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Cultural competency and the reproduction of White supremacy in occupational therapy education

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Abstract

Background: In this two-part paper, critical race theory is used as an analytic tool to examine how anti-Blackness, anti-Indigenous colonial relations and Orientalism have and continue to influence the ways in which occupational therapy is taught and practised in Canada.

Purpose: The purpose of this paper is to incite reflection on the ongoing oppressive narratives that pervade occupational therapy education and support culturally unsafe practices.

Methods: Through the lenses of liberal multiculturalism, liberal recognition politics and neoliberal capitalism, the author demonstrates how notions of 'cultural competency' are the logical product of an institutionalised racism that functions as a tool for the reproduction of White supremacy and racism in healthcare and healthcare education.

Conclusions: Findings challenge the ongoing use of cultural competency frameworks in healthcare systems and education and propose a radical shift towards critical and structural frameworks.

Keywords

Cultural competency, critical analysis, occupational therapy, White supremacy

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He becomes the authentic knower while they remain what is to be known and consumed.

Razack (2007: 379)

A 2017 class action lawsuit filed in Saskatchewan on behalf of two Indigenous women who said they were sterilised without their informed consent reinvigorated discussion about the ongoing racism experienced by Indigenous and racialised groups within Canada's healthcare system. The forced sterilisation of Indigenous women in Canada, which began in the 19th century, is well-documented and now understood by critical race scholars as an act of genocide by early (and late) settlers (Stote, 2015). In a written statement following the 2017 lawsuit announcement, the Canadian Minister of Indigenous Services, Jane Philpott, acknowledged that '[I]ndigenous patients can face systemic barriers in accessing medical services, including discrimination and racism' (Samson, 2018: 24). Despite recognising that the problem lies at a systems level, Philpott, citing the Truth and Reconciliation Report[1] (Truth and Reconciliation Commission of Canada, 2015b), emphasised cultural competency training for healthcare professionals as a principal mode of redress (Kirkup, 2017).

Demands for cultural competency training in healthcare and healthcare education are not new. They began in the early 1980s following social projects initiated by the civil rights movement and gained substantial momentum by the early 1990s (Gallegos et al., 2008). Cultural competency is typically defined as the 'skills that a clinician can employ to understand the cultural values, attitudes and behaviours of patients, especially those whose cultural background differs from that of the professional' (Schouler-Ocak et al., 2015: 432). Today, cultural competency training is required in most Canadian healthcare programs to meet accreditation standards and is often reflected in program mission statements. A number of derivatives of cultural competency have been suggested, including cultural awareness, cultural sensitivity, cultural responsiveness, cultural relevance, multicultural competence and transcultural competence (Beagan, 2018). As Beagan (2018) states, although most derivatives 'give a nod' to features of diversity that are seemingly more entrenched in systems, 'immediately afterward, the focus is almost always reduced to [individual] race and ethnicity' (Beagan, 2018: 124), veiled under the guise of culture. We are warned by Razack (1995) of the dangers of '[c]ulture talk, where race becomes a cultural [individual] inadequacy, deflect[ing] attention away from the structural relations of domination and subordination' (p. 67). According to Razack (1995), the assumption is that if these inadequacies 'could somehow be taken into account [ex: in healthcare services], inequalities would disappear' (p. 67).

The existence of discourses around concepts rooted in decolonisation frameworks is acknowledged, such as cultural humility and cultural safety (Beagan, 2018; Gerlach, 2012; Hook, 2014; Kirmayer, 2013). Nevertheless, this article will focus on the concept of cultural competency (its derivatives are implied) since it continues to be the primary paradigm used in Canadian healthcare and education systems. Regardless of the terms used, current approaches have proven unsuccessful, as demonstrated by the unattenuated rates of racism and health inequities experienced by Indigenous and racialised individuals in Canada.

Critics of cultural competency have mainly argued against its reductionist, static and objectivist definition of culture and potential for stereotyping (Azzopardi and McNeill, 2016: 285; Beagan, 2018: 125; Furlong and Wight, 2011: 48; Kumas-Tan et al., 2007: 544); its lack of an intersectional approach (Beagan, 2018: 125; Kumas-Tan et al., 2007: 555); its objectivist paradigm as a competence or skill that one can acquire through learning and training and which can be assessed (Beagan, 2018: 124; Kumas-Tan et al., 2007: 552; Wear et al., 2012: 752); its assumption of a neutral healthcare professional (Carey, 2015; Kumas-Tan et al., 2007: 555); its lack of attention to critical reflexivity about the healthcare professional's own positionality and

social location (Beagan, 2018: 133; Kumas-Tan et al., 2007: 555); and its liberal approach in which racism is assumed to be the direct result of ignorant and prejudiced individuals, instead of deeply rooted systems-based processes (Azzopardi and McNeill, 2016: 289; Furlong and Wight, 2011: 41; Nylund, 2006: 29; Shepherd, 2019).

While these are all valid and important critiques, a worrisome underlying assumption with these arguments is that cultural competency remains an attempt to respond to the problem of racism. In this article, I argue that cultural competency should be regarded not as a response to, but rather as a logical product of, institutionalised racism that functions as a tool in the reproduction of White supremacy in healthcare systems. To do this, I use the definition of White supremacy, offered by DiAngelo (2017):

> White supremacy captures the all-encompassing centrality and assumed superiority of people defined and perceived as white, and the practices based upon that assumption. White supremacy is not simply the idea that whites are superior to people of colour (although it certainly is that), but a deeper premise that supports this idea – the definition of whites as the norm or standard for human, and people of colour as an inherent deviation from that norm.

I also use the works of critical race theorists, scholars who seek to study and transform 'the relationship among race, racism, and power' (Delgado and Stefancic, 2017: 3), as a means of analysis throughout this paper. To be transparent, I argue this thesis from my self-identified position as a White, francophone, Canadian, non-binary, queer, occupational therapy healthcare educator working in a higher education institution from a working-class background, within the context of a second doctoral degree focusing on the use of critical pedagogies in post-secondary healthcare education. I acknowledge that, as a White person, my work has and will continue to be influenced by this lens.

This article is presented in two parts. Part 1 outlines the ways in which anti-Blackness, anti-Indigenous colonial relations and Orientalism have influenced and continue to influence the ways in which healthcare systems operate in Canada. The profession of occupational therapy is used as an illustration. Part 2 explains how cultural competency is a logical product of these historical processes and how it functions as a tool in the reproduction and maintenance of White supremacy within Canada's healthcare system. In the conclusion, I end with my stance on future directions for occupational therapy and other health professions education.

Part 1 – the moral, rational Westerner and the *Other* in healthcare: a racial-historical context for the emergence of occupational therapy

During the late 18th and early 19th centuries, theories of evolution were gaining power in medical and science disciplines, and the conception of the human became that of an 'evolutionarily selected being' (Wynter, 1994: 48). The European as the basis of our modern biomedical Western healthcare tradition came to embody the desired norm, while 'the 'lower non-White races' and most ultimately the 'Negro' [original wording], [came to] incarnate the most atavistic non-evolved lack of the human' (Wynter, 1994: 49). This assumed White superiority served as a rationale for the oppression and exploitation of the *Other*, the lesser/non-human (Dei, 1996: 42).

Despite the abolition of slavery in Canada in 1834, emancipation 'did not simply give way to freedom' and a greatly modified definition of the human (Wynter, 1994). Instead, 'the legal disavowal of ownership reorganised domination and the former slave became the racialised Black "subject," whose position was marked epidermally' (Wilderson, 2017: 8, citing Fanon, 1954; DuBois,

1903). This anti-blackness was reinforced not only through the legal system, as Fanon (1952) writes, but also through the healthcare system, which was greatly influenced by anti-Black narratives of evolution. Wilderson (2017) argues that despite the absence of forced labour, post-slavery Black individuals became in essence 'socially dead', leaving them 'open to gratuitous violence' and 'general dishonor' (p. 8). Countless examples of state-funded violence against Black individuals within Western healthcare systems (e.g. intentional injection of syphilis, prisoner medical experiments) have been documented up to the present day (Goldberg, 2002; Savitt, 1982; Washington, 2006). In a 1965 speech, Martin Luther King Jr stated, '[o]f all the forms of inequality, injustice in health is the most shocking and the most inhumane' (Washington, 2006: 2). King was referring not only to the exploitation of Black individuals by healthcare systems but also to how neoliberalism (free-market capitalism) has come to commodify healthcare in such a way that it is now a form of property that disproportionality prevents Black individuals from accessing.

Healthcare systems have been complicit in keeping anti-Indigenous colonial relations alive through the continued oppression and exploitation of Indigenous individuals. Occurring concurrently with the anti-Black rhetoric, anti-Indigenous colonial relations reached a pinnacle with the signing of the 1876 *Indian Act*. The *Indian Act* afforded the government of Canada sweeping powers over Indigenous lands, identity, political structures, governance, education, cultural practices and healthcare. Healthcare professionals had a role in furthering the colonial land agenda on Turtle Island:[2]

> Apprehension of sick Indigenous people was made legal by the Indian Act. Not yet having achieved the status of 'persons', never mind citizens of Canada, they were susceptible to quarantine or incarceration at the whim of doctors, Indian agents, or government officials. Declaring individuals contagious was a good means of control, keeping them out of trouble or out of circulation while the task of clearing the land was underway. (Geddes, 2017: 13)

Here, the motivation behind medical racialisation is clear: namely, land appropriation via the genocide of Indigenous individuals. Countless deaths as a result of state-funded medical research (i.e. nutrition studies involving the starvation of children housed in residential schools) and experimental medical interventions have been documented in Canada (Kuokkanen, 2008; Truth and Reconciliation Commission of Canada, 2015a): this paper opened with an ongoing, contemporary example.

Finally, this same time period also marked the post-Gold-Rush and post-Canadian Pacific Railway construction in Canada, a period that saw Chinese workers eagerly recruited for cheap labour. Following the construction of the Railway, strict restrictions on Asian immigration, land ownership (Anderson, 1991), wages and access to social services, including healthcare, were put in place (Li, 1998). As Li (1998) states, '[t]he Chinese were considered useful to the development of western Canada but were not desirable citizens' (p. 17). Chinese immigrants were thus quickly racialised as one of the 'lower non-White races', to use Wynter's (1994) terms (p.49). Similar racialisation and social sanctions are echoed for South Asian, West Asian and East Asian individuals in Canada at this time. Early 20th-century anti-Asian protests attest to the increasing racialisation of Asian immigrants by the Canadian populace (Li, 1998: 18), and the creation of Japanese internment camps during the mid-20th century demonstrates the sustained historical marginalisation of Asian individuals in Canada (Oikawa, 2012).

Orientalism is a process of *Othering* (racialising) manifested in

> a style of thought based upon an ontological and epistemological distinction made between 'the Orient' and 'the Occident' [that is reinforced] by making statements about it, authorising views of it, describing it, by teaching it, settling it, ruling over it . . . and having authority over the Orient. (Said, 1978: 10)

While Said's concept of Orientalism was originally speaking about the Middle East, Smith (2003) extends this definition to the Eastern world more generally to highlight Western domination. We see this process of Orientalism further developing in Canada during the early 20th century with policies designed to exert authority and control over Asian individuals by restricting access to equitable social services (including healthcare), land and pay and by appropriating cultural traditions for the amusement and advantage of White Canadians. This created significant health disparities within Asian communities, which can still be seen in Canada today (Veenstra et al., 2019). The 9/11 attacks on the World Trade Center in New York City in 2001 renewed and intensified Orientalism in Canada and the USA, shifting systemic racism and healthcare inequities disproportionately towards Muslim communities (Agnew, 2009; Razack, 2008; Wilkins-Laflamme, 2018).

It is during these imperial movements of scientifically and medically rationalised oppression and colonisation that occupational therapy emerged in Europe, originally within the domain of psychiatry. The advent of *moral treatment* sought to use work and leisure occupations to treat asylum patients, then labelled 'the insane' (Peloquin, 1988: 538). Prior to this time, asylum patients were believed to be irrational (or possessed by evil) and subhuman (Deutsch, 1949). Remedial strategies for asylum patients previously focused on trying to 'fix' or restore reason through violent means (e.g. involuntary restraints, forced lobotomy, isolation, among others). William Tuke, a White wealthy British businessman/philanthropist and adherent Quaker, and Philip Pinel, a French physician, advocated for more humane treatment of asylum patients and are considered the founders of the moral treatment movement (Peloquin, 1988: 538). Healthcare workers in asylums were comprised primarily of White, middle- to upper-class women, oftentimes nuns or those closely affiliated with religious work and traditions (Meyer, 1977 [1922]). This novel approach of usefully occupying and remediating individuals with mental illness (and later World War veterans) made its way to the Americas in the early 20th century and became the profession of occupational therapy (Meyer, 1977 [1922]), with the first recognised occupational therapy program opening in Canada at the University of Toronto in 1918.

Canadian occupational therapists reflected the demographics of their European counterparts, and this continues to hold true today (Canadian Institute for Health Information [CIHI], 2016). Trentham et al. (2007), analysing the shaping of occupational therapy's norms and values, write, '[a]rguably, occupational therapy culture has been largely defined and perhaps dominated by female, Western, middle-class and heterosexual perspectives' (p. 551, referencing Kinébanian and Stomph, 1992). This is echoed in Townsend's 1993 Muriel Driver Lecture in which she calls for a critical shift in professional practices following a long-standing history of compliance with 'dominant community' norms (p. 179).

Occupational therapy in Canada, consequently, was designed by and for White, Western, middle-class, and heterosexual persons. Occupation-based treatments, thus, had to reflect those sanctioned by White, middle-class society in order to reintegrate patients back into regular White society (Kiepek et al., 2018). Occupational therapy helped to reinforce who was seen as the epitome of the *moral, rational* and socially useful human, as well as whom healthcare was inherently intended for. Entwined in a healthcare system steeped in anti-Blackness, anti-Indigenous colonial relations and Orientalism, occupational therapy 'grew up' contributing to, and being shaped by, White supremist and racialising ideologies within an already deeply racialised Canadian healthcare system – a key site for the maintenance and reproduction of these racial relationships.

Today, the occupational therapy profession remains deeply influenced by White supremist ideologies. For example, 'competency' language remains central throughout our Practice Profile (Canadian Association of Occupational Therapists [CAOT], 2012). Paediatric developmental milestones, which form the basis of the majority of our paediatric assessments, remain firmly aligned with traditional Western child-rearing philosophies. Basic materials and supplies frequently used in

musculoskeletal rehabilitation settings, such as Coban wrapping, pressure garments and orthosis material, often reflect Whiteness as the standard or norm (e.g. in the default colour of materials). The profession's focus on achieving balance between self-care, productivity and leisure occupations is a Western ideal that is realistic for few people worldwide, particularly individuals from geographically underserved regions or from low-income backgrounds (typically non-White). Cognitive testing tools, such as the Montreal Cognitive Assessment (MoCA), presume client understanding of Western notions of time and space. The profession's emphasis on achieving independence in daily occupations assumes that independence in daily tasks (a fundamental value in Western societies), rather than collaborative participation in daily tasks (a fundamental value in many predominantly non-White societies), is the desirable outcome of therapy. These are but a few examples of how White supremist practices continue to be supported and reinforced within our profession, often going unquestioned within our predominantly competency-based frameworks.

Part 2 – educating for White supremacy

Liberal multiculturalism

Following the civil rights movement, racism and racial speech became less socially and politically acceptable, prompting a decrease in the use of race and ethnicity language and a rise in culture language in institutional contexts (Ahmed, 2012: 65). This coincided with the discourse of multiculturalism in Canada. Razack (2007) asks, 'How do white people, Westerners in general and Canadians in particular, like to see themselves portrayed? The answer is simple: as heroes' (p. 386). A quick glance at healthcare program mission statements reveals how the 'hero' narrative underpins nearly every program. The concept of cultural competency places the (assumed) White healthcare professional centre-stage as the hero. She is the one who 'graciously' learns about the Other and perfects her skills to be able to treat 'all Others'. The White healthcare worker, thus, becomes the 'authentic knower', the solution to the racism problem in healthcare (Razack, 2007: 379), while the Other '[. . .] becomes the problem to be solved' (Razack, 1995: 70).

This 'graciousness' extends into the metaphor of the White healthcare professional as the 'welcoming host' and the *Other* (non-White individuals) as the guest within healthcare institutions. This implies that those doing the welcoming have a 'natural' place within the institution, including a 'natural' position of authority within it, compared to the Other who is being welcomed (see Ahmed, 2012: 42 for an analysis in education). Cultural competency is, therefore, a new and sustaining way of reproducing institutionalised White supremacy and relations of power between White healthcare providers and racialised Others within healthcare contexts. Whereas cultural competency assumes that a healthcare provider's knowledge of the Other is sufficient to provide culturally appropriate care, critical approaches (discussed in greater detail later in this paper) demand a deeper questioning of the ways in which healthcare systems and practices uphold White supremist ideologies, leading to culturally inappropriate care, and call for concrete actions to be taken. As such, cultural competency should be considered both a product and an extension of historical 'raciological thinking and practices' that place the White healthcare practitioner in a position of power and privilege and the racialised *Other* in one of subordination (Walcott, 2014: 128). DiAngelo (2018) describes this modern-day covert racism as no less harmful in its systemic oppressive effects than overt forms of racism.

Liberal recognition politics

Coulthard (2014) discusses the ways in which liberal politics of recognition, that is, 'the delegated exchanges of recognition from the colonizer to the colonized' (p. 2), reproduce relations of power

and subordination between White individuals and non-White individuals. Cultural competency is formed within a liberal discourse of recognition where the (assumed) White healthcare professional recognises the cultural differences of the Other (presumed non-White) from her position of assumed moral and rational superiority, cultural neutrality, and racelessness (Beagan, 2018). This, for instance, can be illustrated when a White healthcare professional acknowledges the specific healthcare access challenges that an Indigenous residential school survivor living on- or off-reserve may face without understanding the way that their position as a White healthcare professional could trigger mistrust and fear from their client due to historical and ongoing traumas inflicted on Indigenous communities by White healthcare professionals. Dei (1996) contests this position and argues that '[w]e must talk about White as a colour and challenge the assumed racelessness of Whites as a privilege afforded only to Whites' (p. 49). Liberal politics of recognition, which form the basis of cultural competency, 'equalise [all] oppressions [and] promote a colour-blind mentality that eclipses the significance of institutionalised racism' (Abrams & Moio, 2009: 245), whereby all groups are simply, equally, Other. This masks the unique healthcare challenges and processes that produce inequities for different racialised groups or individuals within those groups, and thereby the possible solutions for healthcare access and healing. For example, cultural competency 'ignores [Indigenous] claims to sovereignty by rendering [Indigenous] peoples as ethnic groups suffering racial discrimination rather than as nations undergoing colonization' (Smith, 2010: 1).

A pause is warranted here to acknowledge how non-White healthcare students and professionals fit in this narrative of liberal recognition politics. Healthcare programs have bolstered recruitment and retention efforts in order to meet increased demands for a diverse and culturally competent healthcare workforce (see Call to Action 23 of the Truth and Reconciliation Commission of Canada, 2015b) and expected diversity benchmarks in higher education. This, as Ahmed (2012) demonstrates in an earlier ethnography, is often done in an inclusion-as-checklist manner, where diversity is celebrated and intentionally included, but little to no changes to healthcare education frameworks, paradigms and pedagogical approaches are implemented that reflect the diverse ways of knowing, being and healing of these increasingly diverse student cohorts. Healthcare service delivery models, thus, remain inherently White while reproducing relations of power and subordination between White individuals and non-White individuals within healthcare. By using cultural competency as a derivative of liberal recognition politics, healthcare and educational institutions become 'absolved' from having to make any meaningful changes to the way in which they are fundamentally organised, reproducing and sustaining a White supremacy legacy.

Liberal capitalism

Cultural competency discourses reify Harris' (1993) concept of 'whiteness as property', that is, the presumed inherent right of White individuals to own, to possess, as well as to own and possess that which belongs to the Other. Cultural competency assumes a certain 'right of access' to the cultural identity of the Other and to position herself as the authentic owner/knower (Razack, 2007: 379). It is a commodity that can simply be taken. For example, current pedagogical approaches in healthcare education frequently focus on service-learning projects and/or international fieldwork experiences that rely on 'exposure' to non-White Others, usually from underserved countries or communities, to increase student cultural competency (Grenier et al., forthcoming). Such projects capitalise on the subordinated state of racialised Others within healthcare contexts to produce an educational object *for* the experience of the healthcare student. This is rarely done within a model of reciprocity and inculcates healthcare students into White supremist ideologies of 'right of access'; the educational experience becomes a form of property whose access is reserved only for the White healthcare student (for uncritical examples, see Grenier et al., forthcoming).

Conclusion

Despite the Truth and Reconciliation Commission's extensive documentation and multiple calls for a critical and anti-oppressive understanding of cultural safety, rehabilitation professionals and healthcare professions continue to fall back on the paradigm of cultural competency. For example, five recent Calls to Action for physiotherapists in Canada, though well-intentioned, fall squarely within a neoliberal, individualistic cultural competency discourse (e.g. suggests reading the Truth and Reconciliation Commission report, attend cultural sensitivity training, and so forth) (Gasparelli et al., 2016). Contemporary critical race scholars argue for a radical shift in the way knowledge is structured in education – a shift that dismantles hegemonic knowledge structures that continue to maintain White supremacy and the oppression of racialised persons (Dei, 2017; Ladson-Billings and Tate, 1995; Tuhiwai-Smith, 2012; Wynter, 1994). Currently, there is increasing support for critical and structural frameworks within education and healthcare contexts, which support this radical shift in knowledge structures (Battiste, 2017; Dei, 2017; Smith, 2010).

As part of a collaborative effort between White and Indigenous occupational therapists, Restall et al. (2016) argued that we first need to shift our units of analysis from individuals to the social and political systems that create injustice, question the underlying assumptions of our theories and concepts, rebuild our theories and concepts to reflect new ways of knowing, and become political activists. This means we must first begin by ridding healthcare education of the liberal concept of cultural competency, which continues to be shaped by and reproduce White supremacy in healthcare contexts. We must also radically shift our professional frameworks toward critical and structural ones. In occupational therapy, this means taking specific actions to dismantle and rebuild some of our 'profession pillars'. For example, the CAOT's (2014) Joint Position Statement on Diversity, which continues to re-employ problematic neoliberal language and approaches, requires a radical re-writing using critical and structural frameworks that target specific social and political systems, specific profession frameworks and models, and specific pedagogical approaches as its units of analysis, rather than individuals (Gerlach et al., 2017). For example, recommendation 1 for educators and researchers of the 2014 CAOT's Joint Position Statement on Diversity states,

> Educators, preceptors and mentors in occupational therapy should critically examine the approaches to diversity being conveyed to learners, to ensure they attend to biases embedded in the profession and in professional education, power relations between clients and therapists and within the profession, and connections between individual experiences and broader social power relations. (p. 1)

While this recommendation appears to suggest a systems-level approach, by using language such as 'critically examine' and 'attending to biases', it is implied that as long as we recognise the biases inherent within our pedagogical and professional approaches, there is no need to make any real changes to the status quo. Again, this places the burden on individuals to 'fix the problem', rather than on institutions (i.e. professional associations and federations), to radically dismantle and rebuild the 'biased' frameworks and models on which the profession has relied for over a century. This recommendation also focuses on the formal curriculum/pedagogical practices and ignores the informal/hidden curriculum that continues to support White supremacy within the occupational therapy profession (i.e. faculty hiring and student admission criteria). Finally, by using language such as 'biases imbedded in the profession and in professional education', White supremacy as the root problem continues to remain unnamed, further supporting its maintenance within the profession.

Suggested throughout this paper is a shift away from cultural competency frameworks towards critical and structural ones in healthcare education programs. First, an explicit naming of White supremacy as the root problem contributing to ongoing healthcare disparities must be made in all position statements, accreditation standards, professional textbooks, and so on. Second, needed is a radical dismantling and rebuilding of key professional frameworks and models that works to eliminate White supremacy as the default position. This process must be undertaken by stakeholders who reflect the diversity of the population the healthcare profession should be able to serve equitably. Finally, health professions curricula (formal and informal) must equip students with the skills needed to question, challenge and change the status quo when the status quo is recognised to be a source of oppression.

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Notes

1. The Truth and Reconciliation Report is a summary report published in 2015 by the Truth and Reconciliation Commission of Canada outlining 94 calls to action to redress the legacy of residential schools and advance the process of reconciliation between Indigenous nations and Canada.
2. Some Indigenous peoples refer to the lands now known as North America as Turtle Island. This name comes from oral histories of Indigenous creation stories.

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