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Situating pluralism in biomedical healthcare practices: Lessons from the ethnomedical approach

Anke van der Merwe ORCID: 0000-0003-1557-5256	School of Health and Rehabilitation Sciences, University of the Free State, Bloemfontein, South Africa	gonzalesa@ufs.ac.za
Motsaathebe Serekoane ORCID: 0000-0002-1310-1340	Department of Anthropology, University of the Free State, Bloemfontein, South Africa	serekomj@ufs.ac.za
Shirley du Plooy	Department of Anthropology, University of the Free State, Bloemfontein, South Africa	duplooys@ufs.ac.za

ABSTRACT

Healthcare interactions have become increasingly varied, prompting the need for revised person-centred approaches that call for curriculum reform. This paper describes the perceived impact of the intentional insertion of medical pluralism into an inclusive, interprofessional health sciences module. A phased multi-method research design was applied. Phase 1 gathered data for an early curricular review. Phase 2 implemented a revised approach focusing on medical plurality. Phase 3 collected qualitative data through structured reflective journaling. Descriptive statistical analysis of quantitative data and thematic analysis of the qualitative data were performed. 41 2022 first-year students (30%) participated in Phase 1, with 83% indicating that engagement was encouraged (83%) within a space of mutual respect (83%). Structured reflective journaling was employed in 2023 with 121 (97%) first-year students participating in Phases 2 and 3 to describe the impact of the revised approach on student learning. Five themes emerged from this experience: uncertainty, fear, overwhelm, gratefulness, and personal impact. Through creating a practically orientated and inclusive curricular space founded on medical pluralism and pedagogy of care, cross-cultural graduate attribute training was transformed to be more contextually relevant and future-focused to effectively steer students towards developing the attributes of desirability, ethics of care, and responsible citizenship.

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Introduction

Healthcare interactions have become increasingly diverse and have resulted in adjusted patient care approaches that beg for context-specific, responsive curriculum practices (Van der Merwe, Barnes & Labuschagne, 2022). However, educators are often so immersed in their routinised ways of teaching that they do not make the necessary curriculum adjustments to align with the students' clinical context, which requires offering context-responsive care. The United Nations' Sustainable Development Goals (SDGs) 3 (good health and well-being) and 4 (quality education) formed the foundation of this study in framing contextually relevant content for developing work-ready healthcare professionals through quality education that is focused on addressing the myriad of health inequalities in the quest for good health for all (Miranda & Scholz, 2023).

High-impact scholarly practices require courageous and engaging classroom spaces, yet these spaces remain siloed and theoretical in nature, which impacts on students' transition to context-responsive clinical practice (Shenoy, Jain, Bhagyalakshmi, Shirali, Shetty & Ramakrishna, 2021). This argument is consistent with the South African Survey of Student Engagement's (SASSE) results on students' views on their experiences of the curriculum, particularly reflective and integrative learning (Centre for Teaching and Learning, 2021). The SASSE results indicate that students are still experiencing the 'dumping' of educational material in their curricula (the traditional system), with limited or no contextual relevance and/or engagement. This view is consistent with Paulo Freire's (1970) assertion that the reluctance to challenge or review the traditional curriculum design and practices (underscored by the hidden curriculum) entrenches the 'dumping down and banking' model of education. In response to this challenge, an interprofessional curriculum consisting of one module in each study year, driven by principles of diversity, inclusion, and student engagement, was created in the School of Health and Rehabilitation Sciences at the University of the Free State (UFS). The overarching aim of this curriculum is to align healthcare students' graduate attributes, also referred to in other contexts as interdisciplinary professional, core, or non-technical skills, with key lessons from medical pluralism. Given the importance of good and effective patient-healthcare professional communication and understanding, and addressing socio-cultural factors in the medical encounter, anthropological and cross-cultural studies have developed clinical guidelines to address these issues (Kleinman, Eisenberg & Good, 1978), which are, however, still not widely adopted in medical education approximately two decades later (Kleinman, 1995). Park *et al*. (2006), for example, maintain that central to the poor endorsement of cross-cultural training in medical education is the general view that this is not useful in medical encounters.

A focus area of this module was to explore the notion of medical pluralism through the introduction of the ethnomedical approach to the usual, established biomedical pre-clinical training. Informing this move was a repositioning or reorientation away from the binary perspective that universal biomedicine exists in opposition to the subordinated camp of traditional, complementary, and alternative medicines the world over. The existing frame uncritically accepts that Western biomedical medicine, which is based on biological sciences, is the superior set of socio-technical knowledge, practices, treatments, and so on, that aims to alleviate and improve the health of individuals and communities (Lock & Nguyen, 2018). Little effort goes into truly unpacking the assumptions upon which allopathic biomedical health are founded. If this were the case, the global population would understand that, like traditional, complementary, and alternative healing modalities, biomedicine is founded on a set of ideological assumptions and knowledge that makes it one of many healing modalities, not in opposition to all these other ethnomedicines, but instead biomedicine as an ethnomedicine with a particular history, epistemological grounding, and ontological view, among many others. To correct the disservice perpetrated against students by privileging biomedicine with its universal view of the human body as biologically the same, its standardised treatment protocols, and its hegemonic positioning, reflexive curriculum change became imminent.

We advocate, on the one hand, for the acknowledgement of varied medical traditions and practices and the provision of context-specific, person-centred care (World Health Organization [WHO], 2003), and that human health and the healthcare systems in society are informed and influenced by cultural traditions, customs, and morals (Nkosi, 2012). If our point of departure is that healing and medical modalities are "assemblages of knowledge and practices" about health and healing, it must be accepted that biomedical knowledge and practice are "inextricably associated with political expediences, social interests and embedded values" (Lock & Nguyen, 2018:53). These broad themes were integrated into the first implementation of the first-year module in 2022. It is in this context that we focused on the "hidden curriculum", which refers to the kinds of learning students derive from the very nature and organisational design of the institution, including the behaviours and attitudes of all staff (Orón Semper & Blasco, 2018). The power of the hidden curriculum lies therein - that it can affect both students' sense of belonging, and their knowledge of the conditions needed for success. At its best, it is complicit in the reproduction of a linear way of knowledge transmission and entrenches the legitimacy of one voice. This approach to teaching does not reflect what Giroux (1992) would have described as Freire's (1970) notion of "conscientisation"; that is, learning that encourages students to cross ideological and political borders by expanding their understanding and

broadening their ability in ways that make them think about immediate experiences and how to transform them (Serekoane, Ochuot-Agumba & Van Vuuren, 2022). This begs for a different learning context. To integrate plurality into this curriculum, we sought to create an inclusive, interprofessional curricular space founded on pluralism-informed pedagogy to aid best healthcare practices, enhance student engagement, and ultimately develop cross-cultural graduate attributes.

Research aim and objectives

This paper describes the perceived impact of the intentional insertion of pluralism-informed medical pedagogy into an inclusive, interprofessional module focused on the development of cross-cultural graduate attributes.

Conceptual framework

The basic proposition of responsive and holistic healthcare practice is that human behaviour and human health emerge from complex interactions that take place in cultural systems (Haviland, 2008; Nkosi, 2012). While neither denying the contribution made by biomedical research, nor the key importance of continuing with it, one nevertheless finds it regrettable that traditional biomedical research approaches that guide healthcare research and teaching are responsible for the neglect of a more holistic view of patient care (Serekoane, 2010). Recognising the significance of effective patient-healthcare professional communication, understanding, and the consideration of socio-cultural factors in medical interactions, anthropological and cross-cultural studies, have formulated clinical guidelines to tackle these concerns (Kleinman *et al*., 1978; Helman, 2002, 2007), which are, however, not widely used in medical education (Kleinman, 1995). Park *et al*. (2006), for example, maintain that central to the lack of endorsement of cross-cultural training in medical education are the generally associated views on the lack of usefulness of these guidelines for medical encounters. Some of the problems caused by such neglect are worth noting:

- The traditional biomedical paradigm is characterised by ethnocentrism and scientism, which prioritise biomedical science and its compatible variables while disregarding social issues. This approach, rooted in biological reductionism and technological solutions, overlooks the valuable contributions of social science to clinical practice (Kleinman, 1980; 1995). Kleinman *et al*. (1978) and Lock and Nguyen (2018) suggest that by breaking free from these biases, we can acknowledge the importance of the socio-cultural context and other neglected factors in professional healthcare practices.

- A noteworthy matter to consider is the tendency among researchers and clinical practitioners, particularly those who work from biomedical perspectives, to approach the study of health and healthcare as if they were entirely autonomous, timeless, and culture-free processes.

To address such challenges, we suggest that healthcare professionals should acknowledge diverse healthcare practices within the communities they serve and how these could potentially affect treatment outcomes. Kleinman *et al.* (1978) introduced the concept of the explanatory model in applying anthropological insight to clinical practice. The position is that explanatory models are necessary additions to the training criteria used by healthcare providers (Kleinman, 1980, 1988; Nanda & Warms, 2002). They maintain that, in the healthcare encounter, patients and practitioners may be working with different and competing models and that such a mismatch may lead to the kind of misunderstandings that result in either ineffective treatment or non-compliance (Dyck, 1998). In line with his view, we developed a conceptual model to prepare a learning experience for the student cohorts of 2022 and 2023 that drew on Kleinman's (1980) idea of explanatory models (see Figure 1). The model seeks to advance a learning experience that shifts the clinical encounter from the siloed, isolated understanding, interpretation, and meaning of ill health to an integrated healthcare explanatory model of practice that is underscored by the nexus that draws from the varied understanding, interpretations, and meanings of ill health. As indicated by the arrow in Figure 1, the different voices intersect and hybridise to establish an integrated healthcare nexus.

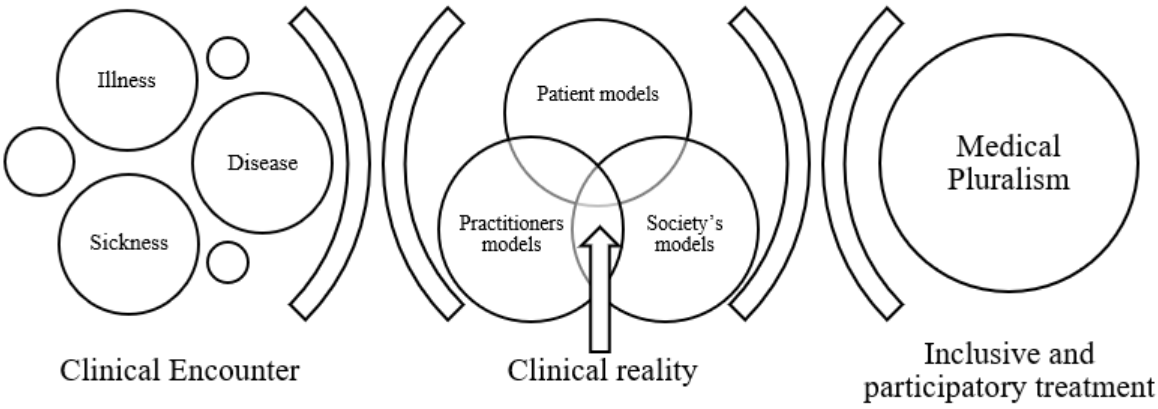

Figure 1: From siloed solitude to an integrated healthcare explanatory model nexus

The key theoretical component is the "explanatory model", a model developed and introduced by Arthur Kleinman (1980) in his influential book *Patients and Healers in the Context of Culture: An Exploration of the Borderline Between Anthropology, Medicine and Psychiatry*. Although the model later received some criticism, including from Kleinman (1995) himself, it is nevertheless a useful tool

when used in combination with other approaches. The explanatory model is defined as the notions about an episode of illness and its treatment that are employed by all those engaged in the clinical process, namely patients, healers, and other members of their local social world (Kleinman, 1980; Kleinman & Seeman, 2000). In addition, a central component of healthcare is where the explanatory models of patients and practitioners intersect.

An integral part of the explanatory model is the conceptual distinction it makes between disease, illness, and sickness (Kleinman, 1980; Hofmann, 2002). In terms of the anthropological point of departure (Eisenberg, 1977; Hardon *et al*., 1995), illness, disease, and sickness capture different aspects of ill health. The concept of illness, according to Hardon *et al.* (1995), reflects the patient's perspective. When speaking of illness, it is important to include not only the patient's estimation of how best to cope with ill health but also the practical problems in their daily environment. The term "sickness", however, refers to the influence of society as a whole on illness and on the particular individual who is suffering from ill health. Sickness is thus related to a different phenomenon, namely the social role a person with an illness takes on or that is conferred to/ assigned by society, which is often in the form of stigma (Wikman, Marklund & Alexanderson, 2005).

Disease, on the other hand, is a condition that is diagnosed by a healthcare professional or medical expert (Hardon *et al*., 1995; Wikman *et al*., 2005). Ideally, this would include a specific diagnosis according to standardised and systematic diagnostic codes. Illness and disease do not stand in a one-to-one relationship and should not be regarded as separate entities (Eisenberg, 1977). Both concepts are explanatory models that mirror multi-level relations between separate aspects of a complex, fluid, total health phenomenon.

Kleinman (1987) argue that interactions between the healthcare provider and patient are, in essence, transactions between the biomedical voice of a healthcare professional and the life-world voice of the patient. In a clinical encounter, the explanatory models held by practitioners, patients, and family can, and indeed do, differ. The communication and negotiation of decisions with respect to managing illness lead to the cultural construction of illness. While healthcare practitioners would draw from their formal healthcare training, patients' explanatory models are influenced by beliefs, norms, values, access to resources, perceived severity of the illness episode, and much more. In other words, it is through their explanatory models that patients assign meanings to the symptoms of illness and the treatment thereof (Young, 1980; Hardon *et al*., 1995). There is evidence that dissonance between the patient's and the healthcare professional's explanatory models may

negatively affect the clinical outcome (Plowden, 2003), treatment compliance (Kleinman *et al*., 2006), satisfaction (Callan & Littlewood, 1998), and culturally sensitive clinical practice and care (Bhui & Bhugra, 2002).

For healthcare treatment to be acceptable to patients, it must make sense in terms of their explanatory models (Kleinman, 1980; Helman, 1981). In South Africa, most patients who consult the professional healthcare sector inevitably consult a practitioner who is trained in the biomedical paradigm, which implies that the encounter between them occurs in a complex context because biomedically trained practitioners and patients often have different belief systems about the causes of illness or the frames of reference regarding healthcare. Having different belief systems or frames of reference means that healthcare professionals and their patients have different ideas about the causes, prognosis, and treatment of the condition (Kleinman *et al.*, 1978; Kleinman, 1980, 1988; De Villiers, 1991; Cockerham, 2005).

In this article, we advocate for a more holistic learning and teaching view/pedagogy; one that recognises the complexity of, and in, the health-seeking and treatment-providing encounters between clients and practitioners. By recognising and grasping this nuanced socio-cultural complexity, among others, that constructs the health treatment encounter, we argue that we can move towards more effective, responsive, and equitable healthcare practices (Serekoane, 2010) that are premised on the notions of medical pluralism. Firstly, medical pluralism refers to the co-existence of multiple healthcare sectors within particular geographical areas that are found in almost every country in the world (WHO, 2003). Secondly, differing healthcare traditions and practices grounded in divergent epistemological positions based on distinctive worldviews exist (Cant, 2020). To this end, for Kleinman (1980) it is obvious why it is necessary to study how the healthcare system relates to its socio-cultural context. As far back as 1980, the growing importance for healthcare providers in diverse sectors to deliver high-quality and inclusive healthcare to patients from a range of backgrounds has been highlighted (Kleinman, 1980). Moreover, Kleinman *et al.* (1978) and Helman (2000) emphasise that ensuring socio-cultural sensitivity in quality care is crucial to address the prevalent issues and challenges related to treatment fidelity and acceptability in communities.

Methods

A phased multi-method research design was applied in this research. Ethical approval was obtained from the General/Human Research Ethics Committee (UFS-HSD2021/0921/21) of the UFS prior to the study. During Phase 1, both quantitative and qualitative data were collected using an annual institutional module feedback survey. The survey included closed-ended questions that focused on module quality, assessment, support, utilisation of technological elements, student-lecturer relationship, and ownership of learning. Additionally, open-ended questions were included to gather narrative accounts of student-participants' module experiences and to capture any suggestions they wished to provide. The submitted group-based case study and individual guided reflections relating to multi-culturalism, social and civic responsibility, and the application of Ubuntu principles were also reviewed by the authors to identify if the taught content translated to different viewpoints in the submitted assignments.

All first-year students enrolled in the module in 2022 were informed of the study by means of an information leaflet sent to their institutional emails and invited to participate. The survey was made available through the institutional Learning Management System at the end of the academic year to all first-year students participating in the new skills development module (N=135). Following the initial curricular review, Phase 2 comprised the development and implementation of a revised approach, based on the results of Phase 1, and focused on a revised approach to situating medical plurality in this module.

Phase 3 utilised the same recruitment strategy as described for Phase 1 to recruit participants from the new first-year cohort participating in the module in 2023. Phase 3 collected qualitative data by employing a structured biannual reflective online journal on the perceived impact of the revised curriculum intervention. Online reflective journaling has been shown to promote higher-order thinking, coupled with the convenience of easily referring to the initial reflection, which results in more robust insights (Alt, Raichel & Naamati-Schneider, 2022; Lamb, Carvalho, Gallagher & Know, 2022; Phipps, 2005).

Descriptive statistical analysis of the quantitative data and thematic analysis (Saldaña, 2021) of the qualitative data were performed.

Results and discussion

Phase 1

41 2022 first-year students (30%; N=135) participated in Phase 1. Thematic analysis of the qualitative data revealed two overarching themes, namely diversity and inclusion, with sub-themes, as indicated in Figure 2. The quantitative and qualitative data are discussed together for Phase 1.

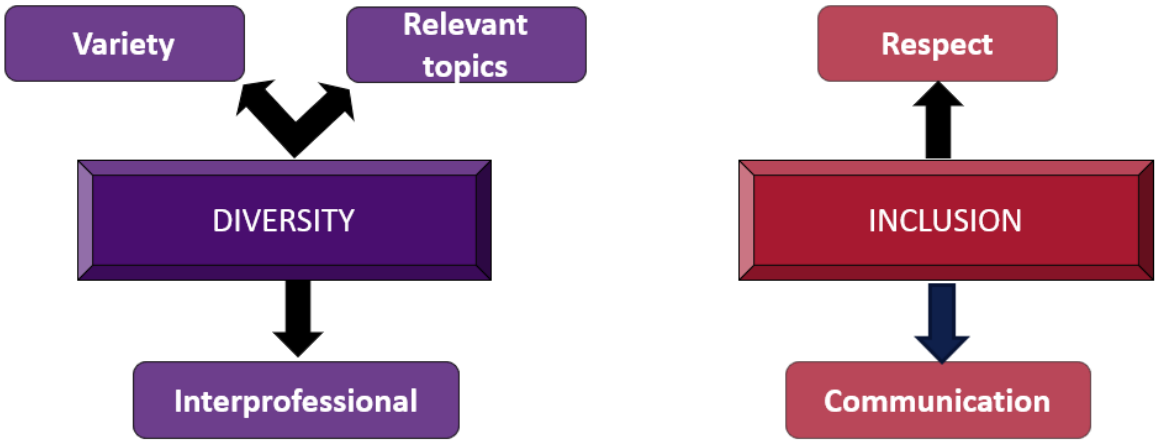

Figure 2: Phase 1 thematic analysis

Most students indicated that they felt the lecturer fostered engagement between all stakeholders (83%), within a space of mutual respect (83%). A basic human need is that of being part of a community, and within a learning and teaching context (Barkley, 2010) being part of such a community has been reported to enhance student engagement and support the movement beyond mere passive inclusivity (Tran, 2021), which was echoed by the participants. In aiming to develop an ethics of care, we are of the view that creating a space where engagement is encouraged through trust and respect is essential. This typical response captures the participants' sentiment:

> *"I like the groups because we were able to build a trusting environment and a supportive one."*

Aspects related to student-lecturer communication, as well as the development of personal communication skills, were also highlighted as positive module aspects. Students "appreciated the continuous communication" between the lecturer and themselves as they felt it enhanced their learning (68%) and ensured that they were better equipped for the world of work upon graduation. The students were also able to identify areas for personal development. One participant stated: "[It] helped me see that I need to work on my verbal communication skills", with an understanding of the importance of acquiring the skills to "interact with different individuals of the community". Developing and honing effective communication skills both in a personal capacity and within a

diverse interprofessional group enhanced learning and could go a long way in establishing dialogues to address good health and wellbeing (Miranda & Scholz, 2023).

The students appreciated the practical application of the diverse module content and the fact that they were able to engage in an interprofessional space on topics that are relevant to their healthcare practice. The following statement summarises this:

> *"We learned about things that nobody really tells you to do; it is just expected of you in your immediate workplace."*

An in-depth analysis of the first implementation of this module is not relevant to the scope of the study and is in press to be published (Van der Merwe & Janse van Vuuren, 2024). Although it was evident that the desired classroom space was created, the impact of the encounter between the biomedical and ethnomedical approaches on student learning remained unclear.

Phase 2

With this uncertainty in mind, our first priority in Phase 2 was to undertake an in-depth interrogation of the module's outcomes. The process resulted in the realisation that although the outcomes were sound, the chosen educational methods required adjustment. Following consensus discussions and collaborative content review, we did not change the content drastically; however, we opted for a more strategically blended approach to learning and assessment (see Table 1). We elected to incorporate "safe" webinars to lay the groundwork for "brave" face-to-face discussions where discomfort was intentionally created. It was essential for us to create an interactive, brave space where students could learn with and from one another (Ravitch, 2020). This was accomplished through more structured, active engagement through small group role play and discussions, based on provided scenarios. In this way, the concepts presented during the module were practically illustrated.

Phase 3

For Phase 3, the students completed the biannual online reflective journal at the start of the second term and again in the third term, once they had gained more experience in their departments and as part of an interprofessional community-based project. A total of 118 (95%) first-year students participated in Phases 2 and 3 through structured reflective online journaling. Three themes, namely growth, connections, and knowledge/insight, with sub-themes, emerged from the thematic analysis of the qualitative data collected during Phase 3 (see Figure 3).

Table 1: Summary of changes to the module

TOPIC	ACTIVITIES 2022	TOPIC	ACTIVITIES 2023
Human rights, social justice	Pre-reading and online quiz One-hour webinar	**Human rights, feminist-relational ethics**	Pre-reading and online quiz One-hour webinar
		Social justice	One-hour webinar
Influence of spirituality on healthcare	Pre-reading and online journal entry One-hour webinar	**Influence of spirituality and diversity on healthcare**	Two-hour face-to-face discussion
Anthropological and social determinants of health	One-hour webinar	**Cultural diversity and sensitivity, anthropological and social determinants of health**	Pre-reading and online quiz Two-hour face-to-face class discussion
Principles of Ubuntu, Batho Pele, civic and social responsibility	One-hour webinar	**Principles of Ubuntu, Batho Pele, civic and social responsibility** *Moved to another module unit*	N/A
Putting it together	Two-hour face-to-face discussion Guided reflection on lessons learned	**Putting it together**	Two-hour face-to-face small group role play (case studies), discussions
Group work	Develop case study to illustrate learned principles Peer evaluation and final group assessment	**Group work**	Develop patient profile to illustrated learned principles Peer evaluation and final group assessment

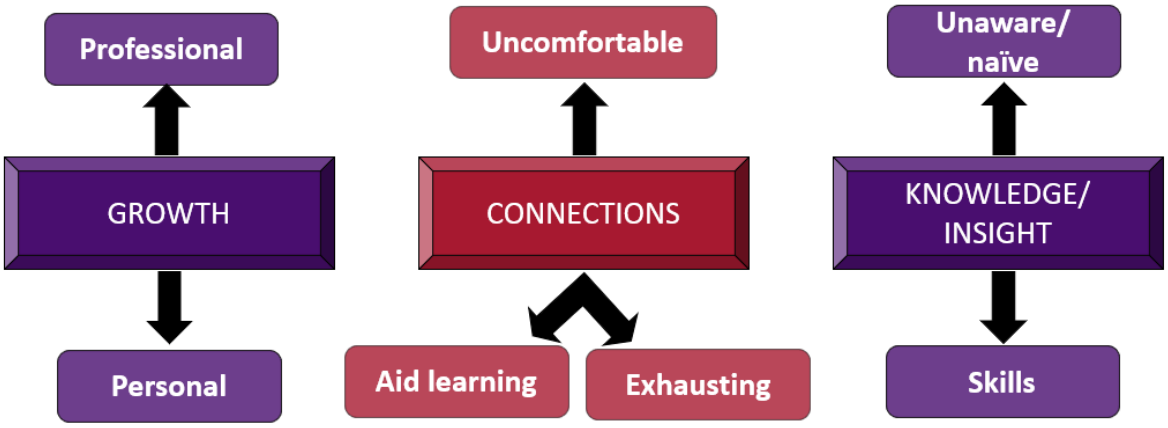

Figure 3: Phase 3 thematic analysis

The participants noted both personal and professional growth, not only through engagement with the module content but also through engagement with others in a safe but brave classroom space. Leveraging the power of online reflective journaling offered various advantages, through being both private and personal, as well as encouraging a safe space in which to bravely express themselves (Phipps, 2005). This was received well by the students. One student was astounded by the transformation they had undergone as they said:

> *"To realise how much I have evolved from the person I was to the person I am today is absolutely incredible."*

In addition, the convenience of easily viewing the initial journal entry also proved motivational and insightful to the students through allowing a space for reflection. Healthcare professionals who have well-developed reasoning, reflection, and self-awareness skills are in a position to potentially positively influence current healthcare services, which will result in the provision of contextually relevant and responsive person-centred care (Hillermann, 2015).

Professional growth and identity formation are essential in healthcare practice and the curriculum with which students engage has been reported as one of the main influences on professional identity formation (Findyartini, Greviana, Felaza, Faruqi, Afifah & Firdausy, 2022). For first-year students to already realise that nothing comes from remaining in their comfort zones and the resultant change in their views on approaching cultural differences attest to the improved implementation of the course material in this module. For example, a participant described their reflective insight as follows:

> *"This week has changed the way I think … it made me aware [that] cultural differences are an important gap to bridge between a healthcare worker and patient."*

The mindfully designed content and specifically selected teaching and learning methods highlight the advantage of including medical pluralism in healthcare practice in the pursuit of creating an integrated healthcare practice nexus.

The participants highlighted the importance of active engagement with diverse presenters situated outside of their academic environment to create a transformational experience. To illustrate, one participant shared the following:

> *"Through engaging case visits from special guests and dynamic discussions, I've come to understand just how important it is to respect the diverse backgrounds, beliefs, and values."*

Forming connections through engagement in their interprofessional module groups elicited a feeling of gratefulness as the students were able "to learn more about [their] different culture and customs". Engaging in multi-cultural discussions around sensitive topics may be extremely challenging for educators and students alike (Serekoane, 2013; Van der Merwe*, et al*., 2016; Van der Merwe *et al.,* 2022) and could result in superficial discussions (Ravitch, 2020). However, we are of the opinion that by engaging with the students in a respectful curricular space, through varied teaching and learning methods, these conversations were "eye opening and uncomfortable or provoking", which resulted in the participants truly engaging and transforming their thinking

(Barkley, 2010; Hussin, 2018; Ravitch, 2020) and striving towards the goal of developing responsible citizens that will champion and embody ethics of care.

In the majority of the responses, the student-participants reported not realising how seldom they considered the views of others. One student admitted that they had always gone "through life with a tunnel vision mindset, which made me dismiss anything that wasn't related to my goal". Through authentic engagements created for the students in this module, a true transformative learning experience was created that resulted in the same student also reflecting, "… but now I am very mindful of most things in my life", which highlights the value of including teaching and learning activities aimed at developing essential reflective abilities both as an individual and as a future healthcare professional.

Closing the gap between theory and practice is crucial in healthcare education as it nurtures the growth of critical thinking skills, which will empower students to navigate complex real-world situations and make well-informed decisions. Providing authentic experiences in the classroom not only promoted student engagement (Barkley, 2010) but also enabled the students to perceive their role within the healthcare system as that of a change agent towards better and equal health for all (Miranda & Scholz, 2023). To illustrate this, one participated stated:

> *"We can always change how our health system is structured since we are the upcoming health professionals … we can make a change in our health system."*

Conclusion

To address the gap identified in the biomedical training of healthcare students, we drew key lessons from the ethnomedical approach and intentionally situated medical pluralism within a curriculum renewal space. Specific reference to and focus on the hidden curriculum also underpinned the development and refinement of learning experiences provided for first-year undergraduate healthcare students, as aligned with SDGs 3 and 4.

Our considered view is that the incorporation of alternative healthcare practices should be seen as complementary and not in competition with established healthcare practices. In the explanatory model context, we reiterate the importance of patients' models as legitimate narratives. Through creating a practically orientated, inclusive curricular space founded on medical pluralism and a pedagogy of care, cross-cultural graduate attribute training was transformed to be more contextually relevant and future-focused.

This intervention is effectively steering students towards developing the attributes of desirability, ethics of care, and responsible citizenship. The first-year students' realisation that they can become change agents for healthcare is a powerful affirmation that small pedagogical moves (turns) can bring about long-lasting and embodied alignments between medical training for rehabilitation and clinical and treatment contexts.

Recommendations and future research

The gap (imagined or real) that exists between the first-year curriculum and subsequent study levels often compromises the foundation established at the entry level. We firstly recommend a constructive curriculum alignment between different levels of undergraduate training. Secondly, we recommend that the cohort of students included in the research be followed over the span of their undergraduate study years to identify if the perceived impact of the intervention is long lasting. We advocate for a collaborative approach to consider the development and implementation of teaching and learning activities throughout all four undergraduate study years. The interventions implemented in the first year of study may be considered as a basic departure point for the scaffolding and development of teaching and learning interventions throughout all four study years to further build on the foundational principles learned in the first year of study.

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