

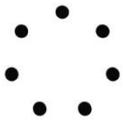
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Faculty of Education and Psychology**

# Developing medical education in a diverse context

Prof. dr. Lan Anh NGUYEN LUU Institute of Intercultural Psychology and Education –  
ELTE BUDAPEST HUNGARY

Live Symposium in Rotterdam - 'Treating patients with Medically  
Unexplained Symptoms in an intercultural context' - October 15, 2021

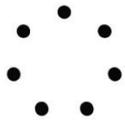


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# Overview

- The aim of medical education: preparation for providing quality care to diverse populations
- Cultural competency
- Structural competency
- Further aspects
- Conclusions



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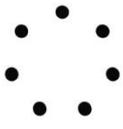
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# Providing quality health care to diverse populations (Betancourt, 2006)

Patient-centeredness and cultural competence in training



Improving quality of health care and reducing disparities in health care among groups.



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# Cultural competence

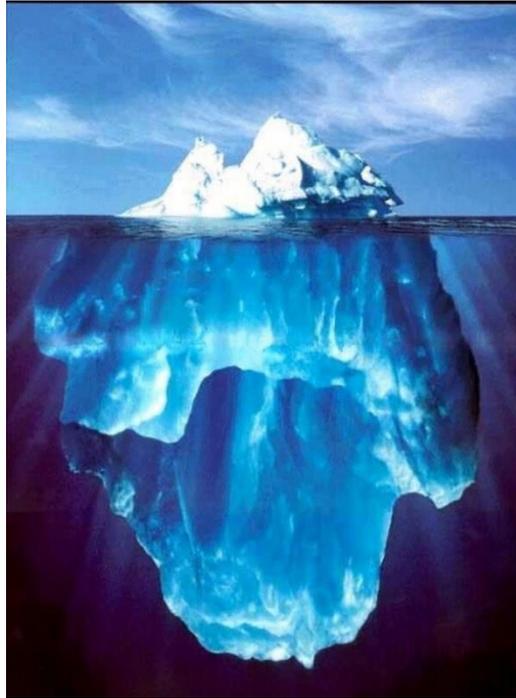
- Interpersonal level, patient-doctor interaction.
- Addressing „cultural distance”.
- Different quality of patient-physician communication in case of patients from different ethnic background (Schouten and Meeuwesen't literature review, 2006).
- Culture shapes every individual's health-related **affects**, **behavior**, **beliefs** (**cognition**).
- The three pillars of (multi)cultural competence: cultural self-awareness, cultural knowledge of the clients, culturally responsive intervention (Sue and Sue, 2016).
- Whose culture is the reference?

# Cultural factors

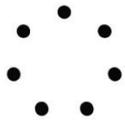
- The case of the bone density test
- Imported devices/machines come with imported reference values (e.g. in Vietnam, these are European females' numbers of the same age).



# Metaphors of culture



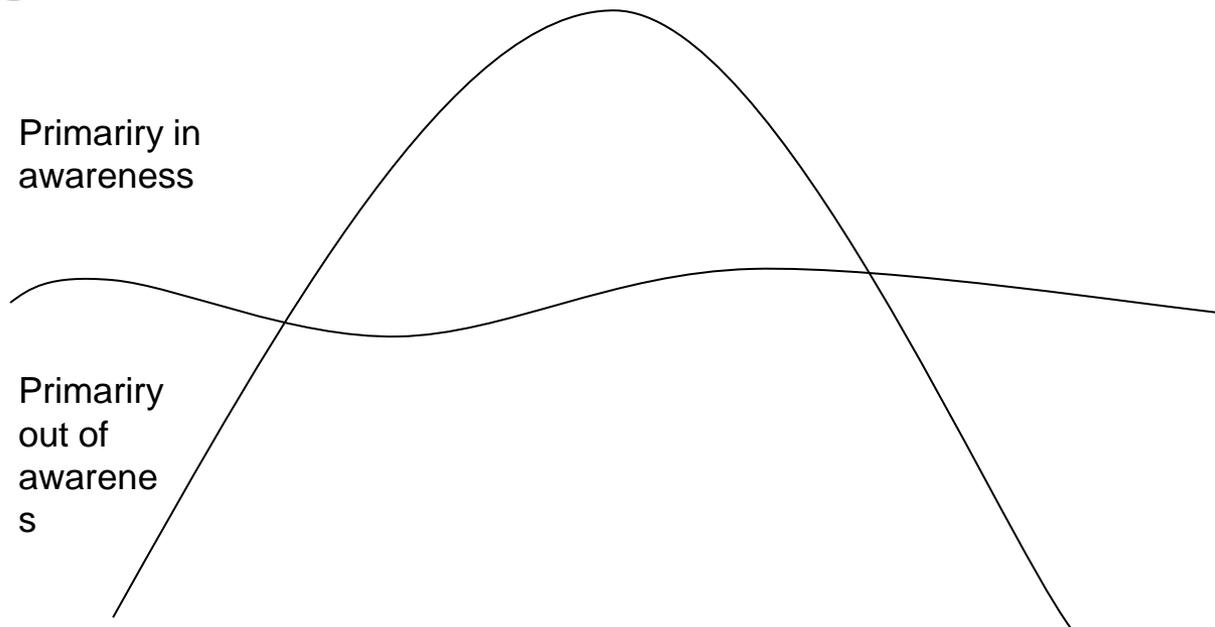
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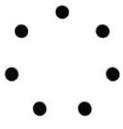


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# Iceberg model of culture



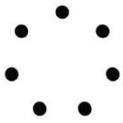


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# Cultural competence: questions

- Question of the conceptualization of cultural competence (is it within the person, is it in the interpersonal interaction, is it in a broader context, as a part of the adaptation?).
- Question of measurement (related to the question of concept) (e.g. adaptation of measurement in Hungary, MUPS MUSIC team).
- Question of the outcome of cultural competence training.

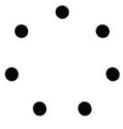


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# Cultural competence: questions

- Question of the simplified concept of culture, of conflating other factors with culture.
- Question of reinforcing stereotypes – combined with the „outgroup homogeneity effect” – about specific group in cultural competence training (e.g. Gregg and Saha, 2006).
- Is it possible to learn, to know about all the individual cultures and their characteristics the clinicians will come across? (previous effort in medical education to teach about certain ethnic minority - „other” – groups.)
- Does focus on cultural competence draw attention from or can it address the „larger factors that contribute to racial/ethnic disparities in health, such as poverty, lack of education, the environment, and poor access to care...” Batencourt, 2006, p. 500.)
- Does the informal (corridor talk, contact – if at all – with medical students from minority groups), and hidden curriculum (e.g. institutional slang, e.g. culture means others, not us) support the formal curricula’s cultural competence focus?
- Cultural competence was introduced as compulsory in the US medical training, results have been mixed. Europe? (Sorensen et al., 2019): rather mixed or poor indicators (but great potentials) in an EU funded project with 12 partners.

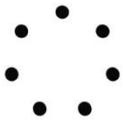


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# Cultural competence

- Disparities in health can partly can be addressed by improving patient-physician communication and trust!
- Shift from teaching about specific cultural group to the understanding of „the issues that arise most commonly due to cultural differences, and how they may affect a physician’s interactions with any patient”. (Batencourt, 2006, p. 499.)
- Understanding the basic mechanisms of intergroup, intercultural interactions. E.g. AUM Anxiety, Uncertainty Mangement Model by Gudykunst (2005). Uncertainty is given, and is being multiplicatively combined with the ambivalent and complex nature of several medical cases: MUS.

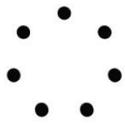


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# Cultural competence

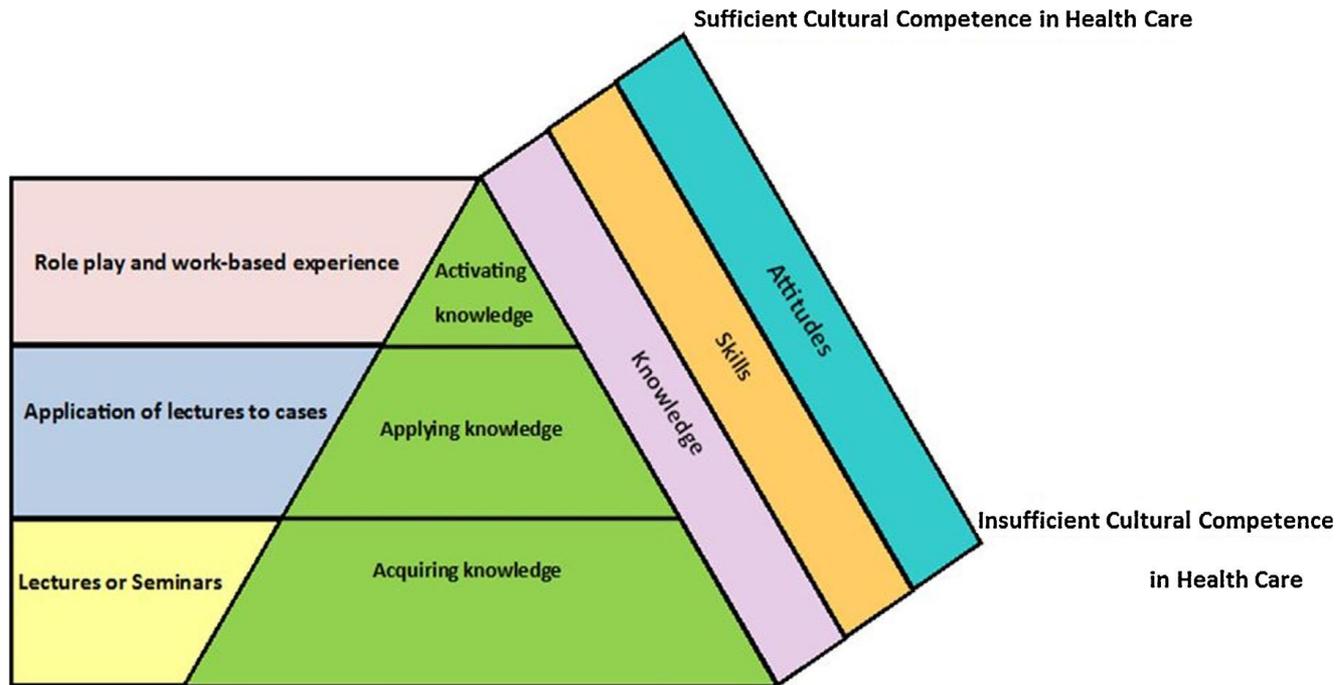
- Some cultural dimensions that could be important
  - individualism/collectivism and the concept of agency (Autonomy vs. Heteronomy). E.g. less patient participation and verbal assertiveness in some collectivistic cultures, it would come with less patient engagement (Timmermans, 2020).
  - Power distance (Hofstede, 2001).
  - Control motivation (Yamaguchi, 2001): the greater role of proxy control in collectivistic cultures that consider harmony (and not autonomy) the most essential task. Proxy control could be given to the physician.
  - Loose vs. Tight cultures (if there are many strict rules, and sanction for deviance from rules and norms → there is higher compliance with pandemic related regulations, Gelfand, 2021).
  - Analytical vs. Holistic thinking (Nisbett, 1993).
  - Important: cultures are not static, and not homogeneous!

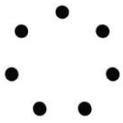


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# Cultural competence: an example -The pyramid model (Costantinou et al., 2018)



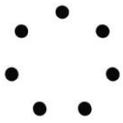


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# Structural competency

- Huge disparities in health care.
- Recommendation for medical training with a **structural focus** (Meztl, Hansen, 2014).
- Not always the interaction between the members of culturally different, but otherwise equal cultural groups. Differences in status, power has an important role.
- Social and economic forces. Above the interpersonal level. Outside the clinical setting.
- E.g. A patient does not take the medication prescribed by the doctor for her. Besides/instead of thinking of possible cultural or individual causes, other important things should be considered: insurance, hospital, or health care administration policies influence the amount of time that the doctor can spend with the patient and explain why it is important. If there is a bus stop nearby, if she has financial resources to buy the medication, to go back to the doctor....

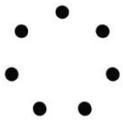


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# The interactional approach

- Myriad aspects of identity and group membership and context of both patients and clinicians: cultural, ethnic, religion, gender, age, socioeconomic, sexual orientation, health status, able-bodied and disabilities...(Sears, 2012).

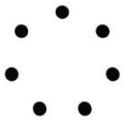


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## Further important aspects and change

- From cultural competence to cultural humility, life-long commitment and active engagement in self-evaluation, self-critique in psychiatric education (Trinh et al., 2021). Resemblance to self-improvement (and not self-enhancement) motivation, more characteristic of e.g. East-Asian cultures (Markus, Kityama, 1991).
- Related to the above: continuous refinement, critical-consciousness of the self, others, and the world; social justice (Kumagai, Lypson, 2009).
- Recognizing implicit bias.
- From patient-centeredness to the concept of the engaged patient who takes initiatives and negotiates (but: cultural differences can be important here).

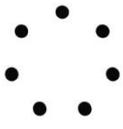


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## Further important aspects and change

- Codesign and coproduction of medical training with patients/customers and other stakeholders (Kealy-Bateman et al., 2021).
- What about the diversity of medical students? Jenkins et al., 2021: stratification of medical profession. Class: very unproportionate (very few from low SES, they face „everyday classism”, it is also „cultural clash”, Markus, 2016). Ethnic background of medical students has become a bit more diverse. Higher rate of women but they experience more stress, facing more difficulties such as harassment.
- Learning from the literature of minority teachers’ assets and difficulties (Juang, 2020).

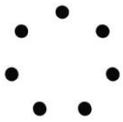


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# Conclusions

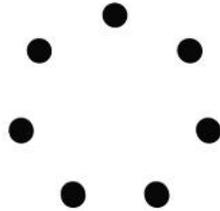
- Medical education in a diverse context: very complex task, a lot of change, a lot of challenge and a lot of potential.
- Cultural and structural; intersecting categories and dimensions; inside and outside the clinical setting; formal, informal and hidden curriculum; life-long time frame; competence and social justice; several stakeholders; the increasing role of the patient.. Just to name a few.
- The knowledge about intercultural, intergroup relations' psychological mechanisms would be essential (for deeper understanding).
- Biopsychosocial (and cultural) approach!



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**Thank you for your attention!**



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