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CHAPTER 7

Veiled ambitions

Female Muslim medical students and their 'different' experiences in medical education

Hannah Leyerzapf, Hajar Rifi, Tineke Abma & Petra Verdonk

ABSTRACT

Background: *In North-Western Europe, medical student populations are both feminised 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.*

Aim: *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.*

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

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Findings: *We found three domains of experienced difference:*

1. *leading a different student life;*
2. *being (considered) a different medical student; and*
3. *anticipating 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 microaggressions and everyday racism and segregation between students with a migrant background and those without, are at play.

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

Keywords: female Muslim students; medical education; visibility of difference; professional normativity & Othering in academic medicine; inclusion

INTRODUCTION

Diversity entering the medical school

While it was once a white male bastion, over the last decades, a group of culturally diverse students have been entering the 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 feminisation 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 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

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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, an 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).

The medical school in the Dutch context

In The Netherlands, medical education is highly feminised 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 1995, around the time the children of gastarbeiders – economic migrants that were recruited by the government in the 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 Muslims, they are considered to belong to the largest minority religious group in the country, together with students with a refugee background from Middle Eastern and African countries (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

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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 of their 'own' religious, cultural and/or ethnic communities (Ghorashi, 2010; 2014). Until now, Muslim women have been 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 VU, 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 a 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 (Van Dun. 2014). This institution 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 the 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 & Verdonk, 2016; Verdonk & Abma, 2013; Verdonk, Muntinga, Leyerzapf & Abma, 2019).

THEORETICAL FRAMEWORK

A critical-intersectionality perspective helps to deconstruct how identity aspects intersect in experiences of female Muslim medical students, and how these

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intersections may work together to produce structural exclusion (Muntinga et al., 2016; Verdonk & Abma, 2013; Verdonk et al., 2019), as well as 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 are 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).

Microaggressions are a form of everyday racism constituting repetitive, aggressive exclusionary actions that are not recognised as such because they are presented as (stigmatising) 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, microaggressions 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-

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class women, who do not practice religion – nevertheless, one was raised in Christianity and one was raised in a Christian-inspired environment, the other 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 was, at the time of the study, a student herself. She conducted the interviews. We all have (had) a career in higher education, two of us also in healthcare. We work at the cross-roads of 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 took place via snowballing starting with 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, as well as 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 was as follows: undergraduate, female and 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 approximately 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

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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's and 8 were Master's students.[1] 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 and outlook on career perspectives. The interviews lasted between 60 and 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 women did their internship. All interviews were digitally recorded after written consent and transcribed verbatim by the interviewer.

Data analysis

The data were analysed 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:

1. familiarisation with the data (first, second and fourth author), as well as setting up a list of *in vivo* codes (second author/interviewer);
2. independent coding and clustering of codes of some transcripts (first and fourth author), followed by a critical comparison of the codes and clusters (first, second and fourth author); and

1 In The Netherlands, undergraduate medical education starts with a 3-year preclinical phase, during which the focus is on acquiring theoretical and practice-based knowledge and skills, followed by a 3-year clinical phase in which students perform internships. On completion of 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.

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3. a discussion of final themes by the research team and through the use of the sensitising concepts described in the theory section. The researchers agreed on 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). The 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 and could ask questions, also signing 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 was anonymised 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 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

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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 "have 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 have to sit there.

Many participants emphasised being both unfamiliar, as well as sometimes uncomfortable with certain aspects of 'Dutch' life styles. They felt like they were missing 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 – 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':

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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 socialising 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.

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In sum, upon entering medical school and facing e.g. introduction rituals, female Muslim students became aware of standing 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 socialising 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 to be 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 they felt both

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stigmatised and marginalised 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 life style 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

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> 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!"

Participants also spoke 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.

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In sum, participants developed a sense of being made out to be 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 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 was the physical examination trainings which in The Netherlands students have to practice on each other. Many participants stated that they strategically prepared themselves for physical examination trainings and shared 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. Similar to 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."

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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 lack of 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,

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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 stigmatisation:

> 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 that they stood 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 being 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 being 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 the were 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

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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, essentialised and oppositional identifications as they spoke in rather polarised terms as 'us' and 'them'. However, they challenged the identifications as well as made clear that they 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 marginalised and silenced. Recognising 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

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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 emphasised 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 and Roggeband (2010) and Van Laer and 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.

Microaggressions and everyday racism

The narratives of our participants not only accounted of being considered and feeling different, they showed patterns of microaggressions, 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. involving professional norms. In case study discussions participants were aware of being Othered as they signaled that patients and they themselves became stigmatised. Stigmatisation focused on Muslim patients and especially on female Muslim patients, and Islamic/cultural/ethnic practices were 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-professionalise' and 'de-value' their status as a medical student and future physician and undermine their professional development.

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In physical examination training, the participants clearly felt wrongly 'disqualified' and Othered. Participants knew female students who were not Muslim and shared their concerns regarding the layout 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 culturalising, i.e. 'blaming' it on culture (Ghorashi, 2010), which earlier studies corroborate (Card, 2012; Chang & Power, 2000; Rees, Wearn, Vnuk & Sato, 2009).

The Othering the 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 racialised Other in medical education.

Hyper/invisibility of female Muslim medical students

Female Muslim students in our study were identified as the ultimate Other. A shift seems to have taken place from seeing women in medicine as the Other

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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 racialisation 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 racialised 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 racialised 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 racialised 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 August 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

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general (e.g. *Medisch Contact*, 8 June 2017; *De Volkskrant*, 10 June 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 racialised 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 racialised/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' which may be depoliticised and racialised 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 became 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 polarised terms of participants unreflectively and reproduced the segregation participants experienced as she had similar experiences as a young female Muslim. The other researchers were sensitised 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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REFERENCES

Ahmed, S. 2012. *On being included. Racism and diversity in institutional life*. Durham: Duke University Press. https://doi.org/10.1215/9780822395324

Alers, M. 2014. *Specialty Preferences of Medical Students: Gender and Work-Life Balance*. PhD thesis. Nijmegen: Radboud University Nijmegen.

Beagan, B.L. 2003. Is this worth getting into a big fuss over? Everyday racism in medical school. *Medical Education*, 37(10):852-860. https://doi.org/10.1046/j.1365-2923.2003.01622.x

Beagan, B.L. 2005. Everyday classism in medical school: experiencing marginality and resistance. *Medical Education*, 39(8):777-784. https://doi.org/10.1111/j.1365-2929.2005.02225.x

Bernard, H.R. 2011. *Research Methods in Anthropology: Qualitative and Quantitative Approaches*. New York: Rowman AltaMira.

Bhopal, R.S. 2007. Racism in health and health care in Europe: reality or mirage? *European Journal of Public Health*, 17(3):238-241. https://doi.org/10.1093/eurpub/ckm039

Boogaard, B. & Roggeband, C. 2010. Paradoxes of Intersectionality: Theorizing Inequality in the Dutch Police Force through Structure and Agency. *Organization*, 17:53-75. https://doi.org/10.1177/1350508409350042

Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2):77-101. https://doi.org/10.1191/1478088706qp063oa

Card, R.F. 2012. Is there no alternative? Conscientious objection by medical students. *Journal of Medical Ethics*, 38:602-604. https://doi.org/10.1136/medethics-2011-100190

Carr, P.L.; Palepu, A.; Szalacha, L.; Caswell, C. & Inui, T. 2007. "Flying below the radar": qualitative study of minority experience and management of discrimination in academic medicine. *Medical education*, 41:601-609. https://doi.org/10.1111/j.1365-2923.2007.02771.x

Chang, E.H. & Power, D.V. 2000. Are medical students comfortable carrying out peer examinations on each other? *Academic Medicine*, 75:384-389. https://doi.org/10.1097/00001888-200004000-00020

Coker, N. 2001. *Racism in medicine: an agenda for change*. London: King's Fund.

Denzin, N.K. 1973. *The research act: a theoretical introduction to sociological methods*. New Brunswick, US: Transaction publishers.

Denzin, N.K. & Lincoln, Y.S. (eds.). 2005. *The SAGE Handbook of Qualitative Research*. Thousand Oaks, CA: SAGE Publications.

DiAngelo, R. 2011. White fragility. *International Journal of Critical Pedagogy*, 3(3):54-70.

Diderichsen, S. 2017. *It's just a job. A new generation of physicians dealing with career and work ideals*. PhD thesis. Umeå: Umeå University.

https://doi.org/10.18820/9781928314578/07
© 2020 African Sun Media and the editors

M Crul, L Dick, H Ghorashi & A Valenzuela Jr (eds). 2020. Scholarly Engagement and Decolonisation. Stellenbosch: African Sun Media.

Essed P. 1991. *Understanding Everyday Racism. An Interdisciplinary Theory*. SAGE Series on Race and Ethnic Relations, Vol. 2. London: SAGE Publications. https://doi.org/10.4135/9781483345239

Essed, P. 2005. Gendered preferences in racialized spaces: Cloning the physician. In: K. Murji & J. Solomos (eds.), *Racialization: Studies in Theory and Practice:* Oxford: Oxford University Press. pp.227-247.

Essed, P. & Hoving, I. 2014. Innocence, Smug Ignorance, Resentment: An Introduction to Dutch Racism. In: P. Essed & I. Hoving (eds.), *Dutch Racism*. Amsterdam: Rodopi. pp.9-30. https://doi.org/10.1163/9789401210096

Fenema van, E. 2017. De diversiteitsmantra wordt vooral gepredikt door mensen die zelf niet gelovig zijn. *Medisch Contact*, 23:13.

Fried, J.M.; Vermillion, M.; Parker N.H. & Uijtdehaage, S. 2012. Eradicating medical student mistreatment: a longitudinal study of one institution's effort. *Academic Medicine*, 87(9):1191-1198. https://doi.org/10.1097/ACM.0b013e3182625408

Ghorashi, H. 2008. Giving silence a chance: The importance of life stories for research on refugees. *Journal of Refugee Studies*, 21(1):117-133. https://doi.org/10.1093/jrs/fem033

Ghorashi, H. 2010. From absolute invisibility to extreme visibility: Emancipation trajectory of migrant women in The Netherlands. *Feminist Review*, 94:75-92. https://doi.org/10.1057/fr.2009.38

Ghorashi, H. 2014. Racism and "the Ungrateful Other" in The Netherlands. In: P. Essed & I. Hoving (eds.), *Dutch Racism*. Amsterdam: Rodopi. pp.101-116. https://doi.org/10.1163/9789401210096_006

Green, J. & Thorogood, N. 2014. *Qualitative Methods for Health Research*. 3rd Edition. London: SAGE Publications.

Guest, G.; Bunce, A. & Johnson, L. 2006. How Many Interviews Are Enough? An Experiment with Data Saturation and Variability. *Field Methods*, 18(1):59-82. https://doi.org/10.1177/1525822X05279903

Hardeman, R.R., Medina, E.M. & Kozhimannil, K.B. 2016. Structural racism and supporting black lives – the role of health professionals. *The New England Journal of Medicine*, 375(22):2113-2115. https://doi.org/10.1056/NEJMp1609535

Hassouneh, D.; Lutz, K.F.; Beckett, A.K.; Junkins, E.P. & Horton, L.L. 2014. The experiences of underrepresented minority faculty in schools of medicine. *Medical Education Online*, 19(1):24768. https://doi.org/10.3402/meo.v19.24768

De Jong, M. 2012. *Ik ben die Marokkaan niet! Onderzoek naar identiteitsvorming van Marokkaans-Nederlandse hbo-studenten*. PhD thesis. Amsterdam: VU University.

Kaatz, A. & Carnes, M. 2014. Stuck in the Out-Group: Jennifer Can't Grow Up, Jane's Invisible, and Janet's Over the Hill. *Journal of Women's Health*, 23(6):481-484. https://doi.org/10.1089/jwh.2014.4766

https://doi.org/10.18820/9781928314578/07
© 2020 African Sun Media and the editors

M Crul, L Dick, H Ghorashi & A Valenzuela Jr (eds). 2020. Scholarly Engagement and Decolonisation. Stellenbosch: African Sun Media.

Karpowitz, C.F., Raphael, C. & Hammond, A.S. 2009. Deliberative Democracy and Inequality: Two Cheers for Enclave Deliberation among the Disempowered. *Politics & Society*, 37(4):576-615. https://doi.org/10.1177/0032329209349226

Latten, J. & Van Dijk, W. 2007. *Jonge vrouwen hoger opgeleid dan mannen*. Available: http://bit.ly/2OgRGff [accessed 9 March 2014].

Lee, K.B.; Vaishnani, S.N.; Lau, S.K.; Andriole, D. & Ajeffe, D.B. 2009. Cultural competency in medical education: demographic differences associated with medical student communication styles and clinical clerkship feedback. *Journal of the National Medical Association*, 101:116-126. https://doi.org/10.1016/S0027-9684(15)30823-3

Leyerzapf, H. & Abma, T. 2017. Cultural minority students' experiences with intercultural competency in medical education. *Medical Education*, 51(5):521-530. https://doi.org/10.1111/medu.13302

Leyerzapf, H.; Abma ,T.A.; Steenwijk, R.R.; Croiset, G. & Verdonk, P. 2015. Standing out and moving up: performance appraisal of cultural minority physicians. *Advances in Health Sciences Education*, 20(4):995-1010. https://doi.org/10.1007/s10459-014-9577-6

Leyerzapf, H.; Verdonk, P.; Ghorashi, H. & Abma, T. 2018. "We are all so different that it is just… normal." Normalization practices in an academic hospital in The Netherlands. *Scandinavian Journal of Management*, 34(2):141-150. https://doi.org/10.1016/j.scaman.2018.03.003

Lucassen, J. & Penninx, R. 1996. *Nieuwkomers, nakomelingen, Nederlanders*. Amsterdam: Het Spinhuis.

Mahoney, M.R.; Wilson, E.; Odom, K.L.; Flowers, L. & Adler, S.R. 2008. Minority Faculty Voices on Diversity in Academic Medicine: Perspectives from One School. *Academic Medicine*, 83(8):781-786. https://doi.org/10.1097/ACM.0b013e31817ec002

Muntinga, M.E.; Krajenbrink, V.Q.E.; Peerdeman, S.M.; Croiset, G & Verdonk, P. 2016. Toward diversity-responsive medical education: taking an intersectionality-based approach to a curriculum evaluation. *Advances in Health Sciences Education*, 21(3):541-559. https://doi.org/10.1007/s10459-015-9650-9

Nierse, C.J. & Abma, T.A. 2011. Developing voice and empowerment: the first step towards a broad consultation in research agenda setting. *Journal of Intellectual Disability Research*, 55(4):411-421. https://doi.org/10.1111/j.1365-2788.2011.01388.x

Van Dun, M. 2014. *PVV wil financieringsstop Vrije Universiteit om gebedsruimte.* Het Parool. Available: http://bit.ly/3aUnD6J [accessed 22 November 2017].

Peterson, N.B.; Friedman, R.H.; Ash, A.S.; Franco, S. & Carr, P.L. 2004. Faculty Self-reported Experience with Racial and Ethnic Discrimination in Academic Medicine. *Journal of General Internal Medicine,* 19(3):259-265. https://doi.org/10.1111/j.1525-1497.2004.20409.x

Petzen, J. 2012. Contesting Europe: A call for an anti-modern sexual politics. *European Journal of Women Studies*, 19(1):97-114. https://doi.org/10.1177/1350506811426390

https://doi.org/10.18820/9781928314578/07
© 2020 African Sun Media and the editors

M Crul, L Dick, H Ghorashi & A Valenzuela Jr (eds). 2020. Scholarly Engagement and Decolonisation. Stellenbosch: African Sun Media.

Phillips, S.P. & Austin, E.B. 2009. The Feminization of Medicine and Population Health. *JAMA*, 301(8):863-864. https://doi.org/10.1001/jama.2009.155

Van der Raad, S. 2015. *Othering and Inclusion of Ethnic Minority Professionals. A study on Ethnic Diversity Discourses, Practices and Narratives in the Dutch Legal Workplace*. PhD thesis. Amsterdam: VU University.

Van Laer, K. & Janssens, M. 2011. Ethnic minority professionals' experiences with subtle discrimination in the workplace. *Human Relations*, 64(9):1203-1227. https://doi.org/10.1177/0018726711409263

Van Miltenburg, T. 2007. *Allochtonen in hoger onderwijs in opmars. Webmagazine of Centraal Bureau voor de Statistieken*. Available: http://bit.ly/2GDk0nT [accessed 9 March 2014].

Rademakers, J.J.D.J.M.; Van Den Muijsenbergh, M.E.T.C.; Slappendel, G.; Lagro-Janssen, A.L.M. & Borleffs, J.C.C. 2008. Sexual harassment during clinical clerkships in Dutch medical schools. *Medical Education*, 42(5):452-458. https://doi.org/10.1111/j.1365-2923.2007.02935.x

Rees, C.E.; Wearn, A.M.; Vnuk, A.K. & Sato, T.J. 2009. Medical students' attitudes towards peer physical examination: findings from an international cross-sectional and longitudinal study. *Advances in Health Sciences Education*, 14:103-121. https://doi.org/10.1007/s10459-007-9094-y

Rowlands, J. 1998. A Word of the Times, but What Does it Mean? Empowerment in the Discourse and Practice of Development. In: H. Afshar (ed.), *Women and Empowerment. Women's Studies at York*. London: Palgrave Macmillan. pp.1-34. https://doi.org/10.1007/978-1-349-26265-6_2

Sauer, B. 2009. Headscarf regimes in Europe: Diversity policies at the intersection of gender, culture and religion. *Comparative European Politics*, 7(1):75-94. https://doi.org/10.1057/cep.2008.41

Selleger, V.J.; Bonke, B. & Leeman, Y.A.M. 2006. Student diversity at Erasmus Medical Centre Rotterdam: does it make any difference? *Medical Teacher*, 28(5):142-148. https://doi.org/10.1080/01421590600776552

Singaran, V.S.; Van der Vleuten, C.P.M.; Stevens, F. & Dolmans, D.H.J.M. 2011. For most of us Africans, we don't just speak: a qualitative investigation into collaborative heterogeneous PBL group learning. *Advances in Health Sciences Education*, 16:297-310. https://doi.org/10.1007/s10459-010-9262-3

Slootman, M. 2014. *Soulmates. Reinvention of ethnic identification among higher educated second generation Moroccan and Turkish Dutch*. PhD thesis. Amsterdam: University of Amsterdam.

Sue, D.W.; Capodilupo, C.M.; Torino, G.C.; Bucceri, J.M.; Holder, A.M.; Nadal, K.L. & Esquilin, M. 2007. Racial microaggressions in everyday life. *American Psychology*, 62(4):271-286. https://doi.org/10.1037/0003-066X.62.4.271

https://doi.org/10.18820/9781928314578/07
© 2020 African Sun Media and the editors

M Crul, L Dick, H Ghorashi & A Valenzuela Jr (eds). 2020. Scholarly Engagement and Decolonisation. Stellenbosch: African Sun Media.

Tong, A.; Sainsbury, P. & Craig, J. 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6):349-357. https://doi.org/10.1093/intqhc/mzm042

Turner, C.S.V.; González, J.C. & Wood, J.L. 2008. Faculty of Color in Academe: What 20 Years of Literature Tells Us. *Journal of Diversity in Higher Education*, 1(3):139-168. https://doi.org/10.1037/a0012837

Van der Velden, L.F.J.; Hingstman, L.; Heiligers, P.J.M. & Hansen, J. 2008. Toenemend percentage vrouwen in de geneeskunde: verleden, heden en toekomst. *Nederlands Tijdschrift voor Geneeskunde*, 152(40):2165-2171.

Verdonk, P. 2013. *Leerlijn Interculturalisatie en diversiteit*. Amsterdam: VUmc.

Verdonk, P. & Abma, T. 2013. Intersectionality and reflexivity in medical education research. *Medical Education*, 47:754-756. https://doi.org/10.1111/medu.12258

Verdonk, P.; Muntinga, M.; Leyerzapf, H. & Abma, T. 2019. From Gender Sensitivity to an Intersectionality and Participatory Approach in Health Research and Public Policy in The Netherlands. In: O. Hankivsky & J.S. Jordan (eds.), *The Palgrave Handbook of Intersectionality in Public Policy (Ch. 18)*. Palgrave Macmillan. https://doi.org/10.1007/978-3-319-98473-5_18

Hooghiemstra, D. 2018. Opinie op zondag: hoofddoek illustreert de kloof met het individualistische Nederland. *De Volkskrant*, 10 June.

Wagenvoort, H. & Lagro-Janssen, T. 2010. *Feiten en cijfers over (aanstaande) artsen m/v.* Nijmegen: Vrouwenstudies Medische Wetenschappen, UMC St Radboud.

Wekker, G. 2016. *White Innocence: Paradoxes of Colonialism and Race*. Durham, NC: Duke University Press. https://doi.org/10.1215/9780822374565

https://doi.org/10.18820/9781928314578/07
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