

## Research paper

# Cultural racism, language prejudice and discrimination in hospital contexts: an Australian study

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### What is known on this subject

- There are known racial and ethnic disparities in health and social care.
- Racism is being increasingly named by researchers as a possible cause of persistent health differences by racial or ethnic classifications.
- Racism as a determinant and predictor of hospital safety and quality care is under-investigated.

### What this paper adds

- Language prejudice is identified as an unacknowledged form of cultural racism in healthcare.
- It describes how English language proficiency is used as a social marker to classify, categorise, and negatively evaluate people from a non-English-speaking background in hospital contexts.
- Language prejudice is positioned as a fundamental patient safety issue for which all health service providers share responsibility.

## ABSTRACT

This article explores the idea that racial and ethnic disparities in healthcare may be expressive of unacknowledged practices of cultural racism. In conducting this exploration, the researchers identify, describe and discuss the practice of language prejudice and discrimination by health service providers, discovered serendipitously in the context of a broader study exploring cultural safety and cultural competency in an Australian healthcare context. The original study involved individual and focus groups interviews with 145 participants recruited from over 17 different organisational and domestic home sites. Participants included health service managers, ethnic liaison officers, qualified health interpreters, cultural trainers/educators, ethnic welfare organisation staff, registered nurses, allied health professionals, and healthcare consumers. Participants self-identified as being from over 27 different ethnocultural and language backgrounds.

Analysis of the data revealed that English language proficiency, like skin colour, was used as

a social marker to classify, categorise, and negatively evaluate people of non-English speaking backgrounds (NESB) in the contexts studied. Negative evaluations, in turn, were used to justify the exclusion of NESB people from healthcare relationships and resources. Further data analysis revealed that underpinning the negative attitudes and behaviours in hospital domains concerning people who spoke accented English or who did not speak English proficiently were a dislike of difference, fear of difference, intolerance of difference, fear of competition for scarce healthcare resources, repressed hostility toward difference, and ignorance.

Highlighting the implications of language prejudice for the safety and quality care of NESB people, the researchers call for further internationally comparative research and debate on the subject.

**Keywords:** Australia, culture, cultural racism, ethnic minorities, healthcare, language prejudice, patient safety

## Introduction

The purpose of this article is to explore the idea that racial and ethnic disparities in patient safety and quality care may be substantively expressive of unrecognised and unacknowledged cultural racism in healthcare contexts (see Box 1). The research data considered in this article contribute to further understanding the often disguised and sophisticated ways in which cultural racism may work in a healthcare environment. To this end, attention is given to describing the specific phenomenon of language prejudice and discrimination as a form of cultural racism that was discovered serendipitously in the context of a broader study exploring cultural safety and cultural competency in an Australian healthcare context (Johnstone and Kanitsaki, 2007a,b). A key conclusion drawn from this study is that the failure to name and distinguish language prejudice and discrimination as a form of racist practice in hospital contexts, and the tendency to portray language prejudice as merely a communication issue, risks at least two undesirable outcomes. First, it risks seriously undermining progressive policy and practice initiatives aimed at genuinely improving the capacity of hospitals and individual healthcare providers to respond appropriately and effectively to the health and care needs of people from minority cultural and language backgrounds. Second, it risks the loss of an important opportunity to identify and eliminate racial and ethnic disparities in patient safety and quality care that until now have been poorly investigated.

### Box 1

For the purposes of this article the notion of cultural racism is used in preference to that of racism itself which is based on debunked scientific theories of race and racial hierarchies.

## Background to the study

The failure to provide culturally and linguistically appropriate healthcare has been substantively implicated in racial and ethnic disparities in health (Smedley *et al*, 2003). More recently, the failure to provide culturally and linguistically appropriate healthcare has also been implicated in disparities in patient safety and quality care, with recent research suggesting that patients of a non-English-speaking background (NESB) may be at disproportionate risk, compared to the average population, of experiencing preventable adverse events, including permanent disability and even death (Flores 2005; Johnstone and Kanitsaki, 2006; Schnittker and Liang, 2006; Divi *et al*, 2007).

Significantly, the language most commonly used to interpret and explain racial and ethnic disparities in health, patient safety and quality care reflects a focus on and valuation of cultural factors (see Box 2). Discourses on possible solutions to recognised disparities in ethnic health, in turn, tend to be framed by language that refers to various pragmatic processes such as ‘valuing cultural diversity’, promoting cultural competency, and adopting the principles and standards of culturally and linguistically appropriate services, which is sometimes referred to using the acronym ‘CLAS’ in healthcare (Johnstone and Kanitsaki, 2007a,b). The use of such language and related discourse is, however, problematic because of its capacity to disguise cultural racism (Johnstone and Kanitsaki, 2008).

### Box 2 Language euphemisms used to disguise cultural racism

- Cultural factors
- Cultural differences
- Cultural discomfort
- Cultural misunderstanding
- Cultural barriers
- Language barriers
- Cultural biases
- Cultural insensitivity
- Cultural incompetence
- Cultural incongruence
- Ethnic dissonance
- Racial/ethnic discordance
- Cultural imposition
- Miscommunication

(See also Cooper-Patrick *et al*, 1999; Schnittker and Liang, 2006.)

Cultural racism is a process whereby people who are strongly identified with certain ‘language groups, religion, group habits, norms and customs, including typical style of dress, behaviour, cuisine, music and literature, are treated in a prejudicial and discriminatory way based on these characteristics (Goldberg, 1993, p.70). Although racism is being increasingly named by researchers as a possible cause of persistent health differences by racial or ethnic classifications in Canada, the US, UK, Europe, and more recently Australia (Smedley *et al*, 2003; Roberts, 2006; Schnittker and Liang, 2006; Larson *et al*, 2007), the possible impact of cultural racism as a determinant and predictor of the hospital safety and quality care of NESB patients is under-investigated (Johnstone and Kanitsaki, 2006; Divi *et al*, 2007). Moreover, the link between cultural racism and disparities in health is one that is highly disputed and contested in some fields (see Wolf, 2006).

A troubling consequence is a tendency by health researchers and scholars to shy away from explicitly using the term cultural racism in their professional discourses on racial and ethnic disparities in health and hospital safety and relying instead on less contentious terms to account for adverse events (see Box 2).

The failure to name cultural racism as a determinant and predictor of patient safety and quality care risks a number of undesirable outcomes. Of particular concern is the risk it entails of perpetuating what we have described elsewhere as ‘the illusion of non-racism in healthcare’ (Johnstone and Kanitsaki, 2008, p.178), an illusion that rests on the frequently articulated belief that racism is no longer an issue (after Miles and Brown, 2003, p.11). The denial of racism seriously undermines attempts to introduce more progressive policy and practice initiatives aimed at improving the capacity of hospitals and individual healthcare providers to respond appropriately and effectively to the needs of NESB people in hospital contexts. It also risks impeding an important opportunity to identify and eliminate ethnic disparities in patient safety and quality care. In contrast, naming cultural racism as a health justice issue provides an interpretive framework to explain the disparities discerned (Bhopal, 2006; Roberts, 2006).

It is acknowledged that education, employment and other socio-economic factors have been substantially implicated in racial, ethnic health and social care disparities. However, socio-economic indicators *alone* do not always explain all of the differences noted, notwithstanding that lower levels of education and employment among different ethnic groups may, in themselves, be indicators of past and current discriminatory social policies and practices (Daniels, 2006; Powers and Faden, 2006; Larson *et al*, 2007). It is also noteworthy that the disparate care and treatment of NESB people is remarkably consistent ‘across a range of illnesses and healthcare services’ (Smedley *et al*, 2003, p.5). Nonetheless an important consideration remains: although racial and ethnic disparities in health have been convincingly demonstrated, and ethnic disparities in patient safety and quality care have been strongly suggested, it doesn’t follow that these disparities are *necessarily* the consequences of racism. That these disparities *are* expressive of racism thus needs to be shown. While certain practices may well be expressive of racism, ‘this must always be demonstrated rather than assumed to be the case’ (Miles 1989, p.84). It is an important aim of this paper to offer such a demonstration.

## Cultural context of the study

This study was conducted in the cultural context of Australia. Australia is recognised as one of the most

multicultural and multilingual countries in the world. According to the 2006 *Census of Population and Housing*, Australians, 22% of whom were born overseas, claim more than 250 ancestries, speak over 400 different languages at home, and observe over 116 different religions (Australian Bureau of Statistics, 2006). Although the majority originates from English-speaking countries and is English speaking, a significant minority, over 19%, does not speak English at home and may have difficulty communicating in English outside of the home context, for example in workplace and mainstream healthcare contexts (Allotey *et al*, 2002).

The cultural and linguistic diversity of Australia’s population has significant implications for the country’s healthcare services and for those at the forefront of providing direct care to its multicultural and multilingual population. It is known, for example, that the emergency presentation and hospital admission rates for people of culturally and linguistically diverse backgrounds, especially those whose first language is not English, in select metropolitan health services in Australia is often close to and in excess of 50% (i.e. one in every two), with an average of between 32% and 44% (i.e. one in every three or four) of all emergency presentation and hospital admission rates per annum (Centre for Culture, Ethnicity and Health, 2003).

## Research problem

The terms used to explain ethnic disparities in health, patient safety and quality care may be indicative of a form of cultural racism – notably language prejudice (see Box 2). The nature of language prejudice and its possible implications for patient safety and quality care outcomes in Australian hospital contexts has not been systematically explored or described, and hence is not known.

## Research questions

The research questions informing the component of the study reported here were:

- Are people whose first language is not English the subject of prejudice and discrimination in hospital contexts because of their ‘language difference’?
- How is language prejudice demonstrated in hospital contexts?
- What are the possible implications of language prejudice for patient safety and quality care, and related outcomes?

## Study design and methods

### Method

The original study on which this report is based was undertaken as a naturalistic inquiry using the data collection and analysis strategies commonly used in qualitative exploratory descriptive (QED) research (Patton, 2002). A QED approach was selected for the purposes of this study since it is eminently suited to facilitating the rich description, comparison, classification and conceptualisation of new knowledge from previously disorganised and/or non-related data (Patton, 2002). It is also a highly pragmatic approach that enables 'quite concrete and practical questions' to be addressed by people who are 'working to make the world a better place (and wondering if what they are doing is working)' (Patton, 2002, pp.135–6). Moreover, unlike other qualitative methods such as grounded theory and critical ethnography:

There is no mandate to produce anything other than a descriptive summary of an event, organised in a way that best contains the data collected and that will be most relevant to the audience for whom it was written (Sandelowski 2000, p.339).

Accordingly, the primary purpose of a QED approach is fundamentally to describe rather than explain, and thereby to permit 'an understanding of the empirical foundations of theory' (Hamel, 1993, p.34). To this end, the descriptive study does not 'go against the grain of theoretical sociological models; it permits them to exist under more propitious conditions' (Hamel, 1993, p.34).

### Participants

Prior to the commencement of the project, institutional ethics committee approval was obtained from RMIT University and participating health services who subsequently advised their staff of the opportunity to participate in the project. Prospective participants, who contacted the researchers upon learning about the study, were given a letter explaining the nature and purpose of the study and were formally asked for their consent before taking part. Participants were assured that confidentiality and anonymity would be maintained by the use of numerical codes on all transcripts of interviews and by the removal of any identifying information from reports of the study. One-hundred and forty-five participants were recruited from over 17 different healthcare organisational and domestic home sites. They represented staff and patients from over 27 self-identified different ethnocultural and language backgrounds.

### Data collection

Data were collected via 52 individual interviews and 28 focus group interviews, as per the eight categories depicted in Table 1. Interviews were conducted by the authors, and were semi-structured and guided by the use of open-ended questions that sought to explore what the participants knew and understood about cultural competency and cultural safety in healthcare; the possible relationship between cultural competency, cultural safety, and patient outcomes; and the processes best suited to promoting cultural competency and cultural safety in healthcare. Participants were also invited to describe their best and worst experiences when working with or caring for people from diverse cultural and language backgrounds in an Australian healthcare context. The length of each interview ranged from 45 to 90 minutes.

### Data analysis

Data were analysed independently by the two researchers leading the study. The specific steps followed included: producing a verbatim transcription of all audiotaped interviews and organising these under each of the categories of participants interviewed (see Table 1). Then, for each category of participants interviewed, summaries of the researchers' respective field notes and memos were drafted; transcript data and summaries were read and interrogated and annotations made in the margins of the transcripts and summaries; tables and matrices were developed, categories created and coded, and comparisons made. The two researchers discussed the categories created and agreed to the themes that had been identified. Quotations were selected and agreed to on the basis that they were representative of the consensual views that had been captured. All material was then sorted into further categories, with variables and relationships between the categories pertinent to each of the groups interviewed noted. Finally the analytic framework and findings of the study were related to the literature (Patton, 2002).

### Research rigour and validity

In order to ensure the rigour of the study, due attention was given to upholding the following principles: credibility, fittingness, auditability, confirmability, and triangulation (notably, source and analyst triangulation; Patton, 2002). The application of these principles, in this study, was described, in full, in companion articles reporting the original research (Johnstone and Kanitsaki, 2007a,b).

**Table 1** Individual and focus group interviews – participant categories

Category	Nursing staff (NS)	Patients/families – relatives <sup>a</sup> (PR)	Ethnic liaison officers (ELO)	Health interpreters (HI)	Allied health professionals (AHP)	Ethnic welfare organisations (EWO)	Health service manager (HSM)	Educators/cultural trainers (CT)	Total
Individual interviews	5 (5)	0	14 (14)	2 (2)	4 (4)	3 (3)	13 (13)	11 (11)	52
Focus group interviews	11 (46)	3 (8)	2 (4)	1 (4)	0	2 (8)	7 (19)	2 (4)	28 (93)
Total interviews	16 (51)	3 (8)	16 (18)	3 (6)	4 (4)	5 (11)	20 (32)	13 (15)	80 (145)

Figures in brackets denote the total number of individuals participating in the individual and focus group interviews, respectively

<sup>a</sup> Does not include consumer perspectives (involving the sharing of personal narratives of in-patient hospital experiences) obtained from other participants

## Presentation of the findings

Three key findings that emerged following analysis of the data were:

- *individual prejudice*: patients and healthcare staff, especially nurses and interpreters, who were born overseas, and who spoke accented English as a second language, or who could not speak English proficiently, were especially vulnerable to being treated in a prejudicial and discriminatory way by others
- *internalised prejudice*: negative attitudes experienced by people whose first language was not English were sometimes minimised, explained and justified as being ‘not racism’ – even though their experience left them feeling upset
- *institutional prejudice*: negative attitudes toward people who either did not speak English as a first language or did not speak it at all were embedded in the system as demonstrated by such things as a lack of infrastructure to support language services, a lack of resources, and a lack of hard data defending the need for resources that, paradoxically, were difficult to obtain because of a lack of resources and infrastructure.

### Individual language prejudice

#### *Patients and families*

In the case of patients and their families, ‘othered’ language usage in hospital contexts was commonly viewed as a ‘problem’ that was ‘caused’ by the inability of patients to speak English rather than the inability of health service providers to meet the patients’ communication needs. As one nurse reflected:

‘Definitely communication is a big issue when you come across people who do not speak a great deal of English ... Somebody that doesn’t have a language problem can freely express whatever it is that is on their mind. Whereas a person like that who doesn’t speak English, they are not less intelligent, they are not less capable, it is just this language barrier.’ (NS09:2, 5)

A lack of access to qualified health interpreters meant that patients who did not speak English proficiently often relied on English-speaking family members to assist them to communicate with hospital staff and, in particular, to help ask the right questions. In some instances, staff who were committed to ensuring that their patients’ communication needs were met encountered significant resistance when trying to obtain the services of an accredited health interpreter:

‘I’m not supported and still, to this day, I feel a little bit of trepidation that I’m going to have to fight a battle to get an interpreter ... Whenever I have approached the topic of an interpreter, cost is immediately brought up ... “Oh no, it’s far too expensive to get an interpreter”.’ (NS16:7–8, 9, 21–22)

Some participants went on to suggest that NESB patients were sometimes deemed by staff to be behaving ‘inappropriately’ when requesting assistance:

‘The nurses have a lot of difficulty understanding what patients who don’t speak English want and they think they’re demanding – that they become “demanding” and do all this “inappropriate” behaviour. The nurses feel it’s inappropriate behaviour to get their attention when, in fact, if they could only understand what the patients are trying to say, then a lot of the problems could be avoided.’ (PR02:R1:18–19)

Moreover, ‘how well’ patients and their family members spoke English, and whether they spoke English at all, had a significant influence on how they were treated by attending staff. Numerous examples were given of NESB patients and families often being judged to be communicatively incompetent and even as not speaking English *at all* when in fact they did. As one registered nurse observed:

‘On a few occasions, because the patient has a strong accent or doesn’t have perfect English, it has been written on the care plan that the patient “doesn’t speak English”. It happened with one of my patients. I looked after that patient and there were no problems whatsoever communicating – maybe in a broken language, maybe with a strong accent, but there was nothing wrong with her English. Why did they put down that the patient didn’t speak English? Because the staff had difficulty understanding the accent.’ (NS09:6–7)

Patients who had been deemed *communicatively incompetent* were also sometimes deemed to be *rationality incompetent* (i.e. ‘stupid’). As one registered nurse reflected:

‘Some staff think they are stupid, I can tell. Sometimes they say, “They don’t understand what I say”. Actually, no, they do understand ... Some people who do not speak English very well, it doesn’t mean they cannot think. Sometimes they can think very well. It’s just they’re not used to English or especially the medical terminology.’ (NS14:23)

Health interpreters reported that when staff thought patients did not understand English, they sometimes responded by treating them in a rude and abusive manner, that in turn intimidated and disempowered such patients:

‘Sometimes the attitude of the reception staff is so cool – they are extremely abrasive, they are extremely rude. They yell at the patients if they don’t understand ... they speak louder, so the patient gets intimidated. The patients are often intimidated. Often the abrasive behaviour of the professionals puts them in their place.’ (HI01:11)

The abrasiveness of staff was observed as particularly acute in situations where they believed strongly that patients who did not speak English were being ‘overly advantaged’ and in ways that discriminated against

English-speaking patients. According to one senior health interpreter:

‘Sometimes the staff will make comments like, “You’re getting free service, you should be grateful”, which puts the patients in their place straight away.’ (HI01:11)

In one instance, nursing staff were observed directly by other staff to interfere with outpatient appointment processes, which they perceived unfairly advantaged non-English speaking patients over English-speaking patients. In some cases staff were so concerned that NESB individuals would get ‘preferential treatment’ that they would delay their appointments and ‘*deliberately put their file on the bottom of the pile*’ (HI01:8), thereby ensuring they would remain at the end of the queue. In one case, when a health interpreter informed staff in an outpatients’ clinic that he could no longer wait because the time for which he had been booked had expired and he had another patient booked in an adjacent clinic, the receptionist responded, ‘But the patient hasn’t been seen’. When he explained, ‘Well, I’m terribly sorry, but my time has expired, I have to go’, he was told, ‘Well, that’s on your conscience then’ (HI01:19).

It was acknowledged that patients who were dissatisfied with the quality of their care could make a formal complaint to the health service concerned. Respondents noted, however, that people who did not speak English tended to be reluctant to make a complaint because of fearing repercussions and that:

‘If we complain we won’t get any more services.’ (ELO12:10)

### **Staff and co-workers**

As in the case of patients, ‘how well’ staff members spoke English also had a significant influence on how they were treated by co-workers and their managers. Nurses who spoke with accented English as a second language were particularly vulnerable to being characterised as communicatively incompetent and marginalised by co-workers. One nurse participant recounted:

‘I have some personal experiences with my accent ... When I get a little bit nervous, you have to say my language isn’t that “fluid” – I can’t find the words, and so on. Where I work, I feel I know so much – I know so much what’s going on every day. But the other nurses don’t come and ask me because they think it’s hard to get information from me.’ (NS13:35)

Participants revealed that, in some instances, hospital staff who spoke their first language at work experienced animosity from their co-workers and in some cases were directly told not to speak their first language even when caring for patients who did not speak English, because it made other co-workers ‘feel left out’. In one case, a nurse overheard to speak her first language at work was reported to management by

other nurses, who subsequently reprimanded the nurse and told her to ‘stop it’ (NS09:R1:28). In another case, nursing staff were so intolerant and disrespectful of a co-worker’s language difference that they repeatedly criticised her given first name and asked her to change it to a ‘shortened version’ (NS09:30).

### **Internalised language prejudice**

Analysis of the data suggested that those who were the targets of negative attitudes and behaviours of their co-workers and managers sought to justify the prejudicial attitudes and behaviours that had been directed at them by normalising and internalising the behaviours. As a nurse who had directly experienced such negative behaviour explained:

‘I think it is quite normal. It is nothing to do with racism. It is just that they don’t know you well and because you look different and you are from a different place, so they are a little bit scared or something.’ (NS09:R2:29)

In another incident, a nurse whose parents had been Vietnamese refugees in the 1970s criticised a professional development session on the use of health interpreters, contending:

‘I don’t believe in all this stuff. This interpreter stuff is all too expensive. If they [patients] want an interpreter, they should bring their own.’ (ELO10:12)

### **Institutional language prejudice**

#### ***Lack of infrastructure and resources***

The lack of infrastructure and resources was most evident in what participants described as the limited availability of and access to accredited health interpreter services. Several participants indicated that their respective health services received only around 10% of their actual funding requirements apropos the provision of accredited health-interpreting services per annum. Although most health services did their best to meet patient demand for health-interpreting services through their mainstream operations, they were not always able to do so because of a lack of infrastructure. And although the Telephone Interpreting Services (TIS) is widely used in the healthcare sector, some participants indicated that using TIS was not an option for them because of a lack of basic telephone equipment:

‘They don’t have a telephone that’s next to the bed. They have the hands-free telephones but they disappear – people take them, they can’t find the hands-free telephones ... So yeah, on the wards, it’s a real trouble, it’s a challenge.’ (HI01:13)

Negative and discriminatory attitudes were also manifested in system processes regulating the availability and

flow of information to patients. For example, participants revealed that in many instances, brochures and posters containing information about a ward or a health service tended to be available only in English. Even when brochures and posters had been reproduced in community languages, some patients still could not access the information either because the text was too small to read, or it was confusing in its layout.

Sometimes patients could not read the material because they were illiterate in their own language, which had not been taken into account.

### *Lack of data*

A key difficulty encountered by staff trying to develop responsive communication services for NESB patients was a lack of good data on the demand for and supply of health-interpreting services. Participants pointed out that the collection of data pertaining to the need for and use of health interpreters was often hampered because of various default options on the computer software used by some services, and a reluctance by staff responsible for completing the relevant documentation, in either electronic or hard copy formats, to ensure that data pertaining to the language backgrounds of patients were recorded accurately, or even at all:

‘I couldn’t work out why we have got so little number of people using so many resources for language services. Where are they coming from? I’ve got data saying: English, English, English, only one out of every thirty patients from diverse linguistic backgrounds. I was puzzled, “Why is my interpreter services budget going up?”. And we then found out that it was the computer defaulting to “English” [when the patient’s proper language wasn’t added in] so that was why I couldn’t pick it up ... The infrastructure was totally against me.’ (ELO07:11–12)

## **Contributors to negative attitudes**

Underpinning the negative attitudes and related behaviours discerned concerning people who spoke accented English or who did not speak English proficiently were: dislike of difference, fear of difference, intolerance of difference, fear of competition for scarce (healthcare) resources, repressed hostility toward difference, and ignorance.

### *Dislike of difference*

Some participants indicated that they did not like and were deeply irritated by patients and families who ‘would not’ speak English even when it was known that they *did not* and *could not* speak English, when being cared for in a hospital context:

‘[What stands out for me] is them talking in their own language while you’re with them. I don’t like that. I think

it’s quite rude to do that when you’ve got somebody in there that can’t speak that language. I think that’s not nice ... When they can’t speak both [English as well as their own language], that really annoys me. I think it’s rude. I don’t know, you go and say, “Hello” and talk to the patient – talking in English – and the family would just talk on in their own language. I just think it’s very rude, I do ... It can make you feel uneasy in a room.’ (NS05:16–18)

### *Fear of difference*

Data suggested that in some contexts healthcare professionals were afraid of the cultural and linguistic differences exhibited by their patients:

‘What is it that frightens people? I don’t know. I think it could be “difference”, depending on the different cultures that you are interacting with. Islam is a very good example. Everyone is either hesitant about engaging with Muslim people or they are afraid of them. They are afraid of either doing something wrong to offend them – that is definitely something – or, they are afraid – no, not afraid, they just have this “hatred of things different”.’ (ELO01:8)

### *Intolerance of difference*

Many examples were given which suggested that in addition to a fear of difference there was also a profound *intolerance of difference*, expressed largely by an attitude of ‘I don’t want to know about it’:

‘They do not want to know ... They often make that very clear to me ... They don’t want to deal with it, they don’t want to fund it, they don’t want to hear how hard it is.’ (ELO10:8)

### *Fear of competition with difference for scarce resources*

A majority of participants agreed that health services have a responsibility to ensure that they provide culturally and linguistically appropriate services to patients of minority racial, ethnocultural and language backgrounds. Nonetheless, even those with progressive attitudes toward this stance included the rider ‘so long as it was practical to do so’. One participant contended that building language services into an organisation’s infrastructure was not an option on account of such services being cost prohibitive. Others went even further, contending that, on the whole, migrants were not entitled to any special consideration on account of their cultural and language differences because they had not earned it.

### *Repressed hostility toward difference*

Some participants indicated that they were harbouring repressed hostility toward ethnic patients and families which sometimes burst through, especially



when under pressure and stressed by their workplace environments:

'People are absolutely stressed to the max ... They are really, really stressed out. They have to juggle so many different priorities, and that is why (a) the priorities that they deem as "lesser priorities" will be pushed down, or will be less important. The other thing is that (b) they will also have to lash out at something because they are so incredibly frustrated.' (ELO01:21–22)

### Ignorance

Ignorance was also identified as a justification of negative attitude and behaviours that were given expression in healthcare domains. As one participant reflected:

'Maybe people just do not know how to deal with it, so they just walk away and it's not because they are mean people or because they don't care. It is just that, sometimes, I suppose, they don't know any better.' (NS09:16–17)

## Discussion

*Cultural racism* is rarely expressed openly and can come in many guises (Goldberg, 1993; Verkuyten, 1998; Ashcraft and Allen, 2003; Horne, 2005). It can occur at several levels, each of which can have a significant impact on health:

- *institutionalised level* characterised by a 'differential access to the goods, services, and opportunities of society by race ... often evident as inaction in the face of need'
- *internalised level* characterised by an 'acceptance by members of the stigmatised races of negative messages about their own abilities and intrinsic worth'
- *personally mediated level* characterised by 'prejudice and discrimination, where prejudice is differential assumptions about the abilities, motives, and intents of others by race, and discrimination is differential actions towards others by race' (Jones 2001, p.300).

Language prejudice is a potent, but overlooked form of cultural racism related to discrimination against people who do not speak a country's official language. Language prejudice originates in anthropological linguistics and is premised on the theory that languages, dialects and accents are constructs that classify people, as do race, in terms of skin colour, nationality, ethnicity and kinship (Urciuoli, 1996; Lippi-Green, 1997). Like other observable differences, the language differences of alien outsiders can be perceived by homogenous insiders as being deeply threatening to 'our way of life'.

When people are subject to language prejudice, 'they are judged communicatively incompetent. Their knowledge of language forms is judged inadequate and contaminated: rules are said to be broken, boundaries crossed, languages mixed, accents unintelligible' (Urciuoli, 1996, p.2). Thus, in countries where English signifies 'the more valued language' and other languages the 'less valued', people whose first language is not English are vulnerable to having their speech typified by proficient English speakers in the moralistic terms, for example, of being "broken" or "mixed" and their accents as "heavy", all of which is contrasted with "good" English, as if good English were a clearly defined object' (Urciuoli, 1996, p.2). Also of concern is the emerging evidence that, in countries where English is the official or mainstream language, and if there is a discordant relationship between the providers and recipients of healthcare, the *way* in which patients of minority racial and ethnocultural backgrounds speak English even as a first language, or how 'well' they speak it, can have a negative influence on whether they are treated fairly and respectfully by attending professional caregivers in clinical domains (Creese and Kambere, 2003; Johnson *et al*, 2004).

The sense that the language of foreign English speakers is 'different', 'bad', or 'wrong' is further reinforced 'by reactions encountered in routine experiences', for example, by 'information barriers: who controls what one needs to know, what one must do or say to be understood or believed' (Urciuoli, 1996, p.3). Language and communication in multicultural contexts are thus highly politicised because, ultimately, 'the interpretations that count depend on who has power' (Urciuoli, 1996, p.3).

Language prejudice, however, is not only manifest in the spurious classification of peoples. It is also fundamentally manifest in the often surreptitiously unequal social structures and power relations that, in turn, support the direct and indirect discrimination of people who either do not speak English or speak accented English as a second language (Lippi-Green, 1997).

The findings of the study reported in this article have demonstrated that language prejudice and related discrimination operated directly and indirectly at three levels: individual, internalised and institutional. When the findings were analysed using, as an analytic frame, the theorised stances of language prejudice and cultural racism advanced in the literature, the following observations were made:

- language difference like skin colour was used as a social marker to classify and categorise patients and staff
- classifications were applied on the basis of whether people:
  - did not speak English

- spoke English, but not ‘proficiently’ or ‘fluidly’
- spoke English as a second language proficiently, but with a ‘heavy’ accent
- people who did not speak English, or who spoke English with only limited proficiency, or who spoke English proficiently as a second language but with a ‘heavy accent’ were at risk of being evaluated negatively as communicatively and rationally incompetent and thus a threat to scarce healthcare resources, the status quo. They were seen as ‘moral failures’ who need to be ‘put in their place’
- negative evaluations of NESB people were used to justify their exclusion from important healthcare relationships and resources. For example, patients were obstructed from getting access to qualified health interpreters in a timely manner, or at all; staff whose first language was not English were not respected or accepted and included as knowledgeable members of the healthcare team
- negative evaluations of NESB patients motivated negative attitudes toward health-interpreting services that, in turn, hampered the collection of sound and reliable data to justify the appropriate funding of responsive communication services for NESB people.

Like racism based primarily on skin colour, the processes that distinguish and motivate cultural racism are extremely complex. There is, however, agreement among racism theorists that social markers and dispositions such as *dislike of difference*, *fear of difference*, *intolerance of difference*, *fear of competition with difference for scarce resources*, *repressed hostility toward difference* and *ignorance* are foundational to racist thinking and behaviour (Goldberg, 1993; Barker *et al*, 2001; Leets, 2001; Lo Bianco, 2001; Horne, 2005). Consistent with the findings of studies in other fields outside of healthcare (Urciuoli, 1996; Lippi-Green, 1997; Verkuyten, 1998; Barker *et al*, 2001), this study has implicated dislike of difference, fear of difference, intolerance of difference, fear of competition with difference for scarce resources, repressed hostility toward difference, and ignorance as key drivers motivating negative attitudes and behaviours.

Communication has long been recognised as the tool by which all interactions in the hospital environment are governed (Raimbault *et al*, 1975) it ‘is not only a means of communication but also a symbol of common ground and a way of gaining deep access to people’ (Clyne, 2007, p.6). In recent years, communication failures have been implicated in 70–80% of formally reported preventable adverse events in hospital contexts and related poor patient safety outcomes (Galvan *et al*, 2005; Johnstone and Kanitsaki, 2006; Divi *et al*, 2007). Language prejudice, by its very nature, involves a profound failure in communication. Moreover, given how vital communication is to the

therapeutic relationship in healthcare, it can be seen how language prejudice stands not only as a profound failure in and a barrier to communication, but also as a symbol of *uncommon* ground and a way of *avoiding* the deep access to people that is otherwise critical to the success of the therapeutic encounter. Thus, while not able to demonstrate a conclusive link between the practices of language prejudice discovered in the context of this study and poor patient safety outcomes, the examples captured nonetheless highlight the risks that language prejudice and discrimination obviously pose to the health, safety and quality care of NESB patients.

## Conclusions and recommendations

This study has underscored the need to recognise and reconcile the manner in which *racism* has persisted insidiously in healthcare domains, arguably because of the illusion of its absence. Unless given practices are shown to be expressive of racism, its harmful effects in healthcare domains will remain hidden and will continue operating in subtle and powerful ways. It will not only go unnoticed and unchallenged, but will also be continually reproduced (Apple, 1999).

The findings of this study suggest that healthcare professionals, who are otherwise bound by anti-racist ethical principles of conduct, sometimes engage in racialised practices towards racial/ethnic minorities, using terms of derogation and accusation that persistently characterise ‘foreigners’ (alien outsiders) as ‘a nuisance’, ‘a problem’, ‘getting out of control’, and a threat to the common interests of ‘others’ (Verkuyten, 1998; Barker *et al*, 2001).

It is acknowledged that just as cultural racism and its expression in the form of language prejudice will probably never be eradicated in the broader community, neither will they be eradicated in hospital contexts. Nonetheless, cultural racism and language prejudice can and should be *managed* to reduce, if not prevent, their incidence and harmful impact in healthcare domains. To this end, we conclude, first, that the problem must be recognised and its incidence reported via formal incident-reporting processes.

Second, robust system processes must be put in place that, although not always able to prevent language prejudice in hospital contexts, may nonetheless make it very difficult for the system and the people in it to express their prejudices in cruel and harmful ways (Horne, 2005). To this end, we contend that representative health professional organisations as well as governments have a responsibility to take into account the mosaic of ‘minority interests that make up any modern society’ and, rather than enforce uniformity, accept the differing values, beliefs, opinions and ways of life of racial and ethnic minority groups and enable their harmonious expression (Horne, 2005, p.41).

Finally, we reiterate that this issue needs to be seen and framed not just as a human rights and anti-discrimination issue, but as a fundamental patient safety and quality care issue for which everybody shares responsibility (Johnstone and Kanitsaki, 2006). Furthermore, professional educational initiatives must include an emphasis not only on cultural competency but also anti-racism.

Despite the obvious importance of the issue of language prejudice to and in healthcare, it has not been comprehensively investigated in the cultural context of Australia. It is our hope that this article will provide a catalyst for much needed debate and further research on the subject, both nationally and internationally.

## REFERENCES

- Allotey P, Manderson L and Reidpath D (2002) Addressing cultural diversity in Australian health services. *Health Promotion Journal of Australia* 13:29–33.
- Apple M (1999) The absent presence of race in educational reform [1]. *Race, Ethnicity and Education* 2:9–16.
- Ashcraft K and Allen B (2003) The racial foundation of organizational communication. *Communication Theory* 13:5–38.
- Australian Bureau of Statistics (2006) *2914.0.55.002–2006 Census of Population and Housing*. Canberra: Australian Bureau of Statistics.
- Barker V, Giles H, Noels K *et al* (2001) The English-only movement: a communication analysis of changing perceptions of language vitality. *Journal of Communication* 51:3–37.
- Bhopal R (2006) Race and ethnicity: responsible use from epidemiological and public health perspectives. *Journal of Law, Medicine and Ethics* 34:500–7.
- Centre for Culture Ethnicity and Health (2003) *Diversity in Hospitals: responding to the needs of patient and client groups from non-English speaking backgrounds. Policy and resource guide*. Report prepared by the Acute Diversity Care Collaboration Program. Melbourne: Centre for Culture Ethnicity and Health.
- Clyne M (2007) Show-offs urgently required. *The Australian, Higher Education Section*, 14 November:26.
- Cooper-Patrick L, Gallo J, Gonzales J *et al* (1999) Race, gender, and partnership in the patient-physician relationship. *Journal of the American Medical Association* 282:583–9.
- Creese G and Kambere E (2003) 'What colour is your English?' *Canadian Review of Sociology and Anthropology* 40:565–73.
- Daniels N (2006) Equity and population health: toward a broader bioethics agenda. *Hastings Center Report* 36:2–35.
- Divi C, Koss R, Schmaltz S and Loeb J (2007) Language proficiency and adverse events in US hospitals: a pilot study. *International Journal for Quality in Health Care* 19:60–7.
- Flores G (2005) The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research and Review* 62:255–99.
- Galvan C, Bacha E, Mohr J and Barach P (2005) A human factors approach to understanding patient safety during pediatric cardiac surgery. *Progress in Pediatric Cardiology* 20:13–20.
- Goldberg D (1993) *Racist Culture: philosophy and the politics of meaning*. Oxford: Blackwell.
- Hamel J (1993) *Case Study Methods*. Newbury Park: Sage Publications.
- Horne D (2005) *10 Steps to a More Tolerant Australia*. Melbourne: Penguin Books.
- Johnson R, Saha S, Arbelaez J, Beach M and Cooper L (2004) Racial and ethnic differences in patient perceptions of bias and cultural competence in health care. *Journal of General Internal Medicine* 19:101–10.
- Johnstone M and Kanitsaki O (2006) Culture, language and patient safety: making the link. *International Journal for Quality in Health Care* 18:383–8.
- Johnstone M and Kanitsaki O (2007a) Health care provider and consumer understandings of cultural safety and cultural competency in health care: an Australian study. *Journal of Cultural Diversity* 14:96–104.
- Johnstone M and Kanitsaki O (2007b) An exploration of the notion and nature of 'cultural safety' and its applicability to the Australian health care context. *Journal of Trans-cultural Nursing* 18:247–56.
- Johnstone M and Kanitsaki O (2008) The problem of failing to provide culturally and linguistically appropriate healthcare. In: Barrowclough S and Gardner H (eds) *Analysing Australian Health Policy: a problem orientated approach*. Sydney: Churchill Livingstone/Elsevier Science, Australia, pp. 176–87.
- Jones C (2001) Invited commentary: 'Race', racism, and the practice of epidemiology. *American Journal of Epidemiology* 154:299–304.
- Larson A, Gillies M, Howard P, and Coffin J (2007) It's enough to make you sick: the impact of racism on the health of Aboriginal Australians. *Australian and New Zealand Journal of Public Health* 31:322–9.
- Leets L (2001) Experiencing hate speech: perceptions and responses to anti-Semitism and antigay speech. *Journal of Social Issues* 58:341–61.
- Lippi-Green R (1997) *English with an Accent: language, ideology and discrimination in the United States*. London and New York: Routledge.
- Lo Bianco J (2001) From policy to anti-policy: how fear of language rights took policy-making out of community hands. In: Lo Bianco J and Wickert R (eds) *Australian Policy Activism in Language and Literacy*. Melbourne: Language Australia, pp. 13–44.
- Miles R (1989) *Racism*. London/New York: Routledge.
- Miles R and Brown M (2003) *Racism (2e)*. London/New York: Routledge.
- Patton M (2002) *Qualitative Research and Evaluation Methods (3e)*. Thousand Oaks: Sage Publications.
- Powers M and Faden R (2006) *Social Justice: the moral foundations of public health and health policy*. New York: Oxford University Press.
- Raimbault G, Cachin O, Limal J, Eliacheff C and Rappaport R (1975) Aspects of communication between patients and doctors: an analysis of the discourse in medical interviews. *Pediatrics* 55:401–5.

- Roberts D (2006) Legal constraints on the use of race in biomedical research: toward a social justice framework. *Journal of Law, Medicine and Law* 34:526–34.
- Sandelowski M (2000) Whatever happened to qualitative description. *Research in Nursing and Health* 23:334–40.
- Schnittker J and Liang K (2006) The promise and limits of racial/ethnic concordance in physician-patient interaction. *Journal of Health, Politics, Policy and Law* 31:811–37.
- Smedley B, Stith A and Nelson A (eds) (2003) *Unequal Treatment: confronting racial and ethnic disparities in health care*. Washington DC: The National Academics Press.
- Urciuoli B (1996) *Exposing Prejudice: Puerto Rican experiences of language, race and class*. Boulder, CO: Westview Press.
- Verkuyten M (1998) Personhood and accounting for racism in conversation. *Journal of the Theory of Social Behaviour* 28:147–67.
- Wolf S (2006) Introduction: debating the use of racial and ethnic categories in research. *Journal of Law, Medicine and Ethics* 34:483–6.

#### CONFLICTS OF INTEREST

None.

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