Nina Halberg

Someone like me; I go after staff with good vibes

An ethnographic study of ethnically minoriti**zed** patients in Danish healthcare through an equity lens

RUC

- a Ph.D. Dissertation from the Doctoral School of People and Technology

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An ethnographic study of ethnically minoriti*zed* patients in Danish healthcare through an equity lens

En som mig; jeg går efter personale med god energi
En etnografisk undersøgelse af etnisk minori*serede* patienters møde
med det danske sundhedsvæsen gennem en (u)lighedslinse

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Preface by the Doctoral School

It is with great pleasure that we can introduce Nina Halbergs doctoral dissertation "Someone like me; I go after staff with good vibes: An ethnographic study of ethnically minoriti*zed* patients in Danish healthcare through an equity lens", which examines what the social categorization of 'ethnic minority patients' does in healthcare.

The social categorization of 'ethnic minority patients' is used as a categorization to define ethnically minoritized patients in Danish healthcare. Originally, the concept of 'ethnic minority patients' was developed to accommodate and advance care for an increasingly 'culturally and ethnically' diverse population. As a category, it is often limited to patients with a 'non-Western' background which is defined as foreign-born individuals, or descendants thereof, not from Western Europe, North America or Australia. 'Ethnic minorities' is historically a concept that has a Eurocentric origin and is used in both Danish society as well as in healthcare. Ethnicity as a concept does not trace colonial legacies in Denmark but emerged following the increased migration to Denmark during the 1950's and 60's migration. Terminologies describing migrants have changed throughout time and went from 'foreigners', 'guest workers', 'immigrants' and today, 'ethnic minorities'. Since the 1990's 'ethnic minorities' or 'other ethnic background/origin to Danish' have been the most widespread terminologies. Health inequities are prevalent for ethnically minoritized patients and epidemiological research has shown both social and economic inequalities as well as lower health status among the ethnically minoritized population. However, the categorization of ethnic minority groups is not used stringently in research nor in practice.

Through ethnographic field work in two orthopedic hospital departments (with 13 interlocutors) and an analysis of policy documents, the thesis aims to explore the productions of ethnicity in healthcare in the intersections between the welfare state, institutions, and the encounters between patient and health professionals. The work is based on the overall aim "to examine the social categorization of 'ethnic minority patients' by exploring (active) productions of ethnicity in healthcare". The explicit aim is to examine what minority ethnicity does (rather than defining what it is) in the context of Danish healthcare. This aim is divided into four research questions:

1) (a) to analyse how political and societal discourses relating to ethnic minorities are translated into the Danish healthcare system and (b) to discuss how these discourses affect ethnic minority patients' encounters with the Danish healthcare system.

2) How is the behavior of ethnically minoritized patients understood and practiced during ERAS pathways and how does this relate to health disparities?

3) Exploration of the engagements that ethnicized patients do to become legitimized and position oneself as an equitable healthcare recipient.

4) to explore productions and representations of becomings that include marked and unmarked power, positionings and sciences.

On this basis, the thesis offers important insight into how interlocutors negotiate the category of 'ethnic minority' that they are positioned within when encountering the health care system. By taking up a post-structuralist approach the thesis gives novel insight into the vulnerability of patients, as it shows how vulnerability is not something ethnicized patients are, but something they become in the encounter with health care. Halberg addresses the constraints that follow the social categorization of "ethnic minority patients" that positions patients within the realms of (possible) non-compliance and thereby as recipients of a reduced level of health care. On this basis she argues for the advancement of the conceptualization of "ethnically minoritized patients" as this explicitly connects the social categorization to the process of becoming minoritized. The work entails thorough empirical work and careful, reflective analysis based on relevant and complex theoretical conceptualizations. Halberg propose the concept of (over)working as a novel theoretical contribution to the field, as "a concrete and action-oriented contribution towards the dismantling of the subtle, contextual, structural, covert, and unintended productions of health inequities for (ethnicized) patients in (Danish) healthcare".

Nina Halberg's work is the result of several years of fruitful collaboration between Hvidovre Hospital, Department of Orthopaedic Surgery and Roskilde University, Health and Society. We would like to thank all partners for making the collaboration possible to investigate health inequalities in a hospital context.

We find that the work of Nina Halberg is an important contribution by shedding new light on the complex dynamics that constitute the unpleasant and persistent problem that the Danish health care system contributes to the production of inequality in health care based on the patient's ethnicity.

Mari Holen
Supervisor
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Trine Schifter Larsen
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and Roskilde University

Aknowledgements

This PhD process has been full of different and conflicting feelings; from highs to lows, from confidence to self-doubt, from joy to tears and everything in between. But most importantly, I feel very privileged to have been able to explore a subject that I feel is so important, and I would not have been able to do this without the support of so many people along the way.

First, this thesis is about ethnically minoritized patients in healthcare. Without your participation, this study would not have been possible. Thank you for courageously participating in this study and allowing me to hear, see and retell your stories and experiences. I also want to thank the two Orthopedic Departments who provided me access and supported this study. Especially the staff who allowed me to be a part of their everyday (working) lives. Thank you for letting me in and sharing the complexities and joys of providing healthcare.

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Nina Halberg,
March 2024

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1. Halberg, N., Larsen, T. S., & Holen, M. (2022). Ethnic minority patients in healthcare from a Scandinavian welfare perspective: The case of Denmark. Special issue on: Anti-racism. *Nursing Inquiry*, 29(1), e12457.
2. *In preparation. Accepted for external review based on early draft.* Halberg, N., Holen, M., Larsen, T. S. (*forthcoming*). Exploring health disparities for ethnically minoritized patients during orthopedic ERAS pathways: an ethnographic study. *Clinical Orthopedics and Related Research.*
3. *Under review.* Halberg, N., Larsen, T. S., Holen, M. (*forthcoming*). Overwork as a concept to understand health inequities for ethnicized patients in healthcare – an ethnographic study. *Sociology of Health and Illness*
4. Halberg, N. (2023). Reflections of a white healthcare professional researching ethnicized and racialized minorities: Autoethnographically explored emotions revealing implicit advantages and consequences. *Health*, 13634593231185261.
5. *Under review.* Halberg, N., Skadegård, M. (*forthcoming*). Kroppen som racialiseret [the body as racialized]. In Dreyer, P, Martinsen, B. (eds.) Kropsopfattelser [working title]. Gads Forlag. [serves as background knowledge]

Chapter 1: Introduction

Danish healthcare operates with the category of 'ethnic minority patients'. As a category, this is often limited to patients with a 'non-Western' background understood as foreign-born individuals, or descendants thereof, *not* from Western Europe, North America or Australia (Frederiksen, 2018; Mock-Muñoz de Luna et al., 2019). As shown in national and international research, social inequalities in health are present and increasing for patients categorized as belonging to 'ethnic minorities' (Blom et al., 2016; Chauhan et al., 2020). Originally, the concept of 'ethnic minority patients' was developed to accommodate and advance care for an increasingly 'culturally and ethnically' diverse population (Halberg et al., *under review*). Over the last ten years, concepts such as 'non-Western' and 'ethnic minority' have been increasingly criticized in critical health research as they are based on a Eurocentric worldview in which (white) European and Western people constitute the starting point and thereby the norm (A. Browne et al., 2023; Epstein, 2008; Halberg, 2023; Harding, 2015). In this thesis, the social categorization of 'ethnic minority patients' constitutes the subject of research as I explore how it is practiced in healthcare. To avoid Eurocentric terminology and instead incorporate the processes of how some groups *become* 'minoritized' by the 'majorized' (Halberg, 2023; Haraway, 1988), I use the concepts of *ethnicized* and *ethnically minoritized* in this thesis. These terms refer to the process (and action) of some groups becoming minoritized based on ideas of different ethnicized markers; here my aim is to explore what ethnicity *does* rather than what ethnicity *is*.

The complexity, uncertainty and uncomfortableness relating to the use of the social categorization of 'ethnic minority patients' in clinical practice can be illustrated by a situation I encountered during my fieldwork. One of the 13 interlocutors included in this ethnographic study is Emir[1]. When I first met Emir, I was uncertain whether to include him as an 'ethnic minority patient'. Emir was 36 years old and born and raised in Denmark. His parents immigrated from Montenegro in the 1970s and came to Denmark as guest workers. After explaining the purpose of the study, Emir was happy to participate and explained how his 'ethnic' status was a major aspect of his life in Denmark as he would encounter many people with negative expectations. This episode involved me, Emir and the surgeon Finn:

A man comes in with what looks like three boxes of catheters. He looks at me [NH] *and asks who is sleeping in the* [hospital] *bed. I answer 'Emir' and the man replies 'Oh, so we have admitted the man just for him to sleep'* [he gives a broad smile]. *Emir wakes up and I realize it is the surgeon who has come. I quickly say that I am following Emir as part of a research project and that is why I am in the room. He responds and asks what kind of research project. I answer 'My PhD. I follow … ethnic*

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[1] All names in this thesis are pseudonyms.

minority patients during their hospital stay'. The surgeon promptly responds, with humor in his voice: 'Oh, there is not much ethnic about this guy' and I quickly reply: 'There doesn't have to be'. The surgeon then says it is a shame that I am not researching orthopedic factors instead, because then he could teach me a lot (…) Later on, Emir and I are talking, and he says: 'Finn has helped me' and I ask who Finn is. He answers: 'It is the surgeon who was in here earlier'. He proceeds to tell me about Finn who has started this whole process of getting a surgery. It started when they met in the outpatient clinic. Before meeting Finn, the process had been long and difficult.

At first glimpse, this could be read as a situation relating to who defines ethnic minority patients: Finn, Emir, me or the staff who suggested Emir as a patient to include in the first place. It also raises questions of how ethnicity becomes something unstable, influential, consequential and unevenly distributed. Emir was very well aware of how his perceived ethnic status was connected to negative expectations and experiences in society. For Finn, it appeared positive to describe Emir as 'not ethnic'. For me, calling Emir an ethnic minority person was uncomfortable and Finn's response made me answer in a way that implied that an 'ethnic status' was not neutral. In that situation, it shows how notions of ethnicity *do* something in healthcare. We were all active participants as the situation unfolded. The situation took place in an orthopedic hospital room where Emir awaited surgery on his shoulder, but it connected notions of ethnicity to broader perspectives of power and social, political and healthcare contexts. This indicates that this categorization *does* something, which ultimately represents the focus of this study.

1.1 Aims and research questions

This thesis aims to examine the social categorization of 'ethnic minority patients' by exploring (active) productions of ethnicity in healthcare. My research interest is not to define what ethnicity is, or is not, but rather what it *does*. This is explored through an equity lens in four research questions that are answered in the four articles. The first article is a policy analysis and uses Bacchi's 'what's the problem represented to be' (WPR) approach to explore what problem representations are produced in policies on the categorized 'ethnic minority patients' – and how these are translated into Danish healthcare. The article explores the following research questions:

How are political and societal discourses relating to ethnic minorities translated into the Danish healthcare system and how do these discourses affect ethnic minority patients' encounters with the Danish healthcare system?

The findings from this paper informed the next three articles. Articles 2, 3 and 4 are based on fieldwork consisting of following 13 patients categorized as 'ethnic minority patients' in two orthopedic departments in two hospitals in Greater Copenhagen, Denmark. This enables an examination of *doings* of ethnicity in healthcare in a clinical practice.

The second article abductively analyzes ERAS (enhanced recovery after surgery) pathways as a social practice to explore how standardized treatment and ideas of adherence risk (re)producing health disparities for ethnically minoritized patients. The research questions are:

How is the behavior of ethnically minoritized patients understood and practiced during ERAS pathways and how does this relate to health disparities?

The third article analyses the work ethnicized patients engaged in during their hospitalization. By theoretically advancing the concept of workings, I aim to answer the following research question:

What workings do ethnicized patients engage in to become legitimized and position oneself as an equitable healthcare recipient?

The fourth article analyzes autoethnographic emotions as a production and explores intersectional social positionings in health research through nursing, healthcare professionality and whiteness and how these risk (re)producing ethnicized and racialized inequalities related to both the interlocutors and the knowledge production. I examine the final research question:

How do I become positioned as a health researcher who is white, a nurse and a healthcare professional in the Danish health system and what very real consequences do the implicit logics and practices following these positionings may have for the interlocutors and my knowledge production?

As I argue for seeing health (in)equities as interconnected between the welfare state, the hospitals and the encounters, these four research questions relate to a macro-level of sociopolitical structures (article 1), a meso-level of institutions (article 2) and a micro-level of patient and healthcare positionings (3 and 4). Throughout the articles, I will demonstrate how these perspectives are closely interwoven. Ultimately, I will discuss how these articles inform the knowledge production, which is my contribution with this PhD thesis.

1.2 Critical entry points to guide an equity lens to ethnicity and health

This study is a critical inquiry, which, in the words of Professor Joan Anderson, means: *'critical scholarship demands that we 'unpack' the concepts that we use in ways that will make them transparent'* (Anderson, 2004). By using a critical approach, I aim to conduct a critical examination of the social categorization of 'ethnic minority patient' as it enables questions of who is an ethnic minority, how the term is used in different contexts and over periods of time, what consequences and impacts it has, and what associations follow the categorization (Anderson, 2004). I see these questions as embedded within social, political and historical positionings and power axes (Anderson, 2004; Halberg et al., 2022; Hilario et al., 2018). The risk with binaries such as minority/majority is that these positionings becomes fixed entities that are perceived as static, which undermines agency and movement between the categorizations (Anderson, 2004). My research interest is to explore what ethnicity does in healthcare and to avoid dichotomous thinking, I rethink concepts and critically explore assumptions and underpinnings (Anderson, 2004) in the uses of the social categorization of 'ethnic minority patients'.

Ethnicity is a complex and contested concept that is widely used in health research. I argue that ethnicity has value as a social category that is influential and consequential especially for minoritized people in healthcare. However, history shows how notions of who belong to specific 'ethnic groups' are constructed and based on ideas of skin color, country of origin and indigenous status, which are tied to the migration and colonial histories of different countries (Kapadia & Bradby, 2021). In Denmark, the 'indigenous ethnic Danish person' is discursively portrayed through notions of whiteness, modernism, Christianity and democracy (Goldberg, 2006; Halberg, 2023; Hervik, 2019a; Rytter, 2019). The 'ethnic minority person' is then the minoritized person, often based on notions of non-Danishness or non-Westerness through appearance, language, religious symbols or names (Halberg, 2023; Skadegård, 2018).

Despite the large heterogeneity within the group categorized as 'ethnic minority patients', health inequities among minoritized patients are internationally well-described and evident (Shannon et al., 2022). In Denmark, epidemiological research has shown lower health status as well as economic and social inequalities in comparison to the defined 'majority population' (Holmberg et al., 2009). Health research has explored barriers between healthcare staff and 'ethnic minority patients' and found these to be based on e.g., prejudice, time constraints, cultural differences, and language and communication barriers (Joo & Liu, 2020; Nielsen et al., 2019). Overall, there is a focus on the low inclusion of ethnically minoritized patients in health research, lower access and use of healthcare services as well as worse patient-perceived outcomes (Cwalina et al., 2022; Rai et al., 2022). Societal and healthcare interventions aiming to reduce these aspects of inequalities have often had a single-axis focus on individual encounters and have been based on educating the healthcare staff and changing the behavior of the patient. These interventions are mostly formed by, and for, healthcare staff but they lack evidence of efficiency which, it has been argued, is due to the lack of inclusion of sociopolitical, structural, power and agency aspects (A. Browne, 2001; Choby & Clark, 2014; Drevdahl, 2018). Ultimately, the use of ethnicity and the knowledge production following notions of ethnicity remain underexplored from a critical perspective in European health research (Helberg-Proctor, 2017).

To advance these perspectives, I apply an equity lens. In Danish, the primary concept of inequalities is 'uligheder'. However, in English there are three interrelated concepts within ‘ulighed’, namely inequality, inequity and disparity. These concepts are often used interchangeably, but they are defined differently. Equality refers to an understanding that equal access to healthcare provides equal care and treatment for patients. Health disparities or inequalities refer to the systematic differences in health between different groups. Inequity refers to inequalities or disparities based on uneven, unjust or disadvantaged systemic and structural conditions (Drevdahl, 2018; Varcoe et al., 2022). Equity is achieved when these conditions are removed in healthcare and the aim is to create equitable care and treatment for all patients. Adopting an equity lens necessitates a focus on patients who experience health inequities (Varcoe et al., 2022), and this will form the basis for my contextualization of the research field.

The research field is healthcare in Denmark. In the Danish welfare state, access to healthcare is free and equal. The Danish Healthcare Act forms the legal basis for universal access to healthcare for all people with a Danish social security number (CPR number), regardless of majorized and minoritized social positionings. Furthermore, healthcare staff have an ethical and legal responsibility to treat all patients equally. Despite professional, political and societal ideals of equality, inequalities are increasing in Denmark. In April 2022, The National Board of Health published a report with a literature review of ‘Social Inequalities When Encountering Healthcare’ (Kjeld et al., 2022). Here, they describe mechanisms that might affect encounters between healthcare staff and patients with a focus on social inequalities in health. This also constitutes the political and societal focus. In this report they describe how:

Problems related to race and ethnicity, in addition to socioeconomic aspects, are quite prevalent in studies conducted in the USA. These problems relate specifically to the USA but will most likely also be relevant in Denmark to a certain extent. It has been beyond the scope of this literature review to explore inequalities in encounters between patients and healthcare related to cultural background, race and ethnicity. However, it is still an important mechanism to understand why some patients have more difficulty in encountering and navigating healthcare’ [my translation] (Kjeld et al., 2022, p. 54).

Not including aspects of race and ethnicity is a feature of the Danish context. Similarly, data on ethnicity in healthcare are not collected in Denmark, as this is seen as inherently racist (Frederiksen, 2018; Kapadia & Bradby, 2021). Accounts of racism and discrimination have had very little legitimacy in Denmark, as they interfere with ideals of equality and social egalitarianism. This is also the case in health research. It is not unusual to hear that there is no racism in Denmark (Gudrun Jensen et al., 2017). Racism derives from ‘race’, which is a concept that has been largely eradicated from Europe since the Second World War. This was due to the atrocities committed during the war, the European decolonialization and the refutation of the concept of biological race (Halberg, 2023; Skadegård, 2018). Instead, ethnicity is used, as it has been perceived to be more politically neutral (Halberg & Skadegård, forthcoming). Thus, the category of ‘ethnic minority patients’ has been used as an objective and neutral categorization in Danish healthcare. But is it a neutral categorization for patients in healthcare? Further, how does this categorization impact patients, health research and healthcare? Ultimately, health inequities related to ethnicized patients are underexplored in the Danish context. Yet the purpose is not to 'prove' that they exist; that has been proven. Internationally, there is a lack of research focusing on how health inequities related to ethnicity in healthcare are created and maintained (Arora et al., 2019; Shannon et al., 2022; Torres, 2018). Therefore, in December 2022, the Lancet published a series on racism, xenophobia, discrimination, and health, which emphasized the imperative of advancing racial and ethnic equity in health (The Lancet, 2022).

Despite universal access, research shows that patients are positioned uneven. This means that inequities are also (re)produced in clinical practice. By adopting an equity lens, I focus on productions of ethnicity from multiple viewpoints, including patients categorized as 'ethnic minorities' but also in healthcare practices and policies. To explore these, I conducted an ethnographic study of policy documents as well as fieldwork in two orthopedic departments in two different hospitals in Greater Copenhagen, Denmark. Here I followed patients categorized as 'ethnic minorities' during their hospitalization and in their encounters with healthcare. These are situated within the Danish context but are also tied to broader universalized and modernized contexts. The study is placed within the field of critical health research, in which the aim is *not* to produce objective and uniform knowledge, nor is it to explore individual encounters, but rather to examine the complex, structural, and powerful hegemony of producing knowledge on sensitive topics such as discrimination and inequities related to ethnicity in healthcare.

Ultimately, the thesis provides knowledge on equity in relation to ethnicity and health to the health sciences and healthcare professions, but also to a broader scholarship of social science and welfare studies. Furthermore, the findings from the thesis will contribute to anti-discriminatory and equity-oriented work within healthcare, both in theory and practice.

1.3 The complexity of terminology

I would like to start by acknowledging the complexity of the concepts in this field of research. Concepts are used to categorize people and we often use the terminology available to us, to the best of our knowledge. Nonetheless, concepts and categories have historical trajectories and can have a powerful or even harmful effect. In this study, there are many concepts related to 'ethnic minority groups' of patients and some, such as ethnicity and race, are often not defined in epidemiological research (Martinez et al., 2023). In everyday Danish, the definition of 'a different ethnic background/origin from Danish' is the most common one, but is problematic in its exclusionary use of language, where it is not possible to have 'a different background from Danish' *and* be Danish (Halberg et al., 2022). Hence, societal and health research most often use the term ‘ethnic minority’. However, this can be seen as Westernized terminology, as we are all ethnic minorities somewhere in the world and health inequities are not equally distributed globally. Furthermore, *who* belongs to the ethnic minority category differs between countries. For example, Denmark still divides migrants by so-called Western and non-Western countries, while Sweden and Norway have abandoned this distinction and currently divide by continent (Mock-Muñoz de Luna et al., 2019). This is also problematic due to the historical origin of the category of ‘the West’, as it was invented by white European imperialists. It is not based on geographical divisions but instead developed as an opposition to the East, which was seen as inferior to the West. Discursively, these divisions have been portrayed as monolithic and static oppositions (A. Browne et al., 2023; Said, 1979). Denmark has received international criticism for using the term ‘non-Western’ (European Commission, 2022). In USA, most health studies divide ethnic minorities according to racial background or first language (Chauhan et al., 2020). Therefore, ‘ethnic minority’ constitutes different groups across the globe and must be studied within its situated use.

In the following, I will make a note on the concepts of ‘race’ and ethnicity, as they both differ and have similarities. In most Anglo-Saxon countries such as the USA, Canada, England, Australia and New Zealand, ‘race’ is more prevalent than ethnicity. This can be seen in the context of different colonial histories (Kapadia & Bradby, 2021). Nonetheless, within the past 5-10 years, ‘race’ and racism have gained traction in Europe, and health research in the fields of racialization and racism is increasing (Hamed et al., 2020, 2022). ‘Race’ is in quotation marks to emphasize that racial categories are social and produced through racialized processes of perceived racial markers. This counters the biological understanding that has been discredited and disproven (Devakumar et al., 2022; Kapadia & Bradby, 2021; Skadegård, 2018). The focus of this thesis is ethnicity and health as the research subject is ‘ethnic minority patient’. However, in my understanding of ethnicity, there will be overlaps between ethnicized and racialized markers.

Finally, health equity is achieved by eliminating disadvantages and discrimination (Drevdahl, 2018) and it is therefore important to situate discrimination. I understand perceived discrimination as a structural phenomenon and not as an individual or personal trait (Halberg et al., 2022). Furthermore, with the epistemological underpinnings in this thesis, I argue there can be multiple ‘truths’ for every situation, which means that the same encounter can be experienced and understood differently. This is not to devalue individual perceptions but rather to welcome multiplicities of ‘truths’ that are intrinsically embedded within unequal power relations. Some ‘truths’ are given more validity than others. Yet discrimination can take place without the intention to discriminate (Halberg & Skadegård, *forthcoming*). Discrimination occurs in the relational and social context between people, but it also has real consequences for individuals. I thus accentuate that these situations are never isolated but closely intertwined with political, societal, and structural contexts. Therefore, discrimination cannot be analyzed without involving these surrounding elements (Krieger, 2014).

1.4 Structure of the thesis

This thesis is divided into seven chapters and contains four articles and one book chapter. The four articles answer the four research questions, and they constitute the four analyses. The book chapter is not inserted as a complete chapter but rather placed as paragraphs within the chapters as suitable. The book chapter serves as background and does not directly relate to the research questions.

Chapter 1: Introduction

Chapter one introduces the overall subject of the research. Here, I have introduced the *social categorization of 'ethnic minority patient'*, the *research questions* guiding the thesis and positioned my research within the fields of *critical inquiry, an equity lens, ethnicity* and *health.*

Chapter 2: Background

Chapter two provides the context for the study. To situate the social categorization of *'ethnic minority patients'* in *modern* healthcare, I present the contexts of *biomedicine, standardization and evidence-based medicine, individualized and person-centered care* and *implicit whiteness.* Lastly, I summarize the main points and situate the category of 'ethnic minority patients' and discuss its implications. These points lead on to the four research questions.

Chapter 3: Theoretical approaches

In chapter three, I introduce my theoretical approaches to ethnicity and health. These are described through *productions of ethnicity, the hegemony of ethnicity, from ethnicity to ethnicized* and *an equity lens on ethnicized patients.* These epistemological approaches inform my research and the knowledge production.

Chapter 4: Methodology

Chapter four introduces the *ethnographic study*. This includes the field sites, fieldwork, research ethics and data process and analysis.

Chapter 5: Results

The results section consists of the four articles. I introduce each article and its theoretical and analytical approach, which enable answers to the four research questions.

5.1 Ethnic minority patients in healthcare from a Scandinavian welfare perspective: The case of Denmark

Chapter 5.1 is an analysis of how '*ethnic minority patients*' are discursively positioned within Danish healthcare as part of a Scandinavian welfare state. This is presented as article 1 and relates to research question 1.

5.2 Exploring health disparities for ethnically minoritized patients during orthopedic ERAS pathways: an ethnographic study

Chapter 5.2 is an analysis of how ERAS as a *standardized concept* risks creating health disparities for ethnically minoritized patients. This is presented as article 2 and relates to research question 2.

5.3. Overwork as a concept to understand health inequities for ethnicized patients in healthcare – an ethnographic study

Chapter 5.3 is an analysis of *the work ethnicized patients engaged in* to become legitimized and position themselves as equitable recipients of healthcare. This is presented as article 3 and relates to research question 3.

5.4. Reflections of a white healthcare professional researching ethnicized and racialized minorities: Autoethnographically explored emotions revealing implicit advantages and consequences

Chapter 5.4 is an analysis of my researcher positionings. These are intersectionally analyzed to discuss how they implicitly risk (re)producing social inequalities in health for racialized and ethnicized minorities. This relates to both *researcher positioning* and *knowledge production* and answers research question 4.

Chapter 6: Discussion

Chapter 6 consists of a focused discussion. Furthermore, I evaluate the advancements and limitations of this study.

Chapter 7: Closing remarks

Finally, in closing remarks I conclude the dissertation by reviewing the findings of this thesis. I furthermore discuss the contribution of the thesis and end by evaluating possible directions for future research within the field of ethnicity and inequities in health.

Chapter 2: Background

This thesis is based on an ethnographic study that included policy documents and fieldwork among patients categorized as 'ethnic minorities' in two orthopedic departments in two hospitals in Greater Copenhagen, Denmark. To situate the context for the four research questions, I will use the background section to discuss central foundations of Danish healthcare. As Danish healthcare is based on *modern medicine,* there are implicit underpinnings that are often not critically discussed within health research. However, these are central to understanding how patients categorized as 'ethnic minorities' are positioned and approached within healthcare. Therefore, the background section will discuss the historical and structural underpinnings of biomedicine, standardization, evidence-based medicine, person-centered care and whiteness to disrupt what is often normalized and neutralized. Finally, I will link up these contexts and discuss their implications for patients categorized as 'ethnic minorities' and relate these to how the four research questions emerge. Sections 2.1, 2.2 and 2.4 are translated and modified from the Danish book chapter (paper 5).

2.1 Biomedicine and its influence on modern healthcare

Danish healthcare is based in biomedical science, also called Western or modern medicine. Biomedicine emerged after the Second World War and spread to most Western countries. Biomedical theory is not a single model but rather based on a variety of sciences such as medicine, biology, and epidemiology. A common feature of biomedicine is its foundation within positivism (Cruickshank, 2012; Horrill et al., 2018). However, positivist thought, and history goes further back, as the philosopher Auguste Comte (1798-1857) is often thought of as the founder of positivism. He coined the term 'positivism' and argued that *the facts* of positivism were central to the modern age, in opposition to *the speculations* of theology. Therefore, positivism is a science founded on the ideal that humans are objective and rational (Cruickshank, 2012; Slemon, 2018). Through quantitative designs, large groups of patients or populations are included as data and by calculating the results statistically, the aim is to produce 'objective' and 'true' knowledge. This type of research is seen to cleanse the results of so-called bias and knowledge thus becomes, in this sense, clean and generalizable. However, this has been criticized in critical health research on social issues, as this type of knowledge is reductionist and neither includes nor explains the social processes of political, societal and historical influences (A. Browne, 2001; Cruickshank, 2012; Halberg, 2023; Horrill et al., 2018). This also affects how specific types of knowledge are valued as more evident than others, as I will now elaborate.

2.2 Standardized and evidence-based medicine

Biomedicine has revolutionized modern medicine and is today the dominant framework in Danish healthcare but also in health science, as the evidence hierarchy places this type of knowledge at the top. Evidence is about statistically proving a hypothesis to the degree of being recognized as evident. Within the evidence hierarchy, systematic reviews and randomized controlled trials (RCT) are considered to provide the strongest form of evidence, while qualitative research consisting of e.g., interviews or fieldwork produces the lowest form of evidence. Based on the evidence provided, standardized treatment and care are designed and implemented into healthcare. This is also known as the new paradigm of evidence-based medicine (Knaapen, 2014; Slemon, 2018). Evidence-based knowledge production thus becomes widely considered as the *truth* (Holmes et al., 2006). The aim of standardized treatment is to create the best possible outcomes, safety and quality for patients (Slemon, 2018). Thus, treatment and care are uniform based on a biomedical understanding of the body as universal and objective and hence, patients are equally responsive to standardized approaches, also known as 'one size fits all' (Lock & Nguyen, 2018; Singla, 2012). Danish healthcare is publicly funded, which means it is a political organ. Since the 1980s, neoliberal practices of cost-effectiveness, productivity and individual responsibility have permeated the healthcare sector (Ahlberg et al., 2019; Halberg et al., 2022). In this manner, the Danish state prioritizes standardization and effectiveness, partly to minimize costs. This also affects encounters between patients and hospital staff (Dybbroe & Land, 2012; Mik-Meyer & Villadsen, 2007). With this development, a uniform 'successful patient pathway' arises, built on the idea that the best accessible knowledge is based on an objective standard of evidence (Dybbroe & Land, 2012). Furthermore, ideologies of individualism and self-responsibility create an expectation that patients will take ownership of their recovery. If they are not successful, they are the ones responsible (A. Browne, 2001; Mannion & Exworthy, 2017). These ideologies are thus based on a liberal point of view in which all people have the same tools to be successful, which simultaneously undermines sociopolitical structures (A. Browne, 2001). In this way, evidence-based medicine and neoliberalism are intertwined and powerful. To counter what has been called a dehumanizing biomedical model of patients, person-centered approaches evolved in the 1970s. Here, the focus is to actively include people, rather than seeing them as passive recipients of healthcare (Smith et al., 2022). I will now discuss the implications of person-centered care as a component of evidence-based medicine.

2.3 Individualized and person-centered care

Evidence-based medicine is an approach that contains more than (a specific kind of) research evidence. It also incorporates the *individualized* patient. This is seen in the well-cited publication by Sackett et al., who define evidence-based medicine as: *"the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients"* (Sackett et al., 1996). Evidence-based medicine then implies a focus on the care of the *individual* patient. Individualized care focuses on the *person* in person-centered care. Person-centered care can be understood as a collection of principles that aim to involve the patient's wishes and suggestions. In this way, the aim is to increase people's understanding of their condition and involve patients in their care (Smith et al., 2022). As described above, evidence-based medicine and neoliberalism are entangled, and concepts of individualism within person-centered care become decontextualized from the *person's* embedded social positionings of e.g., race, ethnicity, gender and history (Smith et al., 2022). Person-centered care is also aligned with the movement towards individual responsibility following the neoliberalist shift. Therefore, elements of hegemony, unequal power and sociopolitical perspectives are not included, which underlines that *access to* person-centered care is not the same (Smith et al., 2022). Person-centered care and evidence-based practice (a concept expanding evidence-based medicine to include a broader healthcare perspective (Halberg et al., 2021)), have been named the *twin ideological pillars* of healthcare (McIntyre et al., 2020). However, in clinical practice this approach creates challenges for treatment and care in standardized pathways as it requires a high degree of adherence from both patients and staff. For patients, being *engaged* in standardized pathways requires adherence to the different elements of the treatment (Thorn et al., 2016). The dilemmas of *individualizing* the care of patients while following an *objectivized* standard treatment have been well-described (Cohen & Gooberman-Hill, 2019). To accommodate and adapt person-centered care to ethnically minoritized patients, models of e.g., cultural competencies arose, where the aim is for healthcare staff to acquire competencies for encounters with *culturally or ethnically* diverse patients. Competence-based training relies on technical and measurable skills that enable e.g., nurses to fulfil a task rather than exploring complex nursing actions (Foth & Holmes, 2017). Competencies are underpinned by neoliberal and modern notions of individual rationality, where the aim is the ability to change the behavior of patients. Ultimately, competencies rely on positivist, reductionist, atheoretical and decontextualized perspectives (Foth & Holmes, 2017). Therefore, critiques of cultural competency models point to these individualized foci that risk reproducing health disparities as they do not include structural, power and social aspects (Drevdahl, 2018). Although the models of care aim to improve care for ethnically minoritized patients, they become inherently entangled with the underpinnings of biomedicine, standardization, evidence-based medicine and person-centered care, which leads to notions and ideals of objective, bias-free, individualistic and equal healthcare that do not consider the historical, political and societal premises for exploring the social category of ‘ethnic minority patients’. I will now discuss how this is problematic in what I call ‘implicit whiteness’.

2.4 Implicit whiteness

Modern medicine has gained momentum and is the dominant framework for care and treatment in Danish healthcare. However, the challenge of this tradition lies in its narrow basis, not only in terms of who founded and developed modern medicine but also of the group of patients that have been mostly included, where the dominant perspective is that of the white, heteronormative, middle-class male (Epstein, 2008; Harding, 2015; Singla, 2012). Historically, this foundation has shaped modern medicine. Based on the positivist notions of objectivity and generalizability, this has led to the construction of a standardized white, male body. This means that this body historically constitutes the norm and thereby the invisible and neutralized basis of medicine. It also implies that other ‘bodies’ are adapted to this standard, e.g., adjusting a dose of medicine to *fit* the ‘female body’ or the ‘black body’ (Epstein, 2008; Flanagin et al., 2021). Historically, women have been portrayed as ‘the same as men’, except for their hormonal and reproductive systems (Harding, 2015), while racially based adjustments towards ‘non-white’ patients rely on a racist and biological understanding of race (Eneanya et al., 2019). Women are more often included in research today, yet female diseases are still systematically given low priority (Lindemann, 2022). As described in the introduction, ethnically and racially minoritized persons are still underrepresented in health research, among both researchers and the researched (Cwalina et al., 2022; Rai et al., 2022). One example is the treatment of skin diseases, where research conducted in the USA, Canada and Denmark shows how doctors find it more difficult to evaluate skin diseases on darker skin, as their training has primarily been on white skin. This risks delaying prognosis and treatment and increasing health inequities (Ashur et al., 2023). With regard to documentation, a large American study found gender and ethnicity bias in digital records (Markowitz, 2022). Another example of how this is consequential in healthcare is pain management and pain treatment. These have been criticized for being based on a white, Eurocentric and male perspective in which ideologies of the rationality and moderation of ‘modern man’ are normalized. Therefore, women’s *emotionalized* forms of expression have been historically portrayed as the ‘abnormal’. Likewise, pain of racialized and ethnicized patients is currently often undermined and undertreated in healthcare (Borell, 2021; Mossey, 2011; Owusu-Akyaw, 2022).

During the 1970s and 1980s, the feminist movement arose and criticized the androcentric dominance that also took place in modern medicine. The 1980s and 1990s saw the emergence of the post-colonial and black feminist movement, which argued that the problem is not just gendered but also racialized (see e.g., Crenshaw, 1990). According to this criticism, the original feminist movement was based on a Western, white, middle-class female perspective that is not transferable and applicable to all women, especially minoritized women. A good example is Chandra Talpade Mohanty's famous article 'Under Western Eyes' in which she challenges the dominant constructions and reductions of 'third world women' within white, Western feminism (Mohanty, 1988).

Ultimately, whiteness comes to (implicitly) represent the neutralized or normalized, as an invisible non-raced identity (Allan, 2022). Whiteness can be defined as a dominant and normative frame that differences are measured from. Others then diverge from the humanity, normalcy and universality that whiteness has come to represent historically (Mørck, 2015). This is reflected in the concept of 'white privileges'. *Not* having to worry about being positioned as e.g., suspicious or being belittled based on one's physical appearance, clothes or name is a privilege that is difficult to define as is it invisible (McIntosh & Cleveland, 1990). It is something that is *not* done to you. These perspectives are furthermore not necessarily *visible* in biomedical research as this research aims to elude social, political, structural, and powerful contexts to achieve bias-free knowledge. However, critics argue that 'good research' has historically been founded within the paradigms of gender discrimination (heteronormative), racism (whiteness as universal) and androcentrism (male-centered).

2.5 The social categorization of 'ethnic minority patients' in modern healthcare: the four research questions emerge

The underpinnings of who represents 'the majority' in Denmark are not neutral but based on implicit and hegemonic whiteness. It is within these underpinnings in modern healthcare that the categorization of 'ethnic minority patients' arises and is practiced and produced. The ideological pillars of person-centered approaches and evidence-based practice lead to individualized and standardized healthcare that affects approaches towards 'ethnic minority patients', as it *homogenizes* people included in the categorization, which then leads to a perceived measurable and quantifiable category that is then compared to 'the majority'. However, the background shows how these constructed delimitations of binary and objective categorizations can be problematic and limited in use for a number of reasons. 1) It is defined differently between countries. 2) It is globally invalid, as the 'ethnic Dane' presented through whiteness would represent 'the minority'. 3) In Denmark, it relies on the problematic ideas of 'Western and non-Western' origins. 4) Ethnicity is often the explanatory factor as a set of attributes rather than the structural, social and intersectional dimensions of how ethnicity becomes problematic. 5) It does not account for movement, agency and flexibility between the dichotomy-based categories. 6) It homogenizes a very heterogeneous group of patients. Research findings show

how perceived health differences in 'ethnicity' then risk increasing health inequalities despite the aim to do the opposite (A. J. Browne et al., 2014; Leopold et al., 2018; Varcoe et al., 2009).

Thus, health inequalities and inequities exist and are real for the group categorized as 'ethnic minorities'. In health research, the solutions often involve an attempt to reduce these through interventions based on an *individualized* perspective. The aim is then to change the behavior of the patients (individual responsibility) and increase the knowledge of the healthcare staff (competencies). Ultimately, health inequities for ethnicized patients are embedded in the social and biomedical theories are limiting as they do not consider social origins that go beyond individual choice or responsibility (Horrill et al., 2018; Thompson, 2015). The limitations of these approaches have been outlined above.

Based on the limitations, I argue that to explore *social* inequalities and inequities in health, it is also necessary to include epistemologies, theories and methodologies that *actively* engage with hegemonic, structural and social processes. This approach has informed the four articles in this thesis. They draw on the ethnographic empirical data consisting of policy documents and fieldwork that methodologically embody notions of positionality, representations, contextuality and power (Madison, 2011).

First, I have briefly introduced the Danish welfare state and emphasized the importance of including sociopolitical aspects. Since there is scant research exploring *how* universal healthcare in a Scandinavian welfare state is translated and affects healthcare for ethnicized patients, that is the aim of article 1. Secondly, article 2 explores the expectations of *proactive behavior* within standardized patient pathways to address *how* underpinnings of modern medicine affect the care and treatment of ethnically minoritized patients. This expands the dominating individualized and decontextualized focus on standardized pathways. Third, ethnicized patients have scarcely been included in health research. Therefore, it has been imperative for this study to explore how ethnicized patients engage within the categorization of 'ethnic minority patients' during hospitalization. This brings new knowledge to the field of ethnicity and health and is explored in article 3. Finally, I have outlined how modern medicine implicitly risks *abnormalizing* ethnicized patients while simultaneously undermining these structures. Therefore, to disrupt the neutrality of whiteness, healthcare professionality and nursing, article 4 centers on these positionings and discusses researcher positionings and knowledge production in relation to ethnicized and racialized minorities.

Chapter 3: Theoretical approaches

Ethnicity is a contested concept in health research and has been criticized for the lack of consensus on its definitions and delimitations. The inclusion of 'ethnic categories' often stems from the positivist epistemology of removing bias to produce a generalizable and objectified variable of ethnicity that can provide 'true', or an essence of, knowledge. Due to recent criticisms of the lack of diversity in healthcare and research, ethnicity, among other social categorizations such as race, gender and age, has been amplified to show disparities in healthcare (Helberg-Proctor, 2017). Critics point out how ethnicity is portrayed as ahistorical and decontextualized, which leads to an essentialist, fixed, single-axis, and homogeneous use of the concept (Bhopal, 2007; Bradby, 2003; Culley, 2006; Varcoe et al., 2009). Therefore, social and critical health researchers have long argued against seeing ethnicity through essentialism (as a set of attributes) or structuralism (something that people have) (Helberg-Proctor, 2017; Torres, 2015; Wanka et al., 2019). As mentioned, research also shows that if a variable such as ethnicity is not defined, used and analyzed carefully, there is a risk of reproducing disparities related to perceived 'ethnicity' (A. J. Browne et al., 2014; Leopold et al., 2018). As ethnicity is still widely used in quantitative and qualitative health research (Helberg-Proctor, 2017), it is important to critically engage with 'ethnicity' as a social categorization. It is also within this criticism that I situate ethnicity in this study.

3.1 *Productions* of ethnicity

In critical health research, there is an increasing understanding of the relevance of ethnicity as a socially constructed concept (Devakumar et al., 2022; Kapadia & Bradby, 2021; Torres, 2018). These perspectives disregard the natural essence of ethnicity and conduct critical explorations of taken-for-granted assumptions about ethnicity. In this sense, exploring ethnicity as a social construction is not only useful in deconstructing, but also in constructing new understandings (Esmark et al., 2005; Wenneberg, 2000). I explore the social categorization of 'ethnic minority patients' as socially constructed but I also include (active) productions of ethnicity in healthcare. My research interest is then to explore what ethnicity *does*. The pioneering work by West and Zimmerman (1987) argues for the doing of gender. Subsequently, gender and feminist studies have shown how social categorizations *become* through performances or practices that rely on doings, undoings and redoings (Butler, 2004; Staunæs, 2003). In this manner, I draw on post-structural and feminist thinkers. Post-structuralist epistemologies argue that knowledge is anti-essential and anti-dualistic. Instead of people 'being' positioned as a gender, 'race' or nationality, Haraway (1988) describes a mobile positioning and a multidimensional vision in which contradictions and splitting are central aspects of exploring how practices of positionings become. This enables an analysis of how multiple practices of ethnicity become in healthcare. Knowledge is then multidimensional and produced and situated from somewhere in particular (Haraway, 1988). This approach includes a focus on how visions of categorizations become or as Haraway describes it: '*vision is always a question of the power to see'* (Haraway, 1988). This means that knowledge *becomes,* and both realities and truths are plural, situational and produced continuously. These inspirations enable me to explore productions of ethnicity from multiple visions, including patients, healthcare practices, health research and policies. Another central element is to include dominant powers of knowledge production and how these enable subtle processes of normalization that affect the production of subjectivities (McIntyre et al., 2020). Knowledge production on perceived ethnicity is important to situate within health research. As I have expressed throughout this thesis, productions of ethnicity are specifically situated and embedded on a Eurocentric basis in Denmark, and to capture these, I also draw on post-colonial approaches, as these engage with the hegemony of ethnicity.

3.2 The *hegemony* of ethnicity

Hegemony was originally developed by Antonio Gramsci and can be understood within a relationship of power as one group dominating another through leadership and authority (Durey, 2015). In healthcare, this affects who has legitimacy of the 'truths' relating to ethnicity due to its embeddedness within Eurocentricity, whiteness and modern knowledge production (Bilge, 2018; Durey, 2015). To disrupt these power balances, post-colonial epistemologies focus on how knowledge is produced within the context of colonialism, both past and present (Collins, 2019; Kirkham & Anderson, 2002). Drawing on post-colonial and critical feminist epistemologies enables analysis of how knowledge is produced within hegemonies of Eurocentricity and whiteness. This incorporates structural aspects of marginalization, privileges, othering, and intersectionality. Post-colonial conceptualizations can then be used to disrupt this hegemony and display covert affects, mechanisms and consequences for patients categorized as ethnic minorities in universal, modern healthcare. To encompass these perspectives, I use the conceptualization of ethnicized and ethnically minoritized patients, as I will now elaborate.

3.3 From ethnicity to *ethnicized*

Scholars have discussed the limitations of perceived ethnicity. Nonetheless, in everyday clinical practice, ethnicity is used for, about and with patients. But productions of ethnicity are not equally distributed, and it is important to consider who produces knowledge and in what context (Holmes & Gagnon, 2018). Biomedical theories dominate the way healthcare staff are professionalized to perform healthcare. However, the uses or definitions of 'ethnicity' are not linearly translated or used. They are produced within social, relational, political, institutional, and societal contexts. To capture these and to explore productions of ethnicity, I advance the conceptualization to situate this study by examining what ethnicity *does* in healthcare. This understanding enables the exploration of the processes (and action) in which some groups *become* ethnicized and ethnically minoritized by the majorized. These rely on an intersectional understanding. Intersectionality differs in definition, but Collins (2019) describes the concept as follows: '*The term intersectionality references the critical insight that race, class, gender, sexuality, ethnicity, nation, ability and age operate not as unitary, mutually exclusive entities, but as reciprocally constructing phenomena that in turn shape complex social inequalities'*. Ethnicized markers are inherently intersectional and unstable. The concept of *ethnicized* then disrupts notions of *beings* by focusing on *doings* that amplify instabilities, (un)(re)doings, agency, and movements of, and between, social (and constructed) categorizations. Furthermore, these conceptualizations decenter 'the ethnic minority patient' and instead engage with how ethnicized patients *are positioned* in healthcare – and how that affects ethnicized patients' encounters with healthcare. These understandings are then a way of moving the categorization forward and engaging with Eurocentric and whiteness underpinnings, avoiding homogenization, opening up heterogenic aspects and including hierarchical power structures (Selvarajah et al., 2020).

3.4 An equity lens on *ethnicized* patients

This thesis uses the terminology of health disparities, inequalities and inequities. The different definitions have been outlined in the introduction and the terms are used as appropriate in the analyses. However, this has not been straightforward, as the literature does not always decipher or distinguish their choice of concepts. In this study, the theoretical and analytical approaches are placed within intersections of sociopolitical, institutional, and social positionings that are hegemonically and intersectionally embedded and to unfold these socially and structurally based health inequities, I apply an equity lens (Varcoe et al., 2022).

With an equity lens, this thesis explores (welfare) representations, (hospital) practices, (patient) workings and (majorized) positionings for, and of, ethnicized patients in healthcare. In the articles, I draw on specific concepts within these theoretical approaches such as othering, intersectionality, doings, positionings, social practices and problem representations. These are elaborated in the results section as they relate to the specific research questions guiding the articles.

However, as this study is empirically driven, I will first introduce the ethnographic study before returning to the theoretical and analytical approaches in the four articles.

Chapter 4: Methodology

In this chapter, I will present the methodology of the study. I will situate my fieldwork, interlocutors, empirical data, analysis, research positioning, and knowledge production. In line with this, the ethnographic study is inspired by Madison (2011), as she explains ethnography as *critical theory in action*. Drawing on critical inquiry, I see ethnographic methodology as the foundation for the inquiry and the engagement with the interlocutors as the point of departure. I did not have sub-studies or hypotheses defined beforehand. Instead, I worked in an empirically driven manner, aiming at a critical inquiry into *what is* by examining what are neutral and taken-for-granted assumptions (Madison, 2011). Having situated the origins of the categorization 'ethnic minority patients' from society to healthcare and health research, I am interested in exploring how the categorization was distributed into practices and interactions in hospitals. Therefore, my research focus is on *how* the social categorization 'ethnic minority patient' becomes in healthcare, which then not only enables a focus on the *how* but also explicitly aims to explore *how it could be*, which implies work towards creating equity (Madison, 2011). Within this understanding, I also incorporate obscure and underlying domains of power. Positionality, hegemony, representations and contextuality then become central in this study and by looking at the *doings*, I have followed sayings, actions and experiences among interlocutors that have normally been restrained in Danish healthcare and society (Halberg, 2023; Halberg et al., 2022; Madison, 2011).

First, I will contextualize the fields and then introduce the fieldwork. Thereafter, I will position the interlocutors and myself as a researcher. Finally, I will describe the research ethics and the overall data process. The specific theoretical and analytical approaches in the four articles are presented in the results section.

4.1 The field sites: hospitals and orthopedic surgery

The vast majority of people defined as ethnic minorities in Denmark live in Greater Copenhagen (Holmberg et al., 2009). Originally, I planned to include a single hospital department in this study but due to the possible sensitivities of studying inequities related to ethnicity in healthcare, I contacted a second hospital that agreed to participate. Based on my previous and current work in the field of nursing, I had contacts in the departments included in the study. Both hospitals are situated in Greater Copenhagen, and they have considerable demographic and socioeconomic variety in their intake of patients. In addition, an increasing percentage of healthcare staff with Danish authorization have an ethnically minoritized background and this is also reflected in the included departments. This is important as it emphasizes my focus on the heterogeneity of patients *and* healthcare staff, and what I would describe as dichotomous ideas of ethnicity in relation to minority/majority and patient/professional are not delimited but interconnected, fluid and transgressive. Both hospitals are publicly funded and provide universal healthcare within the welfare state. This means that the hospitals are politically regulated and managed by the Capital Region of Denmark, which owns and runs them (Vrangbaek, 2020). These hospitals are then relevant to include in this research study as they provide treatment and care to patients categorized as 'ethnic minorities' (articles 2 and 3), they are representative of the welfare state (article 1) and the healthcare staff represent the diversity of healthcare today (article 4).

Both the departments are orthopedic. Orthopedic surgery is a field with a high degree of standardized treatments. I argue that the orthopedic field represents a strong case of what modern medicine and biomedicine aims to do; it conducts surgical treatment that is based on clinical trials, and it is highly regarded as being evidence based. Within this specialty, guidelines and regimes of orthopedic pathways are also standardized, which means that the patient's pathways are pre-planned from pre-surgery through surgery to the post-operative journey (White et al., 2013). The orthopedic wards perform both elective and acute procedures that range from same-day surgery to more long-term patient pathways. They all work with Enhanced Recovery After Surgery (ERAS) as their standard, which consists of multi-modal, interdisciplinary and standardized surgical pathways (Marques et al., 2018; White et al., 2013, Halberg et al., *forthcoming*). In clinical practice, the staff must therefore follow, and record elements of the guidelines based on the care, e.g., recording nutritional intake, changing dressings, and checking scars on a specific day, while the patients have to engage in the treatment by e.g., mobilizing from the bed on the day of surgery or the following day as well as understanding, accepting, and following verbal and written information. This implies a high degree of adherence by both staff and patients. Furthermore, it creates dilemmas for nurses and patients when the latter do not follow guidelines; the nurses find they have to compromise on their ideals of individualized nursing in order to follow standardized regimes (Berthelsen & Frederiksen, 2017; Cohen & Gooberman-Hill, 2019), while for patients it causes surgical and health disparities (Leopold et al., 2018; Marques et al., 2018). For 'ethnic minority patients', this takes on specific forms, as I will now elaborate.

As introduced in the background section, how notions of ethnicity relate to (orthopedic) treatment in Denmark is an underexplored topic. Over the last five years in the North American context, there has been an increased focus on the lack of minority representation in orthopedic clinical trials and of diversity among orthopedic surgeons (Cwalina et al., 2022; Day et al., 2019; Owusu-Akyaw, 2021). In these articles, researchers discuss how this has made the orthopedic specialty slow to focus on health disparities related to race or ethnicity. I would argue that this may be influenced by the high degree of incorporation of standardized treatments that have been valued as generalizable and strongly evidence based. Following these recent discussions, there has been an increased awareness of the possible pitfalls of reporting ethnicity and race without considering other social factors that risk falsely attributing findings to ethnicity (Leopold et al., 2018, 2023). A field where clinical practices are based on standardized pathways and evidence-based knowledge is thus a relevant site to explore the categorization of 'ethnic minority patients', as the focus of my research questions is placed within the context of modern medicine and its effects.

4.2 Fieldwork

4.2.1 Preparation

The fieldwork took place over a nine-month period from May 2021 to January 2022. COVID-19 was still present in the hospitals, and I took regular tests. In both departments, I had a total of five nurses who agreed to help me and support the feasibility of the ethnographic study. Before starting the observations, I held two informal brainstorming meetings with four of the nurses with the aim of exploring the categorization of 'ethnic minority patients' in their work and in the departments (see interview guide, appendix 6). Following these conversations, I informed all the staff about my project at staff meetings in the wards. I also put up posters containing my picture, research focus and contact details in hallways and staff rooms (see appendix 3). These were then available to patients, relatives and staff. Furthermore, I created a pamphlet with a picture of a sunrise over a cornfield to symbolize prosperity, progress, warmth, and positivity. This picture was chosen after a discussion with Özlem Cekic. In this manner, I had informal conversations with five different experts in the field, including Morten Sodemann, professor in global health; Mira Skadegård, assistant professor (now associate professor) in structural discrimination; Özlem Cekic, politician, nurse, debater and author; Naveed Baig, PhD fellow and imam, as well as the ethnic resource team at Rigshospitalet. They were contacted to gain knowledge on how to approach the fieldwork and the interlocutors, which led to assistance on e.g., vocabulary, physical design, and possible challenges. Furthermore, it led to a collaboration with Mira Skadegård on the included book chapter.

The information pamphlet contained information about the study, ethics, expectations, and rights, as well as my information and a picture (see information pamphlet, appendix 1). To accompany the pamphlet, I formed a written consent following ethical guidelines (see appendix 2). These were written in Danish and then translated into seven other languages (Danish, English, Polish, Arabic, Urdu, Somali, Moroccan Arabic and Turkish) by a professional translation bureau. To ensure the quality of the translations, I asked bilingual readers who are fluent in Danish and in one of the other languages to read both the Danish and translated information and provide feedback. This led to corrections by the translation bureau. The pamphlet and consents were handed out in the language that the patient and relatives preferred.

4.2.2 Inclusion

Initially, I would talk to the nurses in the elective wards to find out whether any ethnically minoritized patients were scheduled for surgery. In the acute wards, I would arrive in the mornings. I approached the patients in the morning and explained who I was and what my purpose was. After introducing the study, I handed them the information in the language they preferred and left them to read the material. When I returned, I asked if they wanted to participate. Thirteen patients accepted, while five patients declined due to fatigue, hearing impairment, family members opposing participation, as well as two who did not identify with the categorization. Furthermore, I originally included another patient who was 92 years of age and diagnosed with dementia. I had a long conversation with his granddaughter, and she was positive towards the inclusion of her grandfather. However, following the observations, I decided not to include them in the study, as I did not feel ethically comfortable observing this gentleman when his granddaughter was not present. My inclusion criteria were patients 18 years or older and defined by hospital staff as belonging to 'ethnic minorities'. In line with these inclusion criteria, I only included interlocutors with an Eastern European background at a later stage, as the staff emphasized that they were part of the group. I had initially not thought of including them. This was explained by one nurse: *'Even though they look more Danish.. I mean lighter-skinned, they are culturally very different. Eastern Europe is something completely different. It is a difficult category of patients, and we have a lot of them'.* Furthermore, including Eastern European patients also follows the definition used in Denmark, as initially explained (Frederiksen, 2018; Mock-Muñoz de Luna et al., 2019). I encountered patients that did *not* identify with the categorization of 'ethnic minority' despite the staff seeing them as part of the categorization. In these instances, I kindly thanked them for their time and left their room. This entailed ethical reflections and considerations, as I did not wish to make anyone uncomfortable. It is also relevant to the topic as some relatives did not think the patient should participate, such as the children of a mother who was a patient. The sensitivity and potential risks of reproducing negative stereotypes were always present. I will return to these in research ethics.

4.2.3 Interlocutors

The broad inclusion criteria are reflected in the interlocutors. First, the concept of interlocutors refers to how patients take part in dialogues and conversations (Madison, 2011). This terminology then emphasizes the agency and active participation by ethnicized patients in the hospital contexts described. Being interested in the social categorization of 'ethnic minority patients' was challenging as it includes a wide range of patients in a clinical practice. But as this was my inclusion criterion, I did not select patients on other parameters. Having an intersectional approach to ethnicity, I was aware of aspects of gender, language, age, religion, and migration history. These are reflected in the following table of the interlocutors:

No	*Name and age*	*Sex*	*Language*	*Procedure*	*Self-identified origin*	*Migration history*
1	Baran, 47	M	Danish	Hip surgery	Kurdish from Turkey	Came to Denmark aged 20 years to get married
2	Rehan, 45	M	Danish	Hand surgery	Pakistani	Came to Denmark aged 24 years to get married
3	Dina, 43	F	Limited Danish	Knee surgery	Bosnian	Came to Denmark aged 28 years to get married
4	Ghali, 64	M	Danish	Hip surgery	Berber from Morocco	Came to Denmark aged 13 with mother to join father who was a guest worker
5	Ensar, 61	M	Danish	Diabetic wound	Ex-Yugoslavian from Macedonia	Came to Denmark aged 11 with mother to join father who was a guest worker
6	Kamil, 68	M	No Danish	Amputation	Turkish from Turkey	Came to Denmark in 1987 as a guest worker
7	Emir, 36	M	Danish	Shoulder surgery	Albanian family from Macedonia	Born and raised in Denmark
8	Jamil, 35	M	Danish	Hand surgery	Kurdish family from Turkey	Born and raised in Denmark
9	Hasan, 27	M	Danish	Knee surgery	Arab family from Lebanon	Born and raised in Denmark
10	Elin, 63	F	Little Danish	Hand surgery	Turkish from Turkey	Came to Denmark in 1979 with children to join husband
11	Sara, 65	F	Danish	Hip surgery	Persian from Iran	Came to Denmark in 1987 with children to join husband
12	Simon, 34	M	No Danish	Foot wound	Polish	Working in Denmark for the past 7 years

13	Hristo, 54	M	No Danish	Foot and ankle surgery	Bulgarian from Turkey	Working in Denmark for the past 7 years

(Halberg et al., *forthcoming*)

As this thesis does not work with ideals of data saturation or finding an essence, the aim is not to find a generalizable truth of *being* an ethnic minority. Instead, I present representations from somewhere in particular that have a social categorization in common. The research questions of this thesis imply an intersectional and hegemonic exploration of *becomings*. These are then the methodological underpinnings of including these 13 interlocutors in this study. Additionally, this was communicated to the hospital staff, who were also intersectionally positioned. Finally, when the patients spoke limited or no Danish, I would receive help from relatives, as they participated in the admission. In the cases where no one was with the interlocutor, e.g., Hristo, we would speak in simple Danish or English words, mirroring the positioning between the staff and Hristo.

4.2.4 Participant observations

The fieldwork consisted of participant observations, interactions and conversations with the interlocutors, their relatives and hospital staff. During the fieldwork, I was mostly present in the daytime but also in the evenings. I would sit with the patients and walk with them (or walk alongside them if they were in a hospital bed) when they were in transition between departments. I was also present during surgeries, when the surgery used local anesthesia, otherwise I left the operating room when the patients were sedated. I participated during doctors' conversations, physiotherapists' training, and nursing tasks. I exited the room during personal hygiene for ethical reasons. When the interlocutors were tired, I would sit at the other end of the room or outside the room. During our conversations, I could inquire about observed situations, while we also talked about their background, upbringing, working life, personal life, medical history and experiences with healthcare. There were long periods between interactions with staff, when I had long, uninterrupted conversations with the interlocutors and their relatives. As these were not formal interviews, they were reconstructed afterwards in the data process. I followed the interlocutors for one to four days depending on their hospital stay. I had originally planned to conduct follow-up interviews in the homes of the interlocutors, but as we had had long, uninterrupted, and open conversations of up to four hours at a time, which drained their energy, I did not want to impose additional work on them as these were not always light conversations. The strength of fieldwork is the flexibility to adapt to the social circumstances that arise. This means that the context defines the ethnographic method, rather than the method defining the context (Amit, 2003). This was thus an ethical decision I made during the fieldwork. As my mere presence meant that I *engaged* with the field (Madison, 2011), these factors are important to consider.

4.2.5 Researcher positioning

In both hospitals, I wore a uniform and a name tag that indicated my nursing background. As a hospital site is not accessible to 'outsiders' or people that do not belong there, I found the uniform and the sign to be important to position my belonging in the departments. The patients also indicated familiarity with my physical appearance. However, dilemmas arose due to my wearing a uniform. For example, as I was following Elin and her family (see also articles 3 and 4) into the pre-surgical room, I approached the nurse behind the desk to inform her about my study. She then proceeded to engage with the topic using terminology that made me uncomfortable. It was more about *us* (as nurses) talking about *them* (as 'ethnic minority patients'). This represented a division that I did not want to be associated with, especially not with Elin and her family present in the room. Instead, I sat with Elin's son, Nergis, and had a long conversation. But wearing a uniform also enabled a position where I was able to ask for information such as surgery times that the relatives did not necessarily have access to. With the uniform, I also gained access to the staff rooms, the healthcare staff, the surgical rooms, the medicine room and the kitchens, which are prohibited for patients and relatives. In this case and at the request of Nergis, I asked the nurse about the tentative surgery time and the nurse provided the information. She then proceeded to ask if I wanted a cup of coffee and to sit with her behind the desk. I quickly declined but it made me uncomfortable as my belonging was then under threat to shift away from the patients. I often had such in-between positioning where I looked more like staff, but as I did not participate in the care and treatment and spent long uninterrupted hours with the patients in their hospital room, I was asked to sit down and offered food from their trolley. It was also an advantage as I could create reciprocity by having professional knowledge as well as having quicker access to pain relief, coffee, etc. However, it still demonstrated a power imbalance, which I elaborate on in article 4.

4.3 Research ethics

Ethical dilemmas are an epistemological condition of fieldwork as it both implies involvement with, and the objectification of, people in the field (Tjørnhøj-Thomsen & Hansen, 2009). In this way, ethical considerations have been present during all parts of this ethnographic study. I have described ethical considerations, decisions, and dilemmas throughout this thesis as they have been related to the sensitivity of the research topic, my researcher positioning, methodology, the healthcare staff and the interlocutors. Ethnographers aim to do no harm but I also acknowledge the complexity and contestation of perceived 'right' or 'wrong' (Madison, 2011). Therefore, it has been a continuous process from writing my initial project description to conducting the fieldwork and writing articles and the thesis, to critically engage with my positionings, interpretations, representations, conceptualizations and belonging in this complex, contested and non-neutral field of ethnicity and health inequities in a Danish context. Therefore, this ethical section is by no means exhaustive of my ethical dilemmas but rather a compilation of central aspects of ethics I encountered.

4.3.1 The centering and decentering of 'ethnic minority patients'

First, there is an intrinsic dilemma in the initial focus of simultaneously centering, and being critical of the centering of, 'ethnic minority patients'. During a PhD course, I was asked to quickly jot down notions of ethical dilemmas. There I wrote:

Why is it that the focus often becomes discrimination when racially and ethnically minoritized patients are included in health research? They also experience other problems similar to those who are positioned as the majorized. Therefore, the inclusion of minoritized patients should not always focus on inequalities. They risk othering minoritized patients once again. At the same time, they are also important to describe. Minoritized patients should not be 'reduced' to subjects of inequality or discrimination. Ethnicized patients are just as versatile and different as other patients and should not 'just' be in opposition to the (white) majorized. But discrimination is very underexplored.

Focusing on a group categorized as 'ethnic minorities' risks homogenizing and *othering* a group that is differentiated from the norm. As we are all (myself, healthcare staff and patients) intrinsically embedded within the social site of research, this is also reflected in the different terminology used to describe ethnicized patients. During fieldwork, I most often used the term 'patients categorized in healthcare as ethnic minority patients', the staff generally used 'other background/origin than Danish' or 'ethnic patients' while the interlocutors either used their historical backgrounds as e.g., Arabic, Turkish or Kurdish or terms such as 'foreigner' [udlænding in Danish] or 'immigrant' [indvandrer in Danish]. All these concepts differ but revolve around notions of people perceived to be ethnic minorities in Denmark.

Ultimately, ethnicized patients *are* categorized by specific conceptualizations and if research does not focus on these implications, we risk reproducing invisible and inequitable structures. These notions of reproducing problematized categorizations to enable us to counter-produce the problematic underpinnings have been important considerations in all aspects of this research process. I (and the healthcare staff and patients) have fumbled in the search of exploring what ethnicity does and how it is used while simultaneously trying not to overuse it. This has been a central dilemma during fieldwork but is also reflected in the choices of conceptualization, analytical approaches, and written productions.

4.3.2 Defining ethnicized patients as a majorized healthcare professional

As mentioned, article 4 analyses dilemmas and consequences of my research positioning. In this section, I will explore some of the other ethical dilemmas involved in this ethnographic study. It was not always clear who were relevant (one could ask relevant for *whom*) to include in the study. As I have described above, I originally did not include patients with an Eastern European background but changed this due to the empirical encounters. I also mentioned that five patients declined to participate. Particularly in two cases, this created complex encounters. With the children refusing to allow their mother to participate, they implicitly expressed concern about the topic of research. This can be understood within the discursive landscape of ethnicity in Denmark. I did not have a chance to elaborate and engage further with the children, but it left me with an uncomfortable feeling of representing discourses that I try to problematize. In another instance, I approached a patient who did not identify with, or recognize, the categorization, which led to an uncomfortable situation where I felt I had put a label on her that she did not identify with. These situations indicate the sensitivity and risk of fieldwork of 'Others' (Madison, 2011). I tried to manage as best I could, but I wonder if it left her with uncomfortable feelings. In this second instance, I explained my clear detachment from the care and treatment, and I orientated the nurse in charge of her care to make her aware of the situation. Having official access to the field is not the same as gaining access to the people in the field (Tjørnhøj-Thomsen & Hansen, 2009). I was very aware of the complexity of explaining to the patients that I was interested in their 'ethnic minority status' during hospitalization. As this is not a discursively neutralized status in the Danish context, it was often complicated to find common ground. Some patients immediately accepted the premise while others were a little more hesitant and inquiring. Nonetheless, after these first encounters, I found that the relationships quickly developed and the interlocutors accepted, and even appreciated, my presence. I became positioned as their advocate during hospitalization and had privileged access to e.g., the kitchen and information on timelines, and they provided me with detailed, honest and rich empirical data. The implications of this are analyzed in articles 3 and 4.

During fieldwork, I also reproduced unfortunate patterns. For example, I had a conversation with Dina's husband, Belmin, while she was undergoing surgery:

We return to the conversation about him having to interpret for Dina. However, he changes the subject and tells me how tiring it can be to talk about Bosnia over and over again. He had had quite a long conversation with the anesthesia nurse about Bosnia's nature, location and history. He continues and says that it is always the topic of conversation. I then realize that I did exactly the same thing earlier in the day. I had also talked to Dina and her husband about Bosnia. I can understand how that must be frustrating. Despite my genuine curiosity, it also alienates. Why is 'our' focus always their differentness? Belmin continues: 'Even though I have been in Denmark for so long, I am always asked about our story. It is just something we have to get through.'

Belmin did not state that I had done the same thing, but this is an example of how my embeddedness within my own social positionings showed during fieldwork. I reproduced notions of otherness relating to his 'differentness' from Danish society and healthcare. While I was researching forms of otherness, I implicitly also risked reproducing these. It is also pertinent to consider that I do not have embodied experiences of being othered and discriminated against due to ethnicized markers and therefore I was constantly aware of trying to be sensitive towards not reproducing these unfortunate patterns. Seemingly neutral and well-meaning interactions can have discriminatory effects (Halberg & Skadegård, *forthcoming*). Such interactions led to ethical considerations throughout the fieldwork.

4.3.3 Researching among colleagues

Through my nursing work, I had met several of the nurses in the field sites. This helped me to gain access but also led to ethical dilemmas when researching a sensitive topic such as health inequities for ethnicized patients. Within these concepts, there is an embeddedness of relational power axes and social aspects that inherently involve the hospital staff that encounter ethnicized patients. Therefore, there have been ongoing ethical dilemmas of involving the staff in the research while being sensitive to their positionings. I have explained the research focus and continuously reminded staff of my positioning as a fieldworker. But I also emphasized that while they have individual effects, I look at inequities from a structural point of view to counter the idea of someone embodying an individualized bad attitude or morals (Halberg & Skadegård, *forthcoming*). When I have analyzed empirical data, I have moved away from focusing on individual *behavior* to examine what structural and organizational positionings lie behind specific encounters and conversations. During fieldwork, I also engaged in conversations on the complexity of terminology and mentioned difficult situations that I have encountered during my years of nursing. Healthcare staff aim to do no harm and are professionalized into the healthcare system. This enables specific terminologies and understandings that are reproduced in clinical practice. Furthermore, the included staff also reflected the diversity of Danish society and were intersectionally positioned, which, as with the interlocutors, requires a focus on the heterogeneity of healthcare staff. In order to overcome these ethical considerations, I have not wanted to (re)produce a scientific article on the experiences of healthcare staff with *barriers* in the encounter with ethnicized patients but rather analyze the structures behind such barriers. These are explored in articles 2 and 4. As I discursively *look like* a nurse with my physical appearance and my uniform, this created dilemmas of perceived belonging, which I have elaborated in the section on researcher positioning. I have strongly focused on not risking the trust and access I was given, while also wanting to explore productions of ethnicity in a clinical practice. Furthermore, I was able to include two departments in two hospitals to accentuate that inequities are not produced due to *specific* healthcare staff or 'culture' within a department. While I often encountered questions of *which* orthopedic diagnoses I would include in relation to the healthcare staff, the analyses go beyond the orthopedic specialty, as ethnicized patients do not relate their experiences to specific specialties. They relate their experiences to wider hospital and societal contexts. As educational material on discrimination is absent in Danish society, and in health education, it is often thought to be based on individual behavior. It is important to be sensitive towards these dominant understandings and disrupt them within a potentially uncomfortable research project that is based on ambiguities and uncertainties (Skadegård, 2018). As a representative of the healthcare professions, I chose to analyze these perspectives through autoethnographic emotions that show the dilemmas and consequences of social positionings within nursing, healthcare professionality and (in my case) whiteness.

4.3.4 Researching discrimination and inequalities when no one talks about them

No one during the fieldwork used the terms discrimination or inequalities. This could be because of the field site in Danish healthcare but also due to the Scandinavian welfare state's notion of social egalitarianism (Halberg et al., 2022). Reluctance, insecurity and unfamiliarity of terminology can be seen as inhibitors of studying health inequities based on ethnicity. This has created ethical reflections on analyzing the empirical data within the context of critical health research. My production of representations and analysis from the field notes has made me reflect on ethical dilemmas of representations. How and when do inequalities arise, how do I communicate them and when are they related to ethnicity? As they were rarely explicated directly, I have had to reflect on when notions of ethnicity were implicitly explicit and draw on empirical and theoretical work of others to legitimize the analyses. It has been a continuous ethical demand to reflect upon these notions and to disrupt my own neutralized positionings, and article 4 argues for seeing the researcher's positionings as a culturalized, ethnicized and racialized question. Finally, I did not set out to explore cases of racism, but I was interested in empirically following the doings and workings of ethnicized *processes* that ultimately did lead to ethnicized health inequalities, discrimination, and inequities.

4.3.5 Political landscape and ethical dilemmas

Another important aspect is that politics cannot stand outside ethics (Madison, 2011). Besides the inclusion of political structures in the analyses, this particular field of research has been met with adversity and even a hostile political agenda. The fields of migration and gender research have been under attack from prominent Danish politicians and have been proclaimed pseudo-research. Researchers within these fields have experienced harassment and even threats (Baggersgaard, 2022). The focus on inequalities in health is politically a hot topic but not with regard to inequalities related to ethnicity, as the report in the introduction showed. Researchers in these fields have been discouraged and exposed on social media. Exploring sensitive, uncomfortable, and even unpopular research topics in a political landscape that limits and even threatens researchers has been a part of this PhD study. As political discourses affect all aspects of society, political and societal resistance to the ideas of racism, discrimination and ethnicized inequities exist. This makes it difficult to explore these matters, as there is an underlying skepticism and devaluation in society. The possibility of someone (mis)representing or (mis)interpreting my analysis risks creating real harm for already marginalized people in society and healthcare. This has been an underlying ethical concern throughout this PhD.

4.3.6 Ethics committee and informed consent

This study was approved by the Danish Data Protection Authority (P-2020-1068), which obliges the researcher to follow the Danish legislation on data protection (see appendix 4). The empirical data have been stored on a personal secure drive.

The study was also assessed by the Regional Committee on Health Research Ethics. According to the definition used by the Regional Committee, ethnographic studies are not considered health science research and therefore do not require approval. Instead, the study has been registered with a number (H-20072465) (see appendix 5).

However, ethical concerns and guidelines have informed this study. As mentioned above, the information pamphlet included information about the study, ethics, expectations, rights, and my details including a picture. Both the written and oral information emphasized that the interlocutor's participation, or decision not to participate, would not interfere with, or affect, their treatment in any way. I also highlighted their ongoing right to withdraw partially or fully from the study and included my contact details as a means to ensure this right. Furthermore, I chose the term 'minority status' in the written pamphlet to avoid labeling patients with terms that they did not identify with. The written consent was signed by myself and the interlocutor and then copied for us both. These were stored in a double locked closet following the prescription of the Danish Data Protection Authority. The staff were initially informed and continuously reminded. Informed consent is a continuous process (Tjørnhøj-Thomsen & Hansen, 2009) and I asked if I could use long conversations that took place away from the interlocutors as empirical data, while also reinforcing their right to withdraw statements at any point.

All names in this thesis are pseudonyms and the patient data included in this study have been carefully considered and only included if relevant to the analysis. Therefore, personal information about medical history, migration background, current family, location, work and living situation has been anonymized if it was irrelevant to the findings. This was an ethical consideration to maintain the anonymity of the interlocutors included in this study.

4.4 Data processing

The knowledge production from this thesis is based on empirical data. I will now introduce the data and how they informed the analyses.

4.4.1 Data representations

First-hand participation and written production are the two central elements of ethnography (Emerson et al., 2011). The empirical data were *produced* in different stages. First, I carried a pad of paper and a pen with me during fieldwork. During shorter breaks, e.g., when the interlocutors were sleeping, when I was waiting for someone to return from surgery or when I was sitting in the hallway or in the hospital rooms, I would write down key words. When there were longer breaks, or after a day of engaging in the field, I would jot down notes on the pad. These were then translated into 'thick descriptions' as described by Emerson et al. (2011). I would aim to write these on the day of the fieldwork or the following day in order to recall as many details as possible. This means that I wrote observations, conversations, and interactions but also the sentiments, moods, and emotions I perceived in the rooms. I especially focused on the practices constituted by doings and sayings (Schatzki, 2002) that occurred throughout the fieldwork but also on what happened following these practices. I would revisit the field notes and add thickness to them. I used questions of *how, why, where,* and *what* to expand the field notes. During long conversations with interlocutors that often lasted several hours, I focused on being present. Therefore, the empirical data follow my epistemological approach, as my aim is not to objectively retell the observations but rather to ensure that the empirical data is produced by me as the ethnographer. Secondly, I audio-recorded the brainstorming meetings and transcribed them verbatim using Word365 and Transcribe. As I did not have a preplanned hypothesis, the empirical data informed the research questions presented in articles 2, 3 and 4. All empirical data are stored on encrypted servers. A final total of 160 computer pages constitutes the written empirical data.

4.4.2 Analysis strategy

With the overall research topic being the social categorization of 'ethnic minority patients', there have been important considerations regarding the gathering and differentiation of the empirical data. As I have problematized the homogenizing of such a heterogeneous group, I did not want to risk reproducing homogenizing analyses *about* the interlocutors. The contradiction of analyzing both commonalities and differences led to different analytical strategies.

My research being empirically driven meant that the organization and analysis of the empirical data was central to the knowledge production in this thesis. I first read all the data and started to perform open coding, which entailed creating subheadings for different paragraphs in the margins of the documents. Open coding is an approach to review, reexperience and reexamine all the empirical data (Emerson et al., 2011). These were compared, contrasted, and contested through two overall initial strategies of *producing portraits* and *producing mind maps*.

4.4.2.1 Producing mind maps

To explore commonalities as a way of looking across the interlocutors, I produced several mind maps containing different themes and categories. To visually produce mind maps enabled a visual display of connections, hierarchies and distinctions that helped me to engage with the data (Madison, 2011). By using selected open coding (Emerson et al., 2011), I initially centered the social categorization of 'ethnic minority patients' but then continued to center other themes of e.g., 'gratitude' or 'distancing' that I saw as emerging themes within the data. With different foci, I centered themes that emerged among the interlocutors and the healthcare staff as well as in the hospital practices. This way of centering and decentering different emergent themes was a strategy to produce versatile and differentiated themes and categories. The aim of the different combinations was to group together different possibilities and inspirations for the analysis. Here, I considered factors of analysis, presentations, readership and audiences in the organization of the data (Madison, 2011).

4.4.2.2 Producing portraits

As I was very focused on the risk of reproducing a homogenizing analysis on 'ethnicity', I produced separate portraits of each interlocutor. The portraits cover 1-1½ pages of condensed text describing the demographic data, the individual life situation and the main empirical events from conversations, interactions, and observations. This was a way of displaying the heterogeneity of each interlocutor and forced me to reconsider and revisit emerging themes and categorizations. I would then consider differences and variations within a theme or categorization (Emerson et al., 2011). It also allowed me to focus on *one person* and the truths, experiences and specificity of each interlocutor (Madison, 2011). Fieldwork is always produced in the engagement between fieldworker, interlocutors and context and these portraits are thus empirical *productions* of data.

4.4.3 Compilation

The portraits and mind maps constituted the foundation of the data analysis. My aim has not been to analyze representativeness but rather to explore patterns and variations (Emerson et al., 2011). With an overall aim to explore *becomings* related to the social categorization of 'ethnic minority patients', I continuously developed analytical strategies to answer the research questions. Writing for different journals and audiences did not compromise epistemological, methodological, and theoretical understandings of ethnicity and health inequities in this study. Nonetheless, the four research questions impose different theoretical conceptualizations and analytical approaches. As I mentioned in the introduction, the research topic is relevant for health researchers, healthcare professions, social sciences, and welfare state scholars. The versatility of the chosen research output speaks to the research field as it is relevant to multiple audiences but must be adapted to specific contexts, audiences, and journals. The aim of this thesis is to explore productions of ethnicity in healthcare. These are explored through (1) a post-structurally inspired policy analysis that explores problem representations of 'ethnic minority patients' in a Scandinavian welfare state (article 1), (2) an abductive analysis to explore ethnicized processes within standardized patient pathways (article 2), (3) a situational analysis that develops the theoretical concept of (over)workings to grasp the doings, undoings and redoings of ethnicized patients (article 3) and (4) an intersectional analysis to disrupt the unmarked positionings as a (white) health researcher by exploring my knowledge productions within the social and mobile positionings of race, gender, and professionality (article 4). These analytical strategies are connected to the theoretical perspectives and readerships in the results section to show how they enable answering of the four research questions.

Chapter 5: Results

The results section consists of the four articles included in this thesis. I will introduce each article and its theoretical and analytical approaches to show how these make it possible to answer the four research questions. The results are compiled and discussed in chapters 6 and 7.

5.1 Ethnic minority patients in healthcare from a Scandinavian welfare perspective: The case of Denmark

Article 1 is based on a post-structural policy analysis (Bacchi, 2009). The main shifts within post-structuralism have been named the linguistic turn and representations of reality. These implied a shift from 1) understanding language as truth-bearing and 2) knowledge as structured into objective and stable units. With these underpinnings, Bacchi's 'what's the problem represented to be' (WPR) aims to go behind the policies and explore what problem representations they are based on. This approach enables a focus on analyzing discourses of how the categorization of 'ethnic minority patients' becomes represented in the Scandinavian welfare state, what problem representations these discourses are based on and how the categorization is translated into healthcare and has real consequences for staff and patients.

I draw on othering as a concept to explore discursive practices of how 'ethnic minority patients' are positioned within Danish healthcare. Othering is a post-colonial concept that has been particularly developed by Gayatri Chakravorty Spivak (1985) and Edward Said (Said, 1979). Spivak was born in India and her original work analyses the British colonial power in India while Said was born in Palestine and critically discusses the Western portrayal of 'the Orient' (the East) as the other. Othering can be understood as discursive processes of how some groups are positioned as subordinate by more powerful groups. These are based on ideas of inferiority and often problematized characteristics (Halberg et al., 2022; Jensen, 2011). This can therefore illuminate health inequities related to othering processes that also include the deconstruction of the normalized in health research and embodied knowledge (Akbulut & Razum, 2022; Halberg, 2023). These theoretical approaches inform the critically inspired post-structural policy analysis that can answer *how* political and societal discourses relating to ethnic minorities are translated into the Danish healthcare system and *how* these discourses affect ethnic minority patients' encounters with Danish healthcare.

This article was published in Nursing Inquiry and was aimed at critically based nursing and healthcare staff scholars and practitioners. Situated in the North American context, Nursing Inquiry welcomes critical papers and draws on critical scholarship in nursing.

This article was published in a special issue on 'anti-racism in nursing'. The article then engages with my professionality and aims to disrupt underlying assumptions within the social categorization of 'ethnic minority patients'.

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5.2 Exploring health disparities for ethnically minoritized patients during orthopedic ERAS pathways: an ethnographic study

Article 2 is based on an abductive analysis (Collins, 2019; Timmermans & Tavory, 2012). The social site of the fieldwork is standardized orthopedic and surgical healthcare. As standardized patient pathways are based on 'one size fits all' and require the *active engage-ment* of patients, disruptions are often explored through (non)-adherence. Reading through the empirical data, suboptimal pathways for ethnically minoritized patients were revealed through specific understandings and explanations by staff and in interactions. In abductive analysis, unexpected findings are connected to an existing theoretical frame-work (Timmermans & Tavory, 2012). The understandings and explanations were con-nected to the active elements of ERAS pathways, in which four of the five key elements require the patient's *proactive behavior*. By abductively analyzing right, wrong and reactive proactive behavior during ERAS pathways, and connecting these to the underpinnings of modern medicine, these theoretical approaches helped to generate new theoretical in-sights (Timmermans & Tavory, 2012) into *how* the behavior of ethnically minoritized pa-tients is understood and practiced during ERAS pathways and *how* this relates to health disparities.

This article is currently a draft and focuses on standardized orthopedic treatment. I wanted to reach an audience of clinical orthopedic and surgical specialties. I found the American journal 'Clinical Orthopaedics and Related Research®', which has focused on the current limitations of reporting health disparities for ethnically and racially minori-tized patients within orthopedic surgery. I contacted the editor-in-chief and sent an early draft of this manuscript. He is interested in the content and based on the early draft has agreed to send the article for external review.

5.3 Overwork as a concept to understand health inequities for ethnicized patients in healthcare – an ethnographic study

Article 3 is an analysis of patients' perspectives. To grasp the situational episodes and focus on differences *within* particular groups and *across* different groups, this article is inspired by situational analysis (Clarke, 2003). By focusing on specific situations during fieldwork, I related them to wider positionings and social worlds of e.g., discourses, constructions, social institutions and controversiality (Clarke, 2003, 2016). Based on the findings from the other three articles, I situate the context of institutional othering. Central to othering is the construction of differentiation (Akbulut & Razum, 2022). This implies that the dominant group has the power to relegate subject positions, often based on binaries or opposing pairs e.g., Western and non-Western or Danish and non-Danish, which then constructs the othered as non-belonging. I and other scholars describe how othered patients are positioned as non-conforming, delegitimized and problematized based on ideas of social, ethnic, religious, cultural, or racial groups (Halberg, 2023; Roberts & Schiavenato, 2017; Thorne, 2020). The article also illustrates how e.g., notions of cultural differences become essentialized explanations for inadequate healthcare, based on homogeneous institutional structures (Akbulut & Razum, 2022; Halberg et al., 2022). This can lead to discrimination, exclusion, and marginalization.

To explore *how* this affects ethnicized patients in healthcare, I draw on the concept of *doings*, which relates to the epistemological positionings within post-structuralism. Following Haraway (1988), I am not interested in what the category of 'ethnic minority patients' is (beings) but rather what it does (doings). This involves an understanding of social categorizations *doing something*, which rests on a post-structuralist and anti-essentialist understanding. To capture (un)(re)doings in relation to ethnicized processes, we theoretically furthered the concept of *workings*. Workings also rely on Schatzki's (2002) notions of practices as constructed in a process or *nexus of practice* and entail *active engagement* by patients, implying how they *do* need to *do work* within their categorization as an 'ethnic minority'. Workings then focus on the situationality, agency and instability of ethnicized categorizations in clinical practice based on the premise of hegemony. These theoretical approaches enable the exploration of *what* workings ethnicized patients engaged in to become legitimized and position themselves as equitable healthcare recipients.

This article is aimed at the wider health and healthcare communities that engage with social sciences and critical theoretical perspectives in health, illness, medicine, and healthcare. Furthermore, I aimed for a journal that welcomes theoretical and empirical contributions within these fields of research. The article is currently under review in Sociology of Health and Illness.

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5.4 Reflections of a white healthcare professional researching ethnicized and racialized minorities: Autoethnographically explored emotions revealing implicit advantages and consequences

Article 4 is inspired by Haraway (1988), who argues for seeing knowledge as situational. With the premise of always being somewhere in particular, unmarked positionings (traditionally described as White and male) become marked (Haraway, 1988). Following this epistemological approach, I aim to deconstruct the ideas of knowledge production, researcher positioning and social categorizations *being* neutral, truth-bearing or objective, and instead focus on my social positioning within nursing, healthcare professionality and whiteness to explore *productions and representations of becomings* that include marked and unmarked power, positionings and sciences.

To analyze these, I draw on intersectionality. Intersectionality emerged within black feminism and is a critical social theory to explore oppression of subordinated groups based on intersecting social categorizations of e.g., race, class, ethnicity, ableism and nationality (Collins, 2019; Crenshaw, 1990). Drawing on critical race theory, feminist theory and post-colonial theory, intersectionality is a knowledge project to show inequalities within intersecting systems of power by demonstrating forms of resistance (Collins, 2019; Rafii et al., 2021). The focus of intersectionality is then the *becoming*s of social categorizations and how these are related to inequalities and axes of power. There have been broad international debates on how intersectionality should be used. As intersectionality originated within studies of law and was based on the sexist and racist oppression of black women, some scholars argue that the concept has become deradicalized. Other scholars argue that it is a 'traveling concept', which means that it changes in different contexts (Christensen & Jensen, 2012). Using intersectionality as a concept to deconstruct existing positionings and perceived normalcy, the social positionings of the majorized are also considered in order to explore power and privileges (Christensen & Jensen, 2012). This then enabled an analysis of *how* I become positioned as a health researcher who is white, a nurse and a healthcare professional in the Danish healthcare system and *what* very real consequences the implicit logics and practices following these positionings may have for the interlocutors and my knowledge production.

This article has been published in the journal 'Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine'. It is aimed at a wider interdisciplinary health and healthcare audience in social science and humanities. This was a difficult article to write, and the review process was an important learning opportunity for me. The editor-in-chief also acknowledged the difficulty of writing about these subjects as he stated after acceptance: *I am pleased that this has worked out as it is an important topic but one that can* *be hazardous to write about. I found the reviewers' comments very helpful and eye-opening* (Michael Traynor, 14.06.23) [repeated with his agreement]

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Chapter 6: Focused discussion, advancements, and limitations

The discussion is divided into three subheadings. First, I compile the four analyses into a focused and summative discussion. I then proceed to discuss the advancements and limitations of this study. In chapter 7, I conclude the thesis and discuss the contributions to anti-discriminatory and equity-oriented work as well as avenues for further research.

6.1 Productions of ethnicity in healthcare

This thesis aims to examine the social categorization of 'ethnic minority patients' by exploring (active) productions of ethnicity in healthcare. My research interest is not to define what ethnicity is, or is not, but rather what it does.

To recap, the social categorization of 'ethnic minority patients' arose in the 1990s in Danish healthcare following the increase of immigration to Denmark that started in the 1960s and 1970s. The concept was developed to accommodate and adapt to the care of patients that became increasingly *ethnically and culturally diverse* in Denmark (and internationally). With its intention to help patients categorized as 'ethnic minorities', the concept had an inclusive aim but also became homogenizing in its use. To explore these dualities and complexities, I have explored what ethnicity *does* through an equity lens. In the four articles, I have analyzed welfare *representations*, hospital *practices*, patient *workings* and majorized *positionings*. I will now present how these articles inform each other by discussing the findings in relation to patient compliance and universal access. In the conclusion, I discuss these findings as contributions to equity-oriented work and anti-discriminatory work.

The research field is orthopedic surgery in which standardized treatment is gaining traction. Standardized treatments are also a key development within modern healthcare. Such treatment requires the patient to comply with predetermined protocols. Compliance can be understood as behaving *as told* by staff in order to follow instructions (Mir, 2023). This is seen as essential to create successful patient pathways. Throughout the thesis, I have argued that what forms the basis of these patient pathways is not neutral but rather based within the hegemony of modernized, androcentric, Eurocentric, whiteness, neoliberal and welfare ideals. Therefore, specific ideologies of individuality, responsibility, moderation, evidence, rationality, equality, and objectivity form Danish healthcare. These ideologies then underpin how *the compliant patient* is constructed in healthcare. If patients do not *engage* accordingly, they are perceived and explained as non-compliant. Based on the analyses, I argue that (problematized) notions of ethnicity and culture become *assemblings* towards perceived non-compliance of e.g., cultural and ethnic differentness, different understandings of illness and treatment, language barriers as well as the inherent behavior of e.g., ethnic pain. In this manner, ethnicized markers that are perceived to disturb the hegemony of the compliant patient risk further marginalizing ethnicized patients, who then become *othered*. These markers are formed by discourses of inappropriate healthcare behavior (article 1) that risk creating inaccessibility to standardized treatment (article 2).

For ethnicized patients, this means that they are positioned as potentially non-compliant. This is thus their point of departure. Through article 3, I develop and apply workings as a theoretical concept to explore the work ethnicized patients engaged in to become legitimized and position themselves as equitable recipients of healthcare. In relation to this discussion, this can be understood as a 'dis-ethnicized' process with an aim of *dismantling* ethnicized markers perceived as non-compliant. Workings are based on ethnicized (un)(re)doings and are an analytical tool that enables the exploration of differentiated workings within the social categorization of 'ethnic minorities'.

The interlocutors in this study represent great diversity in terms of age, sex, migration story, background, health story, working life and current life situations. What they have in common is their social categorization within the boundaries of 'ethnic minorities'. Therefore, there are many possible analytical intersections. In this compilation, I will discuss the interlocutors' workings based on three subgroups that also intersect. The first group consisted of the majority of the interlocutors, as they were first generation immigrants that came to Denmark as children or young adults (Baran, Rehan, Dina, Ghali, Ensar, Kamil, Elin, and Sara). The second group is Simon and Hristo, who were (temporary) migrant workers in Denmark. The final group is Emir, Jamil, and Hasan, who were born and raised in Denmark.

The first group of first-generation immigrants is the most representative of whom the categorization of 'ethnic minority patients' was based on. They also form the main basis of the findings from article 3. Here, I analyze how the workings consisted of *(re)producing* othering ideas about non-Danishness including distancing from other othered patients perceived to be problematic and unmodern through ideas of '*old mentality*', '*untrustworthy characteristics*' and '*exploiting Denmark*'. These were then counter-produced by positioning oneself as the opposite: exuding welfare reciprocity by '*contributing to society*' through paying taxes, supporting egalitarian ideas by discounting discriminatory experiences, showing gratitude, and going after staff with good vibes that saw '*the real me*'. Taking this analysis further, by mirroring societal discourses, the interlocutors drew on notions of Danishness to position themselves as deserving healthcare recipients. Workings towards *the compliant patient* then become inherently connected to *the compliant migrant*. From a societal point of view, Rytter (2019) analyzes how integration becomes a concept that promotes specific conceptualizations of Danishness while also problematizing immigrant minorities that are differentiated from the indigenous majority. Similarly, the workings were based on societal discourses and conceptualizations and the purpose became to be *more* in line with

Danishness and *less* in line with problematized minorities. In this manner, integrational discourses crossed into healthcare.

This also relates to how the interlocutors linked their workings to their right to healthcare. They portrayed universal healthcare as a right, but it required (over)workings, which then constituted a premise that they worked from. Importantly, these workings were covert to healthcare. What transpired in the encounters was discounting bad experiences and keeping these workings silence(d). It this way, health inequities were maintained. Nonetheless, the analysis also shows resistance through covert yet active workings that ultimately countered and disrupted othering and hegemonizing processes. This was quite different from the actions of Simon and Hristo, who were in Denmark as migrant workers.

Simon and Hristo were temporary migrant workers from Eastern Europe. Neither of them spoke Danish. Simon spoke some English, but Hristo did not. Simon had a contact in Denmark who would come to help translate essential information. Both Simon and Hristo experienced malpractice during hospital care. In Hristo's case, he did not understand the information on his injury and treatment. Furthermore, he was given conflicting and wrong information on the necessary treatment and physical restrictions. Despite this, Hristo never expressed dissatisfaction: '*Peter* [the surgeon] *asks if Hristo has any questions and Hristo responds that everything is good (…) After Peter leaves, I repeat the information. Hristo is surprised as he had not understood that his foot had not been operated on during surgery the day before, and instead needed surgery the following week. That means he must stay in hospital for over a week longer than first planned. But he is not upset. He smiles and thanks me'*. Hristo was polite and smiling to all the staff he encountered. For Simon, the reason for the admission was an injury that he sustained due to malpractice in another ward. However, he never expressed any dissatisfaction, and his helper told me about the malpractice. On the other hand, a satisfactory positioning became visibly important as Simon expressed concerns about my intentions after I had observed a wound care session: '*Alicja* [Simon's helper] *says that Simon wants to make sure that my aim is not to criticize the staff. He has been very happy and content with the treatment. I promptly respond that that is not my intention at all. We then talk about the purpose of the study and discuss what challenges there might for Simon due to his situation during admission'*. Being positioned as happy and content could be connected to the temporal nature of their stay in Denmark and Simon and Hristo therefore did not grow up with, or know, the Danish model of universal healthcare. This was not a given for them. An additional and important element was their inability to speak to the hospital staff. Similarly, this was also a barrier for me in getting to know Hristo and Simon. This perspective transgressed Hristo's and Simon's positionings, as other interlocutors did not speak Danish (or English). An example is Kamil, who spoke very limited Danish. During the fieldwork, his daughter Maya talked about a feeling of being at the mercy of healthcare due to limited Danish: *"(…) we return to the subject of gratefulness and Maya explains that because her father does not speak Danish well, he always feels that he has to say an extra 'thank you'. She explains: 'When he cannot understand, what if that extra 'thank you' enables him to receive good treatment"*. In article 3, I draw on positional gratitude as proposed by Bradby et al. (2020). Benefiting from universal healthcare was not a given and in combination with poor spoken Danish, gratitude can be seen as workings towards *compliance* that included positioning oneself as satisfactory, uncomplaining, and uncritical by staying silent/silenced. Maybe it was even a positioning of the subaltern that *cannot* speak (Spivak, 2004).

Finally, three of the interlocutors were men in their 20s and 30s who were born and raised in Denmark. For Jamil, Hasan and Emir, there was no question of *if* they had a right to universal healthcare. All three had originally been dismissed with their current injuries during their first encounters with healthcare. To recap:

'*It started when they* [Emir and Finn] *met in the outpatient clinic. Before meeting Finn, the process had been long and difficult*'

'*It turns out that this* ['the slaughter house'] *was the first hospital Jamil went to. They had sent him home without surgery*'

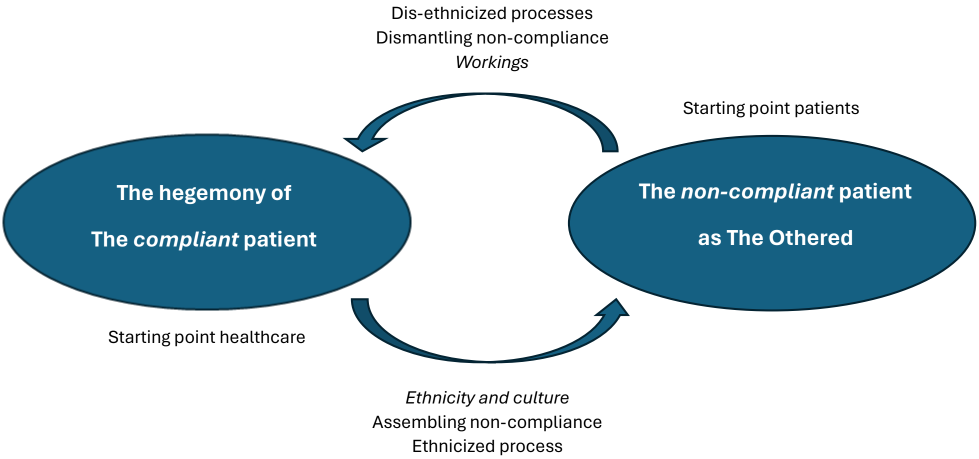
'*Hasan says he was denied an MRI scan in the emergency room. After multiple tries at the ER, Hasan eventually threatened to film the incident. The doctor ultimately prescribed the scan that led to his current needed surgery*'

In different ways, Emir, Jamil, and Hasan were all successful in finding a way to receive proper healthcare. But unlike the other interlocutors, their workings were not based on premises in relation to their right to healthcare. This was perceived as a right with no contingencies. Instead, their workings were persistence and identifying staff or hospitals that would provide good (and correct) healthcare – in other words, those that would position them as legitimate and (trust)worthy. In this way, their workings can be understood as *counter-compliant,* as they did not engage with premises of (un)deserving healthcare recipients, unlike the first group of interlocutors. On the other hand, during their admissions, they still worked from the premise of being positioned as potentially non-compliant through ethnicized markers e.g., Emir being positioned as *not very ethnic*, Jamil being positioned as one *who can take* pain and Hasan identifying staff with *good vibes*. For Hasan, this (unequal) positioning became visible when I was in the room. Unlike the other interlocutors, some of the workings of Hasan, Jamil, and Emir became more visible and unsilenced in healthcare as they also included active engagement *with* healthcare. This group then (more) visibly disrupted and countered othering and hegemonizing processes through *counter-compliance* in healthcare.

6.1.1 (Over)workings as a circular process producing health inequities

From this discussion, I now shift my focus to the norm that constitutes the normalized and compliant patient. Through this compilation divided into subgroups, I show how (over)workings is a concept that grasps and elucidates the covert, subtle, active, and differentiated workings that create health inequities. Productions of health inequities are not uniform or equally distributed, maintained, and created. The hegemony of the compliant patient is produced in the intersection between societal and individual discourses and by exploring what ethnicity *does* in healthcare, I find that implicit whiteness, spoken Danish, Christianity/non-religiousness, modernism and support for welfare (and healthcare) come to constitute the norm and normalization in healthcare. By emphasizing how ideas of (non)compliance interrelate with the creation and maintenance of health inequities, I show that the more ethnicized patients are perceived to disturb this hegemony, the more non-compliant they are considered. For ethnicized patients, this othered positioning as non-compliant was experienced based on different premises that led to differentiated workings. Ultimately, it leads to a circular production of health inequities:

(Over)workings as a circular process producing health inequities



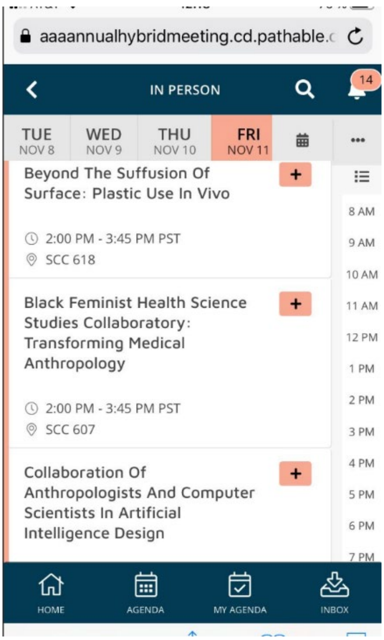
This illustration displays knowledge that can support equity-oriented work. Furthermore, to disrupt the hegemony, article 4 engaged with my majorized positionings and argued for seeing all positioning as a culturalized, ethnicized and racialized matter. The findings analyze empirical situations to illuminate how discriminatory practices are (re)produced, which supports efforts towards anti-discrimination. Ultimately, (in)visibility and silence(d) are key to understanding the persistence of health inequities for ethnicized patients, as I show how 1. (Over)working by the interlocutors is (made) invisible, 2. The hegemony of healthcare is (made) invisible and 3. The sociopolitical influences are (made) invisible. This thesis then contributes to making productions of ethnicity visible. Before the conclusion, I will discuss the advancements and limitations of this study.

6.2 Advancements of this study

6.2.1 Advancing Anglo-Saxon theorizing in a Danish healthcare context

As the report on social inequalities in encounters with Danish healthcare notes, elements of culture, ethnicity and 'race' are prevalent in research from the USA. However, although the authors write that they are relevant *to an extent* in Danish healthcare, that was not part of the scope of the report (Kjeld et al., 2022). This pertains to more generalized discussions in Denmark on theorizations and conceptualizations developed in America, such as critical race theory or black feminist intersectionality, which have been argued as unsuitable in Denmark (and Europe) as we *do not have the same past or present history*. These can be understood as arguments within post-racial and non-colonial past discourses that dismiss any relevance or legitimacy to explore racialized or ethnicized discrimination and health inequities. In other areas of research in Denmark, there is an increasing focus on exploring aspects of structural discrimination, racism, racialization and inequalities, such as in the research fields of education, social studies, gender and migration (see e.g., Andreassen, 2019; Bissenbakker & Myong, 2022; Gilliam, 2009; Hervik, 2019b; Khawaja & Lagermann, 2023; Rytter, 2019; Staunæs, 2003). However, these perspectives are (almost) absent in Danish health and healthcare research.

As I have discussed in the introduction to article 3, there have been debates in academia on intersectionality, as some scholars disagree with how intersectionality is used in the European context and argue that intersectionality has been colonized and deradicalized by European scholars. Other scholars argue that intersectionality is a traveling concept and has validity in different contexts. These have been called the intersectionality wars. I have also wondered if, or how, the *big 3* of 'race, class and gender' in USA 'just' changed to 'ethnicity, class and gender' in the European context, and whether this was right.



Beyond The Suffusion Of Surface: Plastic Use In Vivo
2:00 PM - 3:45 PM PST
SCC 618

Black Feminist Health Science Studies Collaboratory: Transforming Medical Anthropology
2:00 PM - 3:45 PM PST
SCC 607

Collaboration Of Anthropologists And Computer Scientists In Artificial Intelligence Design

Program at the AAA conference

I wish to present two distinct situations during my PhD journey from two different contexts that accentuate these differences. First, I attended the Annual American Anthropological Conference in Seattle, USA in the fall of 2022. Here, I heard many very interesting presentations but because of my research topic, I was most excited about a session on black feminist health studies.

As I walked into the room, I visibly did not fit as a white, heterosexual, and heteronormative female. The presenters had all published in a special issue in Medical Anthropology Quarterly on black feminist health science and they presented their studies in art-based research that included video material, music, dance and voices of friends that they had lost. It all related to black empowerment, black injustice and racism in USA. It made me feel rightfully conscious and questioning whether I should/could draw on black feminist perspectives. On a contrasting occasion, I was in a room in Denmark with 28 medical doctors who were pursuing their PhDs. We were debating difficult words and how to communicate concepts to the layman. I suggested the concept of racialization, for which I received considerable resistance although my aim was not to debate the concept itself. Instead of discussing *how* to translate the concept, I was asked what it even meant, why it was relevant and what we needed it for.

These two episodes emphasize the vast gaps in the differences and multiplicities of geographical, disciplinary, and research contexts. These discussions are important to consider, and it is imperative to include the contextuality of different historical trajectories. Eventually, critical health research on racial and ethnic discrimination and health inequities has become quite advanced in the Anglo-Saxon context in comparison to e.g., Denmark. I have chosen to use the conceptualizations of *ethnicized* patients and health *inequities,* but these also rely and draw on racial theorizing. As discussed in the background section, there are many similarities in social science theorizing on race and ethnicity in health e.g., perspectives of minori*zing*, hegemony, structural embeddedness and social (in)justices. Some European scholars analyze ‘ethnic minorities’ from racialized perspectives (e.g., Ahlberg et al., 2022). In this study, the social categorization of ‘ethnic minority patients’ constitutes the subject of research. As I have ethnographically explored productions of ethnicity, these are based on emic and discursive perspectives of perceived ethnicity *within* Danish healthcare.

With this positioning, I also argue that post-colonial and (black) critical feminist aspects of e.g., *othering* and *intersectionality* enable me to reveal and advance knowledge on *productions of ethnicity* in the Danish context. In article 1, I discuss how notions of welfare state ideologies of post-racial, non-colonial and color-blind images inhibit discussions of health inequities in relation to ethnicity that eventually simultaneously undermine and produce health inequities. Here, I draw on *othering* to demonstrate these productions. In article 2, I draw on the hegemony of modern medicine to show how standardized treatment becomes inaccessible for ethnicized patients. In article 3, I draw on institutional othering and develop the concept of (over)workings to understand how health inequities for ethnicized patients *are produced* in a clinical practice. Finally, in article 4, I draw on intersectionality to center on the privileged in order to disrupt (white) health researchers’ unmarked positionings in knowledge production and health research.

Ultimately, the gap between Anglo-Saxon and Danish theoretical developments has been difficult to grasp within this study. Following the two experiences introduced above, writing to a Danish audience requires different terminology and approaches in comparison to international academic journals. The included articles are published in, submitted to, or in preparation for, journals that proceed from the Anglo-Saxon countries of Canada (Nursing Inquiry), the UK (Health and Sociology of Health and Illness) and the US (Clinical Orthopaedics and Related Research®), but the findings are also ultimately for Danish healthcare professions in research, education, and clinical practice. It is an important aspect of this thesis to produce relevant knowledge that aims to reach both international journals and Danish clinical practices. The book chapter is an example of how I have translated knowledge, as it contributes to a Danish nursing textbook. This focus leads to an important discussion of how to categorize (ethnicized) patients in (Danish) healthcare.

6.2.2 How to categorize (ethnicized) patients in (Danish) healthcare?

This thesis demonstrates the problems or constraints of categorizing patients as 'ethnic minorities' in the Danish healthcare context. As this field is already sensitive and uncomfortable, this thesis might prevent patients, healthcare staff, and policy makers from talking about, or addressing, this topic even more. As this is not my intention, I would like to discuss how to (or not to) categorize 'ethnic minority patients' going forward. This discussion is relevant on different levels, namely national, institutional and clinical practice levels.

As described in the introduction, Denmark does not collect data on ethnicity (or race) in healthcare, as this seems inherently racist. In a Canadian study, scholars found that collecting data on 'ethnicity' by the national health authority was more harmful than beneficial due to the risk of discriminating against, stereotyping, and providing inferior healthcare to certain patient groups (A. J. Browne et al., 2014; Varcoe et al., 2009, 2019). I have discussed how the limits of who is included in the categorization of 'ethnic minorities' differ between countries. However, this does not mean that such data are not relevant. In the Canadian study, the authors argue for collecting data that incorporate structural and intersecting forms of oppression (Varcoe et al., 2019). As it has been proven that ethnicized patients experience discrimination and health inequities, the answer is not to *avoid* differentiations or notions of ethnicity. Rather, from the findings in this thesis I argue for shifting the focus away from the risk of 'ethnicity' or 'culture' becoming explanations for (in)appropriate healthcare behavior (article 1). Conversely, health policies in the European Union categorize 'ethnic minorities' as vulnerable, which then require *targeted solutions* (Baeten et al., 2018). Tracing this back to how the categorizing of 'ethnic minority patients' emerged within healthcare, a well-meaning categorization might have what Akbulut and Razum (2022) call *benevolent intentions*. This concept describes how othered groups are identified as particularly vulnerable and therefore need targeted healthcare. Yet this often leads to reinforcing disparities and increasing social exclusion (Akbulut & Razum, 2022). In contrast to focusing on vulnerability (one could ask who defines whom as vulnerable and what that entails), I have focused on healthcare practices and health research in modern, universalized Danish healthcare to explore *how* institutional practices *produce* (in)accessibility and (de)legitimization in the care, treatment, and research of ethnicized patients (articles 2 and 4), which I argue leads to institutional othering that affects ethnicized patients during hospital pathways (article 3). But it also affects the healthcare staff. In a clinical practice, hospital staff provide standardized and evidence-based healthcare. Research on inequalities is often based on perceived barriers, taught through competencies and solutions that are based on incorporating person-centered approaches. Throughout the thesis, I have found these to be problematic due to their implicit underpinnings and their individualized, single-axis and decontextualized point of departure.

Ultimately, this leads to asking whether the answer is to stop categorizing patients based on ethnic or racial categorizations as this inherently *'others'* patients. I argue for the need for new conceptualizations and understandings in healthcare due to the constraints of binary and dichotomous categorizations (Anderson, 2004). Based on the sociopolitical, institutional, and hegemonic aspects embedded within the conceptualizations of *ethnicized* and *ethnically minoritized* patients, I develop the theoretical concept of (over)work in article 3. This contribution goes beyond individualized barriers and shows the effects on patients that are *minoritized.* (Over)work not only shows *that* health inequities exist but engages with *how*. This enables the discussion to move forward and grasp how health inequities are produced within healthcare. This is concrete and action-oriented and takes the first step of working towards dismantling health inequities for ethnicized patients in healthcare. These are uncomfortable and sensitive subjects, but this thesis urges us to stay within the dilemmas and acknowledge that differences do exist; healthcare is not color-blind, objective, even or equal (articles 1, 2, 3 and 4).

Before the closing remarks, I turn to the limitations of this study.

6.3. When ethnicized markers do not make an impact – limitations to a critical inquiry?

As I have discussed throughout this thesis, this study is interested in what ethnicity *does* but an opposing question in that context is whether ethnicity is always a factor. I have had a dual conflict in both criticizing the homogenizing of a heterogenous categorization while simultaneously exploring interlocutors positioned within this categorization. Furthermore, there remains the question of whether ethnicity is always relevant as patients are arguably more than their perceived ethnicity. To give an example, I turn to Jamil. He was 27 years old and born and raised in Denmark while his family had a Kurdish background from Turkey. Jamil was hit by a car, and he explained that it made him so hot-tempered that he followed the car in anger. He did not manage to catch up with it and afterwards he realized that he had broken his hand. This conversation took place after the surgical procedure when Jamil and I were talking in the inpatient ward:

'As I walk into the room, Jamil smiles and says 'Hi Nina!'. We talk about the procedure, and he says it went well. During our conversation, I ask if he thinks it makes a difference that his name is Jamil and not e.g., Thomas. He doesn't feel that way. He tells me that everyone has been nice and very professional and adds 'I don't think it relates to race'. He then goes on to tell me that he has experienced really bad treatment at another hospital [anonymized] *and explains: 'In the immigration environment* [indvandrermiljøet[2] in Danish] *in the suburb* [anonymized] *it is called the slaughterhouse'. I ask why 'slaughter' and he explains that they always treat patients wrongly. It turns out that this was the first hospital Jamil went to and they sent him home without surgery.'*

Jamil told me that his patient pathway had been unproblematic. Based on some of his remarks in our conversation of being part of *indvandrermiljøet* [the immigration environment], being *hot-tempered,* and using descriptions of a *slaughterhouse,* he reproduced markers that are in line with discourses of the aggressive, trouble-making and suspect Muslim male (Hervik, 2019b; Khawaja & Mørck, 2009). But it did not interfere with his treatment. I also draw on another episode with Jamil in article 2, where I analyze how he was positioned as someone who can *take pain*, for which he received positive feedback. Jamil did not disturb or interfere with treatment. Conversely, he engaged *compliantly* in the patient pathway by following guidelines and he was eager to be discharged (for other, private reasons). In this instance, his *ethnicized* markers were visible but did not interfere with treatment or lead to problematic expectations or experiences. This is an important distinction; every situation is different and cannot be generalized based on perceived stable, uniform, and homogenized attributes within the categorizations of 'ethnic minority patients'. Following this, a limitation of the study relates to the analytical perspectives that I do not advance. As I have argued throughout the thesis, I see ethnicized markers as intersectional. I draw on intersectionality in article 4 to analyze my majorized positioning and to some extent in article 3 with regard to intersections between gender, migration, and ethnicity. Nonetheless, class or other intersecting categorizations were not explicitly explored in this thesis.

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[2] Indvandrermiljø is a concept often used with negative connotations and connected to residential areas that are defined by a high degree of 'non-Western migrants', crime, low income and social problems (Galal & Lund Liebmann, 2020).

Chapter 7: Closing remarks

This thesis explores what ethnicity does in healthcare. Through an ethnographic study including policy documents and fieldwork in two orthopedic departments in Greater Copenhagen, Denmark, I have examined *productions* of ethnicity in healthcare in the intersections between the welfare state, the institutions and the encounters.

I have examined the social categorization of 'ethnic minority patients' through welfare *representations,* healthcare *practices*, patient *workings* and majorized *positionings* and found that the categorization *does* something. This means that patients categorized as 'ethnic minority patients' are positioned within the realms of *ethnicity;* this has individual effects but is closely intertwined with sociopolitical, institutional, and positional perspectives. Denmark is a welfare state offering *universal healthcare* that also comes with (sometimes conflicting) underpinnings of neoliberal individual responsibility and social egalitarianism (all are equal) that do *not* easily acknowledge discrimination as that interferes with a non-colonial, post-racial and color-blind self-image. When translated into healthcare, legal guidelines of providing free and equal healthcare to all leave very little room to discuss or acknowledge structural discrimination or health inequities based on ethnicity. Danish healthcare is furthermore founded on *modern healthcare* which operates within a positivist paradigm of providing evidence-based and standardized treatment. This is underpinned by notions of rationality, objectivity, lack of bias, and generalizability that simultaneously undermine modern medicine's implicit Eurocentric and whiteness foundations. Instead, to accommodate patient needs, healthcare is developed, explored, and intervened in, based on individualized and decontextualized approaches.

Based on the four analyses, these influences affect ethnicized patients in healthcare, as implicit whiteness, spoken Danish, Christianity/non-religiousness, modernism and support for welfare (and healthcare) come to constitute the norm within healthcare. These are perceived differently, as an *individualized* perspective permeates (hospital) practices and (majorized) positionings, while *societal* perspectives permeate (patient) workings and (welfare) representations. Patients are measured against these norms through discourses of *compliance*, and the more patients disturb this hegemony, the more they risk becoming marginalized and positioned as *non-compliant.* This takes on specific forms for ethnicized patients. From a welfare state perspective, notions of 'culture' or 'ethnicity' explain, and are the cause of, (in)appropriate healthcare behavior. In hospitals, this is translated through non-adherence during standardized pathways that risk creating (in)accessibility for ethnicized patients. In encounters, the hegemony of biomedicine, altruism, and whiteness risk (de)legitimizing experiences of racialized and ethnicized inequalities and discrimination, which is consequential for both knowledge production and ethnicized patients. Ultimately, this leads to institutional othering that requires immediate work by ethnicized patients to try and position themselves as legitimate and equitable healthcare recipients. By advancing the concept of workings, I analyze differentiated workings by ethnicized patients through an equity lens and in relation to the hegemony of the compliant patient. By mirroring societal discourses, the interlocutors who were first generation immigrants drew on notions of Danishness to position themselves as deserving healthcare recipients. Workings towards *the compliant patient* then became inherently connected to *the compliant migrant*. However, these workings were covert for healthcare. What transpired in the encounters was e.g., the discounting of bad experiences that kept these workings silence(d). For the interlocutors who were migrant workers from Eastern Europe, workings towards *compliance* included positioning oneself as satisfactory, non-complaint, and uncritical by staying silence(d). This could maybe even be a positioning of the subaltern that *cannot* speak (Spivak, 2004). Finally, for the interlocutors that were born and raised in Denmark, their workings can be understood as *counter-compliant*, as they did not engage with premises of (un)deserving healthcare recipients. Unlike the other interlocutors, some of the workings by Hasan, Jamil and Emir became more visible and unsilenced in healthcare as they *also* (but not always) included active engagement with healthcare. This group then (more) visibly disrupted and countered othering and hegemonizing processes through *counter-compliance* in healthcare.

Ultimately, (in)visibility and silence(d) are key to understanding the persistence of health inequities for ethnicized patients in Danish healthcare. By developing the concept of (over)workings, I propose a concept that captures, elucidates, and grasps these productions of health inequities for patients positioned in the margins of healthcare. This thesis then contributes to making productions of ethnicity visible and unsilenced. This also furthers equity-oriented and anti-discriminatory work in healthcare, in both practice and theory, as I will now outline.

7.1 Anti-discriminatory work: Contributions to healthcare practices

I have critically discussed the dominance of individualized perspectives in modern healthcare through concepts of adherence, responsibility, person-centered care, barriers, competencies, and interventions. This inhibits discussions of health inequities as it is up to the individual healthcare staff to *solve* challenges while the *responsibility* is placed upon patients. Quite apart from the structural embeddedness within intersectional and hegemonic positionings, the sociopolitical influences of the welfare state and historical underpinnings of modern medicine risk further marginalizing ethnicized patients in healthcare and holding the individual patient (and healthcare staff) accountable. My aim with this thesis is to lift the discussion away from individual encounters between patients and hospital staff and instead to discuss the structures that affect these encounters, explored through (active) productions of ethnicity. From a sociopolitical perspective, I show why is it so difficult to discuss discrimination in Danish healthcare in article 1. On an institutional level, I show that (structural) discrimination is not in focus in hospital practices formed by modern medicine. These factors highlight the current constraints in talking about, and working towards, anti-discriminatory healthcare in Denmark. I will here point out two aspects in relation to contributions towards anti-discriminatory work from this thesis:

First, by analyzing positionings of the majorized in Danish healthcare through the intersections of whiteness, biomedicine, and altruism, I turn the gaze towards the powerful and privileged. This is a way of contributing to anti-discriminatory work as this analysis *is a pivotal part of disentangling consequential practices that leave some bodies invisible, unmarked and neutralized in the fields of health, healthcare and health research* (Halberg, 2023). By arguing for seeing majorized positionings as racialized, ethnicized and culturized issues, I decenter the focus on minoritized positionings and instead make the *invisible omnipresent norm* visible (Durey, 2015). This focus is imperative in anti-discriminatory work.

Secondly, I wish to return to the workings of *counter-compliance* of Emir, Hasan, and Jamil. Relating this back to Gramsci, a disjuncture between hegemonic ideas and the lived experiences of disadvantaged groups can lead to counter-hegemony through contestation that ultimately can lead to structural change (Durey, 2015). In this manner, the counter-compliant workings of Emir, Hasan, and Jamil can be understood as counter-hegemonic. Here, these workings were based on the individual interlocutors (and the individual hospital staff) but displayed the agency, movement, and activity of contestation by the interlocutors. This also shows how these were pervasive across this group of interlocutors. By identifying and demonstrating these (counter)-workings by those who were born and raised in Denmark, the thesis provides new knowledge and unexploited perspectives that may constitute an important step towards anti-discriminatory work in healthcare.

7.2 Equity-oriented work: A contribution to scholarship on health and ethnicity

Through an equity lens, this thesis has explored productions of ethnicity in healthcare. These productions have implications for patients categorized as ethnic minority patients. As I have stated in the discussion, ethnicized patients are portrayed as so-called 'hard to reach' groups, which is connected to *vulnerability*. I have outlined some of the implications and I argue that ethnicized patients *become* vulnerable due to their social positionings within healthcare, which counters the idea of *being* vulnerable. This is an important distinction. Furthermore, I employ ethnographic methodology that includes ethnicized patients to show their perspectives, experiences, and workings. With this methodological approach, I have not found the group particularly difficult to reach. The dominance of health research in a positivist framework inhibits important discussions of how other epistemological approaches can add important knowledge production. I draw on theoretical and epistemological perspectives that engage with, and thereby help to examine and advance, the social, uneven, and complex world of healthcare. These perspectives and methodologies contribute knowledge in the field of ethnicity and health. I will outline two main contributions towards equity-oriented work:

The constraints following the social categorization of ethnic minority patients have been outlined and despite well-meaning intentions, this has implications in healthcare as this categorization positions patients within the realms of (possible) non-compliance and thereby as inequitable healthcare recipients. Therefore, I argue for advancing the conceptualization to *ethnically minoritized patients* as this inherently connects the social categorization to the process of *becoming* minoritized. This terminology enables an immediate reflection upon the positioning *of* the patients (in the intersection between the welfare state, the institutions, and the encounters), rather than what the patient *is*. This contributes toward equity-oriented work.

Secondly, I propose the empirical and theoretical concept of (over)workings. This is a theoretical contribution that contains the differentiated, social, uneven, and relational aspects of having to work within the boundaries of non-unanimous and hegemonic perceptions of *ethnicity*. (Over)workings originate from ethnicized patients and describe the process of having to position oneself as a compliant and thereby equitable healthcare recipient. (Over)workings are then a concrete and action-oriented contribution towards the dismantling of the subtle, contextual, structural, covert, and unintended productions of health inequities for (ethnicized) patients in (Danish) healthcare.

7.3 Opening avenues for further research

Finally, I want to highlight three areas that are relevant for future research.

First, educational material on anti-discrimination and equity-oriented work is absent in Danish healthcare as well as in society in general (Halberg & Skadegård, *forthcoming)*. Therefore, there is a lack of vocabulary and understanding of how health inequities for ethnicized patients are produced in healthcare (and society). Furthermore, this makes it more uncomfortable to discuss these issues as there are fears of saying something wrong or being perceived as an immoral person. This hampers important discussions and perspectives and affects both minoritized and majorized persons in healthcare (and society). Developing and incorporating these perspectives in health education, practices, and policies is imperative in order to dismantle health inequities for ethnicized patients and constitute an avenue for further research.

Secondly, the use of ethnographic methodologies that engage with patient perspectives, researcher positionality, structural perspectives, theoretical approaches, and epistemological underpinnings is underexplored in research on ethnicity and health. These perspectives can help to understand, dismantle, and decrease health inequities in healthcare. This is also an avenue for further research.

Finally, there must be a deliberate movement towards representation in healthcare. Ethnically minoritized patients are underrepresented in health research, ethnically minoritized health staff are underrepresented in management and leadership and ethnically minoritized health researchers are underrepresented in health research. These discrepancies are structurally based. Regarding ethnically minoritized patients, research shows that health researchers mostly include patients similar to themselves (Stage, 2022), while exclusion criteria based on e.g., language risk further excluding important patient perspectives. As for ethnically minoritized healthcare staff, they are often hindered from possible promotion and experience discrimination by both colleagues and patients (De Sousa & Varcoe, 2022; Owusu-Akyaw, 2022; Wingfield, 2019). Finally, medical and nursing education is founded on Eurocentric, white (and, in the case of nursing, female) theoretical perspectives (Bell, 2021; Cooper Brathwaite et al., 2022; De Sousa & Varcoe, 2022; Halberg, 2023; Zaidi et al., 2023). It is imperative to include multiple perspectives in health research, education, and practice to encompass, legitimize, and reflect the intersectionality and diversity of the social positionings of healthcare staff, patients, and health researchers in today's society. These inadequate representations are imperative avenues for further research in the fields of health research, policy, education, and interventions.

Summary

This thesis '*Someone like me; I go after staff with good vibes:* An ethnographic study of ethnically minoritized patients in Danish healthcare through an equity lens' is an examination of what the social categorization of 'ethnic minority patients' *does* in healthcare. Through an ethnographic study including policy documents and fieldwork among 13 patients in two orthopedic departments in two hospitals in Greater Copenhagen, Denmark, I have examined *productions* of ethnicity in healthcare in the intersections between the welfare state, institutions, and encounters.

The background of the study is the persistence of health inequities for ethnicized minority patients, which has led to an international call for advancing racial and ethnic equity in health (The Lancet, 2022). Danish healthcare is founded on modern medicine, which operates within a positivist paradigm of providing evidence-based and standardized treatment. This is underpinned by notions of rationality, objectivity, unbiased, and generalizability that simultaneously undermine modern medicine's implicit Eurocentric and whiteness foundation. It is within these underpinnings that the categorization of 'ethnic minority patients' *becomes* and is practiced and produced.

Theoretically, this study draws on the concepts of *ethnicized* and *ethnically minoritized*, as these terms refer to the process (and action) of some groups becoming minoritized based on ideas of different ethnicized markers, and the aim then becomes to explore what ethnicity *does* rather than what ethnicity *is*.

The findings from this study are presented in four articles. The first article analyzes policies to explore how 'ethnic minority patients' are represented in Danish healthcare in a welfare state. The findings indicate that notions of 'culture' or 'ethnicity' come to explain, and become the cause of, (in)appropriate healthcare behavior. The second article abductively analyzes social practices of standardized treatment and finds that in hospitals, (in)appropriate healthcare behavior is translated through (non-)adherence during standardized pathways that risks creating (in)accessibility for ethnicized patients. These findings lead to institutional *othering* that requires immediate work by ethnicized patients to try and position themselves as legitimate and equitable healthcare recipients. These workings are analyzed in article three and as they illustrate consequences of being categorized as an ethnic minority patient in the Danish healthcare system, the concept of 'overwork' is proposed to capture these inequities in healthcare. Article four turns the gaze to my majorized positioning and by intersectionally analyzing the hegemony of biomedicine, altruism, and whiteness, the findings indicate a risk of (de)legitimizing experiences of racialized and ethnicized inequalities and discrimination, which is consequential for both knowledge production and ethnicized patients in healthcare.

In conclusion, this thesis advances the concept of workings to analyze differentiated work by ethnicized patients through an equity lens and in relation to the hegemony of the

normalized (and neutralized) patient. (In)visibility and silence(d) are thus key to understanding the persistence of health inequities for ethnicized patients in Danish healthcare. By developing the concept of (over)workings, this thesis proposes a concept that captures, elucidates, and grasps these productions of health inequities for patients positioned in the margins of healthcare. This thesis then contributes to making *productions* of ethnicity visible and unsilenced. This advances equity-oriented and anti-discriminatory work within healthcare, in both practice and theory.

Resume

Denne afhandling '*En som mig; jeg går efter personale med god energi:* En etnografisk undersøgelse af etnisk minoris*erede* patienters møde med det danske sundhedsvæsen gennem en (u)lighedslinse' er en undersøgelse af hvad den sociale kategorisering 'etniske minoritetspatienter' *gør* i sundhedsvæsnet. Gennem et etnografisk studie bestående af policy dokumenter og feltarbejde blandt 13 patienter i to ortopædkirurgiske afdelinger i Region Hovedstaden i Danmark, har jeg undersøgt *produktioner* af etnicitet i sundhedsvæsnet i snitfladerne mellem velfærdsstaten, hospitalsinstitutioner og i hospitals møder.

Baggrunden for dette studie er den vedvarende ulighed i sundhed for etnisk minoriserede patienter, som internationalt har ledt til et opråb for at fremme racial og etnisk lighed i sundhed (Lancet, 2022). Det danske sundhedsvæsen er forankret i moderne medicin som er baseret på et positivistisk paradigme, der skal sikre evidensbaseret og standardiseret behandling. Paradigmet bygger endvidere på ideer om rationalitet, objektivitet, upartiskhed og generaliserbarhed. Ideer som bidrager til en underkendelse af moderne medicins implicitte fundament i eurocentrisme og hvidhed. Det er indenfor denne ramme, at den sociale kategorisering 'etnisk minoritetspatient' *bliver til* og både praktiseres og produceres.

Dette studie trækker på begreberne etniciseret og etnisk minoriseret, da det beskriver den proces (og handling) hvorved nogle grupper bliver minoriseret på baggrund af forskellige etniciserede markører og formålet bliver da at undersøge, hvad etnicitet *gør* fremfor hvad etnicitet *er*.

Resultaterne i dette studie er præsenteret gennem fire artikler. Den første artikel analyserer policy-dokumenter for at få indblik i hvordan 'etniske minoritetspatienter' repræsenteres i et dansk sundhedsvæsen som en del af en velfærdsstat. Fundene indikerer, at ideer om 'etnicitet' og 'kultur' bliver forklarende, og baggrunden for, (u)passende sundhedsadfærd. Den anden artikel er en abduktiv analyse af hvordan ideer om den *rigtige* proaktive adfærd formes i standardiserede indlæggelsesforløb. (U)passende sundhedsadfærd oversættes i disse forløb til *(non)-adherence,* hvilket risikerer at skabe (u)tilgængelighed til standardiserede forløb for etnisk minoriserede patienter. Resultaterne tyder på en institutionel *andetgørelse,* som kræver af etniciserede patienter, at de må arbejde for at positionere sig selv som legitime og retfærdige (equitable) sundhedsmodtagere. Dette arbejde (workings) analyseres i artikel tre. Da dette arbejde illustrerer konsekvenserne ved at være kategoriseret som 'etnisk minoritet' i det danske sundhedsvæsen, foreslås begrebet *overarbejde* til at forstå hvordan produktioner af uligheder i sundhed bliver til. Artikel fire vender blikket mod min majoriserede position og gennem et intersektionalitetsperspektiv analyseres hegemonier af biomedicin, altruisme og hvidhed. Fundene indikerer en risiko for at

(de)legitimere oplevelser med både racialiserede og etniciserede uligheder og diskrimination, hvilket har betydning både for den viden, der produceres og er tilgængelig, samt for etniciserede patienters adgang til sundhed i sundhedsvæsnet.

I afhandlingen videreudvikles begrebet om det (differentierede) overarbejde som etniciserede patienter må gøre. Det undersøges gennem en (u)lighedslinse og i relation til det hegemoni, som udgør den normaliserede (og neutraliserede) patient. (U)synlighed og tavslig(gørelse) bliver centrale perspektiver i forståelsen af hvorfor ulighed i sundhed kontinuerligt produceres for etniciserede patienter i det danske sundhedsvæsen. Ved at udvikle begrebet (over)arbejde, foreslår denne afhandling et begreb der kan indfange, belyse og forstå, i dette studie etniciserede, produktioner af ulighed i sundhed for patienter, der positioneres i margen af sundhedsvæsnet. Denne afhandling bidrager derfor til at synliggøre og utavsliggøre *produktioner* af etnicitet. Dette for at fremme lighedsorienteret og antidiskriminatorisk arbejde i sundhedsvæsnet – både i praksis og teori.

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Orthopaedic glossary

Acute Surgery: Trauma, critical care and emergency surgery

Clinical trials: Research studies that test a behavioral, medical or surgical intervention on people

Elective Surgery: Surgery that can be planned in advance

Epidemiology: The study of determinants, occurrence, and distribution of health and disease in a defined population.

ER: Emergency room

ERAS: Enhanced Recovery After Surgery is a concept consisting of a multi-modal, interdisciplinary and standardized surgical pathways

General anesthesia: Medication administered to bring the patient to controlled unconsciousness during surgery

Inpatient ward: A ward taking care of patients who are admitted in hospital

MRI: Magnetic Resonance Imaging is a scan to produce detailed images of the inside of a body

Nerve block: A single injection nerve block is a one time injection of numbing medication around the nerve

Outpatient Clinic: A ward in which the patients do not stay overnight

Orthopaedic Surgery: Orthopedic surgery involves the musculoskeletal system. Orthopedic surgeons use both surgical and nonsurgical means to treat musculoskeletal trauma, spine diseases, sports injuries, degenerative diseases, infections, tumors, and congenital disorders.

Same-day surgery: Surgery that does not require patients to stay overnight

Appendices

List of appendices

1. Information pamphlet
2. Declaration of consent
3. Information poster
4. Danish Data Authority
5. Ethics Committee
6. Interview guide

Amager og Hvidovre Hospital

Roskilde Universitet

For you with a minority background and who will let me follow you through and after your hospitalization

What is the project about?

This PhD project has a purpose of describing minority patients' encounters with the healthcare system. It is not very often minorities are included in research. My aim is therefor to learn about your experiences with a hospitalization.

What does it imply to participate?

To get insight into your experiences, I will follow you during your stay at the hospital. To what extent is for us to decide together. I will be on the sideline and have conversations with at the extent you are able to. I can help you with practical doings, questions and follow you to different examinations e.g., X-ray, physiotherapy and surgery.

When you are discharged and have returned home, I will come to your home to interview you and/or your family. This is planned to last approx. 1½-2 hours. We will talk about your experiences in the hospital but also more general experiences with encounters in the healthcare system.

Your participation is anonymous

Your identity is only known by me and my PhD counselor. None of the information you share with me will be shared in a way that will make you recognizable. The project follows current rules for health research and is approved by the Danish Data Protection Authority and evaluated by the Regional Committee on Health Research Ethics.

Your participation is voluntary

It is of course voluntary to participate in this project. If you later regret your participation or parts of your participation, you are always welcome to contact me to have your statements withdrawn. This will not have any effect on current or future hospital care. Before you choose, you have the right to reflect.

I hope you want to be a part of this study.

Kind Regards,

Nina Halberg,
PhD student at Orthopedic Department
Amager and Hvidovre Hospital

Brief information about me

My name is Nina Halberg, and I am a PhD student at Roskilde University, Center of health promotion research. My background is in nursing and anthropology.

You can contact me via phone number
+45 38621664 or e-mail
nina.halberg@regionh.dk

Informed consent to participate in research

Observation and interview study to get insight into minority patients' experiences of encounters within the healthcare system

Research project:
Reframing the discourse of ethnic minority patients in healthcare. From theory to practice

Declaration for the participant:

I have been given information and is sufficiently aware of purpose, method, pros and cons to accept participation. I am informed that data is treated in confidence as well as data being represented in an anonymous format.

I know participation is voluntary, and I can withdraw my consent at any point without losing any current or future rights.

I give consent to participate in the research study and have been given a copy of this written consent as well as the written information about the project.

Participant: ____

Date: ____________________ **Signature: ____**

Declaration from the person giving this information:

I declare that the participant has received information about the project.

To my understanding, I have given enough information to be able to assess a decision on participation.

Name of person to give information:

Date: __________________ **Signature ____**

Roskilde Universitet

Information om observationsstudie

Formål: *Patienter med etnisk minoritetsbaggrunds oplevelser med indlæggelsesforløb*

Baggrund: Indlæggelsesforløb i dag stiller høje krav til både personale og patienter, da forudbestemte kriterier skal opfyldes. Patienter med etnisk minoritetsbaggrund inkluderes oftest ikke i forskning. Dette ph.d.-projekt har til formål at beskrive minoritetspatienters møde med sundhedsvæsnet.

Observationer: For at få indblik i patienters oplevelser, vil jeg følge dem under og efter indlæggelsen. Det kræver ikke noget ekstra af jer. Jeg vil være med på sidelinjen, måske stille nogle spørgsmål og følge patienterne til forskellige undersøgelser fx røntgen, genoptræning og operation. Observationerne vil være med til at afdække patienternes perspektiv og kan bidrage til at udarbejde relevante og mulige interventioner i forbindelse med forløbene. Observationerne fremstår anonyme dvs. der ikke indgår personfølsomme data i beskrivelserne.

Godkendelser: Projektet udføres i henhold til gældende regler for sundhedsvidenskabelig forskning og er godkendt af datatilsynet (P-2020-1068) og vurderet af videnskabsetisk komité i Region Hovedstaden (H-20072465).

Tidspunkt: Observationsstudiet vil foregå september 2021 – februar 2022 og jeg vil være til stede på forskellige tider af døgnet.

Kontakt: I er altid velkomne til at stille spørgsmål. Er jeg ikke til stede, kan I skrive en mail eller ringe.

Venlig hilsen,
Nina Halberg, ph.d.-studerende, pæd. antropolog, sygeplejerske
E-mail: nina.halberg@regionh.dk
Telefonnummer: 38621664

Vedrørende registrering af din anmeldelse til forskningsprojekt med journal-nr.: P-2020-1068 og titel Social ulighed i sundhed blandt etniske minoritetspatienter

Tir 17-11-2020 13:02

Kære Nina

Dit forskningsprojekt er hermed registreret på Region Hovedstadens fortegnelse over forskningsprojekter med overnævnte journalnummer jf. databeskyttelsesforordningens artikel 30.

Godkendelse fra andre myndigheder mv.

Godkendelse fra Videnscenter for Dataanmeldelser forudsætter at forskningsprojektet selv indhenter alle de nødvendige godkendelser fra andre myndigheder mv., som f.eks. Lægemiddelstyrelsen, Center For Regional Udvikling og Videnskabsetisk Komite.

Personoplysningerne må kun benyttes til forskning eller statistik

Personoplysninger, der behandles med forskning eller statistik som formål, må ikke senere behandles til andet formål. Det vil sige, at oplysningerne f.eks. ikke må indgå i administrativ sagsbehandling, kvalitetsprojekter eller patientbehandling.

Kontaktperson

Som kontaktperson på anmeldelsen i Pactius har du ansvar for, at anmeldelsen overdrages til en ny kontaktperson, såfremt din tilknytning til projektet ophører eller du ikke længere er ansat i Region Hovedstaden.

Primær ansvarlig

Den primær ansvarlige har på vegne af Region Hovedstaden det interne ansvar for overholdelse af databeskyttelseslovgivningen samt Regionens retningslinjer for sikkerhed i forbindelse med projektet.

Endvidere er den primær ansvarlige forpligtet til at sørge for, at medarbejdere der håndterer personoplysninger har modtaget instruktion og oplæring i, hvordan de må behandle oplysninger/materiale, og hvordan de skal beskytte oplysningerne/materialet jf. Regionens retningslinjer.

Den primær ansvarlige er også ansvarlig for oprettelse og vedligeholdelse af lister over følgende:

Interne medarbejdere ansat i Region Hovedstaden, der indgår i forskningsprojekt, og som dermed har adgang til data i projektet. Skabelon til sådanne lister findes på Videnscentrets intranetside.

Fysisk opbevaring af data, herunder biobank, papir, samt krypterede og ikke krypterede flytbare medier.

Elektroniske mapper og drev på Regionens servere oprettet via CIMT, der opbevares data på.

Systemer

Det er den primær ansvarliges ansvar at sikre, at de it-systemer, apps eller lignede, der benyttes i forskningsprojektet er godkendt eller har fået dispensation af CIMT til brug i forskningsprojektet. Ligeledes at evt. selvforvaltede eller lokal forvaltede systemer, der benyttes, er godkendt af CIMT.

Videnscenter for Dataanmeldelser gør opmærksom på, at et program/medicinsk udstyr mv. godkendt til brug i patientbehandlingen, ikke nødvendigvis også er godkendt til brug i forskningsprojekter.

Databehandlere

Ved brug af eksterne databehandlere til behandling af personoplysninger i projektet, skal der foreligge skriftlige databehandleraftaler, der lever op til artikel 28 og 29 i databeskyttelsesforordningen.

Skal databehandleren på et senere tidspunkt foretage yderligere behandlinger eller behandle oplysninger som ikke er omfattet af den indgåede databehandleraftale, skal databehandleraftalen opdateres og underskrives på ny. Kontakt i disse tilfælde Videnscenter for dataanmeldelser.

Databehandleraftaler skal altid være godkendt af Videnscenter for Dataanmeldelser for at kunne betragtes som gyldig.

Vær opmærksom på, at det er dit ansvar at fremsende de(n) underskrevne databehandleraftale/databehandleraftaler til de(n) eksterne databehandler(e).

Videregivelse af personoplysninger

Videregivelse af personoplysninger fra projektet kan kun ske efter forudgående tilladelse fra Videnscenter for Dataanmeldelser.

I særlige tilfælde kræves der efter databeskyttelseslovens § 10, stk. 3 derudover forudgående tilladelse fra Datatilsynet. En sådan tilladelse skal indhentes når videregivelsen:

sker til behandling uden for databeskyttelsesforordningens territoriale anvendelsesområde - f.eks. til USA, Canada, Australien og Island mv.

vedrører biologisk materiale – f.eks. blod- og vævsprøver.

sker med henblik på offentliggørelse af oplysninger i anerkendte videnskabelige tidsskrifter eller lignende.

Forskningsprojektet er selv ansvarlig for at søge tilladelse hos Datatilsynet i ovenstående tilfælde.

Oplysningspligt

Indsamles data med samtykke fra den registrerede (patienter, raske forsøgspersoner mv.), vil oplysningspligten jf. Databeskyttelsesforordningens artikel 13, skulle overholdes. Du kan læse mere om oplysningspligten og finde et forslag til et bilag på Videnscenterets intranetside.

Ved projektets afslutning

Ved projekts sluttidspunkt (Databehandlingens sluttidspunkt) skal data enten slettes, anonymiseres eller overføres til Rigsarkivet i overensstemmelse med anmeldelsen i Pactius. Ønsker du at forlænge projektet, og dermed ændre projektets sluttidspunkt, skal der foretages en ændring af din anmeldelse i Pactius. En sådan ændring skal anmeldes i god tid.

Ændringer

Hvis der sker ændringer af de oplysninger, der fremgår af anmeldelsen, skal ændringerne

meddeles til Videnscenter for Dataanmeldelser via det elektroniske anmeldelsessystem Pactius. Du kan kontakte Videnscenter for Dataanmeldelser på cru-fp-vfd@regionh.dk, hvis du ønsker at foretage en ændring i din anmeldelse.

Held og lykke med projektet

Med venlig hilsen

Leyla Atici

Cand.jur

Telefon: 21 36 84 13

E-mail: leyla.atici@regionh.dk

Center for Regional Udvikling - Sundhedsforskning og innovation

Videnscenter for Dataanmelderser

Region Hovedstaden

Center for Regional
Udvikling

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Social ulighed i sundhed blandt etniske minoritetsoatienter indlagt i standardiserede forløb

Du har ved mail af 29-10-2020 spurgt, om ovennævnte projekt skal anmeldes til det videnskabsetiske komitesystem.

Det er oplyst, at projektet er baseret på en etnografisk undersøgelse og interview af sygeplejepersonaler og patienter og pårørende i eget hjem efter udskrivelse.

Jeg har vurderet, at der ikke er tale om et sundhedsvidenskabeligt forskningsprojekt som dette er defineret i komitélovens § 2[1], men at der er tale om observation og en interviewundersøgelse.

Projektet er derfor ikke anmeldelsespligtigt, jf. komitélovens § 1, stk. 4 og kan iværksættes uden tilladelse fra De Videnskabsetiske Komiteer for Region Hovedstaden.

I Danmark har det videnskabsetiske komitesystem til opgave at vurdere sundhedsvidenskabelige og sundhedsdatavidenskabelige forskningsprojekter.

Ved sundhedsvidenskabelige forskningsprojekter forstås projekter, der indebærer forsøg på levendefødte menneskelige individer, menneskelige kønsceller, der agtes anvendt til befrugtning, menneskelige befrugtede æg, fosteranlæg og fostre, væv, celler og arvebestanddele fra mennesker, fostre og lign. eller afdøde. Herunder omfattes kliniske forsøg med lægemidler på mennesker og klinisk afprøvning af medicinsk udstyr.

Sundhedsvidenskabelig forskning omhandler primært forskning inden for de lægevidenskabelige fag, den kliniske og den socialmedicinsk-epidemiologiske forskning. Begrebet omfatter, udover forskning af de somatiske sygdomme, tillige de psykiatriske og de klinisk-psykologiske sygdomme og tilstandsformer. Herudover inddrages tilsvarende odontologisk og farmaceutisk forskning under begrebet.

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[1] Afgørelsen er truffet efter lov lovbekendtgørelse nr. 1083 af 15/09/2017 med senere ændringer

Registerforskningsprojekter (bortset fra sundhedsdatavidenskabelige projekter), interviewundersøgelser og spørgeskemaundersøgelser skal kun anmeldes, hvis der indgår menneskeligt biologisk materiale i projektet.

Undersøgelser af anonymt biologisk humant materiale skal dog ikke anmeldes til en videnskabsetisk komite, med mindre der er tale om et forskningsprojekt vedrørende befrugtede menneskelige æg samt kønsceller, jf. §§ 25 og 27, stk. 2 i lov om kunstig befrugtning i forbindelse med lægelig behandling, diagnostik og forskning m.v. Det er et krav, at materiale er fuldstændig anonymt (der må ikke være en identifikationskode til data), og at materialet er indsamlet i overensstemmelse med lovgivningen på indsamlingsstedet.
Forsøg på cellelinjer eller lignende, der stammer fra et forsøg med indsamling af celler eller væv, som har opnået den nødvendige godkendelse, skal heller ikke anmeldes.

Forsøg, der alene har til formål at fastlægge et kemikaliums toksikologiske grænse i mennesket, er ikke anmeldelsespligtige. Ved et kemikalium forstås i denne forbindelse et stof, der ikke finder terapeutisk anvendelse.

Der ligger således ikke i afvisningen af at bedømme projektet nogen etisk stillingtagen eller negativ vurdering af dets indhold.

Ved sundhedsdatavidenskabelige forskningsprojekter forstås forskning vedrørende særlige komplekse områder i afledte sensitive bioinformatiske data frembragt ved omfattende kortlægning af arvemassen eller billeddiagnostik i forbindelse med forsøg eller klinisk diagnostik af patienter.

Vi gør opmærksom på, at regionerne i visse tilfælde skal godkende videregivelse af oplysninger fra patientjournaler. Det er den region, forsker er ansat i, der skal ansøges om dette. Nærmere oplysninger kan findes på den relevante regions hjemmeside.

Behandling af personhenførbare oplysninger er omfattet af databeskyttelsesloven/persondataforordningen. Nærmere oplysning herom findes på Datatilsynets hjemmeside.

Klagevejledning:

Afgørelsen kan, jf. komitélovens § 26, stk. 1, indbringes for National Videnskabsetisk Komité, senest 30 dage efter afgørelsen er modtaget. National Videnskabsetisk Komité kan, af hensyn til sikring af forsøgspersonernes rettigheder, behandle elementer af projektet, som ikke er omfattet af selve klagen.

Klagen skal indbringes elektronisk og ved brug af digital signatur og kryptering, hvis protokollen indeholder fortrolige oplysninger. Dette kan ske på adressen: dketik@dketik.dk.

Klagen skal begrundes og være vedlagt kopi af Den Regionale Videnskabsetiske Komités afgørelse samt de sagsakter, som Den Regionale Videnskabsetiske Komité har truffet afgørelse på grundlag af.

NB: Der må ikke foretages ændringer i dokumenterne, som har været til behandling i komiteen, da sagen ellers vil blive sendt retur til komiteen.

Med venlig hilsen

Jakoblemming

Jakob Lemming
Cand. Jur.

Interview guide [translated from Danish]

Time: XX

Participants: XX and XX

Artefacts:

- Dictaphone
- Water and accessories
- Books?

Strukture:

- PhD. project. Focus on the group categorized as ’ethnic minority patients’.
- Your role: this brainstorm, possibly diaries, support my presence, workshops following data collection to explore possible intervention/elements in practice to create best possible pathways
- Explorative brainstorm
- Learn about your experiences in clinical practice
- For this to make sense, I need your voices
- The goal is the patients – to create best possible patient pathways
- Ok?

Questions:

Patients and pathways:

- Who are ethnic minority patients? (Who is included in the category when you discuss patients with other ethnic origin than Danish) **(categories)**
- Why is it a group that we talk about? **(subject area)**
    - How is the group spoken about? **(language)**
    - Do you experience specific difficulties?
        - Concerning the group of patients **(subject matter)**
        - Concerning patient pathways **(procedures)**
- How much do this group of patients take up in your daily practices? **(scope)**
- How do this group of patients differ from other patient pathways? **(differentiated treatment both good and bad)**
    - Do you have any examples of something you do different in the encounter? **(the encounter)**
- Do you have some examples of patient pathways that have been **(practice)**
    - Extra good

- Extra challenging

You position and knowledge:

- Do your own position (as a nurse) a difference? **(positioning, asymmetric)**
- What knowledge do you draw on? **(theorizing)**
- How do you think I approach clinical practice? **(observations)**
- What do you think can be done differently? **(perspective of change)**
- Do you any available resources (e.g., etnisk ressourceteam, indvandrermedicnsk klinik) – if yes, how do they help you? **(help resources)**
- The group is often excluded from research. If you think about a patient that does speak Danish. Do you have experience whether they are included? Are they not asked, or do they not want to participate? **(research)**

Subject areas:

• Language	• Problem size	• Procedures (how)
• Complications (why)	• Problem areas	• Measurements
• Taboos?	• Challenges	• Solutions

This thesis 'Someone like me; I go after staff with good vibes: An ethnographic study of ethnically minoritized patients in Danish healthcare through an equity lens', examines what the social categorization of 'ethnic minority patients' does in healthcare. The background of the study is the persistence of health inequities for ethnically minoritized patients, which has led to an international call for advancing racial and ethnic equity in health (The Lancet, 2022).

Based on an ethnographic study including policy documents and fieldwork among 13 patients in two orthopedic departments in Greater Copenhagen, Denmark, the interest is to examine healthcare in the intersections between the welfare state, institutions, and encounters.

By theoretically drawing on post-colonialism, post-structuralism and critical feminist theory, concepts of ethnicized and ethnically minoritized are applied and the thesis actively engages with concepts such as hegemony, othering, Eurocentrism, whiteness and (structural) discrimination in a modern and universal healthcare system.

The findings are presented in four articles which explore the social categorization of 'ethnic minority patients' through welfare representations, healthcare practices, patient workings and majorized positionings. (In)visibility and silence(d) become key to understand the persistence of health inequities for ethnicized patients in Danish healthcare. By developing the concept of (over)workings, the thesis proposes a concept that captures, elucidates, and grasps productions of health inequities for patients positioned in the margins of healthcare. This thesis then contributes to making productions of ethnicity visible and unsilenced and thereby aim to advance equity-oriented and anti-discriminatory work in healthcare both in theory and practice.

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