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Doing diversity: Unsettling the Self-Other binary

Leyerzapf, H.

2019

document version

Publisher's PDF, also known as Version of record

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citation for published version (APA)

Leyerzapf, H. (2019). *Doing diversity: Unsettling the Self-Other binary: Cultural diversity in Dutch academic health care*. [PhD-Thesis - Research and graduation internal, Vrije Universiteit Amsterdam].

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E-mail address:

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Summary

Chapter 1 – General introduction

Academic hospitals are traditionally highly hierarchical, mono-cultural and exclusive, select spaces. In order to secure quality of care and competence of professionals, academic health care organizations increasingly give attention to cultural diversity issues in policy and practice. Although student populations in medicine and health care are increasingly diverse in terms of cultural, ethnic and religious background, professionals with a cultural minority background, i.e. with cultural, ethnic and/or religious roots different from the majority in a particular country, are underrepresented in medical schools and academic hospitals, and especially in leading positions and management. Internationally, insight is lacking into why recruitment, selection, promotion and retention of professionals with a cultural minority background is difficult as well as into what it takes to develop inclusive organizations. However, welfare of the workforce and in particular of professionals with a cultural minority background seems pressurized as high rates of (sexual) harassment, discrimination and racism, and of psychological distress such as burn-out and substance abuse are reported in international academic health care. Specifically, there is a lack of knowledge of how (future) professionals with a cultural minority background experience everyday work place and education practice. In the Netherlands, there are no empirical studies that look into experiences of (future) professionals with a cultural minority background or into exclusion, discrimination and racism in academic health care. By generating empirical and theoretical insight into experiences of (future) professionals with a cultural minority background, into interactions between (future) professionals with a minority and majority background and into processes of in- and exclusion in medical education and the academic hospital, this thesis aims to stimulate inclusion of (future) professionals with a minority background in Dutch academic health care and to support learning about development of inclusive organizational culture within the Netherlands and beyond. The two central research questions are as follows:

1. How do students and professionals with cultural minority and majority backgrounds engage with cultural diversity in everyday education and work floor practice in academic health care?, and
2. What conditions are necessary to enable the transformation of academic health care towards the inclusion of students and professionals with cultural minority backgrounds?

A critical diversity perspective is adopted, which means that everyday practice and relations between people are seen as inherently power-laden, contextual and ever-changing and made and reproduced by these people in interactions. In order to gain knowledge of cultural diversity and inclusion it is crucial to empirically study the foundations of power dynamics and their (re)production. Focus will be on the reproduction and normalization of dominant norms and underlying hierarchies, and how these link up with (self-) identification as 'same' or 'different' and with who is when and why structurally perceived as 'the Other', i.e. less valued than those included and perceived as the

norm or 'the Self'. These insights into privilege and disadvantage may provide a hold-on for how to challenge existing power dynamics and to increase inclusivity in organizations. The increasingly exclusivist and sometimes racist social and political debates in the Netherlands in which people with a cultural minority background are often portrayed as the Other, will be taken into account.

The qualitative and ethnographic research design is inspired by social-constructionist, phenomenological and hermeneutic and critical (organization) anthropology epistemologies and methodologies, and based on a social justice perspective. The descriptive as well as transformative aim of the design is visible in the different methods used in the five studies, namely the combinations of interviews and participant observations (ethnographic) one the one hand, and on the other hand the focus groups and dialogue groups intended at bringing together multiple, diverse stakeholder perspectives and spurring critical awareness, mutual understanding and collective responsibility for practice development in the research settings (responsive and action-oriented).

The five studies in this thesis are situated in VUmc School of Medical Sciences (VUmc SMS) and the Amsterdam University Medical Center, location VUmc (VUmc), and follow the journey of the medical student from undergraduate medical education (Chapters 2 and 3) via postgraduate education (Chapter 4) towards the academic hospital work place in which professionals from medical, care, paramedic and supportive disciplines meet (Chapters 5 and 6). In between these chapters are five self reflections of the researcher on critical incidents that took place in period of the studies and are meaningful for the central findings and conclusions. In Chapter 7, the overarching conclusions and learning experiences for practice and research will be discussed.

Chapter 2 – Cultural minority students' experiences with intercultural competency in medical education

This chapter aims to gain insight into the perspectives of minority undergraduate students and to generate recommendations for educators, policy makers and other professionals in academic medicine to enhance intercultural competency and inclusiveness of medical education. The explorative, qualitative evaluation focused on the intercultural competence activities in undergraduate education in one medical school.

Respondents experienced case studies discussions as stigmatizing cultural minority and specifically Muslims, as they portrayed –presumed– minority or Muslim/Islamic patients and lifestyles as negatively different from normal Dutch behavior and norms. Respondents felt also set apart as cultural majority teachers and students expected them to explain about cultural diversity issues within the study material. They experienced prejudice from majority students as well as teachers as these made disrespectful comments, often meant as humorous, during working groups and lectures, and they felt particularly isolated, vulnerable and unsafe as they did not feel supported by their teachers. Respondents felt more comfortable with minority students and therefore had relatively heterogeneous social groups and increased their intercultural competency –while majority student groups appeared relatively homogeneous. This social segregation was also observed during participant observations. Thus, the success of intercul-

tural competence activities appeared limited and even seemed to add to polarization between minority and majority students and teachers in medical school.

The experiences of cultural minority students can be characterized as ‘micro-aggression’ as they constituted invalidating remarks and questions that happened on a daily basis, of which ‘perpetrators’ were generally unaware because of lack of intercultural sensitivity and existing prejudice, and that were often ‘wrapped up’ in humour and thus difficult to object to. Other, (inter)national studies in medical education corroborate the ‘Othering’ of cultural minority and especially Muslim students. This ‘hidden curriculum’ left the learning potential of intercultural sensitivity of cultural minority and of social connection between minority and majority students and teachers unfulfilled, and it seemed to privilege majority over minority students. Critical consciousness towards the norms from which minority students supposedly differ, i.e. critical (self-) reflexivity, is necessary to develop intercultural competency of students and professionals and to make academic medicine more inclusive and equitable. This requires commitment of teachers and policy makers in medical schools.

Chapter 3 – Veiled ambitions: Female Muslim medical students and their ‘different’ experiences in medical education

In medical school, female Muslim students and especially those wearing a headscarf, are very visible, yet little is known about their experiences. In order to generate bottom-up knowledge on inclusion in academic medicine and support ‘voice’ of female Muslim medical students, this chapter looks into the experiences of these students from a critical-intersectionality perspective, meaning that we aim to deconstruct how intersections of identity aspects work together for exclusion. We performed a qualitative interview study in the undergraduate of VUmc School of Medical Sciences.

Participants had difficulty connecting to students they considered Dutch, and they parallelly were approached as different and non-Dutch by these ‘Dutch’ students. Participants felt a ‘click’ with other Muslim students with a migrant background as they found common ground in their experiences of difference and exclusion. They experienced to be set apart and unsafe as they were met with exclusionary, ‘humoristic’ comments from students and teachers without a migrant background. They also experienced Othering as teachers in the physical examination training ridiculed their objections to the mixed gender setting of the training and stated that participants could only become a physician if they performed the training in the same way as the ‘Dutch’ students. The Othering mostly involved stigmatization of Muslim women wearing a head scarf, and it increased as participants started their internships and clinical supervisors viewed their head scarf as incompatible with becoming/being a physician.

Participants’ experiences involve micro-aggression and everyday racism, namely prejudice on the basis of their –presumed– ethnic/racial identity repeated on an everyday basis, that together constitute Othering. Although different identity aspects intersected, the Othering particularly centred on being not white and thus points to a racialization of female Muslim students with a migrant background wearing a head scarf and a hierarchization between these students and white students/professionals without a

migrant background who are seen as neutral and therefore ‘normal/good’. This led to their parallel hyper- and invisibility, and appeared to devalue and ‘de-professionalize’ their status as a (future) physician. For inclusion in academic medicine, stakeholders need to become aware of their ‘blindness’ towards the exclusionary, racialized norms in medical education and how experiences of exclusion are silenced.

Chapter 4 – Standing out and moving up: performance appraisal of cultural minority physicians

This chapter aims to shed light on the structural barriers to develop culturally diverse and inclusive organizations by studying the everyday practice and experience of performance appraisal on clinical wards in an academic hospital in the Netherlands, and how this is perceived to influence the influx of cultural minority physicians into specialty training. The study followed a critical diversity design that involved understanding identity as intersectional and power as relational and therefore cultural diversity as contextual and dynamic, as well as selection as a complex process constituting more than formal moments of assessment and official criteria.

Minority respondents not yet in training worried that their participation in the research would affect their selection for specialty training. Language was mentioned by cultural majority and minority respondents as a factor for selection, however, since all minority respondents spoke fluently Dutch, sometimes with an accent, this pointed to norms regarding language and communication in medical education. Narratives of minority and majority respondents pointed to other norms that the first could often not comply to, such as regarding the age of physicians and extra-curricular activities. Social networking was mentioned as central to qualifying for a training position and this was also harder to meet for minority physicians because they lacked role models and ‘the right connections’, had difficulty connecting to colleagues and supervisors and felt less at home and safe at work. Minority respondents experienced prejudice regarding their ‘non-Dutch’ identity, to stand out negatively and that they had to perform extra in order to qualify as ‘normal’, ‘good’ physicians. Executives recognized minority physicians as ‘different’.

Minority physicians appear to have more difficulty successfully presenting for selection into specialty training. Selection processes are actively enacted by majority and minority stakeholders in the academic hospital and are affected by prejudice as well as norms on what is ‘normal’, ‘good’, ‘Dutch’ medical professionalism. For inclusion in academic medicine, it is crucial to take these processes of in- and exclusion and qualifications of ‘difference’ and ‘sameness’ into account and critically appraise the norms that create a hierarchy between so-called Dutch and non-Dutch physicians. This requires structural, collective and bottom-up development of organization culture and practice.

Chapter 5 – “We are all so different that it is just ... normal.” Normalization practices in an academic hospital in the Netherlands

By studying how minority and majority professionals experience diversity and how they relate to each other in everyday work, this chapter aims to critically review work floor culture. We understand power as implicitly and ‘invisibly’ enacted in and normalized via

norms, communications and routine practices that are difficult to pinpoint and transform. We conducted an ethnographic study on clinical wards in a Dutch academic hospital.

Majority and minority participants represented diversity as being about the Other, namely foremost about as minority patients and in second instance minority professionals, as well as about difficult situations and interactions that disrupt normal work practice and take (too much) time, nice things such as multicultural foods and festivities or useful things such as minority professionals who can translate for minority patients. Minority participants experienced stigmatization of majority patients and colleagues that they generally not talked about. Cultural diversity was clearly not 'normal', yet all participants stressed it was not important for the work practice. Participants stated that only competence was relevant, and leading professionals emphasized to treat all professionals 'the same'. However, participants also made clear that professionals should fit in and 'click' with the team. While it was stated that all professionals were each so different that it was normal, minority professionals were seen by majority professionals as 'different' and this was cause to question their fitting in and professionalism.

There appears to exist a normalized hierarchy between 'different' –generally minority– professionals who are more at risk of not qualifying as professional and 'same' –generally majority– professionals who are assumed to fit in and automatically qualify as normal and good. Diversity was explained away as an issue between professionals in the work place and the professional was presented as neutral, making experiences of exclusion of minority professionals difficult to acknowledge. This normalization pointed to the reproduction of the 'ideal worker norm' as the basis of an unequal distribution of privilege for 'same' and disadvantage for 'different' professionals to which all disciplined themselves as they aspired to be (seen as) professional. The international idea of professionalism as neutral and objective and the ideology of equality-as-sameness in the Netherlands, supported this. To build inclusive organizations, it is crucial that stakeholders acknowledge their shared 'complicity' in sustaining this inequality.

Chapter 6 – Meaningful Culturalization in an Academic Hospital: Belonging and Difference in the Interference Zone Between System and Life World

The homogenizing normativity of the academic hospital links up with system aspects of rationality, objectivity and the need for fast, measurable output that dominate life world aspects as emotions, time to reflect, awareness of mutual dependability between and social context of professionals, and this pressurizes the inclusion of minority professionals. However, in the 'interference zone' between the system and life world, 'meaningful culturalization' by life world aspects can develop and support temporary safe 'space for difference', connectedness and inclusivity. This chapter aims to find conditions to challenge normalization by zooming in on one team and its team leader in a Dutch academic hospital.

Team professionals stressed that it did not matter who you are in this team and that all are 'the same'. In some instances, however, personal identity and background were explicitly discussed and linked to team values of connectedness and belonging. This culturalization was ambiguous as a minority professional for example felt to belong in

the team because she could be herself and colleagues were interested in her, yet she also felt set apart sometimes as 'different' by their recurrent questions on her religious norms. Professionals mentioned the team leader –female, black, with a minority background– as central to the team culture. This team leader tried to be an open, democratic and caring role model and stimulate relationality, connection and coherence without emphasizing her minority background. She saw 'fitting in' as involving life world aspects of feeling safe and at home that require personal acknowledgement, she stimulated professionals to take time away from the ward in order to reflect and recover from the work floor 'haste-culture', and gave attention to emotions and tensions in the team. This was not uncontentious as her supervisors criticized her leadership style and she herself felt pressurized sometimes as giving personal attention to all team members took up a lot of her energy and time.

Participants to an extent kept up exclusionary norms and normalization of sameness and 'diversity-free' professionalism, but with the explicit support of a leading professional also created temporary safe spaces in which they horizontally experienced belonging and difference beyond essentialist, polarized and hierarchical social positions. Working from 'places of effort' by acknowledging 'difficult' emotions and embodied experience, and taking time to practice reflexivity, helps to develop inclusive space in academic hospitals.

Chapter 7 – General discussion

This thesis aimed to generate empirical and theoretical understanding of cultural diversity and inclusion in academic health care, with a specific attention for (future) professionals with a cultural minority background, and from that to formulate conditions for transformation towards inclusion. The first three studies in this thesis dealt with cultural diversity issues and inclusion in undergraduate and postgraduate medical education, subsequently, two studies dealt with these issues at the multidisciplinary academic hospital work place. In this final chapter the three main findings of the thesis are discussed as well as the learning experiences regarding transformation and inclusion for research and practice.

The three main findings are firstly that cultural diversity is perceived as being about other people and interactions and situations different from normal daily practice, and this renders cultural diversity generally not important to the education or work practice. Specifically, cultural diversity is seen as being about the Other as became apparent in the different manifestations of Othering, i.e. a particular dichotomization and hierarchization between (future) professionals. Secondly, the professional is presented as neutral and professionalism as a neutral and objectifiable quality. This makes it hard to acknowledge cultural diversity issues and experiences of Othering and racism. Thirdly, an ideal worker norm exists that is normalized by the two other findings. The ideal worker norm on what and who is a (good) professional, creates a hierarchy between generally white (future) professionals with a majority background that are automatically perceived as 'same' and qualify as normal, good professionals, and those generally black or of colour with a minority background that are easily perceived as not competent because of their 'difference'. The resulting unequal distribution of privilege and disadvantage

is normalized via everyday routines, structures and discursive practices by all (future) professionals. This normalization prevents (future) professionals to 'see' and 'feel' how they are implicated in sustaining inequality together.

These main findings, however, are not complete without my personal learning experiences described in the Critical Incidents I-V. I gradually recognized how, by being or better *pretending* to be 'absent' as a researcher and through my abstract, cognitive and hierarchical knowing, I was 'white innocent' and 'white fragile' and added to normalization practices and to exclusion, discrimination and racism. This new critical awareness enabled me to identify what keeps inequality in place and to formulate conditions for transformation towards inclusion, but most importantly, it helped me see and feel that *I* needed to change in order to stimulate this transformation.

Therefore, in order to enable structural transformation towards more inclusive and equitable academic health care, as well as research in this context and academia in general, we need to start with ourselves. Instead of 'fixing the Other', focus needs to be on 'fixing the Self'. I can only help to 'unsettle' normalization and help to counter inequality if I ask myself what I perceive as 'normal' and hence what I automatically value and include, i.e. by developing critical reflexivity. If I bring in myself in this way, I can start to review and challenge the norms and underlying hierarchies. This then is an ongoing process of engaging with others with head and heart. Thus, stakeholders in a particular context need to work together to parallelly diversify the (future) work force, critically review organization structure and practice on its inclusivity and critically review the knowledge base of these structures and practices, and to be able to engage in this all need to (1) *acknowledge complicity* in normalization; (2) *work from their emotions of discomfort* in order to take up responsibility from a horizontal position of interdependence and reciprocity, and in this way –particularly as white people with a majority background– acknowledge how we are implicated in structural inequalities, learn to talk about racism as well as white innocence and white fragility, and unsettle normalization; and (3) *build critical-reflexive, embodied common ground* from which space for difference, deep connections and collective action for transformation towards inclusion can grow.



Screenshot from 'Variations on White'. Cinematographer: Jurgen Lisse. Director: Lina Issa, Art Partner. Comenius Teaching Fellowship 2017 of dr. Maaïke Muntinga and colleagues of the department of Medical Humanities VUmc.