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ORIGINAL ARTICLE

Multiculturalism and the Construction of Ethnic Identities in Labour and Health Practices: Avoiding the Culturalistic Fallacy in Applied Research

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Abstract In applied health care research, an essentialised notion of culture is often used when studying ethnic disparities in health and health care access between the majority populations of Western countries and migrants, with ethnic backgrounds that differ from majority population. This notion of culture, however, is considered highly problematic in anthropology and ethnic studies. Therefore, in our research on Dutch illness certification practices, we employed a dynamic conceptualisation of culture. Our research shows that, in practice, when clients fail to meet the implicit norms of this practice, doctors ascribe this nonconformity differently when the client is a migrant than when he or she is a Dutch client. More specifically, when migrants fail to meet the norms, doctors are inclined to automatically ascribe this nonconformity to the assumed cultural background of the client. Consequently, these doctors feel less able to use the tools they normally use to coach their clients. This, in turn, results in more problematic and longer reintegration trajectories for migrants in comparison to Dutch clients in similar circumstances. In other words, framing the problems of migrants in terms of culture results in greater sick leave rates for migrants than for Dutch people. Clearly, culturalistic perspectives on ethnic differences have negative consequences. We therefore implore the application of a dynamic notion of culture in applied research.

Keywords Ethnicity · Illness certification · Labour and health practices · Multiculturalism · Practical rationality

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Introduction

In the past decade, increasingly more attention has been paid to interculturalisation in health care policy in Europe [2, 5, 9, 17]. This extra attention has been provided in response to problems experienced by health care providers regarding health care delivery to migrants that are part of ethnic minority groups,[1] on the one hand, and political concern about the poorer health status of migrants in Western countries when compared to majority population, on the other.

In an attempt to remedy this situation, in 1999, the Dutch Council for Health Care (RVZ) provided recommendations concerning intercultural management, education, expertise-centres and counselling [16]. Consequently, many projects and experiments in health care delivery practice, as well as in research on these practices, were initiated in an attempt to accommodate the diversity of the population [11, 27]. Most projects developed employ different programs or methods for different cultural groups in the hope that the programs will then fit the 'culture' of the group in question. Furthermore, health care providers are often taught about cultural norms and values. The assumption is that knowledge of the ways in which migrants deviate from the dominant Dutch culture in terms of traits, behaviours and beliefs enables care providers to provide better care for these migrants.

The 'interculturalisation' of Dutch health care delivery is, in other words, based on so-called 'cultural' differences between ethnic groups. As in other Western countries, the cultural and lifestyle paradigm is the dominant paradigm for explaining disparities in health between different ethnic groups [15]. In these cultural and lifestyle explanatory paradigms, the poorer health status of specific ethnic groups, the so-called ethnic minorities, is the result, either directly or indirectly, of these groups' specific traits, customs, beliefs and norms. Directly because their lifestyle habits, that are supposedly culturally determined, are unhealthier than those of the various majority populations of Western countries. Indirectly because their access to health care services is considered to be hindered by their deviated cultural habits and beliefs.

The cultural and lifestyle paradigms were initially assumed to be an improvement compared to the biological and genetic perspectives on ethnicity, given that the latter utilise an essentialist notion of ethnicity (race) and therefore are considered to be racist. However, nowadays, anthropologists criticise the cultural paradigm because it simply substitutes race with a newer essentialised notion of culture [15].

> Culturalistic discourse presents a culture as existing more or less independently of everyday reality, as something following its own laws of development. It reifies culture, portraying it as a thing or approaching it as an organism or a collective individual. [30]

In the culturalistic paradigm, culture is conceptualised as a homogeneous and sharply bounded entity that is transmitted from generation to generation with very

[1] In The Netherlands, as in other European countries, the terms migrants and ethic minority groups are used interchangeable and refer to groups of migrants that are of non-western origin. In The Netherlands the major groups are Turkish, Moroccan, Surinamese and Antilleans. In this article we use the term migrant to refer to these ethnic minority migrants.

little change. In anthropology and ethnic studies, this conceptualisation is considered to be highly problematic, and is therefore called the '*culturalistic fallacy*' [30].

In the health care (research) projects that followed from the RVZ recommendations, we indeed see a reified notion of culture. These projects try to tune into the specific cultural norms of different groups, and therefore focus on the assumed specific culturally determined illness behaviour of migrants. For instance, many assume that migrants think about illness in absolute terms: people are ill or not ill and, if one is ill, one is, in fact, totally incapacitated. Examples are given in which a migrant feels unable to work at all due to stomach problems. In another example a migrant is reported to claim that because he uses medication he is unhealthy. Consequently he feels unable to work because he needs his energy to recover [21]. Another example is the idea that psychological disorders are taboo in migrant groups and therefore result in somatisation. This reflects the notion that migrants medicalise their problems and is reinforced by migrant clients claiming that there is medicine for every problem, and refusing to accept instances where no physical cause can be found. A well known example is lower back pain. Migrants wouldn't stop asking for more medical examinations and do not accept socio-psychological explanations for their pain [8, 21]. Furthermore, it is thought that migrants' limited command of the Dutch language and deviating customs in their home countries makes it difficult for them to understand how the Dutch health care system works [8, 20, 21, 26].

These projects in particular, and applied health care research projects in general, have been criticised for employing an essentialised notion of culture. First and foremost, the problems with migrants experienced by professionals are often ascribed to the (deviated) 'culture' of these minorities, without even considering how someone from the majority group would behave in a similar situation. In these cases, researchers rarely analyse the relationship between the problem and the assumed cultural belief nor do they explore whether the individual migrant actually adheres to these beliefs [13, 18]. In addition to criticism rooted in doubts about the factual adequacy of the research, these projects are also criticised on a normative level. Firstly, they lend themselves to stereotyping and generalising, while the actual behaviour and ways of thinking within migrant groups are highly variable [18, 19, 25]. Furthermore, they reduce the plural identities of (migrant) persons to their assumed ethnic identity only and reinforce the 'us versus them' contrast. Lastly, they tend to characterise migrants as 'abnormal' and therefore assign responsibility for difficulties to the migrant client [28, 29].

In anthropology and ethnic studies, the essentialised notions of culture and ethnicity are rejected in favour of a more dynamic and non-essentialised conceptualisation. Culture, it is argued, is not a thing, not something that people 'have' or something to which people 'belong'. "Cultures are, rather, complex repertoires which people experience, use, learn and 'do' in their daily lives, within which they construct an ongoing sense of themselves and an understanding of their fellows" [7]. Culture is, therefore, not an entity that encompasses us and thereby determines or influences our behaviour. Rather, culture is an outcome of interaction and is therefore constantly redefined and changed by interaction processes [7].

Where culture refer to repertoires of action in which norms and values are enacted, ethnicity refers to a shared belief of members of an ethnic group that they are of common descent or to a common descent ascribed to a particular group by outsiders [7]. Ethnic identification, therefore, is not so much the cause of collective action and group formation, but the consequence of it. People see themselves as belonging together and therefore act together. Cultural traits are used to define the boundaries of ethnic group formation. In the context of this perspective, ethnic groups cannot be identified by their shared 'culture'. In fact, it is quite the opposite: "Shared culture is best understood as generated in and by processes of ethnic boundary maintenance" [7]. Consequently, one's ethnic identity is considered to be constructed in social interaction. It is not fixed, but defined by ascription in a given situation, both by members of the ethnic group in question and by outsiders. "Ethnicity is transactional, shifting and essentially impermanent" [7].

Anthropology and ethnic studies demonstrate broad consensus regarding this de-essentialising conceptualisation of ethnicity and culture [1]. Empirical studies using this conceptualisation, however, mainly concentrate on situations and practices in which ethnic group identification processes are primary, and often politically motivated, actions. The main focus is then placed on the way in which migrants settle themselves in their 'new' environments and integrate into society. Because integration and social cohesion are main topics, empirical studies using a dynamic conceptualisation of ethnicity often focus on education, labour market participation, social welfare (participation) and social mobility [1, 3, 31]. Furthermore these studies focus on self definition of migrant groups and study how cultural traits are used by migrant groups to define an ethnic identity. Health care practices in general, and labour and health practices in particular, have received much less attention. In these practices, professionals meet clients in a one-to-one setting. Processes of group identification or categorisation are therefore rarely the main objective of research in this field. Further, when health care practices are investigated, a culturalistic perspective is the norm and culture and ethnicity are therefore reified. In most studies, problems with migrants are ascribed to their 'culture' in the absence of comparative data or a comparative perspective. In our research, we endeavour to fill this gap by employing a dynamic conceptualisation of culture and ethnicity and a comparative perspective in the study of health care delivery practices and migrant people. We will investigate whether professionals refer to cultural traits of clients to define them as 'others' and thus construct ethnic identities for their clients.

Because ethnicity is not a clear characteristic of an individual or group of individuals but rather the result of an interaction process that may or may not impact those involved, we decided to focus specifically on interaction processes. In this article, we present a study on the construction of ethnic identities in Dutch illness certification practices for sick leave [13]. In the next section, we discuss the study's design and demonstrate how we used dynamic conceptualisations of culture and ethnicity. In the sections that follow, our empirical findings are presented. Finally, we conclude by discussing the usefulness of employing dynamic conceptualisations of culture and ethnicity in applied health care research.

Analysing Practical Rationality and Construction of Ethnicity

The aim of our study was to determine whether the illness certification of migrants differs from the illness certification of 'originally' Dutch clients. Because we consider ethnicity to be a dynamic phenomenon that is constructed through interactions, we chose to focus on the practical actions of professionals and thereby investigate whether or not ethnic identities are constructed in interaction between professionals and clients and, if so, when and how. Further, in order to determine if migrants are treated differently than Dutch clients, we had to identify which clients are migrants and which are not. Therefore, we recorded whether a client could be identified as a migrant based on his/her name, appearance, and/or ability to speak Dutch.[2]

In order to investigate practical action, we considered illness certification to be a practice driven by a 'practical rationality' [10, 12, 14, 32]. Practical rationality refers to the 'matter of course' and implicit normative nature of agency. In this conceptualisation of practice, it is assumed that people's actions in a certain setting are not determined by a formal rationality or by explicit rules, in which it is assumed that agency is derived from formal rules or principles [10, 22]. Practical rationality, rather, refers to the notion that human action is guided by an often implicit, routinely and contextually determined view of what is appropriate in a certain situation. This does not mean that (professional) action in practice is arbitrary. However, it does mean that the rationale is implicit and not fully explicable in formal rules or abstract regularities. The rationale of an action can only be explained and judged in relation to the specific context of that action. It is knowing how to handle without being able to explain exactly why. Nevertheless, choices and judgements are made in practical action, and therefore agency is normative in character. This normative nature, however, often remains implicit because practical action and ordering have become self-evident.

This practical rationality thus describes the normal/regular order in illness certification practice. It explicates the 'matter of course' way professionals work. It shows what kind of choices and judgements are made, what it actually means to be incapable of work and what it means to be a doctor or a client. Practical rationality also entails the implicit expectations professionals have of their clients. These expectations are embedded in practice. If clients meet these expectations, interactions should go smoothly and implicit expectations remain invisible. These clients are what is termed 'protoprofessionalised' [4]. However, when clients follow their own routines and thus react in accordance with their own 'matter of course', and if these reactions do not meet the doctor's expectations, normal work procedures will be disturbed which then results in more or less conflicting or stumbling situations. In these cases, implicit expectations should become visible.

[2] In order to investigate our hypothesis that ethnic identities are only constructed in cases in which clients do not comply to implicit norms of illness certification criteria, we need a criterion to identify whether clients could be identified as member of an ethnic minority group. In The Netherlands race or country of origins is not registered. Therefore we used everyday common sense impressions as language, appearance name etc.

Our hypothesis was that ethnic identities are constructed in situations where clients fail to meet implicit expectations of the practical rationality of illness certification practice. In order to investigate the construction of ethnic identities, we studied whether reference is made to ethnicity or culture and, if so, when and how. In other words, we went back and looked at whether ethnicity was constructed and, if so, we studied the kinds of constructions or definitions of ethnicity that were made. Furthermore, in cases where ethnic identities were constructed, we investigated whether the way interaction processes developed differed from the regular order or 'normal' practical rationality in illness certification practice. Essentially, we endeavoured to reveal the consequences constructing ethnic identities have for care delivery by comparing them with care delivery processes offered to non-migrant clients.

In The Netherlands, illness certification is done by physicians employed by so-called 'arbodiensten' (health and safety services).[3] For this study, we followed six physicians employed by different 'arbo' services for 2 weeks each. The main task of these physicians is to advise employers on whether ill-reported employees are incapable of fulfilling their function at work and, if so, whether these employees are capable of fulfilling another function in the workplace. In addition to providing illness certification, these physicians are also responsible for supervising ill-reported employees in their return-to-work trajectories. These physicians do not have curative of treating responsibility. Approximately 2 weeks after reporting ill, Dutch employees are normally invited for an initial consultation with an 'arbo' physician. Depending on the employee's specific situation and complaints, follow-up appointments can be made. Apart from a visit to the 'arbo' physician, clients often went to other physicians for the treatment as well. 'Arbo' physicians, however, rely in their work primarily on the information provided by clients themselves. Normally they do not have prior knowledge about the client and his or her medical condition. If necessary they can obtain the information from the physicians or therapists that are responsible for the treatment, but only if the client gives his/her consent. In practice they rarely do, and only if clients suffer from rare diseases or when the client's claim that he or she is unable to work is not explicable with standard medical knowledge. In total, we observed 250 consultations between 'arbo' doctors and clients. Some of them were first encounters while others were follow-up appointments. In total, the appointments observed covered all different stages of the reintegration process.

During the participant observations, we made field notes of the encounters between physicians and clients and of physicians' comments before and after these encounters. We also interviewed the doctors about the decision-making process. For our background understanding, we followed the doctors in other situations as well, namely in their professional contact with others and in meetings with other experts and employers. However, these meetings were not systematically analysed.

[3] Arbo stands for Arbeidsomstandigheden (work circumstances); these services advise employers in health and safety issues and the physicians employed by these services do illness certification.

In accordance with ethnographic methodology [6, 24], we reconstructed the 'practical rationality' of sickness certifying practices in our analyses. First, we used inductive content analysis, as in grounded theory [23], to identify, code and categorise primary patterns in the ordering of the encounters. At this stage, we identified the themes that were discussed in the encounters and whether there was a specific structure or order in the way these themes were dealt with. In the second stage, we refined patterns by focussing on the way doctors reacted to the answers of clients. In particular, we looked at which answers were taken for granted and which were problematic, which responses were considered satisfactory and which were seen as insufficient. We also explored how some client reactions became 'self evident' while others were more 'out of line'. In the third stage, we compared our findings with the comments of the doctors in an attempt to confirm the patterns we found and deepen our understanding of the practical rationality of certifying practices. We used these comments not so much as literal explanations, but rather as signs that enable a better understanding of what doctors experience as 'normal' procedures or cases and what they consider to be exceptional. Therefore, we focused on the comments they made in regard to the clients and the consultations, the kind of things they found remarkable, the situations they described as difficult, and the cases they found to be exemplary, etc.

After reconstructing the practical rationality using our observations, we selected the cases in which doctors made reference to culture, thus the cases in which doctors explicitly construct ethnic identities. We studied the ways in which they referred to culture and thus the ethnic definitions they made. We also looked for cases in which clients did not meet expectations but no explicit ethnic identities were constructed. We then compared the processes in the return-to-work trajectories of both kinds of cases. Similarly to our reconstruction of the practical rationality, we used the physicians' comments to confirm our analysis and to deepen our understanding of their actions.

In the next section, we summarise the practical rationality of illness certification practice. Subsequently, we report our analyses of what happens when clients fail to meet the implicit expectations that are embedded in the practical rationality. Our focus on these situations is rooted in our expectation that differences between majority Dutch and migrant clients will occur in these situations. Following our analyses, we describe the various kinds of definitions of ethnicity and the consequences these definitions have for return-to-work processes.

The Practical Rationality of Illness Certification

The task of Dutch 'arbo' physicians is to assess whether the employee's health complaints are serious enough to legitimate sick leave and, if so, to what extent and for how long the employee can take sick leave. Additionally, they assist sick employees in their return to work trajectories. These tasks are interwoven in consultations and are performed during all encounters with the sick employee. 'Arbo' physicians must rely on their clients for information about their medical condition as this information is not provided by others such as the treating

physician. The practical rationality of this practice entails the following four components: (a) determining the diagnosis; (b) encouraging the client to take initiative; (c) assessing progress and ensuring that the process continues; and (d) determining if a lack of competences is present [12, 13].

Providing Information

In every case, the 'arbo' physician first attempts to understand the client's complaints. In doing so, they endeavour to determine if the complaints can be explained by a clear medical diagnosis as this helps them to assess the plausibility and severity of the complaints. It also enables them to establish whether it is indeed impossible for the client to his/her normal work tasks and approximately how long it will take the client to recover.

Analytically, two situations can be distinguished. In the first situation, the medical diagnosis is a rather well defined medical condition, for instance a broken leg, cancer or a hernia. In these cases, clients are supposed to provide the medical diagnosis to the 'arbo' physician directly or, alternatively, to provide a description of the symptoms so that the physician can reconstruct the diagnosis. These cases are usually considered easy cases because most clients are able to pass on clear-cut information to the doctor without any problems. They are also considered easy because the symptoms are well defined thus enabling the 'arbo' physician to easily determine the client's work limitations and estimated recovery time.

In the second situation, the patient has relatively vague or diffuse complaints. In these situations, determining whether the employee's health complaints prevent that employee from working is difficult because accurate measures and criteria are lacking [14]. 'Arbo' physicians are therefore unable to assess the plausibility and severity of these kinds of health complaints in purely medical terms. Consequently, they adopt a different strategy, whereby they coach and supervise clients in their return to work trajectory and determine, during that process, the plausibility of the complaints by observing the way in which clients behave and react to this trajectory.

Taking Initiative

'Arbo' physicians expect their clients to take initiative on two matters, namely recovering from their health complaints and returning to work. With respect to the first, they ask clients what they do or have done in order to recover from their health complaints. What clients do is not particularly important as long as they do something. Activity is interpreted as taking responsibility for the situation. Going and seeing the doctor is a primary action. Additionally, things like taking care of yourself or creating structure in your daily activities when suffering from psychological difficulties or exercising when complaints related to back and shoulder problems are present are also considered proper behaviour.

Regarding initiatives to return to work, 'arbo' physicians ask their clients what they do or have done to promote reintegration at work. A primary action expected of the clients is that they have contact with their supervisor. Additionally, they are

asked to discuss with the supervisor whether their specific complaints hinder them in doing their specific job tasks and, if so, whether they can do at least some part of their job tasks or, alternatively, different tasks altogether. Lastly, they are asked by the 'arbo' physician to make plans to return, at least partially, to work and eventually follow through by actually returning to work.

Exhibiting Progress

Regarding progress, the implicit expectation is that health complaints will eventually decrease and work can be partially or wholly resumed. When clients make progress and the health complaints do decrease, the coaching trajectory goes smoothly and doctors assume that clients do experience the health complaints as they claim they do. By showing responsible behaviour and initiating work resumption clients demonstrate their apparent 'trustworthiness'. This implies that they are also telling the truth about their complaints, or at least that is the implicit assumption.

Lack of Competences

However, when clients fail to make progress and do not take initiatives to improve their situation, this does not necessarily mean that their complaints are implausible or unjustified. In fact, when clients do not show progress, 'arbo' doctors will first look for an explanation. Delay can be due to medical complications but also to social circumstances. A client's lack of initiative may also be attributable to particular social circumstances. At the same time, it may also be caused by the client's lack of competences. When an 'arbo' doctor asks his or her client to take initiative, they assume that the client is able to analyse his/her own situation and reflect on his/her own behaviour. However, not all clients are capable of doing so. Consequently, these clients cannot be blamed for not taking initiative.

When a client does not take initiative and it becomes apparent that he or see cannot be blamed for it, 'arbo' doctors utilise a second set of 'strategies'. They first try to gain insight regarding the client's social circumstances and personality by asking the client about his or her personal circumstances. In doing this, the 'arbo' doctor attempts to seek out potential hidden motives. Further, using impressions of the client acquired during the consultations, the 'arbo' doctor will typify the client in experienced-based categories of 'personalities'. These typologies are then used to determine ways in which the client can be influenced in the desired direction. This strategy is discussed at length in the next section.

Avoiding Conflicts

In some cases, 'arbo' doctors conclude that it is not the social circumstances or lack of competences that is responsible for the lack of progress and initiative, but rather the client. Most 'arbo' doctors then hesitate in telling these clients that their complaints are ungrounded and that they should go back to work. This hesitation is

caused by their conviction that conflicts with clients generate more problems in the long run, as these clients will either report sick again in the very near future or appeal the decision. 'Arbo' doctors often believe that clients are most likely to win these appeals and that this further inhibits return to work.

Ethnicity and Illness Certification

The practical rationality of illness certification demonstrates that clients are expected to conform to the implicit norms of providing clear information, being reflective, taking initiative, showing motivation and exhibiting progress. When clients behave in accordance with these norms, coaching goes smoothly. We observed this in encounters between 'arbo' doctors and majority Dutch clients as well as in encounters between 'arbo' doctors and clients that can be classified as migrants based on their physical appearance, unfamiliar name, or the unusual way of speaking Dutch. We also observed that when coaching went well, no reference was made to the client's ethnic background or culture. However, in cases where the process stagnated because the client did not act in accordance with the norms, we observed something very different. These situations are discussed extensively below.

Difficulties in Providing Information

The first implicit norm is that the client provides clear-cut information regarding his or her health complaint(s) and medical treatment, especially when the complaints can lead to a well-defined medical diagnosis. However, we observed that not all clients fully understand and are able to correctly convey what their treating doctors had told them about their illness and subsequent treatment. As mentioned earlier, 'arbo' doctors often explain these kinds of situations by referring to the patient's lack of competences, personality or social circumstances.

Man, Dutch, 39 years old[4]
Sickness absence: six months
Ad: How is your back?
Cl: To be honest, it is still the same. I went to the doctor, and if this kind of radiating pain persists, I will need an MRI scan. He also said that they can operate if I can no longer handle the pain. I found that really strange, that he said that.
Ad: The main problem is then radiating pain. Where exactly?
Cl: (pointing) From my back to my thigh. The pain I initially had is incomparable to the pain now.
Ad: He (the doctor) wants to see what the therapy does and then depending on the pain, operate?

[4] 'Ad' stands for 'arbo' doctor, 'Cl' for client, and 'R' for researcher. In these examples we refer to clients of the majority populations with 'Dutch' in contrast to 'migrants'. We consistently refer to doctors (male and female) in the masculine form.

Cl: Yes, I think that's really odd, how he said that, depending on the pain.
Ad: He didn't tell you anything more about the operation?
Cl: Yes, that there is a 56% risk that the operation will fail and that I will end up in a wheelchair.
Ad: Well indeed, operating is risky, and that's something to consider. If the pain becomes really unbearable, you might choose to take that risk.
Later:
R: What exactly was his health problem?
Ad: Problems with his back, due to constriction in his spinal column.
R: Is an operation that risky?
Ad: Yes, but I cannot imagine the neurologist saying "your chances of ending up in a wheelchair are 56%"…however, on the other hand, by saying it that way, there is no room for misunderstanding. That's typical of this client, that he thinks that it's strange that he said that he will decide whether or not to operate based on the pain. He didn't understand the doctor's argumentation. Later on, I understand what he has said to him.

Clearly, this client did not fully understand his neurologist and therefore it was difficult for the 'arbo' physician to reconstruct what the neurologist actually said. However, after some further discussion, the situation became clear to the physician. He explained the client's lack of understanding as 'that's typical for this client…' thereby implying that the client could not be blamed for this.

While the client in this example is a Dutch man, the greater majority of the difficulties in providing information about diagnosis and treatment we observed occurred with migrant clients.

Man, migrant, 52 years old
The receptionist informs the physician that the man is in the waiting room. He does not have an appointment. Therefore, the physician does not know when he stopped working.
Cl: It is a bit difficult, it troubles me, my heart beat was irregular, here, and I couldn't move this side at all, now I can move it a bit.
Ad: Can you tell me what's going on with you?
Cl: Yes, I just don't feel well, only sleeping and I cannot move that side, just tired and heavy, you know, not well. I sleep and then I wake up and no well. Then still working. It was nightshift. 3 weeks ago also. Suddenly felt down, just not well. I felt all strange. In the nightshift, they say: go home. I say: no I stay. Later, my boss brought me home. He say: not possible. I just sleep and go to the hospital from three to five. Everything checked with, what is the name…scanner. He give me medicines. He just say: wait at home and then come get pictures. Later I go back from ten till five exactly. Everything done, with measuring, blood, neck. Specialist say: everything ok, you can go to another specialist.
Ad: So your heart is ok. The specialist told you that?
This man brought a lot with him including paperwork and various drugs.
Ad: You take the pills properly?
Cl: Yes. And these also. But I regret, because I asked: continue or stop. I don't know. So, what do I do?

The doctor advises the client to stop taking one of the prescriptions because it is uncommon to take it in combination with another drug the client has.
Cl: Tomorrow I have to get a needle.
Ad: (speaks louder) Did one of the specialists tell you what is going on?
Cl: Yes. They say: I don't know how you call it. (shows a letter)
Ad: Ok. That's what I was thinking. (louder) Do you feel better now?
Cl: (a bit louder) Yes. I do, but still heavy. But I came here to see what is going on. Yesterday I felt a tingling.
Ad: Pain?
Cl: No. No pain. A kind of sleep-heavy feeling. I just moved but it feels heavy.
An examination followed
Ad: I will explain what is happening. You have heart beat irregularities, therefore you don't get enough oxygen and that's why you couldn't move properly, because it can be paralyzing. You have to keep calm for a while and then…
Cl: I have to go to the hospital on the 6th of November.
Ad: Is that for treatment?
Cl: Yes. They are going to look because something is wrong, and if it comes back.
Ad: Let's make an appointment for the 8th of November
Afterwards:
Ad: Well, you see with migrants, the consultation is often chaotic. It is difficult to structure the conversation. But this is a good soul, a bit submissive. He has probably never been ill before. I also appreciate that they bring along everything: paperwork, drugs. Migrants do that quite often.

The client has to return in two weeks because the 'arbo' physician wants to see how he feels and because there may be some new information: 'You don't send this client back to work. He has to recover first'.

Similarly to the previous case, this client did not provide the 'arbo' doctor with the right information. However, in the previous case, the doctor attempted to explain why the client did not succeed in providing him with clear-cut information while, in this case, the doctor did not do that. Rather, he relied on characteristics and behaviour he assumed to be typical for migrants, not typical for him as a specific client but rather typical for *them* as a whole group of people.

Too Little Initiative

When clients present with relatively vague complaints, the implicit norms of illness certification assume that clients have insight regarding their health complaints and also that clients will take initiative to ensure progress. If clients fail to make progress, doctors tend to gather information about the client's social circumstances and personality. With this information, they then attempt to establish a reason for non-compliance with the implicit expectations.

Man, Dutch, 33 years old
Sickness absence: four weeks; accompanied by his wife

Ad: You're walking better know, aren't you?
Cl: I don't trust my physiotherapist.
Ad: You don't trust your physiotherapist! For heaven's sake, why not?
Cl: Well I have been at it for three months now and I see no improvement…
Ad: And what does one do in such a case?
Cl: Uhm…. Go back to the GP?
Ad: Correct! And I suppose you went there yesterday of course…
Cl: Uhm, eh no, not yet.
Ad: When this happens, you have to see your GP! I'm only a supervisor
…
Do you get enough rest? You can start working but you can't do more than what we decided on. That is YOUR responsibility!
Cl: But that's hard, I…
Ad: What is written on your forehead when you look in the mirror? Crazy?
Cl: No, but I tend to get too involved in my work and…
Ad: Oh dear… I'll write a note to your employer explaining your limitations. Talk to him about it to see what can be done. You're going to call me and tell me what the GP said once you see him, aren't you? You're not going to wait until the next consultation, are you? Please, don't do more than what we decided on! Otherwise the whole thing will be worthless. We can all do our best for you, but you have to take responsibility for setting your own boundaries. You get that?
Afterwards the Ad remarked: "Another DNIG-type! (meaning: 'did not invent gunpowder'; a Dutch saying for people who are not very quick).

Evidently, this client failed to go back to his GP when he found physiotherapy to be ineffective. Additionally, he appeared to struggle with following the 'arbo' doctor's recommendation regarding his workload. He did not demonstrate initiative and because he lacked assertiveness, a successful return to work is unlikely. Nonetheless, the 'arbo' doctor did not dismiss the client and send him back to work immediately. Instead, he concluded that the client is not very quick. Since a lack of intelligence cannot be considered the fault of the client, no doubts regarding the plausibility of the client's complaints arose. In the following case, we see quite the opposite.

Man, Dutch, 55 years old
Sickness absence: almost a year; possible burn-out
Before the client is called in, the Ad remarks: This man is a little bit of a 'kruidje-roer-mij-niet' (meaning: 'touch-me-not'; a Dutch saying for someone who is easily offended). He would prefer to spend his days in a glass cage. Reintegration is a slow process for him. He now wants to wait for a second opinion. That takes a long time.
Ad: Did the GAK (institute to which clients can turn to for a second opinion when they disagree with their own Ad) call you already?
Cl: Not yet.
Ad: It doesn't make sense to wait for them….
Cl: I saw doctor X and Y. They have strongly advised me not to increase my working hours.

Ad: When was that?
Cl: March.
Ad: But that quite a while ago.
Cl: Yes, but extending to 6 hours a day is far too much.
Ad: Yes, but you have been at 4 × 5.5 hours a week for quite some time now, and…
Cl: Yes, but my dear doctor, the problem is that I do not feel better! I'm really exhausted after 5.5 hours.
Ad: If you try, you'll get used to it. Athletes are also tired after training sessions. But it helps them to reach beyond their limits…
Cl: That's easy for you to say that, but my body is really at its limit. It will never be the same.
Ad: But can't you try?
Cl: Why?
Ad: Because you need to push your limits.
Cl: In that case, I tell you: I will work less! You don't know me. The GAK has advised me to take it easy.
Ad: Your last appointment with the GAK is more than half a year ago… If 4 × 6 hours is too much then maybe Wednesday is ok, 5 × 5.5 hours…
Cl: No!!!. I need that day to rest.
More attempts by the Ad to convince the client that he should try to work more.
Cl: It is still very difficult.
Ad: These things are always difficult, but if…
Cl: You don't take me seriously!
Ad: When you make progress, you will also feel better. Try and we will meet again on the 29th.
Cl: I am not happy!

Clearly, the 'arbo' doctor saw this client is a typical "kruidje-roer-mij-niet". The doctor found him a spoiled man who should know better and not continue to focus on his limitations. Additionally, the doctor attempted on multiple occasions to convince the client to extend his working hours.

The analysis shows that in cases like the one reported above, doctors endeavour to determine whether a client can be held responsible for his or her own lack of progress by referring to typologies and by classifying clients into certain categories of 'typical kinds of people'. In our material, we came across many 'types'. There was the typical farmer's wife, the typical road worker, the typical 'spoiled-adolescent-who-needs-a-kick-in- the-ass', and many others.

Interestingly, in consultations with migrant clients, we observed a very different process.

Man, migrant, 45 years old
Sickness absence: four months
Ad said before the consultation: This man has shoulder complaints and also suffers from lower back pain. He is convinced something is wrong. He insisted on seeing an orthopaedist. I doubt there is really something wrong. Last time I saw

him, I sent him back to work but told him to take it easy. This is a typical case of cultural differences. Difficult client.
Ad: You saw the orthopaedist, didn't you? Nothing wrong I presume?
Cl: Eh, no. But maybe I should see a neurologist…
Discussion about what a neurologist could do for the client follows.
Ad: In fact, you are just scared.
Cl: Yes, I want to know what's wrong.
…
Cl: Yes. Well, the orthopaedist said something about a possible hernia…
Ad explains how the vertebrae function, using a scale model.
Discussion follows on whether an accident could have caused the complaints.
Afterwards
Ad: This is a typical case of unrelenting medicalisation. Physicians refer to each other just to get rid of him.

What is obvious in this case was that this client was scared that something is seriously wrong with his back and shoulders. The 'arbo' doctor, however, thought that his complaints are not all that serious and thus interpreted the client's behaviour as 'medicalisation', meaning that the man is exaggerating and does not want to accept that moving and using his shoulder will cause no harm. The 'arbo' doctor explained the client's apparent lack of responsible behaviour to the researcher by referring the client's assumed cultural background: "This is a typical case of cultural differences." The client's apparent irresponsible behaviour was therefore considered understandable not given his *personal* circumstances and characteristics, but given 'his culture'. Quite often, we observed doctors explaining behaviour that violates the implicit norms in terms of the assumed (deviating) culture of the client.

Ad: Another problem is illness behaviour. In one culture, you're ill when you are more or less incapacitated. In another culture, feeling a little unwell is a reason to stay in bed…
They (migrants) experience pain in a different way, you see. It's quite simple. When I feel some pain that doesn't mean I don't go to my work. But they (migrants)…even a little pain means they can't work.

This 'arbo' doctor's explanation illustrates his assumption that migrants deal different with illnesses than Dutch clients. Clearly, he assumed that this behaviour is culturally determined. We often observed that doctors assume that certain illness behaviour is specific for migrants. In other words, we analysed that doctors construct ethnic identities. In these constructions, illness behaviour was often characterised as somatisation, thinking in black and white, making no distinction between illness and incapability and as medicalisation of problems. When Dutch clients failed to show sufficient initiative, the 'arbo' doctors tended to explain this behaviour in terms of personal characteristics or social circumstances. With migrants, they considered the behaviour to be almost exclusively culturally determined.

We saw similar situations in cases where the clients did not show sufficient initiative in returning to work.

Man, migrant, 37 years old
Sickness absence: 5 months. Unknown infection
Ad said prior to the consultation: The company called. They want to know what kind of infection the client has. He became ill in July and returned home in December.
Ad said just before client entered the consultation room: This man went to X for his holidays. There he got ill. In fact he just returned.
Ad: You have been ill for quite a while now haven't you?
Cl: I went to X and there I caught the dengue virus.
Ad: Ah Dengue! What were the complaints?
Cl: Diarrhoea and painful joints.
Ad: High fever?
Cl: Yes.
Ad: And back pain?
Cl: Yes, here is a note from my GP.
Ad: Is your back getting any better now?
Cl: Yes, no more complaints.
Ad: So your back is better and the fever is gone as well?
Cl: Yes. I don't say I can't work.
Ad: I beg your pardon? You can't work?
Cl: No, eh yes, I can.
Ad: Tomorrow? (surprised)
Cl: Fine.
Ad: Any other questions?
Cl: Could the back pain return? I had problems with it in 1997 as well.
Ad: Could be a weak spot. It is important that you keep exercising the muscles.
Afterwards the Ad called the client's employer to tell him that the client can return to work.
The Ad remarked: They were surprised. Can you imagine not going back to work once the complaints are gone? That's typical for migrants. You don't see that in Dutch clients. It's not that they (migrants) are unwilling to work. It's just that they need confirmation.

This client told the 'arbo' doctor that he no longer had complaints and was therefore able to return to work immediately. The doctor was surprised because he assumed that clients who no longer have symptoms simply return to work without consulting anyone.

Women, migrant, 45 years old
Ad said before the client entered the consultation room: this woman has an allergy for house dust. She returned to work for 50%. Last time we agreed that she extents to 75%. She accepted that rather resignedly. It seems normal for 'black people', they wait and see. You have to tell them what to do and they don't take initiative themselves.

The arbo physician describes the woman as resigned and noticed a lack of initiative to return to work. In our study, we observed a lack of initiative to return to

work in many Dutch clients. Doctors explain this lack of initiative by referring to the specific personal circumstances and/or personalities of these clients. In the cases reported above, he attributes the lack of initiative to the assumed cultural characteristics of the client. The client's need for confirmation was considered something characteristic not of this person, but of migrants in general.

In other cases, we observed 'arbo' doctors ascribing migrant client's lack of initiative to an assumed culturally determined lack of motivation.

> Man, migrant, 35 years old
> Ad said before the client entered consultation room: The gentleman we are about to see is what we call "a frequent ill-reporter". (Ad sums up this client's illness episodes over the last year.) Now he is suffering from psychological complaints. His parents went back home to Turkey but they could not get used to life in Turkey anymore so they came back to The Netherlands. But since they could not find a place to live, they've moved in with their son. And because of the resulting stress, the son is now ill…again. That happens often with these guys (migrants). One has psychological problems and you reward him for that (allowing them access to the disability pension programme). After a while, all of them are on your doorstep with psychological problems. If one is disabled because of an allergy, soon enough they all have allergies.

This 'arbo' doctor clearly considered this client's complaints to be unjustified. He was not convinced that this client is ill. He then stated that reporting ill without a serious or justified reason is typical for migrants: If one has a certain problem, eventually, they all have it. In saying this, he implied that migrants often try to get a legitimated sick leave without actually being ill. A similar ethnic definition was constructed in the following example.

> Man, migrant, 35 years old
> Picks sweet peppers
> Ad before client enters: We know this one well. He has always suffered from a stuffed up nose and has difficulties breathing. Two months ago, he suddenly had an allergy to dust. Sweets peppers are known to cause allergies, but not an allergy to dust. So I told him to return to work. I advised him to get a second opinion but he just went back to work. I obviously wasn't fooled by his allergy trick. Now, he has reported ill because of shoulder complaints. As expected, the shoulder did not heal so I threatened again with a second opinion and he went back to work. Now he has reported ill again. I do not know what makes these guys tick, you know.

In the case, the doctor indicated that he was not fooled by the apparently fake allergy complaints nor by shoulder complaints. He explicitly stated that client was trying to mislead him and that this kind of behaviour is typical for '*these* guys' or, in other words, migrants.

> Woman, migrant, 24 years old
> After the consultation the ad said: There was nothing wrong with her back, just weak muscles. She can work full days. She's not depressed. It seems she does

not want to work, I don't know why, with them (migrants) you never get that under control.

The doctor concludes that this women is not ill, but just doesn't want to work. He claims that this is always a problem with migrants, suggesting that this is a particular characteristic of migrants.

The examples provided above are a small selection of the many cases in which migrants who do not conform to the norms were classified simply according their cultural background. In these cases, 'arbo' doctors did not appear to have discriminated between different ethnic groups or even between different types of individuals within one group, while in their consultations with Dutch clients, they classified clients according to numerous types of personalities. It seems that regardless of where a client or his (grand)parents were born, clients who were not Dutch were viewed as a migrant, as a stranger, and not as an individual. In this sense the categorisation of Dutch in specific types of personalities differ from that of migrants, as a general type.

Consequences for the Return to Work Process

When Dutch clients failed to conform to the implicit norms of illness certification practices, 'arbo' doctors tended to use information about their circumstances, personality and character derived from consultations to typify these clients. These typologies of personalities appear to increase 'arbo' doctors' understanding of their clients' situation. The idea is that, once the doctor knows what 'type' of client he or she has, he or she also knows how to deal with him. Whether this is actually the case is, of course, questionable. Nonetheless, 'arbo' doctors feel and deal in this manner with these typologies. They do not blame DNIG-types, but rather provide them with very clear instructions instead of waiting for the client to take initiative. With the typical farmer's wife, 'arbo' doctors seek to curb their enthusiasm and willingness to return to work as these hard-working and no nonsense people tend to ignore clear physical signs that they are working too hard. The typologies used with Dutch clients are very specific and therefore also useful for the doctors as they coach their clients.

When it comes to migrants, however, there appears to be only one typology, the typology of 'stranger'. Migrant clients' problems and behaviour are almost exclusively attributed to their deviated culture. In these cases, doctors seem not to know how to deal with their clients' behaviour because they consider the cultural norms of the client to be a mystery.

Man, migrant, 52 years old,
Sickness absence: two months
Ad: You are not yet better?
Cl: I'm not completely well yet but when my boss says I have to work, I'll work.
Ad: Are the lungs troubling you?
Cl: Yes, but sadness too.
Ad: Because of your sister's death?

Cl: Yes, it's difficult.
Ad: What do you do when you feel sad?
Cl: I smoke a lot.
Ad: Oh yes, but that was the problem wasn't it?
Cl: Life is short. I only had one sister. She went into the hospital and suddenly she was gone.
Ad: It depresses you, doesn't it?
Cl: Yes.
Ad: Let's see whether you can work whole days
Afterwards the Ad said that she finds it's difficult to help this man. With these people (referring to migrants), it is difficult to assess when mourning turns into depression.

In this case, the doctor attributed the client's psychological troubles to his sister's death. At the same, she conveyed to the researcher that she found it difficult to judge this client's symptoms, because, as she explained, she was unsure if these symptoms are part and parcel to normal mourning behaviour in this client's culture.

While Dutch typologies help 'arbo' doctors to better understand their clients and thus enable to them to determine what kind of action is most appropriate, the typology used for migrants appears to only strengthen the physician's sense that the client is a stranger. As a result, 'arbo' doctors are often left not knowing what to do. With migrants, when the return to work process stagnates, the problems are simply explained by referring to 'culture'. However, when similar situations arise with Dutch clients, the typologies help physicians to tackle the problem and avoid conflict. With migrants, this is not the case. The problems cannot be tackled. In some situations, doctors still avoid conflicts and, consequently, the client does not enter into the return to work trajectory. This can go on for months. At the same time, we observed other cases in which the 'arbo' doctor immediately sanctioned 'improper' behaviour and sent the migrant client back to work.

Man, migrant, 43 years old
Sickness absence: frequently ill since four months.
Ad said before the client entered: This man presents with different complaints all the time (sums up the different illness episodes). He did not show up for the last consultation and the employer is getting fed up. We threatened to stop his monthly payment.
Ad: What's wrong now?
Cl: My foot.
Ad: Which one?
Cl: The right one.
Ad: What about it?
Cl: I can't walk.
Ad: The stairs?
Ad: No, walking in general.
Ad: Did you see your GP?
Cl: Yes. (shows note from GP)
Ad: Ah, you need those special pads for in your shoes—arch supports.

Cl tells Ad that he has a lot of pain.
Ad ignores that.
Ad : What have you done in the last four weeks?
Cl: Nothing. I stayed home. Rubbing a little. I went to the hospital and they gave me medication.
Ad: Medication doesn't work in this case. It seems to me you can work but you need to get those arch supports. And do it quickly! (appears very annoyed)
Cl bows head and stares ahead.
Ad: I will write down that you can work (note for employer) tomorrow. If you don't agree, you can get a second opinion (speaks loud).
Cl leaves without a word
Afterwards the Ad remarked: He will go to work for half a day or so, and then he'll report ill again….

In this case, the 'arbo' doctor sent the client right back to work. At the same time, he was convinced that the client would report ill again in a day or so. Because many 'arbo' doctors do not know how to deal with migrants that do not meet the implicit expectations of the illness certifying practice, their reaction is often confrontational. As a result, clients will report ill more frequently because they do not agree with the doctor's decision. Alternatively, the doctor does nothing and the process stagnates.

Constructing the Migrant into 'a Difficult Category'

In illness certification practices, there are implicit expectations about clients' behaviour in this setting. If clients meet these expectations, the coaching tends to go well. However, when they do not, return to work trajectories often slow or stagnate. In these situations, differences between Dutch clients and migrants become evident. In order to put the process back on the rails, doctors often try to characterise their clients. With Dutch clients, they use very specific typologies to explain the client's personality. These typologies make the clients easier to understand and therefore facilitate the doctor in effectively coaching them. With migrant clients, however, only one typology is used, namely that of a stranger. Migrant clients are viewed as people with a deviating cultural background that the doctor is not familiar with. Further, because the doctor is unfamiliar with the cultural norms, beliefs and customs, he or she often becomes unsure of how he or she should deal with these clients. As a result, the sick leave of many migrant clients is extended. Alternatively, the client is sent back to work only to return a short while later with new or more complaints. In short, stagnation in the return to work process that results from different approaches to migrant and Dutch clients generates differences in sick leave figures between these groups, despite similar complaints and a similar lack of competences.

Discussion

In most applied health care research, a cultural perspective on ethnic differences is employed as a means of gaining insight into difficulties with health care delivery for

migrants, despite the fact that this perspective has been criticised and is considered highly problematic by those working in anthropology and/or ethnic studies. As a result, we chose to use a dynamic conceptualisation of ethnicity in our research on the potential differences between migrant and Dutch clients in Dutch illness certifying practices. Our research questions were: (1) Are ethnic identities constructed in this practice?; (2) If so, when and how?; and (3) Do these constructions influence illness certification and return to work processes?

In order to study these construction processes, we focused on the practical rationality of illness certification in general, and identified when and how reference was made to ethnicity. We found that when clients meet the implicit expectations of illness certification practices by providing the doctor with clear information, being reflective, taking initiative and showing motivation, return to work trajectories tend to go quite smoothly and no reference is made to ethnicity. Even for migrant clients, conformity with norms appears to ensure a smooth return to work process. Interestingly, in these cases, the clients are not identified by their ethnicity and no differences in return to work processes are found between these migrants and other Dutch clients.

However, when clients fail to meet the implicit expectations of illness certification practices, we find differences between Dutch clients and migrants. In these cases, if the client is a migrant, an ethnic identity is most often constructed. These constructions hinder doctors in their ability to coach and supervise what they call 'difficult' clients. Although all 'difficult' clients present similar behaviour, be they Dutch or migrant, when the client is a migrant, his or her behaviour is most often considered culturally determined. In doing this, the procedures doctors normally employ to deal with difficult clients become useless. Consequently, these migrants' return to work trajectories are often more problematic than those of the Dutch clients that also fail to meet the implicit expectations of illness certifying practices. Because of these difficulties migrants' actual sick leave histories become longer, and they appear in statistics worse then Dutch employees.

In constructing ethnic definitions doctors often refer to illness behaviour that is apparently constructed by the client's culture. For example, migrants are expected to think only in terms of black and white. Further, they are thought to medicalise and somatise their problems. An additional notion is that migrants are unmotivated and therefore have a poor work ethic. Interestingly, these notions are quite similar to those posited by the cultural and lifestyle paradigm. In other words, what we observed was that 'arbo' doctors use cultural explanations to explain the behaviour of migrant clients that deviate from the norms. We must realise that these explanations are ethnic constructions and not unproblematic descriptions of the situation. Even if these clients do somatise or medicalise their problems, even if they are unmotivated and fail to take initiative, we maintain that using culture as an all-encompassing explanation for these kinds of behaviours is inadequate and problematic.

First and foremost, automatically referring to apparent culturally defined illness behaviour is problematic because many people that could be categorised as migrants do not somatise their complaints, do not fail to take initiative, etc. In other words, not all members of this group called 'migrants' behave in the same manner despite

the fact that a cultural explanation contends that they do. Conversely, many people who are not categorised as a migrant display the behaviours mentioned above. To consider somatisation a culturally specific behaviour is, in essence, an inadequate and unjust generalisation.

More importantly, however, is that our analysis has demonstrated that non-conforming behaviours such as somatisation and not taking initiative are not the problem *as such.* Rather, it is categorisation of these behaviours as 'typical' for migrants and the tendency to deal with these behaviours as 'cultural' phenomenon that is most problematic. For example, somatisation is problematic in illness certification practices because it represents the translation of psychological difficulties into physical problems and, although somatisation is an unconscious act, it often goes hand in hand with the absence of a reflective attitude towards health complaints. This makes it difficult for 'arbo' physicians to encourage their clients to take initiative and responsibility for their health. When Dutch clients demonstrate these kinds of behaviours, 'arbo' doctors attempt to specify, contextualise and explain, at least for themselves, why this client somatises his or her problems. They gather information and categorise these clients using 'off the cuff' typologies developed through experience. By translating somatisation from a general phenomenon to a specific and contextualised characteristic of a specific type of person, it becomes possible to stimulate the client to, for instance, start work without giving the client in question the impression that their health complaints are being ignored or not taken seriously. By seeing or defining somatisation as a cultural phenomenon, as is done with many migrant clients, the behaviour becomes an obstacle to effective coaching. The normal process of translating the general phenomenon into a contextualised characteristic of a person is replaced by a process in which somatisation is translated into a behaviour that is specific to a deviating ethnic group, only because it apparently belongs to that group's culture. When doctors do this, they construct a collective identity and the behaviour of somatisation remains a general phenomenon instead of becoming a personal characteristic with which the doctor can cope. This, in turn, generates alienation rather than understanding.

Clearly, interpreting behaviour as something that is cultural determined causes problems instead of helping doctors to deal with problems. It is, however, not only a practical problem; it is also normative problem. Viewing behaviour as something that is culturally determined poses numerous normative dilemmas for professionals dealing with migrant people. While doctors are unlikely to refer to it as such, it does speak of cultural relativism and the question whether that imply moral relativism. Not only do professionals struggle with not knowing how they can best encourage migrant clients to get better and go back to work, they also struggle with knowing how to deal with the actual behaviour that is considered culturally determined. Should cultural norms be respected? Can a client be blamed for sticking to his or her cultural norms? Can one ask a client to change his or her behaviour and thus also his or her culture? If we do not, are we not applying double standards, and is that not unfair as well? These questions make it obvious that somatisation is not just unwanted behaviour that doctors try to change, it is also something that receives the status of a cultural trait, and that implies that somatisation is assumed to be

embedded in a deeper value system. Consequently, doctors often feel incapable of encouraging behaviour change in migrant clients. They do not know how to convince or influence their clients without treating them and their 'culture' with contempt. They also ask themselves whether it is even fair to expect people to change their value system.[5] Evidently, interpreting and labelling behaviour as something that is culturally determined further complicates contact with migrants.[6]

To realise that ethnicity is constructed in illness certification practices and that this is problematic does not mean that there are no actual problems with migrants nor does it mean that that doctors do not experience more difficulties in their dealings with specific migrants than in their dealings with similar Dutch clients. Nonetheless, we did observe doctors using cultural explanations and this demonstrates that they are indeed exponents of the cultural and lifestyle paradigm. At the same time, we also observed selectivity in the use of these explanations. Ethnic constructions were not made in all incidences with migrant clients. In fact, they were almost exclusively utilised when problems were present. That many doctors act in accordance with the cultural and lifestyle paradigm is not surprising given that many interculturalisation projects and training programmes are based on this paradigm. Professionals simply learn to deal with migrant groups in this way. Even without specific training, it is quite natural to culturalise differences. This exemplifies the fact that it is not our intention to deny the existence of difficulties in dealing with migrant clients, nor is it our intention to blame doctors for culturalising their client.

Nonetheless, culturalisation is problematic, as are the interculturalisation programs that are based on the cultural and lifestyle paradigm. Our research confirms the previously mentioned pitfalls of using the cultural perspective to explain differences between ethnic groups, namely that it increases the likelihood that people will generalise and stereotype, that it reinforces the us versus them contrast and that is assigns responsibility for problematic social interactions to the migrant. In addition to our ideological objection to the use of the cultural perspective, our research shows that dealing with cultural differences in the manner that is proposed by this perspective is part of the problem rather than part of the solution. It does not help doctors to better deal with difficult clients. Instead, it makes these dealings even more difficult. Consequently, the sick leave of many migrants is longer than it needs to be. Clearly, this inadequate labelling is more than just an ideological issue. It is an actual problem as demonstrated by the sick leave figures that show differences between migrants and Dutch employees. In political, public and scientific debates, these differences are almost always attributed to an apparent lack of onus on the part of the migrant. Migrants are thereby held fully responsible for the difficulties that are created by doctors' tendency to explain migrants' behaviour in terms of culture. Essentially, because they are labelled as "alien", migrants are blamed for behaving in ways that many Dutch people also

[5] In the present political climate, it is fashionable to ask migrants to adjust to Western culture, and indeed some doctors in this study, spoke in ways that resonates with this tendency. However, in their direct contact with migrants, uncertainty about how to interpret behaviour often restrained them from actually confronting the client and demanding that he or she adjust.

[6] See also [25].

behave. Because the culturalistic approach has far-reaching negative consequences, we contend that it is imperative that health care delivery practices be studied more carefully and that, in doing so, a comparative perspective and dynamic notion of ethnicity be employed.

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