Original Article

Journal of Advances in Medical Education & Professionalism

Sentient Intercultural Self-Efficacy: Constructing Intercultural Competence in Health Sciences students

DEBBIE ÁLVAREZ-CRUCES[1*], PhD; JUAN MANSILLA-SEPÚLVEDA[2], PhD; ALEJANDRA NOCETTI-DE-LA-BARRA[3], PhD

[1]Facultad de Odontología, Universidad de Concepción, Chile; [2]Facultad de Educación, Universidad Católica de Temuco, Chile; [3]Facultad de Educación, Universidad Católica de la Santísima Concepción, Chile

Introduction: The increase in migration movements, global health challenges, and the requirements of different organizations have emphasized the importance of Constructing Intercultural Competence (ICC). However, not all countries have policies to achieve this. Therefore, this research aimed to understand the process of constructing Intercultural Competence in the professional training of Health Sciences students.

Methods: A qualitative study with a Grounded Theory design was conducted. Semi-structured interviews, lasting 40 to 50 minutes, were conducted with students in their last year of training to comply with the intensity sampling. Theoretical sampling was achieved using the Constant Comparative Methods, interview refinements, and data saturation by program and university to propose theoretical codes. Focused Coding allowed grouping and establishing relationships between the codes and categories. Two accredited Ethics Committees in Chile approved the study.

Results: 106 students from three universities, including medicine, midwifery, nursing, nutrition, dentistry, pharmacy, and kinesiology, participated. Two categories were formed: 1) the construct of Intercultural Competence, composed of seven stages which were named Sentient Intercultural Self-Efficacy; and 2) precursors of the construct of Intercultural Competence, composed of intrapersonal characteristics, the nature of empathy and the materialization of will.

Conclusion: The precursors to the construction seem to favor critical thinking, which enables the development of Sentient Intercultural Self-Efficacy. However, the strong influence of valid scientific evidence, combined with vicarious learning, causes a setback in achieving the construction. This demonstrates the need to develop a critical perspective among students to challenge the prevailing *status quo* characterized by an equality and ethnocentric approach to patient care. Achieving *Intercultural Alternative Thinking*, where individuals are open to incorporating other treatment alternatives that may not necessarily have scientific evidence but could benefit patient recovery, is essential.

Keywords: Cultural competence; Grounded theory; Healthcare; Intercultural competence; Learning; Students

**Corresponding author:*
Debbie Álvarez-Cruces, PhD;
Facultad de Odontologıa,
Universidad de Concepciyn,
Chile
Tel: +56412203480,
Email: debbiejalvarez@udec.cl

Please cite this paper as:
Álvarez-Cruces D, Mansilla-Sepúlveda J, Nocetti-De-La-Barra A. Sentient Intercultural Self-Efficacy: Constructing Intercultural Competence in Health Sciences students. J Adv Med Educ Prof. 2025;13(2):93-104. DOI: 10.30476/jamp.2025.104564.2067.

Received: 26 October 2024
Accepted: 9 February 2025

Introduction

The increase in migratory movements worldwide (1), the need to respond to global health challenges (2), and the policies and requirements emanating from the United Nations and the World Health Organization (WHO) have made clear the relevance of developing Intercultural Competence (ICC) in future health professionals (3, 4).

In healthcare, ICC is often used as a synonym for Cultural Competence (5, 6); however, currently, the most accepted term in various disciplines is the former (6, 7). The extensive theoretical and conceptual development has resulted in multiple models and definitions (8-10). Garrido compiled a total of 36 ICC models: 24 in the health field, 4 in education, and 8 in other disciplines (11), aligning with the systematic review conducted by Butler et al. (12), who also identified 24 models in health. However, achieving ICC remains an unresolved challenge in various parts of the world.

The most widely used definition in the healthcare field, which appears in the MeSH Thesaurus, was proposed by Cross et al. (8). They define ICC as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."

Educational models generally emphasize acquiring knowledge, skills, and attitudes (11, 13, 14). In contrast, health-related models include an additional component: awareness (8-11). This allows individuals to reflect on their own beliefs and values as a foundation for understanding others, with the goal of providing care free of bias, stereotypes, and prejudices (10, 15-17).

Some countries have mandatory accreditation criteria requiring Health Sciences programs to develop ICC during professional training to provide culturally relevant care (8, 18). These contents are integrated into the curriculum as mandatory or elective components, featuring active methodologies in both face-to-face and virtual formats besides Service Learning Experiences to promote cultural awareness and sensitivity. The effectiveness of educational interventions is often assessed through standardized questionnaires (19, 20). Nonetheless, not all countries have established mandatory and explicit criteria for incorporating ICC into the curriculum (19-22), as in the case in Chile.

In this country, the Ministry of Education establishes that Health Sciences programs may only be offered by Accredited Universities, which must meet high-quality criteria and standards to be recognized as institutions of excellence (23). Additionally, each health program has specific standards, including ensuring ethical training that respects cultural differences (24).

Meanwhile, the Ministry of Health explicitly states that curricula should include topics related to migration, interculturality, human rights, social determinants, and gender in health education. However, criteria to assess these dimensions and respond to the current national context have not yet been established (25).

Thus, in Chile, achieving ICC is left to the discretion of each student and/or professional when confronted with intercultural reality in clinical practice (18, 26, 27). Although efforts to incorporate the topic into the curriculum have been observed, they are limited to determined universities and courses (18, 28, 29), and the content primarily focuses on bioepidemiological and bioethical aspects. This results in technical and procedural knowledge with little emphasis on the cultural implications of the healthcare process (18, 19, 30). Consequently, given the limited training for achieving ICC in the curricula of health programs in Chile, this research aimed to understand the process of constructing ICC in Health Sciences students during the care of migrant patients.

Methods

Research Design and Participants

A qualitative study with a constructivist Grounded Theory design was conducted as it allows for understanding the realities and processes of the research context and its participants (31, 32). Additionally, this method is suitable for research on social justice, as it highlights underlying issues, promotes future actions, and reveals the interactions among the gathered background factors (33). In line with this, the aim is to understand the process of constructing ICC to improve the Health Sciences curriculum, fostering inclusive healthcare that is culturally relevant for migrant patients.

Participants were selected by intensity sampling (34), a type of purposeful sampling, which is characterized by selecting individuals who are familiar with the phenomenon of interest on a frequent basis although they were not experts. Thus, the participants were Health Sciences students in their final stage of training, specifically during their clinical internships, to explore the experiences they had accumulated throughout their years of study with migrant patients. However, none of them had received formal training in ICC, so they were not experts.

Data Collection and Measurements

Semi-structured interviews were carried out with

final-year students of medicine, midwifery, nursing, nutrition, dentistry, pharmacy, and kinesiology from three universities in Chile, from mid-2021 to early 2023, until data saturation was reached by career and university. The questions were characterized by being open-ended to uncover unanticipated meanings and gather as much information as possible related to the research objective. The interview questions are included in Table 1.

Participants were contacted by e-mail, and the interviews were conducted via Zoom, which lasted 40 to 50 minutes on average and were saved in audio format to protect the confidentiality of the participants.

Data Analysis

The data analysis was carried out rigorously and systematically, beginning with the early analysis of the first interviews (31, 32). The initial codes used were primarily *in vivo*, to maintain the descriptions provided by the participants as much as possible. The collected data were compared across different careers and universities. Additionally, various memos were created, which allowed for formulating new questions based on the findings that emerged (31, 33).

This led to theoretical sampling (31, 32), as the new interviews enabled comparisons between different participants—those who had progressed in constructing ICC and those who had not; and a deeper exploration of the factors influencing the process. In this way, the first theoretical codes were established until data saturation was reached by program and university. This required a process of induction, deduction, and abduction to propose the concepts that emerged from the inductive process of this research, as well as from pre-existing theories that guided the fieldwork (31, 32). Then, focused coding grouped the data into two main categories.

Finally, the different categories and theoretical codes were related to one another to establish the causes, contexts, contingencies, consequences, covariances, and conditions that help to understand the process of constructing ICC in Health Sciences students while caring for migrant patients (31-33).

Ethical Considerations

The research has the approval of two accredited Ethics Committees in Chile, the Health Service of Talcahuano and Concepción, in addition to the committees of the universities that participated in the research, whose names were anonymized due to the confidentiality agreement. Participants signed the informed consent form in a PDF file before the interview. Ethics committee approval code: CEC-SSC: 21-06-32.

Results

One hundred six students from seven health programs from three Chilean universities participated, as detailed in Table 2. Based on the data analysis described above, two categories were formed that allowed us to understand the construction process of ICC in Health Sciences students, as described below.

Category 1: Intercultural Competence Construction

This category describes the stages health sciences students go through to provide care to migrant patients. The data analysis, including the quotes supporting the present subcategories, is shown in Table 3.

Table 1: Interview questions

Research objective: To understand the ICC construction process in the professional training of Health Sciences students while caring for migrant patients.
1. What have been your experiences with migrant patients during your years of study?
2. What feelings did you have when attending to your first migrant patient?
3. What challenges or difficulties did you face when providing care to migrant patients?
4. What strategies did you implement to improve your care for migrant patients?
5. What do you think needs to be incorporated to improve care for migrant patients?

Table 2: Characterization of the participants

Career	University 1		University 2		University 3		Total
	Man	Woman	Man	Woman	Man	Woman	
Medicine	4	5	7	1	NA	NA	17
Midwife	NA	NA	2	7	0	1	10
Nursing	2	5	2	6	0	1	16
Nutrition	1	7	0	8	0	6	22
Dentistry	NA	NA	5	5	NA	NA	10
Pharmacy	NA	NA	5	5	NA	NA	10
Kinesiology	3	4	1	7	3	3	21
Total	10	21	22	39	3	11	106

NA= Not Available at this University

Table 3: Category 1; Intercultural Competence Construction

Subcategory	Grounded	Verbatim
Sensible Perception	454	(…) people are arriving from other countries, immigrants with need, looking for work, a better life, and if they are already here, we cannot tell them, "No, go away," "No, we won't take care of you." People think that the worse you treat them, they Will return to their countries, which is not the case (…). They are human beings; they are people, regardless of whether they are Venezuelan, Haitian, or whatever; they are human beings who need our help as health professionals in any health area; the truth is like double the responsibility. If they come to us, we need to treat them with the utmost care; they are people who need us. WNu5(3)
Transfer of learning	181	I mean, with migrants, I'm not familiar with the beliefs they may hold, but I do know they likely use herbs. Just like here, the Mapuches have certain beliefs. I think that if the herbs are used as an adjuvant to the therapy and not as a replacement, there would be no issue. For instance, in the hospital, we often recommend using matico herb water as a healing agent. So, it would also be possible to suggest some of the herbs they use. But if the intention is to replace the treatment, it becomes a conflict because no matter how beneficial and noble plants are, they won't substitute for something like antibiotic treatment, for example. It's a different matter. WN2(2)
Maintaining the status quo	418	We educated the Haitian population about healthy eating. So, we showed them healthy eating, with typical foods from here, from Chile. [Interviewer's question: Didn't they give you dietary guidelines based on your culture?] No, we just showed her the healthy food in Chile based on the dietary guidelines we have here. WNu1(1)
Learning from incongruence	242	**Practical reflection, progressing to the Experiential Knowledge stage.** [Context: Care of a 5-month-old infant. In the room was the teacher trainer, the nutrition intern (who recounts the story), the Haitian mother, and the infant]. She would say, 'Give him this,' while marking on the pamphlet what the child should be fed, but there was nothing instructional about it—no images, just written material. I don't think the mother understood the instructions; she simply repeated what the pamphlet said (...). So, obviously, it was going to be a bit difficult for the mother to follow the instructions, as she wasn't familiar with the local foods either. MNu6(1)
	107	**Technical reflection is moved back to the Maintain *Status quo stage*.** [Context: Following care of a Haitian patient with an ankle fracture.] But looking for something related to that specific patient, in terms of her being an immigrant, not really; it didn't make me feel the need to look anything up because the interaction was so familiar, very similar to how you treat any patient in Chile. It didn't spark that curiosity to search for something related to their nationality. MK1(1)
Experiential knowledge	366	The truth is that I am very international in the sources I look for. I read a lot about other countries; I also read things about Chile. If I have doubts, I use my social networks and talk to professionals from outside the country, generally Argentines, Colombians, and Venezuelans. In fact, I also meet with professionals of other nationalities who work here. WNu6(3)
Modification of practices	84	**Critical reflection progresses to the Intercultural Alternative Thinking stage.** It should be as protocolized as when a patient from another religion arrives for treatment. Like Jehovah's Witnesses who cannot transfuse. If a Jehovah's Witness patient arrives, we all automatically know that this person will not want to be transfused because of their religious beliefs. We should have the same attitude towards anyone, especially if they come from another culture. We should put ourselves in more cases, not just focus on one issue. We are very short-sighted in that sense; we should give ourselves the freedom to understand different patient perspectives and open up to more cultures. MN4(1)
	63	**Critical reflection is at risk, and we could regress to the stage of Maintaining the *status quo*.** (...) but it is still difficult to try to include it [patient's culture or belief] because.... generally, in medicine, we are taught that everything is based on scientific evidence. So, we cannot give indications that do not have a scientific basis... it is hard, but that is how it is... Mostly for that reason, not because it will not produce benefits, but to prevent it from harming them. So, in that sense, it is difficult to include the different ways of doing medicine from other cultures. MM5(2)
Intercultural alternative thinking	9	I mean, no, not because there is no scientific evidence or because we do not know more about it; we should disregard other people's beliefs. I mean, no, it has nothing to do with it; it is disrespectful not to trust what the person says because they are the ones who are feeling it; they are the ones who know if it is better or not. Even if you say: "No, don't do this because it doesn't work", no! I mean, I can stop my therapy there, and the person will stop seeing me and will do whatever they want. WK8(2)

The coding of the textual citations was conducted as follows: First letter: sex of the participant (man: M and woman: W), second letter: career of the participant (medicine: M, nursing: N, midwife: Mi, pharmacy: P, kinesiology: K, dentistry: D and nutrition: Nu), number without parentheses: number assigned to the participant according to the career, number with parentheses: number assigned to the university.

The construction of ICC was called Sentient Intercultural Self-Efficacy because it is activated when the student observes, listens, knows, or ascertains the situation of vulnerability of the migrant patient during the healthcare process. This encounter stimulates their perception of achievement with actions aimed at recovering the patients' health and alleviating their distress. Thus, the Health Sciences student mobilizes different knowledge, skills, and attitudes autonomously to provide healthcare to the migrant patient.

Sentient Intercultural Self-Efficacy is composed of seven stages, which are described as follows:

1. Sensible Perception

This corresponds to the first stage of constructing ICC, when the Health Sciences student faces the reality of the migrant patient during healthcare delivery. This generates various emotions, described by the participants as anxiety, unease, distress, and stress, which translate into genuine concern for the patient's situation, motivating the student to take action.

2. Transfer of Learning

At this stage, students transfer diverse learning acquired during their professional training that, in some way, helps them to understand the reality of the migrant patient. However, they lack knowledge about the specificities of each culture, which could influence the healthcare process.

3. Maintaining the status quo

In the third stage, the student observes and learns from what his/her instructor recommends during the healthcare provided to the migrant patient. It is characterized by equality and ethnocentrism, where universal principles that maintain the *status quo* are applied without making the necessary adjustments to respond to cultural variability. Thus, when the students provide care independently, they repeat the pattern learned from their instructor, which accounts for Vicarious Learning. Nonetheless, a certain group of students reflected on and analyzed the care provided to migrant patients, considering that certain aspects could be improved. This leads to the next stage of Sentient Intercultural Self-Efficacy.

4. Learning from incongruence

In the fourth stage of Sentient Intercultural Self-Efficacy, Learning from Incongruence originates. This is characterized because the Health Sciences student makes a first reflection on the healthcare provided to the migrant patient, in which they detect an incongruence between the care provided (equality and ethnocentrism) and what should have been provided (with cultural relevance). In addition, the student realizes that he/she does not have sufficient knowledge and tools to achieve this. This situation motivates them to deploy various strategies to provide culturally relevant care, which leads to the next stage.

However, a certain group of students, despite detecting the incongruence in the care provided to the migrant patient, considers that the transfer of learning is enough to overcome the situation and respond to the patient's requirements, so they do not go deeper into the cultural aspects, going back to the stage of maintaining the *status quo*, which is characterized by equality and ethnocentric care.

5. Experiential knowledge

At this stage, Health Sciences students develop experiential knowledge while caring for migrant patients and self-manage learning to incorporate new knowledge to provide culturally relevant care. The student becomes aware of all the factors to pay attention to when caring for these patients for proper treatment planning, including language and linguistic adaptation, social and cultural implications in care, and pathophysiological considerations. This allows you to advance to the next stage of Sentient Intercultural Self-Efficacy.

6. Modification of practices

At this stage, the Health Sciences students have a second moment of reflection related to the organizational aspects of the Health System and recognize that it is possible to manage, reorganize, or rethink health care to consider the culture of the migrant patient, which would allow them to advance to the next stage of Sentient Intercultural Self-Efficacy.

However, it is also possible to observe a certain group of students who are more conservative about incorporating the patient's culture into care because it would require structural changes that would be complex to manage on their own because they are based on valid scientific evidence, such as care protocols or clinical standards. Thus, they regress to the stage of maintaining the *status quo* until evidence supports their professional actions.

7. Intercultural alternative thinking

This corresponds to the last stage of Intercultural Sentient Self-Efficacy, in which the Health Sciences student adopts a critical stance towards the hegemonic biomedical model that standardizes healthcare, maintaining the *status quo*.

Table 4: Category 2; Precursors to Intercultural Competence Construction

Subcategory	Grounded	Verbatim
Intrapersonal Characteristics	44	Curiosity I always look for the opportunity to ask questions and to go further. I say: "Hey doctor, why did this patient say this?" or "What happened with yesterday afternoon's patient? How was she? What happened to her? Why did she arrive like this? I am trying to understand my professors' reasoning when caring for these patients so I can learn. MM7(2)
	213	Reflexivity So, I believe that one cannot impose one thing because it is part of the patient's beliefs; it is also valid. So, it is you who has to evolve (...). Maybe it will take a little more time, but you must analyze the patient's global context because you cannot undermine or impose anything on them. We just must adapt to the situation and deal with it in the best possible way. WK5(1)
	256	Social sensitivity I believe a lot is missing in the care of migrants. We need to extend consultation times and be a bit more flexible in that regard to facilitate communication and actions for promotion and prevention. More visual material is needed to overcome the language barrier. Many times, these patients are at greater biopsychosocial risk, so they need more attention and guidance, as well as greater support. WMi1(3)
	76	Professional Vocation I have done many clinical exchanges outside the country almost every summer. I have also been to Europe, so I speak a little French. I learned about multiculturalism as I went along and how patients are handled in other countries. I also participate in a religious group, so it helps me to understand other beliefs. In addition, with the immigration of people from Peru, Bolivia, and Venezuela, I have been able to talk with them. This way, I have encountered different cultures, foods, and diseases. Doctors from other countries have also arrived, and they are also teachers, so we take advantage of the opportunity to ask them all the questions in the same classes. WM2(2)
Nature of empathy	116	Intersubjective It is also necessary to think that the [migrant] patient is involved in the social world or in the world of work, so if they are on medical leave, it is very likely that they are not receiving a salary. So, it is important to do the rehabilitation quickly so that they can return to work and have money for their family. That's why you are a little bit more worried because she needs to work to feed herself and her child. MK2(1)
	167	Fellow Feeling I do think that there is a different treatment for immigrant patients in general, especially for patients of color, which generates a bit of helplessness. They are referred to as 'little Black people,' which, in my opinion, is inappropriate; I also heard them being called 'the dark ones.' So, in that sense, it's a bit infuriating how they are treated. Obviously, it doesn't always happen, but it does happen. WP5(1)
	55	Primordial I try to see what my life would be like if I went to another country. So, I put myself in their shoes; if I were to go to another country where I don't know anyone, where I don't know the culture, where I don't know how to speak the language, the only thing left for me to do is to prepare the food that I have eaten all my life, from my country, to feel at home. I see it that way. I mean, especially if you are alone, you don't even have your family, father, or brother. So, that way, you can have the feeling of being at home, of not feeling so far away. WNu6(1)
Materialization of Will	83	Willingness I believe it's not necessary to speak the patient's language to communicate with them; you don't need to be an expert,but having the intention (…) perhaps we will never be able to learn all the languages, but having soft skills, interest, and the desire to want to talk to the patient and seek strategies helps a lot. It's important for the patient to see that you are interested. WD4(2)
	38	Commitment I believe that the first thing is to seek the interest of both parties. First, the professionals who are in contact with these patients must make an effort, so to speak, to understand their culture and adapt the way they care for them based on their culture (...) The other thing is bringing this population closer to us (...) so that the patients know how to comply with their self-care. MM7(1)
	58	Perseverance She, in particular, did not speak any Spanish. She had a very indifferent attitude; you would ask her something, and she wouldn't even make an effort to answer. She wouldn't move her head, or she would ignore you. So what happened? The health team generally discriminated against her; they said she was lazy (...). Instead of joining the health team, I tried to look for solutions based on what I had available. Then, there were computers in the room, and she was right next to a computer, and I used Google Translate. I started to ask her closed questions, and after much trying, I got to the point of what was bothering her. She didn't know how long she was going to be hospitalized; no one explained it to her, so she had nothing prepared, she didn't bring any clothes, and she felt dirty. So I brought her a robe, and she went to change and wash herself in the bathroom, and when she came back, she was like another person; she even laughed. WMi3(2)

The coding of the textual citations was conducted as follows: First letter: sex of the participant (man: M and woman: W), second letter: career of the participant (medicine: M, nursing: N, midwife: Mi, pharmacy: P, kinesiology: K, dentistry: D and nutrition: Nu), number without parentheses: number assigned to the participant according to the career, number with parentheses: number assigned to the university.

The student is receptive to considering and incorporating other treatment alternatives that do not necessarily have scientific evidence but could benefit the patient's recovery.

Category 2: Precursors to Intercultural Competence Construction

This corresponds to qualities or characteristics that the Health Sciences students have, which contribute to the construction of ICC, allowing Sentient Intercultural Self-Efficacy. The data analysis with the verbatim that supports the present subcategories is included in Table 4.

Intrapersonal Characteristics

The student's own characteristics facilitate the approach to people from other cultures with the purpose of getting to know and understand them. In this sense, progression from curiosity to professional vocation can be observed.

1. Curiosity: Students who are characterized by their inclination to learn what is unusual or unknown to them.

2. Reflexivity: Students with the ability to constantly analyze their performance and external factors that may influence the achievement of their goals.

3. Social sensitivity: Students with the sensitivity and ability to analyze multiple factors to understand others and respond appropriately to their needs.

4. Professional Vocation: Students who are characterized by being curious, reflective, and socially sensitive constantly adjust their professional practice to develop the work they have chosen in the best possible way.

Nature of empathy

The professional vocation requires students to be moved by the situations or circumstances others experience, meaning they must have or acquire empathy. Thus, it was possible to verify that students demonstrate different types of empathy, which are described below:

1. Intersubjective: When the students areimpressed with the reality of the other, although he/she cannot fully comprehend it in its true measure because they have not experienced it, they can understand that the circumstances of the other are difficult or complex.

2. Fellow Feeling: When the student can bond affectively after knowing the circumstances that affect the other feeling compassion. Although they have not experienced them, they can infer the difficulties and sufferings of the other by making an analogy with their own circumstances that have been complex.

3. Primordial: The student has lived a situation similar to the one experienced by the other, so he/she can feel and vibrate with the same emotions.

Materialization of Will

Another important characteristic of Health Sciences students is their will and how it materializes in their professional practice. It is possible to identify different types, as described below.

1. Willingness: Students' capacity to want to perform some action that will allow them to fulfill their purpose. This would correspond to the minimum or basic will.

2. Commitment: The student's ability to analyze and become aware of the factors involved to make the best decision that will allow him/her to overcome the challenges accurately.

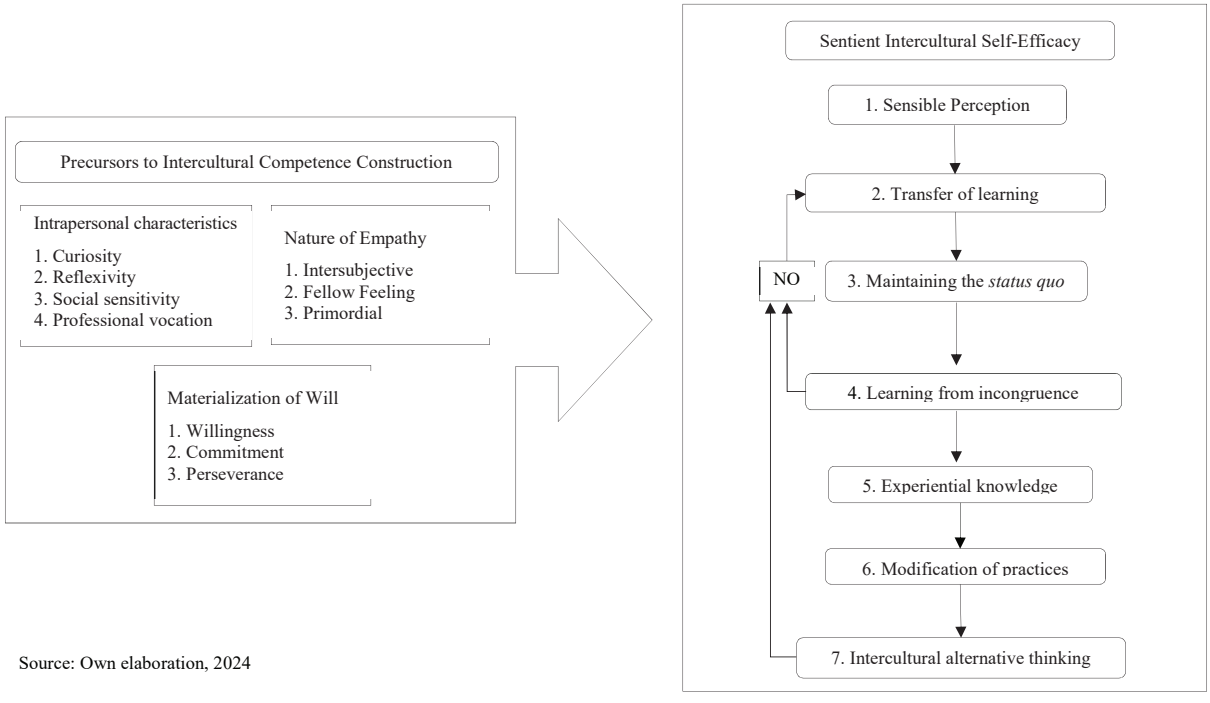
3. Perseverance: It is the highest degree of willpower, in which the student, in addition to being committed, does not give up in the face of the difficulties that arise, exhausting all possible alternatives.

As a result, the 6Cs of this research are based on the Chilean context, where there is limited training in ICC in the Health Sciences curriculum due to the lack of explicit criteria and standards to measure the development and achievement of this competency. However, both nationally and internationally, current conditions require a culturally appropriate response in healthcare delivery.

Figure 1 illustrates the process of constructing ICC, referred to as Sentient Intercultural Self-Efficacy, where the main driving force for students to act is Sensible Impressions, intending to address the health issue affecting the patient without adding to their emotional burden. This leads to implementing a series of strategies and actions aiming at providing culturally relevant care, which improves over time.

The aforementioned process would depend on the contingencies determined by the precursors of constructing ICC, such as intrapersonal characteristics, the nature of empathy, and the materialization of will. Figure 2, provided by the ATLAS.ti 24 program, shows that professional vocation, original empathy, and perseverance are linked to achieving higher levels of Sentient Intercultural Self-Efficacy.

However, two covariances were identified during the construction process that could hinder successful progression. One of these is vicarious learning, where students perpetuate attention patterns learned from their instructors; the other is valid scientific evidence that prevents the incorporation of cultural beliefs in healthcare, as they lack scientific backing.



Source: Own elaboration, 2024

Figure 1: Sentient Intercultural Self-Efficacy

This leads to a regression to the stage of maintaining the *status quo* in migrant patient care, characterized by equal and ethnocentric treatment.

Discussion

This research highlights the construction of ICC in Health Sciences students for caring for migrant patients within a specific context, referred to as Sentient Intercultural Self-Efficacy. It is evident that the sensitive impression of the other's reality motivates the student to act. According to Zubiri, when confronted with the reality presented to them, the individuals respond based on their moral consciousness and freedom of action, which corresponds to the directed will. Furthermore, alterity can have varying degrees of imposition, ranging from a weak influence to a very strong one, which is determined by the subjective value the individuals place on the reality they face (35). The latter is related to the different types of empathy identified since how the individual perceives the circumstances of the other will be under the personal experience he/she has in this regard (36).

In general, the students advance through the first stages of Sentient Intercultural Self-Efficacy without major problems until they reach the level of Learning from Incongruence, in which they make a first reflection on the healthcare provided to the migrant patient and that which should have been provided, detecting incongruencies. This reflection generates two possible responses in the individual; one is that the student manages new knowledge to respond with cultural relevance to the new scenario presented, evidencing practical reflexivity. The other is to continue with equality and ethnocentric attention, which is endorsed by the instructor professor and evidence of technical reflexivity because it does not generate changes in behavioral patterns (37).

Bennet (13), in his model of Intercultural Sensitivity, refers to this as minimization because the person is aware of cultural differences but adopts a neutral position providing universal solutions, which generates uniformity. Furthermore, this pattern of care is supported by valid scientific evidence, which has become a dogma that standardizes care without considering other treatment perspectives. Engel (38) has already glimpsed this, and it continues to be a subject of analysis in current medical education (39). Thus, it constitutes an insurmountable turning point in the healthcare process, as other studies indicate (18, 27).

The latest guidelines indicate that the current disturbances and turning points should become challenges that allow new ways of thinking that decolonize knowledge to generate innovative proposals in healthcare (7, 40). Thus, professional training in health sciences must be transformed towards a critical perspective (37, 41), which allows one to revert from learned dogmatic patterns. This would also contribute to a new generation of professionals developing health research with paradigms and methodological approaches that will broaden the perspectives and therapeutic possibilities.

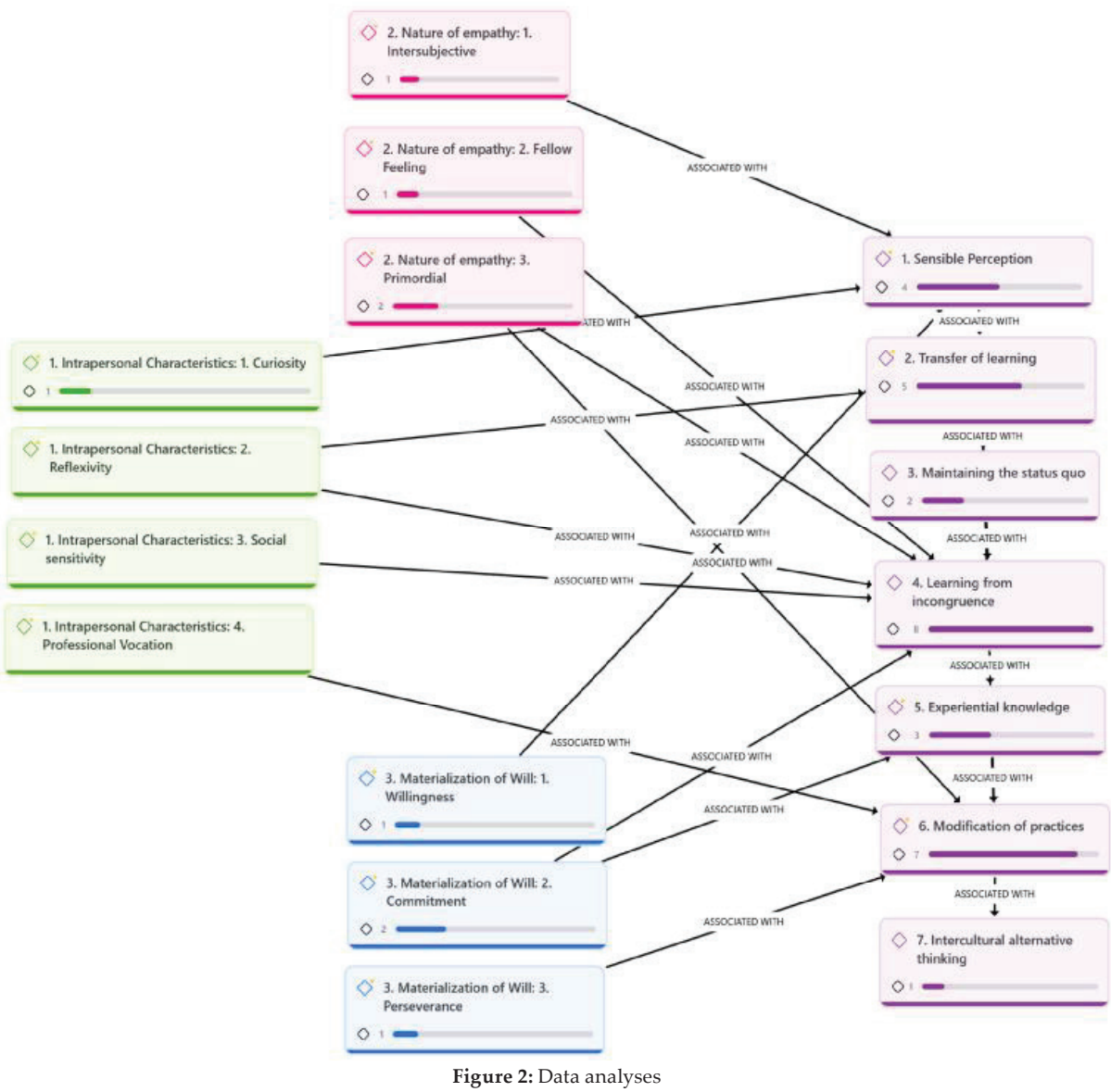


Figure 2: Data analyses

However, certain students continued advancing in the construction of ICC towards the stages of Experiential Knowledge and Modifying Practice despite not having had adequate guidance from the educator. This could be given by the precursors of the construction of ICC, such as the intrapersonal characteristics, the nature of empathy, and the materialization of the will that would be intervening in the achievement of Sentient Intercultural Self-Efficacy.

This is closely related to the studies on life trajectories carried out by Glen and Elder (42), who points out that difficult life circumstances, given by the family, social, economic, or political environment, motivate the individual to control the threat. He adds that the effective coping strategies of the family or close person contribute to the children building a greater achievement self-efficacy. This also influences professional decisions, the acquisition of new knowledge and skills, and the willingness to dare to innovate (43).

However, in the practice modification stage, it was possible to observe, once again, that a certain group of students would question the incorporation of culture in healthcare due to the lack of valid scientific evidence that could put the patient's life at risk. This situation constituted a turning point that could lead to a regression to the stage of maintaining the *status quo*.

In this sense, there is a kind of indoctrination in the professional training of Health Science students, preventing the development of critical reflection, which coincides with other authors (7, 40). Thus, it is necessary for students to recognize how western cultural thought has been constructed, to delve into the political, economic, administrative, and cultural interests that have been involved (44, 45), and to move from an

ethnocentric state to an ethnorelative state (13).

This also requires a formative process to achieve a horizontal dialogue between the educator and the student. The latter must be recognized as a political, historical, and cultural being capable of proposing alternative solutions that probably do not conform to pre-established patterns. Furthermore, the teacher should shed the idea that they are the holder of the truth to make room for new proposals that allow emancipatory and vindicating practices in the healthcare process (37, 46), which would allow the new generation of health professionals to achieve intercultural alternative thinking. This would allow the new generation of health professionals to achieve intercultural alternative thinking so that they can be managers of new knowledge that broaden the treatment alternatives for interculturally inclusive care (7, 18), which would bring benefits not only for the migrant group but for all minority groups.

Limitations

One limitation of this research is that it focused on the construction of ICC in Health Sciences students towards migrant patients, excluding other cultural groups that are also relevant. However, this decision was made because the situation of migrant patients in Chile is a relatively new reality that has not been investigated, unlike other minority groups.

Conclusion

The present research exposes the ICC construction process called Sentient Intercultural Self-Efficacy, composed of seven stages, in which the precursors of the construction, such as intrapersonal characteristics, nature of empathy, and materialization of the will seem to be determinants for the achievement of ICC. However, vicarious learning and valid scientific evidence cause a setback in achieving the construction.

The above points highlight two important issues. The first is that mechanisms should be favored to allow the individual to develop effective coping strategies at an early age since this would favor a better deployment of innovative strategies during professional practice. Secondly, it would seem that the precursors of the construction of ICC would also be involved in the development of critical thinking since those students with these qualities or characteristics achieved, by themselves, the intercultural alternative thinking that corresponds to the last stage of Sentient Intercultural Self-Efficacy.

However, it is also necessary to recognize that the student body of Health Sciences is diverse, so we will not always have individuals who develop ICC autonomously, and there is a risk of maintaining the existing *status quo*. Thus, the formative process must necessarily stop being dogmatic and conservative, and the instances of debate that are generated during the clinical case analysis or in the clinical practices must be taken advantage of, where critical reflection is favored over standardized answers, in which new proposals for clinical care that can be materialized in future health care practices can be accommodated.

Suggestions for future studies

Future research should focus on exploring the alternative therapies used by migrant patients or other cultural groups to highlight, validate, and promote those traditional medical practices that are safe and beneficial for patient recovery. This would have a dual impact: it would contribute to recognizing ancestral knowledge that has been undervalued and help alleviate the uncertainty students face with when incorporating unfamiliar therapies.

Policy and Executive Recommendations

It is necessary and urgent for the Ministry of Education and the Ministry of Health in Chile to establish a joint working group to set criteria and standards for the development of ICC in the professional training of Health Sciences students. This involves fostering intercultural alternative thinking and training professionals to manage care protocols that ensure cultural safety in healthcare delivery.

Authors' Contribution

All authors contributed to the discussion, read and approved the manuscript, and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

Conflict of Interest

The authors declare no conflicts of interest.

References

1. International Centre for Integrated Mountain Development (ICIMOD) [Internet]. World Development Report 2023: Migrants, Refugees, and Societies. ICIMOD; 2023 [Cited 3 June 2023]. Available from: https://lib.icimod.org/record/36335.
2. World Health Organization (WHO) [Internet]. The Global Health Observatory. Explore a world of health data. 2024 [Cited 2 July 2024]. Available from: https://www.who.int/data/gho.
3. United Nations [Internet]. Department of Economic

and Social Affairs. Sustainable Development Goals. 2023 [Cited 21 July 2023]. Available from: https://sdgs.un.org/goals.
4. OMS [Internet]. WHO global action plan on promoting the health of refugees and migrants, 2019–2030. Geneva: World Health Organization; 2024 [Cited 2 August 2024]. Available from: https://www.who.int/publications/i/item/9789240093928.
5. Anand R, Lahiri I. Intercultural Competence in Health Care: Developing Skills for Interculturally Competent Care. In: Deardorff D, editor. The SAGE Handbook of Intercultural Competence. United States of America: SAGE Publications, Inc., 2009. pp. 387-402.
6. Marek E, Németh T. Intercultural competence in healthcare. Orv Hetil. 2020;161(32):1322-30.
7. Álvarez-Cruces DJ, Otondo-Briceño M, Nocceti-de-la-Barra A, Medina-Moreno A, Henríquez-Tejo R. Cultural topics with clinical implications needed in the dental curriculum to develop intercultural competence: A systematic review. J Dent Educ. 2024;88(7):922-32.
8. Jongen C, McCalman J, Bainbridge R, Clifford A. Cultural Competence in Health. A Review of the Evidence. Singapore: Springer; 2018.
9. Martin M, Heron S, Moreno-Walton L, Michelle S (eds.). Diversity and Inclusion in Quality Patient Care. 2nd ed. Cham, Switzerland: Springer; 2019.
10. Álvarez-Cruces D, Otondo-Briceño M. Concreción de competencias transversales para lograr competencia intercultural en estudiantes de ciencias de la salud. REMS. 2023;37(2):1.
11. Garrido Muñoz de Arenillas R. Competencias para la Equidad en Comunidades Culturalmente Diversas: Conceptualización y Medida de la Competencia Cultural Comunitaria [PhD Thesis]. Sevilla, España: Universidad de Sevilla; 2017. p.187.
12. Butler M, McCreedy E, Schwer N, Burgess D, Call K, Przedworski J, et al. Improving Cultural Competence to Reduce Health Disparities. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
13. Bennett MJ. A developmental approach to training for intercultural sensitivity. International Journal of Intercultural Relations. 1986;10(2):179–96.
14. Deardorff DK. How to Assess Intercultural Competence. In: Hua Z, editor. Research Methods in Intercultural Communication: A Practical Guide (1st ed.). West Sussex: Wiley-Blackwell; 2016. pp. 120-34.
15. Transcultural C.A.R.E. Associates [Internet]. The Process of Cultural Competemility; 2022 [Cited 6 December 2024]. Available from: https://transculturalcare.net/.
16. Purnell L. Update: The Purnell Theory and Model for Culturally Competent Health Care. J Transcult Nurs. 2019;30(2):98-105.
17. Papadopoulos I. Culturally Competent Compassion: A Guide for Healthcare Students and Practitioners. United Kingdom: Routledge; 2018.
18. Álvarez-Cruces D, Mansilla-Sepúlveda J, Nocetti-De-La-Barra A. Nivel de Competencia Intercultural en estudiantes de Ciencias de la Salud desarrollada en práctica clínica [Intercultural competences achieved by health sciences students during the clinical practice]. Rev Méd Chile. 2023;151(2):237-49.
19. Alvarez-Cruces D, Nocetti-De-La-Barra A, Mansilla-Sepúlveda J, Otondo-Briceño M, Ortega-Senet M. Competencia intercultural con educación interprofesional en estudiantes de ciencias de la salud, una revisión sistemática. J Health Med Sci. 2021;7(3):157-68.
20. Leaune E, Rey-Cadilhac V, Oufker S, Grot S, Strowd R, Rode G, et al. Medical students attitudes toward and intention to work with the underserved: a systematic review and meta-analysis. BMC medical education. 2021;21(1):129.
21. Heidari M, Norouzadeh R. Factors affecting patient education from cultural perspectives. J Adv Med Educ Prof. 2013;1(4):136-9.
22. Anoushirvani AA, Golaghaie F. Challenges of culturally and linguistically different healthcare students in learning environments. J Adv Med Educ Prof. 2019;7(2):108-9.
23. Consejo Nacional de Acreditación (CNA) [Internet]. Ley de Aseguramiento de la calidad de la Educación Superior; 2006 [Cited 6 December 2006]. Available from: https://www.cnachile.cl/Paginas/Ley%2020129.aspx.
24. Consejo Nacional de Acreditación (CNA) [Internet]. Criterios específicos para carreras; 2003 [Cited 16 December 2003]. Available from: https://www.cnachile.cl/Paginas/Acreditacion-Pregrado.aspx.
25. Ministerio de Salud (MINSAL) [Internet]. Política de Salud de Migrantes Internacionales; 2017. Santiago, Chile; 2018 [Cited 5 September 2018]. Available from: https://www.minsal.cl/salud-del-inmigrante/.
26. Matus-Betancourt O, Ortega-Bastidas J, PÉrez-Villalobos C, McColl-Calvo P, Navarro-HernÁndez N, Silva-Orrego V, et al. Formación clínica en carreras de la salud: ¿dónde se incluye la diversidad? [The inclusion of diversity in clinical training]. Rev Med Chil. 2020;148(4):444-51. Spanish.
27. Álvarez-Cruces D, Nocetti-de-la-Barra A, Burdiles Fernández G. Competencia Cultural de profesionales sanitarios en la atención a inmigrantes a la luz del modelo de Terry Cross. Index Enferm. 2021;30(3):179-83.
28. Correa M, Carstens C, Reyes S. Experiencia del diseño e implementación de un Curso de Formación General de Migración y Salud en la Facultad de Medicina de la Universidad de Chile. Cuadernos Médicos y Sociales. 2018;58(4):55-63.
29. Guerra M, Segovia J. KPSI como herramienta de autoevaluación metacognitiva en el desarrollo de la competencia intercultural en salud en medicina. J Health Med Sci. 2020;6(4):269-75.
30. Bernales M, Pedrero V, Obach A, Pérez C. Competencia Cultural en Salud: una necesidad urgente en trabajadores de la salud [Cultural Competence in health: an urgent need for health workers]. Rev Med Chil. 2015;143(3):401-12. Spanish.
31. Bryant A, Charmaz K. Handbook of Grounded Theory. London: SAGE Publications Ltd; 2007.
32. Charmaz K. Constructing Grounded Theory. 2nd ed. London: Sage Publications Ltd; 2014.
33. Charmaz K. Grounded theory in the 21st Century: A Qualitative Method for Advancing Social Justice Research. In: Denzin N, Lincoln Y eds. Handbook of Qualitative Research (3rd ed.). Thousand Oaks, CA: Sage; 2006.

34. Patton M. Qualitative research and evaluation methods. 4th ed. United States of America: Sage Publications; 2015.
35. Zubiri X. Sentient intelligence. United States of America: Xavier Zubiri Foundation of North America; 1998.
36. Stein E. On the problem of Empathy. Netherlands: Springer Science+Business Media Dordrecht; 1964.
37. Grundy S. Curriculum: Product Or Praxis?. United States of America: Routledge; 2017.
38. Engel GL. The need for a new medical model: a challenge for biomedicine. Science. 1977;196(4286):129-36.
39. Chow CJ, Hirshfield LE, Wyatt TR. Sharpening Our Tools: Conducting Medical Education Research Using Critical Theory. Teach Learn Med. 2022;34(3):285-94.
40. Wenniserí:iostha Jock B, Clavier C, de Leeuw E, Frohlich KL. Romper el statu quo al promover políticas para la salud, el bienestar y la equidad: un preludio a la UIPES 2022. Sage Journal. 2022;29(1):172-7.
41. Brockbank A, McGill I, Beech N. Reflective learning in practice. London: Routledge; 2017.
42. Glen H, Elder JR. Life trajectories in changing societes. In: Bandura A, editor. Self-Efficacy in Changing Societies. United Kingdon: Cambridge University Press; 1995. pp. 36-68.
43. Bandura A editor. Self-Efficacy in Changing Societies. United Kingdon: Cambridge University Press; 1995.
44. Apple M. Ideology and Curriculum. 4th ed. London: Routledge; 2019.
45. Giroux HA. Critical Pedagogy in the Age of Fascist Politics. Policy and Practice: A Development Education Review. 2023;37:159-75.
46. Freire P. Pedagogy of the oppressed. New York, NY: Continuum; 2005.