ORIGINAL RESEARCH

Retrospective study of cultural biases and their reflections among Korean medical students: a cultural hybridity perspective

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Purpose: Most of studies about racial or ethnic biases among medical students have been conducted in English-speaking developed countries. This study explores the hybridity and transformation of Korean medical students' biases, arguing that a nation's identity and culture are constantly in a state of ever-changing hybridity.

Methods: This research used a qualitative document analysis. The study participants were 600 pre-clinical medical students at two medical colleges in Korea, who enrolled in anti-bias programs and subsequently submitted self-reflection essays. Data collection focused on biases related to race, ethnicity, nationality, and medical practices as doctors. Bhabha's cultural hybridity concepts guided the coding of the data in order to explore the hybridity and transformation of the students' biases.

Results: The students presented cultural biases toward patients and doctors with ambivalence related to a person's high socioeconomic status and open-mindedness, as well as doctors' excellence and superiority as Korean authoritative figures. Since the students had ambivalent and complex biases toward patients and doctors, they felt unhomeliness as Korean doctors encountering international patients in Korean clinics. However, after discovering their contradictory assumptions, they transformed their unhomeliness into new hybrid identities. The students' biases were rarely based on race but instead were based on nationality, specifically national class by national income.

Conclusion: Understanding the changing hybrid nature of identities and culture from a cultural hybridity perspective could help clarify medical students' complex and changing biases and improve anti-bias education. Korean medical students' hybridized positions suggest that anti-bias education goes beyond focusing on prestige or racism.

Key Words: Diversity, equity, inclusion, Intersectional framework, Racism, Socioeconomic status

Introduction

Racial or ethnic bias is a critical worldwide issue in medicine [1,2]. Research has reported the presence of medical students' racial/ethnic biases, primarily in English-speaking developed countries such as the United States (US) or New Zealand [3-7]. In contrast, studies in previously colonized countries or countries with different racial majorities such as Korea, are scarce. Previous

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findings regarding students' racial biases have been inconsistent. For instance, some studies have revealed implicit anti- Black attitudes persisting among US medical students [4,7]. Others have found that patients' socio-economic status (SES) impacts medical students' biases [3,8]. Additionally, studies have rarely focused on the biases of students from racial minority groups and findings might be prejudiced. Some studies have reported that other students have fewer racial biases compared to white students [3,5,9]. Other studies have concluded that Asian students prefer light- skinned to darker-skinned people and that their biases do not decrease after anti-bias training [9,10]. These findings imply that not all students have the same racial biases [11]; as such, further research is needed.

Korea, with its long and continuous history with a single ethnicity and a solid national identity, has no record of colonizing other countries, but it suffered forceful Japanese occupation [12,13]. Therefore, the Korean medical students' biases might be different and hybrid from the students in the multiracial countries with a white majority and a colonial history. Moreover, the current generation accepts more varied cultures than previous generations [14]. Recently, there has been an increase of migrant workers, transnational married couples, or international students in Korea [13,15,16]. As doctors, the students would encounter international patients in their clinics; thus, it is time to discuss how we can identify and undo their biases. As such, conducting investigations helps to determine strategies for effective anti-bias education for Korean medical students.

To understand the status of Korean medical students' bias, we examined what happens when Korean medical students, as doctors, encounter international patients. This study aimed to explore the hybridity of Korean medical students' biases to fill the current gaps in the literature on racial biases among medical students [3,5,6,8,9,11]. The specific research questions posed were: (1) In what ways are the biases of Korean medical students hybrid, and how do they manifest? (2) What bias do Korean medical students reflect when they deal with international patients?

Methods

1. Research design and theoretical framework

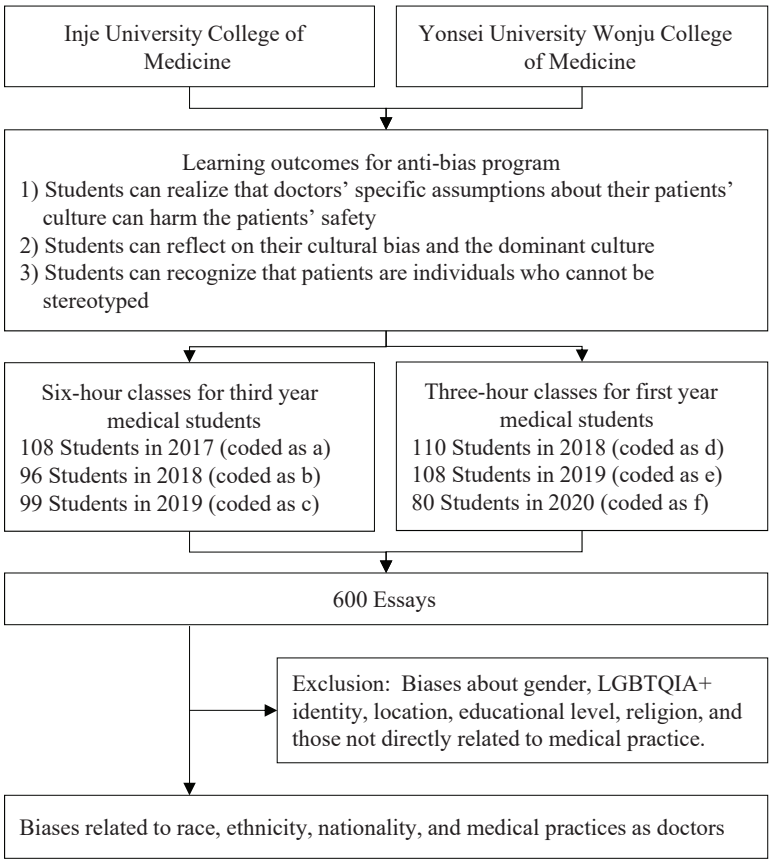
We chose a qualitative research methodology examining the hybridity of Korean medical students' racial/ethnic biases. We used reflective essays to understand students' biases in detail [17], as document analysis may be appropriate for gathering a broad range of voices. The Institutional Review Board (IRB) of Yonsei University Wonju Christian Severance Hospital reviewed and approved this study (IRB approval no., CR321063). As this study involved retrospective research, need for informed consent was waived.

We adopted a research perspective positioned in the cultural hybridity theory of post-colonialism, proposed by postcolonial theorist Bhabha [18-20]. Bhabha's concept of hybridity applies to cultural phenomena beyond their biological and racist meanings in the 19th century [21]. Bhabha [18] asserted that the identity and culture of a nation or nationality are in a state of ever-changing hybridity. He denied the dichotomous classification of the first/third world as Orientalism, superiority/inferiority, and Black/White [19]. He considered it problematic to classify groups as unified and fixed [18,19]; thus, he criticized the premise that colonized people are less advanced than their colonizers [19]. To explain hybridity, Bhabha [18] and Huddart [19] used the concepts of signs taken for wonders, mimicry, the unhomely, and the third space (Table 1).

Table 1. Bhabha' Concepts of Cultural Hybridity Theory

Concepts	Explanations
Signs taken for wonders	English books (such as the Bible) were cited as Signs taken for wonders, representing the authority of civilized colonizers [18].
Mimicry	Mimicry means colonized people mimicked their colonizers' cultural ideas, institutions, and values [19]. However, the colonizers' intention to represent their supremacy failed because colonized people also have an "ambivalence" that simultaneously resists the colonizers' culture [18]. The "almost the same but not quite" mimicry of the colonized people became mockery, threatening colonizers' authority [18].
The unhomely	Unhomely is a foreign feeling, as if colonized people have left their hometowns despite still living there [18,19]. People can feel unhomely in-between, an excluded community from both the colonizer and colonized societies [18,19].
The third space	The third space is in-between, creating the new and transformative identity of "hybridity [18]." The third space deconstructs the self/others dichotomy, which allows different cultures to negotiate. By exploring the third space, we can be free from the colonial legacy to form a new cultural identity in the postcolonial era.

Fig. 1. Diagram of Data Collection



LGBTQIA+: Lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other minoritized gender and sexual identities.

We agree with Bhabha's denial of the dichotomy of Orientalism. We pursue anti-bias education beyond this dichotomy because we believe in the changing nature of cultural identities within this framework.

2. Participants and anti-bias programs

We selected two medical colleges with different academic traditions to collect a diverse range of biases. The study participants were 600 Korean medical students enrolled in anti-bias programs who submitted essays; this

included 302 third-year students from 2017 to 2019 at Inje University College of Medicine and 298 first-year students from 2018 to 2020 at Yonsei University Wonju College of Medicine (Fig. 1).

The anti-bias programs focused on cultural biases related to international patients. The main class activity involved students in dialogue with international guests who had received Korean medical care as patients [22]. The guests shared their experiences of common but unforeseen biases among doctors. Two medical colleges conducted the program using the same learning objectives and self-reflection questions.

3. Data collection and analysis

After the programs, we asked students to write an essay, responding to questions relating to class outcomes. We collected answers on the question, "What kind of cultural biases did you find within yourself?" We began organizing the data collected for this study from July 2022. Biases related to race, ethnicity, nationality, and medical practices as doctors, were included. We excluded other biases that were not directly related to practicing medicine (Fig. 1). We confirmed data saturation after 3 years of data collection as there were no new cultural biases emerging and sufficient repetition of existing biases.

We used a constant comparative analysis to explore the qualitative data according to the cultural hybridity framework [23]. Two researchers (K.H.P. and H.R.), independently and repeatedly read the essays, conducted coding, classified themes, and selected quotes. If opinions differed, the two authors discussed and modified the coding based on mutual consensus. The second author (K.B.L.) reviewed all of the results, and then the three authors discussed and updated the results, considering the ever-changing nature of hybridity. We sorted their biases into prejudice (feelings), stereotypes (cognition), and discrimination (behavior) [10]. Medical doctors and experienced medical educators reviewed the results, as they were experts in medical humanities and taught these for years. We revised the results according to the experts' opinions.

We used credibility, dependability, and confirmability among the four-dimensional criteria by Lincoln and Guba [24] to ensure the study's trustworthiness. For credibility, we collected 3 years of data (prolonged engagement and data triangulation), and three researchers analyzed the data (investigator triangulation). For transferability, we then asked experts to review our results (audit trails) to secure dependability and confirmability.

Results

The students did not comment much on their bias toward the Japanese people, Chinese people, or White people. They attended to people from Southeast Asian countries more than those from African countries. They believed Black people were from African countries, and White people were from the United States. We found that students showed contradictory assumptions and ambivalence toward the doctors' position, international patients, English-speaking individuals, and Westerners.

1. Ambivalence toward doctors' position

The students reflected their belief that doctors were superior and always right. They considered doctors to be like Korean parents who take care of everything for children and 'seuseungs' who enlighten people with their wisdom (Table 2); thus, they intended to help and guide international patients like parents and seuseungs.

The students mimicked the superiority of doctors. As such, the students attempted to show they can care for international patients like a parent and seuseung. They presumed that foreign patients would be weaker and more

Table 2. Contradictory Ambivalence toward Doctors' Position according to Cultural Hybridity Perspectives

Themes	Subthemes	Codes	Quotes
Doctors as a symbol of wonder	Doctors are a symbol of superiority	- Doctors are of superior status - Doctors are parents - Doctors are seuseungs	- In our culture, doctors are superior to me [as a patient]. [They] know my conditions … and [are] superiors who can tell me about diseases (f1).
Mimicry of superior doctors	I care for international patients like a parent and seuseung	- I help and guide them - They do not know Korea - Westerners are too assertive - People from developing countries do not listen, while Western patients follow doctors - I am unskilled and unaware of foreign cultures and languages	- I intended to help them more because I thought they would struggle more than me, a citizen of Korea (c28). - I thought people from underdeveloped countries like China did not attend (e131). - I am not quite used to how to deal with them (f67).
Unhomeliness in a doctor's clinic	I feel uneasy in my clinic	- I feel uncomfortable - I feel resistance - I feel distant - I feel daunted - I am scared - I feel burdened	- I wanted to treat them well. I was scared I could not respect patients' cultures (a88). - I worried I would get frightened and unable to make the right decisions when encountering foreign patients (a44).
	I am respectful	- I refuse authoritarian doctors - Doctors should be well-mannered - I respect Western culture	- I also called Western patients by their first name, not their full name, without a title. I didn't think foreigners would expect Korean etiquette (c29).
	They are not respectful	- They have disdain for Korean hierarchical culture - They distrust Korean doctors - They disregard me - Here is Korea!	- Above all, I had thought that foreigners should bow to us while we treated them in our culture since they are the ones who came to our country, even though I felt that it would be uncomfortable for them to show such respect. I reflected on my thoughts (c21).

ignorant than Koreans when receiving healthcare owing to their unfamiliarity with Korea. A student confessed believing that foreign patients would want doctors to take care of everything; thus, it was reasonable that patients should follow doctors' instructions. However, they were concerned about non-compliant international patients. They worried that Westerners might demand too much and perceived them to be assertive. They also worried that patients from underdeveloped countries would not listen to the doctors because of poor health literacy; meanwhile, they expected that Western patients would follow doctors' advice due to their high level of education.

Those assumptions of doctors' superiority made the students feel uneasy in an international care setting because they worried about the possibility of unconscious mistreatment or wrong decision-making due to unwariness of foreign cultures and languages. In reflections, students believed themselves to be respectful because they were not authoritarian, unlike "patriarchal middle-aged Korean doctors." The students found that they were uncomfortable with disrespectful foreign patients because they expected respect to be reciprocated. Additionally, the students felt that mutual respect between superiors and subordinates was essential. They were concerned that foreign patients might disdain Korean medical hierarchical culture, distrust Korean doctors, and disregard them because of racism. Some commented that foreigners must comply with Korean culture because they are in Korea.

2. Ambivalence toward English-speaking Westerners

English proficiency symbolized excellence and high SES, while they did not comment on the Japanese or Chinese language (Table 3). Since they believed that proficiency in English is an excellent marker of the doctor, they felt that foreigners would not trust doctors who spoke

Table 3. Assumptions on English-Speaking Westerners according to Cultural Hybridity Perspectives

Themes	Subthemes	Codes	Quotes
English and Westerners as a symbol of wonder	English is a symbol of excellence and high SES	- English proficiency is an excellent doctor's marker - English-speaking people are from high SES	- I felt that multicultural patients would not trust doctors who cannot speak English fluently (b38).
	Westerners are good patients	- Westerners can speak English - Westerners are rich - Westerners have good occupations - Westerners are open-minded	- I unconsciously thought they could stay in Korea without worrying about medical expenses. I realized they also might be undocumented immigrants who could not pay their medical bills (f75).
Mimicry of English-speaking Westerners	I strived to study English	- I can use English - Some patients cannot speak English - Some patients cannot understand the Korean language - I cannot express my thoughts in English	- I had communication obstacles because I tended not to express my thoughts when I thought I was incompetent [in English] (c26).
	I am open-minded like Westerners	- I embrace all - Koreans are closed off - Westerners are discriminative - I cannot wholly understand foreign cultures	- I have resistance to patriarchal culture with gender discrimination (f30). - I had thought that Whites had liberal thoughts (a24). - I had believed that Whites feel superior to other races. They tend to discriminate against other races (f10).
Unhomeliness between Korean and English-speaking Westerner identities	I belong nowhere	- I avoid foreigners - I do not feel I belong anywhere	- It was hard for me to answer the question of where I am from. I felt that I wholly belong nowhere (c65).
	I am familiar with Western culture, but not a Westerner	- I feel a sense of kinship with Western culture - Westerners exclude me	- I relate to most foreigners because I have lived with Western culture often. I studied abroad when I was young and am of a digital generation (f62). - Some guys had discriminated against me when I was in a United States school. My experience drove me to try not to have any bias (b70).
	I am unfamiliar with Korean culture, but a Korean	- I feel strange about Korean culture - I live in Korea	- My cultural bias was one against Korea. Korea was strange to me and different from the Western culture I know. So, I misunderstood my peers and was so frustrated (f23).

SES: Socioeconomic status.

broken English. Additionally, Westerners symbolized good patients to the students, although students did not comment on White supremacy related to Western culture. The students confessed believing Westerners to be good patients because of their English proficiency, wealth, good occupational status, and open minds.

The students mimicked the English-speaking Westerners. The students attempted to show that they can speak English and are open-minded to the foreign patients. They studied hard and strived to gain English proficiency; thus, insisting that they were unlike other Asians (including Koreans) who could not speak the language. They found themselves sometimes speaking less in English, avoiding foreigners, when they felt less confident in expressing their thoughts in English. Additionally, they tried to show respect for liberal and open Western cultures; emphasizing a global and open mindset, unlike 'close-minded Koreans' and 'discriminative racist Westerners.' However, they confessed to having an inner conflict, as they could not fully understand foreign cultures.

The students expressed unhomeliness between Westerner and Korean identities. They felt that they did not belong in either Western or Korean society. They felt kinship with Western culture; however, racism from Westerners made them realize that they were not Westerners themselves. Conversely, while they were unfamiliar with Korean culture, which they perceived negatively, they ultimately realized that they were Korean. Finally, they felt out of place in Korean culture.

3. Questioning assumptions and forming hybrid identities

During dialogues, students realized their assumptions of doctors' positions, foreign patients, English-speaking individuals, and Westerners might be contradictory and unconsciously cause the patients distress (Table 4). The students recognized that doctor-patient relationships might not be hierarchical, and that the Confucian hierarchy influenced their assumption of doctors' superiority. They accepted that caring for international patients like parents or seuseungs may be unhelpful. Further, the students understood that foreign patients might be the same as Koreans, needing compassion for their pain. They were relieved to find that many foreigners respect and love Korea, while they admitted that the foreigners might be disrespectful. At this point, students realized their contradictory ambivalence toward doctors' position and experienced unhomeliness, but they formed new hybrid identities while erasing ambivalent in the third space.

The students also discovered and erased their contradictory assumptions about English-speaking individ-

Table 4. Questioning Assumptions

Themes	Subthemes	Codes	Quotes
Erasing ambivalent assumptions about doctors	Erasing symbols of wonder	- Doctor-patient relationships may not be hierarchical	- It seemed that Confucian culture's hierarchical relationships, such as respect for elders and [seuseungs], and parent-child relationships, may connect to the doctor-patient relationship (b77).
	Erasing mimicry of superior doctors	- Caring for them like parents and seuseungs may be unhelpful - They may know Korea	- I thought [patients] would be satisfied when I switched to [their] culture, but it may make them uncomfortable, as they already know what our culture is like (c14).
		- They may not be assertive	- I learned that even assertive Westerners also have many words they cannot say to doctors (a95).
	Erasing unhomeliness	- They may be the same as us - They also need compassion - They may be respectful - I may not be respectful	- I lived with biases that White people have disdain for people from Eastern countries, but I found that, in reality, many Westerners like Easterners very much (b61). - I had a bias against patients from other cultures where they talk freely regardless of age because I think people should be very polite toward aged people (e140).
Erasing assumptions about the English language and Westerners	Erasing symbols of wonder	- English is not all - Westerners may not be rich - Westerners may not have suitable occupations - Westerners may not be open-minded	- I felt at ease after hearing from the guests that they came to the clinic to receive doctors' help, not to evaluate [their] English proficiency. I realized they didn't care about doctors' English proficiency (b65).
	Erasing mimicry of English-speaking Westerners	- They may not speak English - Korean culture may be better than I thought - Korean culture may be open - They may be open to Korean culture - I may be closed to foreign patients	- I came to grip that hierarchy includes different expressions of Koreans' warmth (f23).
	Erasing unhomeliness	- They may speak Korean - My culture is hybrid	- My culture is potpourri (a7).

uals and Westerners. They realized that speaking English to all international patients could be considered rude, and understood that avoiding foreigners owing to their lack of confidence in speaking English might distress patients. They recognized that not all Westerners were of high SES, have good occupation, or open-minded. The students were amazed to discover that not every foreigner speaks English. They realized that Korean culture may be better and more open than foreign cultures, and accepted that Westerners might be open to Korean culture while others may be close-minded. At this point, students confronted their assumptions about the English language and Westerners, and realized they were positioned between Western and Korean cultures. However, they overcame this unhomeliness and formed new hybrid identities in the third space. Finally, they relieved their unhomeliness by realizing that their biases were culturally hybrid.

4. Rewording and debiasing racial biases

After erasing their contradictory assumptions, the students recognized their bias was based on nationality rather than race, particularly a nation's development level (Table 5). They found that they assumed a patient's nationality based on appearance, SES, or development level of their country. They evaluated patients' English proficiency and SES according to their country's economic situation.

The students identified several prejudices, stereotypes, and discriminations related to nationality. First, they found their prejudices to be associated with fear of cultural unfamiliarity. Second, they reflected on their stereotypes of countries that are less advanced than Korea, judging the status of people's culture, hygiene, education level, and violence level according to their nationality. Lastly, they reflected on their discriminative behaviors against

Table 5. Rewording and Debiasing Biases

Themes	Subthemes	Codes	Quotes
Biases based on nationality	I am biased	- I may have biases	- My bias was the assumption that I have no cultural biases (b19).
	I had national biases	- Developing countries	- I reflected that I unconsciously segregated foreigners based on developed and underdeveloped countries and judged them differently (b6).
	I assumed patients' nationality from their appearance	- Appearance represents nationality	- I learned I must not assume a patient to be multicultural from their appearance (f75).
	I judged patients' English proficiency and SES by national economic status	- English proficiency - Financial conditions - Occupational status	- According to the national images, I evaluated whether they are rich or poor (b58).
Identifying and debiasing nationality biases	Debiasing prejudice related to nationality	- I had a fear	- I still fear the culture of the countries I have never experienced (c41).
	Debiasing national stereotypes	- I stereotyped their culture as backward - I stereotyped them as unhygienic - I stereotyped them as less educated - I stereotyped them as violent	- I had a ridiculous bias that the culture of people from undeveloped counties also would lag behind (a55). - I had a bias that most people from Southeast Asia are laborers (f12).
	Debiasing discriminative behaviors related to nationality	- My behaviors were discriminative	- When I walked the street, I used to control my pace to avoid them because I was scared (e162).
	They are individuals	- They are culturally different individuals	- I learned that all foreigners are not the same…. Each foreigner was born in a different place, and their language, hairstyle, and clothing style differ. I should respect the uniqueness of individuals (f32).

SES: Socioeconomic status.

people of different nationalities.

Consequently, the students realized that foreigners did not always share the typical cultural traits of their home countries, and neither did Koreans. They learned that personal characteristics depended upon individual differences instead of national differences.

Discussion

This study revealed the hybridity and ambivalence of Korean medical students' assumptions toward doctors' position, international patients, English as a language, and Westerners. The students considered doctors to be Korean authority figures, rather than Americanized or Japanized superiors. They focused on the English language and US citizens rather than the language and people of Japanese or Chinese although Korea has been historically influenced by Chinese and Japanese culture. These findings are consistent with the theory by Bhabha [18] that identity and culture are a form of evolving hybridity.

The study also showed the students' ambivalence as doctors. Like rulers, who repeatedly stereotyped and ruled people out of fear in a failed attempt to enforce supremacy [18], students' unhomeliness manifested as fear, thus projecting international patients as racists or non-compliant persons. Like rulers suffering from their dominant discourse [19], the students suffered from their discourse of the "superiority of respected doctors." The students believed that they must sacrifice themselves and be wise in order to do everything for their patients, similar to Korean parents and seuseungs. Yet, this was too burdensome and turned out to be unhelpful.

In this study, English represents an important tool for higher social status, not a symbol of English supremacy. The students considered Westerners remarkable because they believed Westerners to be "compliant" patients who could afford medical costs, not because Westerners belong to a "supreme race." These results are consistent with Bhabha's explanation that ruled people mimic the rulers' culture almost identically but not quite so; consequently their "mimicry" becomes a kind of mockery, resisting the ruler's intention of positioning rulers as superior [18,19].

The study discovered that Korean medical students felt unhomeliness, as they were neither Westerners nor Korean, but resided between the two. However, they transformed their unhomeliness into new hybrid identities in the anti-bias programs. When they understood that cultural identities continuously change with hybridity, they were freed from the fixed stereotypes which presume that people never change [19]. The unhomeliness disappeared when they realized the contradictions of their fixed stereotypes regarding doctors and international patients. Students formed new hybrid identities in which they recognized their non-superior position to patients, acknowledged the necessity of treating all patients with compassion and respect, and understood that Korean and Western cultures exist on a continuum rather than as a dichotomy—realizing that both they and foreign patients exist within hybridized cultural spaces. These findings will help us understand the evolving hybrid biases among today's medical students, who are negotiating differences between cultures with ambivalence.

The study identified that the students' biases were not based on race but rather on nationality. Korea's long history of national identity might influence Korean students' nationality biases [13]. Overall, the results demonstrated that the students had biases against foreigners; therefore, the students' biases might be more a global version of place-ism than racism. Place-ism is the concept of "strong discrimination against and suspicion of outsiders of all kinds," and "discretionary practices against a locality or geographic location [25]."

The study also found that the students were specifically

biased against national class, based on the incomes and development levels of nations. These findings support previous studies which have reported that patients' actual SES influences students' biases more than race [3,8]. The results were also consistent with research observing that Korean university students' biases are based on developed country discourse [26]. Korea's historical diplomatic relations with Ancient China and Imperial Japan, which aimed to maintain Korean independence, and the Korean government's policy toward developed countries might influence Korean students' biases against different nationalities [12,26-28].

The students' biases might have been more based on classism according to income and occupation than racism. They used countries' development status and national income level to judge patients' social class. They also used appearance and skin color to guess individuals' nationalities, not their race. Korean medical students might consider international patients' SES level to prevent patients from falling into financial trouble. The Korean government's policy of national health insurance service might have encouraged the students to consider the national income of their patients' countries. However, their nationality biases caused them to discriminate against people from less-developed countries.

The results inspired us to improve anti-bias programs. First, the findings imply that anti-bias education and policies that only emphasizes doctors' prestige and power might be unsuccessful. In the international clinics, students may have more difficulties finding their prestige and power in the patient-doctor relationship [29]. Reflections on prestige and biases can only be successful after the students have realized contradictory assumptions and relieved unhomeliness during anti-bias programs. The classroom could provide the safe place to create new hybrid identities in the third space. Second, the results imply that anti-bias education and policies that focuses only on racism might be unsuccessful. The students in this study avoided international patients because they were concerned mistreating patients owing to their unpreparedness, not racism. The students tried their best to respect Western patients, even though they had been racially discriminated against by Westerners.

However, the students' behaviors resulted in discrimination against people for hidden reasons, such as place-ism and classism. The findings suggest we should consider the silently embedded inherent biases that exist within a culture. The literature recommends covering biases based on national origin and class and stratifying by primary language and SES in anti-bias education to encourage diversity, equity, and inclusion [2]. Social determinants of health framework would also help us determine immigration status, poverty, and unemployment to reduce biases [17,30].

This study has several limitations. First, no in-depth interviews were conducted to explore individual biases because this study aimed to provide a broad overview of biases. Second, we only investigated Korean students' biases; examining the hybrid biases of students from other countries in their respective contexts is necessary. Third, we did not explore other cultural biases, suggesting further research on biases against low SES or less advanced regions with low-income levels.

In conclusion, this study revealed that Korean medical students had ambivalence toward the patients and doctors based on their beliefs about high SES, excellence, and superiority. However, they transformed their unhomeliness into new hybrid identities during anti-bias education. The students' biases were not based on race but on nationality, implying that these biases might be based on place-ism or classism in the global context.

Understanding the changing nature of identities and culture from the perspective of cultural hybridity could help identify implicit biases and improve anti-bias

education and institutional policies. The findings of this study suggest that we should not assume that all students consider themselves prestigious or even racists, implying that anti-bias education and policies should go beyond focusing on doctors' prestige and racism.

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