

Racism in a Place of Healthcare: The Qualitative Case of a Rural Australian Hospital

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Abstract

Objective: This article explores how racism manifests in a rural place of healthcare from the perspectives of patients—both a patient's experience of racial vilification and patients' racially-prejudicial views towards healthcare providers. In the analysis, we illuminate the important implications of racism for experiences of health and healthcare in rural Australian places. We argue that critical interrogation of these enduring racial tensions is required to improve the quality of rural healthcare.

Methods: This article analyses two interview data sets, originally collected in a study investigating rurally-living patients' experiences of chronic obstructive pulmonary disease that exemplify how racism manifests in a rural hospital environment. Each transcript was selectively coded for instances of racism and/or instances pertaining to the phenomena of racism. These codes were then reviewed, developed and refined into themes that were contextualized within broader social discourses and race politics that sustain racism.

Results: Contrasting themes of feeling 'unwelcome and unsafe' in the hospital and expressions of being 'privileged and strong' were identified. These themes were situated within participants' particular contexts and circumstances, most especially their racialised subject positions. These themes illustrate the profound effects of racism on access and the maintenance of culturally unsafe environments for hospital patients, specifically those identifying as First Nation Australian, and emphasise the critical importance of cultural diversity within the rural health workforce.

Conclusion: The analysis demonstrates how racism impacts upon and affects two central functions—accessibility and acceptance—in the provision of healthcare in rural places. It is suggested that a range of health actors, including policy makers, health service managers and translational researchers, need to converge on and engage with how racism manifests in contemporary rural healthcare settings to address issues of 'race' and racism in contemporary places of rural healthcare from multiple, intersecting subject positions.

Keywords Racism; Racial prejudice; Rural hospital; Australia; Health disparities; Patient experience; Rural health

Introduction

Racism has a substantial impact on healthcare provision and health outcomes in multicultural societies [1-5]. Racial prejudice remains a serious access barrier to mainstream health services for many people [6-14]. Racially prejudicial views marginalise and exclude health professionals who occupy racially marginalised identities in the health workforce [15-18]. The emotional, mental and physical costs of racism are recognised within current health research [5,6,16,19-21].

Place-context informs the particular manifestations, experiences and consequences of racism in formal healthcare settings [10,22]. In rural Australian places, racism is embedded within health institutions [23], reinforcing racial discrimination and White privilege [22]. Rural context and associated service access complexities [23] mean that residents have few service choices [24,25], most especially secondary services [26]. Further, rural places have a limited pool of health professionals to draw on to staff services [27-30].

In this paper, two contrasting interviews that exemplify how racism manifests in a rural place of healthcare from the perspectives of patients are analysed: a patient's experience of racial vilification and patients' racially prejudicial views towards healthcare providers.

These findings are then contextualised within broader social discourses and race politics that sustain racism. We illuminate both the important implications of racism for experiences of health and healthcare in rural Australian places and the development of healthcare in rural places.

We argue that critical interrogation of enduring racial tensions within rural Australian places is required to improve the quality of rural healthcare. This is relevant both for access to care and the acceptance of health professionals from a variety of socio-cultural backgrounds into the rural health workforce.

Literature review

Racism in contemporary health services

Racism is grounded in historical ideologies that categorise people into racialised identities that are assigned different, differentiated statuses within a given society [1,5,20,31]. It involves the mistreatment, intentionally, unintentionally, consciously or unconsciously, of people assigned to racialised identities that are constructed as inferior or marginalised in relation to others [1,5,20]. Different types of racism or discriminatory treatment based on the fallacy of 'race' as a biological category [1] have been conceptualised in contemporary literature. For example, 'everyday racism' has been described as 'systemic, recurrent, familiar practices' where 'socialised racist notions are integrated into everyday practices and thereby actualise and reinforce underlying racist and ethnic relations'. Today, 'overt' racism, otherwise known as blatant or old forms of racism, co-exist with subtler, 'covert', or modern/new forms of racism that are normalised, especially in relation to First Nation Peoples [1-5, 8]. Racism, in its varied, complex and overlapping forms, is manifest across all levels of society, from routine institutional practices to interpersonal, everyday interactions [2-5,20,32].

Consequently, despite protestations [4,33-36], there is a considerable body of evidence documenting patient encounters with systemic, institutionalised racism within contemporary health services [6-8,19,37,38]. Experiences of racism in healthcare settings among First Peoples is an international phenomenon [20,39-43]. Several studies have investigated First Nation Australians' experiences of racism in mainstream health services [2,3,5,9,42,44-48]. This research is consistent in positioning racism as a key determinant of health and underlying explanation for persistent health disparities [5,9,19,20,37,38,45,47,49-51].

The relationships between racism and (poor) health experiences and outcomes are many, intersecting, and multileveled. For instance, on a structural level, Harris et al. [20] have argued racial prejudice plays a role in determining how societal resources and other health determinants, including education, employment and housing, are structured and organised. On a relational level, experiences of racial discrimination in the healthcare sector can lead to avoidance or delay in seeking healthcare for health-related concerns and/or conditions [3,9,20,38,40,49] and the cultivation of a lack of trust in health professionals and services [9,19,7,52]. It has been demonstrated that when patient trust is low, the advice given to patients by health professionals is less likely to be followed [19,37].

On an individual level, there are serious long-term consequences of repeated experiences of racial discrimination on people's physiological and psychological wellbeing. For example, the physiologic responses triggered by stressful experiences like racial discrimination can contribute to chronically elevated blood pressure [5,6,19,20,47]. Racial discrimination has been identified as a risk factor for the development of ischaemic heart disease [6] and has been found to negatively impact mental health and health-related practices (e.g., rates of smoking and the consumption of alcohol) [19,20,38,45,53]. However, despite this growing body of evidence, political attention remains on the individual and individual health practices rather than on relational and structural dynamics, including experiences of racism and standard healthcare, that inform an individual's health practices and status [6].

Research documenting health professionals' experiences of racial discrimination in health service settings is sparse [54], particularly in

relation to racial prejudice directed towards medical doctors from patients and/or patients' families [55,56]. In the context of exploring the experiences of internationally trained nurses in English hospitals, Alexis [15] found 'race' and racial prejudice were central to themes of marginalisation and exclusion in the workplace. Relatedly, Cottingham, Johnson and Erickson's [16] study examining the roles of race and gender in the emotional practices of hospital-based nurses in the United States found that encounters with racism from colleagues and patients were common. In managing these experiences, Cottingham et al. [16, p. 145] found that nurses of colour perform an 'emotional double shift' to 'remain and succeed in white institutions' that depletes emotional resources and, in turn, compromises the quality of the healthcare that can be provided to patients. Other research from the United States has also highlighted how nurses' experiences of racial discrimination in the workplace can negatively affect retention [57].

In the field of medicine, it has been argued that the class and occupational status afforded to practitioners can 'shield' doctors from racial vilification [58]. However, Murti [59] found that Indian doctors who had immigrated to the United States were only afforded 'partial, situational protection' from racism by their status as medical doctors and still encountered racism from their White medical colleagues. This is consistent with research from the United Kingdom that highlights the historical prejudice, discrimination and stigma experienced by overseas-trained doctors and doctors occupying racially marginalised identities [17,18]. In a rare example of research focused on doctors' encounters of racism from patients and/or patients' families in Israel, Popper-Giveon and Keshet [54] examined refusal of treatment based on the ethnicity of the practitioner. Their results indicate incidences of ethnic-based treatment refusals weigh heavily on practitioners, but 'the ethos of neutrality in medicine...masks and silences various incidents of racism directed against healthcare professionals from various ethnic and racial minority groups' [54]. For Popper-Giveon and Keshet [54], treatment refusals based on the ethnicity of the practitioner reveal an as yet unresolved tension between two central values underpinning contemporary approaches to the delivery of health care - apolitical medical neutrality and patient-centred care.

Methodology

Research setting and data source

The research project for which the data reported on here was collected aimed to investigate the experiences of rurally based residents living with chronic obstructive pulmonary disease (COPD), which is currently the third most prevalent cause of death globally. Cigarette smoking is recognised as the most common risk factor for its development [60]. COPD is a long-term, irreversible condition that reduces people's lung function, damages other internal organs and inevitably depletes the ability to manage everyday life [61]. Breathlessness and suffocation have been identified as common fears for those with COPD [61].

As part of this project, 14 semi-structured interviews were undertaken with a convenience sample of residents living in north-east Victoria, Australia who had a diagnosis of COPD and were admitted to a rurally located hospital in the preceding 12 months [62]. Signed consent was obtained from each participant in the study prior to the commencement of an interview [63] and each interview was audio-recorded and transcribed verbatim. The majority of participants identified as Australian citizens with Anglo-Saxon heritage; some

spoke about having been born in Australia and living in rural communities for much of their lives. One participant whose experiences are detailed in this paper identified as First Nation Australian. Ethical clearances were approved by both The University of Melbourne and the clinical institution assisting researchers with recruitment (please note that to protect confidentiality/anonymity the authors are unable to include the name of the health service).

During the preliminary stages of analysis, in which data were coded line-by-line [64], researchers observed sections of data in two interviews wherein participants were describing experiences of racism from or articulating racist discourses towards healthcare providers in the hospital [65,66]. These accounts were identified as important by the researchers [67]. Considering these data worthy of further analysis, an additional researcher with an interest in cultural processes in the field of rural health was approached to join the research team [68] and ethics approval to conduct analysis focused on racism was requested and granted. The objective of this analysis was to concentrate on what the data across two contrasting interviews – one involving a patient who had experienced racial discrimination in quite overt forms, and one involving a patient (and the patient’s partner) who directed racially prejudiced views towards a healthcare provider in quite covert ways – contributes to current debates and knowledge about the phenomena of racism in contemporary rural places of healthcare and the need to engage with its manifestation in healthcare development for rural places.

The two contrasting interviews

In their exploration of data saturation as a concept in qualitative research, O’Reilly and Parker [67] return to the foundational purpose of research: ‘to extend and advance knowledge’. They draw critical attention to how different epistemological assumptions underpin different forms of qualitative research, which is ignored by dominant contemporary mechanisms for assessing ‘quality’ in qualitative research. Braun and Clarke [69] develop this argument. They illustrate how neo-positivist assessments of quality in qualitative research are becoming accepted as the ‘gold standard’ against which all qualitative inquiry, regardless of appropriateness to the research undertaken, is assessed by knowledge gatekeepers; a trend that impacts upon the kinds of qualitative analyses that are published, and thus heard by wider audiences [69]. However, some well-regarded journals in the social sciences maintain a respect for alternative qualitative traditions and resist these trends.

In focusing on two interviews in this paper, we hold, along with other qualitative researchers who have published similar analyses (see for example, [70] in the *Journal of Rural Studies* that analyses a single interview transcript), that there is merit and value in giving primacy to the voice, knowledge and experience of a few, not because they are necessarily representative of other individuals (although this may be the case), but because our purpose as qualitative researchers is to explore perspectives and each individual’s life is unique, rich, complex; and worthy of exploration [67,71]. Voices like ‘Violet’s’, the First Nation Australian participant in this research, are seldom heard in the Australian context [72] we have an ethical responsibility to circulate the findings presented in this paper [70].

The stories and perspectives shared in the two interviews are important for collective knowledge about how racism works in rural hospital settings. They are rich in information, complex in nature, and demonstrate how intersecting social and political structures and processes sustain racism. Thus, these accounts are adequate to achieve

the aim of the analysis [67,69,73,74]. We offer an extension and advancement of current understanding about how racism operates in and effects health care for those who are underserved in rural communities and call for future inquiries to extend and build on this work [67,75,76].

Data analysis and interpretation

The first author read and re-read the interview transcripts to become familiar with the data and make some initial observations about the potential meanings that could be interpreted [64,65,77]. Each transcript was then selectively coded by this author for ‘instances’ of racism and/or instances pertaining to the phenomena of racism [65]. These codes were reviewed, developed and refined by repeatedly examining each identified section of data until the central idea interpreted from that section of data was able to be clearly articulated and all instances across the data were collated [65,78]. The resulting codes were then examined for potential relationships to one another [64,65,79,80].

During this process, Braun and Clarke’s [65] advice to focus on identifying a ‘central organising concept’ that links different codes together was taken to ensure that the proposed themes clearly articulated what was meaningful about the data in relation to the aims of the analysis [77]. The resulting themes were reviewed by all authors by returning to both the coded and un-coded data to cross-check whether the codes and the grouping of codes into themes made sense and were faithful to the data [64,65,80] from the perspectives of all authors [81,82].

Discrepancies and points for clarification were raised and discussed among the authors and group decisions were made about how to reconcile and clarify the analysis [83].

In the proceeding section, a short description of participants’ context and particular circumstances, synthesised from details supplied in the interviews, is provided prior to the specific findings related to racism. This has been done to situate the analysis and ensure that readers have sufficient information to connect and orientate to, and gain an insight into, the worlds of the participants around whose interview data the analysis is focused [75,84]. Direct speech is quoted to demonstrate fit between the analysis and the data [75,85,86].

Results

Violet

Violet is a First Nation Australian woman in her early 50s. She describes herself as suffering from ‘quite a few illnesses’, including COPD, since her mid-40s. Violet has lived in rural communities since her diagnosis of COPD, which has led to frequent emergency hospital admissions; sometimes, multiple admissions in the same week. From her own description, Violet is socially isolated, but has one adolescent child who she describes as her major source of support and motivation.

Violet’s story: Unwelcome and unsafe

Violet’s experiences with healthcare providers evidenced the enduring dominance of racist discourses and stereotypes within the hospital, which were articulated in quite blatant and explicit ways. For example, Violet described feeling ‘scared to go to the [local rural] hospital’ because of how she was perceived by staff. This feeling was

based on her previous experiences of being admitted to the hospital. Violet explained that she had heard staff saying, 'here comes [Violet] again', which had made her feel uncomfortable going to the hospital, like she was a 'burden' to staff: '...I just don't feel comfortable, because I feel like I'm being a burden to them every time I go in there...' Other research has found those with COPD can feel like burdens to healthcare providers because of how the disease forces them to seek help and thus demeans [61].

However, for Violet, feeling like a burden was 'all tied up together' with her identity as a First Nation Australian and the popular stereotype that First Nation Australians go to hospitals to 'get drugs'. Goodman et al. [87] argue that this racially prejudiced stereotype of First Nations peoples has a profound impact on the quality and safety of clinical and broader healthcare practice, and this is borne out in Violet's experience. For example, one encounter Violet described involved a nurse who used a highly derogatory and offensive term in the Australian context, 'Abo', and drew on racially prejudiced stereotypes of First Nation Australians to justify their disregard and mistreatment:

- I said to the nurse, is it all right if I go to the toilet? She goes, yeah, I can't stop you... Then she turns around and says, lunch is coming, do you want a hot meal or would you like a sandwich? I said, well, I don't eat bread, can I have a hot meal. She goes, okay. I get back and there's a sandwich there, and I said, but I told you, I don't eat bread. She goes, you should be grateful you get anything... you Abos are all the same. You just come here to get food and get drugs...

Experiences like these led Violet to understand that disclosing her identity in this place of healthcare can lead to serious mistreatment. For this reason, she described being 'too scared to tell them [hospital staff, that she identifies as First Nation Australian] because of the way that they'd treat it' and 'too embarrassed to tell anyone' beyond 'a couple of people' who she trusts in the local hospital. Violet described herself as 'proud' of her identity, but 'I just don't want to get treated different...'. From past experiences, identifying more openly in the service had led Violet to receive 'different' treatment. 'Different' in this context meant substandard care rather than an appropriate adaptation of care to best meet the cultural needs of the patient [88]. Violet's experiences of racial abuse and discrimination in the hospital – a place people are often in during times of high stress and uncertainty – had led her to be unable to express her very identity. Being essentially closeted in this fashion has serious implications for health and access to healthcare [89,90].

Following the incident described above, Violet left the hospital and refused to be readmitted, despite being considerably unwell. Experiences of racial discrimination, which were described as connected to other perceptions, for example, being frequently admitted to emergency and feeling like a 'burden', had also led Violet to delay seeking healthcare [also see 87].

Violet described how 'There's a few times where I've been here where I've held off and held off...'. It was only at the insistence of her adolescent child that Violet eventually sought care. The experience of shortness of breath and other COPD symptoms is often frightening and debilitating [61]. Violet's decision to delay care whilst in this state is an indication of how intense her feelings of unsafety were, and the powerful impact racial discrimination has on access to healthcare in rural places where service options are limited.

Violet's experiences of racial discrimination, related feelings of being a 'burden' and stereotypes that First Nation Australians are

always 'after something' had also made Violet feel uncomfortable asking hospital staff to help her in organising assistance with showering at home. Violet described waiting for a particular (trusted) staff member to ask. This staff member 'asked me why didn't I ask the other nurses... and I said no, it's – I didn't want them to think she's after something else this time. What does she want now?' Goodman and colleagues [50], in their work on the relationship between racism and forms of social support and relationships for Indigenous youth, describe the important role service providers can play in offering social support for those with few other options. For Violet, who was socially isolated with a limited in-place support structure, hospital staff represented an important potential source of support; one that was closed-off to her through the operation of racially discriminatory ideas.

Violet's experiences reflected another important effect of racial discrimination in hospital: the impact of these experiences on mental as well as physical health. For Violet, the impact of COPD on mental health was complicated by the racially discriminatory treatment she received whilst needing to seek care. She relayed how, in the case of the interaction with the nurse described above, she could feel herself 'getting weaker and weaker... to the point where I'll work myself that much that I can't – that I'll just collapse'.

Violet's compromised mental wellbeing, compounded by repeated incidences of racial discrimination and vilification [20], demonstrates yet another dimension and implication of racism within this place of healthcare. Considering Violet's experiences in this place, which reinforce exclusion and discrimination, the 'weakening' she articulates is an understandable though distressing response to the environment.

Violet explained how having healthcare providers, particularly clinicians, who also identify as First Nation Australian can help First Nation Australian patients feel safe in ways not always easily understood in the mainstream health sector [91,92]. Having providers with diverse identities helps to make the service more accessible. Violet expressed that working with health professionals who also identify as First Nation Australian is different because: 'You feel like you're on their level. You're not being judged, because a lot of people think Abos are junkies, petrol sniffing, bums and – do you know what I mean? Shit like that...' whereas 'the way they [health professionals who identify as First Nation Australian] approach people and talk to people and don't make assumptions'. Violet expressed that staff who identified as First Nation Australian were needed in the local hospital. However, as she explained, the importance and value of having workers who identify as First Nation Australian for access is not always recognised in rural health services. Violet described asking at the local hospital '...have you got any Aboriginal workers here? I want to speak to someone that's Aboriginal. No, we don't [when in fact they did]... They said no, we don't. Any complaints, ring the ombudsman.'

This response demonstrates a lack of understanding, and even a lack of interest in investigating why the presence of workers who identify as First Nation Australian is so important to First Nation Australian patients. It also evidences an important disconnect between what organisations purport to be doing and prioritising in official discourse and the discourses that actually guide everyday action and practice [also see 93] in rural places of healthcare.

Norm and Jill

Norm is an elderly, long-time, White resident in a small rural community. Prior to retirement, Norm ran a local business and was

heavily involved in mainstream community service groups. Despite initially downplaying his health concerns, Norm suffers from a number of serious chronic conditions and has done so for many years. He has experienced several major health 'events' and undergone a number of surgeries, some of them serious. Norm participated in the interview with his wife Jill, whom he heavily relies upon for physical, social and emotional support. Jill is a strong advocate for Norm's health. Both Norm and Jill have high expectations for the quality of healthcare received by Norm.

Norm and Jill's story: Privileged and strong

Norm and Jill's experiences within the hospital evidenced a clear expectation and ability to demand the provision of quality healthcare on their terms. Their racial and other privileges enabled this expectation and underpinned their response to healthcare providers who occupied racially marginalised identities. The only person Norm and Jill described as 'unhelpful' in their many years of intense contact with the local hospital was a female 'Asian' doctor who was assigned to Norm upon entry into the local emergency department following a collapse. This doctor was described as a 'little Asian bird' with an 'abrasive' demeanour.

Norm and Jill explained that when they returned to the emergency department later that same day because they could not get in to see their usual primary health care physician, '[Jill speaking] she [the female "Asian" doctor] was still there, so she was quite rude to me'. It was then implied that this doctor lied to Norm and Jill about the availability of other doctors, senior local physicians of White descent, who were well known to them (and well known in the town generally) working at the hospital.

When asked whether this doctor (the 'Asian') had checked Norm's medical history, Jill responded, 'When we first went in in the morning, she did'. Norm explained, however, that 'She [the female "Asian" doctor] didn't have the skills. She was Asian...', to which Jill interjected, 'we're not racist', but this doctor was 'aggressive'. When explaining the nature of this aggression, Jill described how this doctor told Norm he was 'grossly overweight' though, according to Jill, 'he wasn't as big as what he is now' and told him to 'go home and lose three stone'. This was 'instead of telling me [Norm] my heart's not working...She was only an intern or something. By now she's probably a professor'. This dialogue implied that the doctor's racialised identity, as 'Asian', meant that she 'didn't have the skills' to care adequately for Norm. The quick denial and deflection away from this statement suggests that there was an awareness of how such claims could lead to accusations of racism. It illustrates the process van Dijk [36] described in their account of how denying racism structures race talk in ways that allow the Other to be portrayed negatively and the speaker/s' self-presentation to be protected.

Describing this doctor as a 'little Asian bird [emphasis added]', a term often used to infantilise and dismiss women [94], served to further undermine this doctor's credibility. Consider the specific reference to her size, 'little', in relation to the recommendation for Norm to lose weight. Neither Norm nor Jill acknowledged the relevance of overweight, possibly obesity, to cardiovascular and other important dimensions of health. However, it is likely that other doctors have discussed with Norm the need to lose weight, especially given his particular health issues, on a number of occasions both prior to and since the specific event described here. Instead, identifying this doctor as 'little' works to both undermine her substance and account for the perception of Norm as exceptionally large from her standpoint.

The descriptors of 'aggressive', 'rude' and 'abrasive' used by Norm and Jill are commonly assigned to female-identified subjects in positions of influence stereotypically occupied by male-identified subjects and used to discipline them by re-asserting the dominance of orthodox constructions of femininity [95,96]. The statement that this doctor was an intern and is now 'probably a professor' implies that simply by virtue of being an 'Asian' and female-identified doctor, promotion has 'probably' been inevitable, rather than based on skill or experience attained. There was no concession given for this doctor being an intern at the time of this event.

Despite describing this encounter as a 'bad experience', Norm and Jill expressed that they felt comfortable returning to the hospital to seek care. Jill explained:

- I'll stand up and get it. I wasn't leaving the hospital...I knew he was crook. I knew there was something wrong. It wasn't his three stone. Like he would have been dead if we had to wait for him to lose three stone.

According to Norm, Jill is 'in her element' when she is 'speaking up' for his healthcare: 'you [Jill] become aggressive' and '...you've [Jill] made mistakes from time to time...I've never been as sick as you've said'. Here, neither Norm nor Jill have been perturbed by their only reported 'unhelpful' encounter in this place of healthcare; both are confident they can receive quality healthcare in the local hospital and in their abilities to extract it. This was emphasised by Norm and Jill both referring to several consultants providing care in the region (who are also all White) by their first names, which suggested a level of familiarity and intimacy with these healthcare providers. Unlike the 'Asian' doctor, Norm and Jill occupy a racially privileged identity in Australia and a number of other socio-cultural privileges in addition to their Whiteness [97,98]. In this context, Norm describes Jill as 'aggressive', which is embraced, yet when it was assigned to the 'Asian', female-identified doctor, it was constructed as a negative trait. It is also suggested by Norm that he was never as sick as has been implied; thus, it could have been reasonable that upon first presentation, further action was not taken by the 'Asian' doctor. It is also possible that, given this statement – he was never that sick – Norm was directed to a metropolitan hospital not because of the seriousness of his condition, missed by the 'Asian' doctor, but because of the particular race and class privileges he occupies [99], and the strong, aggressive advocate he has in Jill.

Discussion

Encountering racism as a patient negatively affects access to health services over a long-term period [100]. In rural Australia, there is often only one hospital servicing a relatively large geographic region [26], making service choices limited. Feeling unsafe in places where healthcare is provided and avoiding seeking care as a result, particularly as a patient with a chronic illness, is likely to compromise ongoing health and wellbeing for rural residents [20]. The effects of experiencing racism and engaging in avoidance-type practices on a person's mental, emotional and social wellbeing, as well as physical health, are not insubstantial [3,20,101].

Ensuring that community diversity is represented within the staff body of health services, and relatedly in health professions, has long been identified by those who are racially-marginalised, most particularly First Nation Peoples, as an important means by which health services can work towards improving their safety and accessibility [21,91,92,102]. However, despite official discourses

supporting the aim to address a lack of workforce diversity in the health sector, there has been little improvement in stimulating such representation, especially in rural healthcare [103,104]. Consequently, when health professionals who occupy racially marginalised identities are encountered, particularly by White patients, there can be tension and uncertainty [16]. These responses can be accentuated in the case of medical doctors (who are, traditionally, important carriers of authority and influence in many cultures) [105] who occupy racial identities other than White.

Hospital patients and staff are part of wider communities and embedded within and influenced by dominant racist discourses and prejudicial views [106]. As the research of Popper-Giveon and Keshet [54] highlights, this socio-cultural context cannot be left at the hospital entrance; it plays out within places of healthcare [107]. It is possible that, for patients positioned within a racially privileged category (Whiteness), perceptions of inferior healthcare can arise when healthcare providers are viewed as non-White. However, as the analysis here articulates, such experiences for White patients do not necessarily affect long-term access to health services; they continue to expect, and feel able to demand, high quality healthcare from their local hospital and are unlikely to experience such services as unsafe, or to avoid seeking care. In this research, Norm and Jill persisted until their needs were met, and did not position themselves as a 'burden'. This contrasted with Violet, who was highly conscious of being perceived as a burden and had been deemed unworthy even to receive a hot meal by local hospital staff. Walter [108], in their analysis of nationalism and new racism in Australia, argues that notions of equality have been influenced and redefined by race politics so that 'what were previously defined as efforts (albeit inadequate) to ameliorate the gulf of inequality and exclusion of Indigenous Australia from participation in Australian society are now deemed preferential treatment and therefore decried as unfair and unacceptable'. Violet's experience powerfully illustrates this re-framing of equality, and with it the rebuilding of barriers to basic rights [108] like access to safe, quality healthcare in rural places.

This analysis adds to literature on cultural safety, specifically for First Nation Australians, and extends current scholarship centred on racial tensions within rural Australian health services. It provides a critical account of patients' experiences and use of racist discourses in a rural Australian hospital. Thus, it contributes to current understandings of an important dimension to contemporary health care issues for underserved population groups: enduring racial prejudice in rural places. The analysis illuminates the importance of engaging with racism and racial tensions in the development of accessible healthcare in rural places.

Further research is needed in the local place to explore how endemic these findings may be, but also, given the prevalence of racism generally, nationally and internationally, to build a substantive evidence-base for future action [67,109]. Targeted studies exploring racism, including implicit and subtle forms, from multiple positions, in contemporary healthcare contexts are needed to develop substantive explanatory models for its mechanisms [84,86]. Moreover, while rural and urban-based health services are situated in different kinds of place contexts and thus, manifestations and effects of racism may differ, racism remains a substantial issue to be addressed across all healthcare settings. Thus, future research is needed in and across different place contexts.

Conclusion

A range of health actors, including policy makers, health service managers and translational researchers, need to converge on and engage with how racism manifests in contemporary rural health care settings. Racism impacts upon and affects two central functions – accessibility and acceptance – in the provision of healthcare in rural places. Accessibility, and thereby the effectiveness, of services in providing care to residents who occupy racially marginalised identities is critical for the development of healthcare in rural places. The ability of health professionals who occupy racially marginalised identities to be accepted as providers of care by White community members is similarly critical because health professionals with diverse identities play an important role in building a rural health workforce and increasing the cultural safety of rural health services [91, 110]. By interrogating two contrasting instances of how racism manifests, this paper highlights the need for greater critical engagement with issues of 'race' and racism in contemporary places of rural healthcare from multiple, intersecting subject positions.

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