Journal of the British Islamic Medical Association

Advocacy
Vol 18 - No.6 | December 2024 | www.jbima.com
ISSN 2634 8071

Facilitating Acculturation in Medical Training: Moving Away from "Melting Pots"

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Keywords: *Discrimination, Islamophobia, faith inclusion, faith accommodation, acculturation, medical education, medical training, wellbeing*

Medical training acts as a "secondary socialisation process", predominantly through a hidden curriculum which "instils behaviours, attitudes, and values among trainees"[1]. It has been argued that increased secularisation of society and medical practice[2] is creating an observable trend towards radical secularism, the active erasure of religion, with modern medicine described as being "hostile" to religion and spirituality[3].Meanwhile, religious diversity is increasing in the UK, with minority religions over-represented compared to the general population and just over 10% of doctors identifying as Muslim[4], although, this is likely to be an underestimate due to stereotype threat and identity concealment reported by Muslims[5].

Research also demonstrates that religion/spirituality has an influential role in medical student socialisation, and can be a protective factor in moderating emotional stress, compassion, work-life balance and interpersonal relationships with colleagues[1].Acculturation theory, from the field of group relations in psychology, can be a useful lens to explore the interaction between Muslim learners and their learning environment, analogous to migrating to a secular-atheist dominant "host" culture of UK medical institutions.

Research shows that religious medical students can struggle with issues around identity and self- esteem but they are also more likely to use faith-based methods as positive coping mechanisms, experience less empathy fatigue, and report increased religiosity as medical school progresses.[1] However, students can also experience religious discrimination that adversely impacts educational experience and outcomesat several points across medical school, and is more pronounced during clinical placements[6].

For Muslim medical students and residents, the experience of religious discrimination is amplified by Islamophobia, with compounding intersectional forces of gender and race, often referred to as "The Triple Penalty"[7]. Islamophobia occurs on a spectrum; from biases, prejudices and micro aggressions to overt discrimination, resulting in pervasive marginalisation and exclusion.

The Manchester Muslim Student Guide (MMSG), co-produced by medical students, faculty and educators[8], is a guide which aims to highlight practical steps that can foster inclusion and wellbeing for Muslim medical students. Areas covered in the guide include prayer rooms, religious practices, dress codes, and strategies to address discrimination and Islamophobia. The authors of the guide reflect on the value of empowerment-led student advocacy and the importance of faculty engagement and accountability. However, many challenges and conflict remain. In a recent GMC survey, amongst Asian medical trainees, Muslims were found to have lower pass rates[9]. Studies on differential attainment have consistently shown that a suboptimal learning environment is the main contributor, rather than individual learner deficit[10].

Acculturation theory as theoretical lens

Drawing on the work of Berry, acculturation theory can be a useful lens to understand the processes of adaptation

and accommodation to underpin advocacy work on faith and cultural inclusion in medical training. It has been used extensively in research looking at International Medical Graduates (IMGs) experiences[11-13]. Acculturation is "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members…resulting in various forms of mutual accommodation and longer-term psychological and sociocultural adaptations between both groups"[14]. From the perspective of the non-dominant group, two critical factors determine the acculturation strategies adopted: the desire to maintain cultural identity and heritage, and the desirability of intercultural contact[14].

Acculturation can result in four outcomes: integration, where individuals preserve their cultural identity whilst simultaneously maintaining intercultural contact to facilitate participation as an integral part of a larger social network; separation, where individuals turn inwards towards their heritage culture and disengage from involvement with other cultural groups; assimilation, where individuals shed their culture and become absorbed in the dominant culture; and marginalisation, where there is limited interest in having relations with others and in maintaining their own cultural heritage, which often occurs due to enforced heritage loss and in response to experiences of discrimination and exclusion[14].

Additionally, there are three observable behavioural shifts that can be observed: cultural learning, culture shedding and culture conflict[15]. Culture shedding is associated with assimilation, whereas integration involves cultural learning with limited cultural shedding[15]. The opposite is the case with marginalisation and separation is a consequence of a lack of bothcultural shedding and cultural learning[15]. Additionally, conflict and stress in the process of acculturation can result in acculturative stress, with specific manifestations around poor mental health, feelings of alienation and heighted psychological and psychosomatic symptoms[15]. These are consistent with discriminatory and exclusionary experiences reported in the MMSG[16].

Acculturation at the individual level is termed psychological acculturation and different adaptation outcomes have been identified[15]. These include adjustment, where there is increased congruence between the individual and environment, and is often the strategy intended by the term adaptation; reaction, where there is retaliation against the environment to increase congruence; and withdrawal, which can be voluntary or forced exclusion and results in removal of the individual from the environment[15]. Importantly, Berry demonstrates that assimilation is not the only way to acculturate and adjustment is not the only way to adapt[15]. In wider research, policy and political narratives around British Muslims, integration can be highly charged with Islamophobic and racist overtones underpinned by assimilatory objectives[17]. This distinction is important to understand for both Muslim learners and educators.

On an institutional level, adaptations can be divided into accommodations and modifications. In simple terms, accommodations change how a student learns, whereas modifications change what a student learns[18] . However, terminology is often confused with all three terms used interchangeably. This is problematic as it may give the impression that faith/cultural adaptations are in response to learner deficit, which contradicts the prevailing literature around differential attainment highlighted above.

Applying acculturation theory

When groups choose to acculturate, there are large variations in the way they do this and even engage in the process[15]. At the sociocultural level, the two groups, in this case Muslim learners (students and residents) and secular educators, may have some initial ideas about preferences or goals they wish to achieve, as well as the steps that need to be taken to achieve them[15]. The strategic goals set by the groups of which individuals are members of influence longer term outcomes both in terms of sociocultural and psychological adaptations[19].

It is important to note that whilst adaptations in both groups are implied, most changes occur in the non-dominant group[15]. This is partly because individuals from the non-dominant group do not always have complete autonomy over their choice of acculturation strategies and outcomes[20], such as due to an absence of psychological safety, as evidenced by the reluctance to report concerns amongst medical students experiencing discrimination[6]. Additionally, the strategies of the HC society in relation to the two critical factors of identity/heritage attachment and contact desirability also determines outcomes[11].

Furthermore, the experience of religious discrimination and Islamophobia amongst Muslim students points to cultural conflict, separation and acculturative stress, which can contribute to poor adaptation, negatively impacting educational experience and outcomes[16]. Pioneering work by Ying Fei Heliot explores the

intersection of religion in the workplace and highlights how religion/occupation identity tensions have a negative impact on psychological wellbeing and work outcomes amongst healthcare staff[20], which is relevant to Muslim residents who have a dual role as learners and service providers.

The term "host receptivity" has been used to describe the HC'swillingness to accommodate those from other cultures and provide opportunities to participate in local social communication processes'[21]. It is argued that for integration to occur, there are key attributes that the dominant society must possess: open and inclusive orientation and a willingness for mutual accommodation[21]. However, the dominant group significantly influences the way in which acculturation takes place, with four possible objectives: melting pot, segregation, exclusion and multiculturalism[15]. This is relevant when considering the strategies that medical institutions adopt to accommodate faith and belief, a protected characteristic under the Equality Act[21].

When assimilation is sought by the dominant acculturating group, it is termed "melting pot", when separation is forced through, it is called "segregation", when marginalisation is imposed, it is termed "exclusion", and when diversity is an accepted feature inclusive for all ethnocultural groups, it is termed "multiculturalism"[15]. Inconsistencies and conflicts between these acculturation preferences can be sources of difficulty for acculturating individuals and result in acculturative stress.

The hidden curriculum can be a particularly potent source of acculturative stress for Muslim learners, through shaping sociocultural norms and behavioural practices, such as alcohol-fuelled social gatherings. Additionally, the formal curriculum, can perpetuate exclusion of Muslim medical students both in form, such as timetabling during Friday prayers, which is a source of moral conflict and distress for students who wish to pray, andcontent, being focused on colonial Eurocentric concepts of health and healing. Thus, the current learning environment resembles a melting pot that is not open, inclusive or adaptive.

Towards a middle way: cultural humility

In current trends of increasing cultural and religious diversity amongst the medical student body, equality, diversity and inclusion (EDI) initiatives must move away from promoting melting pots to multiculturalism within medical institutions. As Berry writes: "we all ask: how can peoples of different cultural backgrounds encounter each other, seek avenues of mutual understanding, negotiate and compromise on their initial positions, and achieve some degree of harmonious engagement?"[14]. Research in the NHS demonstrates that where religious and occupational identities are actively brought into alignment, occupational practice is enhanced and creates the possibility of integration such as empathy in caring professions[20]. This can be extended to student/residentlearning and the positive development of professionalism and achievement of capabilities.

Ward and Szabo present an integrated framework for social learningexperienced by"non-natives"[23]. Here, this translates to non-nativeMuslim learners in a religiously-hostile learning environment[3] who need to undergo social learning to develop behavioural and sociocultural adaptation, in addition to the early learning and psychological adaptation that takes place during acculturation[11,23].The framework references personal and situational factors which shape antecedents of culture learning, and learning strategies, processes and outcomes, which over time lead to behavioural and sociocultural intercultural competence[23].

Cultural (or intercultural) competence, is described as 'the ability to communicate effectively and appropriately in intercultural situations based on one's intercultural knowledge, skills and attitudes'[24]. However, the focus on cultural competence training seen in current EDI initiatives is based on short-term interventionswhich are unlikely to be effective[24]. Cultural humility CH) is an alternative practical and sustainable approach which has a reflexive and practical ethos and focused on developmental processes emphasising process-in-context. CH places emphasis on self-awareness and relationships and shifts the focus from cognitive approaches towards socio-emotional skills[26].

CH places onus on those holding privilege to recognise and challenge assumptions and redress power imbalances at interpersonal and institutional levels. This can create cultural safety, as an outcome of conscious efforts to address power differentials and biases[26]. Practically, this involves setting up "brave spaces" for regular respectful dialogue, learning and reflection based oncuriosity, courage and compassion. Drawing on acculturation theory, cultural humility is thus likely to increase cultural contact and learning and decrease cultural shedding, conflict and acculturative stress, associated with improved integration and adjustment, whilst avoiding the extreme strategies and outcomes of assimilation/ melting pots on the one hand, and separation/segregation and

marginalisation/exclusion on the other. CH can therefore promote positive outcomes of sociocultural integration and psychological adjustment with thriving multicultural learning environments which welcome and celebrate religious diversity and where each learner flourishes.

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