



Employee perceptions of race and racism in an Australian hospital

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ARTICLE INFO

Handling Editor: Susan J. Elliott

Keywords:

Race
Racism
Hospital employees
Health inequity

ABSTRACT

Background: Racism contributes to health inequities faced by people of colour and marginalised groups. Despite widespread recognition of the impacts of racism, mitigating strategies and legislation have been largely unsuccessful. Research into racism in healthcare has mostly examined personal experiences of healthcare workers and patients, assuming that the definitions of racism and race are similarly understood by all. However, ethnicity and race are often conflated, and racism seen as primarily interpersonal and ahistorical.

Purpose: This paper explores hospital employee understandings of racism, its impacts and how to reduce it.

Methods: Forty-nine staff within one Australian hospital participated in individual qualitative interviews regarding the definition, impact, and ways of reducing racism. Interviews were analysed with a reflexive thematic analytic approach using a Postcolonial framework.

Results: Participants described racism as being experienced by marginalised groups of people in Australia. They identified that racism has detrimental effects on health and wellbeing. Not all were clear regarding what constituted racism: it was not described as an ideology created to justify colonial distribution of power and resources. Some thought that racism was individual prejudice while others noted it was also structural in nature. Participants commonly defined race as involving physical or cultural differences, suggesting that discredited historical and colonial concepts of race continue in Australian society. While many felt that education was the best way to reduce racism and its impacts, some participants noted that being educated did not necessarily change racist behaviour.

Conclusions: The lack of accurate understanding of the concept of race and racism likely contributes to the relatively poor effect of current strategies to combat racism. As an initial part of deeper systemic anti-racist reform, this research supports calls for anti-racist education to clarify the definition of racism as an ideology.

1. Introduction

Racism is an ideology based on the created concept of human difference, such as skin colour or culture, which serves to privilege some people and oppress others (Elias et al., 2021; Garner, 2017). Ideology is defined here as a set of beliefs on which the organisation of a society is based (Cambridge Dictionary, 2023). Colonial institutions and policies were founded upon the ideology of racism, creating and perpetuating disparities in power and resources (Moreton-Robinson, 2015). Racism is an established cause of inequity across multiple domains, including health, education, housing, and employment (Elias et al., 2021; Garner, 2017; Gee et al., 2019; Kendi, 2019; Marmot and Friel, 2008). The need

to address racism has been long recognised; for example, the Declaration on the Elimination of All Forms of Racial Discrimination was adopted by the United Nations in 1963 (United Nations Human Rights Office of the High Commissioner, 2016). However, racism continues to be a concern, causing significantly inequitable healthcare and perpetuating health disparities (Hamed et al., 2022; Institute of Medicine, 2003; Kelaher et al., 2014; Maina et al., 2018; Marmot and Friel, 2008; Paradies, 2006; Sim et al., 2021). For instance, in declaring racism a serious public health threat in April 2021, the Centre for Disease Control and Prevention in the USA noted that the significantly higher death rates of people of colour due to COVID-19 revealed 'a known but often unaddressed epidemic ... [of] racism' (Centres for Disease Control and

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<https://doi.org/10.1016/j.socscimed.2023.116364>

Received 7 June 2023; Received in revised form 9 September 2023; Accepted 24 October 2023

Available online 9 November 2023

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Prevention, 2021). The Black Lives Matter movement further contributed to increasing global awareness of the need to combat racism, alongside growing calls to address racism in healthcare (Henry et al., 2004; Institute of Medicine, 2003; Paradies et al., 2015).

The healthcare workforce is an important part of a multi-tiered approach to addressing racism in the healthcare system (Neblett, 2023). However, there remains no clear consensus on how healthcare workforce programmes aiming to address racism and promote equity should operate. A review of anti-racist interventions in healthcare settings found that there were unclear goals and inconsistent anti-racist literacy (Hassen et al., 2021). Additionally, there was variable leadership commitment, resourcing of programmes, lack of time for staff attendance at anti-racism training and paucity of longitudinal evaluation or research (Hassen et al., 2021). Furthermore, programmes directed at individual staff to eliminate the impacts of racism in healthcare appear to have only short-term gains (Durey, 2010). The above issues are important to note as healthcare staff understanding of race and racism is problematically lacking (Hamed et al., 2022).

In countries which have experienced colonisation, qualitative studies focusing on several healthcare employee groups have shown some commonalities. Shaburidin et al. (2022) and Cunningham and Scarlato (2018) presented studies that included perspectives of a wide variety of occupational roles. Shaburidin et al. (2022) analysed the use of language by twenty-one health employees to describe Aboriginal peoples, migrants and refugees, as well as their accessibility to health services. Participants included nurses, psychologists, social workers, reception staff and community engagement officers in two rural health services in Australia. Findings showed that participants problematised the culture of the service users, and at times expressed inaction or discomfort in having to deal with different cultures (Shaburidin et al., 2022). Similarly, in the USA, Cunningham and Scarlato (2018) held interviews and focus groups with 46 participants, who included senior managers, directors, equity team members, researchers, clinical service leaders, nurses, primary care providers, cancer care providers and social workers (Cunningham and Scarlato, 2018). When asked about their organisations' approach to achieving health equity, participants described socioeconomic status, cultural differences, and patients' choices as drivers of health disparity and refuted the existence of racial bias (Cunningham and Scarlato, 2018).

Other qualitative studies focused on one or two healthcare employee groups (Clark-Hitt et al., 2010; Grant and Guerin, 2018; Manhire-Heath et al., 2019). For example, focus group discussions with family care nurses in South Australia regarding how they understood racism revealed a limited understanding of racism and its impacts (Grant and Guerin, 2018). In New Zealand, eight General Practice receptionists were interviewed about their understanding of Māori health and inequities, and experience of working with different cultures (Manhire-Heath et al., 2019). The authors reported stereotypes about Māori peoples and a tendency to perceive health disparities arising from within Māori communities with no structural, historic, or social context (Manhire-Heath et al., 2019). Another USA study analysed 26 doctor and nurse participants' views regarding the causes of racial health disparity (Clark-Hitt et al., 2010). The study found that participants situated causes of disparity within Black patients, relating to perceived shortcomings or poorer medical insurance coverage (Clark-Hitt et al., 2010).

The qualitative study findings outlined above have in common the tendency of healthcare employees in Australia, New Zealand, and the USA, irrespective of role, to lack understanding of racism and minimise its impact. Similar to the qualitative studies, literature reviews confirm that healthcare workers erroneously cite culture or socio-economic factors rather than racism as a cause of disparity (Hamed et al., 2022; Sim et al., 2021). Thus, racism is essentially obfuscated as a causality for health disparities, and a tacit narrative of patient blame ensues (Boyd et al., 2020). In summary, racism commonly exists in healthcare, and the entire healthcare workforce has an important role in addressing this.

However, there appears to be little known about healthcare staff perceptions of race and racism, particularly in Australia. As such, this paper adds to existing literature and presents a qualitative study of Australian hospital employee perceptions of race and racism. First, we introduce the conceptual framework of Postcolonial theory, which informs the study.

2. Conceptual framework postcolonial theory

This study is informed by the postcolonial theory, which recognises that power imbalances arising from European imperialism and colonisation are built upon the ideology of racism (Miller et al., 2010). The theory notably provides a framework to interrogate the impacts of colonial history (Gandhi, 1998; Miller et al., 2010; Moreton-Robinson, 2015). Postcolonial theory tends to focus on understandings of colonisation from the perspectives of colonised peoples, as opposed to predominantly considering the colonisers (Gandhi, 1998). The theory has been described as being situated within critical theory, as its application can reveal colonial issues relating to power and racism, including within healthcare institutions (Bleakley et al., 2008; Mohammed, 2006; Wilmot, 2021). The theory is pertinent to this study set in Australia where settler colonisation prevails, as it can provide insights into the impacts of this form of colonisation.

The colonisation of Australia was underpinned by the racial hierarchy of European superiority. The British declaration of *terra nullius* (the doctrine that Australia was unoccupied land) at the first colonial encounter set the basis for ensuing race relations in Australia (Moreton-Robinson, 2015). Settler-colonisation processes in Australia sought to replace Indigenous peoples' lives and livelihoods with settler societies (Wolfe, 2016). The British justifications for settler-colonisation were based on false concepts of race. Particularly positing that white people are intelligent, superior and civilised, and people of colour diametrically opposite to this (Wolfe, 2016). This concept of race took its ideological form as a false and unethical human hierarchical classificatory system developed during what some consider as the European Enlightenment (1720–1820) (Lupu and Ryan, 2022). The socially constructed ideas of race supported 'a technology for the management of human difference ... a project of colonial distinction and a system of legitimation to justify oppressive and discriminatory practices' (Lentin, 2020, p. 11–12). However, these were false ideas as there are no heritable links between ethnicity and traits such as intelligence or industriousness (Fairchild, 1991; Rutherford, 2020).

This practice of settler-colonisation, alongside further policies in Australia, aimed to ensure a white colony with British ideals of productivity and industriousness (Anderson, 2002; Garton, 2010; Moreton-Robinson, 2015). One such example is the White Australia Policy (WAP), which existed from 1901 to 1973 to promote the migration of white people to Australia (Anderson, 2002) and maintain a preferred Anglo-Celtic hegemony (Elias et al., 2021). By the 1940s, and with the onset of the Second World War, there was a lack of British migrants, therefore the policy was relaxed to allow European refugees into Australia (Anderson, 2002). As such, the policy promoted particular ideas of race, such as the segregation of people into groupings based on religious belief, physical characteristics and cultural difference (Hall, 2017; Wolfe, 2002). Essentially, colonisation and particular policies in Australia have led to a situation whereby commonly, 'whiteness confers certain privileges to those whose skin colour represents sameness' (Moreton-Robinson, 2015, p.9) promoting a 'regime of power' (Moreton-Robinson, 2015, p. xxiii) that operates in all domains of life.

Despite this situation, there have been attempts to address racism in Australia. For instance, a Racial Discrimination Act was introduced in 1973 (Paradies et al., 2008), Australia ratified the United Nations Declaration on the Elimination of All Forms of Racial Discrimination in 1975 (United Nations Human Rights Office of the High Commissioner, 2016) and anti-racist guidelines were published in 2006 (National Health and Medical Research Council, 2006; Paradies et al., 2008).

However, these policies exist alongside a legacy of racist policies and practices whereby ideas of race and racism are well entrenched and normalised in Australian society (Elias et al., 2021). This discordant situation also occurs in healthcare whereby racism is generally considered undesirable but is well documented as an issue with harmful effects (Henry et al., 2004; Kelaher et al., 2014; Mayes, 2020; Thurber et al., 2021).

Postcolonial theory can assist to investigate this discordancy via the application of a critical perspective. For instance, postcolonial theory can uncover the hegemony and centring of whiteness by challenging the unstated cultural and positivist assumptions in healthcare which lead to stereotypic representations of the other (Bleakley et al., 2008; Mohamed, 2006; Moreton-Robinson, 2015). This approach, however, can be at odds with the dominant healthcare paradigm in Australia. Particularly as Australian healthcare is founded upon colonial healthcare epistemologies and ontologies which predominantly involve a positivist and individualist biomedical model (West-McGruer, 2020). Broadly, biomedical models posit a single objective truth to be found by impartial observation, that is not affected by politics or history (Guba and Lincoln, 1994). Arguably, this dominant healthcare paradigm may be unsettled by critical approaches such as postcolonial theory. Particularly as the application of the theory requires significant and regular re-interpretation of how existing epistemologies and ontologies have been shaped by colonial socio-historic-political contexts (Wilmot, 2021).

3. Method

3.1. Study context

The research question for this study was to determine hospital employees' understanding of racism, its impacts and how to reduce it. Of our researchers, two are migrants of colour with health professional and research backgrounds in Australia and other countries, and two are Aboriginal; one is an anthropological historian and the other is an academic in the health disciplines. This study forms a second qualitative phase of a larger program of research (D'Costa et al., 2022) conducted with employees at a hospital located in South-East Australia upon unceded lands of the Kulin nation. The aim of the first phase of the research was to quantify implicit racial bias among hospital employees.

We considered it important to capture diverse perceptions of racism among hospital employees because inequities occur due to interpersonal interactions and racist policies and procedures that may be designed and implemented by all staff.

In addition, all staff contribute to the culture of an organisation, which collectively impacts the care provided to patients (Bourke et al., 2019; Cunningham and Scarlato, 2018; Henry et al., 2004; Johnstone and Kanitsaki, 2008). As such, we invited all 2871 employees to participate in an Aboriginal Australian race based Implicit Association Test. Further details can be found in the following publication (D'Costa et al., 2022). Briefly, 538 staff completed the IAT between January and June 2020. Of the participants, 60% had a preference for white over Aboriginal Australians, and 21% of employees (95% CI 17.65–24.53) had moderate to strong preference for white over Aboriginal Australians, compared to 7.1% with moderate to strong preference for Aboriginal over white Australians. Participants from this quantitative phase were invited to participate in the qualitative study presented here.

3.2. Ethics approval

Ethics approval was obtained via Monash University Human Research Ethics Committee, Project ID 22230. The Human Research Ethics and Governance Manager at the hospital was consulted and as part of the process, letters of agreement were obtained from The Chief Medical and Nursing Officers at the health service.

3.3. Participant recruitment

All hospital employees (538) who participated in the IAT (D'Costa et al., 2022) had the option to proceed to a follow up interview. One hundred and ten people provided their email address for contact purposes. The researchers then emailed those participants to organise a time and place for an interview. Forty-nine participants responded and signed a consent form agreeing to a recorded interview.

3.4. Participants

Of the 49 participants interviewed, 33 identified as female and 16 as male. There were 8 participants under 30 years of age, 27 participants between 31 and 45 years, 10 aged 46–60 and 4 over 60 years old (Appendix A). In keeping with the research question, participants came from a range of professions. They included nurses, allied health therapists, doctors, physicists, researchers, radiation therapists, and administrative staff. All had policy and/or client-facing roles, which are known to potentially contribute to various forms of racism within hospitals (Bourke et al., 2019; Cunningham and Scarlato, 2018; Henry et al., 2004; Johnstone and Kanitsaki, 2008). Participants were also diverse; however, diversity and employment categories were not recorded due to concerns about confidentiality. Particularly as participants were employed in a single hospital and the research topic contained potential sensitivities. In keeping with Postcolonial theory, we elected to allocate letters of the alphabet for each participant when providing indicative quotes rather than assigning anglicised or ethnically derived pseudonyms to participants.

3.5. Data collection

Semi-structured interviews were conducted in March 2020 by the first author in private rooms within the hospital. The interview guide included questions on how participants understood racism, participant experiences of racism, how racism impacts people, and participant views on how to eliminate or reduce racism. Times ranged from 14 to 40 min, with an average time of 25 min. Following the interview, reflective notes were made regarding initial impressions. Verbatim transcriptions were sent to participants for further comments or changes. Several participants clarified their responses in the returned transcription.

3.6. Analysis

Data were analysed using the reflexive thematic approach described by Braun and Clarke (Braun and Clarke, 2006; Braun et al., 2019). The six phases are: familiarisation with data, coding, generating initial themes, reviewing and then defining and naming themes, and finally, writing up (Braun and Clarke, 2006; Braun et al., 2019). All transcripts were read and reviewed thoroughly by the interviewer with notes on impressions. Selected transcripts were read and coded independently by two authors, followed by group discussions to achieve consensus. We did not generate new codes after about 20 of the 49 transcripts were reviewed. Coded data was then entered into NVivo release R.1 version 1.6. During this stage, we met to further reassess codes over several weeks. We then finalised coding, sub-themes and drew themes, which we reviewed over the ensuing 6 months to ensure the underlying concepts and stated beliefs in the transcripts were captured as we saw them. The codes, sub-themes and themes are summarised in Table 1.

4. Results

Data analysis identified four themes: (1) understanding of racism and race, (2) causes of racism, (3) impacts of racism, and (4) how to reduce racism and its impacts.

Table 1
Codes, sub-themes and Themes.

Themes	Sub-theme	Codes
Understanding of race and racism	Perceptions of groups of people as a race	Physical characteristics, such as, skin, eyes, hair. Perceptions of belonging to a cultural group for instance, style of dress Based on accent or use of English as a second language.
	Types of racism	Discrimination, mistreatment, or bias toward a group based on physical or social factors. Perceiving, stereotyping, or making assumptions - as negative or positive. Physical or verbal abuse. Systemic racism: Lack of diversity - in positions of power (e.g politicians, police, policy makers) including those in higher paid jobs. - in representations of people in media including advertisements. Worse access to education, health, employment for people of colour.
Causes of racism	Unsure: leading to speculation	Overlap with 'simply don't know' and possible causes as listed below. Irrational or illogical
	Inevitable	Human nature to categorise people. Human nature to feel 'good' or belong to an inside group such as in a workplace setting. Human nature to identify throughout evolution with more superior groups. Human nature to differentiate outer/inferior groups (people perceived to be from less materially successful countries)
	Emotional	Fear of unknown. Fear of other/difference. Anger arising from fear. Anger arising from false or inflammatory reportage in media: - of crimes or anti-social behaviours attributed to people of colour, - of handouts and perceived benefits received by people of colour. Anger in general (dominant) population on hearing false or inflammatory reports commentary on groups of people of colour by people in power, such as, police, politicians or people perceived as experts, usually in relation to situations like rising unemployment or crime rates, recent pandemic etc.
	Previous experiences	Influenced by being brought up in a family with racist views. Influenced by family member's bad experiences. Driven by own bad experiences

Table 1 (continued)

Themes	Sub-theme	Codes
Impacts of racism	Impacts on people experiencing racism Physical and mental health effects missed opportunity available to dominant groups	Loss of esteem/wellbeing, confidence. Worse physical and mental health, higher rates of death than public. Verbal and physical abuse Feeling alienated, undervalued, and marginalised personally and 'unable to contribute to society widely', sense of threat, feeling oppressed, unable to speak without fear of backlash. Psychological and emotional impacts can be intergenerational. Lack of fulfilment Reluctance to access human services, such as, education, health, housing. Loss of opportunity: can be temporary, (Missed employment); usually lifelong and cumulative, is corrosive, causing person to create barriers to success. Less cohesion and poor communication within groups. Perpetuation of great economic and material disparity between population groups, leading to people living in segregation. Great disparity in types of services, accessibility to different population groups. Unrest and riots. Genocide. Missed opportunity of 'getting most from everyone'; better outcomes with greater diversity No consequence. Public censure. Loss of employment. Loss of fulfilling life experiences.
	Impacts on society Disharmony to genocide Missed opportunity	Calling it out. Stronger self -awareness, engage in training to build cultural awareness and empathy. Anonymous reporting is possible but does not allow for right of reply. Appropriate institutional and governmental procedures to enable people impacted by racism to report without fear as often there is a power differential involved. Education about what racism, (Especially implicit bias) and its impacts in school from earliest years and all through tertiary and beyond. Education that confirms racism is not acceptable within communities, (schools, university etc) as well as nationally. Consequences for racist behaviours. Truthful education about Australian history. Exposure to diverse peoples,
How to reduce racism and its impacts	Impacts on people perpetuating racism	
	Individual actions: Be anti-racist in speech and action. Self-educate. Protective mechanisms for individuals: within institutions and nationally	
	National or Institutional actions (some overlap with individual actions): Education Exposure Equitable access Leadership- all levels Diversity representation Equitable programs Higher media standards	

(continued on next page)

Table 1 (continued)

Themes	Sub-theme	Codes
		cultures and foods from earliest years. Accessible Services for all: Transport, good food, health care, health information in appropriate format, online access for all. Leadership- to promote anti-racism at nationally and locally. More diversity representation in media/politically/all professions. Representation of diverse people in advertisements, toys, books, films. Institutional changes for better supports/mentorships, recruitment. Supports for becoming more 'established' - businesses, food sharing etc. Less negative/biased media cover.
	Elimination of racism:	Not possible as human tendency to perceive own group as best. Not possible as there will always be people who hate others. Possible with time, effort and education.
	Not possible	
	Possible	

4.1. Understanding of racism and race

Participants described seeing and experiencing racism at work and in public spaces. For example, in the public domain, Participant Gg noted media promoting racism about African-Australian youth and witnessing racism on public transport: "The whole newspaper campaign against African gangs, that's pretty blatant ... You see it on public transport ... people using racist names. Participants also mentioned seeing various forms of racism at work. For instance, through personal interaction with patients:

Certainly, I have seen it from ... white patients ... to different members of staff who may not necessarily be from Australia. So, I am talking about people with a ... Muslim background, and sub-continent background ... sometimes, it's ... it's ... more reading between the lines rather than the saying 'I don't want to see that doctor ... It's a feeling you get ... it's behavioural and non-verbal. An example would be where the patient might say - "I would prefer to see just you" - and you know it's not because of the clinical ability ... (Participant Z)

Participants also described being subject to racism. For example, Participant Uu commented:

In my own experience, coming in as a person of colour, I am very aware that I am not ... of the majority, that I don't fit into that ... mould or whatever it is even though I speak the same language, same English. I probably had similar education to a lot of different people, but there's still an underlying feeling that ... maybe you are in the 'other' category.

Q- Is that in the area you work in or more a general sense of the whole hospital?

A- General sense of the whole hospital and other organisations around. These places can feel very ... colonial or very white. It's not just here, it's a lot of organisations ... it was ... micro-aggressions,

like people ... touching my hair without consent or all the other things that I have experienced a lot even in clinical areas.

Structural racism was also described, for example: 'I have not seen overt racism, but if you look around in management, there aren't many ethnically diverse people' (Participant B). Some noted racism was systemic, mentioning the privilege of circumstances that come with birth or whiteness:

It is a systemic structure ... that asserts the perceived superiority of one race or group of people over another ... you would say you are not racist ... (yet) you definitely still work within racist structures that are continually lifting up people from white backgrounds and it's implicit in ... most workplaces ... If you were to look around ... the people who do the cleaning and deliver food ... are often people of colour or have English as a second language, and you just can't say that racism isn't present there ... it's just so blatant. (Participant Q)

I think racism is structural ... it's to do with white people and white privilege, white people having everything easier for them, having more opportunities ... which don't get shared to non-white people. (Participant R)

Participants sometimes required reflection time to consider racism. For instance, they initially thought they had not seen racism at work, but after further thought, they described forms of racism they had seen. For example:

Q- Have you seen any racism at work?

A- No I don't believe I have.

Q- Do you think there is a level of racism in the workplace?

A- Yes, I do. Very much so. for example, staff or contractors speaking in their own language, is often frowned upon by some. (Participant D)

Or as Participant Ll commented:

I do my job and off I go. Perhaps without knowing we turn a blind eye to any subtle forms of racism we see ... perhaps this is learnt behaviour. I will need to have a think. (And post interview in transcription notes are added): certainly people with an 'accent' or physical appearance that suggests a non-white Australian culture are often commented on as being 'more incompetent.' This is something seen and often and heard in various side conversations both between staff and patients.

Minimisation or justification of racism were also described, and notably absent from these descriptions were considerations of the people subject to the racism. For example, minimisation involved explanations that some forms of racism were worse than others or by classifying some forms of racism as not racism at all:

that horrible name calling, we don't do that at work. There are often assumptions made on patients irrespective of what the staff members race is ... 'difficult Asians' etc ... Among staff not so much though ... It's not so much racism as racial profiling ... not actual racism. (Participant Ww)

Some participants stated racism did not exist at work because they believed healthcare employees are 'pretty well educated ... they study about overt biases, all this stuff we are talking about ... we are trained to deal with everybody' (Participant Gg). However, while an ideal scenario, this statement is not borne out by employee descriptions of racism observed at work.

Participants also provided explanations for seeing no evidence of racism. Some explained that this was due to the people they socialised with, such as: 'to where and who I sit with ... People around me are very open minded' (Participant H) or 'maybe I am not exposed to those circles ... and outside work I am within my own community' (Participant Nn).

Others thought their ability to see racism may be lacking: 'maybe I am just too obtuse' (Participant J) or 'blinker' (Participant X). Some thought privileges inured them against seeing or experiencing racism:

I think it would be harder for me to see it in Australia, because this is where I have grown up and whether I just think it is the status quo or I don't experience it directly ... being white. (Participant Dd)

While participants spoke easily on their understanding of racism, they tended to be uncertain about the concept of race. There was a range of ideas from problematic assumptions to more accurate understandings of race. For example, Participant P rightly noted that races as biological constructs do not exist:

I am not particularly comfortable with the word race anyway ... because I don't think we should identify people as of different 'races' anyway, we are all part of a human race. People are very much similar we just look different.

Some problematically essentialized race through physical appearance consistent with discredited theories of biological race (Fairchild, 1991). For instance:

You know how you have friends who don't have the same skin, the same race ... you know how that person is Aboriginal, and that person is Chinese ... (Participant H)

For the most part, race was perplexingly perceived as a difference. For instance, Participant Ii described this as 'points of difference ... a white attitude to darker skinned people.' Defining race, took some thinking out loud by participants to clarify how differences between groups of people may be distinguished by those who may then discriminate against specific groups. Participants speculated that differences such as religion, speaking English with an accent, and the way people dressed, in combination with physical appearance, were likely such points of difference. For example:

If you drill down to how to make that decision, that the person is different ... I'm not quite sure, but I presume a lot of it must be how they appear ... around religious difference, or how people culturally live their lives ... that must be how they make that judgement, I don't know. I think it's skin colour, it might be hair, it might be their eyes, it's the whole thing, isn't it? Because different races will have a whole different mix of things. (Participant J)

In summary, participants described seeing and experiencing racism both in public and at work. Mitigation and justification of racism were also described. Additionally, some described not seeing racism at work and gave various reasons for that. Others denied racism existed at work entirely. Understandings of race were problematic, and participants generally struggled to articulate what race is.

4.2. Causes of racism

In general, participants found racism 'irrational' or 'incomprehensible.' Some suggested various causes of racism, such as social circumstances and ignorance. For instance:

because they also struggle with things like drugs and alcohol ... or socially ... whereas most 'average' groups can afford to have a bit more sympathy towards others. I think perhaps there's also an ignorance basis as well. (Participant Ww)

Some participants considered a lack of formal education a factor in racist thinking. For example, Participant Kk noted, 'I think it's more prevalent among those that aren't educated.' However, historically, and contemporarily, wealth and tertiary education have not prevented racism. Participants also commented on ignorance in the form of a lack of capability to break past belief systems from family, community, or personal experience, as Participant F commented:

I think a lot of it is ignorance ... whether it's who raised you, ... their beliefs ... the community you live in and maybe even personal experience ... it may colour your belief about every member of that race ... probably a very human thing ... but it is not acceptable. And people may not even realise that.

Arguably, confusion about the social creation of the concept of race, which is what racism is built around, leads to a search within the psychology of individuals for explanations of racism. This may account for participants' speculation that emotions such as fear of the unknown or of perceived impending loss of privilege could cause racism:

People have a great deal psychologically invested in assuming they are living life the correct way, so it's hard not to instinctively interpret somebody else's beliefs and lifestyle as "wrong" if it differs from yours. Secondly, I think there is also an underlying fear that the lifestyle and privileges people currently enjoy will be degraded and they will be forced to accept a lesser role in their community if different cultures are able to thrive. (Participant Hh)

Rather than a socially created ideology, some considered racism intrinsically human and so ineradicable:

I think ... it's part of human nature unfortunately. Aeons ago there were races of one sort or another ... all those tribes ... I think that's where it started. (Participant X)

Others, however, commented on deep-seated and historic systemic processes, for instance: 'a lifetime of people being bred to feel they are superior' (Participant V).

Some considered that a possible cause of racism lay in the process of evolution and preservation of limited resources for one's own group. Once again, absent from these descriptions was acknowledgement of the history of a purpose-built Imperial ideology to gain resources which forms the basis of racism. For instance:

Throughout evolution resources were finite ... protecting our own group and fending off invading hordes ... That is obviously not the case in modern society, but that attitude is possibly hard wired into the human psyche. (Participant Ss)

To summarise, for the most part, participants found the causes of racism to be inexplicable or related to individual or socio-psychological factors, which were rather hesitantly teased out in discussion. In contrast, there was no equivocation about the impacts of racism.

4.3. Impacts of racism

Participants recognised the serious harm caused by racism to communities and individuals. For instance, impacts were described as poorer mental and physical health, isolation, and reluctance to access essential services:

It is corroding ... it has huge impacts on health, well-being, life expectancy, satisfaction with life. It constrains a person's possibility to live a fulfilled life personally and contribute to society widely. (Participant A)

Consistent with anti-racist literature, (Marmot and Friel, 2008; Neblett, 2023) participants noted that structural racism could lead to a lack of resources, opportunities for education and employment or intergenerational trauma:

The damage ... psychologically and emotionally, for the following generations too. that will affect the children ... be ongoing. (Participant G)

Participants stated that there could be negligible consequences for people with racist behaviours. The reason for this included a lack of transparent processes coupled with the matter that perpetrators tend to be in privileged positions:

It's hard for me to imagine what the negative impact on them would be ... for harbouring unconscious bias ... majority, if you are a white heterosexual male, what negative impact is there, what incentive to change your view? (Participant B)

Others thought the effect on perpetrators was 'corrosive' (Participant A) and would limit their flourishing:

It is bad for the racist. ... You lead a more constrained life, constantly living with relationships based on ignorance and hate. (Participant C)

Overall, participants understood there were detrimental effects for people experiencing racism, which could be intergenerational. Some participants considered people with racist behaviours would be unaffected, while others noted an eventual corrosive effect.

4.4. Reducing racism and its impacts

Participants expressed several assumptions about what would and would not reduce racism. For instance, some participants thought exposure to diverse people and cultures would reduce racism and its impacts:

I really believe in putting a human face to all issues helps ... giving people an opportunity to know others as humans, being open to getting to know others.

(Participant E)

Participants also thought that education aiming to 'increase people's understanding of what racism is' (Participant L) would help reduce racism. Others assumed that online anti-racism training would be ineffective at reducing racism. For instance, Participant B expressed they were more of a box-ticking exercise for organisations to 'just say "We are against racism," that's just lip service.' There was widespread agreement that more was needed than just education as Participant C stated, a reduction in racism would require society to 'recognise and judge (racism) as unacceptable ... it needs committed political leadership.'

Participants suggested that leadership for societal change was needed to create systemic changes. Many felt that changes were required to remedy lack of diversity representation, not only in positions of power nationally and in institutions, but also for example in advertisements, toys, and books. As Participant A noted, 'So growing up in Australia there's only one model of ... for example of what beauty looks like. A white woman or man in a glossy magazine.'

Several participants felt there should be stricter media regulation to avoid inflammatory or biased reporting:

I think social media and media in general, definitely plays an important role in almost making racism worse ... The impact it has on society is damaging and can be very awful. Can make people not accepting of each other. (Participant Kk)

Some participants noted that the media and authority figures could reduce stereotyping groups of people with criminal behaviour, for example:

I think the media and the police can give a poor ... unknowingly ... taint a whole community with one person's criminal activity which can promote fear in certain parts of the community. (Participant D)

Participants also mentioned that media could have a positive influence. For instance, Participant I noted that the 'power of the media' would be best utilised to 'normalise and reflect society ... as it is, have more programmes ... with and by ... different people'.

Participants also thought individuals needed to take an active role in challenging racism when they saw it. Some thought this required critical self-reflection and that challenging racism could cause discomfort, for example:

It takes people being more honest with themselves, able to look at their own beliefs and reflect on where those narratives come from ... it is quite a painful process, and I can see why people would want to avoid it. (Participant Uu)

Some also commented on the inherent difficulty of addressing racism, which may occur across hierarchies in a workplace, for example:

It is about saying it is your job as an employee to raise these issues when you see them ... to feel empowered as an employee ... so proper systems are in place.

(Participant E)

In summary, all participants considered the reduction of racism and its impacts to be important in building a cohesive society. While many thought that education and exposure to diverse people and cultures was paramount to achieving that goal, it remains unclear how it would operate. Despite diverse cultures living and working together for several decades in Australia, racism shows no signs of decline.

5. Discussion

The aims of this study were to determine hospital employees' understanding of racism, its impacts and how to reduce it. This study, to our knowledge, is the first hospital-wide study in Australia to specifically ask a range of healthcare employees about these concepts. Using thematic analysis and a postcolonial framework, we identified four themes: employee understanding of racism and race, causes of racism, impacts of racism, and how to reduce racism and its impacts. Our findings concur with other research examining healthcare employee understanding of racism in healthcare and also provides further key information.

Like other studies (Grant and Guerin, 2018; Hamed et al., 2022; Manhire-Heath et al., 2019), we found participants recognised that health disparities exist and have detrimental effects. However, participants also tended to attribute the disparities to people's culture or socioeconomic status. Additionally, participants rarely discussed historical and social contexts for health disparities. Also similar to other studies (Clark-Hitt et al., 2010; Cunningham and Scarlato, 2018), we found some employees did not acknowledge that racism existed within their health services. This seems an unlikely premise given the many indicators of racism's existence in healthcare (which we detail further in following paragraphs).

A key finding of this study is that participants tended to describe race as people's physical and cultural differences. They simultaneously absented from their discussions, that race is a constructed ideology for the purpose of privileging one group of people and oppressing others (Lentin, 2020). In appreciating how and why these historic and problematic signifiers of race remain in the present, it helps to recall that health sciences have been historically entwined in racism. For instance, scientists, physicians, medical institutions, and universities have played a significant role in centring Western knowledge and white bodies as the superior norm (Anderson, 2002; Mayes, 2020; Moreton-Robinson, 2004). Anderson (2002) and Mayes (2020) amongst others, have argued that the historic roots of racism continue to inform Australian healthcare today.

Indeed, indicators of racism existing in healthcare are prolific. For instance, racial stereotyping continues to result in differential and poorer treatment, such as inadequate pain management (Hoffman et al., 2016). Further, Vyas et al. (2020) describes several examples in clinical medicine, where problematic medical guidelines continue to be adjusted for patients' race or ethnicity, potentially leading to poorer healthcare. Additionally, in Australia, systemic inequitable healthcare access and outcomes for marginalised groups are well documented (Australian Institute of Health and Welfare, 2022). It is likely that the above indicators of racism in healthcare are being partially fuelled by healthcare employees' misunderstandings of race and racism and disregard of

biomedicine's role in constructing discredited ideas of race.

A further key finding in this study involves participants' problematic understandings of the causes of racism. For instance, similar to Grant and Guerin (2018)'s Australian study with child and family nurses, we found participants considered the causes of racism to be incomprehensible, perceived resource scarcity, or driven by people being irrational and ignorant. Additionally, we found that participants could also believe that eliminating racism is impossible as it is part of human nature or people's desire to conform to and prioritise specific social identities. It is possible that healthcare employees would have a clearer understanding of the causes of racism if they knew more about how and why race as a concept was constructed. This may clarify the fact that since colonisation, race remains deeply embedded within Australian society to benefit European settlers (Moreton-Robinson, 2015; Wolfe, 2006).

Racism in healthcare is complex, and working towards its elimination will require a reform of current anti-racist strategies. We suggest that while individual anti-racist training is important for increasing understanding, individuals cannot maintain effective anti-racist actions while operating within a society in which racism remains entrenched. For example, in healthcare, awareness of racism may not translate into action to counteract it, due to hierarchical structures and a reluctance to expose potential systemic flaws. As well as addressing individual behaviours and attitudes, anti-racist education should include clear definitions of race and racism as an ideology. There needs to be acknowledgement of how healthcare has been historically intertwined with racism and that this history is linked to racism in the present. Incorporating such knowledge into anti-racist education may be an important step in beginning to dismantle the embedded inequities in current healthcare institutions and rebuilding a more equitable society.

6. Limitations

This study involved a single Australian hospital, where 49 of the 2781 staff were interviewed. More employees volunteered, however COVID-19 restrictions led to recruitment closure. As with all qualitative analyses, this study had a selected group of volunteer participants,

Appendix A. Demographic participant data

Summary: Age and Gender.

Characteristics	Total (%)
Gender	
Female	33 (67)
Male	16 (33)
Age	
<30	8
31-45	27
46-60	10
>60	4

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suggesting they may have already been interested in the issue of racism. Participants may have personally experienced racism or been motivated by a sense of social justice. Therefore, the group may not represent the full breadth of employee opinions. Ethnicity or cultural background may have influenced the responses of participants. This was not documented to protect participant confidentiality, as all participants were from one hospital.

7. Conclusion

We found that hospital employees lacked a detailed understanding of the concepts of race and racism. Participants' descriptions of racism focused more on individual behaviours, absencing the fact that health institutions were founded on privileging whiteness, which remains the default position. All participants readily recognised the harmful impacts of racism, and recommended amelioration of these through education and exposure to different people and cultures. An important part of this education is including a critical approach to knowledge of the origin and purpose of the concept of race to enable a clearer understanding of the embedded nature of racism in the present. This understanding may help foster the start of deep systemic change necessary for individual racist attitudes and behaviours to be addressed.

Source of funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Data availability

The data that has been used is confidential.

Acknowledgement

The authors would like to thank the participants for their time and cooperation.

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