Social Science & Medicine 174 (2017) 35–42

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Neutrality in medicine and health professionals from ethnic minority groups: The case of Arab health professionals in Israel

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ARTICLE INFO

Article history:
Received 4 May 2016
Received in revised form
6 December 2016
Accepted 12 December 2016
Available online 13 December 2016

Keywords:
Israel
Arabs
Ethnic minority
Health professionals
Neutrality

ABSTRACT

The ethos of neutrality dominates biomedicine. It has, however, been criticized for leading to a disregard for diversity in medicine. In this article we employ the 'inclusion and difference' approach to gain an understanding of why the ethos of neutrality, on the one hand, and tensions associated with race/ethnicity, on the other, are relevant to the work of ethnic minority health professionals. We sought to explore tensions associated with neutrality in medicine from the point of view of ethnic minority professionals who work in a context of political conflict. We conducted 33 in-depth interviews with Arab health professionals – physicians, nurses and pharmacists – working in Israeli health organizations. The Arab health professionals perceive medical knowledge as being politically neutral; and medical practice as being impartial, universal and humanitarian. They regard the healthcare sector as a relatively egalitarian workplace, into which they can integrate and gain promotion. Nevertheless, the interviewees experienced various instances of treatment refusal, discrimination and racism. In line with the ethos of neutrality, the Israeli medical code of ethics does not relate specifically to Arab professionals and takes their inclusion and integration in healthcare organizations for granted. The ethos of neutrality in medicine underlies the ambivalence inherent in the approach of 'inclusion and difference'. While perceptions of neutrality, alongside values such as equality, cultural competency, impartiality and humanitarian healthcare, do indeed promote the inclusion of minority professionals in health organizations, these same perceptions mask the need to address political events that impinge on the medical milieu and may present an obstacle to designing specific policies to deal with such events.

1. Introduction

In this paper we rely upon and expand the theoretical bio-political 'inclusion and difference' approach. While this approach has generally been employed in scholarship with regard to biomedical research, we suggest that it may also be profitably used to explore the various tensions experienced by ethnic minority health professionals who work in a context of political conflict. The 'inclusion and difference' approach encompasses a strong social justice element, since it touches on scientific and state policies and socially subordinated groups (Epstein, 2007, 2008, 2010). It is therefore an approach suited to understanding the experiences of ethnic minority healthcare professionals in public organizations. Moreover, studying experiences of ethnic minority healthcare professionals allows us to further expand this approach by showing how the ethos of neutrality in medicine underlies the ambivalence inherent in the approach of 'inclusion and difference' since it constitutes a vehicle for these minority healthcare professionals' inclusion in health organizations (especially in a context of political conflict), but at the same time tends to mask their difference.

The ethos of neutrality in medicine guarantees neutral, impartial and humanitarian healthcare. All health services and personnel are expected to adhere to the principle of impartiality, which in practice means providing services "on the basis of need alone, giving priority to the most urgent cases of distress and making no distinctions on the basis of nationality, race, gender, religious belief, class or political opinions" (OCHA and Humanitarian Principles, 2010). The principle of impartiality is reflected in international medical ethical codes. The World Medical Association's Declaration of Geneva, the modern version of the Hippocratic Oath, for example, states that: "I will not permit considerations of age,

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http://dx.doi.org/10.1016/j.socscimed.2016.12.019
0277-9536/

disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing or any other factor to intervene between my duty and my patient" (World Medical Association, (2016: 1), Declaration of Geneva, as amended). The principle of medical neutrality has been enshrined in international humanitarian laws such as The Geneva Conventions and The Hague Conventions that guarantee neutral and impartial provision of humanitarian aid in contexts of violence (Moorehead & ICRC, 1998). Neutrality in medicine is also one of the fundamental principles of medical humanitarianism, according to the International Committee of the Red Cross, regarding the provision of medical, public health and epidemiological services in conditions of emergency or crisis (IFRC, 1965).

The ethos of neutrality in medicine is derived from the very essence of biomedicine itself. Relying heavily on scientific knowledge and perceptions, biomedicine incorporates an ideal of the socially and politically neutral physician who works with universal medical knowledge, and follows universally accepted scientific processes to arrive at the same diagnosis that any other medical colleague would have reached. This orientation is consistent with and based on the ideal that science should be neutral or impartial with respect to social and political values (Beagan, 2000). Although the value-free ideal of science has been widely criticized by scholars (Pielke, 2007; Proctor, 1991; Shapin and Schaffer, 1985; Latour, 2007; Brown, 2015), and these critical views have penetrated the realm of medicine, the claim of neutrality is still maintained among medical professionals (Beagan, 2000; Celik et al., 2008). The impartiality of biomedical science is accentuated during training, when an ideal version of the medical profession is presented and taught to students; and again later, in practice, by standards such as the objectivity of controlled trials and evidence-based decision-making that guide the medical practice (Beagan, 2000). Objectivity is guaranteed by scientific instruments and their inscriptions (Daston and Galison, 1992; Baird, 2004), as well as by quantitative and statistical measurements (Porter, 1992). These elements of objectivity have played, and continue to play a major role in the development of modern biomedicine (Cambrosio et al., 2006).

Following World War II and the Holocaust, the ethos of neutrality in medicine was reinforced by the horrific results that notions of biological race produced. A general rejection of the concept of biological race gave rise to the idea that race was a social construction. This notion implies that differences in achievements and capabilities among races are linked to the privileges that society accords specific groups and the impediments that it places on others. This idea has underpinned advances in civil rights, human rights and constitutional law (Obasogie, 2012).

Within debates such as the above, origin-based concepts such as race and ethnicity continue to be strongly contested. The term 'ethnicity' places an emphasis on cultural differences that might encompass ancestral origins, religion, language, national identity and group ascription. Yet in the socio-medical literature the concepts of 'ethnicity' and 'race' are frequently used interchangeably, such as in the compound term race/ethnicity (Afshari and Bhopal, 2010; Aspinall, 2013). Over the past decade geneticists have reclaimed the term 'race' to denote discrete clusters of human genetic diversity within a population (Aspinall, 2013), and efforts are now made to recruit individuals who belong to racial and ethnic minorities to medical research (Epstein, 2008). This trend is associated with an approach to 'race' that differs considerably from former attitudes. While in the past claims concerning biological race were made explicitly to subordinate racial minorities, current practices are frequently articulated as efforts to help reduce inequality and to resolve health disparities. However, a thread of typological thinking persists (Obasogie, 2012), and tensions continue to arise around questions such as when concepts of race/ethnicity should be used and how they should be put into practice (Aspinall, 2013). The line of demarcation between discriminatory and ostensibly beneficial uses of the concepts of race/ethnicity in medicine is neither clear nor intuitive (Obasogie, 2012).

A prominent example of the need to address racial/ethnic diversity is the controversy that erupted in the United States. During the 1980s, health advocates argued that in practice, the standard biomedical human was imagined as a white, middle-aged male and that other groups were underrepresented in biomedical trials and research. The upshot was inadequate medical knowledge about the safety and efficacy of medications among women, racial and ethnic minorities, children and the elderly. Subsequently, developments in medical research have led to the recognition of niche standardization, which introduced an intersecting set of standard human subtypes (Timmermans and Epstein, 2010). The standard practice governing the selection of subjects to be included in biomedical research was fundamentally altered. It has shifted from a focus on individual or universal subjects to that on groups defined by race, ethnicity and gender, a process which Epstein (2007) has termed the 'inclusion and difference' approach.

However, while advocates of the 'inclusion and difference' approach repudiated the notion that humanity could be standardized at the level of the species, they did not go so far as to embrace the medical uniqueness of each individual. Rather, they proposed that the working units of biomedical knowledge creation should be broad social groups such as women, children, the elderly, Asian Americans and so on. Such groups were transformed into standardized objects available for scientific scrutiny, political administration and marketing (Epstein, 2007; Timmermans and Epstein, 2010). Thus, the 'inclusion and difference' approach opens up a new conceptual space within clinical research for thinking about racial and ethnic minorities as collective social actors embedded in fields of power relations (Epstein, 2008).

The ethos of neutrality is linked to questions of ethnicity and race among health professionals in the context of the need for workforce policies that enhance access to care for racial and ethnic minority groups. Concerns over ethnic disparities in health care have long preoccupied scholars, policy-makers and health care providers. Increasing the ethnic diversity of the health care workforce is commonly regarded as a promising means of providing culturally and linguistically competent care to minority populations, thereby reducing health disparities (Ballejos et al., 2015; Cohen et al., 2002; McGee and Fraher, 2012). Moreover, minority health professionals are more likely to deliver health care to those most in need of it (Saha and Shipman, 2008). Thus, institutions of higher education, especially across the US, are pursuing the goal of diversity.

Nevertheless, tensions tend to arise around the use of affirmative action in the admission process, centering mainly on race-neutral versus race-conscious admission policies (Steinecke et al., 2007; Ballejos et al., 2015). In Israel, this issue is relevant to the Arab population, for which the health professions offer a major route toward social mobility. The academization of nursing, for example, which was originally designed to raise the status of the profession, became a new form of the exclusionary mechanisms that operate on minority women in various aspects of their social lives. Practical nurses in Israel, many of whom are Arab women, are expected to study while continuing to perform all their routine domestic tasks. This social norm puts great stress on women who come from a culture that has a clear division of gender roles, and which places most of the burden of the household and childrearing on them. Furthermore, restrictions on practical nurses' authority present a very real threat to their professional status, turning them into 'auxiliaries', rather than independent professionals. This puts pressure on them to study and comes with an emotional cost