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Making the invisible visible: How cultural hegemony and uncertainty help us understand health professional education inequities

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Abstract

Despite societal, financial and wellbeing costs related to discrimination, and increasing literature on improving diversity, equity and inclusion (DEI), sustainable movements towards addressing health professional education (HPE) system inequities remain elusive. Here, we critically examine contemporary HPE systems, exploring how invisible barriers prevent meaningful DEI action. We draw on *cultural hegemony* and its relationship to unconscious/implicit bias within HPE's culture. We also explore how DEI initiatives can introduce uncertainty and often challenge our uncertainty tolerance while addressing HPE system inequities. Drawing on *uncertainty-identity* theory, we explain how HPE professionals' diverse responses to the discomfort typically provoked by such DEI initiatives may impact meaningful cultural change. Collectively, this critical reflection of HPE practices highlights challenges and suggests potential solutions for addressing persistent inequities across Australia and New Zealand HPE systems.

Keywords: cultural hegemony; uncertainty; diversity; equity; inclusion; health professional education

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Current trends in health professional education academia

A lack of effective diversity, equity and inclusion (DEI) in academic practices is increasingly identified (Brown et al., 2022). In using the term DEI, we are referring to both the diversity (e.g., whom is represented) as well as the equity and inclusion strategies (e.g., actions and mechanisms for ensuring representation) used to represent that diversity.

From disparities in publishing, homogenous leadership and curricular exclusions, there is growing awareness of the recalcitrant structural and systemic inequalities that still exist across health professional education (HPE) (Abdalla et al., 2022). While existing literature *highlights* these inequities, there is less exploration of the reasons behind HPE systems' resistance to enact effective and sustained change. Furthermore, directions for addressing these contemporary challenges, particularly in the Australian and New Zealand HPE academic context, are few. This paper seeks to address these gaps by drawing on social sciences and humanities theories explaining the structural barriers in disciplinary cultures and providing recommendations for closing this gap.

Underpinning many existing DEI challenges is recognition that HPE remains predominantly taught from western, colonial and positivist paradigms (Drummond et al., 2021). This contributes to a growing mistrust of mainstream western HPE exacerbated by student, educator and health professional experiences of widespread interpersonal and institutional discrimination (e.g., ableism, sexism and racism) (Mellifont et al., 2019; Ruzycki et al., 2022).

Diversity of academic leadership is also lagging. A study mapping governance and senior executive roles within Australian and New Zealand academia, the main systems within which HPE reside (Croucher et al., 2020; Walker et al., 2020), illustrates a failure to represent the population that the HPE system serves. In Australia, the homogeneous nature of academic leadership is striking, with the vast majority (94%) from Anglo-Celtic backgrounds and 61% male (Croucher et al., 2020). Across the sector, females worked more in education and less in executive-types roles (e.g., vice chancellor), with culturally diverse females representing only 7.3% of total Australian university board members (Women on Boards, 2022). Within universities, directors who are Indigenous Australians remain low, at only 2.9% (Women on Boards, 2022). This trend is also reflected in the academic workforce in Aotearoa New Zealand (Abdalla et al., 2022) as well as the healthcare foundational science workforce, with a 2022 study finding no significant changes in the Māori and Pasifika academic workforce from 2008–2018, highlighting the underrepresentation of Māori academics in Aotearoa New Zealand universities (T. McAllister et al., 2019; T. G. McAllister et al., 2022).

Healthcare professional educators are being called upon to do more to address structural and systemic inequities across both academic and healthcare systems, but the academic staff themselves may be uncertain, uncomfortable and/or lack the critical reflective skills needed to enact change (Bullen & Flavell, 2022; Francis-Cracknell et al., 2022b). In

an effort to make the invisible more visible, we explore theories that could help explain why HPE academia continues to lag in effective and sustainable DEI efforts and suggest solutions for collectively moving forward to address this gap.

The role of cultural hegemony in reinforcing bias

In his seminal work, *Prison Notebooks*, philosopher and political theorist Antonio Gramsci (1971) discusses civil society in relation to the state and its institutions of power through the notion of "cultural hegemony". According to Gramsci, society's social elites establish a way of life, including acceptable beliefs, values, norms and patterns of behaviour, in order to create social structures reinforcing the supremacy of the elites. In other words, those in power create a system to sustain their power.

This system of beliefs, norms and behavioural patterns, which we can collectively refer to as "culture", are perceived as necessary and, in some cases, as a benefit to society. As Hughes (2013) argues, Gramsci's idea of cultural hegemony denotes "the *process* whereby the interests of ruling elites or dominant groups come to have the status of common sense" (p. 128). The community begins to believe that the values and priorities it holds as "civil" and "right" are fundamental to society functioning as it should. These embedded sociocultural structures are often taken for granted in social discourse, becoming part of "the order of things" and "the way of the world". Consequently, marginalised groups, or those who find themselves at the lower end of the social order, come to believe in, and consent to, the orthodoxy of the cultural hegemony imposed on them.

There are parallels between Gramsci's notion of cultural hegemony and "unconscious bias" and/or "implicit bias". According to Akram (2018), implicit bias refers to "the bias in judgement and/or behaviour that results from cognitive processes (implicit attitudes and stereotypes) that operate at a level below conscious awareness and without intentional control" (p. 121). The influence of Gramsci's notion of cultural hegemony on implicit biases lies precisely in those "automatic", "taken for granted" or unexplored attitudes and behaviours that maintain the status quo. In HPE, unconscious bias can impact interpersonal interactions (e.g., communication with colleagues or people seeking medical care) and teaching of clinical practices, and may contribute to the structural inequalities across HPE practices.

Embedded cultural hegemony in HPE

Applying the cultural hegemony lens to HPE, we can see a variety of historical and contemporary forms of hegemony reinforcing implicit/unconscious bias and preventing or hampering DEI efforts in academia. Contemporary healthcare system educational practices continue to be critiqued for being patriarchal, hierarchical and individualistic, and for privileging dominant western knowledge and practices (Drummond et al., 2021; Moreton-Robinson, 2015; Rennie & Remedios, 2022). The driving force behind these practices may be cultural hegemony.

Privileging colonial and western notions of "objectivity", "truth" and "normality" over other forms of knowledge and evidence (Holmes et al., 2006; Sherwood & Edwards, 2006) results in ongoing reinforcement of the dominant white majority at the exclusion and marginalisation of others (Bastos et al., 2018). These hegemonic practices extend to healthcare systems that continue to uphold unconscious, unexamined beliefs so that those outside the established "norms" of the system face inequity across healthcare practice (Rockich-Winston et al., 2022; Ussher, 2009) and health professions in academia (Acholonu & Oyeku, 2020), which perpetuates both social and financial costs (Elias & Paradies, 2021). For example, Elias and Paradies's (2016) paper "examined the health cost of racial discrimination, using burden of disease estimates to measure lost years due to mental health disability associated with experiences of racial discrimination" (p. 51) and found this to be equivalent to 3% of the Australian gross domestic product (GDP) each year—roughly half the GDP for the country between 2021 and 2022 (Elias & Paradies, 2016, 2021).

Another example includes the exclusion or marginalisation of Indigenous people's knowledge and epistemologies across HPE systems. This exclusion continues despite growing global interest in the value of Indigenous knowledges and practices (Adams et al., 2022; Brand et al., 2023). Memorialisation of figures, such as Florence Nightingale, who had problematic relations with Indigenous peoples (Adams et al., 2022), continues today. Indigenous health teaching, when undertaken by non-Indigenous educators, often focuses on cultural differences rather than on critical reflections of power, privilege, race and settler colonial processes (Francis-Cracknell et al., 2022a). The incorrect framing of Indigenous knowledges within western discourses and structures (Nakata, 2007) prompted a recent position statement by rural health journals that they will publish "nothing about Indigenous Peoples, without Indigenous Peoples" (Lock, 2022, p. 4).

Being curious: Critically reflecting on HPE cultural hegemony

In critically reflecting on HPE cultural hegemony, we do not want to (and arguably cannot) be prescriptive. Those in leadership and power positions are called upon to assume responsibility for their privilege and come up with context-specific solutions that consider, and integrate, local lived experience, perspectives and voices from the community and embed them within their workplaces. Here, we provide some examples of HPE hegemony, outline the challenges such hegemony brings to the workplace and acknowledge that this critical reflection is an ongoing discussion, which cannot foresee all possible future solutions to raised challenges.

Expanding epistemologies

Genuine DEI advancement requires epistemological expansion and critical reflection on our/HPE biases and systems of inequity that we consciously and unconsciously uphold. We need to challenge the "norms of credibility" by asking whose knowledge is valued in HPE research and practice, and why? (Brand et al., 2022). This is often reflected in what

we decide to include (or not) in healthcare curriculum and resources or what is published in academic journals or presentations, or even who is recruited into academic positions. For example, in New Zealand, while Matauranga, or Māori ways of knowing, are integral to conceptualisations of health and wellbeing (Reweti et al., 2022), they are often taught through traditional western and hegemonic academic approaches (Rangiwai, 2018). So, let's all start to collectively ask: "Why is 'scientific' written evidence the only source of 'truth' in HPE?" Are there other forms of knowledge that may inform our understandings of a topic? Are there novel transdisciplinary methods that integrate divergent paradigms (e.g., Indigenous *and* western ways of knowing), address the challenge and expand epistemologies and lead to greater and more inclusive ways of knowing? Through curiosity and critical reflection, we may begin the work of seeing, and then challenging, current HPE cultural hegemony.

One way to expand HPE worldviews is through co-designing HPE with people with lived experience, including healthcare consumers (Brand & Dart, 2022; Mark & Hagen, 2020), to ensure we are realigning knowledge to reflect consumer and community needs, values and expectations of healthcare (Brand et al., 2022). This approach extends from the theory of "post-normal science", where expertise is drawn from the community impacted by the findings and challenges scientific elitism (Ravetz, 2004). It is important to emphasise that our advocacy work in expanding epistemologies does not negate the value of health professional expertise but, rather, proposes that expertise and ways of knowing come in a variety of forms—and that multiple factors need to be considered when we "bestow" upon someone the title of expert.

A path forward: Inclusive language and communication strategies

The language we use plays a big part in healthcare culture. Our recent call to action for healthcare academics to resist and unlearn dehumanising language (Truong et al., 2022) speaks to the embedded nature of language in HPE systems that maintains structural inequities. Language in HPE tends to be underpinned by a deficit-type discourse focusing on risk, abnormality and impairment. Words are often used to negatively "label" and stigmatise people. For example, describing patients as "drug addicts" can confer addiction as the defining feature of a person's identity and places the condition or disease *before* the person. This communication style also serves to perpetuate a reductionist framing of health and illness to a "disease focused lens that fails to *see* the whole person" (Truong et al., 2022, p. 3).

By critically reflecting on how HPE language maintains positions of power and reduces individuals to less-than-whole, we can explore alternative communication strategies. For example, an HPE setting could develop a "recommended register" of terms to avoid, including a rationale explaining the problematic nature of such terms for those unaware (Hamilton et al., 2022). Terms such as "black-list", for instance, can serve to reinforce negative views of darker skin tones, while phrases such as "okay guys" can perpetuate

gender bias—and both would be good candidates for the "no-go" register. By questioning the language we currently use, and being purposeful in phraseology moving forward, we can help to describe healthcare recipients with language that represents them in a more inclusive manner.

In Aotearoa New Zealand, Māori-centred models and frameworks of health and healthcare are increasingly being taught in HPE, and these guidelines serve to increase cultural safety and improve health outcomes for Māori peoples (Jones et al., 2010; Matenga & Westenra, 2022; Pitama et al., 2017). For example, the Hui process and the Meihana models, which focus on Māori world views, can be used to teach clinicians how to improve their responsiveness to Māori clients and their whānau (extended family) (Pitama et al., 2017).

While many are motivated to improve the HPE systems and structures in support of DEI, there is evidence that not everyone is ready, willing and/or able to critically reflect, unlearn and act for this important change. When we destabilise the systems and structures within which we work (i.e., dismantle the HPE cultural hegemony), we also destabilise the foundations of what the healthcare system was built on, including our own HPE academic identities. Presently, we are paid to be healthcare experts; we have policies and procedures of what is or isn't acceptable or "professional". We have a visible hierarchy of who does and does not belong and where we sit within this pecking order. When we challenge this embedded HPE hegemony, uncertainty is introduced for not only individuals but also the HPE system. How we manage this uncertainty can impact the uptake and sustainability of DEI initiatives.

The uncertainty of dismantling cultural hegemony

The relationship between experiencing a sense of community belonging and uncertainty is explained by social psychologist Dr. Michael Hogg through "uncertainty-identity" theory (Hogg & Adelman, 2013). This theory centres around the idea that humans are fundamentally motivated to "belong to and be accepted" within a socio-cultural community, in this case the HPE community (Hogg & Adelman, 2013, p. 436).

When we change the "established HPE rules" (e.g., through co-designing or adjusting language), uncertainty-identity theory postulates that this destabilises individuals as they begin to feel uncertain about their own professional identity and their role within the HPE system. Consider a reframing of, for instance, what behaviour is considered "professional". Those in the system, even those marginalised by the system, may start to question how they should behave, communicate and/or even dress when the traditional "rules" are challenged or changed.

When faced with such self-uncertainty, Hogg and Adelman (2013) find that many choose to suppress and/or avoid the accompanying feelings of discomfort by seeking external sources of "certainty", electing to revert back to, for instance, the old ways of knowing or

doing. These individuals may actively seek out HPE systems that support rigid, and clear, beliefs, norms and values. For instance, a HPE educator who is less well equipped in handling the destabilising nature of expanding epistemologies and ways of knowing may consider leaving the profession entirely or may seek out HPE systems that reinforce western traditional HPE approaches, such as rigid hierarchies and teacher-centred education.

Those with more adaptive responses to this self-uncertainty may have the capacity to sit with the discomfort and begin exploring to what extent, and in what ways, they will manage and/or fit in. These more "uncertainty tolerant" professionals could approach such change with curiosity (Hillen et al., 2017), increasing their capacity for rescripting their identity and role within this new and evolving HPE system.

When embarking on the necessary structural changes required to support sustainable DEI initiatives, considering the following is recommended: professionals within the existing system depend on roles for defining their identity and for their livelihoods. Uncertainty-identity theory suggests that when we question ourselves in such contexts (where risk to self-preservation is high), we have a greater tendency to manifest features of uncertainty *in*tolerance (Hogg, 2007; Hogg & Adelman, 2013). Knowing this, the goal of effective and sustained changes may depend on appropriate titration of changes through incremental and staged introductions of structural uncertainty when initiating DEI initiatives that challenge HPE hegemony. Additionally, building in support to those managing uncertainty-related discomfort (Lazarus et al., 2022) and tying structural changes of HPE hegemony to supporting individuals' identity and financial security will increase the likelihood of success (e.g., providing positions, bonuses and awards to those engaging in the evolutionary rescripting process).

Conclusion

How do we balance the need to recognise, critically reflect on and act to dismantle existing cultural hegemony, which continues to impede sustainable changes toward a HPE culture that truly values diversity, equity and inclusion? The answer may lie in supporting both individuals and systems to be more uncertainty tolerant and in providing the space necessary for critical reflection. To do this, we call upon those in HPE leadership to lead by example, for example, reflect upon their own positions of power and privilege and actively pursue steps backing DEI initiatives (Figure 1) and provide support to their colleagues to proactively manage the uncertainty that comes with an evolving HPE system. Only then will the status quo be more effectively challenged in a manner that leads to genuine and sustained changes in HPE culture towards one of greater diversity, equity and inclusion.

Figure 1

Examples of Contemporary Challenges and Future Solutions to Addressing Inequities in Health Professional Education (HPE) Systems
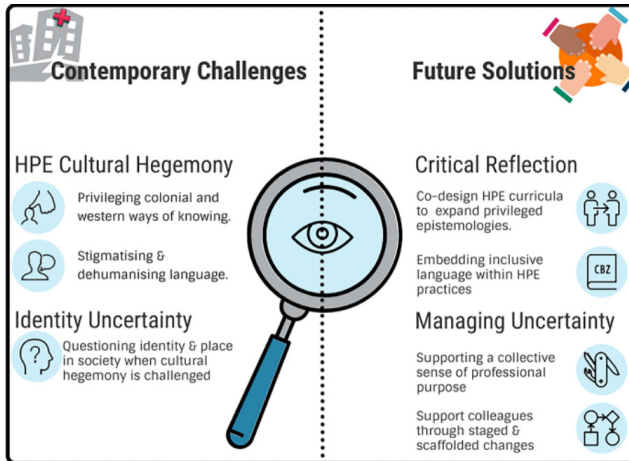
Note: This figure is not meant to be a panacea for addressing HPE inequities but rather represents some of the current challenges (left) and potential solutions (right) highlighted in this paper to address HPE inequities. As the discourse on HPE inequities changes, so must our approaches and solutions to addressing these inequities.

Acknowledgements

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