on where they come from, their background. I think being able to relate, you don’t have to be so high up you can’t talk to people. I think a lot of folks fail in communicating with people because they don’t know how to talk to them. It’s not coming down to their level, but being able to explain to them what exists. What is available, and what do you have to do to get what you want.

Lisa had done nutrition education programs with ex-prisoners, women in homeless shelters and eventually culinary arts classes for teenagers on Chicago’s West Side. When asked what she thought made them successful, she responded as follows:

You did it by building confidence and being patient. You had to be very down to earth and not give anybody the impression you thought you were “Miss It” because you had your degree and stuff...because they could make you or break you. But it was a joy for me to see the light bulb come on in somebody’s head when I knew they got it...It made them happy and it made me happier because I accomplished that. And then you could build on something because you had laid a foundation.

Carol addressed the issue of communication:

Nutrition can be complicated, but if you can paraphrase, that’s all I do. Just take this section, read this stuff and paraphrase. Break it down and throw it to them and they’ll take it because it goes down better in small doses. The way it really is, I got to change my whole life! You will get overwhelmed. But if you look at the little picture you can go one day at a time.

Another term that was used by several participants was “getting connected.” Food was often the medium, as described by Lynn:

Food is such a social thing. In the beginning when you bring food they just want to eat, but when they still hang around after the food is gone and continue to come back. It’s just
a way to relate to people. Sometimes to give a person a banana or a bag of food, it just makes their day. Because when you are depressed or stressed out it’s just nice that somebody or something, to have some joys in your life. No matter how small they are for that short time, it makes people feel good. When people have all kinds of problems in their life and here’s someone treating them with respect, I think that makes a difference. Interns participated in programs using food, cooking and eating, games and interacting with clients in a community setting. Working in these settings, under the supervision of the experienced community educators, and then processing them in a seminar format, allowed dietetic students a workshop to appreciate the diversity of the clients and staff. Kachingwe (2000) developed a meta-policy guideline for professional programs to help them achieve what she has called interculturalization through diversity, multiculturalism and conviction. A diverse population and multicultural curriculum are not enough. Educators must model the conviction that values culture and diversity in order for students to adopt and advocate these values themselves as professionals.

References


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