Doing diversity:
Unsettling the Self-Other binary.
Cultural diversity in Dutch academic health care.

Hannah Leyerzapf

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Cover image: Medical students in the project *Anders in de witte jas*, Different in the white coat, in 2014. Project of students and teachers of VUmc and artist Lina Issa of Art Partner. Photographer: Bart Majoor, Art Partner.

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Doing diversity: Unsettling the Self-Other binary.

Cultural diversity in Dutch academic health care.

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Hannah Leyerzapf

geboren te Amsterdam

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De Ander is
iemand die niet in ons straatje past

All images on the inside and outside of this book are a courtesy of artist Lina Issa, MA, and Drs. Sandra Boer from Art Partner. The images give an impression of the projects developed since 2013 in collaboration with the department of Medical Humanities of Amsterdam UMC - location VUmc (VUmc), dr. Petra Verdonk, dr. Maaike Muntinga, drs. Hannah Leyerzapf and colleagues, and with the director of Amsterdam UMC - location VUmc School of Medical Sciences (VUmc SMS), prof.dr. Gerda Croiset, the vice-dean drs. Margreeth van der Meijde, the students of MFVU-D.O.C.S., and together with many students, teachers and physicians at VUmc and VUmc SMS. The projects focus on development of empathy, perspective-taking, diversity-responsiveness, and critical reflexivity. Short context and acknowledgements can be found on the flip side of each image.

The Other is someone who does not fit in our alley, Dutch saying that signifies that someone does not fit in and is not welcome. Statement from conversations of Lina Issa with professionals in VUmc. Photographer: Bart Majoor, Art Partner.

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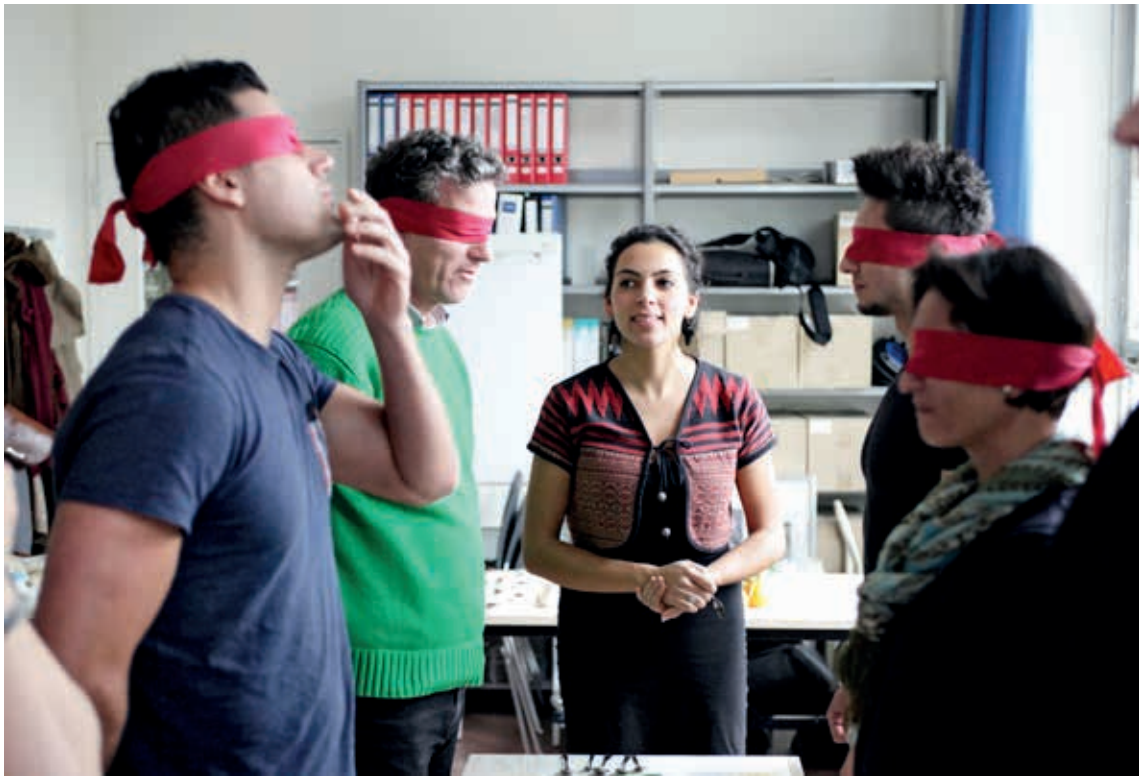

Teachers of the department of Medical Humanities VUmc and Lina Issa (middle) in 2015 during the teacher training developed with teachers from this department and students from the student committee D.O.C.S. in the C2ME project (Culturally Competent in Medical Education, European education project). Photographer: Lina Issa, Art Partner.

Chapter 1 – General introduction

Motivation: Cultural diversity in academic health care and education

Cultural diversity has been one of the greatest challenges of organizations for several decades. Traditionally, academic hospitals are described as highly hierarchical, mono-cultural and exclusive, select spaces, i.e. difficult to gain entrance to for cultural minorities as well as for e.g. women and people from lower socio-economic backgrounds (Essed, 2005; Taylor, 2003; Wear, 1997). Recently, academic hospitals as well as medical schools and health care organizations in general, are increasingly giving attention to cultural diversity issues in policy and practice (Betancourt et al., 2005; Helman, 2000; Napier et al., 2014). Often, the attention for diversity in (academic) health care starts from the motivation to deal with and accommodate to the needs of patient populations with a cultural minority background. Some diversity management policies and interventions in (academic) health care specifically focus on increasing access to health care services for patient groups with a cultural minority background in order to reduce health disparities in society (Betancourt et al., 2005; Kumagai & Lypson, 2009; Napier et al., 2014; Smedley et al., 2003). These diversity policies mainly have the aim to provide access and secure quality of health care by linking care and treatment optimally to patients' needs and health situation (Kumagai & Lypson, 2009). In this sense the acknowledgement of cultural diversity as a health care issue is related to developments towards more demand-driven, consumer-oriented and person-centered or personalized medicine and care (Miles & Mezzich, 2011; Napier et al., 2014).

In addition to this patient-oriented diversity focus, there is also attention –although to a lesser extent– for healthcare professionals. This is manifested in the need for professionals to be competent, i.e. the need to integrate diversity issues in medical, care and health sciences education and training of professionals. The objective is then to teach professionals to adequately deal with patients with a cultural minority background, which has led to development of studies, education and policy on '(inter)cultural competency', 'diversity-responsiveness' or 'diversity-sensitivity' of professionals (Betancourt et al., 2005; Campinha-Bacote, 2002; Dogra, 2007; Kleinman & Benson, 2006; Lee et al., 2009; Like, 2011). When the attention turns to cultural diversity of (future) professionals in (academic) health care themselves, i.e. a culturally diverse work force, this is foremost motivated by three assumptions. Firstly, that professionals with a cultural minority background would assumingly provide a better quality of health care for patients with a cultural minority background. Secondly, and linking up with this first idea, that culturally diverse teams in general generate creativity, innovation, effectiveness and efficiency, and hence are valuable for the welfare of organizations and 'good for business' –although this appears difficult to proof (e.g. Dreachslin, 2000; Horwitz & Horwitz, 2007; Watson et al., 1993). Thirdly, reasoning from a social justice and human rights perspective, it is claimed that we need to strive for equal representation of all groups in society in all domains of life, including health care.

Over the last decades, the populations of students and professionals in the medical and (health) care education and professions have culturally diversified in many countries.

Overall, however, students and professionals with a cultural minority background, i.e. with cultural, ethnic and/or religious roots different from the majority in a particular country, remain highly underrepresented in academic health care, and the underrepresentation is highest within the medical professions (Merchant & Omary 2010; Smedley et al., 2004; Sullivan, 2004; Yu et al., 2013). Historically, women are overrepresented in the care professions yet male nurses up to date acquire executive positions in care more often, and women are underrepresented in executive and management positions in academic medicine notwithstanding the 'feminization' of academic medicine (Adams, 2010; Kaatz & Carnes, 2014; Phillips & Austin 2009). Similarly, professionals with a cultural minority background are particularly underrepresented in executive and management positions in academic medicine and health care (Beal et al., 2003). Furthermore, cultural diversity of education staff and management of medical and to a lesser extent care and health sciences education is low (Turner et al., 2008). Studies conclude that inclusion of students and professionals with a cultural minority background is generally insufficient and they call for stakeholders in academic health care to discuss strategies to increase it (Napier et al., 2014; Smedley et al., 2004; Sullivan, 2004; Turner et al., 2008).

As reasons for the underrepresentation of (future) professionals with a cultural minority background in (academic) health care, studies point to difficulties in recruitment and selection, as well as in retention and promotion of these professionals and relate these to the broader organizational or education 'diversity' climate (Merchant & Omary, 2010; Nunez-Smith et al., 2012; Price et al., 2009). Indeed, the climate in the academic health care workplace and in medical and (health) care education seems to lack inclusiveness and safety (Essed, 2005) and well-being of students and professionals seems to be under pressure. This is particularly the case for students and professionals with a cultural minority background –and similarly of female (future) professionals, as rates of harassment, discrimination and racism are reported high (Beagan, 2003; 2005; Coker, 2001; Fried et al., 2012; Hassouneh et al., 2014; Peterson et al., 2004; Rademakers et al., 2008). Moreover, overall, well-being issues are at stake as rates of burn-out, other forms of psychological distress and substance abuse especially in academic medicine are high (Akvardar et al., 2004; Dyrbye et al., 2006; Verdonk et al., 2014). As such, cultural diversity is not only a health care issue in relation to patients, but also in relation to (future) professionals with a cultural minority background, i.e. cultural diversity relates to the welfare of the academic health care workforce.

However, few academic hospitals or universities seem to execute cultural diversity policy or practice interventions that have harassment, discrimination and racism of students and professionals with a cultural minority background as a focal point (Beagan, 2003; Coker, 2001; Kumagai & Lypson, 2009). Although also in general social connections and interactions in (culturally) diverse teams relate to well-being of (future) professionals (Finn et al., 2010; Mitchell et al., 2011; Weaver et al., 2011), few studies discuss the personal experiences of students and professionals with a cultural minority background (Hassouneh et al., 2014; Singaram et al., 2011) or how students and professionals with a cultural minority and majority background mutually relate in education and the workplace. Thus, there is a need for practice-based and in-depth insight into

the underrepresentation of (future) professionals with a cultural minority background, into the foundations of their pressurized well-being in education and the workplace and into what it takes to build a 'diversity climate' and include (future) professionals with a cultural minority background in academic health care.

Cultural diversity in Dutch academic health care

In the Netherlands, where the studies in this thesis are taking place, cultural diversity –among other aspects of diversity such as sex/gender– since the turn of the century receives increasing attention within academic health care (Van Mens-Verhulst & Bekker, 2005; RVZ, 2000; Seeleman et al., 2009; Suurmond et al., 2007; Verdonk et al., 2009; Van Wieringen et al., 2003). As internationally, focus on cultural diversity is mainly related to the increasingly diverse composition of patient groups and quality of health care. Since 2001, awareness and knowledge of (cultural) diversity is included in the final attainment levels of Dutch medical education as an important aspect of medical professionalism (Van Herwaarden et al., 2009). However, the attention for intercultural competence of professionals and for cultural diversity issues in medical and care and health sciences education and the academic health care work place, as well as the attention for cultural diversity among students and professionals –instead of among patients– in these fields is still low (e.g. Ingleby, 2009; Selleger et al., 2006; Verdonk, 2013). Earlier studies have shown that, overall, state policies on diversity and diversity policies in Dutch (academic) health care organizations –as in organizations generally– are insufficiently effective both in ensuring quality of care for patients with a cultural minority background and in furthering inclusion of professionals with a cultural minority background (Essed, 2002; Groeneveld & Verbeek, 2011; Heres & Benschop, 2010; Ingleby, 2009; Verbeek & Groeneveld, 2012).

Since the 1990s, the cultural diversity of student populations in medicine, care and health sciences education has significantly increased as the descendants of labor migrants from Morocco and Turkey recruited by the Dutch government in the 1960-70s, entered higher education (Lucassen & Penninx, 1996). Moreover, in the last decade, migration from countries in the Middle East and the North and Middle of Africa to the Netherlands –as to other (North-Western) European countries– has increased (Ingleby, 2009). Students with a cultural minority background make out approximately 26% of the total student population in health care and medical education (CBS, Statline, 2014). However, as within the public sector in general, professionals with a cultural minority background in (academic) health care are represented in lower levels of organizations yet in general underrepresented –especially in executive and management positions (Essed, 2002; Groeneveld & Verbeek, 2011; Verbeek & Groeneveld, 2012). Discussing the persistent high unemployment rates of Dutch people with a cultural minority background in higher positions, Essed (2002) points to discrimination, racism and 'cultural cloning' in the work place that lead to minority professionals having to assimilate to majority (organization) culture in order to be included and majority professionals being privileged. Indeed, Agyemang et al. (2007) suggest existing cultural bias, discrimination and racism in relation to students and professionals –besides patients– within the fields of Dutch health care and medicine.

These observations ask for research into education and work place interactions between (future) professionals. However, up to date, such bottom-up, practice-based insight into these issues is missing and studies that voice the experiences of (future) professionals with a cultural minority background in academic health care are strikingly absent. In view of the persisting report on discrimination and racism within academic health care in international studies, as well as the reluctance to discuss discrimination and racism in relation to the issue of diversity in Dutch organizations and society as in other European countries (Agyemang et al., 2007; Essed, 2002), it is about time to study practices of inclusion and exclusion and distribution of privilege and disadvantage in academic health care, highlight the perspectives of students and professionals with a cultural minority background and try to find the conditions for inclusion of these (future) professionals in Dutch academic health care.

Research questions and aims

The central focus of this thesis is cultural diversity in academic health care and medical education in the Netherlands. Starting from a social justice perspective, the main objective of the thesis is to stimulate the inclusion of students and professionals with a cultural minority background in academic health care. With this objective, the ultimate aim is to increase the well-being of (future) professionals with a cultural minority background, the sensitivity on cultural diversity issues of all stakeholders in academic health care and education, as well as to add to the theoretical body of knowledge of critical diversity studies on issues of inclusion and transformation in organizations in the fields of academic health care and medical education, and possibly beyond.

The main objective of this thesis is divided into three concrete subgoals. Firstly, the aim is to learn about the experiences of processes of in- and exclusion of students and professionals with a cultural minority background in medical education and the academic hospital. Secondly, the aim is to learn how cultural diversity issues are enacted in everyday interactions between students and professionals with a cultural minority and majority background in medical school and the academic hospital workplace. Thirdly, the aim is to learn about the conditions to stimulate an inclusive organizational culture and for transformation in these academic health care settings towards inclusion of (future) professionals with a cultural minority background.

The different studies in this thesis will focus on how students and professionals with a cultural minority and majority background experience, perceive, and deal with cultural diversity issues in everyday education and work contexts, i.e. acquiring empirical, qualitative insight into the lived realities of students and professionals in academic health care and the meaning of the issues of cultural diversity and inclusion from a critical diversity perspective. A critical diversity perspective involves a specific understanding of power and how power dynamics are present in and shape daily reality, people's interactions and (im)possibilities. We have chosen for this perspective in this thesis because, this perspective enables us to shed light on the continuing underrepresentation and pressurized well-being of students and professionals with a cultural minority background, and more specifically on what is necessary for inclusion of these students and professionals in academic health care organizations.

Also, the studies in this thesis will look into the ways in which students and professionals with a cultural minority and majority background in everyday interactions engage in practices of inclusion and exclusion, and in (re)production of distribution of privilege and disadvantage in academic health care. Specifically, the studies will highlight the perspectives of students and professionals with a cultural minority background as their perspectives may be marginalized by dominant perspectives in academic health care. As such, the studies will try to give insight into how the different stakeholders involved in the research settings give shape and meaning to cultural diversity issues and inclusion from different positions of power, with different interests and in mutual interaction, and try to identify the foundations of inclusion and exclusion and of privilege and disadvantage and the mechanisms that enable and sustain these power dynamics.

On the basis of the gained empirical and theoretical insights from the different studies in this thesis, recommendations will be discussed for stakeholders in medical education, academic hospitals and health care organizations in general on how to support inclusion of students and professionals with a cultural minority background, as well as for future research into cultural diversity issues, inclusion and transformation in academic health care.

This thesis evolves around the following central research questions:

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?
2. What conditions are necessary to enable the transformation of academic health care towards the inclusion of students and professionals with cultural minority backgrounds?

Theoretical background

Below, the following central concepts in this thesis will be explained: inclusion and power; cultural diversity; identity and sameness/difference.

Inclusion and power

The choice of a critical diversity perspective (Zanoni et al., 2010) in this thesis entails the basic idea that all practice as well as theoretical structures are routed in, formed by and established through power relations between people. Consequently, studies from a critical diversity perspective assume that to adequately consider and deal with diversity issues and inclusion of people with a cultural minority background in organizations takes considering the culture and structure of those organizations and how these reproduce inequality. Thus, critical diversity studies argue that in order to make sense of diversity issues and inclusion, the foundations of power dynamics as well as their (re)production in day-to-day practice need to be reviewed (e.g. Ahmed, 2007; Essed, 2002; Kumagai & Lypson, 2009, Price et al., 2009). This means that besides ideas about these diversity issues and inclusion, such as captured in diversity policy and education curricula, the actual practice needs to be considered. Overall, the critical diversity perspective aims to approach reality as

(a) power-laden, i.e. people hold different positions of power and will be able to enforce influence on others and their surroundings to different extents,
(b) embedded in, dependent on and constituted by –geographical, historical, time, political, social, emotional– context, and
(c) ever-changing and relational as it is made –(re)produced and confirmed– by people in everyday interactions.

When looking at processes of inclusion and exclusion this means acknowledging that these processes result in the distribution of privilege and disadvantage, i.e. in people structurally experiencing unearned benefit or advantage, or unearned detriment or disadvantage. This experience of privilege or disadvantage is never static and individual people are never completely privileged *or* completely disadvantaged as experiencing disadvantage in one context does not exclude experiencing privilege in another. Keeping this in mind, the focus will be on the distribution of power that is unequal in a structural sense as, over a longer period of time, a group or groups of people are favoured over another group or groups of people in different social contexts and interactions. Similarly, the focus on transformation will be on how these structural inequalities can be challenged.

Earlier critical diversity studies point towards dominant norms in specific contexts that connect with who is in- and excluded when and why. These studies show that a structural hierarchy can come to exist within an organization as certain people are seen as similar or 'same' to the organizational norms and prototype(s) and are more likely to be included and experience privilege, while certain people are seen as 'different' from these norms and are more likely to be excluded and experience disadvantage (e.g. Benschop, 2009; Ghorashi & Sabelis, 2013). People who are seen as belonging to a group or groups of people that generally do not live up to the dominant norms in (a) certain context(s) can come to constitute the prototypical 'Other' and be subsequently less valued than those fitting in with the norms. Thus, in relation to cultural diversity issues and inclusion in organizational contexts, it is important to look at the categorizations of sameness/difference and possible Othering, namely the construction of people as 'Other' on the basis of certain characteristics (Said, 1979), and how stakeholders socially (re)construct norms (Cox, 1994; Nkomo & Cox, 1996; Thomas & Ely, 1996; Zanoni et al., 2010). In processes of Othering, the perspectives of people considered 'the Other' are structurally perceived as less legitimate and credible than those of people considered to represent the dominant norms (Kuper & D'Eon, 2011). In this thesis, attention will therefore go out to perspectives that are possibly marginalized. Inclusion entails a sustainable situation in which students and professionals with a cultural minority background do not experience structural disadvantage and their perspectives are equitable to those of other stakeholders. Transformation entails identifying and deconstructing categorizations of sameness/difference and challenging possible Othering practices.

In order to learn about the conditions for transformation towards inclusion, it is necessary to learn how norms and hierarchies are (re)produced into inclusion and exclusion and into privilege and disadvantage in everyday practice. Here a dynamic understanding of power inspired by a Foucauldian approach is valuable. In line with Foucault power is fo-

remost viewed as discursive and normalized (Foucault, 1989; Ghorashi & Wels, 2009), i.e. enacted in everyday (non) verbal communications and everyday, routine practices. This means that besides material in the sense that certain people in a particular context can 'have' the authority and the means to excert power over others, power exists in concrete interactions between stakeholders with various, changing and variably valued or acknowledged goals and interests, and thus is and has to be (re)established in these interactions over and over. As such power is not a static 'given' but is dynamic and up to an extent a contextual, fluid and relational practice. When for example medical professionals are dominantly male, while care professionals are dominantly female, the norm can become for men to become doctors and women to become nurses, and language such as having no feminine form of the term doctor[1] will reflect these norms and the use of this language will enable, underscore and normalize these norms further. Also, the routine practice in health care in which the patient's contact with the doctor is generally very short, while her/his contact with the nurse is generally more extended, reflects as well as underscores and normalizes the norm that doctors hold a higher social status compared to nurses.

A Foucauldian approach to power furthermore stresses that the praxis of power is all-pervasive and performative, i.e. it is performed by people and changes them and is in a sense 'shared' as everyone is both subject and object in power relations (Foucault, 1989). In order to explain how power in modern time is generally horizontally dispersed instead of top-down and coming from one identifiable source, Foucault used the example of the mental hospital (Foucault, 1965). Since the 17th century people in European societies have been put into mental hospitals with the parallel aim to control and confine social outliers and simultaneously let them be studied and cured from madness by doctors. As the patients in these hospitals were constantly monitored and corrected within the institution, they disciplined themselves and each other into adapting to the rules and prescribed behavior. These rules and this behavior became everyday routine; unquestioned and normal. So, doctors' authority did not come from applying force, but followed from the belief that the doctor knew what was good for the patient and was the only one who could care and treat the patient well. Their position signified a natural form of authority. As such both patients and doctors internalized, (re)produced and normalized the norms of the hospital but from their position of authority doctors had a central role in actively establishing norms and determining who fitted in and who not. In general, as people grow up and are socialized in a particular society and particular cultures, they internalize the norms of these contexts to an extent and (un)consciously discipline themselves and each other into adopting, normalizing and legitimizing them (Foucault, 1989). Thus, to shed light on enabling and sustaining mechanisms of power relations in the research settings, the focus will be on how different stakeholders, both with a cultural minority and majority background, enact normalization processes of inclusion and exclusion and of privilege and disadvantage in their everyday interactions.

Cultural diversity

Departing from a critical diversity perspective means that concepts of diversity, identity

[1] As the studies in this thesis are based in the Netherlands, it is relevant to mention that, different from most English nouns, Dutch nouns have a masculine, feminine or neuter form.

and power are approached in this thesis as closely related (Foldy, 2002; Ghorashi & Sabelis, 2013). The concept of 'cultural diversity' is used here as it is the common terminology in the field of Dutch academic health care –where the studies are based. In line with this concept, the expressions 'cultural minority background' and 'cultural majority background' are used to signify (future) professionals who have non-Dutch or Dutch roots respectively. Internationally, the term 'diversity' in relation to the descent of individual or groups of people is used in different ways and can refer to different aspects such as their cultural, ethnic, religious, racial, national, geographical, linguistic roots. Given the established relation between diversity, identity and power, the everyday meaning of 'cultural diversity' for different stakeholders needs to be learned from what is told by participants and observed by the researchers within the studies.

Focus will be on how stakeholders practice and (re)produce diversity and identity categories in their everyday interactions within the research settings. Linking up with the approach of language as communicative action (Abma & Widdershoven, 2006; Foucault, 1989), we assume that the term may not only describe and represent certain human characteristics but that it is also –both intentionally and unintentionally– *used by people with particular goals and agenda's* and may thus have a particular impact on inclusion and exclusion and subsequently on privilege and disadvantage. In particular, discrepancies will be kept in mind discussed by Ahmed (2007) and Essed (2002) in relation to the term 'diversity', namely between strategic and rhetorical communication on (cultural) diversity in organizations in which diversity as a form of social justice is used to build a favorable organizational profile on the one hand, and actual practical efforts on inclusion of people with a cultural minority background on the other hand. Ahmed (2007) and Eriksen (2006) furthermore show how the concept of diversity is often used in an uncritical, de-politicized way to 'celebrate' diversity without paying attention to or even while actively ignoring social inequality (Ahmed, 2007; Eriksen, 2006). These discrepancies may affect the transformative potential of the terminology and hamper inclusion within organizations (Ahmed, 2007).

Identity and sameness/difference

A critical perspective to cultural diversity and inclusion in organizations, requires approaching the concepts of diversity and identity as political, power-laden practices enacted by stakeholders in a particular context. A critical, relational and dynamic reading of identity entails not only taking otherness into account or what is perceived as other than the self, but specifically Othering, namely what is perceived as the Other from the norm of the Self and the process by which this Othering is enacted in practice. Together with taking into account the empirical terms sameness and difference or what is perceived and presented as 'same' or 'different' to this dominant norm, this understanding of identity enables a critical reading of diversity and helps to shed light on the conditions for inclusion and how to support development of inclusive organizational cultures. These assumptions are explained below.

An uncritical reading and 'celebratory' use of cultural diversity that helps to ignore social inequality is possible if we think of collective or individual identities as clear-cut, static and self-evident and of relations between identities as neutral, 'power-free' and

'horizontal' (Ahmed, 2007; Eriksen, 2006). Eriksen (2006) extends our understanding of identity by calling attention to the 'vertical' perception and use of the concept. Identities are not only often perceived and presented as categorical but also as 'vertical', namely as binary, mutually exclusive and hierarchical, thus they relate to development of social difference as well as of social hierarchies (Eriksen, 2006; Ghorashi, 2010). For example, someone is either seen as native or foreign to a country but not both and children from parents with different nationalities are described to have a split-identity, and some differences are seen as more meaningful or more problematic than others. For example, being a Christian American or a Muslim American are generally seen as different differences, and the difference between a Dutchman and a German is generally seen as a different difference from that between a Dutchman and a Congolese.

From a power-sensitive approach to diversity it is thus necessary to acknowledge and deconstruct the role of hierarchical self-other differentiation. This approach is furthermore related to a postcolonial perspective on identity in which the Self and the Other and subsequently experience of sameness and difference are linked to historical, global and structural power relations between '(post)colonizers' and '(post)colonized' (Baumann & Gingrich, 2004). From this view, who is perceived and presented as the Self and who as the Other springs from colonial relations and couples geographical location to physical qualification and political voice. The Self constituted the –white as well as generally male, heterosexual etc.– center of the colonizers, North-Western Europe, and one's geographical closeness and especially physical sameness to this center related to one's political power, while the farther removed from and especially the more physically different from this center defined someone as the (colonized) Other and generally resulted in lack of political voice (Fabian, 2014; Said, 1979). Critical, postcolonial studies understand this as a hierarchical process of Othering of people who are not white, not male etc. which they see reflected in present-day societies (Baumann & Gingrich, 2004; Fabian, 2014; Said, 1979). In this thesis, attention will go out to to what extent Othering, Self and Other categorizations and experience of sameness and difference in academic health care organizations may be meaningful and performative and thus should be taken into account in identifying conditions for inclusion of (future) professionals with a cultural minority background.

Context: Diversity debates in the Netherlands

The research projects that will be discussed in this thesis take place from 2011 until 2017. Because of the aim of this thesis to generate bottom-up and practice-based knowledge on conditions for inclusion, i.e. knowledge that is interconnected with the geographical, socio-political, cultural, physical, emotional and temporal context, it is important to give a description of the context of the studies in the time period in which they are performed. Therefore, below, some socio-political developments within Dutch society will be sketched that happened leading up to the time that the different studies in this thesis start out and that may relate to the issue of cultural diversity and inclusion in academic health care.

The terminology used in the Netherlands to address people with a cultural minority background at the time the studies started out signifies a focus on socio-cultural and

political exclusivism, and underlying racist tendencies (Essed & Hoving, 2014; Essed & Trienekens, 2008). After the term 'foreigners' was no longer adequate as the newest generations of migrants had settled in the Netherlands, brought their spouses and young children and new children were born who no longer could be considered foreign, the dominant term for people with a cultural minority background has become 'allochthones' (Ghorashi, 2010a). According to the Dutch research institute for government statistics (CBS) someone is 'allochthone' when at least one parent is born outside the Netherlands as opposed to 'autochthone' when his/her parents are both born in the Netherlands (CBS, 2000)[2]. In 2011 just over 20% of the Dutch population was defined allochthonous (CBS, 2011). Considering the literal meaning of 'from different soil' and 'from own soil', and the breakdown of allochthone into 'western' and 'non-western', the categorization of people in the Netherlands into 'allochthone' or 'autochthone' seems to involve combined connotations of geographical, socio-cultural, genealogical and emotional difference (Geschiere, 2009). Thus, the use of allochthone/autochthone as well as the supposedly more neutral terms of 'second- or third-generation migrant' in societal and political debates not only fit an increased focus on cultural assimilation apparent from the 1980s onwards (Ghorashi, 2010a), since the new millennium and especially since 2011, they also fit an increase in racist expressions (Essed & Trienekens, 2008). For people with a non-western cultural minority background born in the country and thus carrying a Dutch passport and nationality, it seems virtually impossible to acquire the label of 'autochthone', hence, in practice, a sort of second-class citizenship seems to have developed (Essed & Hoving, 2014; Ghorashi, 2014). The subdivision into non-western versus western may point to the (post)colonial hierarchy between white colonizers and non-white colonized, and thus to issues of racism –a topic that has historically received little attention as a potential reality within Dutch society (Essed & Trienekens, 2008).

Developments since the 1980s underlie these increasingly exclusivist societal tendencies in the Netherlands. Since then, Dutch left-wing politics have been increasingly reproached for being cultural relativist, i.e. ignoring or even adding to increasing numbers of criminalization, unemployment, Islamic terrorism and low emancipation of women, and as such seen as responsible for the 'failure' of the Dutch 'multicultural society' (Prins, 2004; Scheffer, 2000). Accordingly, 'new realism' and later 'hyperrealism' in Dutch social and political debates prevailed (Prins, 2004). Parallel to these right-wing populist politics, rightist, populist and sometimes openly racist styles of speech and language use have gained ground in everyday life (Essed & Hoving, 2014). This shift took place particularly after 9/11, when the terrorist attacks in the US gave rise to specific negative connotations to Islamic identity in the country, as in other North-Western European countries (Eriksen, 2006). In particular Islamic women wearing a veil became symbols of oppression as individual freedom linked to a hierarchy in moral values became central within debates (Eriksen, 2006; Ghorashi, 2010b). The murder of filmmaker Theo van Gogh by a Muslim 'allochthone' led people to openly declare Islamic values and culture as being of a lower moral standard than majority ethnic, Dutch values and culture, and to motivate

[2] More recently, the terms 'allochthone' and 'autochthone' are no longer used as official government terminology signifying a potential change towards more inclusivity in terminology, policy and practice (https://www.cbs.nl/nl-nl/corporate/2016/43/termen-allochtoon-en-autochtoon-herzien, retrieved 04-09-2018).

this open declaration as well as the hierarchy by the ideal of freedom of speech –itself signifying the Dutch high moral standard as e.g. entailing tolerance and freedom from oppression (Ghorashi, 2010b; 2014). It became common while talking about equality, to judge 'other cultures', i.e. cultural minority cultures and Islamic culture specifically, as less valid. Different from the 'Islamic or Muslim Other', existing racism against citizens with a Surinamese or Indonesian background seems strikingly absent in these debates and may signal the taboo to talk about race (Essed & Hoving, 2014; Wekker, 2016). As such, debates in the Netherlands on diversity appear centered on moral and cultural difference that identifies particular Others versus a higher moral, cultural Self and on cultural, moral assimilation of these particular Others (Eriksen, 2006; Essed & Trienekens, 2008). The exclusivist and sometimes racist tendencies are likely to impact the lives of Dutch people and especially those with a cultural minority background as well as the debates on cultural diversity issues and inclusion in Dutch organizations. As such, these diversity debates in the Netherlands form the backdrop of the studies in this thesis.

Research design & methodology

The qualitative, ethnographic study design of this thesis is based on a combination of social-constructionist, phenomenological and hermeneutic epistemologies and methodological and theoretical insights from critical (organization) anthropology, and is based on a belief in human equity and social justice from which follows the aim for value-driven transformation towards social equality (Abma & Widdershoven, 2011; Gupta & Ferguson, 1997; Fabian, 2014; Van Manen, 1990; Medina, 2013; Prasad, 2003). The research questions in this study are formulated as broadly as possible to include experiences and knowledge from the field. This allows for emergent learning about the ways in which the central concepts of this thesis are socially constructed by participants and other stakeholders within and in reaction to the specific characteristics of the study contexts –i.e. medical school and the academic hospital workplace. The research design aims to facilitate bottom-up, critical learning through studying the meanings of the central concepts of this study for the stakeholders, as well as how this meaning is (re)produced in everyday social interactions and materialized in structural social and power dynamics in the research contexts. While making use of a combination of social-constructionist, phenomenological and hermeneutic critical epistemology, instead of a positivist belief in singular truth and objective knowledge, two assumptions underlie this thesis, namely (1) the multiplicity of reality and (2) that knowledge is always political. These related ideas –that link up with the critical diversity perspective which is the theoretical background of this thesis– are explained below.

Firstly, human thinking and doing in this thesis is perceived as feeding back onto each other, i.e. influencing each other in a continuing interaction process that results in never static but ever-evolving everyday human praxis (Gupta & Ferguson, 1997; West & Fenstermaker, 1995; West & Zimmerman, 1987). Reality is approached here as:

(a) something that has to be enacted in order to *be*,

(b) inherently social and relational since actions and thoughts become 'real' by acquiring meaning as they are experienced and engaged with by individuals in continuing interaction with others, and

(c) inherently contextual as these processes necessarily take place in and are

shaped by a particular context.

On the one hand, people in everyday practices (un)intentionally materialize experiences and thought into structure and these structures then legitimize and to an extent 'prescribe' specific practices, experiences and tought. On the other hand, in parallel, people enact agency as they actively engage with, react to and reproduce these structures, practices, experiences and thought in relation to the specific context and others involved within it, and thus they do not 'photo-copy' but actively recreate and generate development and change of these structures, practices, experiences and thought (West & Fenstermaker, 1995; West & Zimmerman, 1987).

West and Zimmerman (1987) and West and Fenstermaker (1995) discussed how people 'do' gender and how they 'do' difference in this way. They discuss how gender –as well as difference– is 'made' over time, i.e. does not constitute a one time interaction but involves complex repeated, routine social and embodied interactions, and how it becomes performative as it is made into a 'natural' category that impacts and structures people's (inter)actions, e.g. the assignment of a gender to babies at birth requires girls to display 'feminine' behavior and acquire a female gender role, while it requires boys to act 'masculine' and take on a male gender role (West & Fenstermaker, 1995; West & Zimmerman, 1987). West and Fenstermaker (1995) subsequently show how 'doing gender' dominantly involved white, middle class feminist perspectives and therefore introduce 'doing difference' in which they look into intersecting categories of gender, race and class, and how this doing of difference leads people to experience reality in different ways, for example child-rearing meant different things for black women as compared to white women during slavery, yet also involves similar mechanisms of justifying and sustaining social divisions and inequalities in society. This 'doing' of diversity is captured in the title of this thesis.

As daily praxis is contextual and historically situated it is also inherently connected to bodily experience and *bodies* per se –that are not neutral mediators of experience but actively 'carry' as well as transform experience, social and political structures, and meaning (Said, 1979; West & Fenstermaker, 1995; West & Zimmerman, 1987; Waldenfels, 2004). For example, being a man or a woman in the 19th century as compared to the 21st century may have led to very different personal experiences of health and illness, and being the only man at a 19th century convent may have been blasphemy, while being the only woman at a 21st century fire brigade may set in change towards a gender balance in this profession. Thus, with these premises to the research design, the insights that are generated in this thesis are both praxis-based, i.e. bottom-up, dynamic and contextual, as well as emotional, embodied, socially positioned and 'lived' (Van Manen, 1990).

Secondly, from the basic point of the multiplicity of reality and daily praxis as well as of knowledge of this praxis, follows the idea of knowledge as political. The attention for experiential, empirical ways of knowing is important because of the focus in this thesis on the foundations of and enabling mechanisms of inclusion and exclusion, privilege and disadvantage. This attention is especially relevant as the studies in the thesis deal with hierarchical contexts where power imbalances are at stake and dominant power structures may obscure so-called alternative practices and perspectives. Not only is

knowledge –as is reality– multiple, dynamic, contextual, embodied, etc., it is therefore also –as reality– not objective or neutral but socially constructed and political. What is considered knowledge and how it is valued differs according to context and across time as some people's perspectives and experiences and hence their agency, i.e. ability to act influence, as well as the materializations into structure are deemed more legitimate than others' (Said, 1979). In order to learn about the (re)production of inclusion/exclusion and privilege/disadvantage in a particular context, it is necessary to portray its multiple lived perspectives and be specifically sensitive towards the quality and equity of representation and potentially invisible and unheard perspectives (Fabian, 2014; Said, 1979). Different from studies that focus on 'the center', i.e. study voices and practices that represent mainstream, dominant perspectives, this thesis tries to include and study voices in the margin, i.e. 'silenced' perspectives (Abma & Widdershoven, 2006). With this, the hope is to support the 'voice' and the acknowledgement of 'alternative' stakeholder perspectives, support redressing of power imbalances and live up to a social justice perspective aiming for equity in participation and (re)presentation in all daily praxis and organization contexts (Abma & Widdershoven, 2011). Since reality and knowledge are viewed as fundamentally relational and contextual, development of specific aspects of a context can only take place when people engage with each other, and therefore the conditions for transformation towards inclusion can only be established bottom-up and praxis-based within the research contexts (Abma, 2003; Ghorashi & Sabelis, 2013).

Research setting

The studies of this thesis have taken and are taking place in the medical school VUmc School of Medical Sciences (VUmc SMS) and in the academic hospital of Amsterdam University Medical Center, location VUmc (VUmc). Besides to anonymize quotes and individual participants, it has been considered to also anonymize the research setting as a whole in order to protect privacy of all stakeholders. However, anonymizing the setting as such is likely to be ambiguous since people familiar with it as well as those familiar with –academic health care within– the Netherlands in general can easily recognize it since the country is relatively small and has few big cities, universities and academic hospitals. Moreover, as this thesis aims to generate bottom-up and experiential knowledge, and aims to shed light on conditions for transformation, it is valuable to consider the specifics of the setting. Therefore below, the research setting is described in some detail. In the different studies, all research contacts and participants will naturally be asked for consent to report on the study findings.

VUmc SMS, where the studies that focus on undergraduate medical education are (being) conducted, is part of the VU University Amsterdam (VU). The university is located in the highly-urbanized, western part of the country and its student population is among the most culturally diverse in the Netherlands (Van Miltenburg, 2007). The attention for diversity within the university is often seen as related to and indeed presented by the university as inspired by its original signature as both Christian and emancipatory (www.vu.nl/en/about-vu-amsterdam/mission-and-profile/history/index.aspx, visited on 19-07-2018). It was the first academic institute in the Netherlands for Reformed Christian students from lower socio-economic backgrounds. Since the 1960s the university is open to everyone and has a particular philosophical, ideological orien-

tation. The university has attention for diversity issues since at least 2007 (Ghorashi, 2011). Since 2014, explicit policy on diversity was instated, a chief diversity officer was assigned to promote inclusion of diversity within the organization (VU, undated; ww.vu.nl/nl/nieuws-agenda/nieuws/2014/okt-dec/vu-geeft-met-chief-diversity-officer-vorm-aan-diversiteitsbeleid.aspx, visited on 19-07-2018) and Islamic prayer rooms were opened that became the topic of national societal and political debates as the university was criticized for being too tolerant towards certain cultural or religious practices (e.g. Het Parool, 2014).

The medical school of this research setting, VUmc SMS, is both part of the VU and affiliated with VUmc. Approximately 20 to 30% of the students of VUmc SMS have a cultural minority background, depending on the exact definition used (Verdonk, 2013). Recently, the focus on cultural diversity and other diversity aspects within the curriculum is increasing (Abma & Tjitra, 2011; Croiset, 2013; Verdonk, 2013). Since 2013, a new longitudinal learning pathway named 'Diversity and Interculturalisation' emphasizing the development of empathy and critical reflexivity of students and teachers (Verdonk, 2013) is being developed and implemented together with students and artist Lina Issa (Art Partner) in the undergraduate medical education (Verdonk, 2013). Furthermore, D.O.C.S. (Diversity. Openness. Culture. Students.) a commission of the MFVU, the student association of the medical faculty, was set up in (2014) with the aim to promote diversity values and advocate for medical students with a cultural minority background (www.med.vu.nl/nl/studenten/studentenorganisaties/mfvu/docs/index.aspx, visited on 19-07-2018). Teachers and D.O.C.S. collaboratively and separately organize extracurricular activities on diversity in medical education, such as the symposium 'Different in the white coat' in 2014.

The academic hospital of VUmc is affiliated with but separate from the VU. As the hospital was originally part of the university, it shares its philosophical, ideological signature springing from the historical religious roots of the university. Within the academic hospital, diversity –especially cultural and religious– has been put on the policy agenda in 2007 in order to support cultural competence of employees and inclusion of diversity in the organization (e.g. Tracer, 2007). It was the first hospital in the Netherlands to employ a Muslim spiritual counsellor (Leyerzapf & Abma, 2012). Since 2007, the 'Interculturalisation' program consists of activities to increase awareness on diversity issues, such as a 'Colourful VUmc week', trainings for employees, leading professionals and management, development of the kitchens into a 'kitchen of the world', an interpreter pool of bilingual staff members and moral case deliberation with specific focus on cultural dilemma's (VUmc, 2013). In 2013, the portal for staff and students launched a website with information on (cultural) diversity aspects in relation to health (VUmc intranet, visited on 15-07-2018). The program is facilitated by a project leader and led by a steering committee consisting of staff members VUmc and ambassadors on the work floor at different departments from VUmc.

Research methods

Fitting the bottom-up, emergent and critical design, qualitative and responsive research methods, namely in-depth and/or semi-structured interviews, homogeneous focus groups, heterogeneous focus groups –i.e. dialogue groups– and participant observations

will be used to one the one hand build an in-depth ethnographic account of Dutch academic health care (Gupta & Ferguson, 1997). On the other hand these methods will be used to bring multiple, diverse perspectives within this research field into contact with each other to stimulate development of personal and collective learning and critical awareness of and mutual understanding between stakeholders, of open, critical dialogue and of shared commitment and collective responsibility for practice change (Abma & Widdershoven, 2006; Denzin & Lincoln, 1994). As such, the thesis is intended not only as descriptive (ethnographic account) but also as transformative research (responsive, action-oriented research) (Abma et al, 2019).

The different studies in this thesis make use of different research methods in accordance with the specific objectives of the study. The five studies differ in their focus, stakeholder perspectives, setting within academic health care and aim of knowledge production. Together, they represent the journey of the medical student from undergraduate education, via postgraduate education, towards the academic, clinical work place, where professionals from different disciplines meet and work together.

The studies in Chapters 2, 3 and 4 are three separate, explorative qualitative research projects that are conducted in VUmc SMS and the academic hospital of VUmc. These studies deal with cultural diversity and inclusion in academic medicine. Chapters 2 and 3 will focus on the early phase of medical education, i.e. undergraduate education. Chapter 4 will focus on postgraduate medical education and the selection process to enter this education phase. Chapters 2 and 3 will discuss the perspectives of medical students with a cultural minority background, while Chapter 4 will discuss both those of medical students and physicians in training to become a medical specialist with a cultural minority background and those of medical specialists with a cultural minority *and* majority background. Chapters 2 and 3 primarily intend to generate knowledge of experiences of students with a cultural minority background in academic medicine where insight is up till now missing. Chapter 4 shares this objective but furthermore intends to support critical awareness and mutual understanding of stakeholders in academic medicine with a cultural minority and majority background by including leading professionals with a minority and majority background.

Subsequently, Chapters 5 and 6 will discuss two separate studies based on ethnographic data collection that is being performed from 2013 until 2017 within the academic hospital. These chapters will deal with cultural diversity issues on the academic health care work floor, i.e. they move beyond medical education and besides medical professionals involve care, paramedic, administrative and supportive staff from different clinical wards in the hospital. Besides the perspectives of professionals with a cultural minority background, the perspectives of professionals with a *majority* background will explicitly be included. With this, the chapters intend to redirect focus from 'the margins' to the center and to professional and work place norms, and as such spur learning on inclusive organizational culture. Moreover, as Chapters 2 to 5 will foremost focus on raising critical points of attention for inclusion of professionals with a cultural minority background in academic medicine and health care, Chapter 6 will focus on situations and moments in which professionals experience inclusion and on potentials for change.

Furthermore, to support the bottom-up, emergent and critical design and descriptive as well as transformative qualitative research, reflexivity of the researchers towards the research process and their own positioning is important. This thesis includes five personal reflections in which I reflect on my own role, position and normative reference frames as a researcher and developments within these in the course of the five different studies. These 'critical indicents' give an impression of several situations and their impact on me based on abstracts of my personal logbook, field notes, conversations with my supervisors and colleagues and conversations with the students and professionals I encountered in the research settings. They are both 'critical' in the sense that they signal critical events in my personal-professional development and development of my critical awareness on issues of diversity and inclusion, and generate key insights on conditions for transformation. I will discuss why I included these critical incidents in this manner and discuss the lessons learned in the General discussion (Chapter 7).

Outline of the thesis

Chapter 2 – In this chapter experiences of students with a cultural minority background with cultural diversity issues in undergraduate –preclinical and clinical– medical education will be discussed. Despite the relatively high number of students with a cultural minority background within the medical student population of VUmc SMS, little is known about the perspectives of these students. The central research question underlying this study deals with how the students with a cultural minority background experience the intercultural competence activities within the medical curriculum and the education and campus climate in general. The aim is to generate bottom-up insight into the lived experiences of students with a minority background in medical education, especially regarding intercultural competence activities, as well as to formulate recommendations on how to stimulate inclusion of cultural diversity in academic medicine. The study was conducted in 2010 and followed a qualitative evaluation design (Abma & Widdershoven, 2011). Data collection consisted of semi-structured interviews (n= 23), a focus group (6 participants) with students with a cultural minority background in undergraduate medical education and participant observations (20 hours) in medical school and on the university campus. Thematic analysis was performed (Braun & Clarke, 2006).

Critical incident I – Here I will reflect on how I became aware through the narratives I heard and encounters I had of the implications of the differences in my own lived reality and those of people I worked and engaged with in the research, and how this awareness emotionally impacted me personally and professionally.

Chapter 3 – As Chapter 2, this chapter will deal with experiences of students with a cultural minority background with cultural diversity in undergraduate medical education. Although in VUmc SMS, as (inter)nationally, the medical student population as well as the population of medical students with a cultural minority background is highly feminized, and female Muslim students are very 'visible' within medical school, little is known about the perspectives of female Muslim medical students. The research question of this study is how female Muslim medical students experience (pre)clinical medical education and the general education climate in medical school and on campus.

By zooming in on the apparently marginalized perspectives of female Muslim medical students, the aim is to support development of (political) voice of these students and to gain bottom-up insight on inclusion in medical education and the criteria for making academic medicine more inclusive. The study is being conducted (in the year 2014) and entails an explorative, qualitative interview study (Green & Thorogood, 2014). Data collection consists of semi-structured, in-depth interviews (n= 14) with female Muslim students with a cultural minority background in undergraduate medical education. Thematic data analysis is being performed (Braun & Clarke 2006).

Critical incident II – Here I will reflect on how I became aware of how all people in the research settings are socially positioned and implicated in social power dynamics as they are embedded in everyday practices such as language, and how this raised critical questions and feelings to my personal positioning as well as my role as a researcher.

Chapter 4 – In this chapter the focus will move from undergraduate to postgraduate medical education and besides VUmc SMS, the academic hospital of VUmc will become involved as site of research. The number of medical specialists with a cultural minority background appears to be strikingly low compared to the number of medical students with a cultural minority background. Therefore, the first research question of this study is how graduate physicians, physicians in training to become a specialist and medical specialists with a cultural *minority* background experience (postgraduate) medical education and especially processes of selection, evaluation and performance appraisal in the clinic, and what are their perspectives on cultural diversity issues in academic medicine. The second research question is what are perspectives of medical specialists with a cultural *majority* background on cultural diversity issues in postgraduate medical education and academic medicine, and what are their perspectives on processes of selection, evaluation and performance appraisal in the clinic. The aim of the study is to gain contextual and practice-based knowledge related to –the development of–inclusion of cultural diversity in academic medicine. The study was performed from 2011 until 2012. It followed a qualitative, responsive research study design inspired by critical diversity perspectives (Hood et al., 2005; Verdonk & Abma, 2013). Data collection took place via semi-structured, in-depth interviews (n= 27) with physicians (in training) and specialists with a cultural minority background, and with specialists with a cultural majority background. Following the interviews, a focus group (7 participants) was conducted with physicians (in training) and specialists with a cultural minority background, and subsequently a dialogue group (8 participants) with physicians and specialists with a cultural minority and majority background. Data analysis happened via a combination of thematic and integral content analysis (Bernard, 2011).

Critical incident III – Here I will reflect on how I became aware of my own race and how my everyday reality as a white person connects to how I am implicated in structural historical and political dynamics of inequality, and how this impacted me.

Chapter 5 – This chapter will deal with perceptions on cultural diversity of professionals with a cultural minority and majority background on the academic hospital work floor. The number of professionals with a cultural minority background in the hospital and

especially in executive positions appears to be low. Management expresses difficulty with recruitment, selection and retention of professionals with a cultural minority background in the organization despite efforts in policy and practice. The research question of this study is to learn how professionals at the academic hospital workplace deal with and experience cultural diversity in everyday practice and interactions vis a vis each other. Specifically, it looks at how professionals with a cultural minority and majority background (re)produce difference and sameness, and subsequent privilege and disadvantage through practices of normalization. The aim of the study is to generate dynamic, holistic and critical insights on the power dynamics of the academic hospital work floor in order to identify conditions for transformation towards inclusion regarding cultural diversity in academic health care. The study has started in 2013 and will be conducted until 2017. It follows a critical diversity design (Zanoni et al., 2010). Data collection consists of semi-structured, in-depth interviews (n=62) with professionals from several clinical wards in the hospital as well as extensive participant observations (approx. 100 hours) on these clinical wards. Data analysis is being conducted through sensitizing concepts (Blumer, 1954), close reading (Yanow & Schwartz Shea, 2006) and 'thinking with theory' (Jackson & Mazzei, 2013).

Critical incindent IV – Here I will reflect on how I became aware of how my socially embedded personal-professional positioning, role and references frames spur emotions that both encourage these and discourage personal-professional development and that of its social context.

Chapter 6 – Based on the same research project as Chapter 5, this chapter will zoom in on the experiences with cultural diversity issues of professionals with a cultural minority and majority background on one clinical ward in the academic hospital. The aim of the chapter will be to explore how normalization of unequal distribution of privilege and disadvantage of professionals in academic health care organizations can be challenged via meaningful culturalization in the interference zone between system and life world, and how subsequently space for belonging and difference can (be) develop(ed) in academic health care. It will involve a nested case study design (Abma & Stake, 2014) and is, as Chapter 5, based on insights from the data collection that is presently being conducted and will continue until 2017. The design is inspired by critical diversity perspectives and aims for development of dialogical spaces in organizations (Ghorashi & Sabelis, 2013; Kunneman, 2005).

Critical incident V – Here I will reflect on how I became aware of how my emotional, embodied presence in the research could be vital for personal as well as collective transformation.

Chapter 7 – This chapter is the general discussion of this thesis and will discuss the overarching conclusions of the five core chapters and the five critical incidents regarding inclusion of cultural diversity in academic health care and conditions for transformation towards inclusion. Subsequently, the answer to the two central research questions of the thesis will be formulated here, as well as the implications of the learning experiences for practice and future research.

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A moment during the intervention of D.O.C.S. during the first day of medical school. A number of older students seated among the first year students share stories about their motivation to study medicine and the importance of bringing in the diversity of your identity to your study and practice. In this specific moment the students are turned to face each other and answer the question: What are you afraid of at the beginning of your medical studies? Photographer: VUmc, Art Partner.

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

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Abstract

Medical schools increasingly value and focus on teaching students intercultural competency within present-day multicultural society. Little is known about the experiences of cultural minority students in intercultural competence activities.

This article discusses the intercultural competence activities of medical education in a Dutch university from the perspective of cultural minority students. We will formulate recommendations for how to stimulate intercultural competency in, as well as inclusiveness of, medical education.

A qualitative evaluation was performed within a medical school in the Netherlands. Data were collected through interviews (n = 23), a focus group (six participants) and participant observations (20 hours). Thematic analysis was performed.

Cultural minority students experienced a lack of respect and understanding by cultural majority students and teachers. Education activities intended to transfer intercultural knowledge, address personal prejudice and stimulate intercultural sensitivity were perceived as stigmatising and as creating an unsafe climate for cultural minority students. Cultural minority and majority students on campus seemed segregated and the intercultural awareness of minority students was not integrated in intercultural competence activities.

As cultural minority students were confronted with microaggressions, the medical school did not succeed in creating a safe education environment for all students. Contrary to their aims and intentions, intercultural competence activities had limited effect and seemed to support the polarisation of cultural minority and majority students and teachers. This can be seen as pointing towards a hidden curriculum privileging majority over minority students. For structural integration of intercultural competency in medical education, the focus must penetrate beyond curricular activities towards the critical addressing of the culture and structure of medical school. Collective commitment to creating a safe and inclusive education climate is vital. This requires fostering social cohesion between minority and majority students and teachers, raising awareness and the practice by all involved of critical (self-) reflexivity on cultural prejudice and dominant, exclusionary norms in academic medicine.

Introduction

Mirroring culturally diverse societies, medical schools in northwest Europe increasingly value and focus on medical students' learning of intercultural competencies that will enable them to deal with cultural diversity issues (Seeleman et al., 2011). Training is generally directed at enhancing knowledge, skills and awareness of how culture, ethnicity and religion can play roles in the presentation, experience, treatment and outcome of illness (Seeleman et al., 2009; Wolffers et al., 2013). Ultimately, the objectives are to ensure quality of care and equal access to care for increasingly culturally diverse patient populations. Research has shown, however, that the quality of care for minority patients is generally low (Lillie-Blanton et al., 2000; Napier et al., 2014; Seeleman et al., 2008; Smedley et al., 2003). Reasons given are that physicians lack knowledge of minority patients, and also lack knowledge and awareness of existing differences in communication styles, in expectations of the doctor–patient relationship and in the meaning and experience of health and illness, as well as the skills required to address these (Betancourt, 2004; Van Wieringen et al., 2003).

The situation in the Netherlands is comparable with those in other countries in northwest Europe. More than 20% of the Dutch population is considered 'allochthonous' and most of these people live in big cities in the urbanised western part of the country (CBS, 2016). Research shows that the quality of care for minority patients is low here too (Seeleman et al., 2008). To counter this, since 2000 Dutch medical schools have instituted activities to further intercultural competency in their curricula in order that students can acquire the cognition and skills necessary to deal effectively with cultural diversity (Ingleby, 2006; 2009; Van Wieringen et al., 2001). 'Cultural diversity' is the term commonly used to describe the context that arises in the presence of ethnic, national, cultural and religious identities that are perceived as non- Dutch. This presence includes people with migrant or refugee backgrounds, but also new generations born in the Netherlands whose parents were migrants or refugees. In general, the diversity of the Dutch population is categorised as 'autochthonous' and 'allochthonous'; the latter literally means 'from different soil' and in this context signifies people who were themselves or whose parent(s) were born in a foreign country. 'Allochthonous' in this context is used to indicate a 'non-Western' origin from a country other than any in Europe or North America, Japan, Australia and New Zealand, as countries elsewhere are perceived to inhabit a culture different from 'Western' culture. The terminology is debated as exclusionary, discriminatory and racist as it seems to create a hierarchy between 'allochthones' as definitive cultural *Others* as opposed to 'autochthones', who represent a 'natural and normal' part of Dutch culture and identity (i.e. the 'true Dutch').

Cultural minority, henceforth called 'minority', students have entered higher education in the Netherlands in large numbers since 1995. This can be traced back to the mass migration of immigrant workers from Turkey and Morocco who were recruited by the Dutch government from the 1950s onwards, but especially in the 1960s and 1970s. As wives joined their husbands in the 1970s and 1980s, migrant children began to enter higher education from approximately 1995 (e.g. Ghorashi, 2010). Medicine is one of the most popular of the subjects for which minority students apply (CBS, 2014). The number of minority medical students is highest in the two largest cities in the country,

Rotterdam and Amsterdam, where minority students account for 20–30% of medical students depending on the definition of minority (Hertz & Bakker, 2007; Stegers-Jager et al., 2012).

Strikingly, the performance of minority students in medical education, especially in the clinical phase, seems to fall behind that of cultural majority, hereafter 'majority', students (Stegers-Jager et al., 2012; Woolf et al., 2012). Lack of social connection with fellow majority students and teachers and existing cultural prejudice have been indicated to play a part in this 'underperformance' (Leyerzapf et al., 2015). As little is known about how minority students experience medical education and, in particular, there is no known research on their experiences of intercultural competence activities, it is necessary to gain insight into minority students' experiences and needs in relation to intercultural competency and medical education.

In this article, we describe the experiences of minority undergraduate and graduate medical students in the context of intercultural competence activities within the medical school of a university in the highly urbanised western region of the Netherlands. We discuss the findings of a qualitative evaluation in order to formulate recommendations for educators, policymakers and other professionals in the field of academic medicine on how to generate intercultural competency and inclusiveness in medical education.

Methods

Setting: the intercultural competence activities

The intercultural competence activities of the medical school that we evaluated were initiated in 2007. They focused on integrating intercultural competencies, consisting of skills, knowledge and awareness, in all phases of the undergraduate and postgraduate curricula. Intercultural competence activities included joint discussion of case studies and reflection on personal prejudices in working groups, the dissemination of knowledge through lectures and literature (Helman, 2007), and training in intercultural communication. Teaching staff could attend training in intercultural competencies on a voluntary basis.

Research design

This explorative, qualitative evaluation aimed to generate insight into practices in the field of intercultural competence in a medical school and the lived experiences of its minority medical students (Baur & Abma, 2014; Goodyear et al., 2014). Semi-structured interviews and a subsequent focus group with minority students were conducted, as well as participant observations at the medical faculty. The qualitative character of the study enabled evaluation of the experiences and expectations of students within the day-to-day context and thus supported a grounded, bottom-up evaluation of their needs for intercultural competence activities and medical education (Abma & Widdershoven, 2011; Gupta & Ferguson, 1997).

Recruitment and selection of respondents

Minority students were recruited through personal approaches by the conducting re-

searcher within public areas of the medical faculty and via snowball sampling (Bernard, 2011; Burlew, 2003). The fact that earlier non-personal recruitment through, for example, e-mail had yielded little response emphasised the central importance of the researcher establishing trust, confidence and a personal rapport with respondents in research with minority groups and on sensitive, politically laden themes such as social exclusion (Burlew, 2003). Respondents found the evaluation relevant and important and expressed their motivation as a wish to support other minority students and to develop intercultural competency in medical education. Central selection criteria were diversity in the cultural background of the respondent, as determined by the respondent's or his or her parents' country of birth, religious affiliation, gender and year of study.

Respondent characteristics

Students from every year of study, both undergraduate and graduate, were included. Respondents constituted an almost equal representation of female and male students. Reported religious affiliations, in addition to a 'non- religious' category, were:

- Christian;
- Hindu;
- Jewish, and
- Muslim.

Respondents reported the following cultural backgrounds in addition to Dutch:

- Afghan;
- Cape-Verdean;
- Chinese;
- Congolese;
- French;
- Indonesian;
- Iranian;
- Moroccan;
- Pakistani;
- Surinamese;
- Syrian;
- Turkish, and
- Ugandan.

Data collection

Semi-structured pilot interviews (n = 3) were conducted using a topic list formulated on the basis of a literature review and the researchers' expertise. Topics were: (i) experiences of education on intercultural competencies, and (ii) this education in relation to culture, ethnicity, religion, gender and future medical practice. Based on the pilot interviews, the following topics were added: feelings of stigmatisation in medical school; social conduct of majority students and teachers; social cohesion between majority and minority students, and experiences in physical examination training. A total of 20 semi-structured interviews with minority students were conducted at the medical faculty. Interviews lasted 45–60 minutes.

A focus group was held with minority students (n = 6) who had not been interviewed to deepen and validate interview findings. Majority students and teachers were not included as several respondents made it clear they would not feel safe enough to speak freely in a 'mixed' setting (Krueger & Casey, 2000). The focus group was moderated by the supervising senior researcher (second author) and the conducting researcher made on-site notes. Both the interviews and the focus group were digitally recorded after the

provision of verbal consent from participants and transcribed verbatim.

Data collection was supplemented by short-term participant observations (approximately 20 hours) by the conducting researcher focusing on social interactions between minority and majority students in the medical faculty. On-site notes were made. Participant observations provide opportunities to further validate and contextualise interview and focus group data and are particularly relevant in the case of socially sensitive and (partly) implicit themes as they provide contextual, relational data on how these themes are enacted by and what they mean for respondents in daily social practice.

Data analysis and quality criteria

Data analysis occurred parallel to data collection as much as possible to create a cyclical research process and build on the emerging insight of the researchers (Denzin & Lincoln, 2005). Analysis followed a thematic approach and used open coding, axial coding and the clustering of findings (Miles & Huberman, 1994; Moretti et al., 2011). The conducting researcher and supervisor analysed the data separately and subsequently engaged in a critical discussion of the data to enhance validation and limit bias (Denzin & Lincoln, 2005). The conducting researcher, a student in the field of health and life sciences and with a minority background, kept a diary in which to reflect on personal bias and role in the research process (Blaxter, 1996; Mays & Pope, 1996). Credibility was enhanced by the member checking of all interviews with the respondents via a short report (Blaxter, 1996; Mays & Pope, 1996; 2000). The Medical Ethics Review Committee of the organisation within which this study took place confirmed that the Medical Research Involving Human Subjects Act (WMO) did not apply to this study and that official approval of the study by the committee was not required. All data were anonymised and handled and stored with care and respect for privacy. Audio files were destroyed after transcription had been completed.

Results

All quotations in this section are literal citations from the interview and focus group transcripts, translated from Dutch by the first author. The translation process focused on conveying contextual meaning (Van Nes, 2010).

Stigmatising case studies

All respondents viewed the intercultural competence activities in which they participated as confirming prejudices about minority groups instead of adding to intercultural awareness and sensitivity. They especially pointed to case studies on cultural diversity issues presented in lectures and working groups. Instead of facilitating critical (self-) reflection in students about how to deal with culturally sensitive topics and culturally diverse patients, the cases were experienced as both highly stereotypical and negative or normative and therefore as contributing to the stigmatising of the minority. Case examples introducing minority patients rather than majority patients did not cover common 'normal' medical conditions, suggesting that minority patients are not normal patients, as are majority patients. As the central themes in the cases involved, for example, consanguineous marriage, female circumcision or mutilation and abuse of women, themes that were predominantly

evaluated as negative and fundamentally different from and contrary to normal Dutch behaviour and cultural norms, they added to negative essentialist imaging of minorities in general. The following statement from a Year 2 female student illustrates these points:

> So it struck me that if you have a case of a Moroccan or a Turk, she was always unwantedly pregnant. You also have other patients with other symptoms. I was like: "Oh no, not again!" We also sometimes have the flu or something like that.

Respondents reported inaccuracies in the cases that gave them the impression that the medical school was not well informed and caused them to take medical education less seriously. Many inaccuracies and prejudices, according to respondents, referred to Islamic culture and made Muslim students feel especially set apart. A Year 2 male student said:

> It [the case] implied female circumcision as required by Islam. What total nonsense! And then I, being the only Muslim in a group of 12 people, must always defend Islam and explain what is wrong. They [the medical school] really need to use better sources.

Teachers lacking as role models

Respondents reported that they recurrently felt set apart during lectures and working groups by the negative and judgemental ways in which minority groups were spoken of. A Year 4 female student reflected on a working group on personal prejudice and bias:

> There are tutorials to [help you] recognise prejudices. We had to shout out loud things in the classroom... It was all not true... Yet things were mentioned like: "Turks can't educate their children"... And I noticed that I and another foreign girl clammed up completely. And the rest [majority students] were just shouting things.

As well as feeling vulnerable and unsafe, the respondents made it clear that they both felt responsible themselves and were made to feel responsible for clarifying things and giving accurate information as both majority students and teachers looked to them when cultural or religious topics were addressed in the study material. A Year 5 female student said:

> I noticed that if a lecture is about religious allochthones it becomes very personal. Then it must be in such a manner [with a lot of respect for this group]. In any case, I felt very much responsible.

Respondents expressed feelings of disappointment that teachers did not support minority students in situations in which they felt set apart or stigmatised and that they seemed unaware of their feelings of isolation and vulnerability, which the students did not feel safe enough to discuss with staff. A Year 3 female student, stressing that for her it is dishonourable to show certain parts of her body to a man without medical necessity, recounted an experience in physical examination training:

> I once had an experience myself during the back examination training. Then we had to do it again and the [male] tutor came to stand right next to us. I think that is just so disrespectful, waiting for me to undress and then subsequently watching the examination. He just wanted to make me look foolish.

Experiencing disrespect from majority students and teachers

A central theme to emerge from the interviews and the focus group concerned respondents' feelings of being structurally met with disrespect and misunderstanding by majority students when it came to non-Dutch backgrounds, religious beliefs and cultural values. The following comment from a female Year 3 student showed a generalised and negative perspective on religious practices, namely the wearing of a veil and female circumcision or genital mutilation, and a Moroccan ethnic or cultural identity:

> I was drinking coffee with a female friend. She is Moroccan. She wears a headscarf and the subject of marriage came up. There were also Dutch students present, who then said: "But they [Muslim-Moroccan women] are stitched up before marriage, right?"... I just found that so rude and disrespectful.

Respondents also reported instances of teachers, who are mostly from the majority group, making disrespectful statements about non-Dutch cultures and non-Christian religions during working groups and lectures. A male Year 3 student related:

> One time during my presentation I said: "Some say evolution and some say God." My tutor stopped my presentation and exclaimed: "What are you doing here?" He said: "So you believe in God? Then you have no business here [in medical school]."

Disrespectful comments were often infused with humour, as the following comment from a female Year 5 student indicates:

> When they talk for instance about Ghanaians with HIV [human immunodeficiency virus]... I understand that in certain groups or with Blacks this is more common than for example with the Dutch. But make sure to say it with a certain respect. Well, if you're going to say it in such a way that people in the lecture hall will laugh, then I'm like...

Respondents described how humour could add to their feelings of social exclusion, such as in this comment from a female Year 2 student:

> Yeah you know, then they start laughing. It disappoints me, even with Ramadan [the Muslim fasting month]. They do not know that I am a Muslim and they show their disapproval. People do not always see that I am a Muslim and then I hear these things: "How can people not eat for so long!" I don't say that I'm Muslim then. I just keep quiet. I also think that they [majority students] do not know much about it.

Segregation between students
In interviews and the focus group, respondents also reported feeling more comfortable with minority students than with majority students. A Year 5 female student said:

> I only associate with allochthonous students. I just get along with them more than with White people.

This social segregation between students, clearly present in the language used by respondents ('allochthones', 'Whites', 'Dutch', 'Blacks', etc.), was also observed during participant observations. It seemed that minority students sought each other out in lecture halls and cafeterias during break times, and majority student groups on their part did not include members of minority groups in their social circles. Because of this segregation, minority student groups seem in general relatively heterogeneous in cultural, ethnic and religious backgrounds in comparison with majority student groups, which are relatively homogeneous. Respondents also stated this as a fact in the interviews and focus group. A Year 2 male student referred to the segregation on campus thus:

> I'm in a group of friends of 10 allochthones. A few Moroccans, some Turks, some Pakistanis, Chinese and Surinamese boys. Sometimes a Dutch student joins us who is "turned allochthonous". But sometimes when I sit in a Dutch group myself and the allochthones pass by, they look at me a bit like "what are you doing there?"... I just feel at ease with allochthonous people... Jokes that they understand and I know the habits. The Dutch, for example, are very outspoken about what they experience. We think we would never be allowed to do that. Then I feel more relaxed and drawn towards allochthones.

Respondents reported that they learn from one another's minority backgrounds, such as about norms of social conduct, the use of humour and how to address culturally sensitive topics. As a result of segregation, majority students are likely to miss out on this important contribution to the development of intercultural competency.

Discussion
Intercultural competence activities within the medical school in which this study was conducted appeared to be limited in their ability to enhance the intercultural competency of students and to some extent even seemed to support the polarisation of minority and majority students and teachers. Overall, it appears that the medical school did not succeed in creating a safe and inclusive learning environment for all students.

The disrespect and misunderstanding our respondents experienced throughout their study can be identified as 'microaggression'. This concept was introduced by Sue et al. (2007) to address particular everyday discrimination in contexts in which formal discrimination is rare and illegal as equal rights are secured by law, as in the Netherlands. Microaggressions are continuous invalidating remarks or questions made on the basis of presumed 'differences' in ethnic or racial identity (Sue et al., 2007). They are usually not recognised by their perpetrators as awareness and sensitivity on cultural diversi-

ty issues is lacking and underlying cultural hierarchies are normalised (Ahmed, 2015; Leyerzapf H, Verdonk P, Ghorashi H, Abma TA. '"We are all *so* different that it is just... normal." Normalisation practices in health care teams in an academic hospital in the Netherlands'; unpublished study 2016). Microaggressions are difficult to both pinpoint and challenge because they are often not 'seen' and may be wrapped in humour, with the result that the individual who objects is likely to be perceived as nitpicking and as a spoilsport or killjoy (Ahmed, 2015; Essed, 1991).

Other studies addressing cultural diversity in medical education corroborate the marginalisation of and microaggressions against minority students in the undergraduate and postgraduate phases (Leyerzapf et al., 2015; Stegers-Jager & Themmen, 2013; Stegers-Jager et al., 2012) and indicate that ethnic disparities and cultural bias exist in medical education as in health care (Betancourt, 2006; Smedley et al., 2003; Verdonk & Abma, 2013; Woolf et al., 2011). The use of simultaneously stereotypical and generalised, as well as negatively normative, case studies in which 'non-Dutch' cultures, ethnicities and religions are predominantly problematised feeds this marginalisation of minority students and the polarisation of minority and majority students and teachers in medical school. What develops is a process of *Othering* in which all (presumed) minority students become the Other and all (presumed) majority students constitute the normal or Self and thus the norm (Ghorashi, 2010; Ghorashi & Sabelis, 2013; Johnson et al., 2004).

It seems that Muslim students in particular are set apart and misunderstood as prejudices as well as the case studies used often involved traditions associated with Islam that are evaluated negatively in Dutch society. This links with current societal and political debates in the Netherlands, as well as in other countries in northwest Europe, in which minority groups are largely portrayed in negative and problematising ways, especially those originally from Muslim countries (Essed & Hoving, 2014; Wekker, 2016). A study from the USA reported similar experiences of exclusion in specifically Muslim minority students and showed that these students, who feel less welcome at and supported by the university, have an increased risk for stress, burnout and other psychological problems (Worthington et al., 2008).

We encountered a cognitive, rational focus in intercultural competence activities that left bias in majority medical students and teachers undiscussed because the critical review of dominant social norms was not included. Critical consciousness is necessary in order to provide inclusive, equitable education for all students, as well as adequate development of intercultural competency (DiAngelo & Sensoy, 2010; Kumagai & Lypson, 2009). According to Wear (2006), medical education should address 'the complex interplay between medicine and culture' to prevent education from being simplified and reified and 'doing as much harm as good'. Although intercultural competence activities are intended to sensitise 'students from the dominant culture to minority "differences", toward an end of recognising and responding "appropriately" to cultural features that affect medical care', Wear makes it clear that such activities can have 'hidden or unintended components that can actually lead to the erosion of professional attitudes toward patients' (Wear, 2006). As long as academic medicine is presented as outside society and history, and existing power relations and social hierarchies are ignored in

education activities, intercultural competence activities are likely to support a hidden curriculum in which majority individuals – students, teachers and patients – are privileged over members of minority groups (Razack et al., 2015). Therefore, intercultural competency must be approached as an ongoing, dynamic and two-way process centred on the critical (self-)reflexivity of all – but particularly majority – students and educators on existing dominant norms and their value for medical education (Kumagai & Lypson, 2009; Razack et al., 2015; Verdonk & Abma, 2013; Wear, 2006).

Our findings demonstrate bonding among minority students that was experienced positively by the students involved. Earlier studies show how social cohesion among undergraduate medical students is important to the development of successful professional attitudes and identities (Finn et al. 2010; Weaver et al., 2011). Studies (Benschop, 2009; Van den Brink & Benschop, 2012; Leyerzapf et al., 2015) also point to the central role of social and emotional connection and networking with possible future colleagues and supervisors – who are dominantly majority group members – to build a successful professional profile and career opportunities: '[m]edical students must develop not only their professional identity but also *inclusive social attitudes* for effective medical practice in the future' [emphasis by HL] (Weaver et al., 2011). However, although it seems that supporting feelings of belonging can improve academic achievement (Cohen et al., 2006; 2009; Walton & Cohen, 2011), it is also reported that – as in our study – minorities often feel they do not belong in academia (e.g. Navarro et al., 2009; Walton & Cohen , 2007) and this can be believed to affect their academic performance and careers.

Our study indicates that intercultural competence activities depend highly on the attitude of the teacher. Studies within and outside academic medicine relate the development of successful professional identity and professionalism to adequate role-modelling (Falconer & Hays, 2006; Finn et al., 2010). Teachers need to take responsibility in implementing intercultural competency in medical education as they could make a difference by facilitating the development of a safe and inclusive classroom and inviting minority students to introduce their intercultural understanding. This requires, however, attention and development in all facets of the medical school, the possibility of which seems remote in the context of this study, as well as in other medical schools in the Netherlands and neighbouring countries, where teaching and management staff are still largely drawn from the majority population, and training in intercultural competence education is often not compulsory. Crucial to the structural development of intercultural competency is thus not only critical awareness, but also the commitment of medical and teaching professionals, management and policymakers to addressing and facilitating change in the structure and culture of the medical school (Verdonk et al., 2016).

In response to our findings in 2013, cultural diversity was put on the agenda and newly framed within the medical school evaluated here with a focus on emphatic, relational and contextual practice in medical education and the clinic, with the aim of making academic medicine more inclusive (Croiset, 2013). Since then, with a broad cultural development in mind, new intercultural competence education has been developed and implemented in the curriculum in a manner involving medical students themselves and with the help of an artist focusing on embodied connectivity between people (Ver-

donk, 2013), and from a perspective of critical intersectionality (Verdonk P, Muntinga, M, Leyerzapf H, Abma T. 'Strategic reciprocation between condensed categories and fluid identities. Understanding and studying dynamic differences in health care from an intersectionality perspective'; unpublished study 2016).

Strengths, limitations and future research

This evaluation was limited in scope. Further research will be valuable for generating deeper insight, particularly by including more focus groups and participant observations to validate findings from interviews, as well as interviews with majority students and teachers to involve their perspective. The representativeness of the sample could be viewed as limited because participants were recruited and selected by one junior researcher, starting with his personal contacts. The establishing of trust and confidence, however, is essential in research on minority and diversity issues (Burlew, 2003). Therefore, we see the recruitment and selection method principally as representing a strength, as is the fact that the conducting researcher had a minority background and was at the time of the study a student and peer of the respondents. Future research should make use of dialogue groups comprising minority and majority students, teachers and other stakeholders in order to work towards mutual understanding and collective commitment (Abma et al., 2016). A critical intersectionality perspective can support the building of critical reflexivity, the finding of common ground and the development of practice. Further, it is important in order to develop structural insight and solid implementation policies to study other medical schools and their intercultural competence activities within the Netherlands and internationally.

Conclusions

To secure quality of care and a diverse and equitable medical workforce, intercultural competency must be integrated in medical education. However, despite intentions, intercultural competence cultural diversity issues were described as stigmatising minority students and patients. Social segregation between minority and majority students on campus further hampered intercultural learning. Adequate and structural implementation of intercultural competency in medical education requires it to be acknowledged as embracing more than the acquisition of cognition and skills, and as representing an ongoing, two-way process of critical (self-)reflexivity in all stakeholders on dominant social norms in academic medicine that involves the curriculum, as well as the medical school culture and structure. Management and educators, together with (especially minority) students and staff, need to develop policy and implement educational activities that incorporate critical reflection and awareness raising on the possible exclusion of and cultural prejudice towards minority group members. (Extra) curricular activities and networks in medical school should focus on creating a platform to stimulate the social integration of minority and majority groups and social cohesion between students in general. When trained adequately in intercultural competency, teachers can set the tone in facilitating a safe and inclusive educational environment within the classroom.

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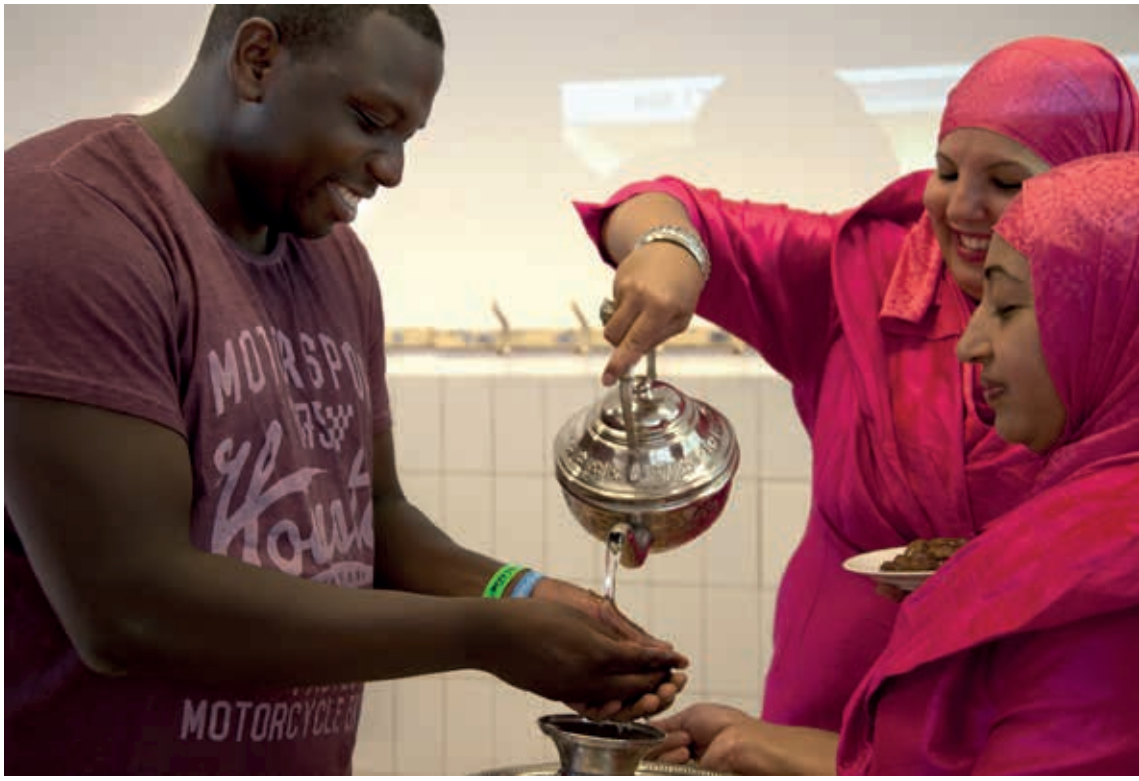
MOTORCYCLE

Student and two women from Zina Platform. First-year medical students visit the Zina Platform, which aims to build connections between women's organisations in local neighboorhoods, together with Lina Issa during the introductory week in 2016.
Photographer: Bart Majoor, Art Partner.

Critical incident I - My privilege, my fragility

August 2011, the academic hospital

He is a physician within the academic hospital. He also works on his PhD - in his own time mind you, it' s really a hassle, he laughs and jokingly wonders out loud if it will ever be finished. He is one of the first physicians my colleague and I speak with in our research. We haven' t really started the interview. And then we suddenly seem to have. He hates the word *allochtoon* (allochthone) he says. 'New Dutch men,' that' s the term he rather uses. He tells us about his children. Who are born in the Netherlands, are growing up here and are called by that word *allochtoon* by their friends. The children they play with call them names, ask where they' re from and why they don' t go home. The parents of these children do it as well, question their Dutch-ness. Their teachers too. His children ask him about it. They ask: why do they call us this, what do they mean with these questions? He hates it and is sad about it. He tries to explain, but doesn' t know what to say. It wasn' t like that when he came here. If he has these experiences, so be it -yes, he answers to my unspoken question, it happens on a daily basis. He learned to live with it... But, he continues determinedly, that his *children* have to feel it, that they' re different, do not automatically belong, are not automatically recognized as having the right to be here, are not seen as normal Dutch children, are rejected by the environment they grew up in... that' s what he cannot live with. He thinks about going away. But this is his country, this is their country...

I' m upset. It gets to me. I knew this, this is not new to me, yet it has a big impact on me. I feel indignant about his story. About this injustice. This is not fair. It' s not good, it cannot be, it shouldn' t be - I become angry. This is ridiculous. They' re born here, they have a right to be here. Every right. As much as anybody else. End of discussion. I want to tell those people they are wrong. Make them see. Make them ashamed of what they did. Right this wrong. I want to end this discussion period. But I am speechless, silent. Flustered.

You don' t have to be so shocked. He sees that what he said touches, affects me, that I can' t seem to step over it, let it go, take it for a fact, like he seems to do. I feel ashamed because I act like this, perhaps even make it harder for him, while he seems to handle it in such an easy, resigned manner. But I also taste his disappointment and pain. That is what hurts me. I feel sad. I want to take it away. I feel ashamed because this is not me. I do not have these experiences, do not have to live with them. I feel fear. Do I carry responsibility for this? Am I to blame? I feel guilty. And I want to take that guilt away as well, resolve it, do something with it and transform it.

I feel small in this conversation. What does it mean that I' m sitting there with two men who are not white? My colleague and the physician we' re interviewing together. I feel ignorant. Because I feel or think that this may be day-to-day reality for both of them, being approached as an outsider? They know this about life, have grown up with it. Or are these my assumptions with which I put myself in the position where I' m different from them －or rather, they different from me? I feel green as grass. And embarrassed. I feel like a deep world is behind these experiences, opening up beneath me and I hadn' t really been aware of it before. I start to see the surface, I feel there is a bottom somewhere deep, yet I can' t see it because it' s dark. I start to see-feel it but I do not really dare to talk about it with my colleague. We talk about the stories of the people we interview, share our indignation but I do not feel like we touch upon the core, because we don' t go there. I don' t. I' m afraid to be too naive if I show too much emotion in reaction to the stories we hear, that I' ll appear unknowing. Afraid to realize that we are different in this. Afraid to ask my colleague about his experiences －that' s personal, I don' t want to intrude. And I' m afraid to make him different, make him feel different. I want him to trust me, feel safe with me, know I am an ally. Know that I' m not one of them, that I do not see him as different, that I don' t categorize, judge people like that, that I' m beyond that, above that, that we' re on a different level. Yet I feel inadequate. Incompetent. I' m running in circles. All in my head. Do I really understand? Am I really open to these realities, do I really feel their stories?

What kind of researcher, anthropologist am I? What kind do I want to be? Can I be?

First-year medical students visit the ‘Chinese neighbourhood’ in Amsterdam together with doctor Chi Lee and learn about the wholistic approach of Chinese medicine and how it is interwoven with food, movement and ritual practices. Photographer: Bart Majoor, Art Partner.

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

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Abstract

In North-Western Europe, medical student populations are both feminized and increasingly culturally diverse. Students with a migrant background, particularly female Muslim students and especially those wearing a headscarf, are very visible in medical school, but little is known about their experiences with in- and exclusion.

The study aimed at generating bottom-up insight from a critical-intersectionality approach in order to support political voice of these students and provide starting points for inclusion of cultural diversity in medical education.

A qualitative interview study (n=14) focused on the experiences of female Muslim students in the Bachelor- and Master phase at VUmc School of Medical Sciences. Thematic analysis was performed.

We found three domains of experienced difference: (1) leading a different student life; (2) being (considered) a different medical student and (3) anticipating on being a different physician. Students are identified as well as self-identify as different. Balancing work is needed in order to fit in and be considered a good student. Experiences of Othering through micro-aggressions and everyday racism and segregation between students with a migrant background and those without, are at play.

The findings reflect dominant norms on what it takes to be a normal/good medical student and physician.

Introduction

Diversity entering medical school

While it was once a white male bastion, over the last decades, a group of culturally diverse students has been entering medical school. Students with a migrant or refugee background that enter higher education often opt for studies in professional fields that hold high social status such as medicine. Parallel to this, the feminization of medical education is a fact since female students in most medical schools outnumber male students (Phillips & Austin 2009).

There are concerns over the well-being of students from a minority background. The literature reports on high rates of harassment of students and professionals, mostly of women (e.g. Beagan 2005; Rademakers, Van Den Muijsenbergh, Slappendel, Lagro-Janssen & Borleffs 2008) and discrimination and racism in academic medicine (Beagan 2003; Carr, Palepu, Szalacha, Caswell & Inui 2007; Coker 2001; Fried, Vermillion, Parker & Uijtdehaage 2012; Hardeman, Medina & Kozhimannil 2016; Hassouneh, Lutz, Beckett, Junkins & Horton 2014; Mahoney, Wilson, Odom, Flowers & Adler 2008; Peterson, Friedman, Ash, Franco & Carr 2004). These forms of exclusion as well as a lower performance evaluation of students from a minority background compared to students from a majority background by teachers in medical education are mentioned as reasons for the underrepresentation of students from a minority background as medical specialists (Carr *et al* 2007; Fried *et al* 2012; Hassouneh *et al* 2014; Lee, Vaishnani, Lau, Andriole & AJeffe 2009; Singaran, Van der Vleuten, Stevens & Dolmans 2011; Turner, González & Wood 2008).

Thus, in order to make academic medicine more inclusive, issues of harassment, discrimination and racism require attention. As most studies on exclusion in medical education are performed in the United States and Canada, understanding of in- and exclusion processes in practice, especially in Europe, is missing. In particular, empirical insight into the experiences of *female* students with a migrant or refugee background in medical education is scarce (Hassouneh *et al* 2014).

Medical school in the Dutch context

In the Netherlands, medical education is highly feminized and among the most popular studies for students with a migrant or refugee background (Van Miltenburg 2007; Latten & Van Dijk 2007; Van der Velden, Hingstman, Heiligers & Hansen 2008; Wagenvoort & Lagro-Janssen 2010). Students with a migrant background have entered Dutch higher education in large numbers since approximately 1995 as around that time the children of *gastarbeiders,* i.e. economic migrants that were recruited by the government in 1970s and 1980s especially in Turkey and Morocco, started education in academia or applied sciences (Lucassen & Penninx 1996). Students with a Turkish or Moroccan background are now considered to belong to the largest cultural/ethnic minority groups in the Netherlands (Van Miltenburg 2007). Furthermore, as many of them are practicing Muslim, they are considered together with students with a refugee background from Middle Eastern and African countries to belong to the largest minority religious group in the country (Van Miltenburg 2007).

Muslim women lack political voice

In public and political debates on migration and inclusion in the Netherlands, Muslims and especially Muslim women since the turn of the century are extremely visible due to negative connotations with Islamic culture as in general not compatible with what is considered Dutch culture because of its assumed oppression of women (Ghorashi 2010; 2014). In these debates, the perspective of Muslim women with a migrant background is generally absent and Muslim women lack political voice as they are denied agency and deemed victims from their 'own' religious, cultural and/or ethnic communities (Ghorashi 2010; 2014). Until now, Muslim women are relatively 'invisible' and their experiences can shed light on the processes of in- and exclusion in medical education.

This study therefore focuses on the experiences of female Muslim students in undergraduate medical education in the Netherlands. The study was performed at the VU University which is among the most diverse universities in the Netherlands considering cultural, ethnic and religious background of students. Up to 30% of the student population is considered to have a migrant background (Verdonk 2013). In 2014, the medical school became subject in national media and political debate as their dealing with (female) students with a Muslim, migrant background and certain religious practices was seen as too tolerant in view of women's rights and gender equality (Het Parool 2014). This school therefore seems a relevant setting to study the perspective of female Muslim students in relation to in- and exclusion in medical school.

The paradox of being hypervisible and invisible

With this study we want to generate bottom-up knowledge in order to support development of political voice of female Muslim medical students. There is a paradox of being both hypervisible, i.e. standing out because of the headscarf, as well as invisible, i.e. having no voice. We will use a critical-intersectionality perspective in order to deconstruct how intersections of gender, religion, culture, ethnicity and social class are at stake in the experiences of these students and to study what these intersections mean for their social and professional (self-) positioning (Muntinga, Krajenbrink, Peerdeman, Croiset G & Verdonk 2016; Verdonk & Abma 2013; Verdonk, Muntinga, Leyerzapf & Abma *accepted*).

Theoretical framework

A critical-intersectionality perspective helps to deconstruct how identity aspects intersect in experiences of female Muslim medical students, and how these intersections may work together to produce structural exclusion (Muntinga *et al* 2016; Verdonk & Abma 2013; Verdonk *et al* accepted) and processes of Othering, i.e. unravel the different differences at stake in academic medicine and which differences are at stake in making certain students/professionals/people into the Other. In current Dutch society, intolerance towards people with a migrant background and the existence of racism is denied on the one hand, while on the other hand there is a strong norm of cultural sameness from which particular social groups are identified/self-identify as different as well as can come to constitute the Other (Essed & Hoving 2014; Wekker 2016). Everyday racism as a concept points out how structures of racism are ingrained in day-to-day expressions, humour and social interaction styles in a particular context and as such

'untouchable', hard to alter as well as to protest against since anyone objecting will easily be seen as a 'kill-joy' (Ahmed 2012; Essed 1991). Micro-aggressions are a form of everyday racism constituting repetitive, aggressive exclusionary actions that are not recognized as such because they are presented as –stigmatizing– jokes or –judgmental– questions and because they happen in contexts where equality is believed to exist (Sue, Capodilupo, Torino, Bucceri, Holder, Nadal & Esquilin 2007). Besides practices of exclusion, micro-aggressions and everyday racism signify underlying Othering practices that (re)produce a hierarchy between the perceived Self or norm on top of a deviant Other and on which people are both silent and silenced on. To deconstruct the dominant normativity that produces this social hierarchy and underlies structural exclusion, we use the concept of Othering as a 'sensitizing concept' (Denzin 1973) to report and discuss our findings and as such aim to highlight experiences of Othering within the lived perspective of female Muslim medical students.

Method

Design and research team

This is a qualitative interview study following a constructivist grounded theory approach aimed at generating insight into lived experiences of female Muslim students within medical education. In our analysis we took into account that 'reality' is not clear-cut or univocal but multiplicit and ambiguous as it is socially constructed within a particular and political context and thus differently meaningful for different stakeholders. Three of us are white, middle class women, who do not practice religion –nevertheless, one was raised in Christianity and one was raised in a Christian-inspired environment, and one had an a(nti)theist upbringing. One of us (second author) is a female, Muslim researcher with a migrant background who wears a headscarf and at the time of the study a student herself. She conducted the interviews. We all have a career in higher education, two of us also in healthcare. We work at the cross-roads of the humanities, social sciences and medical sciences.

Recruitment and selection

A personal approach was chosen for recruitment in view of the assumed need of participants for trust and safety (Leyerzapf & Abma 2017; Leyerzapf, Abma, Steenwijk, Croiset & Verdonk 2015). Purposive sampling happened via snowballing starting from the interviewer's network, meaning that people from the priority group were asked to name candidates for participation and they were asked to name other candidates (Bernard 2011; Denzin & Lincoln 2005). In order to recruit enough participants to eventually conclude saturation (Guest, Bunce & Johnson 2006), recruitment additionally took place via flyers distributed over the Islamic prayer rooms at the university, an invitation to participate on social media and the medical student association's network MFVU-DOCS ('Diversity. Openness. Culture. Students') for students with a migrant background and/or an interest in diversity issues.

Selection criteria were as follows: undergraduate; female; Muslim. We recruited and selected participants on diversity in cultural, ethnic and socio-economic background, age, year of study and whether they wore a headscarf or not. After inviting approxima-

tely 30 students, 14 female Muslim medical students consented to participate. Although students motivated their choice not to participate with lack of time and busy study schedules, the perceived risk of being open about their experiences may also have been a factor.

All participants were born in the Netherlands or came to the country with their parents at a young age, i.e. they have a Dutch nationality. Reported countries of origin were as follows: Afghan, Egyptian, Moroccan, Pakistani, Somali, Surinamese, Tunisian and Turkish. As they came from different geographical parts in the Netherlands and their countries of origin, participants varied according to cultural, ethnic, linguistic and socio-economic background. Some participants' parents had followed higher education/ medical education. Most participants or their siblings were first-generation students. Most participants had grown up in and lived in urban areas at the time of the study. Participants' age ranged between 19 and 25 years. Six participants were Bachelor and 8 were Master students.[3] Eleven participants wore a headscarf. Most participants lived with their parents. One participant was married and one was engaged to be married.

Data collection

Data collection consisted of 14 in-depth, semi-structured interviews conducted between March and June 2014. The topic list included topics based on an exploration of relevant literature and the expertise of the researchers and was refined based on a pilot interview. Topics discussed were for instance experiences of entering medical school and during medical education; self-identification and social identification; outlook on career perspectives. The interviews lasted between 60 to 180 minutes and were conducted in Dutch. Most interviews were held on campus in a secluded, quiet place. In four cases the interview was conducted in a peripheral hospital where the participant did her internship. All interviews were digitally recorded after written consent and transcribed verbatim by the interviewer.

Data analysis

The data were analyzed using thematic analysis (Braun & Clarke 2006). We engaged in an iterative process that allowed for emergent insight and adjustment of data collection (Denzin & Lincoln 2005). Analysis took place through, firstly, familiarizing with the data (first, second and fourth author), as well as setting up a list of *in vivo* codes (second author/interviewer), secondly, independent coding and clustering of codes of some transcripts (first and fourth author), followed by critical comparison of the codes and clusters (first, second and fourth author), and thirdly, discussion of final themes by the research team and through the use of the sensitizing concepts described in the theory section. The researchers agreed upon having reached data saturation –as much as possible considering time and other practical resources.

Quality criteria and research ethics

This study was performed in accordance with quality criteria and research ethics (Green & Thorogood 2014; Tong, Sainsbury & Craig 2007). Privacy of participants was central during all phases of the study. With regard to privacy, detailed profiles of the participants could not be included. Besides oral and written information on the research prior

to the interviews, participants received information about the research, could ask questions and signed an informed consent form at the start of the interview. After minor textual alterations, all participants gave their consent to the interview transcript. The data were anonymized and coded to secure privacy and confidentiality during handling, transport and storing of the data. The file with participants' names and details was only accessible to the research team and was destroyed with the interview recordings after conclusion of the study.

Findings

The findings cover three domains of experienced difference: (1) leading a different student life; (2) being (considered) a different medical student; and (3) anticipating on being a different physician. The term different should be read as being a socially constructed concept used by participants to make sense of their experiences. All words and sentences between double inverted commas within the following description of central themes are literal quotations from participants that were translated from Dutch by the first author.

Leading a different student life

Most participants reported to have experienced going to university as a big step and an imposing experience of "moving into another world". They attributed this in part to being first-generation students, i.e. the first in their families to enter academia and study medicine, whereas many students without a migrant background have family members with university degrees –many of whom also practice medicine. This caused participants to "having to really find their way" in medical education and medical school as well as having to do this on their own.

Predominantly, however, participants attributed their experience of feeling 'different' in a more fundamental way. Many had "always felt Dutch" and now experienced a change in their social identity and self-image:

> [F]rom when I was little (...) I really thought 'okay, I am really Dutch'. And then you come here and ... I was shocked [to find] that okay apparently I am not Dutch.

> I (...) came from an Islamic high school with in fact hardly any students from a majority background, and that was for me now very different, eehm, because in fact almost everybody was Dutch (...) I noticed very much in the first week that I didn't have the connection, because I wanted to participate in the introduction week but ... well going to a bar at night that is something I really don't feel like (...) everybody drinks and I just sit there.

[3] In the Netherlands, undergraduate medical education starts with a 3-year preclinical phase, in which focus is on acquiring theoretical and practice-based knowledge and skills, followed by a 3-year clinical phase, in which students perform internships. On completing the undergraduate phase, graduate students are allowed to practice medicine as a 'basic physician' and can apply to enter postgraduate medical education to become a medical specialist.

Many participants emphasized being both unfamiliar as well as sometimes uncomfortable with –certain aspects of– "Dutch" lifestyles. They felt to miss out on the connection with students without a migrant background and student life in general. Some said they therefore did not want to participate in a student association –also because most of these associations had hardly any members with a migrant background. Some participants' parents had tried to prepare them for this visibility by making them aware of it, as one student stated:

> [W]hen I was raised and my mother always told me (...) you are of colour, you are female and you are Muslim and those are three things that can work against you in your daily life eehm and by making me aware (...) [she made clear to me] that means that not everything will come easy for you.

Participants who wore a headscarf, i.e. the majority of the participants, specifically related their visibility to this fact. This also happened during the interviews. The interviewer, wearing a headscarf herself, identified the participant as 'different':

> Participant: [E]ehm yes I think I was the only allochthone at my school (...)
> Interviewer: Okay, yes but you consider yourself an allochthone?
> Participant: Yes
> Interviewer: But I don't see you as looking like one so to say
> Participant: No that's right but when I wear a headscarf I do, you know.

Participants also related their difference to having to work to finance their study and obligations to help out at home and taking care of siblings. Participants often found it difficult to connect with "Dutch students", while all expressed to easily "click" socially and emotionally with other students with a migrant background. They linked this to wearing a headscarf and/or sharing the same faith:

> I got to know another friend who just came up to me in the subway eehm she also wore a headscarf, she also was Muslim (...) we started talking and thought in fact it is just nice to [have] someone with the same ... not completely the same (...) but share the same faith and do the same things (...) and in the following months just others joined that also were ... not all Muslim but almost all of them not originally of Dutch descent.

Many participants said that they felt they could share certain things with other Muslim students and/or students with a migrant background, as they felt they better understood each other and shared the same humour. Some participants referred here to experiences of exclusion by non-Muslim students and teachers from a majority Dutch ethnic background, and reported that they only felt safe with other students with a migrant background. They pointed towards finding common ground as well as a sense of personal and collective empowerment stemming from socializing with other students with a migrant background. All participants mentioned that mutual support and recognition of similar –negative– experiences helped them continue their studies, as one of them concluded:

> [W]e really support each other in a lot of ways, without these girls I really wouldn't have made it, because you just need people who stimulate you and who give you hope and just give energy.

In sum, upon entering medical school and facing e.g. introduction rituals female Muslim students became aware to stand out and felt that they led a different student life from the majority of the students. Moreover, they experienced that their identity was different from that of the majority of the students. They looked around for social connection and started socializing with students who validated their experiences, offered social support and shared their values.

Being (considered) a different medical student

Reflecting on the curriculum and educational activities, participants became more explicit about negative experiences. All participants told of their own and their friends' experiences of exclusion by fellow students and teachers:

> [O]ne time I wanted to get into the elevator and then they [students from a majority Dutch ethnic background] said 'yeah, the elevator is full and so is the Netherlands'.

> [D]uring a lecture a physician just completely went against me, just out of the blue (...) I was getting something from my bag (...) and then he started (...) –I was wearing a purple headscarf– (...) 'that girl with the green headscarf' (...) 'what's that in your hand, probably a bible'. I looked at him and (...) I just didn't know what to say.

From this last quote, it appears that the student not only felt uncomfortable at being singled out by the teacher in front of all her fellow students, but also ridiculed and 'attacked' as a practicing Muslim. As the teacher –from a majority Dutch ethnic background– seemed to mix up the colour of the headscarf and two religious traditions –Islam with Christianity– on purpose, he seemed to use humour to identify the student as both different and deviant from the norm, i.e. the dominant faith in the Netherlands.

Furthermore, all participants mentioned that they felt set apart as different during educational activities in which case studies centering on patients with a migrant background were discussed. Cases were dominantly about 'problematic', negatively evaluated traditions and norms and the assumption seemed that 'all people with a migrant background do/believe this'. A recurrent example was that of female genital mutilation –when that was discussed in the student groups "they all look at me [assuming I would do that]", as one participant said with exasperation. Many participants said to feel both stigmatized and marginalized because they were addressed as representing all people with a migrant background or all Muslims and had to motivate or "defend" migrant/Muslim practices during these case elaborations. A student recounted:

> I would personally never do that. But I have family members in a 'cousin-marriage' [consanguineous, H.L.] (...) But then you just get all these looks, and then

> the teacher knows you're the only allochthone and then asks 'are you in a cousin-marriage and what do you think about it?' (...) I have that pretty often, that you have a working group and that it's about a Turkish patient who (...) cannot speak Dutch or something. And then they all have questions (...) and then you get a teacher who says: '(...) Do you also think like we do?!' (...) You have to account for yourself because they think this is about your culture.

The feelings of exclusion seemed to become most poignant, however, as the participants started their internships. They felt that their visibility as well as their social conduct and attitude or how these were interpreted by their clinical supervisors and colleagues –mostly with a majority Dutch ethnic background– became particularly salient in this education phase. A student stated:

> [E]specially on the first day, then you are again the first allochthone with a headscarf, there you are during the morning transfer and then you see everyone looking at you like that (...) then I don't know what to do (...) I just felt that those physicians have an image in their mind and think that is how a doctor should be. (...) if you are a bit different, if you are a bit deviant or you are a bit more quiet, then immediately there is something wrong.

Participants experienced particular expectations from supervisors to which they felt they could not live up to so easily. They mentioned lifestyle aspects which they saw as "typically Dutch" to which they did not want to or could not adhere such as going out for drinks, sometimes late at night, or playing hockey. They also felt a strained communication and connection with professionals with a majority Dutch ethnic background on the wards in general:

> I always had the feeling (...) that we are in fact one point behind or even two points maybe. First point because you are allochthonous and second because I wear a headscarf. (...) you are not really seen by the physicians whereas they do socialize with other interns. You noticed (...) they had a harder time communicating to you. (...) I don't know if that was because of my headscarf (...) I thought 'Ooh I don't want to stand out too much' (...) it's a pity when you see your fellow students having a good time with them [supervisors] and being able to build a connection sort of and, because of that, getting a higher grade than you.

Often, exclusionary remarks were introduced as humour, as in the following quote:

> During my internship (...) I went and introduced myself properly, like 'Hi I'm [name]' and then he [the specialist] said 'Oh she speaks Dutch, and without an accent even!

Here participants also told of patients making insulting, 'humoristic' remarks about people with a migrant background in general. The headscarf was often a central point of attention in remarks by patients and supervisors, as in the following account:

> [T]hat [specialist] said (...), just in the middle of the ward (...) a whole discussion about my headscarf, like 'yeah you'll never get a job and eehm I advise you to take it off because you're a very good student, and I think you'll achieve much more' (...) 'and you make a statement with this'. But (...) to me it's just something very small, I just wear a small scarf.

However, patients with a migrant background, according to participants frequently showed their happiness and positive surprise at meeting a medical student with a migrant background. Some participants said that they felt they could sometimes do more for these patients than their colleagues and this was also often assumed by these colleagues without a migrant background: "they [students with a migrant background] would know how to deal with these patients". Nevertheless, participants told of disrespectful conduct they witnessed by colleagues towards –especially Muslim– patients with a migrant background, and how this made them feel "different" and "an outsider" themselves:

> [T]here was this child that uhm that was abused. And, let's see, it was an allochthonous family, and then everybody thought that it would be the father again that was violent, and, really, I had been there for 4 months at that ward then they say during the morning transfer like 'yeah such a typical woman with a headscarf [using the diminutive] again'.

In sum, participants developed a sense of being made different from non-Muslim majority Dutch ethnic people during educational activities, in relation to the medical curriculum and the campus and educational climate in general and also in dealing with patients. Overall, this negatively affected their professional identity. They felt they were less valued as a medical student and incapable but also unwilling to meet certain expectations of teachers.

Anticipating on being a different physician

The accounts of participants showed how they were aware of their 'difference' both as a student and a future physician and how they consciously tried to cope with their experiences of Othering. An example were the physical examination trainings which in the Netherlands students have to practice on each other. Many participants stated to strategically prepare themselves for physical examination trainings and to share advice on what (not) to wear with their friends:

> [S]ome [teachers] are just a bit more relaxed than others and I know one time I had to perform a leg examination and it was summer and everybody wore those shorts and then I got the question 'Would you come in front of the class to [show] your legs' (...) I really thought 'Well half of these people wear shorts so they already have their legs exposed' (...) I just didn't get it why I had to come forward (...) I just was so frustrated. Yeah I said like 'Sorry but I don't want to come in front of the class (...) But then you get those looks again [rolls her eyes].

Participants not only felt rejected but also often ridiculed, as apparent in the above quote and the reaction of the students at the end. These experiences appeared to be

linked by teachers to the professional identity that they intended for students. As several other participants, a student said that her teacher deemed her to be unfit to become a physician as she did not feel comfortable performing the training in the regular way:

> It was the rule that (...) you take your clothes off and that everyone is then going to examine you, so I said 'I won't do that'. Then I had very long discussions about that with my teacher (...) I said 'Okay I can pull up [my clothes] until here; if you want to feel my pulse or measure my blood pressure, that I do', I really try to compromise (...) [T]hey didn't understand it at all (...) 'Why don't you just do that, later you're going to treat patients too.'

In their arguments the teachers seemed to uphold the norm that as a medical student you have to let other students practice on you and be willing to expose yourself, and that this is both what will make you a good physician and the only way to become a good physician.

All participants said they found it hard to cope with these experiences and the apparent lacking support from teachers and the medical school in general, and that it caused them to sometimes consider quitting their study and/or taking off their headscarf. Although one student preferred being asked directly they noticed a double standard: other religious students, for instance Christian students, did not get such questions. In relation to physical examination training, participants saw that, although many female students from a majority Dutch ethnic background did not want to perform the examination in front of the class as well, these students were not identified as problematic.

Participants expressed the wish to be part of the team of the clinical ward without having to check their religion upon entering. They considered their religious and cultural expertise an asset. One student for instance mentioned her "value as a Muslim physician with a second language". Similarly, they regarded their personal background as a valuable part of their professional identity and thus important and necessary for themselves in order to become a medical professional. Most worried about their future as a physician as they felt stressed by the difficulties they experienced in meeting expectations and keeping religious and cultural norms. They also doubted if they would be able to make the social connections within the clinic that are necessary to build a successful professional profile and be selected for a postgraduate training position to become a specialist:

> Participant: Just the effort it will take, you have to like fit into that group but it is again like okay you are the only one then, I don't know a single [specialist] with a headscarf
> Interviewer: But you can be the first, right?
> Participant: Haha yeah but (...) I will feel then that I'll have to prove myself even more.

Although their parents mostly supported them in finishing their studies and having a career in medicine, participants also worried about meeting their families' expectations

about getting married and starting their own family, and about combining work as a medical specialist with a private life. Several students worried that they would face more obstacles than peers in building a medical career because of their migrant background and religious identity. One student thought that colleagues would think likewise, and thus cause further stigmatization:

> I do think that there are people who think like 'Hey she will remain at home later anyhow' (...) there are just not that many (...) female physicians that eehm are Muslim too and wear a headscarf and that it will really stand out like hey, I think that that is just a general idea about those people, like 'Hey they maybe work less or they quit working when they have children.

To sum up, participants struggled to create a successful professional identity in which personal values, social expectations and professional norms met. They had few role models and felt to stand alone in clinical practice, worried about meeting family expectations and anticipated difficulties in getting into specialty training and in their future work practice as a physician.

Discussion

Below we relate the findings to the theory and literature on in- and exclusion.

Segregation

Participants experienced to be different from many fellow students. Earlier research corroborates these experiences of difference among students with a migrant background who are also first-generation students and/or students with a lower socio-economic background (Leyerzapf *et al* 2015; Slootman 2014). Participants experienced to be different from their fellow students as they missed out on a social, emotional connection with them (Leyerzapf & Abma 2017; Leyerzapf *et al* 2015; Slootman 2014). As participants had assumptions about the 'typical' and 'typically Dutch' student life of which they seemed to disapprove, they seemed to add to the segregation. Participants furthermore felt to be considered different from a 'normal' medical student. This is in line with earlier research which pointed towards 'visible' characteristics such as a 'migrant' accent, a headscarf and a non-white skin colour that seem to affect the connection between students/professionals with a migrant background and fellow students/professionals and supervisors in the clinic, as well as the performance evaluation of students with a migrant background in undergraduate and postgraduate clinical education (Leyerzapf *et al* 2015; Leyerzapf, Verdonk, Ghorashi & Abma 2018).

Thus, participants experienced a segregation along the lines of a combination of their Muslim religion, and their migrant and minority Dutch ethnic background, between themselves and other students with a migrant background –considered 'not Dutch'– on the one hand, and students and teachers without a migrant background –considered 'Dutch'– on the other hand. Earlier research also pointed out a segregation in medical education between students with a majority Dutch ethnic background and all students different from this –meaning that the latter group is generally much more heterogeneous in background (Leyerzapf & Abma 2017; Selleger, Bonke & Leeman 2006). It seems

that students in both studies have a binary choice between being (considered) 'Dutch' or being (considered) 'not Dutch', and that 'not Dutch' was being equated with being Muslim, while 'Dutch' was implicitly equated with being Christian (Leyerzapf & Abma 2017). To some extent, participants from our study seemed to (re)produce these fixed, essentialized and oppositional identifications as they spoke in rather polarized terms as 'us' and 'them'. However, they challenged the identifications as well as they made clear to have felt e.g. both 'Moroccan' or 'an allochthone' *and* 'Dutch' prior to medical school and many continued to self-identify as 'Dutch' in medical education.

Personal and relational empowerment

Participants developed personal and relational empowerment (Rowlands 1998). They acquired personal strength as they found and shared stories with like-minds and these friends corroborated that their perspectives were unjustly marginalized and silenced. Recognizing similarities with their friends' stories, participants discovered they were not alone, experienced mutual recognition and acknowledgement, social support and safety, and thereby developed relational empowerment. According to Rowlands (1998), personal and relational empowerment cannot develop separately and both depart from a relational enactment of agency, meaning that actions become and can only be meaningful in engagement with the particular context and meaningful others in this context. As earlier studies report for students with a migrant background (Leyerzapf & Abma 2017; Leyerzapf *et al* 2015), participants in our study experienced their social circles as home-like 'safe spaces' (Ghorashi 2010) essentially different from the general space in medical school dominated by students and teachers with a majority Dutch ethnic background and without a migrant background.

In view of supporting inclusion, the experience of relative safe spaces with like-minds within medical education is positive. Studies discuss 'enclave deliberation' as vital for minority groups to be able to develop political voice and strive for inclusion in a hierarchical context where unequal power relations exist (Karpowitz, Raphael & Hammond 2009; Nierse & Abma 2011). In this safe space students can mutually acknowledge and become critically aware of their lived reality and the structural aspects of individual experiences of exclusion and inequality. However, enclave deliberation also emphasized participants' difference from mainstream perspectives in medical school and as such could add to the segregation and the exclusionary attitude by fellow students and teachers. Boogaard & Roggeband (2010) and Van Laer & Janssens (2011) similarly discuss how professionals with a migrant background in the work place appropriate social identities to create autonomous space and social status on the one hand, yet with this on the other hand enact disempowering mechanisms that sustain structural social inequalities.

Micro-aggressions and everyday racism

The narratives of our participants not only accounted of being considered and feeling different, they showed patterns of micro-aggressions, everyday racism and Othering (Essed 1991; Sue *et al* 2007). This came particularly to the fore in case study discussions and physical examination training and during clinical education. It seems to link up with specific expectations towards medical students and future physicians, i.e. involve

professional norms. In case study discussions participants were aware of being Othered as they signaled that patients and they themselves became stigmatized. Stigmatization focused on Muslim patients and especially on female Muslim patients and Islamic/cultural/ethnic practices seen as harmful to women. Female Muslim students could not be as 'invisible' and 'neutral' as expected of medical students and therefore they could not really be seen as one. The equation of female Muslim students with patients/the Other appears to 'de-professionalize' and 'de-value' their status as a medical student and future physician and undermine their professional development.

In physical examination training, the participants clearly felt to be wrongly 'disqualified' and Othered. Participants knew female students who were not Muslim and shared their concerns regarding the lay out of the training –signaling a broader gender issue. Nevertheless, participants' objections were seen by students and teachers as directly related to their identity as female Muslims with a migrant background –a form of culturalizing, i.e. 'blaming' it to culture (Ghorashi 2010), which earlier studies corroborate (Card 2012; Chang & Power 2000; Rees, Wearn, Vnuk & Sato 2009).

The Othering participants were confronted with, had a specific impact when it came from teachers, especially in the clinic. This seemed due to participants' outer appearance and visibility as students with a 'different' name, speaking a 'different' language (besides Dutch), wearing a headscarf and –although this was not said explicitly– being not white. This is similar in debates on migrants and inclusion in the Netherlands and North-Western Europe in which Muslim women wearing a headscarf constitute the central signifier of difference (Ghorashi 2010; Sauer 2009). A combination of gender and ethnic/racial bias seems at stake. The insecurity that our participants –especially those wearing a headscarf– expressed about their future professional career, show a present sense of not-belonging, displacement and alienation (Ghorashi 2008).

The worries participants had regarding issues of work-life balance, are reported for (future) professionals with a migrant background in other educational and professional contexts (e.g. De Jong 2012; Van der Raad 2015), as well as for women in academic medicine (e.g. Alers 2014; Diderichsen 2017). Thus, in our study, factors of gender, culture/ethnicity, religion and socio-economic background intersected in participants' narratives. Participants encountered everyday racism in which the identity of participants was represented as static and uniform and religious, cultural and ethnic aspects were equated with each other (religion = culture = ethnicity = religion etc.) (Essed 1991). Notwithstanding the complex and dynamic intersecting identity aspects of participants, they appear to have become the ultimate and racialized Other in medical education.

Hyper/invisibility of female Muslim medical students

Female Muslim students in our study were identified as the ultimate Other. There seems to have taken place a shift from seeing women in medicine as the Other as it was historically a male-dominated space (Kaatz & Carnes 2014) –women here being white women, towards identifying Muslim women as the Other. Our intersectionality perspective revealed that the Othering of female Muslim medical students, taking place at the intersection of gender/religion/race, highlights the gendered racialization

of medical education as an exclusive white space (Essed 2005). Because of this, students and professionals –male and female– who are considered to be white/have a majority Dutch ethnic background are likely to experience privilege in this respect, while female Muslim students –and students/professionals with a migrant background more generally– are likely to experience disadvantage.

The racialized space of medical education is also why female Muslim students are both hypervisible and invisible here, as are Muslim women in society in general. They signify, as veiled women, the antithesis of the 'modern', liberated, democratic and emancipated Self, and the victims of 'traditional', 'non-modern', undemocratic and un-emancipated Islamic Other (Petzen 2012; Sauer 2009). In this racialized discourse, in which religion is equated with Islam and culture with ethnicity, Muslim women are thus the 'ultimate Others' that stand out yet are speechless (Ghorashi 2014; Wekker 2016). It is not likely that not wearing/taking off their headscarf would help female Muslim students being included in medical education as they would still not be (quite) white. It is also not likely that the racialized Othering affects converted, white female Muslim medical students in the way it impacts those with a migrant background. The parallel hyper/invisibility of female Muslim students in medical education appears to signify a hierarchy in which white students and professionals without a migrant background/with a majority Dutch ethnic background are allowed to look at and critique female Muslim students, while these are not allowed to enact (political) 'voice' and talk back.

The parallel hyper/invisibility of female Muslim medical students and Muslim women in general was reflected in the critique in 2014 within national media and politics on the VU for being too tolerant towards Islamic practices, i.e. separate prayer rooms for both sexes, that were seen as 'women-unfriendly' (e.g. *Het Parool*, 18-08-2014), as well as in recent media coverage in which professionals with a headscarf are presumed to disrupt and erode the desired neutrality of the medical workplace, of institutions and of, in fact, society in general (e.g. *Medisch Contact*, 08-06-2017; *De Volkskrant*, 10-06-2018). While racism in academic medicine in North-Western Europe appears to be a silent issue (Bhopal 2007; Coker 2001), many studies in North America discussed the issue of racism within medical education and academic medicine (Beagan 2003; Carr *et al* 2007; Fried *et al* 2012; Hardeman *et al* 2016; Hassouneh *et al* 2014; Johnson *et al* 2004; Mahoney *et al* 2008; Peterson *et al* 2004). In the Netherlands the denial of race/racism is linked to white innocence and white fragility, i.e. white people refusing to acknowledge as well as not seeing –their investment in– racialized and racist structures from a segregated position of white privilege (DiAngelo 2011; Wekker 2016).

In order to make academic medicine structurally inclusive it is important that teachers and policy makers become aware of Othering practices and acknowledge racialized/racist tendencies in medical education and the clinic. For –white– researchers studying diversity issues in (Dutch) academic medicine, it is important to engage in critically reflexive dialogue on their own role in the research and on how research concepts such as 'cultural diversity' and 'migrant background' may be depoliticized and racialized terms that link up to white innocence and silencing of antiracism perspectives in society and academia (Ahmed 2012; Leyerzapf *et al* 2018; Wekker 2016). In our research we beca-

me aware of how we 'were present' in the research project as individuals with social identities embedded in political and historical structures. The interviewer became aware that she used the polarized terms of participants unreflectively and reproduced the segregation participants experienced as she had similar experiences as a young female Muslim. The other researchers were sensitized to their privilege as white, majority Dutch ethnic, non-Muslim professionals and their sameness to the norm although their (grand)mothers all wore a headscarf or hat while outside. Nevertheless, we all experienced contiguity towards participants and between ourselves as we all were first-generation students from lower socio-economic backgrounds and share the experience of exclusionary and undermining comments as female professionals in male-dominated contexts. While engaging with these parallel experiences of sameness and difference, we could identify the everyday reproductions of inequality in participants' narratives in a more holistic and embodied way than we could have done separately.

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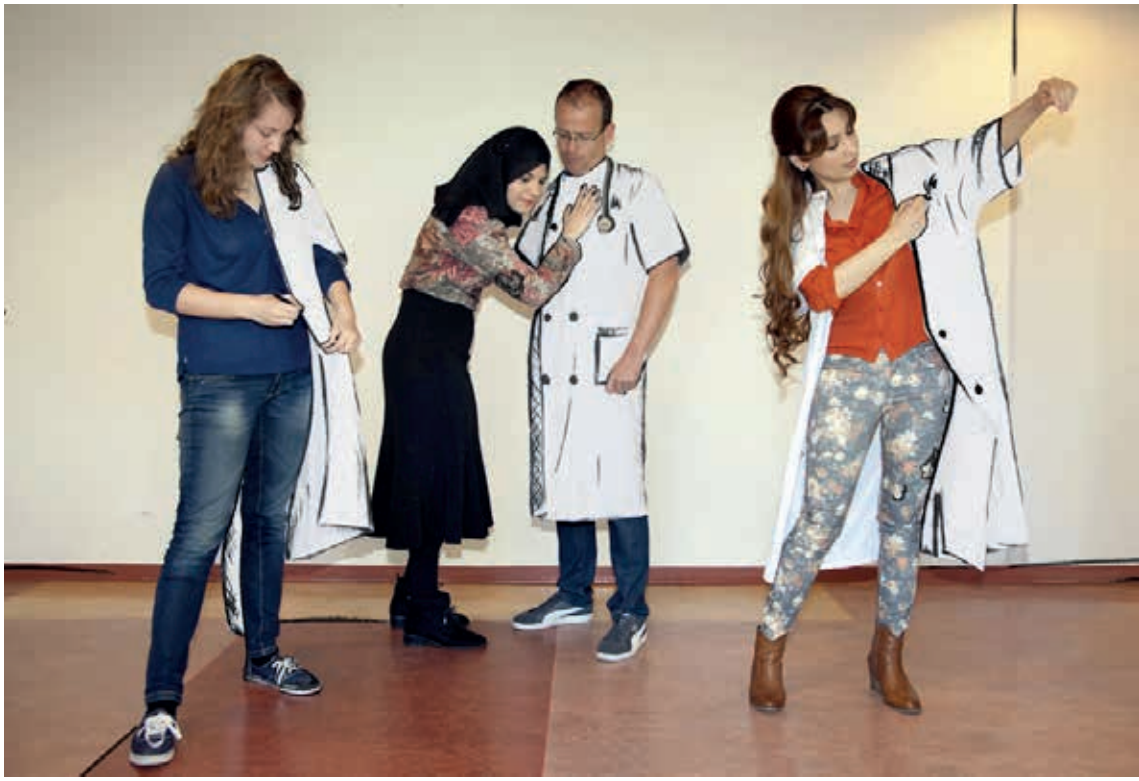


Project *Anders in de witte jas*, Different in the white coat, in 2014. Lina Issa in collaboration with students and teachers of VUmc SMS and VUmc. Photographer: Bart Majoor, Art Partner.

Critical incident II - Who am I in this contested arena?

June 2014, at home

Language! I'm stuck in between words. I can't find the words. The words that are there do not feel right. I don't like the word *allochtoon*, making it into 'person with an *allochtoon* background' is a cover up, same thing, its feels as a sham. I keep repeating this to people I talk to during the research. Still I use it: I do not like the term but... Then I continue using it. The people I interview do it too. Also the people that are signified by it. The alternatives feel unnatural, fabricated, fake, are too much of a hassle. Bi-cultural. Moroccan-Dutch... but what if you do not know where someone is from, do you just assume -as we often do? And if someone is French and Caribbean and Chinese as well as Dutch... All these categories stifle me. I feel I do not get to the core. I want to move beyond them. But is this possible? Desirable? Diversity -there's a stupid word. Images signifying it everywhere: colour pencils, coloured marbles, a mosaic, colourful fruit... What does it even mean? I'm annoyed because it feels empty. Like a cover-up. 'Is' it something real at all? Everyone seems to use it in a different way. And yet not -some people are 'diverse', others are not. It leaves a sickly feeling in my stomach. Cultural minority and cultural majority. They feel politically correct, policy terms that are constructed on an abstract level -it's not what seems to be in people's heads, at least it's not what I think. What's that then?... I think about what appeals to me because it feels different, or because it feels familiar, or something in between. Who do I feel close to, with whom do I feel distance... What raises questions with me, what doesn't strike me at all, who do I not see? But this is not what I say, write. Why not? I want to be correct, cover all aspects of the issue at hand, do justice to all everyday forms, refrain from choosing sides, I want to be straightforward as well as impartial.

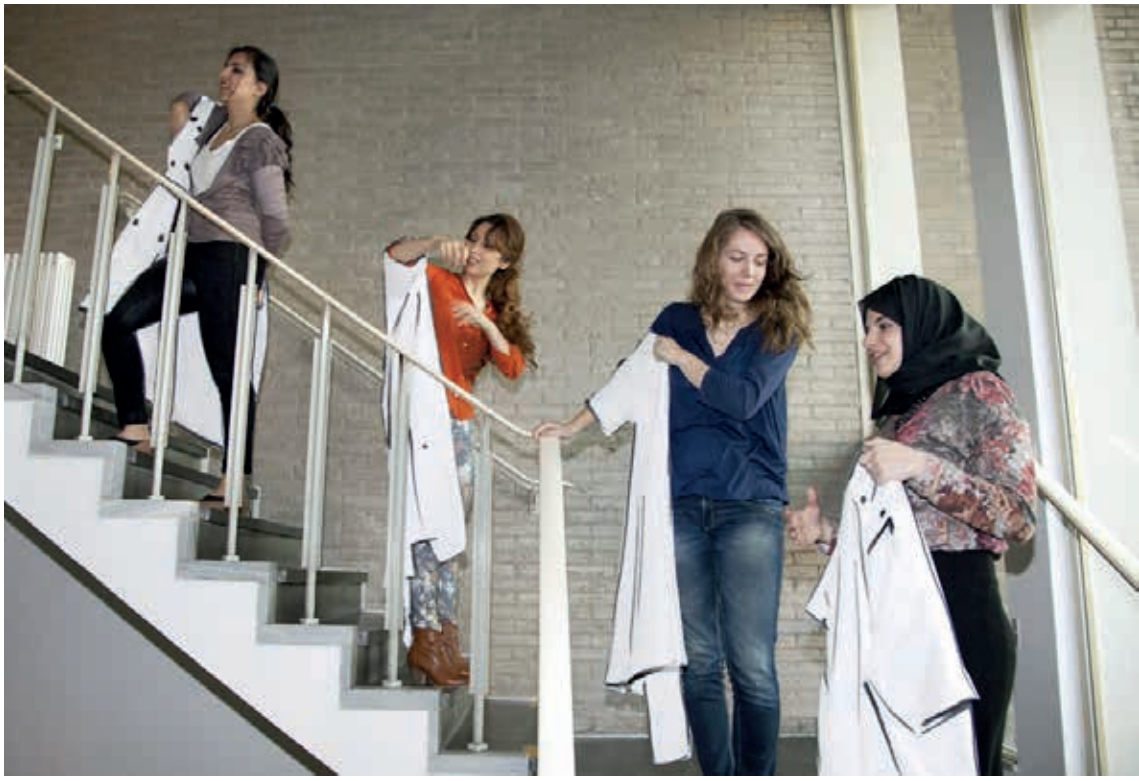
I am stuck. So what is the actual topic of my thesis? As an anthropologist I like to think everything is culture and everything is in constant flux. How to discuss, name, identify interactions that are so fluid that by naming them you make them too static to really get their essence. Yet, what's the alternative? Not name them at all? And how to name unnamed things, unnameable things? These diversity words feel like wax dripping from a candle and once you touch them they're already too solid to (re)move. I want to discuss these things, I think I have to... Do I not do more harm than good by naming them, or is it worth the risk? Whose risk is this anyway? And who am I in this?

I try to be in-between. That's where I like to be. I feel comfortable when I think of myself as in the middle -not like being in the center, just not

on either side of the aisle, not in opposition to anyone. I introduce myself as a researcher, sometimes anthropologist, not trained in medicine or care. I stress that I'm not part of the hospital environment when I'm in the hospital. I stress that I'm working on a small department specialized in qualitative, empirical research from a multidisciplinary perspective. I emphasize that I want to learn, that I'm here to understand – I try to present myself as a harmless observer. I look young and female so it seems to fit. My gender, clearly gender-conform and heteronormative, enables me to blend in. Yet it also doesn't leave me with an authority base to lean into. I teach medical and health sciences students is what I bring forth to support my position as a professional. I work in this organization since 2010, I say. I am married to a physician I add – and I cannot say it without pride, although I try to treat it as a trifling fact. And I see students and professionals, the heads of department, suddenly eye me differently. I feel it raises my status, my authority. I'm amused as people subsequently approach me in a different way, sometimes annoyed. Yet it feels good to be seen as someone who belongs, has a right to be there.

And what do I not say? I don't have to say I'm Dutch. I do not really have an accent, not one that sticks out negatively. I can pass as 'normal'. I am perceived an insider. I am trusted, and gain entry to the research field. But this is not all. This is how I present, try to, in front of people I recognize as Dutch, as similar to me. In front of people who I think are being classified as different, or who I think themselves feel different, I say I am *allochtoon* myself. I tell about my father who is German. I am quick to make the connection; why doesn't it seem to matter that I'm a Western *allochtoon,* nobody ever says that to me, asks me about it, compliments me with my Dutch, says that I look German, yet when your father is from Turkey it does? I emphasize I am not religious yet I am very interested in faith. I have focused on religion during my studies, written my master thesis on religious activism. I sometimes stress that I'm a first-generation student, I do not have a high socio-economic background. I think I am often seen as an academic. I am too vague, too abstract. I try to sound confident, clear, convincing, someone who knows how life works, is a hands-on person – yet in a nuanced way, I can listen, ask open questions, I want get to know your perspective, I don't judge, I take you seriously, that's how I try to outsider-insider, insider-outsider.

I feel discomfort, shame, guilt, hurt when a 'diverse' person tells me about experiences of exclusion at work, in the classroom. It causes me to feel Dutch. I'm not used to that. Except when I'm travelling. Or when people are making jokes about Germans – than I feel very German *and* Dutch at the same time. I'm suddenly aware of having a group identity and I want to discard it as an old, itchy skin that I don't need because it's inflexible, stiff. I want to step over it, this box is not important, this is not what I want to be... I want to be more, do more. I want to address injustice.



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

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Abstract

Despite a growing diversity within society and health care, there seems to be a discrepancy between the number of cultural minority physicians graduating and those in training for specialization (residents) or working as a specialist in Dutch academic hospitals. The purpose of this article is to explore how performance appraisal in daily medical practice is experienced and might affect the influx of cultural minority physicians into specialty training. A critical diversity study was completed in one academic hospital using interviews (N = 27) and focus groups (15 participants) with cultural minority physicians and residents, instructing specialists and executives of medical wards. Data were digitally recorded and transcribed verbatim. A thematic and integral content analysis was performed. In addition to explicit norms on high motivation and excellent performance, implicit norms on professionalism are considered crucial in qualifying for specialty training. Stereotyped imaging on the culture and identity of cultural minority physicians and categorical thinking on diversity seem to underlie daily processes of evaluation and performance appraisal. These are experienced as inhibiting the possibilities to successfully profile for selection into residency and specialist positions. Implicit criteria appear to affect selection processes on medical wards and possibly hinder the influx of cultural minority physicians into residency and making academic hospitals more diverse. Minority and majority physicians, together with the hospital management and medical education should target inclusive norms and practices within clinical practice.

Introduction

Globalization and migration have led to more culturally diverse societies. To correspond with these societal developments government and organizational policies aim to open up medical health care services to culturally diverse patient groups and reduce health disparities. Policy measures are taken to enhance the competence of health care professionals in dealing with cultural diversity and so, increase quality of care (Congress and Lyons 1992; Dogra et al. 2007; Like 2011).

In addition, referring to basic human rights and social justice, a more diverse representation of the population in the medical faculty and clinic is perceived necessary to establish equal career opportunities for all (Thomas and Ely 1996). Although evidence is lacking, a recurrent perception is that if diversity is managed well, culturally diverse teams could work more creatively and effectively and be better equipped to meet the demands of a competitive medical field (Cox 1994; Jackson and Ruderman 1995; Thomas and Ely 1996). Aspects addressed in studies following this perspective are team communication and team leadership, as well as social guidance and organisational structures (Bell et al. 2011; Dreachslin et al. 1999, 2000; Grumbach and Bodenheimer 2004; Homan and Greer 2013; Mannix and Neale 2005; Wang et al. 2013; Watson et al. 1998). Up till now, however, the cultural diversity of health care professionals is reported to be low (CBS 2014, Statistics Netherlands; Flores and Combs 2013; Merchant and Omary 2010; Nunez-Smith et al. 2012; Price et al. 2005).

In reponse to this underrepresentation quite a few studies focus on instrumental solutions to enhance the inclusion of cultural minority students and doctors. Merchant and Omary (2010) call, for instance, on cultural minority academic professionals to make themselves 'more visible', seek out role models, participate in diversity-promoting programmes and become active role models. Similarly, Mahoney et al. (2008) focus on actions cultural minority faculty must undertake for themselves, such as ask for mentoring support. Price et al. (2005, 2009) identify the need for improving the 'diversity climate' of organizations and stress the need for 'more transparent and diversity-sensitive recruitment, promotion and networking policies and practices'. These solutions tend to be one-sidedly focused on the integration of minority groups into the majority culture and are characterized by a top-down approach.

This study was performed in the Netherlands where student populations in highly urbanized parts of the country are increasingly diverse. Cultural minority students entered higher education since 1995 and within the medical student population of the universities now approximate 20–30 % (CBS 2007, 2012b). This cultural diversity is not reflected in the medical staff (Herfs 2009; Leyerzapf and Abma 2012; Stegers-Jager et al. 2012). In the Netherlands most medical wards have set times within an academic year in which they open up to application letters for training positions. Most accepted residents are chosen from the existing team on the ward, i.e. have prior work experience as a physician within the team. In fact, only those deemed qualified and to stand a chance are invited to motivate themselves before the selection committee, which is partly formed by the specialists, clinical executives and residents of the same ward. Although sometimes physicians are asked to wait -and develop themselves further- and

try within the next application period, often this implies that they are considered not qualified for the specialty.

The purpose of this article is to gain better understanding of the structural barriers to create a more culturally diverse and inclusive organization (Chambers and Alexis 2004; Konrad et al. 2006). We do so by exploring how performance appraisal in daily practice on medical wards of an academic hospital is experienced and perceived to influence the influx of cultural minority physicians into specialty training and specialist positions. The main aim is to generate insight on how professional performance and qualification are perceived in practice and how this according to participants influences medical selection processes. In doing so, we meet with Zanoni et al.'s (2010) and others' call for critical research on workforce diversity (Herring and Henderson 2012; Jonsen et al. 2011; Zanoni et al. 2010).

Theoretical framework

The theoretical framework of this study corroborates with three core points of critique on diversity research, namely a 'positivistic ontology of identity', 'downplaying the role of societal and organizational contexts in shaping meaning of diversity' and an 'inadequate theoretization of power' (Zanoni et al. 2010). The concept of intersectionality is helpful to prevent these pitfalls when studying ways in which physicians communicate and interact in their work, how they present and profile themselves professionally in order to qualify for specialty training and what constitutes good performance in this context (Clair et al. 2012; Van den Brink and Benschop 2012). Intersectionality refers to the multiplicity of identity and acknowledges the complex ways in which different aspects of identities intermingle and subsequently influence and 'enable' forms of social exclusion in health care settings (C¸ elik 2009; C¸ elik et al. 2011; Hankivsky and Christoffersen 2008). This research employs a critical perspective towards dominant societal and social imaging on culture and identity. By refraining from stereotyping cultural minority groups as self-evident and homogeneous, we try to avoid making cultural minority physicians into 'the definitive Other' (Ghorashi 2006, 2010; Ghorashi and Sabelis 2012) and normalizing majority physicians as naturally representing professional medical quality (Essed 2005).

Being sensitive on categorical ways of thinking and social imaging in society is especially relevant in the Dutch context where public and political discourses on diversity and multiculturalism are strongly culturally exclusive. Here, the dominantly used terms 'allochtones' versus 'autochtones' are key, literally meaning 'from different soil' and 'from own soil' respectively (Eijberts 2013). Being allochtonous is formally defined as someone born outside the Netherlands or with at least one parent who is, and is further divided in 'Western' and 'non-Western', i.e. people with origins in countries in Europe, North-America, Australia or New-Zealand, or outside these areas (CBS 2012a). The term also applies to people born in the Netherlands, but with a 'migrant background', i.e. 'second-generation migrants'. Societal debates specifically focus on non-Western cultural minorities being the most 'different' and thus central when considering the topic of diversity.

Related to the dynamic perspective on identity, we view qualification for specialty training as a complex, contextual process ingrained in the daily work environment and en-

acted in social interactions between medical professionals, as those being selected and those doing the selection interact on a daily basis in medical practice. This differs from an interpretation of selection limited to official evaluation and assessment moments and the actual moment of application before a selection committee. It means that residents are constantly informally assessed, while not all of them are aware of this process. Furthermore, we assume that implicit criteria for performance appraisal, such as whether one fits into the team, might be used in addition to the criteria officially stated. In other words, underneath the espoused official performance appraisal with explicit criteria at certain moments in time, there is a constant informal performance appraisal process based on implicit criteria. To capture these complex selection processes we use the concept of performance appraisal as it is holistically defined by Bratton and Gold (2007) as ''a process that provides an analysis of a person's overall capabilities and potential, allowing informed decisions to be made for particular purposes'' and taking in consideration 'subjective' aspects in evaluation and assessment (Bratton and Gold 2007, p. 284).

Accordingly, we stress the fundamentally relational and reciprocal character of power, forming a process that is enacted by individuals and groups in daily practice. In line with this 'rhizomatic perception of power' (Ghorashi and Wels 2009), we perceive cultural identity as inherently fluid and contextual and propose a broad and emic interpretation of cultural diversity. Culture here incorporates a complex and daily dynamic through which people try to make sense of themselves and their surroundings and thus both *forms* human beings and *is formed* by them (Bauman 1999). People are therefore viewed as strategic and knowledgeable agents continuingly (re)positioning themselves vis à vis their social environment (Mahmood 2001). Hence, doing research on cultural diversity should include considering this socio-political context, dominant social norms and imaging and processes of social networking in normalizing social hierarchies, as well as consider intersecting factors as gender, class, race and age (Benschop 2009; Essed 1991; Hankivsky and Christoffersen 2008).

Method

Study design

The design used a critical diversity approach of the workplace. Critical diversity studies point towards the need for bottom-up changes within (health care) organisations, diversity sensitivity and development in social dynamics to create an inclusive climate to diversity (Abma 2003; Cox 1994; Zanoni et al. 2010). A critical diversity perspective meant in this study that we focused on including cultural diversity perspectives and less on other diversity aspects such as gender and class or being first generation student. It also meant that we felt a moral commitment to strive for inclusion through our research and tried to be reflexive to decrease the risk for stigmatisation of cultural minority or otherwise 'different' participants due to the research (Abma et al. 2001; Greene 2001; Hood et al. 2005; Verdonk and Abma 2013).

Recruitment and sampling participants

Leading selection criteria for inclusion of respondents were diversity of position, -planned- focus of specialty training (see Table 1 below), cultural background and

equal representation according to gender (both not included in the table to protect the anonimity of respondents). The respondents belonging to a cultural minority reported as their own or their parent's country of origin the following: Afghanistan, Bulgaria, Canada, Curaçao, Czech, France, Iceland, Iran, Iraq, Italy, Marocco, Lebanon, Pakistan, Poland, Suriname and Turkey. In the interviews 14 male respondents and 13 female were included, and in the first focus group 4 were male and 3 female. In the dialogue group, the female participants made around 2/3 of the group (5 of 8 participants).

Selection was done largely through snowballing and personal contacts (Bernard 2011). At the end of each interview respondents were asked to introduce other potential respondents. Later on in the study, in striving to meet the objectives on selection, respondents were also selected from the intranet data base for employees on the basis of family names (Chang et al. 1988; Himmelfarb et al. 1983).

Table 1.
Respondents according to position and -planned- specialty training

Medical ward	Physician (not in training)	Resident	Specialist/ clinical executive
ENT		x	
Neurology		x x	X
Paediatrics	X	x x	
Gynaecology		x	
Oncology		x	
Cardiosurgery	x		
Dermatology		x	
Gastroenterology/ Hepatology		x x x	x x
Pathology	x	x	
Haematology		x	
Nephrology		x	x x
Pulmonology		x	
Anaesthesiology		x x	
Ophthalmology		x	
Radiology			x

Interviews

Semi-structured interviews, executed along the lines of the topic list, were conducted with 27 physicians, i.e. junior doctors graduated from medical school but not in training for specialization, residents, specialists and heads of department both involved in selection and one head nurse (Table 1). The interviews lasted 30 min to an hour and a half and took place in the restaurant of the medical centre or respondents' offices (see Table 2 below for an indication of discussed topics).

Respondents supported the initiative for the research. Most respondents were open and eager to speak about the topics. Anonimity was an important premise to participate for all respondents, however. Especially the cultural minority physicians stressed this. Moreover, cultural minority physicians not yet in training voiced their concern on the possible influence of their participation on their future selection chances. The fluent way in which respondents shared their stories indicated they are used to receiving questions on their -perceived- cultural identity. A complicating factor was the time pressure in their work. Due to this, interviews often had to be rescheduled, some were cancelled and two had to be conducted via email. The conducting researchers tried to be sensitive and (self)reflexive when discussing experiences of social exclusion and feelings of discrimination. They were careful not to make statements that could be interpreted as supporting categorical ways of thinking and stereotyped social imaging and tried to create a safe and respectful atmosphere.

Table 2.
Indication of dicussed topics with respondents in interviews and focus groups

	Physicians in training (residents) and not in training	Specialists & clinical executives
Interviews	- personal background - motivation for studying medicine and wanting to specialize - application experiences - experiences with current work as resident in an academic hospital - social contact with colleagues and seniors (specialists/ executives) - role models - view on (cultural) diversity in relation to health care - demands for the future	- experiences with current work as professional in an academic hospital - social contact with colleagues - role models - view on selection processes for specialty training and influx of cultural minority physicians - view on (cultural) diversity in relation to health care - demands for the future
Focus groups	- findings of the interviews and participant observation, - ie. factors that might play a role in selection processes on academic medical wards and influence influx of cultural minority physicians into specialty training	

Focus groups
Data from the interviews were used as input for the focus groups to validate and deepen findings. Two focus groups were held, which both had a duration of 2 h and were moderated by a senior researcher (see Table 2). The first focus group was organized

with seven cultural minority residents. Focus groups with a homogeneous composition of participants, in this case similarity in training position, cultural minority background (though different cultural minorities) and age, function as a way to create enclave deliberation and relational empowerment and enable to work towards a joint perspective and agenda setting (Krueger and Casey 2000).

The aim of a second, heterogeneous dialogue group was to further evaluate and reflect on gathered insights from a multi-stakeholder perspective and enhance mutual understanding. The eight participants included cultural minority residents, specialists, heads of department and other clinical executives (cultural majority and minority) and a cultural minority intern. The specialists and heads of department were directly involved in selection within their respective wards. Specific attempts of the conducting researchers to include cultural minority physicians were unsuccessful. In both focus groups the reported findings and first conclusions from the collected data were recognized by the participants and considered relevant and important.

Participant observation
Data collection further consisted of short-term participant observation on a ward for two times half a day to gain insight on informal social interactions and communication styles without imposing too much influence on the setting through overt intervention. The ward Gastroenterology/Hepatology was selected as it was frequently presented as an example of 'good practice' by participants primarily due to the role of the head of department. Observation was executed along the lines of the topic list but focused on atmosphere within daily clinical work and communication and interactions (Bernard 2011; Glesne 1999).

Data analysis and quality criteria
All interviews and focus groups were digitally recorded after consent. The recordings were transcribed *ad verbatim* and returned to the respondent for validation as member check. On-site notes were taken during all data collection (Bernard 2011; Glesne 1999). Data collection continued until saturation of findings, considering available time and resources, was determined (Ritchie and Lewis 2003). Data collection and analysis were performed parallel as much as possible, following a cyclical proces in which both mutually reinforced and informed each other, enabling the researchers to profit from emergent insights (Miles and Huberman 1994). Analysis was carried out on the basis of a combination of systematic thematic analysis which follows a structure of open coding, clustering and axial coding of themes and subthemes, and repeated reading of all texts with the use of the item list (Anderson and Jack 1991; Berg and Lune 2004; Bernard 2011; Gupta and Ferguson 1997; Lieblich et al. 1998).

The cyclical research process and member checking enhanced the credibility of our analysis. Further validation was realized through triangulation via the use of different methods and analyzing the texts for mutual parallels and differences. To enhance reflexivity the interviewers kept a diary and the research team critically discussed interpretations throughout the research process (Blaxter 1996; Mays and Pope 1996).

Research ethics applied were privacy of respondents, confidentiality of reported data and transparency in handling and transport of collected data. (Blaxter 1996; Kuper et al. 2008; Mays and Pope 1996, 2000).

Results

Processes of evaluation and qualification of physicians in academic hospitals seem to be influenced by implicit professional norms on social interaction within wards and stereotyped social imaging on cultural diversity, and these seem to veil the influence of existing intersections with other identity factors. These themes will be illustrated below.

Intersecting factors in performance appraisal: cultural minority physicians at a disadvantage

Next to explicit criteria as motivation and excellence (Van den Brink and Benschop 2012; Mitchell et al. 2011), social norms on professionalism seemed to act as implicit criteria playing a role in performance appraisal. Language was given first as an implicit criterion for appraisal by most respondents; *''Well, of course you have to speak good Dutch''*. They stressed the need for correct grammar and vocabulary and to know how to formulate professional motivation and personal drive when applying for a position. Since all participating respondents spoke perfectly correct Dutch (some only with a slight accent) the issue here seemed not so much correct command of a language or language skill *per se*, but different types of language use and the way language is performed socially (Eijberts 2013; Essed 2005). *''If you talk with a foreign accent, it will turn off people''*, stated a cultural minority male resident.

Age was also perceived as an implicit criterion affecting the appraisal and influx into specialty training. Both specialists and heads of department, and minority physicians saw it as a barrier, because the latter are believed to generally be older than their fellow cultural majority physicians. Majority specialists and heads of department pointed out that a minority background might have caused delay in students' career paths. The cultural minority respondents stated, however, that many minority students got low school level evaluations and were less stimulated by instructors to pursue an academic career. Therefore, they often had to pass through longer and more complex educational paths than cultural majority students. All respondents agreed that relatively 'old' minority physicians were perceived as less 'attractive' for a training position. A male cultural majority head of department, involved in training, stated that they might even be perceived as 'a risk' regarding the quality of their future performance:

> If you can choose between two residents of which one is 24 and the other 31, and if they are both good, you'll still take the youngest (...) because from our perspective [the selection committee] there is some risk involved (...) So that is why you'll choose the one of which you are most certain, who you believe to be predictable and loyal and will do exactly as you tell them.

Further, respondents told of implicit criteria concerning building a medical career. They reported that cultural minority physicians participate less in extra-curricular activities, e.g. commission work, and less often do internships abroad or perform PhD-research

before graduating than their cultural majority peers. Several respondents explained cultural minority medical students need to work to enable their studies which leaves them less time to invest and thus end up with a relatively unimpressive resume. Specialists and heads of department believed that cultural minority students and physicians had less knowledge on what it takes to enter into specialty training and are less aware of the need to start planning ahead early in medical education. Many cultural minority medical students come from 'first generation families', i.e. they are the first in their family and/or social environment to go to university or to start a medical education.

Social support was mentioned as a facilitating factor for the influx. Indeed, the cultural minority physicians reported positively on active support from surrounding social key figures, such as a parent or a sibling with a degree in medicine, or a general practitioner of the family acting as a role model. In the interviews, all respondents seemed to assume that cultural minority physicians in general lack social support from their family and wider social milieu and have difficulty finding professional role models. In the focus groups, when the issue of social support was discussed, 'family' was mentioned as important but working as a physician might also be perceived as a barrier. Female ánd male, both minority and majority, physicians concluded that it is difficult to balance work with family and social life because of the dominant norm within the academic medical environment not to bring these topics in in the work practice and as something incompatible with medical professionalism. Several female minority respondents stressed that they are frequently questioned by colleagues on how they cope with combining work with being a wife and a parent.

Selection processes through daily social networking practices
When asked how the above implicit criteria act out in daily work, minority physicians pointed to active social networking as important for obtaining a specialist position and saw these social factors as means through which physicians need to develop and present as a 'good professional' to qualify for specialization. Specialists and heads of department stressed that a high level of assertiveness is essential in profiling for selection. Cultural minority respondents, however, emphasized that this profile can be harder to meet for minority physicians because of their cultural background. They believed that respectful conduct of cultural minority physicians for senior professionals can be misunderstood as professional insecurity and lack of knowledge or skill. This cultural minority resident pointed towards the importance of being strategic and conscious in professional presentation:

> In Holland, you have to show yourself and be heard (...) I think students have to realise that they are in a different setting now and will have to show certain qualities and particular characteristics of themselves.

All respondents stressed that specific presentation and social networking with -cultural majority- colleagues and senior professionals is, although not exclusively, of more importance to minority than to majority physicians. Minority physicians, they explained, have a smaller or less relevant academic social network, are generally less practiced in active networking and lack social support, role models and 'the right connections'.

Thus, respondents recommended social and professional support for cultural minority medical students and physicians, such as coaching and training in job interviews, writing application letters, networking and building a resume.

However, these measures do not appeal to underlying aspects that also seemed present here. Minority respondents expressed the feeling that they are less connected and less able to connect with majority colleagues and therefore experienced difficulty putting themselves forward in a positive way and network successfully (Tjitra et al. 2011; Weaver et al. 2011; Wolff 2013). Examples given were the frequent 'drinks' on medical wards which function as a platform for professional networking. Here, the dominance of alcoholic drinks and traditional Dutch snacks often from pork meat, made some minority physicians, for instance practising Muslims, feel uncomfortable or unwelcome. Furthermore, it was mentioned that cultural majority and minority professionals have less common reference points to converse on topics such as holidays and hobbies. A head of department acknowleged to converse more easily with a colleague who went skiing during the winter holidays than with a colleague who visited family in Marrakech. Traditional Dutch and elitist hobbies like hockey and sailing were reported as key topics for conversation and ways to build connections with fellow physicians and as difficult to relate to for cultural minority physicians. Respondents indicated at the role of the daily work atmosphere, feelings of social belonging and 'being at home' within a medical team and affecting the selection process. According to minority respondents, heads of department and specialists can influence the atmosphere by being a role model and creating a safe environment in which -critical- questions can be asked. Several cultural minority residents referred to their instructing seniors as having had a positive influence in their own career progress.

Overcoming stereotyped imaging in order to move up

Cultural minority respondents stressed their experience of constantly standing out in a negative way because of their cultural background. A minority specialist: *''You stand out in the crowd (...). You can get singled out because you're just different''*. As minority physicians found their multicultural background a quality feature that makes them valuable and multi-faceted professionals, they dissapointedly reported that they are almost exclusively addressed as cultural minority, i.e. allochtonous and 'non-Dutch', by colleagues. Several gave examples of situations in which they felt set apart and identified as 'other than normal'. A minority male physician related he was regularly met with jokes and comments linking his person with camels since his parents are Moroccan. A minority female resident who wore a headscarf explained that she often received probing questions as to her motivations, how her husband felt about her becoming a specialist and if this was 'allowed' by her religion. Another minority resident, male and dark-skinned, recounted a case in which he was called to assess a patient on another ward and got mistaken for a mechanic by the secretary. Some cultural minority physicians encountered patients, both majority and minority, who would not be helped by them or questioned their ability and position because of their -perceived- cultural identity.

Although minority physicians stated these experiences to be hard to define and often multi-interpretable, they felt they were met with prejudices and stereotyped imaging

on a day-to-day basis. A minority female specialist argued that in theory cultural minority physicians can stand out positively within selection processes when their multicultural identity is perceived as a 'plus' and through the fact that their first or family name stands out. In practice, though, she found that minority physicians were likely to stand out in a negative way as the idea that 'they' are not 'we' seemed to lead to cultural minority physicians being at a disadvantage as 'non-Dutch' versus 'Dutch' colleagues. With this, minority physicians ran the risk at falling beyond the norm of what constitutes a 'normal' and thus 'good' physician and felt they had to work extra hard and prove themselves to be able to claim the professional performance standard of majority physicians (Finn et al. 2010).

Cultural majority specialists and heads of department involved in selection recognized the difficulty cultural minority physicians experience in profiling for specialty training. They signalled their own difficulty, i.e. of selection committees, to look beyond the social imaging of minority physicians as 'different'. Hence, in the opinion of all respondents performance appraisal for specialty training is not as neutral or objective as it should be.

Discussion

The results show that it can be difficult for cultural minority physicians to present and profile themselves successfully for specialty training. Respondents indicate that this is influenced by social norms on what is considered 'normal' and 'good' medical performance and professionalism, and by stereotyped social imaging. The problem here is threefold. Firstly, cultural minority physicians are stereotyped as constituting a group with a homogeneous and static identity and tradition, inherently different from or even opposed to, cultural majority physicians. Secondly, -perceived- ethnic background is equated with cultural identity, which reifies culture as the sole determinant of people's actions and views, leaving little room for the intersection of identity factors as gender or socio-economic background and for aspects of process and context. Thirdly, the possible influence of stereotypical social imaging on academic medical selection is ignored. Therefore, the complex dynamics of daily social practices within social hierarchies and bottom-up *enactment* of processes of performance appraisal by individual and groups of professionals in the work environment tends to become overlooked.

The results indicate that to profile for specialty training skills and knowledge or good grades are insufficient. To gain understanding on the processes of medical selection, implicit social criteria and the interplay of diverse identity aspects should be studied. Respondents' accounts point out a situation in which styles of communication, age, class, social support, role models, culture, gender and religious differences, as well as social imaging on all these themes play a role in selection processes and appear to affect influx of cultural minority physicians. Looking from an intersectionality angle, the specific position of cultural minority physicians becomes clear. To give an example, think of a cultural minority female physician, first generation student with a Turkish, working class background and a delay in her academic career due to her migration background, an early marriage and the birth of twins. She appears to have a much greater chance at being excluded from selection than a cultural majority male physician with a family and

social circle familiar with academic education and the 'medical world'. Her chances at being selected are probably less when she would speak with a 'foreign' tongue (as opposed to a majority physician speaking with an upper class tongue) or wear a headscarf. This corroborates with studies that report identity aspects as cultural background and gender to play a role in assessment of academic excellence and hence affecting career options of minority physicians (Van den Brink and Benschop 2012; Diderichsen et al. 2013; Esmail and Roberts 2013; Price et al. 2005; Van Tongeren-Alers et al. 2011).

The experiences of our respondents point towards the processes of in- and exclusion that are enacted through daily social networking practices on medical wards within academic hospitals and result in specific social hierarchies reflected in professional profiles, in which cultural minority physicians seem easily marginalized. This corresponds with research that being 'non-white' and 'non-male' can lead to disadvantagement and that certain forms of medical skill and performance, based on gendered characteristics such as rationality and emotional detachment, emphasizing authoritative positioning, high ambition and *''a workaholic mentality prioritizing work above family''* (Essed 2005, p. 231), are more valued and acknowledged than others (Benschop 2007, 2009; Essed 2005; Sue et al. 2007; Van Tongeren-Alers et al. 2011; Verdonk et al. 2014). Our findings are also in line with studies on culturally diverse interactional and communicative styles and ways to socially 'connect' in relation to barriers to career advancement (Prasad 2003; Prasad and Mills 1997). Konrad et al. (2006) conclude the following:

> Belonging to certain ethnic groups might mean that individuals express specific interactional and communicative styles that could be at odds with mainstream organizational cultures (...) as a result [some] (...) are systematically passed over for (...) promotions on the grounds that they lack initiative and leadership potential. In this case, one brand of ethnic socialization turns out to be a cultural handicap (...) at work (Konrad et al. 2006, p. 9–10).

Overall categorical ways of thinking on culture and identity seem to underlie enactment of medical selection processes, which could profoundly hinder the structural integration of diversity in academic hospitals. The actual Dutch term of 'allochtones' practised here, signals that physicians classified as cultural minority are in fact perceived as 'non-Dutch' and 'the Other'. When minority physicians are seen as 'the Other' and majority or 'Dutch' physicians constitute the natural norm, it easily follows that non-Dutch physicians are not only different but miss something that Dutch physicians have naturally and therefore should do something extra to acquire normal quality standards (Adams et al. 2000; Essed 2005). It might even be virtually impossible for cultural minority physicians to 'compensate' completely, because their social identity remains non-Dutch. In relation to categorical thinking it is important to note the dominant belief within the Netherlands in equality as 'being similar'. This results in professionals in organizations being reluctant to address 'difference' and instead focus exclusively on 'sameness', which, paradoxically, can lead to *less* understanding and equality (Ghorashi and Sabelis 2012).

The processes of 'othering' can have other implications as well. Majority and minority respondents both speak of minority physicians 'at a disadvantage' and 'lagging behind'.

With this terminology full responsibility and opportunity for change is easily placed solely in the hands of individual minority physicians or with minority collectively (Ghorashi 2010; Ghorashi and Sabelis 2012; Konrad et al. 2006). The role of existing social power relations remains obscured here, since the fact that due to the same process of othering majority physicians are generally at an *advantage* is not addressed. The use of this terminology also seems to imply that this process of falling behind 'just happens' instead of being actively enacted in specific practices and interactions and stemming from certain prejudices and stereotyped thinking of professionals within an organization. Additionally, it presents the issue of enhancing influx of cultural minority as presumably solvable through instrumental and top-down intervention, instead of something that requires structural and collective development of organization culture and practice. Lastly, when cultural majority but also minority professionals generalize cultural minority physicians as constituting one homogeneous and static group, within-group differences can be missed (Stegers-Jager et al. 2012).

Further research should focus on normalizing practices and perspectives of cultural majority physicians on diversity and qualification processes. A limitation of this study is that it included only three cultural minority physicians who were not yet residents. Though recruitment is likely to remain a challenge and requires specific attention (Proudford and Nkomo 2006), future research should concentrate on including these physicians a´nd those who drop out of the profession after medical school in order to be able to report a balanced and complete account. Further critical and empirical research should combine an intersectionality perspective with actively exploring how space for diversity, i.e. for variation within the norm through acknowledgement of 'difference', can be jointly developed by medical professionals and be supported by policy within academic hospitals and medical education programmes (Ghorashi and Sabelis 2012; Stegers-Jager and Themmen 2013; Zanoni et al. 2010). Here, the intersection of cultural diversity with gender could be further explored. In this research gender was occasionally mentioned in the interviews, whereas in the focus groups it was an explicit topic. This might have to do with the fact that most interviews were conducted by a male researcher, whereas the focus groups were led by female researchers. There appear to be interesting parallels in the respondents' feeling that there is little space to bring in personal aspects, the dominance of specific aspects in performance appraisal on what constitutes good professionalism and the influx of cultural minority or otherwise considered 'different' professionals within the organization that need to be further explored. Lastly, studying other medical specialties and academic hospitals and perform quantitative research is important to put this study in a broader context.

An instrumental approach towards cultural diversity in organizations is visible within the dominant terminology of 'managing diversity', which suggests notions of control, hierarchical leadership and organizing workplace diversity top-down (Konrad et al. 2006; Zanoni et al. 2010). This approach is incongruous with the findings of our study. The experiences of cultural minority and majority respondents suggest that understanding of, dealing with and acting on diversity *in praxis* is more complex. The obstructing influence of categorical imaging on culture and identity and the facilitating role of social coherence and an inclusive atmosphere on medical wards seem to lead to the conclusion that to adequately deal with

cultural diversity in medical selection processes, awareness-raising among cultural majority professionals and bottom-up changes in the work environment enacted by *all* participating professionals are essential (Ahmed 2007; Seeleman et al. 2009; Zanoni et al. 2010).

Conclusion

To increase diversity of academic hospitals, attention is needed on the fact that besides explicit quality criteria, implicit and thus difficult to anticipate on norms of medical professionalism and performance appear to affect medical selection. Based on categorical and stereotyped ways of thinking on cultural diversity, these implicit criteria especially influence cultural minority's opportunities to qualify for selection into training positions but also other professionals perceived as 'different' according to class or gender. Therefore, to decrease possible biases within performance appraisal, and with this to move beyond simplistic top-down management of diversity in organizations, focus should be on intersectionality of identity factors and their specific social and hierarchical enactment within the medical work environment. To develop more space for 'difference' and diversity, critical dialogue on implicit criteria and underlying categorical ways of thinking between all stakeholders in clinical practice is required. Specialists and heads of department could play an important role by setting the example in creating the required respectful and safe atmosphere. This notwithstanding, emphasis should be on the *joint* exploring and scrutinizing of exclusionary and normalizing processes and the *jointly* developing of inclusionary practices. Organisation management, policy makers in the academic hospital as well as professionals involved in the medical school need to support these explorations and dialogues within clinical practice and accept them as viable input to create inclusive organisation structures. As competition seems to be increasing because training positions are getting more scarce due to factors as an increase of the medical student population, the heightening of the retirement age and the economic crisis, this will only become more urgent in the near future in the Netherlands.

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kuddegedrag
dat je je EMOTIES VERSTOPT
Dat een Alcoholboon Zich 6 keer moet Bewijzen
prikken moet, empathie mag
DAT JE STATUS ZOEKT
DE DOKTER WEET HET BETER DAN IEDEREEN

Medical students holding out signs with statements about what they consider norms in medical education. From left to right: that you hide your emotions; herding behaviour; that an '*allochtoon*' needs to prove him/herself 6 times; to sting [draw blood] is compulsory, [but to show] empathy is voluntary; that you seek status; the doctor knows it better than anyone else. Photographer: Bart Majoor, Art Partner.

Critical incident III - Acknowledging my race

February 2017, research visit South-Africa

She introduces herself and tells me she' s a master student in environmental studies, while walking me to the building where I have an appointment. She' s quite happy to study here as there is not so much racism and race inequality going on here as in other universities like Stellenbosch and UCT [University of Cape Town] you know, you can concentrate on your studies...

I blink. I am surprised, puzzled. I asked her for directions and this is the first thing she tells me. She' s sincere, sharing her opinion on race matters, but also 'just' making conversation. Talking relaxed, everyday talk. I don' t get it. Such a short walk and yet she confides in me. Is it normal to talk about racism and inequality here? She is open, welcoming. Yet she doesn' t know me. And I' m Dutch -and white... It shocks me that the word is just there. I blink. Race. And that racism is there as an unwanted yet normal, natural, obvious phenomenon in the world in the sense that it' s not questioned. It' s real. An issue to be addressed, and that needs to be addressed. But it' s a relief as well. Like a heavy weight lift off of my shoulders -that it' s not something silent, unnamed, unnameable, lurking in the dark.

Race and racism seem laced in everyday practice here. Coloured, black, white people I meet tell me about coloured, black, white people. Are aware of racialized political dynamics, national and international. It' s not unexpected. This is South-Africa -those things are still relevant over there, is what people back home would say. They really have problems with that over there, problems between black and white, inequality. That' s what would be said -without mentioning the words. Race. Racism. Do they mean, think that people in South-Africa are different from us, as 'we' in the Netherlands are all equal? I mumble. I do not know what to say. And I do the same. In South-Africa, I notice that all things to do with race feel filthy to me. The words leave a rancid taste in my mouth. Race. Racism. They scare me. I don' t want to use them. I feel every time I use them, I make them real. Every time I think them, I feel responsible. They should not be mentioned... because it shouldn' t be there, shouldn' t be reality. These are silent issues. That' s what I' ve learned. But I didn' t know it.

...

The white staff of the lodge where I' m staying says I have to order a taxi. For two blocks? You shouldn' t talk to black people. You cannot go for a walk in the center of town. Take a taxi. The white taxi driver talks favourably about the German actions in the Second World War. I am silent.

...

The black taxi driver on my way back from a walk in the only park I could find in the city – you shouldn't have walked there on your own, not even in daylight. Every place in this city can turn into a crime zone in a second. I am silent.

...

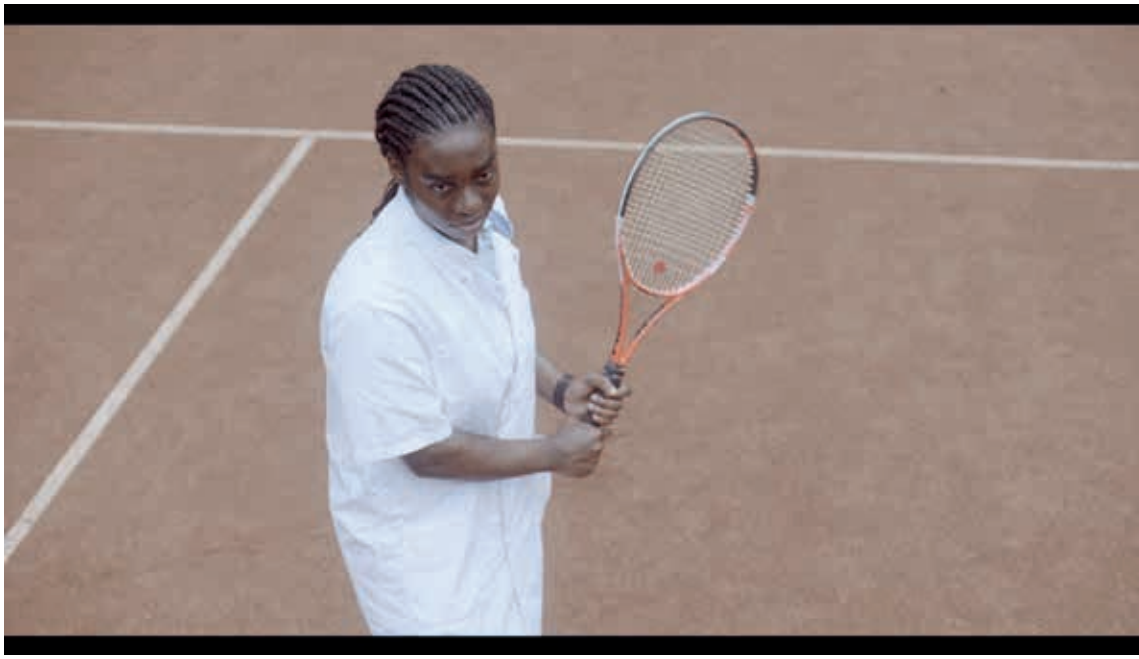
In search of a cafe with wifi. I'm the only white person on the street. No, I see an older white woman smoking a cigarette, not looking very inviting, waiting for a bus or something... Why do I not find her inviting, do I expect every white person here to acknowledge each other... as to comfort me and each other... in some kind of secret bond, contract, or something?

Is it safe for me to walk here? It's getting more run down and some younger men make some remarks or look at me closely. Can I walk any further? Ah, there is a white couple, clearly tourists of the daring, 'alternative' sort, determinedly striding along – to where? I feel a weird sort of connection with them and at the same time feel uncomfortable just feeling this.

McDonalds. I order McFlurry for the free wifi code and later coffee to order an Uber to take me home. I'm the only white person in the store as far as I can see. I get up and then realise that I forgot to take the empty cups and tray with me, I walk back and take them and throw them away. The lady who's been cleaning the place continuously says 'thank you, Ma'am'. I want to go to the toilet and she directs me to the upstairs toilets as those on the ground floor are out of order. I thank her and then walk up the stairs and stumble on one of the first stairs – she says 'sorry Madam'. I laugh uncomfortably and mumble something and continue up the stairs. At the top I stumble again... Getting flushed and jitty, I hope no one has seen me... Why did she say 'sorry' to me?!

The wifi isn't working, at least the Uber app doesn't work... I'm trying now for half an hour and getting sweaty, frustrated and inpatient. The shops are closing and it's getting towards sun-set. How long will it be safe enough for me to be around here? I feel dependent and trapped. I don't know how to interpret social signs, I don't know what the 'rules' are, I don't know what to rely on, what to take seriously and when I'm being paranoid... I'm looked at incredulously when I ask certain things, I'm not really taken seriously...

I know nothing.



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

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

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Abstract

Internationally, academic hospitals are giving increasing attention to diversity management. This paper sheds light on the actual praxis of cultural diversity management by professionals in workplace interactions. An ethnographic study in a Dutch academic hospital showed that normalization practices were obscuring diversity issues and obstructing inclusion of cultural minority professionals. The normalization of professionalism-as-neutral and equality-as-sameness informed the unequal distribution of privilege and disadvantage among professionals and left no room to question this distribution. Majority and minority professionals disciplined themselves and each other in (re)producing an ideal worker norm, essentialized difference and sameness, and explained away the structural hierarchy involved. To create space for cultural diversity in healthcare organizations in the Netherlands and beyond, we need to challenge normalization practices.

Introduction

Cultural diversity is increasingly acknowledged as an important issue in academic medicine and healthcare organizations internationally. In the United States, diversity management in organizations became an issue in the late 1980s, and it arrived in northwestern Europe 10–20 years later (Holvino & Kamp, 2009; Zanoni, Janssens, Benschop, & Nkomo, 2010). Programs addressing diversity in organizations are mainly legitimized by two arguments. The first is based on a moral argument of equality and social justice; it is aimed at equal representation of and equal opportunities for professionals. The second is termed the "business-case scenario" because it argues that diversity among professionals enables creativity and competitive advantage (Ahmed, 2007; Cox, 1994; Thomas & Ely, 1996).

In practice, diversity management is generally thought effective or successful when it enables professionals and organizations to better connect with a diverse clientele and society, resulting in improved performance for organizations (Prasad & Mills, 1997; Prasad, Pringle, & Konrad, 2006). As such, diversity management often takes on an instrumental character (Thomas & Ely, 1996) in which "'the other' is invited to the organization, but is only tolerated and accepted in as far as he or she enriches [but does not challenge] the center" (Holvino & Kamp, 2009, p. 399). Thus, diversity management and diversity programs grounded in equality risk being reduced to "fixing the numbers" – that is, solely focusing on minority representation without addressing organizational culture – while those programs grounded in the business argument risk being acceptable only when their efforts produce efficiency and create profit. These rather limited options for diversity programs may be one reason that – in the US context – the programs seem to have limited impact on recruitment, promotion, and retention of cultural minority professionals (Betancourt, Green, & Carrillo, 2002; Janssens & Zanoni, 2014; Nelson et al., 2002; Turner, González, & Wood, 2008).

Critical diversity studies signal the need to move beyond the often instrumental equality perspectives or business perspectives in diversity management (Cox, 1991; Zanoni et al., 2010). They emphasize that, to achieve actual inclusion of diversity, the role of power and the – foundations of – structural inequalities in organizations and diversity management need to be explored (Ghorashi & Sabelis, 2013; Van Laer & Janssens, 2011; Zanoni et al., 2010). In this paper, we take a critical diversity studies approach toward structural factors of diversity in organizations and contend that for structural inclusion of minority professionals, diversity programs and diversity research need to consider and critically review work floor and organizational cultures. In particular, we answer Zanoni et al. (2010) call for an increase in critical empirical research. Little attention has been paid in diversity management studies to how – minority – professionals actually experience and deal with diversity in their daily work environment and how cultural majority and minority professionals relate to each other (Ostendorp & Steyaert, 2009; Van Laer & Janssens, 2014; Zanoni & Janssens, 2007). Moreover, how power "works" and how the production and reproduction of norms, privilege, and disadvantage takes place empirically is largely unclear.

To understand the (re)production of norms and privilege/disadvantage in organizations, we investigated the academic healthcare context in the Netherlands. As the combined

field of academia, medicine, and healthcare is traditionally highly exclusive, hierarchical, and monocultural (Taylor, 2003), the academic hospital seemed a relevant setting to study practices of normalization and inclusion of diversity. To our knowledge, there are no empirical studies in academic hospitals that study these topics from a critical diversity perspective. Within the Netherlands, cultural minority professionals in academic hospitals are overrepresented in support staff but underrepresented in many nursing teams and especially in medical and executive staff (Groeneveld & Verbeek, 2012). Earlier empirical studies on cultural diversity in this setting indicate that minority professionals, particularly those who are "visibly different," (e.g., not white, wearing a headscarf), have difficulty "fitting in" Leyerzapf & Abma, 2017; Leyerzapf, Abma, Steenwijk, Croiset, & Verdonk, 2015; Leyerzapf, Rifi, Abma, & Verdonk, submitted; Verdonk, Muntinga, Leyerzapf, & Abma, 2015). The lack of diversity in Dutch academic hospitals may be due to two factors: the Dutch culture's self-image as a society of equal opportunities, a tradition of social justice rhetoric combined with the "celebration" of tolerance for diversity (Ahmed, 2007; Essed, 2002; Heres & Benschop, 2010); and, more recently, the occurrence of polarized discourses that openly show racist tendencies (Essed & Hoving, 2014). Ghorashi, Carabain, and Szepietowska (2015) observed a general paradox in Dutch society of an expressed willingness to include diversity but the incapability to do so in practice, which they attribute to deeply rooted assumptions about cultural minorities as "the Other," who are seen as not only different but also not competent enough to meet the profile of the "normal employee." Thus, the Netherlands is an appropriate context for studying the empirical workings of structural factors for inclusion.

Here, we aim to shed light on the daily *praxis* of cultural diversity management by professionals – that is, how they perceive and deal with diversity in interactions at work and how this relates to inclusion and exclusion as well as privilege and disadvantage. By presenting case examples from an ethnographic study in a Dutch academic hospital, we aim to illuminate how workplace inequalities take shape and are enacted. We hope to extend knowledge within critical diversity studies on the workings of implicit power and normalization in relation to the inclusion of diversity. Ultimately, our objective is to stimulate an inclusive and equitable workplace and work practice for all professionals in academic healthcare and other organizational contexts. Before presenting and discussing our findings, we explain in our theoretical framework the concepts of power and normalization, and in our methodology describe how we operationalized 'cultural diversity' and 'minority/majority'.

Theoretical framework

Developed in the mid-1990s as a reaction to diversity management's inability to improve the position of minorities (Holvino & Kamp, 2009), critical diversity studies stress the power dynamics and the structural, contextual aspects of shaping diversity and its inclusion in organizations (Zanoni et al., 2010). Critical diversity studies assume that dominant views on power and diversity prevent power issues and social hierarchies from being challenged (Ghorashi & Sabelis, 2013; Van Laer & Janssens, 2011) as difference – and identity – tend to be reified as something definite, all-encompassing, and exclusive (i.e., essentialism; Nkomo & Cox, 1996). From such dominant views organizations are represented as open, a-political zones in which professionals can "move neu-

trally" (Ahmed, 2007). By adopting a power lens, critical diversity studies have started to approach the topic of diversity in organizations by involving the concept of difference. They critically address the processes through which certain professionals are included on the basis of their perceived fit with and sameness to organizational norms and other, professionals are excluded on the basis of their perceived non-fit and difference (e.g. Ghorashi & Sabelis, 2013; Holvino & Kamp, 2009). Analyzing this "difference-sameness" axis (Holvino & Kamp, 2009) is a way to start deconstructing the social hierarchies and power structures in organizations. As these are clearly dynamic, dialectical processes (Atewologun, Sealy, & Vinnicombe, 2016; Van Laer & Janssens, 2011, 2014), in particular, the processes of (re)production of these hierarchies need to be unraveled.

Janssens and Zanoni (2014), Zanoni et al. (2010), and Holvino and Kamp (2009) challenged diversity management programs/studies, claiming that these helped to reproduce unequal power relations because they often do not question the strategic, rhetorical objectives of diversity management programs and how these reproduce power imbalances and privileges and disadvantages. Indeed, Heres and Benschop (2010) critical analysis of diversity and equality discourses from leading Dutch companies found that the companies' diversity management remained limited in its impact because it was "framed as an issue for those who are 'different,' not those who, under the dominant norm system, are seen as 'normal'" (p. 452) – showing uses of diversity that are likely to add to exclusion processes. Looking at reproduction of inequalities, Boogaard and Roggeband (2010) discussed the paradox that minority professionals within the Dutch police force occasionally challenge inequality due to their attributed social identities, yet simultaneously reproduce inequality as they deploy these same identities as positive in order to empower themselves and preserve individual power. Other critical diversity studies as Van Laer and Janssens on subtle discrimination (2011), hybrid identity (2014) and agency of minority (2017), and Atewologun et al. (2016) on minority professionals' intersectional identity work, similarly put the interplay between structure and agency at the center of their analysis. These studies show how this dynamic requires active balancing and compromising of minority professionals, resulting in spaces for micro-emancipation (Ghorashi & Sabelis, 2013), yet not in structural inclusion.

In this paper, we adopt a discursive understanding of power, that may provide a more constructive way to address power relations in the workplace and the split minority seem to find themselves in, and that is important in view of the objective of critical diversity studies of generating potential for transformation in organizations. Instead of understanding power as domination or hegemonic power in the tradition of e.g. Gramsci (Foldy, 2002), we propose a Foucauldian-inspired perspective to power. From a perspective of power as domination, power in organizations is perceived as identifiable, visible and material in for example occupational hierarchies, as something "in the hands of" leading, "traditional", and majority professionals "at the expense of" minority (Foldy, 2002; Janssens & Zanoni, 2014). Following Foucault, power is however more implicit, omnipresent and "invisible" (Foucault, 1989, 1982; Ghorashi & Sabelis, 2013). In this Foucauldian tradition, we approach power as performative as it is enacted within discursive spaces in social interactions and routine practices. Moreover, power is rooted in and expressed through norms, or more precisely in processes of normalization

of these everyday behaviour, linguistic expressions and non-verbal, bodily interactions that are/become internalized and engrained in mind, body, and culture, and are difficult to pinpoint and transform (Foucault, 1982; Ghorashi & Wels, 2009). Discursive power and normalization are inherently dynamic and dialectical as they are both signifiers and signified of social relations between people, namely who fits in and who deviates. When we focus on normalization practices, we see how power and structures of inequality are thus not unilaterally oppressive. They are productive as all people are necessarily part of its enactment, are mutually dependent on each other in the hierarchical production process, and in that sense all "carry responsibility" (Ghorashi & Sabelis, 2013). In order to gain insight on the dynamic, dialectical enactments of power, we focus on the processes of normalization.

With this study, we hope to show how normalization materializes in everyday encounters on hospital wards and with this to uncover and deconstruct enabling mechanisms of exclusion/inclusion (Ghorashi & Sabelis, 2013). Previous studies have pointed towards yet not placed the praxis of normalization at the center of their research and analysis (e.g., Ghorashi & Sabelis, 2013; Van Laer & Janssens, 2011). Van Laer and Janssens (2011) described how processes of normalization, legitimization and naturalization enabled subtle discrimination in the workplace and worked to disempower minority professionals. Within an approach of power as discursive and normalized, however, agency of minority is not restricted to opposing – majority – structure, and empowerment is an inevitable relational process involving relatively privileged as much as disadvantaged professionals (see also Larruina & Ghorashi, 2016). We therefore look at how privilege and disadvantage are, interrelatedly, reproduced. How the reproduction of power dynamics via normalization practices happen, as well as what actually constitutes this praxis of normalization is still largely unclear. Studies (e.g. Ghorashi & Sabelis, 2013; Larruina & Ghorashi, 2016; Van Laer & Janssens, 2011) make use of different, related concepts besides normalization in this context, such as disciplining, internalization, socialization, naturalization, legitimization, institutionalization, routinization, formalization, homogenization, silencing, and it is not clear how these mutually relate. Therefore, we do not predetermine normalization but aim to build an operationalization of its empirical manifestations by analyzing what is considered "normal" rather than what is considered "different"; how "the Self" is positioned versus "the Other"; and what is implicitly included and privileged instead of only on what constitutes "difference" and "the Other" (Essed, 2002).

Table 1.
Overview of data collection and participant characteristics.

		Ward A	Ward B	Ward C	Other wards	Total
Interviews (formal & informal), n = 62	By H.L.	7	8	14	2	31
	By research interns	2	14	15	–	31
Participant characteristics of Gender (informal) interviews	Female	6	14	22	1	43
	Male	3	8	7	1	19
Cultural background	Majority	5	19	21	–	45
	Minority	4	3	8	2	17
Position	Nursing staff or doctor's assistant	3	2	8	–	13
	Nursing staff executive	4	6	4	–	14
	Administrative, supportive, or paramedic staff	1	8	2	-	11
	Medical specialist/ executive	1	6	4	2	13
	Medical specialist-in-training–	-	-	6	-	6
	Medical student	–	–	5	–	5
Participant observations (approx. 100 h)	By H.L.	10	15	10	-	25
	By research interns	10	35	20	–	65

Methodology

Study design, research team, and research setting
This ethnographic study investigated the diverse lived experiences and narratives of professionals in their daily work environment (Yanow & Schwartz Shea, 2006; Ybema, Yanow, Wels, & Kamsteeg, 2009).

As awareness of identification and positionality is important in this research, we highlight here our own positioning as authors and come back to it in the discussion (Verdonk & Abma, 2013). We are all female. One of us has been trained as a nurse, and three of us work in a medical center and teach in medicine and health sciences. One of us is not white and has a refugee background. The others are white and from the majority Dutch culture – although one has a white non-Dutch father. We are all privileged in that we are highly educated and, as academics, occupy a high socioeconomic position.

Five research interns supported data collection. One was male, and one identified as a minority. Two were medical students, one was a health sciences student, and two were social science students.

The academic hospital where the research was conducted is situated in the highly urbanized, Western part of the Netherlands, and the university is among the most culturally diverse in the country. To protect the privacy of the participants and the wards, we do not give (personal) details about either. We use the term "ward" to indicate the clinical department representing one medical specialty, including its sub-wards, such as admission wards and the outpatient clinic. The term "team" indicates the different professional teams (i.e., nursing, medical, administrative) that operate in these areas.

Participant selection and recruitment

Participant selection and recruitment was closely related to and influenced by our use of the key terms "cultural diversity," "minority," and "majority." Cultural diversity is commonly used in Dutch parlance and healthcare regarding issues of migration, integration, inclusion, and diversity management. It suggests cultural/ethnic/racial/religious plurality. We took an emic perspective – "from within" – in this study, asking participants to explain what they perceive as (cultural) diversity. Besides the term "cultural diversity," or "diversity" for short, we use the terms "(cultural) minority" and "(cultural) majority," common in diversity research and scientific debates on inclusion and equality (e.g., Essed, 2002; Ghorashi & Sabelis, 2013). Here majority refers to Dutch professionals with dominant Dutch ethnic backgrounds, and minority refers to Dutch professionals with non-Dutch ethnic backgrounds. Choosing these categories above other comparable terms used in the Netherlands (such as "autochthones" and "allochthones") is based on the critical approach of our study. We believe the category of difference is connected not solely to ethnic, cultural, or racial difference but also to the position of power, that is, the level of privilege.

To get a broad spectrum of perspectives, our selection criteria were: diversity in profession (medical, nursing, administrative, paramedic, or support staff); position (executive, management, and so on); cultural/ ethnic/racial position (majority and minority); gender; age; religious affiliation; socioeconomic background; and professional seniority (see Table 1 for an overview).

Recruitment took place by direct approach and by snowball sampling. Minority professionals seemed more hesitant or even reluctant to participate in interviews than majority professionals, more often saying they were too busy to participate or not returning researchers' phone calls and emails. This might be due to their not feeling safe enough to tell majority researchers their experiences or to their fearing consequences at work from being critical about work floor interactions, feelings that may have been increased by the fact that recruitment sometimes happened via majority executives. Researchers were dependent on executives to gain access to the wards and to be able to recruit and collect data; although all general communication about the research to professionals was done on behalf of the researchers, leading professionals forwarded these messages across the ward and this possibly affected professionals' consideration to participate. Overall, there were few minority professionals to recruit.

Data collection

Based on a literature review, exploratory interviews, and researchers' knowledge, topic lists to structure interviews and participant observations were formulated (Bernard, 2011). Interview topics were as follows: participant demographics; professional motivation, career background, current position; recruitment and promotion (executives only); daily routine; social interaction with colleagues; professional norms and culture; ideas for the future; humor, being critical, positive and negative work experiences; professional role models; perception of/ dealing with cultural diversity; reflections on the research. Topics for participant observations were as follows: demographics; purpose, structure, content of activity; interactions between participants and their roles during those interactions; atmosphere; communication styles, humor, silences, (critical) questions raised, language use, use of stereotypes, prejudice; talk of cultural diversity, labeling majority/ minority, different/same; parallels/differences with interviews, other observations; research reflections and researcher expectations.

The sequence of interview topics differed in practice. The goal was to generate reflections about the team, ward, or organizational culture; norms/normativity, difference/"the Other," and normality/"the Self." Participants were first asked how they perceived diversity then how they perceived *cultural* diversity, to observe possible parallels and differences in these categorizations and their own identification with them.

In total, 62 interviews, including the exploratory interviews, were conducted (see Table 1). Fifteen were informal and not recorded. Most interviews were conducted individually, though in two cases, two people, and in one case, three people, were interviewed together. Interviews generally lasted 1 hour, ranging from 30 min to 2 h, and usually took place in private rooms on the wards, though some were conducted in one of the hospital cafeteria's. All formal interviews were recorded, with verbal consent; they were transcribed, made into short reports, and sent to participants for member check (Lincoln & Guba, 1985). On-site notes were made and later turned into reports (Bernard, 2011).

Participant observations (approximately 100 h, see Table 1) were essential in gaining participants' trust, openness, and commitment, which enabled relationship building (Burlew, 2003). They also helped us acquire in-depth, contextualized insight into daily interactions and professionals' social identifications and positionings vis à vis colleagues, which are often difficult to put into words. Again, on-site notes were turned into extensive reports. Observations were made during coffee and lunch breaks, team meetings, management consultations, multidisciplinary patient consultations, patient rounds, and educational seminars, and ranged from 30 min to 8 h. On all three wards, researchers also acted as a "shadow observer" (McDonald, 2005), sometimes in uniform, for a half- or full-day shift.

Data analysis

Data collection and analysis happened in parallel as much as possible and provided insight for new data collection (Lincoln & Guba, 1985). In this cyclical process, partici-

pants were asked to reflect on preliminary interpretations. Different, parallel methods of data collection, namely, formal interviews, participant observations, and informal conversations during observations, enabled us to visualize dominant and alternative perspectives and narratives (Abma, 2006; Jackson & Mazzei, 2013).

Analysis was supported by the use of sensitizing concepts (Denzin, 1973). The conducting researcher (first author) read all notes, reports, and transcripts recurrently to thoroughly familiarize herself with the data and stimulate "close reading" (Yanow & Schwartz Shea, 2006). She wrote preliminary interpretations, which were extensively discussed by all researchers and analyzed to incorporate methodological, theoretical, and philosophical expertise into the interpretation process. These interpretations were subsequently brought back into interviews and participant observations to help focus and stimulate deep, critical reflection by participants and researchers. This "plugging in" of empirical data to theoretical knowledge, and vice versa, is described by Jackson and Mazzei (2013) as thinking *with* theory and data, and it prevents simplistic interpretivism as well as letting empirical data "speak for themselves."

An example of how thinking with theory and data worked was our labeling of preliminary data with the term "normalization." Preliminary interpretations indicated that the term "cultural diversity" related primarily to individual uniqueness and thus all professionals, and defended work floor culture and the status quo on the one hand, while on the other hand it related only to minority people in order to explain experiences of exclusion of minority and problems with their recruitment, selection and retention. This appeared to connect with Ahmed (2007, 2015) on the non-performativity of diversity, that is, the strategic, rhetorical uses of the term "diversity" and diversity-related language to "silence" diversity programs as potential incentives for organizational change. This led us to review our data, focusing on particular language use such as "normal" and "different," and pointed us toward processes of normalization. In subsequent interviews and observations, we were alert to these particular uses and meanings of "diversity" and "majority/minority" and arguments for inclusion and exclusion of what is considered normal at work. In this way, normalization – as closely related to performativity of diversity and organizational change – became a sensitizing concept in data collection and analysis.

Quality criteria and research ethics

Credibility was enhanced by different data collection methods (triangulation), critical discussion, and looking for differences in interpretations and exceptions in the data (Yanow & Schwartz Shea, 2006). Comparing data from interviews (what participants narrated) and participant observations (how participants related in practice) generated insight into the social praxis of the sensitive, politically laden research topics. The first author kept a diary to critically reflect on her own (automatic) assumptions and her role in the research process (Verdonk & Abma, 2013).

Credibility was validated by presenting anonymized (preliminary) findings to an interdepartmental committee within the hospital, which advocates for inclusion of diversity. Formal quality of the research was consented by the Medical Ethical Board of the hospital and the conducting department's science committee.

Data collection continued until data and theoretical saturation was established (Lincoln, 1995). Confidentiality – crucial to all participants – was ensured as much as possible by anonymizing reported data and the research setting. This was especially important due to the difficulty of maintaining anonymity from people familiar with the setting. Privacy was central in handling, transporting, and storing data (Lincoln, 1995).

Findings

Below we describe participants' perceptions of and experiences with cultural diversity issues in the workplace.

Diversity as being only about the Other

When reflecting on the meaning of diversity at work, both cultural majority and cultural minority participants initially talked only about patients. Majority professionals told of minority patients who did not want to shake hands with professionals, did not want to be treated by a professional of the opposite sex, or did not speak Dutch well, causing "longer-than-necessary consultations" and delay. They also described patients bringing or being visited by too many family members, and patients and their families expecting too much from hospital staff and medicine in general when facing serious illness. A female minority nurse told of recurrent situations in which patients did not want to be washed by her because she wears a headscarf and of how they commented on her assumed identity:

> I just get that every day ... patients [...] [t]hey assume I'm Moroccan [because of my] appearance – head scarf and... I am dark-skinned [...] And when they hear me talk, it's like 'Hey, an accent, your talk is not really Moroccan ...' [laughs] And then it starts! 'Hey! You're not Moroccan are you?! [...] But your pronunciation is different' ... You know?! This way we always come to the topic of my head scarf, to the Islam.

All minority participants reported these types of recurrent experiences that they themselves or minority colleagues had had, where – often majority – patients refused their help because of their headscarf or where these patients expressed disrespectful comments or questions about their minority background.

Whereas minority professionals mentioned *majority* patients when asked to reflect on diversity issues at work, majority professionals mostly referenced *minority* patients. A majority nurse recounted:

> [S]uch hypes like, shouldn't we now start translating all our patient letters into Turkish or Moroccan, and should we now learn that language or not [...] I'm a nurse, I am male [...] so, uh, I can care for a Moroccan or Turkish female, but, eh, not if it involves the bare skin. So how am I supposed to [do my work]?

A female, majority administrator told of a situation in which a "foreign" man in the company of four women fully veiled in black came to register. She recounted how she

was struck by this and thought "these must be his wives." Immediately, she laughed and added that this was a "silly thought, of course." This situation to her was a clear example of "diversity in the workplace." However, it was the only example she could think of, and she emphasized that cultural diversity was "not really an issue."

As mentioned, all participants initially considered diversity as a relevant topic at work only in relation to patients. Even the minority professionals who described difficult encounters with majority patients did not indicate this was something the organization should address. They presented it as a problem of individual patients; it was a hassle but it did not really affect them:

> You will always have them, these kinds of patients ... [they can] just be rude ... That's just how it is you know.

In general, diversity issues involving patients were associated with difficult, uncomfortable situations, or even "difficult patients" (e.g., not shaking hands), that were seen as obstructing and disrupting normal (clinical) interactions and taking up (too) much time. Hence, diversity was generally perceived as problematic. Furthermore, diversity was primarily interpreted as cultural diversity, which in the Netherlands also encompasses ethnic, racial, and religious diversity, but not, for example, diversity in sexual orientation, gender, or educational background. These narratives indicated an Othering process whereby diversity became about cultural Others (patients) instead of the normal Self (professionals). Thus, the role of diversity in professionals' conduct, attitudes and wellbeing and diversity as a (potential) issue among professionals themselves seemed obscured.

Diversity essentialized as either nice or problematic and not quite normal

Eventually, participants related issues of cultural diversity to professionals and the work floor. It was almost exclusively presented as "nice" or "fun" and useful. Examples involving food were mentioned by both majority and minority participants, such as festive lunches or the "multicultural" snacks or sweets colleagues brought to celebrate their birthdays. All participants, majority and minority alike, used such examples to show how diversity is "normal". However, they always added expressions as "yet no problem at all", "yet very much valued", "you know", and "*gewoon*" and "*hoor*", Dutch words difficult to translate, used to normalize an argument. Also, most participants stressed how useful and valuable it is "to have diversity in the team" for working in a plural society. A majority participant said:

> It's good to have colleagues who speak another language, you know, know another culture, to help out with patients with diverse backgrounds.

Majority participants emphasized the convenience of "having culturally diverse colleagues" who would work on Christmas, allowing majority participants to take that holiday off. Again, they dominantly referred to minority colleagues, not mentioning colleagues from Christian or non-urban backgrounds, for example. Minority participants had the same argumentation; they stressed the "importance" and "usefulness" of their own

and others' minority backgrounds for enabling the work practice to deliver "culturally diverse care." One minority participant said:

> I actually view my background as an asset to the team, you know ... that's my contribution to the work, that I can help them [majority colleagues] with those patients.

Diversity in the context of professionals was approached in a rather instrumental way. Furthermore, it was put forth as something uncomplicated, natural, and not really an issue (i.e., not worth discussing or studying). "Explain to me please *why* you want to study diversity" [emphasis added], said one of the several executives and medical specialists who implicitly or explicitly made their skepticism known to the researcher. This constituted a sort of obscuring and explaining away of diversity issues as well, because the narrative of diversity as a nonissue was upheld and stressed even in situations that appeared to be experienced as complicated and difficult.

Several majority specialists, for example, spoke about a female specialist-in-training who wore long clothes and dark-colored veils. They had pressed her to change her veils in order to "not scare the patients." Dark veils "simply did not fit" the work context, they said. They gave this example to illustrate that diversity "is not an issue in our team," since the specialist-in-training, as one of them stressed, "just did this [without making trouble]," and another added that "that is really the only thing we had here [concerning diversity of professionals]. In fact, however, with this story, they implicitly narrated diversity as problematic, as did the statement they all made that diversity "is no problem." This view was supported by the majority specialists' description of the only minority specialist in their team, saying that "he has a funny name and accent but, otherwise, you do not notice anything about him."

Similarly, minority professionals seemed to explain away the difficulties they experienced at work as they presented cultural diversity among the professionals as unproblematic. Most minority professionals told us that their religion or their wearing a headscarf, having an accent, not drinking alcohol, or not joining team outings "is just accepted," "okay," or "tolerated." Some stressed that, when they had worked on other wards, they had felt excluded and experienced discriminatory remarks from colleagues. Only a few minority participants mentioned that, when they or minority colleagues had addressed the conduct of majority professionals or patients that they had experienced as stigmatizing them because of their cultural background, they felt they were not taken seriously by majority and sometimes also by minority colleagues. One minority recounted:

> Uh, ... then they just said it was of course not intended as such and that I probably heard it wrong or also [that] I must have misunderstood ... and [they] laughed and said I shouldn't make it so serious.

Several majority participants mentioned that minority professionals sometimes "complain" about disrespectful conduct but that they thought this claim was often "biased"

and it was “not clever to deal with it that way.” Overall, both majority and minority participants indicated that cultural diversity was not commonly discussed among colleagues. Majority participants said, “No, it’s not something we think about really, it’s not important ... this is just normal here,” or “We don’t think it’s a problem.” A minority participant said, “I don’t need to think about it because it’s just accepted here.”

However, the way in which diversity was presented and the words that were used – normal, just, okay, no problem – indicated that the statements obscured an underlying perspective in which the existence of cultural diversity was in fact a potential problem. Furthermore, it suggested that cultural diversity among the professionals resulted from minority professionals being not normal, with their backgrounds, identities, appearances, traditions, and behaviors seen as different and deviant from the norm. The stories of several minority professionals (doctor’s assistants) in an outpatient clinic, who, as an exception, were very outspoken, supported this view. They spoke about the majority specialists(-in-training) they worked with and who were often disrespectful to them. One doctor’s assistant said:

> Then they yell at you like that, just really yell at you, in the hallway, in front of all the patients [...] they don’t do that to the [mostly majority] nurses ... they only do that to us.

Several observed situations portrayed the perception of diversity as problematic and as about being different from the majority culture, as well as the active explaining away of this perception by both majority and minority professionals. A majority research intern shadowed a minority support staff member as a form of participant observation. When the minority professional entered the nurses’ administrative office and, addressing all, asked for some information, the nurses directed their answers to the majority research intern, who was not wearing a uniform and was standing next to the minority professional. “It seemed as if she was just made out of thin air or something!” the intern said. When asked, the minority professional acknowledged that she had noticed but said she was “used to that” in a rather excusing way. We also observed that – the few – minority professionals who had an executive position were regularly the subject of joking and teasing by – subordinate – majority professionals, relating to their minority identity. For example, these majority participants directed the researcher to their minority colleagues for corroboration that indeed their team was okay with cultural diversity, saying “Oh, ask [XX], he’s our foreign guy” or “We have [XX], she’s been here for years,” and they called their minority colleagues “our diversity” or “our multicultural part.”

These examples connect with majority and minority participants speaking of minority professionals as “being culturally diverse,” implying a norm from which only minority deviate. Moreover, the examples suggest a process of Othering of minority professionals that is obscured, but apparent in the way “their diversity” was to some extent *tolerated* because nice, fun or useful, yet never quite fitting the norm as it had to be continuously and explicitly defended as being “normal”.

Diversity as individual and professionalism as neutral

When asked to reflect on what they deem important to the work practice, all participants said competency and professionalism. Most minority professionals said that "my diverse background has nothing to do with my work, as only skills, competences, and qualities are important" or "my different background does not matter since they only look at how you work." Majority executives and the few minority executives often concluded their reflections on cultural diversity with saying "But of course, professional quality remains and should remain the leading consideration." In this context, some majority executives brought up "positive discrimination" (i.e., affirmative action) and addressed their fear that attracting more "diverse professionals" would compromise team quality. One said:

> We can't just go and favor culturally diverse professionals ... [...] we look at their résumé, their experience [...] we have to watch the quality.

Competency was mentioned as the only factor that should determine whether someone is "a good professional," and "the only way you may/are allowed to discriminate between professionals." Overall, competency and professional performance were presented as neutral and objective – and independent from cultural, ethnic/racial, or religious identity. Majority executives even seemed to see professionalism and diversity as being at odds with each other, which relates to the explaining away of diversity among professionals as an issue.

However, when it came to actual appointments, minority and majority professionals – executives and non-executives – pointed to factors other than official criteria for professional competence. They identified as crucial "who fits in with the team" and "experiencing a *click*," as, for example, a majority executive explained:

> There has to be a special connection felt [...] if you don't have this personality, you won't fit in the team.

A majority executive recounted how a majority, long-time employee came to her, frustrated, because she had heard that a minority intern was given a position. The executive asked the majority employee if she found the intern's performance lacking. She answered, "No ... she is not incompetent, she is just ... different." Majority executives discussed cases of "equal performance or qualification" – "in that case you choose the one you feel best fits the team." This indicated a consideration of implicit criteria concerning emotional and social aspects beyond or sometimes more important than competency, as well as specific ideas of what good professionals were and what they should look like.

With these norms of professionalism professionals not only explained away but declared diversity among professionals an invalid issue. This happened when majority and minority professionals presented the click or the fit as being based on personality and involving individual difference unrelated to cultural difference or group identity. Minority professionals justified the importance of such "normal differences" of attitude and personal or communicative style at work; as one said:

> You have to have a specific mindset to be able to function in this team ... to do this kind of work.

Similarly, a majority executive reacted to a researcher's question about why a certain minority professional was let go: "Oh, but that is personality. You have to fit in of course!" A white, minority executive said that, to "treat every professional equally," he did not look at "irrelevant identity factors like culture or gender but at what personality you have and if it can be an asset to the team." Another majority executive explained why a minority professional had obtained a training position as follows: "...but that was personality. We don't discriminate against people here!" Although this was one of the few times the issue of discrimination was mentioned, most majority executives seemed to want to defend the fairness of their selection practices. In one team, tensions between two "black" professionals and the rest of the team were labeled as "just not functioning properly" and "complicated persons." Thus, these tensions were portrayed as not being related to cultural diversity issues; such tensions did not affect the executive's perception of the team (culture) as open and accepting toward diversity or the general characterization of diversity as positive and uncomplicated. Even in a ward known in the hospital and by its own members as an exemplary "well-functioning *multicultural* team," professionalism and diversity were disconnected and professionalism was identified as the only thing that mattered as diversity among the team was dealt with by highlighting individual differences other than cultural identity. Like one majority team member said:

> We are all *so* different that it is just ... normal!

Thus, the process in which cultural diversity issues were declared invalid in relation to professionals and work floor practice was based on strong ideas about what "a professional" is, agreement that "we all should (want to) be one," and norms regarding who is suited to be a professional or who matches the image, as well as presenting professionalism, competency and quality as neutral and objective criteria. These ideas and norms became normalized by the obscuring, explaining away and silencing of diversity issues, with words such as "just" and "of course" signaling that the status quo was, and should be, taken for granted. Furthermore, these norms were normalized by framing cultural diversity issues among professionals as being about personality and personal, *individual* difference instead of on group identity, and thus independent from social, societal, political – that is, collective – relations, contexts, and structures.

A normalized social hierarchy: privilege and disadvantage for professionals?

Though the dominant narrative was that cultural diversity was not an issue, participants' accounts and practices indicated an alternative narrative in which cultural diversity was an important aspect in relation to establishing one's professionalism. Most examples, given by both majority and minority professionals, about people not really qualifying as good professionals or as good professional fits for the team were about *minority* professionals. Being a minority seemed – implicitly – identified as not fitting, as being different from or even at odds with the norms of professionalism. Majority professionals generally did not discuss other majority professionals. They seemed to view the norms of professionalism as matching themselves: they described examples of "a

non-fit" as "having a foreign/different/strange accent," or plainly said that "people with a minority background often do not display an assertive, open, direct communicative style." Minority professionals were to some extent aware of the need to live up to the norms, to prove they fit in, and of the hierarchical dynamic involved. This was seen, for example, in a minority participant's comment about a fellow minority colleague who wanted to discuss feelings of exclusion or discrimination:

> It's not professional to let yourself be affected by this or let your work of delivering care be affected by it. It's not functional.

This representation of the connection between cultural diversity and professionalism pointed to a – potential – hierarchy between those who fit the norms and those who do not. This hierarchy appeared linked to selective privilege and disadvantage among professionals, as was illustrated by the case of a male, minority physician-in-training. Several majority and minority colleagues mentioned this person as an exemplary "good professional." However, upon obtaining his specialist degree, he organized drinks without serving alcohol, which was met with incomprehension and disappointment by his majority colleagues. As they recounted the situation, it became clear that, by not serving alcohol, he suddenly stopped fitting in and meeting the norms. As one of them said:

> We had expected different from him! ... We were surprised and didn't understand this. ... He had been so nice all the time and then ... this.

The majority professionals not only changed their personal opinion of him but perceived what happened as breaking with a dominant workplace norm (drinks with alcohol), and this discredited his professionalism.

Thus, the workplace was presented by majority and minority participants as neutral in the sense that there were no diversity issues at stake and selection happened on supposedly factual and objective aspects such as competence and individual character. However, it also involved the normalization of majority professionals' physical, social and/or cultural characteristics as constituting the image of the good professional and of minority professionals as differing from those norms, as well as a hierarchical ordering between the two groups. A majority specialist expressed this by using "always" and "of course" and seeing the group as the normal standard to which the minority is the deviant:

> The minority should, of course, always adapt to the group.

The route to successfully qualifying as a professional therefore required identifying and being identified as normal instead of as culturally different. Although minority professionals generally seemed more at risk of not qualifying and being disadvantaged, while majority seemed to qualify more easily and hence were privileged, all participants engaged in these normalization practices – thus upholding the normalization and the potential selective privileging among them.

Discussion

Our findings showed how cultural diversity among professionals was narrated as a nonissue, explained away as irrelevant, celebrated as nice and uncomplicated (Ahmed, 2007), or addressed in an instrumental way as being useful only in dealing with difficult or minority patients. Thus, cultural diversity issues such as minority professionals' experiences of exclusion were obscured. Furthermore, cultural diversity issues were declared invalid in a work context by presenting professionalism as unrelated to or even adversely related to and incompatible with cultural identity. Because professionalism, and determining whether someone qualifies as professional, was represented as neutral, objective, rational, context-less, and individual, all differences between professionals became individualized and labeled as variations in personality characteristics. However, strong ideas existed on what constitutes a good professional and who fits the norms. Professionals were thus identified as either normal or different, which created a hierarchy between professionals that was subsequently normalized by the dominant narrative on diversity and professionalism. Thus, cultural diversity was stripped of its structural situatedness and seen as individual, apolitical and independent from social hierarchies and power dynamics. Therefore, normalization of the selective distribution of privilege and disadvantage (i.e., inequity among professionals within the organization) could not be challenged.

We will now look more closely at how normalization practices took place and how they connect with the concept of the ideal worker norm. We discuss the reproduction of the unequal distribution of privilege and disadvantage as well as the process that prevents this distribution from being addressed. Subsequently, we will discuss contextual aspects and the meaning of our findings on normalization for critical diversity theory and future studies.

Normalization of the ideal worker norm

Our study showed how normalization happened through downplaying cultural diversity by framing it as being about patients only. For the professionals, difference was emphasized as something "we all have or are," that is, cultural diversity was relegated to individual difference. Framing took place via emphasizing the "positive," the nice and uncomplicated aspects of cultural diversity, such as food and festivities, while downplaying the "negative," such as minority professionals' experiences with exclusion, and reframing these as unintentional or misunderstood. Normalization was further enacted through the framing of professionalism as neutral. Qualification as a good professional was emphasized as being based on objective and rational factors. And differentiation between professionals was presented as being based on personality differences only, while the importance of emotional, social, and cultural connection between professionals was downplayed. Particular language use such as the expressions "of course," "just," "always," and "normal" added to the normalization of these narratives on cultural diversity. These discursive practices represented a dominant narrative that cultural diversity as well as social and political issues of minority inclusion and equality are not at stake in the workplace (see also Ahmed, 2007). Through the enactment of these practices, professionals disciplined themselves and each other into adopting this narrative, hence the narrative became reproduced as well as normalized (Foucault, 1989, 1982).

However, in an alternative narrative, cultural diversity *was* at stake. Cultural diversity was incorporated into professionalism norms regarding who qualified as professional and what constituted normality and difference (e.g., no headscarf vs. a headscarf, respectively). These exclusivist norms played a role in professionals' inclusion. The alternative and dominant narratives both informed each other. The dominant narrative veiled the existence of the alternative narrative in everyday interactions by disarming its logic, countering that we are all the same and emphasizing that cultural diversity is not relevant because professionalism is the only thing that matters. The alternative narrative reinforced the dominant narrative by normalizing its logic, narrating that we are *not* all the same as those that are – seen as – belonging to a minority culture, ethnicity/race, or religion *may* not be able to fit the norms and *may* be less or unprofessional. Together the discursive enactment of these narratives normalized the idea that professionals are all measured against exclusivist norms regarding cultural sameness and difference. This, however, is not an equitable process for majority and minority professionals.

Besides the formal, official criteria on professionalism (the skills and competencies of the dominant narrative), implicit criteria, that is norms on professionalism existed (the "good professional" of the alternative narrative). Adding conceptualizations of the ideal worker in our analysis helped reveal the potential effects of these exclusivist norms in the academic hospital workplace and show how they translated into privilege or disadvantage for professionals. Originating in the field of gender diversity, the norm of the ideal worker – often seen as dominant ethnicity, white, middle/higher social class, fit, heterosexual, young and male – affects careers differently depending on the professionals' socially and personally acknowledged (dis)similarity with this organizational prototype (Ghorashi & Sabelis, 2013; Van den Brink & Benschop, 2011). This ideal seems particularly at play in academic healthcare because of existing tendencies for homogenization, uniformity, and conformity to "fit into the white coat," which are supported by professional claims on neutrality and objectivity and, hence, scientific legitimacy and status (Beagan, 2000; Wear, 1997). Essed (2005) calls this a "cloning process." The existing pressure to fit the norm of a particular kind of professional and the subsequent normalization process are strongly present here and are built on patriarchal, individualistic, principles-based components and a division between the patient as "the Other" and the professional as "the Self" (Bleakley, 2013; Wear & Aultman, 2006).

Indeed, the ideal worker norm in our study seemed to correspond with majority norms in which both majority and minority professionals were engaged. Majority professionals fitted in more easily than their minority colleagues. This agrees with earlier studies in the academic hospital that indicated that minority professionals have to prove themselves against a standard image of a professional that is based on majority norms and risk standing out in a negative way (Leyerzapf & Abma, 2017; Leyerzapf et al., 2015; Verdonk et al., 2015; Leyerzapf et al., 2018; Van den Broek, 2014). Our findings showed how implicit power worked and was dispersed in the norms, culture, narratives, and discursive practices of this setting, thus making it "invisibly" (re) produced by all and difficult to circumvent (Foucault, 1989, 1982).

Understanding a structural hierarchy between difference and sameness

Normalization was enacted by professionals in different ways, yet all included a reification of difference and sameness. Difference was reified as either a problem concerning – difficult – minority patients or as nice addition (being "multicultural"/minority food or festive traditions) and a useful tool (minority professionals as cultural interpreters) but not primary to the work practice. Sameness was reified in professionalism as the normal, natural Self and equated with all (assumed) majority professionals and the norm worker ideal from which all (assumed) minority professionals deviated. The reification of difference and sameness was based on a simplistic understanding of cultural diversity in which difference was equated with minority workers, or those "culturally diverse," and constituted a static, essentialized cultural Other inherently different from the "normal" Dutch Self (i.e., those qualifying as same). Thus, the reification of difference and sameness springing from the limited understanding of cultural diversity implied not only a dichotomy but also a *hierarchical ordering* of professionals at the workplace (Ghorashi & Sabelis, 2013; Ghorashi et al., 2015; Nkomo & Cox, 1996; Ostendorp & Steyaert, 2009; Zanoni et al., 2010). As this fundamental hierarchy formed the core of being (considered) professional, professionals had little space to criticize it or its consequences and, moreover, worked to normalize and reproduce it.

Professionalism in academic healthcare and equality-as-sameness

The normalization we saw is supported by international discourses on professionalism in academic medicine that focus on attitudes and behaviors "that can be taught, modeled and evaluated" (Wear & Aultman, 2006, vii), and by discourses in healthcare and society in general that put predominant value on assessment and evaluation (Kipnis, 2008). Internationally, professionalism holds its dominant position because of its conceptual vagueness and legitimized claim to neutrality and objective truth (Van den Brink & Benschop, 2011). In academic healthcare, professionalism constitutes something that can be managed and controlled as neutrally objective, rational, and apolitical, but it has inherent associations with masculinity and individualistic, principles-based thinking that excludes doubt and uncertainty (Beagan, 2000; Bleakley, 2013; Taylor, 2003). However, this professionalism-asneutral can have very real exclusionary outcomes (Razack, Maguire, Hodges, & Steinert, 2012; Wear & Aultman, 2006).

A further contextual aspect that supported the normalization our study found is the strong norm of equality as constituting cultural sameness in Dutch organizations and Dutch society in general (Essed, 2002; Ghorashi & Sabelis, 2013; Van den Broek, 2014). It stems from the sociopolitical ideal of equality in the Netherlands and a firm belief in Dutch society as democratic and meritocratic (Essed & Hoving, 2014; Van den Broek, 2014). According to Ghorashi (2014), however, difference is tolerated as long as appearance and conduct are "same" and do not challenge the status quo ("*passive* tolerance"). Recent discourses on Dutch superiority over Others – especially non-Western Others and, in particular, assumed Muslims – seem to involve the normalization of racist expressions in society, because the dominant normativity of equality-as-sameness prevents racism from being acknowledged as a real social pattern (Essed & Hoving, 2014; Essed & Trienekens, 2008; Wekker, 2016). Similar mechanisms for normal-

ization practices may be present in other northwestern European countries as well: the professionalism rhetoric is internationally established, and studies in countries such as the UK and Sweden indicate existing ideologies of equality-as-sameness, albeit in the contexts of sexual and gender diversity, respectively (Söderberg & Nyhlén, 2014; Willis, MaegusukuHewett, Raithby, ö Miles, 2014).

Strengths and limitations

Interviews and participant observations provided a dynamic understanding of how issues were enacted in everyday interactions. They enabled critical awareness of the multiple roles of participants in practicing normalization, as well as that of the researchers in "stepping into," questioning and writing about these workplace realities. The research and the researchers' presence on the wards surely affected how participants dealt with diversity. Because our study involved naming invisible interactions and experiences and exploring sensitive topics, such as the – possible – exclusion of employees, confidentiality was an issue throughout the research. This study was limited by privacy concerns (for the participants and the participating wards), which prevented us from providing detailed reflections on context and on – differences in – participants' positionings and (self-) identifications. Furthermore, this study also confronted the researchers with the issue of (their own) whiteness in research (Chadderton, 2012). As a white conducting researcher, it proved difficult to address reports and observations of exclusionary, racist interactions without confirming the hierarchical reification of difference and sameness and thus adding to the normalization taking place, while also trying not to compromise the research.

Normalization in relation to critical diversity theory and future research

Our findings make clear that future research and projects directed at change toward inclusion of diversity in organizations should focus on the unsettling of normalization as this is the core of the praxis of inclusion/exclusion. Earlier studies have advocated for critically addressing normalization (Ahmed, 2007; DiAngelo, 2011; Fletcher, 1999; Van den Broek, 2014; Wear ö Bickel, 2009; Wear, 1997). Our study showed how normalization is at play and is enacted in situations where there is a disconnect between "talking" diversity and "doing diversity" and that are perceived as unsettling for the organizational status quo. By analyzing the empirical praxis of normalization, our study illustrated how normalization practices constitute an *active* performance of "unseeing" social hierarchies and unequal distribution of privilege and disadvantage and its impact on – minority – professionals at work. They not only entailed a covering up of the power imbalances in professional workplace norms, but also 'deactivated' the – potential – arguments and motivations to address inclusion/exclusion and the need to strive for a more inclusive and equitable workplace culture by declaring these arguments and motivations as invalid. Other critical diversity studies stressed how agency of minority professionals is inherently ambiguous and contentious as they need to "manoeuvre" discursive spaces of power and make "trade-offs" between identity, career and social change (Van Laer ö Janssens, 2011, 2014, 2017), and how majority professionals are crucial in normalizing differences and broadening competency norms to establish equality, especially in larger, hierarchical organizations (Janssens ö Zanoni, 2014) – such as in this case the academic hospital. We share the emphasis these studies put on the burdening experience of ex-

clusion of minority and the need for majority leaders to further organizational change, however, we believe structural practice change requires an integral starting point that focuses on the restraint on agency of *both* minority and majority due to normalization.

With our study, we have shown how majority and minority professionals are all "complicit" in normalization and dealing with inequalities is hence not a matter of redistribution of quantifiable privilege/disadvantage but about a certain quality of social relations. Unsettling normalization, i.e. "re-seeing" inequalities and "re-enforcing" the performativity of diversity management, can only happen when all involved first of all recognize and acknowledge their shared participation and interdependence in power structures, and subsequently practice shared responsibility in the process of change (Medina, 2013). We build on the existing critical diversity theory by researching the specific, namely traditionally hierarchical, context of the academic hospital workplace, and illustrating how here the agentic potential of minority professionals or those relatively disadvantaged is bound with that of majority professionals or those relatively privileged and that they therefore have to work together to challenge social hierarchies and enable transformation. To unsettle normalization, redress power imbalances and make academic healthcare structurally inclusive and equitable, professionals in the hospital need to engage in critical and reflexive "courageous conversations" (Acosta ö Ackerman-Barger, 2017) to rethink professionalism norms, thereby explicitly addressing tacit sources of inequality and exclusion.

To consolidate theory on normalization from a critical, discursive power perspective, we suggest further empirical research in other academic and peripheral hospitals in urban and rural areas within the Netherlands and internationally. Discussions of the parallels and differences in health professionals' narratives and experiences of diversity linked to intersecting identity characteristics other than race, ethnicity, religion, and culture, were beyond the scope of this paper. New research should use an intersectional approach that works from cultural/ ethnic/racial diversity but also involves aspects such as gender and social class, and discusses their joint roles in normalization and the unequal distribution of privilege and disadvantage. Research in different geographical, professional, social, and political contexts could investigate how ideologies of sameness, exclusivist discourses, and white privilege are contextually related to normalization (DiAngelo, 2011; Leyerzapf et al., 2015; Verdonk et al., 2015; Wekker, 2016). Critical reflexivity about – normalization of – whiteness in research settings and among the researchers should be part of such studies (Chadderton, 2012).

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De norm hier is dat je
nooit over je twijfels,
emoties en kwets-
baarheid spreekt.

The norm here is that you never speak about your doubts, emotions and vulnerability. Inspiration lunch in 2013 with students, teachers and the director of VUmc SMS to talk about diversity, inclusion and the curriculum. On display are '*krentenbollen*' with butter, typical Dutch food. Photographer: Kevin van der Brug.

Critical incident IV - Sweet white girl?

November 2017, in another academic hospital

The first question when my presentation is done. The lights are bright and I'm hot. My last thank you and contact slide is open. I think I had a truthful, urgent, important story -one that is new to most people in this group. I hope I provided a new perspective to things. Talked about what is at stake, what matters in a clear, connecting voice. I hope people will recognize what's at play, recognize it in themselves. There are people listening to whom I look up to, who I hope will see my intentions. I hope everyone understands me, that they get my point, are convinced. That they'll share my urgency. I'm not sure, but I feel I did my best, I did good. I'm satisfied. At least I told the truth. Now it's up to them.

That all sounds very sweet, he starts. It's very nice, you have a nice story, he says. But why don't you talk about discrimination, about racism? Why don't you name it? Why do you speak about exclusion, micro-aggressions, normalization? These expressions, these interactions are racist...

I'm glad you bring that up, I say.

I feel my heart in my throat. It skips a beat and my stomach clenches. I feel the heat in my face.

And then I continue to explain, to defend, to re-direct, to re-claim. What I see, hear is certainly about discrimination, I say -and I do not use the word racism. I give the example of the physician who told me that he was often met with 'jokes' of his colleagues about camels since they thought of those in relation to him and his Moroccan roots.

I look into the public with an expectant and meaningful look. Reactions are shock, indignation, anger, dismissal. It's what I feel as well. Yet, there is also silence, discomfort, people shuffle, shift in their chairs. And then -ridicule and laughter filled with all these emotions.

I realize I'm almost laughing myself. I cannot help it. I have trouble keeping my face in check as people are pulling up the corners of their mouths. I see people start to smile-smirk-grunt -and they dismiss it all. This is funny. This is not about them. This is unacceptable, incorrect, we all recognize it and of course it's not something we, any of us would do. I didn't foresee this. It goes so quick. What happens here? This is not funny at all.

I am split. I want to be acknowledged and be strategic -I do not want to harm my professional-personal relation with these people, with this depart-

ment. I want to be accepted, included, belong to these people opposite me. Do I want to be seen as nice? No! Not nice! I want them to take me seriously. I want them to feel responsible, to see their responsibility in upholding inequality, in veiling, silencing, normalizing it with ideals and dogma's about equity and with talks about nice, happy things and with calls to keep a positive outlook because as long as you're negative about things, you make problems and won't get rid of them. I want that they take their responsibility. And I want all to see that I take mine.

Yet we laugh. And create distance. Put a safe distance between us and the people who would say such a thing, would make jokes like that. Put a comfortable distance between ourselves and our discomfort. So that we don't have to feel it anymore –responsibility, complicity. Never mind my intentions, bringing up this example in this way, reacting to this question in this way, I provided space to normalize social hierarchies, to discard racism again.

I am uncomfortable. I feel cold. And I sit down.

While the next speaker talks about bias and prejudice, how it's largely unintentional and unaware, something we all do –human nature, and people sit –I sit comfortably listening, I build my argument, think my apology. I hesitate to use the term discrimination as often the experiences I would like to bring across become bogged down in a discussion about was it discrimination yes or no. I do use the term racism in trainings and talks... I should have made explicit that my example was an example of racism.

And I realize I am uncomfortable talking about discrimination and racism when there are not white people present. I remember myself in class, the only black student in a group of white students and as the topics are diversity issues and inequality and I feel all eyes of the white students slowly dart towards the black student, I try hard to not *only* look at the black student –simultaneously trying to look at him like I look at all other students. And I remember a workshop on racism and white innocence and that I cannot refrain from locking eyes with one of the few not white people present and cannot stop myself for trying to nod-smile in an encouraging, reassuring way. I feel responsible when there are not white people with a migrant background present. I don't want them to be urged to bring in arguments, proof for racist and discriminatory experiences, I want to protect them from others, white people, terming racism an opinion, from having to explain why it doesn't really matter if it was in fact meant as racist or only 'accidentally' so... I want to be acknowledged by black people, people of colour. Let them know that I know this might be about their life, yet also that I see them as an individual, unique person, not a representative of a group. I want to be perceived as an ally.

Someone who is white yet means well and is not to blame, someone who is nice. I try to do all this and be relaxed and comfortable. But I'm not. It feels strained, forced, unnatural, counterintuitive. I wonder if it looks that way. I am ashamed. I realize that I feel more comfortable talking to a white public. Then I do not feel so much discomfort, shame, frustration, anger, guilt, sadness when people say that black people can be racists too. It's when unsafe things are safely at a distance, fit in a quote, in a story line. I feel limited, inadequate as a white researcher. I am just the storyteller, telling about other people's experiences – they become abstract in a blink. I want to talk *with* other people. I don't want to talk about people who experience racism as victims of oppressors. Of people who don't encounter racism as oppressors. Yet as I aim to talk about how normalization of inequality is the air we breathe, I just re-create the hierarchies that are there, create a hierarchy between myself who explains to those who do not get it... so that I can go home with the comfortable feeling that it's not me. That it's up to them now.

I feel compressed. The air I breathe is too thick. My emotions too heavy. And I am disappointed in myself. I feel soft. My story too fuzzy, too friendly, too abstract, not forthright enough. I want to talk to the man who asked me the question. Show him that I'm not afraid of critical questions, that I value those. I want to show him that I don't want to smooth over, whitewash things, that I'm angry, aware, that I care, that I know I'm privileged... I want to be thought of as a researcher who has a contribution to make. I'm scared that he thinks I'm not. I feel vulnerable. Why is it so difficult for me to ask what there is to laugh about a person who is being signified by camels? I'm scared that I'm not an activist. Yet also to not be nice any more. I want people to pause, to listen to and hear each other, be curious *and* critical, open towards new thoughts, questioning old ones. I want to do that myself. I try to be this. What do I want to ask him? If I'm getting there? If he still thinks I'm a nice person?

He gets up as the presentation is still going on. No chance to talk to him anymore.

Project with the student committee D.O.C.S. (Diversity. Openness. Culture. Students.).
Photographer: Lina Issa, Art Partner.

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

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Abstract

In this chapter, we explore how normalization of exclusionary practices and of privilege for seemingly same professionals and disadvantage for seemingly different professionals in academic healthcare organizations can be challenged via meaningful culturalization in the interference zone between system and life world, subsequently developing space for belonging and difference.

This nested case study focuses on professionals' narratives from one specific setting (team) within the broader r esearch and research field of the Dutch academic hospital (Abma & Stake, 2014). We followed a responsive design, conducting interviews with cultural minority and majority professionals and recording participant observations.

In the Netherlands, the instrumental, system-inspired business model of diversity is reflected in two discourses in a cademic hospitals: first, an ideology of equality as sameness, and second, professionalism as neutral, rational, impersonal, and decontextual. Due to these discourses, cultural minority professionals can be identified as "different" and evaluated as less professional than cultural majority, or seemingly "same," professionals. Furthermore, life world values of trust and connectedness, and professionals' emotions and social contexts are devalued, and professionals' desire to belong comes under pressure.

Diversity management from a system-based logic can never be successful. Instead, system norms of productivity and efficiency need to be reconnected to life world values of connectivity, personal recognition, embodied knowledge, and taking time to reflect. Working toward alternative safe spaces that generate transformative meaningful culturalization and may enable structural inclusion of minority professionals further entails critical reflexivity on power dynamics and sameness–difference hierarchy in the academic hospital.

Introduction

Parallel to the increasing diversity of society, academic hospitals worldwide focus greatly on how to include diversity, particularly cultural diversity, in their work forces and organizations. Diversity management generally entails human resource policies aimed at recruitment and selection of cultural minority professionals. These policies connect with what is described as a business-case scenario in which diversity is intended to realize organizational goals such as increased innovation, effectiveness, and efficacy (Cox, 1994; Thomas & Ely, 1996). Diversity policies, however, often do not work as intended, showing little progress in organizational effectiveness as well as difficulties in recruitment, selection, and retention of cultural minority professionals (Holvino & Kamp, 2009; Thomas & Ely, 1996). Diversity management is characterized by an instrumental approach to diversity and criticized for ignoring work floor culture and structural inequalities in organizations (Ghorashi & Sabelis, 2013).

The instrumental character of diversity management fits formalized and standardized evaluations, assessments, and audit cultures, which have become increasingly decisive in policy and decision-making in organizations (Dahler-Larsen, 2012; Kipnis, 2008; Power, 1997; Strathern, 2000), and it is especially dominant within health care (Wear & Aultman, 2006). The combined instrumental and assessment-based perspectives within organizations can be seen as representing the concept of "the system," which dominates "the life world" of actual practices, the lived experiences and morally, emotionally laden interactions on the work floor (Abma, 2010, 2016; Habermas, 1987). System aspects such as rationality, objectivity, and fast, measurable outputs dominate in academic hospitals, where the hierarchical, mono-cultural fields of academia and medicine meet (Essed, 2005; Wear & Aultman, 2006). In the context of the homogenizing normativity of the academic hospital workplace, life world aspects such as emotions, time to reflect, social contexts of professionals, and values of trust and mutual dependability tend to be ignored, and therefore, inclusion of cultural minority professionals in academic health care is strained (Beagan, 2000; Essed, 2005; Sabelis, 2002; Sue et al., 2007).

In the Netherlands, two discourses characterize the approaches to diversity and reflect the imbalance between system and life world in academic hospitals. First, an ideology of equality constituting sameness, also present within Dutch society as a whole, exists within these organizations. Paradoxically, the focus on equality supports the norm that all professionals should profile as "same." This results in the normalization of evaluating cultural minority or seemingly "different" professionals as less competent or professional than their seemingly same, cultural majority colleagues, who qualify more easily as successful professionals (Leyerzapf, Abma, Steenwijk, Croiset & Verdonk, 2015; Leyerzapf, Verdonk, Ghorashi & Abma, forthcoming; Van den Broek, 2014). Second, the idea of (medical) professionalism that promotes the professional as a neutral, objective, rational individual without history, culture, and context renders cultural diversity of professionals and diversity issues in general irrelevant. These discourses, enacted in everyday practices, normalize unequal distribution of privilege and disadvantage in the academic hospital workplace. They result in professionals disciplining themselves and colleagues into disregarding emotionally challenging and "difficult" interactions

related to relative sameness and difference, and making experiences of exclusion and feelings of not belonging invisible and unspeakable (Ahmed, 2015; Leyerzapf et al., forthcoming).

In this chapter, we use the concepts of system and life world and their "interference zone" to gain more insight into practices of inclusion and exclusion of professionals on the Dutch academic hospital work floor. The interference zone is the space where life world and system intersect (Kunneman, 2005). Here, in addition to the "colonization" of the system over the life world, alternative processes of "culturalization" of the life world over the system can –under certain circumstances and conditions – be developed (Abma, Leyerzapf, & Landeweer, 2016; Kunneman, 2005). Professionals in academic hospitals do *sometimes* and to *some extent* take time and feel safe to share personal narratives at work (Leyerzapf et al., forthcoming). These culturalization practices, although marginal(ized), inspire connectedness and belonging and "space for difference" in the workplace (Ghorashi & Sabelis, 2013). As such they challenge inequalities and selective privilege and disadvantage in academic hospitals and enable structural inclusion of cultural minority professionals in these organizations.

Culturalization, here, has a positive connotation different from how it is used in Dutch culturalist discourses on (descendants of) migrants, in which migrants are designated as "the Other" and equated with an essentialist culture fundamentally different from and incompatible with Dutch culture (Duyvendak, 2011; Ghorashi, 2006). By using the concept of *meaningful* culturalization, we support a perspective on diversity that is sensitive to people's need to feel culturally acknowledged without being reduced to a fixed, essentialized category – different from the static, categorical, and polarizing way diversity is interpreted from a culturalist paradigm (Ghorashi, 2016). We use "cultural diversity" as encompassing intersecting aspects of culture, nationality, ethnicity/skin color, and religion, and when speaking of cultural minority professionals, we avoid the common Dutch terms "allochthones" and "autochthones," which are exclusionary and support culturalist discourses (Ghorashi, 2016). The purpose of this chapter is to explore how the status quo in academic healthcare organizations, that is, the normalization of exclusionary practices and of privilege for seemingly same professionals and disadvantage for seemingly different professionals, can be challenged via culturalization and subsequent development of space for belonging and difference. The case examples we present stem from participant observations and in-depth interviews with cultural minority and majority professionals on a clinical ward in an academic hospital in the Netherlands.

Culturalization as Transformative Process in Organizations

Our study design was inspired by responsive research (Abma, 2005, 2006; Abma & Widdershoven, 2006). Building on the work by Habermas (1987), Gadamer (1960), and Stake (1975, 2004), Abma in cooperation with others (e.g., Abma & Widdershoven, 2011) developed a view on creating dialogical spaces in healthcare organizations to further change toward more equitable, inclusive organizational structures and work floor practices. Following Habermas (1987), Abma (2010, 2016) perceived organizations as being formed by two different, competing logics, namely, the logics of the system and

the logic of the life world. The system is represented by formal, hierarchical organizational structures and characterized by functional reason and top-down-directed protocols, assessments, and other standardized, formalized means of control. Although systems provide stability, under contemporary social conditions many systems have become relatively autonomous, rigid, and uncoupled from the life world. Once uncoupled, system-thinking and functionality can dominate the life world of work practices in places where daily reality asks for pragmatic, diverse, creative, spontaneous, and emotionally involved interactions. Habermas (1987) coined the term "colonization" to describe the process in organizations and society in general in which the system, with a focus on strategic generation of efficiency and material/financial prosperity, is valued higher than and structurally overrules the life world. Because mainstream power bases and decision-making are located within the system, life world values such as solidarity, trust, and shared responsibility are repressed and hence possibilities for bottom-up, dialogically generated actions (Abma et al., 2016).

People are embedded in various life worlds. Key in Habermas's (1987) understanding of life worlds is that, despite their diversity, there are common, universal components that include social integration, identity formation, and the reproduction of cultural traditions. If the system gets decoupled from the life world, precisely these components come under pressure, which can lead to feelings of fragmentation and alienation. Although the system is useful for practical matters that can be dealt with via money exchange or administrative regulation, it cannot answer issues related to life world components of social integration and belonging. However, there is an "interference zone" between system and life world where both logics struggle (Habermas, 1987). It entails the possibility of being temporarily freed from functional reason and strategic behavior and entering into deliberation (Habermas, 1987). As this zone is ambiguous, fluid, and open for contestation, it can inspire "communicative action," the strive for intersubjective agreement, mutual understanding, and transformation (Abma et al., 2016; Habermas, 1987).

Working from these insights, responsive research is action-oriented and strives for practice development in order to give voice to relatively marginalized, "invisible" groups and to redress social inequalities and inhuman situations (Abma, 2005; Abma, Nierse, & Widdershoven, 2009; Greene, 1997; Guba & Lincoln, 1989; Schwandt, 2002). Habermas's work has been criticized for being potentially exclusive, particularly for groups not familiar with the rational forms of deliberation he proclaims (Young, 1990). A more inclusive conceptualization of dialog therefore incorporates forms of expression as personal anecdotes, stories, diaries, photographs, movies, and theater (Barnes, 2008; Williams, LaBonte, & O'Brien, 2003) and involves reflexivity on the power relations and the privilege or disadvantage of different "stakeholders" within the research field (Young, 1990). Departing from a critical power perspective, responsive researchers focus on supporting balanced dialogs, where stakeholders gather as persons by highlighting alternative perspectives and agendas and bringing these "in dialogue" – face-to-face or otherwise – with more mainstream ideas to stimulate awareness and acknowledgment without fueling polarization (Abma & Widdershoven, 2011; Niessen, Abma, Widdershoven, & Van der Vleuten, 2008).

For practice development within organizations, Kunneman's (1996, 1998, 2005) concept of "culturalization" is valuable. As a counterprocess to colonization of the life world, it describes the bottom-up "trickling up" of morally and emotionally laden practices based in the life world to the system hegemony (Kunneman, 2005). Culturalization happens in the space where system and life world intersect, namely, the interference zone (Kunneman, 2005). We understand "space" here as more than indicating an imaginary location but as signifying a complex whole of physical/material, ideological, temporal, emotional, and social spatiality (Lofland, 2000; Meininger, 2013). This interference zone is where people meet as persons with names and faces, apart from their professional function and position. When professionals for example take time to chat and listen to each other in between chores, lived experiences and life world values can flourish and establish culturalization (Kunneman, 2005; Sabelis, 2002). It presupposes a space in which professionals feel safe enough to encounter each other and share narratives. Here then, professionals can experience social integration and belonging as well as the reproduction of various cultural traditions and identities that provide opportunities for "space for difference" to emerge (Ghorashi & Sabelis, 2013).

Establishing conditions for culturalization and development of these alternative safe spaces is not easy, because in practice, reflexivity and dialog often get distorted by time pressure and practical constraints. It requires a temporal suspending of general format and hierarchical roles, which is challenging in the context of an academic hospital with a lot of bureaucracy and hierarchy. Alternative safe spaces are created through the acts of delay (taking time) and epoché (suspending one's judgment temporarily) to create the necessary conditions for connection in encounters beyond the defining – and limiting – power of dominant, categorical discourses. In relation to cultural diversity, this means that not only subject positions but also organizational choices should be negotiated in a spatial–temporal niche that is not solely defined by culturalist discourses of Othering and the norm of sameness. In this niche, narrations come together from positions of difference to negotiate common goals and shared meanings and so establish equity (Ghorashi & Sabelis, 2013). Through this balancing act between sameness and difference, unreflective discursive positionalities are challenged and *meaningful* culturalization can emerge, connecting life world to system components and offering the opportunity to learn to handle diversity through dialog and reflexivity and acting, instead of through top-down management (Abma et al., 2016; Ghorashi, 2016).

To explore in depth the possibilities for developing a space for belonging and difference within an organization, we now turn to the everyday work practice in the academic hospital and to examples of contentious interactions and potential culturalization. We focus on the experiences and practices of cultural majority and minority members of one team to gain concrete, local knowledge and stimulate vicarious experience (Abma & Stake, 2001, 2014). We chose the nested case example of the team and their team leader because they seemed relatively successful in creating space for cultural diversity (Abma & Stake, 2014). The term "nested case study" denotes that we studied a bounded entity, in this instance a team within an academic hospital, and nested within this we studied another case, namely, the leader of the team. In research aiming for

practice development, contextual, in-depth descriptions of participants' narratives are valuable. Participant narratives enable naturalistic generalization and knowledge transfer, and they support a sense of urgency by revealing the "invisible" and articulating the "unspeakable," and thus they have educational potential, particularly for stakeholders within the mainstream (Abma & Stake, 2001, 2014).

Belonging and Difference within the Researched Team

Within the academic hospital existed the image of the team as "successful and diverse." Hospital professionals as well as team members mentioned the team's relatively high number of cultural minority professionals[4] and that it functioned well – whether despite or because of this was not clarified. Accounts from majority and minority team members stressed the cultural diversity as being normal, natural, self-evident, and invisible. A majority team member recounted: "A patient said a couple of years back, 'You [the team] are the example of the multicultural society.' I thought, 'Huh? Why?' But it is true. Only, it's so obvious that you don't see it anymore."[5]

Team members, furthermore, presented their team as an open, warm, and coherent group. In describing the basis for this connectedness, both majority and minority pointed out the need for "fitting in" and "clicking" with the team as a whole and individually. A majority professional said: "In our team it doesn't matter at all who you are or from what background you are." When the interviewer subsequently asked about an earlier-mentioned dismissed professional, the professional said: "Oh, but that is personality! ... You have to fit in of course!" Team members indicated a social and cultural match or similarity and the experience of an emotional connection with team members and the team's culture or norms as central. Simultaneously, fitting in and clicking with the team were presented as essential components of professionalism concerning individual disposition *disconnected* from cultural diversity issues. An example was a professional who, when asked to reflect on what is important for working in the team, did not attribute great value to cultural diversity but emphasized personality by stating: "Here you have to have a hands-on attitude." This seems a politically desirable perspective, fitting the instrumental approach to diversity management in the hospital, where personal history or context should not count.

Contrary to these system perspectives on professionalism and cultural diversity, the following situation recounted by a majority professional, Thea,[6] during an interview suggests that background and personal history of professionals *do* relate to feelings of connection and belonging in the team:

> The other day in the physicians' office, we discussed your research [indicating the study on which this chapter reports], and I asked everybody "Say, now, tell

[4] The professionals mostly used the term "allochthonous," commonly used in the Netherlands to designate (descendants of) migrants, particularly "non-Western" and non-white people; that is telling of the highly exclusivist and culturalist societal and political discourse on diversity and inclusion in the country (Essed & Trienekens, 2008; Ghorashi, 2010). For practicality, we refer to cultural minority professionals and cultural majority professionals as "minority" and "majority" professionals, respectively.

[5] All quotations from participants were translated from Dutch by the conducting researcher (first author).

[6] All participant names used here are pseudonyms in order to protect participants' privacy.

me where you were born." – Well, that was ... on Java, Indonesia, somewhere in India, I myself am from Amsterdam, and then there was [name x], and he is from [small village in the Netherlands, composed of the typical Dutch words "cow" and "dam/dike"] ... I say, "Well [name x], I don't know where that is, but that doesn't count!" [laughing] In between all those exotic places – this is sooo ... it is almost exotic too. [laughing]

In this example we see fitting in, connectedness, and belonging in the team are actively practiced and linked to the geographical origins of team members. This could be seen as an ambiguous reproduction of the dominant norm of "we are all different and therefore the same" – thus doing away with cultural diversity. However, told as a positive, joint-learning experience, it appears an example of a moment and space in which the background and roots of team professionals *do* matter. This seemingly new conversation topic sparked by the research stimulated a sharing of personal stories between colleagues and gave names and faces to people who commonly knew each other foremost as neutral professionals. A space emerged from the interference zone where the life world temporarily fostered culturalization and enabled feelings of belonging and space for difference.

A situation observed during one of the team's morning coffee breaks also showed that background and culture do play a role at work. In this example, Graca, a team member whose first language is Portuguese, admitted that "Graca" is not her real name. When Graca started on the team two years ago, she had introduced herself with a simplified, shortened version of one of her family names as, in her experience, most people in the Netherlands have difficulty with her real first name. Where she had earlier not felt secure enough to tell this, she now decided to be open. As she explained about her real name, a silence fell over the team, followed by surprised, incredulous exclamations. Team members realized they did not know this colleague as well as they thought and apparently wanted to; at that moment they collectively expressed that a name is crucial to *knowing* a colleague as a *person* and seeing her as fitting in and belonging to the team circle and identity. The system logic of being depersonalized, decontextualized professionals was disrupted here, and life world values were acknowledged, enhancing each team member's sense of belonging at work.

In Rabia's account, we see that, for individual professionals, the practice of fitting in, connecting, and belonging is dynamically, dialectically connected to team identity and culture. It appears a social, relational, and emotional everyday process. Rabia, a Turkish-Dutch team member who wears a headscarf, said she likes this team as opposed to the team she worked in before, which she described as "very white" and "having an *eilandjescultuur*," a Dutch expression designating a categorical team culture in which team members group into subgroups with little social contact between them. She stressed that, while she could not be "herself" at all there, her current colleagues are interested in who she is, what Islam means to her, and what her values and views on life are: "People here ask each other 'How do you celebrate Christmas?' ... You can learn from each

other." It also mattered, she added, that in her earlier team she was the only professional considered "allochthonous," and she was still a student and thus held a dependent, low position within the professional hierarchy. In her former team she really "didn't dare to say anything" or speak her mind. Reflecting on her current team, she said:

> We started together – that's special. We laugh a lot. There is room to give each other feedback. Both positive and critical. ... In the beginning, we evaluated how things were at the end of each day – questions were reviewed.

Hereby she pointed out that she felt safe at work due to the fact that she and her colleagues were invited to be vulnerable and open and to learn from this. Rabia's account points to experiencing safety, belonging, and connectedness within the team, to personal and professional appreciation and acknowledgment, and to simultaneously being able to be different *and* a part of the team. These team practices appear to have stimulated meaningful culturalization in the workplace, instead of essentializing cultural diversity.

Later during the interview, Rabia reported that she is also tired of and annoyed by team members who keep asking her questions about her religion, religious practices, and lifestyle:

> Always those same questions about my beliefs. ... But are you allowed to do this now? ... And what does your family think about that? At a certain point I had completely had it.

Similarly, during a coffee break in the Islamic fasting month, several majority team members asked an Islamic, minority male colleague about fasting: "Don't you have to fast? – Oh, you don't do that/join the fasting. But is that allowed? – Oh, you make up for it/do it later. Is that possible then?" Although Rabia started out by telling how she felt at home and appreciated in this team, she also made clear that these recurring remarks and questions make her feel different and set her apart from the team in a negative way. This points out that sharing personal stories is new and potentially painful in a professional context where neutrality and sameness is the norm, as it breaks with routine and scripted behavior. It suggests a tension for perceived *minority* professionals between belongingness, which thrives on personal narratives, on the one hand, and personal questions, which are felt as stigmatizing due to earlier experiences and accumulated pain in existing social hierarchies, on the other. Also, it indicates that *majority* team members may be uncomfortable and try to resist when normalized, exclusionary, system-based professional norms that privilege sameness as opposed to difference get challenged. It shows, first, the centrality of emotions in culturalization, as the interference zone is not static but ever-contentious. Second, it points to the need for meaningful culturalization as cultural acknowledgment without essentializing culturalism, that is, away from dominant diversity discourses.

Another minority professional, Sabrina, dealt differently with experiences similar to those of Rabia. Sabrina reported that she is met with inquiring questions on her religious, ethnic, and cultural identity on a day-to-day basis. Colleagues as well as patients are

not able to put a conclusive label on her – she has a typically Dutch first name, wears a headscarf, has a brown skin color, and speaks with a Surinamese accent. She stated she saw questions and comments on her identity and background as "only natural and normal"; they are an opportunity to tell about herself and the "positive side" of Islam and Muslims and to make contact with patients and bond with her colleagues. Is Sabrina's positive interpretation of the remarks and her not feeling uncomfortable or threatened related to the fact that she holds a senior function and presumably senior status in the team? Does her professional status allow her to feel part of the team anyhow, whereas minority colleagues in lower positions feel vulnerable in their belongingness? Or does her " nontypicality" as a minority allow her to come across as a *person* with a unique story, different from seemingly "typical" minority colleagues encountering prejudice?

Graca and Sabrina approach the questions about their background as a way to relate to their colleagues and patients, feeling recognized as a person with a particular (hi)story and thus being able to belong *and* to differ in positive ways. Rabia interprets these *partly* as depersonalizing and dehumanizing her, reducing her to being a part of her cultural identity, identifying her as not the same and thus not fitting in. Considering system and life world dynamics, the situations in which (majority) team members pose questions to Rabia and Sabrina are all examples of spaces in which personal, life world aspects concerning belonging and difference trickle into the work sphere, where it is usually system aspects of professionalism and sameness, that is, team members as neutral, diversity-free, and "faceless" people, that matter.

The Team Leader: A Role Model for Meaningful Culturalization?

To delve further into interference zone interactions as alternative safe spaces within the team, their potential for meaningful culturalization and their relation with belonging and difference, we now discuss the case of the team leader.

When reflecting on the team and team culture, majority and minority team members mentioned the team leader, Florence, as central to its success. They described the good cooperation, warm atmosphere, connectedness, and space for cultural diversity in the team as being enabled by her energizing, approachable, and empathic way of leading. As the team, consisting of about 30 care, administrative, and support staff, started out as a new ward in the hospital at the end of 2012, it was a "fragmented, noncoherent, patchwork" team according to a majority professional. Florence's open and caring leadership style, emphasizing the need for critical and open but considerate feedback between team members, made the team more unified and coherent. Florence is a role model for many team members. A minority professional said:

> [Florence] listens very well, she really takes your perspective. She doesn't yell her feedback through the corridors but speaks to you individually. There is absolutely no barrier to pass to visit her ... [to] tell her what's eating you, what's on your mind. When for example you have a small falling-out with a colleague, then you can count on her – such a person is [Florence].

Florence is a Surinamese-Dutch professional who has worked in hospitals for almost 40 years and is about to retire.[7] She described herself as "mixed" – her mother "white" and her father "black" – and therefore used to dealing with different cultures and communication styles. Earlier, she worked in a ward in the hospital of a traditionally highly hierarchical, male-dominated, competitive medical specialty with top medical and societal status, where she eventually became a leading professional. She recounted that, when she started working in that hospital, she was the first "dark-skinned" professional.

Originally, Florence did not want to become a team leader. However, her discontent with the way things were motivated her to accept the position. When she came home one day and told her husband about a patient with anemia who had to wait hours before someone came to attend, she realized that she wanted to change things. To make that happen she had to become a leading professional herself. She started in a shared position as team leader with a female colleague. Now she works four nine-hour days per week: "And I haven't been ill for a day since we started this ward one and a half years ago," she contentedly added. Nevertheless, she acknowledged that her work or work style is a "balancing act" with which she sometimes struggles. "Team members come to me daily to tell their story ... [and t]hey all expect personal attention," she said. Although she wants to give personal attention and "of course they do not come all at once," it stresses her somewhat.

Florence comes across as a low-key, accommodating, caring, and warm professional who has a democratic, motivating, and very conscious leadership style. This was underscored when she apologized for speaking so much and said that she hoped it would be of use for the research, and when she said she felt uncomfortable praising herself but nevertheless wanted to say that she was very proud of her team. Florence's account showed a clear, conscious vision for the team and team member interactions, one that valued relationality, belonging, and openness. She said that she feels she has influence as a team leader, and thus she tries to be a role model and transfer her ideas and values onto the team. Florence described the team as very amicable and fraternal – something she deliberately strives for:

> It's important that they form one team, one whole. ... It is important that everyone is open toward each other, that everybody feels that he or she is included/belongs, and that everybody feels and can feel comfortable and okay within the team.

Florence's cultural and racial background is rather absent from her story, and when she first talked about the team culture, cultural diversity in general was not presented as a relevant topic. This is reflected in that, when someone from outside the team said to her that her team is such a "diverse one, since *you* are there and [name of leading physician, male, black, with a refugee background] is there ...," she said that she started thin-

[7] We discussed this case example as well as the whole paper with Florence as a member check. She said to recognize the described experiences and narratives as truthful and fitting her own perspective and that of her colleagues, and gave her consent after some minor alterations and additions in the text.

king: “Yes, that might be right compared to other wards in the hospital.” She appeared surprised, as if she does not think about the team in this way. She later confirmed this, stating that she does “not really pay attention to cultural diversity” and that cultural diversity is “not really an issue” between team members. Here, she seems to support the norms of sameness and professionalism that fit the system hegemony in the hospital.

However, cultural diversity and difference in the team resurfaced as Florence stressed that the team culture is not about skills that can be learned but has to do with personal and social things “that you have to have ... it has to fit.” She gave the example of an Afghan-Dutch professional who now performs really well in her team but previously felt isolated and discriminated against on another ward in the hospital. As such Florence acknowledges that the expression “fitting in” as used in the context of professionalism based on system logic does not suffice. Instead, she refers to life world aspects of feeling at home, safe, valued, and connected and indeed emphasizes cultural background in relation to belonging and inclusion in the team. In another example she told, Florence was motivated by these values and actively encouraged them. She recounted about a team professional with a minority background, Sabrina (mentioned earlier). As a student Sabrina did not feel at all at home at work; she did not connect with fellow students and teachers or the work culture in general. Florence supported Sabrina, encouraging her to keep on trying, and proudly reported that, after finishing several school levels, Sabrina completed her management education, became a mother of two children, and now holds a senior position in the team. With this, Florence pointed out – her awareness of – how feelings of belonging and positive, personal recognition of difference go hand in hand. It shows her successful balancing of sameness and difference and of meaningful culturalization that is different from essentializing culturalism.

In relation to some team members lacking language and writing skills, Florence voiced her ideas and values on giving and receiving feedback. Grammatical errors in patient reports are addressed by team members among themselves, she said: “But they don’t make it personal. They say, ‘We have to pay attention to the reports because there are so many language errors in them.’ So that happens in a nice, correct way.” Thus, according to Florence, it is a team norm that mutual, collective responsibility is emphasized and valued more than individual responsibility. This connects with Florence’s set of rules, which foremost includes “no gossip or slander,” in which feedback should “not only focus on the negative but focus on the positive in your views about the other person,” and where “the tone makes the music,” a Dutch expression that means that what you say, and what you want to achieve with it, is largely determined by the manner you say it in – indicating that people should be positive, respectful, and understanding toward each other.

Regarding responsibility, it appears that Florence wants to set an alternative example to common practice in the hospital. She pointed out that there exists “a culture of always-keep-on-going” in the organization. She clearly relates to and is aware of system logic within the organization, its colonizing tendencies and the time-pressure culture that can inhibit connection between professionals. She tries to counter this by stressing life world values such as taking time to reflect, repair bonds, and evaluate

within the team, and for example encouraging team members to leave the ward for their breaks:

> Otherwise it all just continues. ... Physicians come storming in to ask things or give assignments. They don't pay attention to whether a professional is on break. ... It's everybody's own responsibility here [the hospital].

Florence herself tries to set an example by helping out in the ward when it is busy or taking over a weekend shift when someone is ill. This, she stressed, to her is normal and the only way to do her job properly and be a good professional. By answering the phone at the administration desk when the administrative staff wants to have a meeting together, or washing patients when there is nobody else to do it, she consciously tries to create a specific work mentality and atmosphere and bring the team together. She said this is in part because "her heart is with the patients," and she wants to keep connected to them. Furthermore, Florence emphasized that her connection with the team members is very important: by helping out on the work floor, tensions between team members and with patients can be prevented, and she is able to notice things going on in general. By being on the actual work floor, she is also trying to be approachable for all team members. With this, she is in fact going against hospital policy and management norms. She said that during performance evaluations with her superiors, she repeatedly receives feedback that, as a leading professional, she should spend less time on the work floor and focus on management and delegation of work tasks. She stated, however:

> If I have to change [my current time division between the office and work floor], if I can't leave my office anymore ... if I have to be behind a computer all the time – I'm gone!

To professionals and management in the hospital, Florence, being a nonwhite team leader of a so-called multicultural team, is a diversity role model. This fits an instrumental perspective on diversity and system logic because the reference is commonly used to showcase the success of the organization's cultural diversity policy and does not relate to Florence as a person. In part, it is a positive example since cultural diversity is being related to professionalism; but Florence's being seen as a diversity role model is also a form of colonization since the norm of sameness remains unchallenged. Florence does not present herself as a diversity role model, nor do the professionals in her team perceive of her as such. Instead, they see the caring, relational, and personal way of being a professional at work – in which they balance sensitivity to personal difference with attention to connectedness and belonging – as the only right way to be (a good) professional. As such, they implicitly argue against the limited, normative professionalism as neutral and impersonal. They enact a process of meaningful culturalization from below that unsettles imposed hierarchical and essentialist discursive culturalist positionings. Accordingly, they generate an equitable, inclusive space for belonging and difference, a life world alternative to the existing system norms in the organization. Florence's approach to work is embodied in how she actively acknowledges the roles of emotions, tensions, the need to take time to talk and reflect, and the need for belonging in her

team. She implicitly criticizes the system norms of professionals as neutral, detached, depersonalized, and decontextualized. Without explicitly proclaiming diversity issues, she creates spaces for *minority* team members as well as majority team members in the interference zone between system and life world, where they can feel safe, connect, belong, and be different. Florence's role is not uncontentious or easy – her supervisors see a risk in her way of working, and she herself experiences tension in upholding her alternative work practice. This signals the struggle within the interference zone, which can be transformative but also takes effort.

Establishing Meaningful Culturalization and Structural Space for Difference

From our study in the academic hospital, it becomes clear that, on the one hand, minority and majority professionals are involved in keeping up exclusionary norms and the normalization of sameness and a "diversity-free" professionalism that selectively privileges and disadvantages professionals. On the other hand, these professionals engage in creating alternative safe spaces of belonging where more space for difference exists. We see that these dialectic practices happen in the interference zone between life world and system. Although these dynamics are ambiguous, we believe that, *when supported and facilitated by leading professionals*, they can create opportunities for practice development toward inclusion of minority professionals and an inclusive, equitable work floor practice in healthcare organizations.

In the team we discussed, colonization, as understood by Habermas, was apparent in the norms of being professional and neutral, that is, being without personal (hi)story and cultural background and always being in a hurry – productive and efficient. These norms sometimes led to feelings of fragmentation and alienation, particularly for minority professionals. However, culturalization was also visible. We saw that team members, occasionally and temporarily, took time to share their personal backgrounds, to connect and learn about each other's cultural traditions and personal values. The team leader was important as a role model setting the tone. She deliberately paid attention to everyday work floor interactions and was attuned to emotions and tensions between team members. She took time to hear team members' personal stories and worries, encouraged shared responsibility, and urged team members to take time for themselves to reflect away from the fast-paced culture of the ward. Team practices supported a shared commitment, mutual connectedness, and belonging in the team and stimulated meaningful culturalization. Nevertheless, the existing colonization tendencies made this a contested situation. This tension is reflected in the story of the team leader who struggled in balancing the normative expectations of being a manager with her values on what makes a good leader. Her story shows the precariousness of the culturalization process.

These complex interactions in the interference zone show how space is closely linked to time. Sabelis (2002) described the concept of time in organizations as undervalued and dominantly understood as "clock time." She signals that in a globalized world of "acceleration," where "time = money," "([c]lock-) time increasingly determines what people do and especially how they do it" (Sabelis, 2002, p. 2). In daily practice on the work floor, however, broader and more complex understandings of time(s) exist, and

professionals feel that "deceleration" is a way to retain their "human standard" (Sabelis, 2002). Sabelis shows how the clock time of the system (*chronos*) and time in the life world (*kairos*) establish a central dynamic in organizations that influences space for difference and inclusion of cultural diversity (Hermsen, 2010; Sabelis, 2002). In a clock time-organized workplace, representing system logic, professionals' performance is driven by the need to act and predominantly assessed according to how many tasks are done in how short a period of time. These tasks are usually highly specialized and clearly delimited, and they require strict targeted action. In such a fast-paced culture, professionals' rhythm, personal time, and relational, caring involvement in work practices – requiring spontaneity, shared commitment beyond preset tasks, reflection, responsiveness, and time – are problematic (Sabelis, 2002). Lived time, reflecting the life world, involves time and space for reflexivity, namely taking the time to gain awareness and from that find the space for substitution, alterity, and contiguity, that is, to meet and connect with others (Ghorashi & Ponzoni, 2014; Waldenfels, 2011).

It is in this alternative time/space that professionals can ask each other questions, which cannot be answered straight away, the so-called slow questions (Kunneman, 2005). Thus, reflexive dialog can develop, and professionals can experience contiguity, alterity, and epoché (Ghorashi & Sabelis, 2013). In our study, we saw this reflected in team members who cautiously opened up to each other to exchange personal stories, majority team members who asked about beliefs and values of minority colleagues, the team leader who was prepared to take others' – her team members' – perspectives, and minority and majority team members who experienced the team as a safe and connected circle where they felt "at home." These "delayed interspaces" (Ghorashi, 2014a) enable exchange on the parallels and differences between professionals, recognition of mutual equity, and critical dialog on dominant norms and practices within the organization (Ghorashi & Sabelis, 2013). Here, an open, intimate, and *safe* space can develop as people temporarily encounter each other "horizontally," from person to person, all unique and different, and difference is stripped of its categorical-essentialist and hierarchical meaning equating social and cultural power relations (Ghorashi & Sabelis, 2013).

These alternative safe spaces typically spring from the interference zone where system and life world, uncoupled and hierarchically ordered yet both a reality in actual work practice, "collide," and their frictions become tangible; it is here that their opposition becomes an issue. As the interference zone is contentious and noninconclusive, the culturalization is also ambiguous and temporal. Space for belonging and difference can be built when, instead of mistaking safety with the exclusion of discomfort, emotions and tensions that are unavoidably at stake are acknowledged instead of "glossed over," and critical reflexivity is enacted – comprising also a coupling and dismantling of the hierarchy between system and life world. In this way, *meaningful* culturalization can develop as an alternative to imposed, hierarchical, and essentialized culturalism – namely, a balanced, appreciative focus on personal difference incorporating equity, instead of normalization of inherently exclusionary sameness. Pain or resentment and discomfort are necessary here as these embodied experiences foster awareness. This "pathic knowledge" points in the "right" direction by raising critical questions about dominant

structures and practices (Van Manen & Li, 2002; Waldenfels, 2004). Davis (2015) emphasizes that embodied, pathic knowledge is difficult to put into words and needs translation but is essential to gaining understanding and awareness of "how restrictive social norms and dominant hierarchies and exclusions get played out at an affective level" (Davis, 2015, p. 6). We saw this reflected in the minority professional voicing her ambiguity about questions related to her background, which simultaneously made her feel at home and as if she belonged in the team while they also set her apart as different. Her ambiguous feelings constituted pathic knowledge and a clear yet tentative beginning of culturalization. Awareness of alternative safe spaces as both embodied and contested is crucial because precisely these characteristics make those spaces potentially transformative.

The small, unpredictable, "difficult" events with agentic and transformative potential are what Kunneman (2005) calls "places of effort/ pain." As long as diversity management is approached in a rational manner, it has a colonizing, instrumental character and cannot be successful. Practice development is generated from life world logic via meaningful culturalization but involves a reconnecting with the existing system. This means infusing organizational structure and policy with the value of professionals' sense of belonging at work as well as the value of difference, namely, including different perspectives and being able to be "different." Structural inclusion of minority professionals requires explicitly addressing the power dynamics and sameness–difference hierarchy that are ignored in business-case perspectives on diversity, system logic, and culturalist discourse. Within the organization we studied, the organization's leaders would have to acknowledge the discrepancy that the team and their team leader experience between meeting professional norms and the desire for engaging in a relational, caring work praxis (Tronto, 2010). Management needs to acknowledge that life world aspects like emotions, embodied knowledge, lived time (*kairos*), reflexivity, safety, and belonging are essential in (understanding the complexity of) diversity management, and together with professionals, look for ways to facilitate their integration and recognition in organizational life. When those involved meet the "places of effort/pain" (Kunneman, 2005) with reflexivity, and they "slow down" and find "the language" (Ahmed, 2007) of sharing personal narratives (Abma, 2003; Ghorashi, 2014b) or art (Verdonk, Muntinga, & Issa, 2016), the academic hospital can develop into an equitable and inclusive place to work.

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IK VOEL ME
KWETSBAAR
WANNEER IK VEEL VAN
MEZELF LAAT ZIEN

I feel vulnerable when I show a lot of myself. Project by Lina Issa with professionals in VUmc that raises questions about normativity, Othering and vulnerability in the work place. Photographer: Bart Majoor, Art Partner.

Critical incident V - Hiding myself, finding voice

February 2018, medical faculty

I'm tired and my body can't handle coffee any more -my heart is in my eardrums, my head, my fingers, my arms, my stomach. Shaky, jittery. It doesn't stop at night. I feel like a stretched rubber and can't find rest.

I'm in a morning meeting with two of my supervisors discussing the general discussion of my thesis. I've already scanned their comments. Still, their question strikes me in the face.

Where are you in this?... Who's speaking? To whom? What's your voice? Why are you hiding behind the literature?

My smile feels strained. I know they're right. I feel something is missing. I feel I can do better. But I feel I cannot connect to the level within me that's needed to do this. I feel pressurized.

You've already done the thinking, my supervisors say. You're already there. It's about finding that voice and putting it out there.

I feel hollow. And there's something else. They say this to me? I know I have voice. It's what I've brought with me all these years, what I shared at department meetings, what I put into my presentations, I'm always fully present -I try to be. Don't they know?

I worked so hard. Long, irregular hours. Invested my whole private live with my work, until I couldn't see a difference between the two. Invested my whole self. There's no space to do better. I'm tired of self-improvement. I want to take time for myself. Be considerate. Compassionate.

...

I take some time off. Slowly the rubber feels less tight and my fingers stop crawling on the inside. I stop doing yoga and meditation and it helps to lose the feeling that I'm disciplining myself, that I'm in a regime that makes me go on -no matter what. It helps to start seeing, and feeling again.

I think about the feedback of my supervisors. Yes I felt indignation. I felt attacked. I was angry. Why couldn't they be nice to me? But I knew they had pointed out what I had sensed: I was on the wrong track. I needed to change lanes. Because that was where I wanted to go. I had just missed the fork.

I feel grateful and start to explore the depth, the hollow... And slowly I disappear into the cognitive vortex, my running wheel again.

Distance. That's what I felt in my discussion. And authority, my supervisor added, the all-knowing researcher writing from the almighty standpoint of nowhere[8]. I feel hurt. That's not who I am! I don't like hierarchy. I don't enforce it. Do I?

I need to develop voice in order to impact. But isn't that centring the white voice again?

I feel I am at a distance, feel I am a professional through distance, feel safe by it. I have extended conversations. Papers under review, 5 minute questions at conferences, reading an inspiring paper and quoting it in my next... Indirect dialogue. It's in the language as well. Writing in academic English I feel less. It's not where I live in. In this language, where I get stuck in between academic words, it is easy to remain abstract. Remain comfortable. It's where I feel pretentious and a pretender as well. As soon as I start reflecting on my own position, try to deconstruct my social position and my relation to others around me, I feel inappropriate. I'm taking up too much space.

I know and feel I need to bring myself in in order to be critical, reflexive, yet I don't want my texts to become an apology, asking for forgiveness of people who have experiences of discrimination and racism. Proof of my good intentions – a performance of good whiteness. I am scared others will think they are. Think I'm unqualified, unworthy. Can I say something? As a white researcher? I'm ashamed I have this doubt. And I feel guilt for centring myself. I want to serve purpose. Not make myself feel better. And I'm afraid of what will happen... what if my voice isn't right, that I'm ignorant... Or, worse. What if I feel it all. And then do the wrong things. What if I do nothing?

...

After a presentation, June 2018. I'm so glad that you do this, that you talk about this, tell this story! This is exactly what I've experienced, what I'm experiencing now for 35 years. This is so important. This is great.

She's overwhelmingly open and appreciative. She tells about the academic health care team she's been working in for all those years – her colleagues are fine. But. She tells how her white colleagues without a migrant back-

[8] Harding, S. (1992). After the Neutrality Ideal: Science, Politics, and "Strong Objectivity". Social Research, 59 (3): 567-587.

ground tell her that they like her as a colleague. But. That they would go to their Dutch colleague instead of her when they want to discuss worrying family matters.

There it is again. I am shocked, indignant, raving angry, so sad, so ashamed, I feel guilty and I want her to stop being thankful.

I feel naked. Like people can see through me. All these emotions. I want to go to a happier place.

But. I don't want to be indifferent, I am not indifferent. I care. I want to be response-able.

And I realize I need my anger. My emotions keep me on track. No stamina there. This is my moral compass. E-motions enable me, spur me into action, let me engage with painful realities, engage with others, care with them, instead of for. My pain listening to this professionals' story points me in the direction of the purpose I can try to serve. My discomfort makes me feel-know what is unjust and that I'm privileged as I lack this lived daily reality. That I'm complicit as I am part of the world that enables and upholds these practices. And that I can engage with these realities by acknowledging them as being about me as much as anybody else. My anger, proximity can be constructive.

But I need distance as well. Time to reflect. It's what is necessary for reflexive, slow questions. Connect hart with head. I don't need to suffer for that.

What do I have to lose? I benefit from researching diversity issues. Why do I want to be safe? Do I stand a risk? I could work in other places. I have little to lose. And yet so much. What if I have no impact at all?

If I tried to be a fly on the wall, I failed.

I started out looking at others. I ended up looking at myself. Now I want to connect. I'll let go of the assumption that I have to know what's going on, have to provide answers. I will doubt, waver, ask, listen, question. Myself. And engage with others from this point. Take a step aside and back, make space for difference and engagement in my heart and head. I hope I dare.

Inaugural address of prof. Gerda Croiset as director of VUmc SMS in 2013. 1 hour intermezzo, a performative intervention with the 150 people in the room by Lina Issa and Art Partner. Photographer: Yvonne Compier.

Chapter 7 – General discussion

> How we understand and respond to the world comes from how we see the world; to change the world, we have to change our perspectives towards the world as well as towards ourselves (inspired by Robin DiAngelo, 2011).

Central research questions and aim of this thesis

The focus of this thesis is cultural diversity in academic medicine and health care. I began with the following central research questions:

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?
2. What conditions are necessary to enable the transformation of academic health care towards the inclusion of students and professionals with cultural minority backgrounds?

My main objectives were to provide empirical and theoretical understandings of cultural diversity issues and inclusion both in medical education and on the work floor of the academic hospital, specifically relating to the lived experiences of (future) professionals with cultural minority backgrounds. I aimed to formulate the conditions for transformation towards the inclusion of cultural diversity, especially the inclusion of (future) professionals with cultural minority backgrounds (Chapter 1). The first three studies included in this thesis focused on cultural diversity issues in the undergraduate and postgraduate phases of medical education and on the experiences of students and professionals with cultural minority backgrounds (Chapters 2–4). Subsequently, two studies on cultural diversity issues in the academic hospital addressed the experiences of medical, nursing, paramedic, and supportive professionals with cultural minority and majority backgrounds (Chapters 5–6). In five descriptions of critical incidents located between these chapters, I reflected on my own personal-professional development towards critical, embodied awareness of structural inequality, how I am implicated in that inequality, and how I can work for change. In this final chapter, Chapter 7, I will discuss my main findings as well as the critical incidents. Furthermore, I will discuss what I have learned about transformation in academic medicine and health care and how these lessons apply to both practice and research. I will use the term ‘professionals’ to refer to all students and professionals regardless of their cultural background. When I want to talk about students or professionals separately or those with a cultural minority background or those with a cultural majority background, I will make this explicit. I will use the terms ‘minority background’ and ‘majority background’ to signify people with cultural minority and cultural majority backgrounds, respectively.

Main findings

There are three main findings that relate to the first central research question of how professionals engage with cultural diversity in academic health care. First, cultural diversity is seen as being about other people and therefore not about what is considered normal or ‘the norm’. Second, the professional is presented as neutral. Third, an ideal

worker norm exists that is normalized by the first two findings. These interlinked findings point towards a praxis of normalization that creates and maintains an unequal distribution of privilege and disadvantage in the academic hospital and in medical education. This praxis obstructs inclusivity in academic health care and contributes to the reproduction of inequities in the distribution of academic and professional opportunities. In some instances, however, professionals have been able to breach normalization and the dominant norms to experience cohesion and connection.

Over the years it took to complete my research, I came to see that the processes exposed in these main findings are also at work in my own research and that they tie in to my own role and positioning as a researcher. I came to understand how I am very much a part of the lived realities I witnessed in the research settings, as well as of their continuation. This emergent insight and acquired level of reflexivity compelled me to include the five critical incidents in this dissertation. I realized that for transformation towards inclusion to come about, researchers themselves had to change, as well as research practice and academia in general. Reflecting on those critical incidents and on what I learned about the particular conditions under which professionals experienced inclusion helped me identify conditions for transformation. It also helped me to think concretely about what I could do differently and to start doing that, rather than just writing about what others should do. Below, I will explain the main findings, including how they relate to the research process and my own position, and subsequently will answer the first central research question.

Cultural diversity is about the Other

Whenever and wherever cultural diversity was addressed in the research settings and within the research and research team itself, the subject was not about normal daily practice but about exceptions in routines and about behaviour and interactions perceived as different from those perceived as normal, natural and regular. Specifically, professionals in the research settings foremost presented cultural diversity issues as being about professionals with a minority background and not those with a majority background. Often, cultural diversity was presented as being about the Other, and it was professionals with a minority background who experienced the Othering. Othering points to a specific dichotomization and hierarchization between people, namely between a group or groups of people considered deviant from and structurally less valued than the Self group, which is perceived as the natural, and thus generally implicitly assumed norm (Fabian, 2014; Ghorashi, 2014a; Said, 1979).

I encountered different manifestations of exclusion and Othering. Othering is involved when 'difference' becomes linked to negative connotations. It can take the form of micro-aggressions and everyday racism, that is, repetitive stigmatizing or racist remarks generally wrapped up in 'humour' and therefore difficult to identify and object to (Essed, 1991; Sue et al., 2007). In Chapters 2, 3 and 4, professionals in academic medicine who have a minority background generally experienced themselves as being 'different' from their peers, teachers and clinical supervisors with a majority background, and those people also approached them as being 'different'. This points to a lack of inclusivity in medical education, and it could potentially explain the exclusion experienced by professionals

with a minority background. However, the chapters also demonstrate that these professionals were met with Othering as micro-aggression, such as when fellow students and teachers with a majority background ridiculed their objections to mixed-gender physical examination training. They experienced Othering, stereotyping and stigmatizing during working groups meant to address cultural diversity issues and raise awareness on cultural and personal bias, but during which fellow students' and teachers' attention mostly circled around minority students. Another example is the case histories that presented essentialist accounts of patients with minority backgrounds. Students and teachers with a majority background seemed to assume students with a minority background shared the identities and cultures of the patients; thus they expected these students to explain the patients' harmful and unhealthy conduct presented in the cases. When the 'difference' of professionals with a minority background became a reason for others to question their professional performance and to relate their performance to being 'not Dutch', Othering took on a more explicit form than micro-aggression and began to show racist tendencies.

Chapters 2, 3 and 4 show how Othering as everyday racism happens when professionals with a minority background are primarily seen as representatives of a static and homogenous group that has less value than and is compared negatively to 'Dutch' identity. Such Othering seemed especially present in relation to professionals assumed to be Muslim. Female Muslim students who wore headscarves seemed to constitute the racialized Other (Chapter 3). Cultural identity was equated with ethnic and religious identity, and everything non-Dutch was generalized as being equally different. Implicitly, then, everything Dutch was generalized as being equally same; in-group differences were left out, as were intersecting identity aspects such as gender and social class. Therefore, even though skin colour or race was not named, a hierarchical dichotomy between Dutch/non-Muslim and non-Dutch/Muslim identity manifested itself along the lines of white and not white professionals. Based on this partly racialized Othering, professionals with a minority background experienced social segregation between themselves and others with a minority background on the one hand, and those with a majority background on the other hand.

Chapters 5 and 6 show that the different manifestations of exclusion and Othering also appeared on the academic hospital work floor. Foremost, cultural diversity was perceived as having to do with 'different' patients – those with a minority background, specifically those groups portrayed as 'difficult' – and sometimes with Muslim patients presented in a stigmatizing way. It was also associated with difficult situations that differ from and disrupt routines and take (too) much time. Professionals with a minority background were associated with patients with a minority background and were therefore seen by colleagues and executives as useful to have on the team because they would be able to deal with this specific type of patient. This seems to be a reflection of the implicitly held notion that minority professionals are less suited than majority professionals to participate in regular everyday practice.

Furthermore, cultural diversity was presented by professionals either as constituting fun things that are nice and 'harmless', such as foods and festivities different from those perceived as normal, majority Dutch culture, or as things that are difficult, problematic,

time-consuming and non-routine. This caused professionals with a minority background to experience exclusion, and it points to a lack of inclusivity in the academic hospital. However, Othering, or a specific hierarchization, was also at play because the 'difference' of professionals with minority backgrounds often came with the implication of that 'difference' being less valued than the dominant norm(s). Moreover, this Othering appeared to happen along racialized lines because the professionals who were implicitly assumed as 'same', and thus automatically valued as 'the Self', were white and were represented as 'Dutch', while 'the Others' were not white and were represented as 'not Dutch' (Chapter 5). Professionals with a minority background experienced that their need for trust, social connection and belonging was under pressure because of these Othering practices. Some professionals with a majority background also missed having trust, social cohesion and connection, and one team leader applied a conscious leadership style to spur these aspects (Chapter 6).

In the course of the research process, I began to realize that I was implicated, along with my supervisors and colleagues, in the exclusion of professionals with a minority background and in the lack of inclusion found in the research settings. I had mainly associated cultural diversity with situations and interactions that I recognized as different and had directed my research focus towards people with backgrounds different from the majority's and my own. As such, I had confirmed my own automatic assumptions on what is normal and had normalized dominant norms. I had also used terms such as 'allochthone background', which were common in the research settings yet were also used in essentialized, polarized, culturally exclusivist and sometimes racist debates in the Netherlands generally.

In the critical incidents, I describe how I became aware of how performative and power-laden these terms are and how using them is a contentious, ambiguous act. Although I knew in an abstract sense that I was implicated in making and normalizing these norms and was thus a part of the structures of inequality and racism, I started to recognize this in an embodied way. Reflexive writing throughout the research helped me to acknowledge my emotions of pain, anger, shame and guilt in reaction to the narratives of participants, and it helped me acknowledge how these emotions identify my identity and position as a white, female researcher. As I hope to make clear in the following paragraphs, this personal-professional critical awareness subsequently helped me to deconstruct and identify ways to challenge the normalized hierarchy between the Other and the Self and to help develop inclusivity in the research settings and beyond.

The (good) professional is neutral

Professionalism in medical education and the academic hospital work place was (re) presented as a neutral, depersonalized, rational, objective or objectifiable, and measurable quality. Acting and looking in ways that followed those professional norms was presented as the only way to be and to be considered a good professional. Moreover, professionalism was perceived as being oppositional to cultural diversity because, in fact, what was perceived and presented as 'neutral' was having a majority background and being white. Having a minority background appeared to endanger one's ability to meet key aspects of professionalism. Therefore, these professionals needed to prove

themselves. Before discussing what underlies the norms of the neutral professional in the next section, I will first describe professionalism norms and explain how I reproduced those norms myself by trying to be neutral, rational, distant, impartial and objective.

According to participants, their teachers and clinical supervisors in medical education, who generally had majority backgrounds, made it clear that professionals had to adapt to the curriculum and the expectations for educational and clinical practice. For example, they asked professionals to take off their headscarves or to change to smaller or lighter-coloured veils, suggesting that these items would not be compatible with being good physicians (Chapters 2, 3 and 4). Participants told about how teachers argued that they treated everyone the same, that students could only become good physicians if they performed every educational activity in the same way as all other students and that doing so would be the only proper way to study medicine (Chapters 2 and 3). Teachers and clinical supervisors also deemed having an accent as not compatible with being professional (Chapters 3 and 4). Moreover, clinical supervisors with a majority background questioned whether professionals with a minority background would be able to be(come) good professionals because of their cultural background and assumed lack of assertiveness (Chapter 4).

Often, the appearance, language/accent and professional or social conduct of professionals with a minority background was identified as coming from their 'non-Dutch' identity and as such signified their Otherness and deviance from the Self and thus their subsequent devaluation as professionals (Chapters 2, 3 and 4). In general, when professionals talked about cultural diversity, it was never about 'Dutch culture' but only about non-Dutch, 'allochthone' culture(s). This signals that people from the majority are not acknowledged as having a culture, which in fact means that culture is 'invisible' because it constitutes the norm (Chapters 2, 3 and 4). Besides indicating exclusion and a lack of inclusion, these examples also point to racialized Othering in relation to performance and professionalism.

Compared with the preclinical undergraduate phase, Othering of professionals with a minority background began to be more explicit starting in the clinical undergraduate and postgraduate phases. This appears to signal the centrality and impact of the professionalism norms in academic medicine in the (re)production of the hierarchy between professionals that fit the Self and those that constitute the Other. As they advanced in the education program and moved closer to actual work practice, professionals apparently needed to inhabit and represent a particular worker identity in order to qualify and be included as good, competent professionals.

The norm of professional neutrality in the academic hospital was reflected in the fact that executives and other professionals with a majority background said that they treated everyone the same, and therefore, cultural diversity and having a minority background was not really important or relevant at work (Chapters 5 and 6). In general, the emotions, tensions, interactions and social backgrounds of professionals received little attention (Chapter 6). Executives stated they only made distinctions between professio-

nals based on professional quality, claiming that professional quality is neutral and that it is and should always be the leading criterion for selection and evaluation (Chapters 4, 5 and 6). As in medical education, a minority background was presented by all professionals in the academic hospital as something 'different' and deviant from normal professionals, and cultural diversity was only about non-Dutch culture(s) (Chapters 4, 5 and 6). However, professionals with a minority background themselves said that their cultural background and identity had nothing to do with their professionalism, as the latter was independent from the former, and they stressed that they wanted to be evaluated on their professionalism only.

Thus, different from the students with a minority background, who upon entering medical school, were generally struck by being labelled as 'different', the professionals with a minority background in the hospital seemed to have incorporated the 'different' and 'same' dichotomy and to some extent participated in the (re)production and normalization of exclusion and Othering processes (Chapter 5). Parallel to this, the professionals said that they did not feel safe enough to share their experiences of Othering and the emotions it caused with executives or team members with a majority background (Chapters 4 and 5). Professionals with minority and majority backgrounds emphasized that all professionals within the organization were so different in (cultural) background and identity in their own ways that, in fact, they were all the same (Chapter 5). Nevertheless, some executives and professionals specifically stated that they wished they could talk with their colleagues, reflecting on and sharing stories about their social and cultural backgrounds, discussing their emotions and their well-being at work and in their personal lives, so they could feel connected to their work place and like they belonged there (Chapter 6).

Initially, I had also normalized the norm of the professional and professionalism as neutral. This is apparent in the fact that I could not find the words or did not feel I had the space to involve certain interactions and the emotions of discomfort they had triggered in the studies (Critical Incidents 1–5). Even while writing the critical incidents down, I still struggled to bring in myself. I felt embarrassed and insecure about bringing in my emotions, raising questions instead of providing insight, admitting to 'mistakes' and doubting knowledge, particularly *my* knowledge. But I slowly realized that the reason I felt awkward and had trouble finding my voice as a researcher had to do with professionalism norms as well, not only in the research context but in academia in general. As a junior academic, I felt it would be risky to bring in my 'vulnerabilities'. I would put myself at risk if I did not use my time well and did not conclude my thesis by providing answers, showing relations and establishing certainties to fall back on – as many academics with authority and power do. I felt the norm was to not waver and to not be (too) emotional, because doing so would weaken my professional authority. Worried that I would be considered unworthy of being a professional, I disciplined myself. I also felt I was being disciplined by my academic environment to reproduce and normalize the neutral-professional norm. And this left me feeling disembodied. I started to feel that something was wrong, that I was disconnected from myself as well as from the work and research practice I was engaged in. I realized that I felt I could not be a good researcher and a real anthropologist if I could not be neutral and open to everyone. While I wanted to

increase social justice, I had been trying to be seen as not belonging to or representing any social position or identity so I could be impartial, disconnected from and 'above' the social and political dynamics in the research settings and thereby be the best researcher for all the people I encountered. This is similar to physicians who think they need to be neutral, treating all patients as the same, in order to provide the best care, when in reality, good care requires taking into account the politics of skin colour, gender, and so on.

In a way, I had tried to be invisible, which is also how I gained entry to the research settings. In trying to be a 'fly on the wall', I was left with increasing feelings of discomfort. I realized I had tried to be a disembodied academic who criticized inequalities and wanted to challenge them *without* actually being involved in and sharing responsibility for these lived realities. As if my presence and the norms that I brought with me did not do anything, did not connect to privilege and disadvantage and shape my interactions with the people I encountered. As I had filtered away my emotions, I had also tried to filter away my complicity in (re)producing power imbalances and to filter away my social identity and position as a white female researcher in diversity studies. But in doing so, I had actually placed myself in a hierarchical position above the people I engaged with in the research settings, particularly those who were not white. Moreover, I now realize that by engaging in these normalization practices, I stood in the way of my aim to do something beyond mere words – to engage with people in practice, be actively involved and take responsibility. I disabled and disempowered myself from actually making a contribution to inclusion and equality.

The ideal worker norm, its normalization and its impact

Professionals in medical education and on the academic hospital work floor had a strong idea about what a professional is and how she/he looks and acts. In this image, the neutral professional overlapped with the normal professional and the good professional. The neutral professional is a representation of the 'ideal worker norm', an implicit, unnamed norm. This ideal worker norm seemed ingrained in the medical curriculum and medical education practice as well as in routines and work practices in the academic hospital; it was thus (re)produced and normalized in everyday interactions between professionals. It showed when professionals categorized each other as 'different' or 'same' compared to the norm. Some professionals could more easily adapt to the ideal worker norm and were perceived as better fitting it, while others had more difficulty adapting to the norm and more difficulty being perceived as fitting it. Hence, because those in the former group could qualify as (good) professionals more easily than those in the latter group, they were privileged, while the latter were disadvantaged. White professionals with majority backgrounds were categorized as 'same' and often as 'the Self', while non-white professionals with minority backgrounds were consistently identified as 'different' and often as 'the Other'. These categorizations often impacted the level to which they were evaluated as competent or not competent (enough), respectively.

Through this process a seemingly racialized hierarchy between professionals was created and reproduced. Professionals normalized the ideal worker norm and the hierarchy it (re)produced through two other norms: first, that cultural diversity is about the Other

instead of its being about the Self and about normal, everyday practices (Finding 1); second, that the professional and professionalism are neutral (Finding 2). While professionals 'measured' themselves and each other against this ideal worker norm, since they all wanted to be considered competent, the unequal distribution of privilege and disadvantage proved difficult for everyone to challenge or even acknowledge. I am implicated in the normalization of the ideal worker norm and the unequal distribution of privilege and disadvantage. For example, I selected participants based on whether I thought they would be considered 'different' or 'same'. Also, I did not want to acknowledge my own discomfort; I wanted to stay in my position of relative comfort and tried to ignore my whiteness and privilege and my complicity in the structures of inequality (Critical Incidents).

In the medical school and the academic hospital, the ideal worker norm could be seen in how professionals had to fit in and how they were selected based on how well they 'clicked' with others socially, culturally and emotionally. Similarly, it could also be seen in what qualities were mentioned in relation to not fitting in and not clicking with others, such as having a Turkish or 'allochthone' accent, having a 'different' (family) name, wearing a headscarf, going on holidays to a Moroccan town instead of going skiing, not drinking alcohol, being religious (i.e., Muslim). These selective associations made it clear that there was something *besides formal professionalism criteria* that professionals could deviate from and that could discredit them as an ideal worker. The looks, behaviour and identities of this ideal worker were generally not made explicit, which confirmed that these qualities involved automatic assumptions that are highly internalized and normalized (Chapter 5). This made white professionals and their perspectives generally visible in a positive way, while it made black professionals and those of colour and their perspectives generally (hyper)visible in a negative way.

The ideal worker norm became obvious as soon as its boundaries were transgressed and someone was identified as not/no longer fitting in and thus – potentially – not/no longer qualified, for example, the wearing of headscarves (Chapter 3), or the black physician who was regularly mistaken for the handyman by professionals in the hospital (Chapters 4 and 5). Professionals normalized the ideal worker norm and the subsequent hierarchy between the Other and the Self through specific expressions and terminology, such as using the words 'just', 'normal', 'of course' in relation to 'Dutch', as well as by *not* talking about what was included and 'Self-ed', yet explicitly addressing what was excluded, not normal, and Othered (Chapter 5). When, as part of this research, professionals discussed cultural diversity in their teams, some with a majority background realized that they knew little about the backgrounds and personal lives of colleagues who also had a majority background. Generally such conversation topics were reserved for colleagues with a minority background. They also realized that sharing personal (hi)stories could actually support cohesion and connectedness on the work floor (Chapter 6). Sometimes, when supported by executives, professionals were able to create horizontal, instead of hierarchical, and inclusive spaces in which it was possible to belong at work *and* be 'different' without risking social devaluation and professional disqualification (Chapter 6).

Thus, through the 'invisible' ideal worker norm, unequal opportunities in the educational practices and work place were explained away, depoliticized, and made inviolable. Moreover, the shared, collective responsibility of all professionals for keeping up these inequality structures became invisible. Whether the argument was 'we are all equal/the same, and therefore diversity/difference does not matter', or 'we are all different in our own, unique ways, and therefore we are all equal/the same and diversity/difference does not matter', or 'professionalism/quality is the only thing that matters, and it is neutral and has nothing to do with diversity/difference', the outcome was always the normalization of particular, exclusive ideal worker norms.

The critical incidents show that I gradually learned how deeply I was involved in the praxis of normalization and how difficult it was to actually 'see' and acknowledge Othering and racism, let alone to deconstruct and challenge them. I learned how I sometimes consented to the normalization of Othering and racism because I wanted to be comfortable; I wanted to be considered nice and accepted by white people with a majority background, that is, those who represented the norm and were in a relative position of power. I also consented because I feared I would otherwise compromise my research. I learned how my shame about being complicit as a white person and my fear that non-white people would not consider me nice (anymore) overruled my anger about the inequality I witnessed – and which I wanted others who were white with a majority background to see with me – and caused me to be silent and to confirm inequality. I felt that I lacked the language to really discuss or challenge exclusion, Othering and racism. I felt like I was running into a brick wall in trying (Ahmed, 2015), that my emotions were in the way and that I did not really know where I was heading or should be heading anymore. These frustrating, discomforting and disorienting feelings and moments (Kuper, 2018) have not left me since. They signify my ongoing awareness and learning process. However, as they unsettle me, they also help to unsettle the normalization I am both subject to and an object of.

I have started to ask the critical questions spurred by my emotions of discomfort. For example, questions about how my 'white innocence' (Wekker, 2016) and 'white fragility' (DiAngelo, 2011), that is, my relative ignorance and reluctance to consider and engage with racist structures, practices and thoughts, as well as the fact that I am often in rather segregated, privileged white spaces, are part of the wall of normalization that I walked into and tried to tackle. Realizing this, I have struggled even more regarding how to bring my white voice into this research and this thesis. I felt it was taking up too much space, space I felt I was not entitled to, space I felt should be taken up by people who are *not* white. However, I have also gradually started to understand how my emotions could be productive in supporting inclusion and equality. I now recognize how my feelings of shame and discomfort have stood in the way of my practicing empathy, taking the perspective of the other and experiencing contiguity and how they have left me feeling disempowered within normalized structures. And I recognize my anger and my guilt as the route to helping me acknowledge the ways in which I am complicit in upholding unequal structures that make my life generally easier because I am white, while they make the lives of those who are not white generally harder. These feelings are also the route to actually engaging with and relating to others in a horizontal, reciprocal

way – that is, sharing responsibility and daring to care *with* others instead of caring for or about them in a hierarchical way (Tronto, 1993; Zembylas et al., 2014). I used the term 'started' to describe this process because I feel it is and needs to be a continuous, ongoing practice if it is to establish a transformation towards inclusion. In addition, empirical and affective questions remain regarding how these insights can translate to a transformation in practice as well as in research.

Answer to the first research question

The findings described in the paragraphs above provide an answer to the first central research question of this thesis: 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? They support the conclusion that students and professionals with a minority background are structurally disadvantaged and not included in academic health care in the Netherlands, because of normalization practices. And, as became clear during this research, researchers who study cultural diversity issues and inclusion are very much a part of these normalization practices. Therefore, the findings lead to the conclusion that for inclusion and for enabling transformation towards inclusion, normalization practices in medical education and the academic hospital work place as well as in academia more generally have to be 'unsettled'. By this, I mean that for students, professionals *and* researchers to be able to address the unequal distribution of privilege and disadvantage, they need to acknowledge the existence of the ideal worker norm and the norms that cultural diversity is the Other and the professional is neutral. To be able to 'see' these norms, however, and subsequently critically review them, people must first acknowledge their normalization – that is, normalization is in the way of change. I have observed that under particular circumstances, such as by taking time and acknowledging emotions of discomfort in 'disorienting' interactions, normalization can be unsettled to such an extent that professionals experience equity and inclusion. In the next sections, I discuss what this unsettling of normalization could look like in academic health care *and* in research in order to provide an answer to the second central research question: What conditions are necessary to transform academic health care towards the inclusion of students and professionals with cultural minority backgrounds.

Transformation towards inclusion

This section discusses how stakeholders in academic health care and in research could work towards inclusion. My original objective in this thesis was to stimulate the inclusion of cultural diversity and specifically of students and professionals with a minority background. However, as the answer to the first central research question has made clear, the primary focus should not be on the inclusion of others in the sense of 'fixing' these others, or requiring them to adapt to the norm in order to fit in (Schiebinger, 2008). Instead, the focus should be on what we – stakeholders in a particular context – recognize as the norm, what we include automatically and invisibly, what we undervalue and exclude without questioning and how we can work against the inequality that springs from all this. Thus, we need to fix everyday practice, which includes realizing that cultural diversity issues not only matter in relation to patients but also to professionals. Stakeholders in organizations can jointly start the transformation of everyday

practice by:

a) 'fixing the numbers', namely, diversifying the (future) work force,
b) 'fixing the institution(s)', namely, critically reviewing organizational structures and practices regarding inclusivity, and
c) 'fixing the knowledge', namely, critically reviewing the knowledge base of these structures and practices (Verdonk & Janczukowicz, 2018).

Below, I will explain how these three fixes are interlinked and must be addressed in parallel to trigger transformation. One cannot work without the others. With each direction for transformation, I will provide examples of learning experiences from my own research and from developments within the research settings during my studies.

Fixing the numbers

It sounds like a rather obvious recommendation: diversify student populations, the work force and researchers in academic health care and academia in general. Despite the efforts of organizations in health care and beyond, the cultural diversity of professionals, especially those in the higher echelons of health care organizations and in the teaching staff of medical schools, is still limited, as are the promotion rates of professionals with a minority background in these contexts in general. Similarly, yet less often addressed, is the fact that academic researchers are generally white with a majority background (Ghorashi, 2018; Wekker, 2016). The fundamental tenet of a critical diversity perspective is the value of social justice, and this is also the foundation of health care and education systems in a democratic society. Fixing the numbers is necessary to fulfil this central democratic pillar of equal access to work, education and care. Diversification of professionals is also important because students need role models, including ones with similar backgrounds as their own – be they similar in (combinations of) gender, culture, religion, sexual identity, and so on. Furthermore, it is fundamentally important to have multiple, diverse perspectives and voices represented in education and work in order to spur new, innovative, transformative ways of thinking and doing as well as to counter social fragmentation and polarization (Medina, 2013).

Ghorashi (2018) describes how societal and political debates in the Netherlands are becoming increasingly characterized by fragmentation and polarization due to the Othering of migrants and refugees, especially those who are visible as Muslims. As debates have become more hostile and aggressive towards these Others, social groups have shown an increasing tendency to homogenize, to exclude those considered different from themselves. Ghorashi (2018) discusses three subsequent stages in these developments to show why they are worrying and to suggest necessary steps to help redirect them. First, because people stay within their relatively homogeneous comfort zones, they become unaccustomed to dealing with diversity and with perspectives, lifestyles and appearances different from themselves. One example is what Ghorashi calls 'clumsy language' – language use that can unintentionally offend or harm others. Second, social fragmentation and closed-off comfort zones cause people to lose the ability, the sensitivity and the willingness to identify with others and connect across social categories in spaces where people from diverse backgrounds generally meet, for example, schools or the work floor. Third, because of this social disconnect, people

eventually lose trust in others. They can feel threatened by others and by diversity and can become hostile and even aggressive, which can lead to social conflict. Diversification of the (future) work force is essential in countering the first stage of disconnect and thus the development of the next stages.

I first started to get a sense of how I was implicated in normalization and how my social identity and position of privilege related to the lived inequality of others as I noticed my own 'clumsiness' in talking about cultural diversity issues and particularly racism (Critical Incidents). My intense feelings of shame, guilt, anger, pain and powerlessness led me to create a distance between myself and the people whom I assumed experienced disadvantage. I therefore had difficulty taking the perspective of the other and practising empathy (see also the documentary *Wit is ook een kleur* by Sunny Bergman, 2016[9]). Engaging with people who experienced, talked about and dealt with disadvantage, exclusion and Othering in different ways, as well as with people who did not have these experiences, helped me to connect to different perspectives and, from this connection, to deconstruct normalization practices. Besides my encounters with people in the research settings, this included encounters with colleagues and working together with medical and health sciences students with minority and majority backgrounds. Conversations with my supervisors helped us all recognize the layeredness of difference/sameness and the persistence of the normalization of Othering, which helped us envision how these are ingrained in (our own) everyday verbal and bodily interactions. On the one hand, for example, we shared experiences of difference as first-generation, female critical academics, such as getting comments on our appearance, being alert to whether we are considered professional and discussing (c)overt strategies to counter (c)overt questions about our competence. On the other hand, we experienced relatively different positions of privilege and power as three of us are white with a majority background and one of us is a person of colour with a refugee background. Thus, we are somewhat differently implicated in taking responsibility for normalization: for the white researchers, this would specifically require critically examining our white privilege and our tendency to 'un-see' our unearned advantages in life, as well as our inclination to stay in the relatively homogeneous comfort zones of academia (at work) and our private lives and to keep on 'swimming in the ocean of whiteness' (DiAngelo, 2011).

Because my department has attracted some teachers and researchers with a minority background, my supervisors and I were further sensitized in normalization and its impact on academic careers as we witnessed how these colleagues were questioned by students and other colleagues regarding their professional positions and competence. However, working with these colleagues also facilitated opportunities to have informal discussions about experiences of exclusion and Othering from diverse perspectives. It therefore enabled us all to recognize the multiplicity of privilege and disadvantage and to see inequality as dynamic and contextual. I saw that both formal dialogue meetings with professionals with minority and majority backgrounds organized within the research and informal chance conversations between these professionals during the study period could help to temporarily breach the norm that professionals are neutral and should

[9] Retrieved on 21-10-2018 from https://www.vpro.nl/speel~VPWON_1281152~wit-is-ook-een-kleur-2doc~.html

all be the same and to move beyond essentialized ideas of identities and hierarchical sameness/difference categorizations (Chapter 6). In fact, these temporary reflexive encounters spurred horizontal space for difference and feelings of connectedness and cohesion that supported the inclusivity of the work place. Some professionals with a majority background stated that listening to colleagues' experiences of exclusion had 'opened their eyes' and had shown them aspects of life they had not known existed. For professionals with a minority background, opening up about their personal (hi) stories helped them be acknowledged as a unique person by their colleagues while it also helped them connect with and belong to the team. Thus, I learned that bringing people with diverse backgrounds together in education and the work place as well as in research practice triggered personal transformations in stakeholders and sparked relational transformations in all those involved as critical awareness and reflexivity, mutual understanding and connection grew (Abma et al., 2019; Davis & Vaughan, in press; Kajner, 2013; Medina, 2013).

Fixing the institutions

Fixing the institutions is necessary because to facilitate diversifying of the (future) work force in academic health care and academia, interventions need to be supported by formal organizational structures, protocols and routines (Verdonk & Janczukowicz, 2018). From the different studies in this thesis, it became clear that having professionals with a minority background on your team is not a guarantee for diverse, open, innovative spaces to develop. The inclusion of professionals with a minority background requires that parallel attention is given to their recruitment, selection, promotion and retention. It thus requires a focus on their well-being and on everyday organizational practices and structures. Furthermore, critically reviewing the organizational structure is necessary because organizational policies and practices are never neutral; they are always socially and politically enacted, constructed and embedded, and thus, they will be always be more favourable for some than for others, generating either privilege or disadvantage for different groups. If organizational structures remain static and uniform, they will unquestionably be exclusionary, as different stakeholders in an organization hold different positions and have different needs: for example, an older male professional may require different things compared to a younger female professional. Thus, to fix the numbers and fix the institutions in order to ensure equal access and education and work place equality, we, as a society, need to step away from treating everyone equally and step towards working on equity via paying attention to differences – in addition to similarities – in experiences and needs (see Hammarström et al., 2014, for a discussion of the difference between equality and equity in relation to inequality). Moreover, to achieve quality improvements, it is also important that organizational practices and structures established and normalized from one or more specific perspectives are open for critical questioning and reviewing. An example of how critical reviewing of organizational structures can help institutions be dynamic and inclusive is the intercultural competence education discussed in Chapter 2 which has been successfully adapted, according to curriculum evaluations.

Reviewing the structure and culture of organizations in light of the inclusion of professionals with a minority background requires acknowledging that cultural diversity issues are a part of everyday practice and involve all professionals – including researchers. It

also means that all stakeholders together hold responsibility for experiences of exclusion, discrimination and racism in everyday practices, and together they hold the key to change. Hence, cultural diversity issues need to be part of an organization's structural policies at all levels and in all departments instead of being a temporary project or the responsibility of a few diversity workers. Building shared, collective commitment and responsibility for inclusion in the organization is fundamental to an equity approach that goes beyond a mere equality focus. Moreover, we need to acknowledge that diversity work is not straightforward. Diversity workers are often professionals who constitute 'the other' within an organization, such as professionals with a minority background. Therefore, to be able to actually do diversity work, they first have to establish that they are acknowledged as 'normal' students or professionals by their colleagues. Furthermore, because the walls of normalization that prevent diversity issues from being acknowledged as important and that prevent structures of inequality from even being 'seen' are generally more difficult for professionals who are thought to fit the norm and who experience less or no exclusion to see, diversity workers are often responsible for bringing down those walls – for creating change – on their own (Ahmed, 2012, 2015).

Equity and equal outcomes require that white professionals also become diversity workers and engage in bringing down the walls of normalization. Doing so requires that they review how their relative position of privilege prevents them from having to perform diversity work in order to be acknowledged or from addressing exclusion and inequality in a horizontal way (DiAngelo, 2011). Sharing responsibility will be easier for all professionals involved when they realize that inclusion is not about handing over packets of power; it is not a zero-sum game in which opportunities for one endanger opportunities for another. I have seen that executives and management are crucial in paving the way for an inclusive climate in which there is space for difference, in which diverse perspectives are shared and valued, in which their value for the education, work, research or care practice is critically and openly reviewed and in which all professionals with diverse backgrounds – all unique human beings with their unique personal and professional (hi) stories – can flourish (Chapter 6).

There are many diversity programs for securing and critically reviewing sustainable recruitment, selection, promotion, retention, and so on, in organizations, and these often focus on methods like diversifying and training selection committees and management (e.g., Cox, 1993); however, many such interventions lack impact in terms of inclusion (Ahmed, 2007). Here, Ghorashi's (2018) second stage of potential disconnect is relevant. As in the first stage, people lose the ability to deal with diversity and difference because of social fragmentation, and this may subsequently lead people to lose the ability to identify with others and prevent them from connecting when they meet in semi-public spaces such as medical schools and hospitals (Ghorashi, 2018). Therefore, it is important to deal with diversity as a practice, a practical competence and a process that takes time. Training, for example, should move beyond one-time sessions or short-term programs, beyond checklists or standard protocols that can be ticked off and beyond abstract cognitions that can be learned individually and without attending to the specific context and its history. Instead, training should encourage participants to engage repeatedly with colleagues who experience exclusion, thereby engaging with

and *feeling* the everyday manifestations of diversity issues. Thus, material, social, temporal and emotional or affective spaces should be created within organizations, where professionals can meet in face-to-face everyday encounters across identity categories – personal and professional – and can experience and build common ground and, from this, develop new imaginaries together (Ghorashi, 2018; Ghorashi & Sabelis, 2013).

In research initiated by my department, researchers worked with students and professionals with minority and majority backgrounds to develop, conduct and evaluate research projects and to implement their findings (e.g., Muntinga et al., forthcoming). The earliest project was a cooperation with the director of the medical school, VUmc SMS, and the Interculturalisation program for the VUmc academic hospital and its program leader. Joint research that builds on these earlier projects and their findings continues to be developed today. The earlier projects also led to the development of a longitudinal learning pathway titled Interculturalisation and Diversity and department-coordinated educational activities, both of which use an intersectionality perspective to link diversity aspects, such as gender, religion, culture/ethnicity, LGBTQ+, social class and (dis)ability, and teach students about the similar underlying mechanisms of exclusion of these 'different differences'. Forming alliances is important in developing incentives and urgency for transformation and in helping to mainstream diversity issues in organizations (Verdonk et al., 2016). Therefore, in the future, we aim to develop research from a critical-intersectional perspective (Verdonk et al., 2019), in particular, bringing in the whiteness of professionals in relation to gender and social class. Internationally, we presented our work on medical education and research in academic medicine at conferences of AMEE, the largest international association for medical education (e.g., Leyerzapf et al., 2015, 2016, 2017, 2018; Verdonk et al., 2018). From the contacts we made and the mutual wish for social and moral support in addressing inequality in our separate organizational and national contexts, we formed an International Community of Practice on Diversity, Equity and Inclusion that aims to make academic medicine more inclusive internationally. On a more individual level, my supervisors and I felt our collaboration was a meeting ground that triggered new insights, energy and horizons for research and practice because we all come from different professional disciplines and have different personal and professional histories, and we have all followed different personal–professional trajectories and are at different stages in those trajectories. All of these provide each of us with different outlooks and 'awarenesses' and require that we take on different roles.

Collaborations and connections across disciplines, including care, medical, paramedic, administrative, and supportive staff in the academic hospital, help all participants to 'see' the automatic assumptions we all have. They help to identify the norms and hierarchies dominant within our specific environments and to feel how these affect us and others around us. Moreover, they facilitate our collective ability to relate to those effects and to engage in joint thinking about how the resulting structures can be innovated and transformed towards more inclusivity. Bottom-up, practice-based co-creations between different stakeholders from work floor, executive and management levels are necessary to connect organizational aspects based on system-thinking – that is, a dominant focus on standardized practice and quantifiable outcomes – with aspects of every-

day practice, such as trust, connectedness and belonging. In addition, such co-creations are needed to build and feel a shared commitment and responsibility. Thus, by bringing unconnected assumptions and lived realities into direct, embodied contact, people can recognize each other as unique persons with unique (hi)stories and can understand how each person is implicated in different ways in the structural make-up of these unconnected worlds. In this way, in-between spaces can develop in which people can connect and establish common ground for collective action (Abma et al., 2019; Davis & Vaughan, in press; Ghorashi & Sabelis, 2013; Medina, 2013; Verdonk & Abma, 2013).

An example from the VUmc SMS was the 2014 start-up of an MFVU student association committee for diversity and inclusion named D.O.C.S. (Diversity. Openness. Culture. Students.). Initiated by the director of the VUmc SMS, D.O.C.S. was a co-creation between students with minority and majority backgrounds and the artist Lina Issa from the organization Art Partner. D.O.C.S. was consciously set up as a committee in the existing VUmc SMS student organization in order to facilitate and stimulate connections between all students and to discourage segregation. As such, it seems to contribute to the need for safe spaces, such as the one undergraduate research participants had (Chapters 2 and 3), where students could meet like minds and experience belonging and relational empowerment. As I saw in my research, however, students who needed such spaces sometimes added to their own segregation because they felt approached as 'different' *and* because they felt 'different' themselves. Therefore, all students engaged in this complex dynamic of segregation. D.O.C.S. also struggles to balance establishing relatively homogenous safe spaces where students can be 'amongst themselves' with open, diverse, new spaces where everyone is welcome. Thus, to counter segregation and prevent spaces from becoming closed off, static and homogenizing and to provide safety as well as space for deep connections across categories that are also valuable for building a successful career in health care (Chapter 4), specific policy and vision is necessary.

Furthermore, to be able to create these balanced, inclusive spaces, stakeholders need to develop the language to actually connect with each other when they meet. Researchers can support this as engaged researchers by stimulating polyphony in critical-reflexive, participative, action-oriented research (Abma, 2003; Abma et al., 2019; Davis & Vaughan, in press; Ghorashi, 2014b; 2017). I have seen how stakeholders in the research settings, myself included, normalized privilege and disadvantage through particular words and expressions – I still do this as I categorize people into those with a minority background and those with a majority background in this chapter. Therefore, I need to ask myself how I can do research and teach in an inclusive way. This includes the language I speak and write in, the journals I publish in, the places and communities in which I share the stories I hear and the experiences I have in my research and teaching, the manner I (do not) engage in dialogue and with whom, and how and to what extent this dis/enables me to connect with others in a meaningful way. Changing only 'the documents', the formalized, written structures (Ahmed, 2007), will not challenge the underlying norms, hierarchies and normalization praxis. Changing only 'the documents' means acting as if by writing about the need to address diversity, we have addressed diversity, as if the documents do the addressing, as if the documents change the praxis.

Fixing the knowledge

For transformation to be more than superficial reform, we need to switch perspectives in our production of knowledge and truth that is reflected in dominant norms and hierarchies. Instead of studying diversity as being a quality of and something that concerns others and from a distanced and hierarchical position, we need to study it using a diversity lens and together *with* others (Abma et al., 2019; Kajner, 2013). This requires that we question and undo the hierarchical Self-Other binary ingrained within academic health care and academia generally (Kajner, 2013). In this binary, the perspectives and knowledge of particular people, such as people who are not white, who have a disability or who are not academically trained, are dominantly viewed as less valuable and true than the perspectives and knowledge of others, such as white, able-bodied, academically trained people. If we study diversity issues from within diversity, we can come to recognize that dominant ways of acquiring, valuing and producing knowledge involve epistemic injustice (Medina, 2013) as well as ontological injustice (Kajner, 2013), a way of denying some people's right to existence and of their being in the world. Moreover, with epistemic and ontological injustice, we deny not only the humanity of others but also of ourselves. If we engage in horizontal co-creations with professionals from diverse backgrounds, including those who in one or more ways – are considered to – belong to a minority, and we work from the premise that diversity involves all of us and everyday practices, but *foremost ourselves*, we will see and feel different, new, innovative things. However, how can stakeholders engage in potentially painful and difficult dialogues in heavily normalized contexts, and why would they want to? Ghorashi's (2018) third stage of potential disconnect is crucial here. When people do not or hardly ever meet each other in everyday life, they can lose the ability to engage with diversity and difference (Stage 1). Therefore, they more easily identify and feel safe with those they perceive as relatively the same as themselves, and they may lose the ability and willingness to identify and connect with those they perceive as different (Stage 2). This can fuel emotions such as distrust, aversion, anger, fear and powerlessness and may lead to social conflict (Stage 3) (Ghorashi, 2018). However, if we develop relatively safe spaces where we can meet and where we can dare to acknowledge and bring in these emotions of discomfort, we can touch upon the ingrained knowledge that spurs those emotions and breach the normalization that prevents us from seeing how we are both different *and* equitable. And from there, we can enable each other to work for deep connections.

I learned (Critical Incidents) how acknowledging emotions of discomfort could enable me to be engaged as a researcher (Davis, 2015; Hemmings, 2012; Koobak & Thapar-Björkert, 2014). This helped me recognize how I was being both 'white innocent' and 'white fragile' because I wanted to stay in my comfort zone from where I could tell others that 'race' is really a non-existent, socially constructed idea without biological foundations. It also helped me see how I expressed my position in the 'invisible' centre and how I 'centred the white voice' (Chadderton, 2012), believing I could somehow be above the lived realities of inequality. Pretending to be 'colour-blind' made me somewhat insensitive and numb, and as such, I added to the marginalizing and silencing of particular others (Kajner, 2013; Medina, 2013). Acknowledging my emotions helped me to see and feel how I was part of 'the problem' as well as 'the solution'. Such reflexive 'emotion work' (Lutz, 2002) can open up in-between spaces (Ghorashi & Sabelis, 2013) in which

people can engage with taking responsibility – not in a hierarchical, formalistic, instrumental, accountability form, but as a critical, relational awareness of how we are all connected in a 'chain of interdependencies' and dependent on this 'life sustaining web' to trigger transformation towards inclusion (Tronto, 1993; Zembylas et al., 2014). We need to make discomforting, disorienting, unsettling emotions in the face of inequality explicit because they are empowering and help us to envision new horizons.

Participatory art-based research can help people tap into emotions, making them explicit and productive in working towards equality in hierarchical, non-inclusive and normalized contexts (Abma et al., 2019; Bruin et al., 2018; Muntinga et al., forthcoming). For example, in the Interculturalisation and Diversity longitudinal pathway and in teacher trainings, we worked with artist Lina Issa to help students and teachers use empathy, the willingness to take the perspectives of others, to critically review dominant knowledge bases in academic health care. And, in a recent co-creation research with students, teachers and physicians, Issa and researchers from our department worked to visualize and challenge exclusionary professionalism norms via narrative and video methods (Muntinga et al., forthcoming). Finally, in the academic hospital, the Interculturalisation program leader worked with Mercedes Zandwijken, founder of the Keti Koti Dialogue Table (http://www.ketikotitafel.nl), which aims to bring white people, black people and people of colour into dialogue on slavery and colonial history and to inspire them to work for a society free of discrimination and racism. They organized lunch meetings for professionals in which sensory, embodied experiences were used to stimulate participants to openly listen to each other's experiences of exclusion and difference. These projects used creative methods and sensory experiences to help participants step out of their relatively homogenous comfort zones and temporarily set aside their own convictions in order to make space for different, new, innovative perspectives and experiences. However, we need more structural understanding of how discomfort can become productive for social justice in more and diverse contexts, and we need to enable more and diverse stakeholders to take up responsibility for gaining that understanding.

Conclusion

In this chapter, I discussed the main findings of this thesis: the norm that cultural diversity is primarily about the Other, the norm that the (good) professional is neutral, and the normalization of an unequal distribution of privilege and disadvantage via the ideal worker norm. Learning how I reproduced and normalized these findings myself brought me to three main conditions that are necessary for challenging these exclusionary norms and stimulating transformation in order to make education, care and research practices in academic health care and beyond more inclusive and equitable. These conditions depart from one central starting point, namely, that instead of 'fixing the Other', we need to focus on 'fixing the Self'. The three main conditions are that we (1) *acknowledge our complicity* in normalization practices and acknowledge that we are all both part of the problem as well as the solution and, thus, we need to work together for change; (2) *work from our emotions of discomfort* in order to take up responsibility from a horizontal position of interdependence and reciprocity, and that we – particularly white people without a migrant background – acknowledge how we are implicated in structural inequalities, learn to talk about racism as well as white innocence and white

fragility, and work to unsettle normalization; and (3) *build critical-reflexive, embodied common ground* in which space for difference, deep connections and collective action for transformation towards inclusion can grow.

We have learned that quick fixes are not the answer to the puzzle of diversity (Chapter 6). 'Doing diversity' is about feeling what our relation to others around us tells us about ourselves and the structures in which we are embedded, and it is about 'being in the world' from this place of embodied critical and relational awareness (Kajner, 2013). Confronting one's own emotions and experiences and those of others can be unsettling and painful; it takes time and repeated effort, and it requires the explicit support of professional leaders. Transformation also asks that we see dialogue as inherently contentious, emotive and unresolved and that we connect in dialogue as an embodied act – more than an abstract, cognitive one – that requires us to be really present, to work from our own bodily presence and to relate to each other in that way (Van Manen & Li, 2002). This then involves us in 'bringing in the power' by engaging in visualizing the different agendas and positions of privilege and disadvantage of all present. If we acknowledge that our social position(ing) is made up of multiple intersecting identity aspects that together make up how we differently experience privilege and disadvantage in particular contexts, we can deconstruct how our 'different differences' are (re)produced by similar mechanisms of inclusion/exclusion and privilege/disadvantage, and from this, we can experience common ground for collective action (Verdonk et al., 2019). This keeps us away from the danger of a single story (Adichie, 2009) and helps us refrain from a discussion over who is most invisible and whose pain is most legitimate and urgent, that is, it keeps us from entering the 'Oppression Olympics' (Martínez, 1993). Instead, we can experience how difference and sameness are dynamic categorizations, how Othering is sustained by everybody (Prasad & Prasad, 2002), how power is not a zero-sum game, because we are all subject and object in normalized power structures, and how our empowerment is mutually connected. Thus, we can learn to talk about racism, white innocence, and white fragility (DiAngelo, 2011; Wekker, 2016) as well as gendered oppression and other forms of disempowerment, exclusion and discrimination. To develop inclusive education, research and care practices, we need to further experiment with and experience these creative, embodied and contentious methodologies and dialogues and see how they can become a part of organizational structures and practices without losing their 'unsettling' quality.

An example of such experimenting is a training that my colleagues and I organized on white innocence to move beyond the racism taboo. We engaged with our shared complicity in inequality practices to envision ways for collective transformation in our own, dominantly white department, as well as in other universities. Similar to what white participants with a cultural majority background had experienced in other contexts and to what I had experienced at different times during this research (Critical Incidents), we learned that some colleagues – white and with a majority background – had felt insecure and *unsafe* during the meeting in our department that was led by Mercedes Zandwijken, who is black. Indeed, in a context of social fragmentation and disengagement, 'courageous conversations' (Acosta & Ackerman-Barger, 2016; DiAngelo, 2011) may require temporarily feeling unsafe, as the lack of connection fuels the feeling that it is actually unsafe or even harmful to engage with difference and Others. It is important here to acknowledge that for

participants speaking from a relative position of power, in this case our white colleagues with a majority background, engaging in these conversations is generally not really unsafe in terms of the likelihood that doing so could negatively impact their careers or private lives. However, such conversations may have very different impacts for participants with less power, which could be colleagues with a migrant background or in the case of the department meeting perhaps Zandwijken as the only black person present, who experience exclusion, especially when exclusion is part of the specific context at hand (DiAngelo, 2011). At the same time, however, these conversations will likely be *uncomfortable* for all participants. Engaging with these 'spaces of difficulty' (Chapter 6; Kunneman, 2005) together is precisely what enables us to see and feel collective counter-narratives and counter-hegemonies (Ghorashi, 2018; Medina, 2013) to which we can all relate and that spur horizons of change.

In addition to the direct impact of the studies in this thesis, learning was generated because the studies had 'ripple effects', many of which have not been described and are often hard to put into words. They also appear to link to and may have been influenced by the waves set in motion by other projects, both inside and outside the organization where the studies took place. During the years of my research, diverse students and teachers within Dutch universities, created alliances and called for democratization and decolonialization (see, e.g., University of Colour, or New Urban Collective, https://www.advalvas.vu.nl/nieuws/%E2%80%98daar-heb-je-hem-weer-met-zijn-suriname-dingen%E2%80%99, visited on 13-11-2018), following international student movements for democratization and decolonialization in academia. Racism, white privilege, and white innocence also became topics in public, political and scientific debates in Dutch society (e.g., Essed & Hoving, 2014; Nzume, 2017; Wekker, 2016) – possibly slowly whittling away at the taboo on talking about race in the country in general as well as in local education and research contexts. In the broader European context, the 'refugee crisis' developed, which in the Netherlands triggered grassroots movements for inclusion of refugees as well as a hardening of migration discussions (Rast & Ghorashi, 2018).

From the learning experiences described in this thesis, I can conclude that transformation is not linear and does not follow causal patterns. There is no direct link between my actions as a diversity worker and their impacts. However, it is fundamentally contextual and relational. I learned that finding openings for change starts with building personal contacts and listening to and engaging with their stories, but also with seeking and taking opportunities. Transformation is about developing bottom-up space, yet it also requires formal backing and practical conditions such as time and money. It requires that we – researchers, students, professionals in health care and beyond – encounter each other as well as ourselves as unique persons with personal and professional (hi)stories, emotions and values embedded within historical, social, political, economical structures, all of which bring norms into everyday interactions that shape everyday lived reality and the privilege and disadvantage that connects us. And it requires emotional work that dares us – specifically if we are white – to move out of our comfort zones into contentious, diverse, creative spaces where the horizontal experience of difference can spur new ways of being in the world (Kajner, 2013). This will never be 'finished' but is an ongoing everyday praxis.

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

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 then 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 humoristic, 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 Duch 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 interdepence 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. Maaike Muntinga and colleagues of the department of Medical Humanities VUmc.

Samenvatting

Hoofdstuk 1 – Introductie

Academische ziekenhuizen zijn traditioneel hiërarchisch, mono-cultureel en exclusief van opzet. Voor het borgen van de kwaliteit van zorg en de competentie van professionals geven organisaties in de academische gezondheidszorg toenemend aandacht aan culturele diversiteit in beleid en praktijk. Hoewel studentenpopulaties in de gezondheids- en zorgopleidingen steeds diverser zijn qua culturele, etnische en religieuze achtergrond, zijn professionals met een migratieachtergrond ondervertegenwoordigd in medische scholen en academische ziekenhuizen en vooral op leidinggevende posities en in management. Internationaal is onduidelijk waarom werving, selectie en promotie van professionals met een migratieachtergrond hapert en de uitval en uitstroom hoog is, evenals wat er nodig is voor het ontwikkelen van inclusieve organisaties. In het geheel lijkt het welzijn van professionals in de academische gezondheidszorg en vooral van die met een migratieachtergrond onder druk te staan gezien de hoge cijfers van (seksuele) intimidatie, discriminatie en racisme. Inzicht in de ervaringen van (aankomend) professionals met een migratieachtergrond ontbreekt echter.

Ook in Nederland zijn geen eerdere studies gedaan naar de ervaringen van (aankomend) professionals met een migratieachtergrond of naar exclusie, discriminatie en racisme in de academische gezondheidszorg. Door empirisch en theoretisch inzicht te genereren in ervaringen van deze (aankomend) professionals met een migratieachtergrond, in de interacties tussen hen en die behorend tot de culturele, etnische en/of religieuze meerderheid, en in processen van in- en uitsluiting in medisch onderwijs en de werkvloer van het academische ziekenhuis, beoogt dit proefschrift bij te dragen aan de inclusie van (aankomend) professionals met een migratieachtergrond in de Nederlandse academische gezondheidszorg. De twee centrale onderzoeksvragen zijn als volgt:

1. Hoe gaan studenten en professionals met een migratieachtergrond en die behorend tot de meerderheid in de academische gezondheidszorg om met culturele diversiteit in de dagelijkse onderwijs- en werkvloerpraktijk?, en
2. Welke condities zijn nodig voor transformatie van de academische gezondheidszorg naar inclusie van studenten en professionals met een migratieachtergrond?

Er wordt gebruik gemaakt van een kritisch diversiteitsperspectief, wat betekent dat de dagelijkse praktijk en relaties tussen mensen worden gezien als inherent macht-geladen, contextueel en veranderlijk en gemaakt en gereproduceerd door deze mensen in alledaagse interacties. We bestuderen de grondslagen van machtsrelaties en de mechanismen van hun alledaagse (re)productie. Om inzicht te krijgen in de condities voor transformatie, ligt de focus bij de normalisering van dominante normen en onderliggende hiërarchieën, de relatie met (zelf-) identificatie als ‘gelijk’ of ‘anders’ en met wie er wanneer en waarom als ‘de Ander’ wordt gezien, oftewel als minder wordt gewaardeerd dan zij die ingesloten en ervaren worden als de norm of behorend tot ‘het Zelf’. Zo wordt inzicht in privilege en structureel nadeel verkregen, en kunnen aangrij-

pingspunten worden geformuleerd om machtsdynamieken uit te dagen en inclusieve organisaties te bevorderen. Daarbij wordt ook de Nederlandse context meegenomen van excluderende en soms racistische sociale en politieke debatten waarin mensen met een culturele minderheidsachtergrond vaak de Ander vormen.

Het kwalitatieve en etnografische onderzoeksdesign is geïnspireerd door het sociaal-constructivisme en de fenomenologie en hermeneutiek, en gebaseerd op een mensenrechten- en sociaal rechtvaardigheidsperspectief. Het tegelijk beschrijvende en transformatieve doel komt naar voren in de verschillende gebruikte methoden, namelijk de combinaties van interviews en participerende observaties (etnografie) met focusgroepen en dialooggroepen gericht op het samenbrengen van verschillende, diverse perspectieven en het stimuleren van kritisch bewustzijn, wederzijds begrip en collectieve verantwoordelijkheid voor praktijkontwikkeling in de onderzoekssettings (responsief en actiegericht).

Er vonden vijf studies plaats in VUmc School of Medical Sciences (VUmc SMS) en in het Amsterdam UMC, locatie VUmc (VUmc), die de weg volgden van de geneeskundestudent van de bachelor en master basisopleiding (Hoofdstuk 2 en 3) via de vervolgopleiding (Hoofdstuk 4) naar de werkvloer van het academische ziekenhuis waarin professionals vanuit medische, zorg-, paramedische en ondersteunende disciplines elkaar ontmoeten (Hoofdstuk 5 en 6). Daarnaast zijn vijf zelfreflecties van de onderzoeker van kritische incidenten tijdens de onderzoeksprocessen geïncludeerd die van belang bleken voor de bevingingen. Hoofdstuk 7 bespreekt de overstijgende conclusies en leerervaringen voor praktijk en onderzoek.

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

Medische scholen in Nederland hebben steeds meer aandacht voor interculturele competenties van studenten. Ongeveer 20 tot 30% van de geneeskundestudenten heeft een migratieachtergrond. Vanaf de klinische fase in de opleiding dalen de beoordelingen van deze studenten, en studies wijzen op een gebrek aan sociale connectie en vooroordelen over cultuur als redenen voor dit ogenschijnlijke onderpresteren. Dit hoofdstuk beoogt inzicht te verkrijgen in de perspectieven van geneeskundestudenten met een migratieachtergrond en op basis hiervan aanbevelingen te doe aan docenten, beleidmakers en andere professionals in de academische geneeskunde om interculturele competentie en inclusiviteit van de opleiding te vergroten.

Deze exploratieve, kwalitatieve evaluatie focust op het interculturele competentie-onderwijs in de basisopleiding van één medische school. De uitvoerend onderzoeker met een migratieachtergrond verzamelde data via semi-gestructureerde interviews (n=23), een focusgroep (6 deelnemers) met studenten met een migratieachtergrond en kortdurende participerende observatie in de medische faculteit (20 uur). Er is een thematische analyse gedaan.

Respondenten ervaarden casuïstiek als stigmatiserend voor mensen met een migratieachtergrond, vooral voor moslims, aangezien patiënten met een migatieachtergrond en

hun leefstijlen –vooral dus veronderstelde 'Islamitische'– hierin gepresenteerd werden als negatief verschillend van 'normaal Nederlands' gedrag en culturele normen. Respondenten voelden zich apart gezet doordat docenten en studenten behorend tot de meerderheid leken te verwachten dat zij de issues rondom culturele diversiteit in de studiestof zouden uitleggen. Respondenten kregen tijdens werkgroepen en colleges te maken met vooroordelen in de vorm van kwetsende opmerkingen vaak bedoeld als humoristisch van de kant van deze studenten en docenten, en ze voelden zich vooral geisoleerd en onveilig omdat ze hierbij steun misten van hun docenten. Zoals ook bleek uit de participerende observatie, hadden respondenten relatief diverse vriendenkringen waarin hun interculturele competentie groeide, terwijl de groepen met studenten zonder migratieachtergrond relatief homogeen leken. Zo lijkt het succes van intercultureel competentie-onderwijs beperkt en zelfs bij te dragen aan polarisatie tussen studenten en docenten met en zonder migratieachtergrond.

De ervaringen van respondenten kunnen gekarakteriseerd worden als 'micro-agressie' aangezien het invaliderende opmerkingen en vragen betrof die op dagelijkse basis gebeurden, waarvan de 'daders' zich doorgaans niet bewust zijn door een gebrek aan interculturele sensitiviteit en culturele vooroordelen, en die vaak 'verpakt' waren in humor waardoor ze moeilijk aan te kaarten zijn. (Inter)nationaal onderzoek in de basis- en vervolgopleiding lijken dit proces van het tot 'de Ander' maken van studenten met een migratieachtergrond, vooral van moslims, te bevestigen. Dit 'verborgen curriculum' lijkt studenten met een migratieachtergrond structureel te benadelen en maakt dat de interculturele competentie van studenten behorend tot de meerderheid achterblijft. Kritisch bewustzijn ten aanzien van de normen waarvan studenten met een migratieachtergrond zouden verschillen, oftewel kritische (zelf-) reflexiviteit, is noodzakelijk om interculturele competentie van studenten en professionals in de opleiding te ontwikkelen en de academische geneeskunde meer inclusief en gelijkwaardig te maken. Dit vereist commitment en verantwoordelijkheid van docenten en beleidmakers.

Hoofdstuk 3 – Veiled ambitions: Female Muslim medical students and their 'different' experiences in medical education

De studentenpopulatie van geneeskunde in Noord-West Europa is zowel gefeminiseerd als toenemend cultureel divers. In Nederland zijn sinds 1995 grote aantallen studenten met een Marokkaanse of Turkse migratieachtergrond de geneeskundeopleiding binnengestroomd. Migranten en specifiek (vrouwelijke) moslims zijn 'hyper-zichtbaar' in debatten over migratie en inclusie maar ze missen politieke stem. In medische scholen zijn studenten met een migratieachtergrond en vooral vrouwelijke moslimstudenten en met name zij die een hoofddoek dragen, ook erg zichtbaar. Toch is er weinig bekend over hun ervaringen. Om bottom-up kennis over inclusie in de academische geneeskunde te genereren en de erkenning van perspectieven van vrouwelijke moslimstudenten te stimuleren, bestudeert dit hoofdstuk de ervaringen van deze studenten vanuit een kritisch-intersectioneel perspectief, oftewel door mee te nemen hoe verschillende identiteitsaspecten samenwerken in het produceren van uitsluiting.

In een kwalitatieve interviewstudie in de basisopleiding van VUmc School of Medical Sciences zijn semi-gestructureerde diepte-interviews (n=14) gedaan door een vrou-

welijke onderzoeker die ook moslim is, en is een thematische analyse uitgevoerd. De meeste participanten droegen een hoofddoek.

Participanten hadden op drie manieren de ervaring 'anders' te zijn: ze ervaarden dat ze een ander studentenleven leiden (1) en gezien worden als een andere geneeskunde-student (2), en ze anticipeerden erop een andere arts te zijn (3). Participanten vonden moeilijk aansluiting bij studenten en onderdelen van het studentenleven die zij als 'Nederlands' zagen. Omgekeerd werden ze als anders en niet-Nederlands benaderd door 'Nederlandse' studenten. Participanten voelden een 'klik' met andere moslimstudenten en die met een migratieachtergrond, en vonden onderling (h)erkenning en sociale steun voor hun ervaringen van anders-zijn en uitsluiting. Participanten voelden zich vaak apart gezet en onveilig vanwege de uitsluitende, 'humoristische' opmerkingen en vragen van studenten en docenten zonder migratieachtergrond. Ook ervaarden ze dat ze, samen met andere moslims en speciaal vrouwen met een hoofddoek, 'tot de Ander' werden gemaakt. Dit was bijvoorbeeld het geval wanneer docenten hun bezwaren tegen het lichamelijk onderzoek in gemixte gender setting belachelijk maakten en dit afstraalde op de mate waarin ze als competent en een waardevolle aankomend arts werden gezien. Dit gevoel 'de Ander' te zijn, werd sterker vanaf de co-schappen wanneer supervisoren bijvoorbeeld verklaarden dat hun hoofddoek onverenigbaar was met een arts zijn.

De ervaringen van participanten omvatten een proces van '*Othering*' dat hun status als (toekomstige) arts lijkt te devalueren en 'de-professionaliseren'. Hoewel verschillende identiteitsaspecten een rol spelen in de ervaringen, leek vooral het moslim en niet wit zijn bij Othering centraal te staan en dus racistische aspecten in zich te dragen. Vrouwelijke moslimstudenten lijken als 'ultieme Ander' in de geneeskundeopleiding parallel hyperzichtbaar én onzichtbaarheid te zijn, en dit wijst op een hierarchisering tussen deze studenten en witte studenten/professionals zonder migratieachtergrond die overwegend als neutraal en zodoende 'normaal/goed' worden gezien. Voor inclusie, moeten stakeholders in de academische geneeskunde –inclusief (witte) onderzoekers– zich bewust worden van hun eigen 'blindheid' ten aanzien van uitsluitende, soms racistische normen en hoe ervaringen van uitsluiting en racisme weggemaakt worden aangezien deze normen als 'normaal' en 'neutraal' worden gezien.

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

Hoewel stakeholders in de geneeskunde en gezondheidszorg streven naar het cultureel diverser maken van de werknemerspopulatie, is deze tot nu toe weinig divers. Onderzoek en beleid gericht op het vergroten van de representatie van studenten en professionals met een migratieachtergrond, focust vooral eenzijdig op de integratie van deze studenten/professionals in de meerderheidscultuur en wordt gekenmerkt door een top-down aanpak. Dit hoofdstuk brengt de structurele barrières in kaart voor het ontwikkelen van meer cultureel diverse en inclusieve organisaties door de dagelijkse praktijk en de ervaring van beoordelings- en selectieprocessen op klinische afdelingen in een academisch ziekenhuis in Nederland te onderzoeken, evenals de ideeën over hoe deze processen de instroom van artsen met een migratieachtergrond in de opleiding tot specialist beïnvloeden.

De data verzameling in dit onderzoek bestond uit semi-gestructureerde interviews (n=27) met artsen-niet-in-opleiding, artsen-in-opleiding-tot-specialist, specialisten, afdelingshoofden en een leidinggevende zorg. Vervolgens is een focusgroep gehouden met artsen-in-opleiding met een migratieachtergrond, een dialooggroep met artsen-in-opleiding, een co-assistent en specialisten met een migratieachtergrond, en met specialisten en andere klinisch leidinggevenden uit de meerderheid, evenals kortdurende participerende observaties op een klinische afdeling. Data analyse was een combinatie van thematische en integrale content analyse.

Respondenten met een migratieachtergrond, vooral die nog niet in opleiding waren, maakten zich zorgen dat hun participatie hun selectie voor de opleiding zou beïnvloeden. Taal werd door respondenten met en zonder een migratieachtergrond genoemd als een selectiecriterium. Aangezien alle respondenten met een migratieachtergrond vloeiend Nederlands spraken maar wel soms met een accent, wees dit op het bestaan van sociale normen ten aanzien van taalgebruik en communicatiestijl. Leeftijd werd ook genoemd als factor en wees op normen op het gebied van loopbaan en kennis over wat er nodig is voor een academische medische carrière. Hieraan konden artsen met een migratieachtergrond vaak niet aan voldoen omdat ze veelal eerste-generatie-studenten waren en naast hun studie moesten werken en dus minder tijd hadden voor extra-curriculaire activiteiten. Sociaal netwerken werd benoemd als centraal in het kwalificeren voor een opleidingspositie. Ook aan deze norm omtrent specifieke sociale presentatie konden artsen met een migratieachtergrond moeilijker voldoen omdat ze sociale steun, rolmodellen en 'de juiste connecties' misten, en omdat ze vaak moeite hadden met het vinden van sociale aansluiting bij hun collega's en supervisoren en bij teamactiviteiten, en omdat ze zich in het geheel minder thuis en veilig voelden in hun werk. Artsen met een migratieachtergrond voelden dat ze makkelijk negatief opvielen en hadden te maken met vooroordelen ten aanzien van hun 'niet-Nederlandse' cultuur en identiteit. Dit werd bijvoorbeeld zichtbaar in stereotype 'grapjes' van de kant van hun collega's zonder migratieachtergrond. Aangezien ook leidinggevenden artsen met een migratieachtergrond als 'anders' typeerden en zagen, moesten deze extra hard werken en zich bewijzen om te kunnen kwalificeren als 'normaal' en dus als 'goede' artsen.

Artsen met een migratieachtergrond lijken dus moeilijker succesvol te profileren voor selectie voor de opleiding tot specialist. Tegelijk blijkt dat deze selectieprocessen actief gepraktiseerd worden door zowel de artsen behorend tot de meerderheid als die met een migratieachtergrond. De selectieprocessen worden beïnvloed door normen ten aanzien van wat doorgaat voor 'normaal', 'goed' en 'Nederlands' en wat wordt verstaan onder professionaliteit, evenals door stereotype sociale beeldvorming. Andere studies bevestigen dat verschillende, intersectionele identiteitsaspecten hierin een rol spelen, zoals dat niet wit en niet man zijn, kunnen leiden tot structureel nadeel in beoordeling. Voor inclusie van culturele diversiteit in academische ziekenhuizen moeten deze kwalificaties van 'anders-zijn' en 'gelijk-zijn' aandacht krijgen, en is het noodzakelijk dat onderliggende normen die een hiërarchie tussen veronderstelde Nederlandse en niet-Nederlandse artsen lijken te creëren, kritisch worden geëvalueerd en uitgedaagd.

Hoofdstuk 5 – *"We are all* so *different that it is just ... normal."* Normalization practices in an academic hospital in the Netherlands

Management van diversiteit in organisaties wordt vooral gelegitimeerd door enerzijds het streven naar gelijke representatie van en gelijke kansen voor professionals, en anderzijds het doel om creativiteit, competitief voordeel en winst te genereren. Diversiteitsmanagement heeft vaak een instrumenteel karakter waarbij 'de ander' getolereerd wordt in de organisatie zolang deze de dominante organisatiecultuur en normen verrijkt maar niet uitdaagt of bekritiseert. Dit instrumentele karakter wordt gezien als de reden van de beperkte impact van diversiteitsprogramma's op werving, selectie, promotie en behoud van professionals met een migratieachtergrond. Om inclusie te bevorderen roepen kritische diversiteitsstudies op tot kritisch, empirisch onderzoek naar de (re) productie van normen en daarmee de basismechanismen van macht en ongelijkheid in organisaties. In dit hoofdstuk beogen we de werkvloer- en organisatiecultuur kritisch te evalueren door te bestuderen hoe professionals met en zonder een migratieachtergrond diversiteit ervaren en omgaan met elkaar.

We hebben etnografisch onderzoek gedaan op verschillende klinische afdelingen in een academisch ziekenhuis in Nederland. Dataverzameling bestond uit formele, verkennende en informele semi-gestructureerde interviews (n=62), en uit participerende observaties (ongeveer 100 uur). Dataverzameling en analyse gebeurden in een parallel en cyclisch proces en door middel van 'sensitiserende concepten' zoals normalisering, oftewel het normaliseren van dominante normen via alledaags taalgebruik en routines.

Professionals met en zonder een migratieachtergrondpresenteerden diversiteit als iets van de Ander; ze zagen het vooral als iets van culturele Anderen zoals patiënten met een migratieachtergronden in tweede instantie als iets van professionals met een migratieachtergrondzagen. Culturele diversiteit werd ook geassocieerd met moeilijke situaties en interacties die de normale werkpraktijk doorbreken en (te) veel tijd kosten, of als leuke, vrolijke dingen zoals multiculturele hapjes en feesten, en als nuttig en bruikbaar zoals professionals met een migratieachtergronddie tolken wanneer een patiënt niet goed Nederlands spreekt. Professionals met een migratieachtergrondervaarden stigmatisering van patiënten en collega's behorend tot de meerderheid maar spraken hier doorgaans niet over. Professionals benadrukten allemaal dat culturele diversiteit geen aandacht vereist en dat culturele identiteit niet belangrijk is voor het werk.

Professionals met en zonder een migratieachtergrond gaven aan dat alleen kwaliteit en competentie relevant en belangrijk zijn voor de werkpraktijk. Leidinggevenden benadrukten alle professionals gelijk te behandelen. Tegelijk moesten professionals echter in het team passen en moest er een sociale en emotionele klik zijn om geselecteerd te worden. Spanningen in teams of met individuele professionals werden uitgelegd als persoonlijkheid en individuele verschillen in plaats van gerelateerd aan issues omtrent diversiteit. Hoewel werd gezegd dat professionals in een team allemaal zo verschillend waren dat het gewoon normaal was, werden professionals met een migratieachtergronddoor collega's behorend tot de meerderheid gezien als 'anders'. Dit leidde ertoe dat het in het team passen en de professionaliteit van professionals met een migratie-

achtergrond ter discussie stond en in twijfel werd getrokken.

Er bestaat een hiërarchie op de werkvloer van het academische ziekenhuis tussen 'andere' professionals die meer risico lopen om niet goed en/of professioneel te worden bevonden, en professionals die automatisch als 'gelijk' en in het team passend worden gezien en die makkelijker kwalificeren als normale, neutrale en goede professional. Deze hiërarchie wordt genormaliseerd door specifieke discoursen over diversiteit en professionaliteit. Enerzijds werd diversiteit weggemaakt als een issue, en anderzijds werd professionaliteit afgeschilderd als neutraal, objectief, rationeel, context-loos en individueel. Zodoende was het moeilijk om uitsluiting van professionals met een migratieachtergrond aan te kaarten of zelfs om deze waar te nemen.

Deze normaliseringspraktijken duiden op de norm van de 'ideale professional' die de basis vormt voor een ongelijke verdeling van privilege voor ogenschijnlijk 'gelijke' en structureel nadeel voor ogenschijnlijk 'andere' professionals. Zowel professionals met en zonder een migratieachtergrond probeerden zich aan deze norm te conformeren aangezien ze allemaal erkend wilden worden als (goede) professionals. De normalisering wordt ondersteund door het internationale idee dat professionalisme neutraal en objectief is, en door de ideologie in Nederland dat gelijkheid vooral 'hetzelfde-zijn' is. Voor inclusieve organisaties in de academische gezondheidszorg is het cruciaal dat normalisering wordt doorbroken en stakeholders de ongelijke machtsverhoudingen op de werkvloer gaan 'zien', evenals hun gedeelde verantwoordelijkheid voor en onderlinge afhankelijkheid in het in stand houden hiervan.

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

De homogeniserende normativiteit van het academische ziekenhuis houdt verband met de dominantie van systeemaspecten zoals rationaliteit, objectiviteit en de nadruk op snelle, meetbare productie over leefwereldaspecten zoals emoties, tijd voor reflectie, bewustzijn van wederzijdse afhankelijkheid, en sociale verbinding tussen en persoonlijke achtergronden van professionals, end it zet de inclusive van professionals met een migratieachtergrond onder druk. In Nederland bestaan twee vertogen die zowel de omgang met diversiteit in de academische gezondheidszorg, als deze disbalans tussen het systeem en de leefwereld ondersteunen. Enerzijds bestaat er een sterke nadruk op cultureel gelijk-zijn onder de noemer van een ideologie van sociale gelijkheid. Anderzijds bestaat er het idee dat professionalisme vooral neutraal en objectief is, wat een beeld van de professional als individu zonder persoonlijke achtergrond en geschiedenis, identiteit en cultuur voortbrengt. Deze twee vertogen leiden ertoe dat professionals zichzelf en elkaar disciplineren om emotioneel uitdagende interacties omtrent 'anders-zijn' en 'gelijk-zijn' te negeren, en dat ze moeite hebben –ervaringen van– uitsluiting te bespreken. Echter, in de 'interferentie zone' tussen systeem en leefwereld, kan naast 'kolonisatie' van de eerste over de tweede ook 'betekenisvolle culturalisering' van leefwereldaspecten tot ontwikkeling komen en zo tijdelijke veilige 'ruimte voor verschil', verbinding en inclusiviteit tussen professionals stimuleren.

Dit hoofdstuk bestudeert deze processen van culturalisering om condities te identificeren voor het uitdagen van normalisering en het bevorderen van inclusieve organisaties. We maken gebruik van de data die zijn verzameld tijdens een etnografisch onderzoek in een academisch ziekenhuis in Nederland (zie Hoofdstuk 5), en zoomen in op een team op een klinische afdeling en daarbinnen de casus van de teamleider.

Het team bestond uit een relatief groot aantal professionals met een migratieachtergrond. Alle team professionals benadrukten dat het niet uitmaakte wie je bent in dit team en dat ze allemaal 'hetzelfde' zijn maar ook de noodzaak om in het team te passen en hier een 'klik' mee te hebben. Alleen op sommige momenten was persoonlijke identiteit en achtegrond expliciet onderwerp van gesprek en werden deze onderwerpen gerelateerd aan de team waarden van verbinding, thuisgevoel en connectie. Hiermee werden de system-geïnspireerde gedepersonaliseerde en gedecontextualiseerde normen rondom professionaliteit opengebroken. Deze 'culturalisering' was ambigue aangezien bijvoorbeeld een professionl met een migratieachtergrond het gevoel had in het team te horen omdat ze zichzelf kon zijn en collega's zonder migratieachtergrond in haar geïnteresseerd waren maar zich tegelijk soms juist apart gezet en 'anders' voelde door de terugkerende vragen van deze collega's over haar religieuze normen en waarden.

Team professionals noemden de teamleider –vrouw, zwart en met een migratieachtergrond– als de centrale spil in de cultuur van het team. Deze teamleider probeerde een rolmodel te zijn door middel van een open, democratische en zorgzame manier van leidinggeven en stimuleerde wederkerigheid, connectie en onderlinge verbondenheid zonder dat ze daarbij haar persoonlijke achtergrond en identiteit benadrukte. Ze zag 'in het team passen' als iets dat over leefwereldaspecten zoals veiligheid en thuisvoelen gaat en dat dus vraagt om persoonlijke (h)erkenning van een professional door collega's en leidinggevenden. Ook stimuleerde ze teamleden om bijvoorbeeld tijdens pauzes de tijd te nemen voor reflectie weg van de afdeling en zo te herstellen van de 'haastcultuur' van de werkvloer, hielp ze mee op de afdeling wanneer het druk was en gaf ze aandacht aan emoties en spanningen in het team. Haar manier van leidinggeven was niet zonder conflict, aangezien haar leidinggevenden er kritiek op hadden en ze zich zelf soms onder druk voelde staan vanwege de energie en tijd die het haar kostte om aan alle teamleden persoonlijke aandacht te geven.

Professionals bleken dus normalisering van excluderende normen van 'gelijk-zijn' en professionaliteit als neutraal op te houden maar ontwikkelden met de expliciete steun van een leidingegevende tijdelijke veilige ruimte voor 'horizontale' verbinding en verschil die voorbij ging aan essentialistische, gepolariseerde en hierarchische sociale posities en identiteiten. Vanuit 'plekken der moeite' werken, oftewel 'moeilijke' emoties en belichaamde ervaringen erkennen en de tijd nemen om hier vanuit gezamenlijk kritische reflexiviteit te beoefenen, ondersteunt de ontwikkeling van inclusieve tijd/ruimtes in academische gezondheidszorgorganisaties.

Hoofdstuk 7 – Discussie

Dit proefschrift had als doel empirisch en theoretisch inzicht in culturele diversiteit en inclusie in de academische geneeskunde en het academische ziekenhuis te genereren.

Specifiek ging de aandacht uit naar (toekomstige) professionals met een migratieachtergrond, en het identificeren van condities voor transformatie richting inclusie. De eerste drie studies gingen over culturele diversiteit en inclusie in de basisopleiding (bachelor en master) en vervolgopleiding van geneeskunde. Vervolgens bestudeerden twee studies deze thema's in de multidisciplinaire werkpraktijk van het academische ziekenhuis. In dit laatste hoofdstuk worden de drie hoofdbevindingen besproken, evenals de leerervaringen op het gebied van transformatie richting inclusie voor praktijk en onderzoek.

De hoofdbevindingen zijn als volgt: ten eerste wordt culturele diversiteit gepresenteerd als iets van en over 'andere' mensen en geassocieerd met interacties en situaties 'anders' dan de normale dagelijkse praktijk, waardoor het in het algemeen als onbelangrijk voor de onderwijs- en werkpraktijk wordt gepresenteerd. Specifiek wordt culturele diversiteit gezien als iets van 'de Ander'. Dit kwam naar voren in de verschillende vormen van '*Othering*', namelijk de dichomotisering en hiërarchisering tussen (toekomstige) professionals met en zonder een migratieachtergrond en het structureel onderwaarderen van de eersten. Ten tweede wordt de professional gerepresenteerd als neutraal en professionaliteit als een neutrale, objectiveerbare kwaliteit. Dit maakt het moeilijk om issues rondom culturele diversiteit en ervaringen van uitsluiting en racisme te bespreken en zelfs te *erkennen*. Ten derde bestaat er een norm van de 'ideale professional' die genormaliseerd wordt via de andere twee bevindingen. Deze norm over wat en vooral wie een (goede) professional is, leidt tot een hiërarchie tussen sommige (aankomend) professionals, doorgaans wit en behorend tot de meerderheid en die automatisch worden herkend als 'gelijk' en dus kwalificeren als een normale, goede professional, en anderen, doorgaans zwarte professionals of professionals van kleur met een migratieachtergrond, die gemakkelijk als anders worden herkend en dus als niet geschikt en competent.

De drie hoofdbevindingen dragen gezamenlijk bij aan een ongelijke verdeling van privilege voor witte (aankomend) professionals zonder een migratieachtergrond en structureel nadeel voor niet witte (aankomend) professionals met een migratieachtergrond. Deze ongelijkheid wordt gereproduceerd aangezien de 'ideale-professional-norm' verankerd zit in alledaagse routines, structuren en discursieve praktijken (vertogen en taal) en zo wordt genormaliseerd door alle (aankomend) professionals die allen als goede professional willen worden erkend. De normalisering voorkomt dat (aankomend) professionals zien en voelen hoe zij met elkaar aandeel hebben in het in stand houden van deze ongelijkheden.

Deze hoofdbevindingen zijn echter niet compleet zonder mijn persoonlijke leerervaringen beschreven in de Critical Incidents I-V. In de loop van de studies ben ik op een directe, belichaamde manier gaan voelen *dat* en *hoe* ik zelf deel uit maak van deze bevindingen. Gaandeweg herkende ik hoe ik mezelf afzijdig hield of deed alsof ik mezelf afzijdig kon houden als onderzoeker en hoe ik door mijn abstracte, cognitieve en hierarchische weten en mijn 'witte onschuld' en 'witte kwetsbaarheid', bijdroeg aan normalisering van ongelijkheid en aan uitsluiting, discriminatie en racisme. Dit nieuwe kritische bewustzijn hielp me te identificeren hoe ongelijkheid in stand wordt gehouden en om condities voor transformatie richting inclusie te formuleren, maar bovenal om te zien and te voelen dat ik zelf moest veranderen om bij te kunnen dragen aan deze transformatie.

Dus, om transformatie mogelijk te maken en de academische geneeskunde, het academische ziekenhuis en onderzoek in deze contexten en de academie in het geheel meer inclusief en gelijkwaardig te maken, moeten we bij onszelf beginnen. In plaats van de Ander te willen veranderen, *'fixing the Other'*, moet de focus komen te liggen bij het veranderen van onszelf –*'fixing the Self'*. Normalisering kan alleen maar doorbroken worden als ik bij mezelf onderzoek wat ik 'normaal' vind and wat ik dus automatisch waardeer en includeer, oftewel door kritische reflexiviteit te ontwikkelen. Als ik mezelf op deze manier inbreng, kan ik helpen dominante normen en de onderliggende hiërarchieën uit te dagen en ongelijkheid tegen te gaan. Dit is een dagelijks terugkerend proces van de verbinding en het contact aangaan met anderen vanuit hoofd *en* hart. Stakeholders in een bepaalde context moeten samen werken aan het diverser maken van de (toekomstige) beroepsgroep ('fixing the numbers'), het hervormen van de organisatiestructuur en –praktijk zodat deze inclusiever zijn ('fixing the institutions') en het herdefiniëren van de fundamentele ideeën over kennis waar deze structuren en praktijken op zijn gebaseerd (niet over de Ander maar met anderen) ('fixing the knowledge'). Dit aangaan, vraagt van iedereen dat zij (1) hun *'medeplichtigheid' in normalisering erkennen*; (2) vanuit hun *emoties van ongemak werken* om verantwoordelijkheid op te pakken vanuit een horizontale relatie van onderlinge afhankelijkheid en wederkerigheid, en zo –vooral als witte mensen zonder migratieachtergrond– herkennen hoe we allemaal aandeel hebben in stucturele ongelijkheden, leren spreken over racisme evenals witte onschuld en witte kwetsbaarheid, en normalisering uitdagen; en (3) hiermee *kritisch-reflexieve, belichaamde en gedeelde ruimtes creëren* waarin plaats voor verschil, diepe connecties en collectieve actie voor transformatie richting inclusie gestalte kan krijgen.

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

Dankwoord

To all diversity workers in the Netherlands and beyond: respect for your Sisyphus-work, I hope you keep it up. I hope this book counters the fatigue that makes diversity issues into a boomerang, and inspires conversations that make brick walls – and glass ceilings – crumble.

I had the pleasure to meet lots of inspirational people in the course of my phd that steered me to my current focus on the cross roads of inclusive, caring and participatory research and theory, performative action and sensory-emotive scholarly engagement. I cannot name all of them, also to protect their privacy, but I am grateful to all. To name a few: Philomena Essed, Guno Jones, Ayelet Kuper, Gloria Wekker. Inspirational speakers. Jennifer Greene, Stafford Hood on my first trip to the US and to an international conference. Sarah Banks, Tina Cook, who give PAR heart and feet. Janusz Janczukowicz in Lodz, I hope to visit – with Maaike – soon. The inspiring colleagues of the AMEE special interest group Gender & Diversity, I hope to see you again in 2020. Katarina Hamberg, Emelie Kristoffersson, Jenny Andersson & Bodil Formark, Saima Diderichsen and colleagues of the department of public health & clinical medicine, Umeå University, Sweden. Your welcome was so generous and warm that I never felt the cold. I hope to be back. Don't hesitate to come down south and stay with us at Basse. All colleagues from the UFS-UCLA-VUA network, I hope to participate in more of your highly engaging, bordercrossing and unsettling conferences-with-bbq. Vivienne Bozalek, Veronica Mitchell, Neil Henderson, Nadira Omarjee, Tammy Shefer, Melissa Steyn and colleagues, for meeting with me during my stay in South-Africa and helping me broaden my horizon. Thanks to Sheri Six for her adequate and personal editing work on the General Discussion of this book. All colleagues of the IDI-group for enriching discussions at the end of the day –and good food. Marjolein Broese van Groenou en Bianca Beersma van de VU voor jullie warme en enthousiaste welkom. Joris Rijbroek en het ISR. Het is een groot plezier met jullie samen te werken. Alle collega's van Sociologie, Organisatiewetenschappen. Alle collega's van de NVMO-werkgroep Diversiteit, van de Taskforce VU-EUR-LU, en alle anderen die in UMC's, aan de universiteit en vanuit cliënten- en zelforganisaties handen en voeten geven aan diversiteit. Alle VUmc-ers die diversiteit een warm hart toedragen en/of hun kritiek niet onder stoelen of banken steken. Alle mensen die direct of indirect betrokken waren bij mijn onderzoek, bovenal iedereen die me in vertrouwen nam en zijn of haar verhaal deelde; dat blijft me altijd bij en ik hoop dat we in gesprek blijven om verder vorm te geven aan inclusie. Eric Akum, Alan Betasi, Sandra Boer, Nina Boom, Gerda Croiset voor het in gang zetten, Lina Issa, Rosanne Leguijt, Hajar Rifi, Reina Steenwijk, Mara van Stiphout, Willeke Stitselaar, Manon Stockmann en alle leden van de Interculturalisatie commissie van VUmc, Joeri Tjitra. Alle studenten van D.O.C.S. Bedankt allemaal voor jullie vuur en betrokkenheid. Lieve Metamedica-ers, lieve mede-junioren, wat een bijzonder vat vol bruisende energie; bij jullie kreeg ik het plezier en de motivatie terug én leerde ik de noodzaak zelf rust in te bouwen en te vertragen. Lieve Wieke, etentjes om weer moed te vatten, gaven energie; en nu zijn we allebei ook moeder, wie had dat gedacht. Lieve Tineke, Halleh en Petra, ik prijs me gelukkig met jullie als begeleiders op deze reis. Onze gesprekken gingen alle kanten op, bezorgden

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About the author

Hannah Leyerzapf (1983) was born and raised in Amsterdam and studied cultural anthropology at the University of Amsterdam. She focused on empowerment, social and religious activism, identity politics and multiculturalism, and wrote her Master thesis under supervision of prof. Thijl Sunier on empowerment processes and Islamic women's activism of Muslim women in Rotterdam. During her studies she worked on a project of dr. Ibrahim Yerden on domestic violence within families with a migrant background in the Netherlands ('*Families onder druk. Huiselijk geweld in Marokkaanse en Turkse gezinne*n', Van Gennep, 2008). After obtaining her Master's degree, she worked at the International Institute for the Study of Islam in the Modern World in Leiden and the Amsterdam School for Social Science Research with prof. Annelies Moors on projects on face veiling of Muslim women in the Netherlands and Islamic fashion in Europe ('*Gezichtssluiers. Draagsters en Debatten*', ISIM/ASSR, 2009). Since 2010 she is a researcher and teacher at the department of Medical Humanities of Amsterdam UMC, location VUmc. She performed research on diversity, participation, empowerment, joint decision-making and care ethics from a critical diversity and intersectionality perspective together with experiential experts and social partners in health care and academic medicine. She has worked as a tutor and mentor in medicine and the health sciences, taught on diversity issues, care ethics, medical sociology and research methods, and was involved in the development of the new longitudinal pathway Interculturalisation and Diversity of VUmc School of Medical Sciences. She also developed workshops on diversity and exclusion, normalization and white innocence in higher education and health care. Since 2017 she is affiliated to the department of sociology of the VU University, were she coordinates the Expertise Lab Diversity in Care/ *Diversiteit in Zorg* of the Institute for Societal Resilience. Her current focus is to bring together diversity and intersectionality issues with care ethics and action oriented and embodied methods in order to develop reflexivity and inclusion in health care, education and research together with students, professionals and advocates. She was rewarded a Comenius Teaching Fellowship 2019 with a participatory theater project on student well-being, safety and inclusion. Since 2018 she lives in the countryside in the '*Kop van Overrijsel*' with her husband who is a psychiatrist and their newborn son.

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What is the norm? Who stands out as the Other? Who is 'invisible' and automatically included? This book reports on the experiences of exclusion, discrimination and racism of Dutch students and professionals with a migrant background in medical education and the academic hospital in the Netherlands. It describes the normalization and white innocence at play in determining who is perceived as different and who as normal, and how this impacts the appraisal of professionalism, i.e. who is at risk at being undervalued and who is more easily recognized as a good professional. Through a critical understanding of everyday education and work place interactions, the book discusses how students, professionals as well as researchers with and without a migrant background are implicated in 'un-seeing' and sustaining inequality. Moreover, it focuses on how (future) professionals –including researchers–, black, white and of colour, need to 'unsettle' normalization and develop reflexive practices together in order to make academic health care within the Netherlands and beyond more inclusive and equitable.

The author, blindfolded, at the C2ME teacher training in 2015. Photographer: Lina Issa.