



## “Diversity” in hospitals: social identities and discriminations

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### **Abstract**

“Diversity” is a structuring dimension of healthcare institutions in France today. Public and private hospitals employ a very socially and culturally diversified staff, to which they offer upward social mobility opportunities. This diversity constitutes an asset, which allows healthcare institutions to welcome a very diversified public, including people with an immigration background or coming from the French Overseas Territories or Departments (DOM-TOM).

The social perceptions and representations that frame this diversity are part of an institutional logic specific to healthcare

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institutions, and differ from the dominant frames used in public debates on this topic. While public debates focus on the issue of *laïcité* in the hospital (refusal of care for religious purposes, the wearing of religious symbols by staff members), this issue is not perceived as a priority by professionals on the field. Racial discrimination, which takes various forms in hospitals (between staff members, between professionals and users), is not either seen as a priority in discussions or actions of healthcare institutions' managers (directors, HR), or rarely so.

This research on the construction of social identities and discrimination in hospitals is based on fieldwork conducted in 4 public and private hospitals in the Paris region, between March 2009 and December 2010. In total, 116 interviews have been conducted with healthcare professionals (medical, paramedical and administrative staff members), patients and members of non-profit organisations working in hospitals.

### **An institution providing integration and social mobility**

The professionals that we interviewed understand the hospital (public or private) as an institution of integration. It provides them with a job, the possibility to catch up qualifications, an upward social mobility, a positive status and social dignity and prestige. Becoming a healthcare professional is also a very socially positive involvement in the work of an institution "serving" French society. This dimension is particularly important for staff members with a post-colonial immigration background who are transformed, through their status as healthcare professional, from a "population to be integrated" to "agents of integration": through care, they also work for a more integrated society.

When defining their perception of professionalism, healthcare professionals express their attachment to institutional values that enshrine the universal character of care (principle of equal treatment, professional neutrality). They also give value to their cultural belonging or experience, which enhance their professional skills. They perceive this complementarity between "universalism" and "cultural features" as enabling them to be better workers, providing tailored and successful services to users with an immigration background or originating from overseas territories.

Interviewees share a "universalist" conception of healthcare professionals' social identity, while simultaneously recognising the need to cater for the cultural or religious identities of patients through adapted social practices.

Staff members - including staff members with an immigration background or originating from overseas territories - consider

public and private hospitals as culturally neutral spaces, linked to the practise of a professional ethic that focuses primarily on the treatment of patients. Interviews thus reveal the absolute incompatibility between the objective of interviewees' professional practise (care), and racism, xenophobia, Islamophobia or anti-Semitism.

That said, hospitals are very hierarchical and differentiated institutions (medical vs. paramedical, prestigious vs. less prestigious units, etc.), in which minority groups are over-represented in less qualified professions. This sometimes generates culturalised interpretations of the relations between different staff members based on the function that they occupy. A culturalised boundary also separates French staff members from foreign staff members. Despite equivalent degrees, the latter are unable to access positions accessible to the former, even when they endorse equivalent professional responsibilities (the so-called "faisant fonction").

#### **« Diversity » as a component of the institutional relation of care**

The perceived "diversity" of healthcare professionals and patients influences the development of the patient-provider relationship. The cultural proximity/intimacy felt by hospital agents and users often make it possible to reduce the institutional asymmetry and distance that exists between professionals and patients, and thus facilitate the negotiation of the care's modalities. Healthcare professionals consider the accommodation of professional practices to patients' religious or cultural practices as an important aspect of their work, aiming at giving care in the best possible conditions.

In the absence of clear and adequate institutional rules on this issue, and of professional training in managing diversity in healthcare institutions, medical and paramedical staff members are often forced to resort to "do-it-yourself" solutions: taking care of patients that do not speak French, respecting eating habits or restrictions, receiving patients' families, etc. Staff members with an immigration background play a central role in implementing these "do-it-yourself" solutions because they know how to use the necessary cultural skills in their relations with patients. These "do-it-yourself" solutions sometimes lead healthcare professional to circumvent formal rules, with the approval of unit managers. For example, caregivers can sometimes accept the introduction of food products from outside the institution.

In the eyes of the patients, these "do-it-yourself" solutions can sometimes diminish the gap separating the professional identity

of the agent from his personal identity. Healthcare professionals can be perceived by some patients as being more familiar and "owing" them more attention because of their perceived "sameness". Users might then settle down more comfortably within the institution's premises, appropriating its space and operational rules, resulting in constant negotiation between patients and carers to keep an "appropriate distance" – one that establishes a balance between the patient/provider relationship and the personal relationship, between institutional distance and cultural proximity, that is necessary if caregivers want to perform their tasks in a satisfactory manner.

### **Differing stakes "inside" and "outside": the institution and the public debates**

Healthcare institution members are not insensitive to debates occurring in the public space (on integration, diversity, *laïcité* or Islam), but they will tend to draw a boundary between their own ideological convictions and the frames of their practice as healthcare professionals. Hospitals remain, in their view, a separate space, in which issues of cultural or religious diversity cannot be apprehended based on the abstract or normative definitions given by republican public philosophy, but rather through a practical appreciation of the treatment to be given while preserving the units' functioning.

Observations from the field and analysis of the interviews conducted also indicate that none of the "issues with Islam in the hospital" portrayed in public debates are reflected in the day-to-day work inside the hospital.

The institution is not the subject of "identitarian" claim-making, or of "communalistic" practices that would prevent it from functioning well. That said, the recent politicisation of such issues in public debates sometimes creates situations that are difficult to manage inside the hospital: laws that do not apply to hospitals (such as the law of the 15<sup>th</sup> of March 2004) are invoked to ban staff members from wearing religious symbols; internal agreements between staff members to replace the veil or the kippah by mob caps are the subject of debates in the media; healthcare professionals are asked to justify their permission of religious practice within patients' rooms, which are considered by law as private spaces. The consequence of these "interventions" is to freeze the internal negotiations that are essential to the functioning of all medical units.

### **Racial discrimination, an invisible man in the hospital**

We observed three forms of racial discrimination, actual or perceived, in hospitals: patients discriminating against healthcare professionals on the basis of their actual or perceived origin; healthcare professionals discriminating against patients; staff members and/or managers discriminating against other healthcare professionals. The first type of discrimination is the one most often quoted by interviewees. Healthcare professionals say that they suffer from this discrimination every day, through a questioning of their professional skills or refusal of care, for example. They call this discrimination "ordinary racism". Most of the time, medical and paramedical staff members trivialize these racist attitudes and comments, and giving as a justification for it the asymmetry of the patient-provider relationship: the patient is old, sick and fragile, and can therefore be forgiven. Healthcare professionals are used to ignoring this racism in order to perform effectively in their job, and take care of all patients.

Some patients can also feel discriminated by staff members. The professionals interviewed say that they are aware of this dynamic, and analyse it as being the result of the inferior position that patients have within the patient-provider relationship: as patients are ignorant of the operational rules of care units, they may interpret perceived differences in treatment as a form of racism they fall victim too, even if it is not the case. A patient may notice for example that patients that have arrived later than him are taken-in more rapidly, and explain it in racial terms, when in fact healthcare professionals organise their priorities among patients based on the seriousness of their situation. Professionals interviewed, however, consider that racism and racial discrimination from staff members against users can exist, and report situations they witnessed in which xenophobic discourses were held, or the equal treatment principle was not respected.

Working in an institution structured by universalistic principles does not prevent healthcare professionals from suffering from racist or discriminating displays on part of their colleagues or superiors. Medical and paramedical staff members belonging to minority groups are likely to be confronted to racism throughout their carrier: from training to working in a full-time position, within their own unit or in the context professional promotions. Staff members that benefit from "improved leave" (*congés bonifiés* – a special regime of paid holidays for civil servants originating from the French overseas department) based on them originating from the overseas territories constitute a special case, as managers openly recognise their discriminating attitude toward them.

The analysis of the solutions implemented to address racial discrimination, as described by interviewees, shows a strong similarity across the three types of discrimination observed in the terms of the settlements found. In each case, staff members settle conflicts first and foremost within their working unit. Cases of racism or racial discrimination are only exceptionally put forward outside the unit, to members of the institution's management team, or even more exceptionally to external authorities such as the *Défenseur des droits*. The "local" settlement of cases of racial discrimination leads managers to remain unaware of the extent of the phenomenon within the institution. Furthermore, the victims will tend to silence their experience of a racist relation, for all three types of discrimination described. Patients will fear the impacts of such a revelation on their medical treatment, while healthcare professionals will have no institutional solution at their disposal to fight the racial distance imposed on them by patients or colleagues. The experience of racism is a generator of shame in the victims. Their silence and the absence of evidence to sustain their claims prevent the establishment of effective institutional solutions to racist conflicts within healthcare institutions.

## Recommendations

On the basis of our research and analysis, we propose a series of recommendations to strengthen the fight against discrimination and for equality in private and public hospitals.

### Raising awareness, informing, clarifying

One of the main results of this study is that it sheds a light on the lack of information external agents have on the day-to-day work in medical units: healthcare institutions' senior management are not aware of racist and discriminatory practices occurring within the units. This combines with the very weak sharing of information on this issue within the hospital to prevent the fight against racist and discriminatory practices from becoming an operational priority.

The results of the study also highlight the fact that dealing with "diversity" in the hospital generates numerous "do-it-yourself" solutions, which can present some advantages (a certain degree of flexibility in the care relationship can allow for the accommodation of professional practices to each patient). However, these "do-it-yourself" solutions can also be responsible for some difficulties that may hinder the administration of care. To avoid such difficulties, the fight against racial discrimination must be formalized, and become an explicit mission of healthcare institutions. To this end, we suggest the following recommendations:

- Systematize and reinforce the offer of vocational training on sociocultural and religious diversity
- Reinforce the teaching of social and human sciences during university studies that offer a better knowledge of cultural and religious differences and their implications for care
- Create a working group/training session on discriminations and the tools that can be used against it
- Display and communicate on the institution's commitment in favour of the fight against discrimination and for equality
- Clearly display, within the hospital grounds, information on different organisations concerned with the fight against discrimination and for equality in healthcare institutions
- Inscribe racial discrimination on the healthcare institutions' agendas for the fight against abuse
- Clarify the law on *laïcité* and religious freedom within healthcare institutions

### **Improving the fight against discriminations, promoting equality, enhancing "diversity"**

The lack of information of senior managers in healthcare institutions on the extent of the discriminatory phenomenon in medical units prevents the setting up of efficient internal procedures.

Healthcare professionals and patients often express their doubts on possible solutions proposed to deal with a situation of discrimination that they suffer within the hospital. It therefore appears necessary to raise awareness on the issue of discrimination in the hospital, and convince professionals as well as patients of the need to make it an operational priority, but also to devise and implement operational tools within the hospitals. This must be done while showing that the fight against discrimination and for equality does not constitute a burden for hospitals, but that the institution and its members have a lot to gain from supporting it, such as the strengthening of the social legitimacy of hospitals, be they private or public, while still respecting the republican principle of equal treatment. To implement such a strategy, we suggest the following:

- Mobilizing existing mediator/ombudsman (users' representatives, clients' services, quality services, etc.)
- Involving Human Resources Departments in the fight against discriminations
- Using existing tools to report discriminatory situations
- Establishing an operational relationship between the *Défenseur des Droits* and the HAS (High Authority for Health)
- Collaborating with the *Agences Régionales de Santé* (Regional Agencies for Health)
- Reminding the law in the case of discrimination against French people originating from overseas territories and benefiting from *Congés bonifiés* (specific leave)
- Recognizing as a professional skill and added value the knowledge of different languages by the staff.
- Generalising the establishment and use of places of worship in all institutions
- Respecting patients' eating preferences

## **Methodology**

### **Presentation of the fieldwork**

The fieldwork was conducted from March 2009 to December 2010 in 4 healthcare institutions located in the Parisian Region.

Two techniques d'enquête were used: observation in several medical units in the chosen institutions (from a week to a month depending on feasibility), and the conduction of 116 semi-directive qualitative interviews (20 exploratory interviews and 96 fieldwork interviews). All interviews were based on the principles of voluntary participation, anonymity and confidentiality. They have all been integrally transcribed.

### **Research sample**

The investigation's sample was composed of 20 patients and 76 healthcare professionals (13 medical staff members, 50 paramedical staff members, 7 administrative staff members, 6 chaplains or NGO members). Interviewees are divided into 4 categories: French people born in overseas territories (12 interviewees); French people born in France, from foreign parents born in a foreign country (23 "second generation" interviewees); foreign people born in a foreign country and having obtained or not French nationality (37 "immigrant" interviewees); French people born from French parents, themselves born in metropolitan France (24 interviewees).

Women are strongly represented within this sample (69 on 96 interviewees). This clear majority reflects the strong feminization of healthcare positions (particularly paramedical positions). Among the 37 male interviewees (7 patients and 30 professionals), the majority had a position of responsibility.

### **Fieldwork**

We conducted the research's fieldwork in 4 general healthcare institutions located in the Parisian region: 3 public hospitals (two of which are AP-HP institutions) and a private clinic. Three institutions are located in departments where social and economic difficulties combine with a strong ethnic, cultural and religious diversity. These departments are often taken as examples in the media to illustrate the so-called "problem with the 'banlieues'". The fourth institution is radically different from the two others, as it is modern and prestigious Parisian hospital,

located in a much more privileged area in socio-economic terms. It receives a less diversified and older population.

- Croult-la-Ville hospital<sup>3</sup> is a public hospital located in a department that used to be rural but is rapidly urbanizing today, welcoming in the process mostly poor and sometimes foreign populations. It is one of the 10 most important hospitals in the region, with 1000 hospitalisation beds and ambulatory places. It employs around 2000 people, 300 of which are physicians and surgeons.
- The Grand Chemin Clinic is a private and independent clinic, originally a family business. Located in an area characterised by a very strong social and cultural diversity, it possesses 320 hospitalisation beds and ambulatory places. It employs 450 people, 80 of which are physicians and surgeons.
- The hospital of Ermine-lès-Paris was created in the 1930's. It became an AP-HP institution and a teaching hospital in the 1960's. This institution has always been rooted in its local environment, characterised by a strong density of foreign populations or populations with a migration background. It possesses 570 hospitalisation beds and ambulatory places. It employs more than 2000 people, 450 of which are physicians and surgeons.
- The Hôpital Parisien opened 10 years ago. Settled in modern and comfortable buildings, this institution brings together the highest skills and competencies of the AP-HP. This hospital pursues a very local strategy, catering for a wealthy and old population, as well as for younger and poorer patients coming from the nearest suburbs. This institution also attracts 3% of very wealthy and sometimes prestigious patients who come from abroad to benefit from specific surgical treatment. It possesses 900 hospitalisation beds and ambulatory places. It employs 3200 people, 450 of which are physicians and surgeons.

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<sup>3</sup> All investigated institutions' names have been changed for confidentiality reasons.