"It's a cultural thing":
Excuses used by health professionals on providing inclusive care

by

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Abstract: Although health services in Australia have an aim to provide inclusive care for their patients/clients, this study highlights how barriers to care can lie at the centre of patient-provider interactions. Racial microaggression is a subtle form of racism that can occur in health settings, leading to further exclusion for First Nations Australians, immigrants and refugees. This paper is guided by Derrida's approach to deconstructionism by unpacking how language is used by health professionals - as holders of organisational power - and how they construct "truths" or discourses about clients that historically have been marginalised by health services and system. Data comprise 21 interviews with staff from two rural health services. It identified three racial microaggressions were used to justify the challenges of providing care to people from First Nations, immigrant and refugee backgrounds: (1) Participants problematised culture(s) of service users; (2) participants implied cultural superiority in their conceptualisation of "other" cultures; and (3) participants shared stories of inactions, discomfort and relegating of responsibility. The findings identified these discourses as forms of racial microaggression that can potentially lead to further exclusion of people seeking services and support.

Keywords: microaggression; racism; communication; rural health; culture; inclusion

Acknowledgement of Country

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peoples have had and continue to have a unique role in the life of these lands. We acknowledge that some findings may be upsetting but we aim to make visible racial microaggressions in order that health professionals may reflect and change their practice. Please be aware that this paper contains reference to the name of a deceased Aboriginal woman and her unborn child.

Introduction

There are many ways health services practise care that excludes and obstructs access for particular service users including First Nations peoples, immigrants, refugees, people who identify as gender and/or sexually diverse, and people with disability(ies). From structural processes, such as cost and strict appointments-only service delivery, to everyday microaggressions by health professionals, such practices contribute to the increase in the burden of diseases held by the above-mentioned people (Bastos et al., 2018; Durey & Thompson, 2012b; Henderson & Kendall, 2011; Sherwood, 2013; Ziersch et al., 2011). They also risk contributing to preventable deaths, such as that of Wiradjuri woman Naomi Williams and her unborn child in Tumut hospital in 2016 as a result of the health service's negligence and presumptions of her being an illicit drug user. This is a significant reminder that mainstream health services can be a dangerous and unsafe place for First Nations people (State Coroner's Court of New South Wales, 2019). While already a difficult space to navigate, accessing health services becomes more challenging when specific groups of people are treated as non-compliant or problematic when their behaviours do not fit into categories determined by the dominant group (i.e white, heterosexual, able-bodied, middle-upper class) (Anderson et al., 2012; Mitchell et al., 2018). As a result, they are deemed "difficult" due to their difference(s). Once stereotyped, they can be regularly excluded, particularly through the use of language and the discourses surrounding them.

Although race is widely understood to be a social construct that perpetuates myths of superiority/inferiority and domination/subordination (Akintunde, 1999; Case, 2017; Paradies, 2006; Wadham, 2004), it can at times be used to justify in/actions of racism. First Nations scholar Yin Paradies defines racism as 'a societal system in which actors are divided into "races", with power unevenly distributed (or produced) based on these racial classifications' (Paradies, 2006, p.144). Racism as a societal system is expressed – overtly and subtly – through beliefs and attitudes in interpersonal and/or systemic interactions perpetuating inequalities in the distribution of power, resources and opportunities (Australian Human

Rights Commission, 2019; Walton et al., 2013). Racisms and exclusions are thought to be subtler now than in previous decades (Nelson, 2014; Sue, 2010). The occurrence of racial microaggressions in health services is one form of subtle exclusion. Racial microaggression, sometimes referred to as everyday racism, can be defined as a subtle form of racism that occurs verbally or non-verbally without the intention to cause harm to those that occupy marginal identities (Almond, 2019; Ballinas, 2017; Sue, 2013). It is an assault that is based on race and can at times be layered and intersected with other cultural and social identifiers, such as gender, class, sexuality, accent, immigration status, phenotype or language (Pérez Huber & Solorzano, 2015). Microaggressions are manifested in various contexts at interpersonal, organisational, institutional and societal levels. They are often used by those who belong to the dominant group in a given society to subtly assert dominance and superiority through language (Almond, 2019; Essed, 1991; Sue, 2010). Essed defines everyday racism to be:

> systematic, recurrent, familiar practices…the fact that it concerns repetitive practices indicates that everyday racism consists of practices that can be generalised. Because everyday racism is infused into familiar practices, it involves socialised attitudes and behaviour. Finally, its systematic nature indicates that everyday racism includes cumulative instantiation (Essed, 1991, p. 3).

As 'systematic, recurrent, (and) familiar' (Essed, 1991, p.3), it can be difficult to identify racial microaggressions when they occur. This form of racism often transpires briefly but frequently, allowing the impact on the receiver to compound over time that ultimately results in harmful effects (Levchak, 2018).

While studies have linked poorer health outcomes to institutional racism (Henry et al., 2004; Larson et al., 2007; Nadal et al., 2014), research on racial microaggressions or everyday racism in health settings is limited. Some studies have explored how interpersonal or everyday racism can impact on how people engage and access health services (Durey et al., 2012a; Larson et al., 2007; Paradies et al., 2013), identifying that microaggressions lead to exclusion, disempowerment and prevent a service from genuinely practising inclusive care. Inclusive care is understood to be care that is accessible to everyone but more so for those who have historically been excluded from receiving safe, accessible and welcoming care (Levesque et al., 2013; Malatzky et al., 2018). Racial microaggressions and the lack of culturally inclusive practice in Australian mainstream health services are inextricably linked to service user's experience of cultural safety. To explore this further, this paper analyses various ways language is used by staff in health services to describe First Nations Australians,

immigrants and refugees, and how these staff make sense of service users' access to rural mainstream health services.

Background

Language plays a strong role in the way societies build their social processes, systems and discourses. It is dynamic, constantly moving and changing. Derrida approached language from a deconstructionist perspective, deeming it an unstable medium of communication through subjective meaning-making and interpretations that are never fixed (Derrida & Spivak, 2016). By calling all certainties, binary oppositions, dichotomies, appearances and realities into question, deconstructionism argues that a singular interpretation or absolute truth is untenable (Whitehead, 2011, p. 118). This paper is guided by Derrida's approach to deconstructionism to understand and uncover perceptions and assumptions made by health professionals when caring for service users from First Nations, immigrant and refugee backgrounds.

For Derrida, language can reveal a culture's norms, values, beliefs and attitudes, and as such, language itself is political. He argues that 'mastery begins, as we know, through the power of naming, of imposing and legitimating appellations' (Derrida, 1998, p. 39). There is power in the naming, especially when those doing the naming belong to a powerful organisation such as a health service (Larner, 2015, p. 437). This paper focuses on the language used by those with organisational power, that is, staff from two small rural mainstream health services. It explores how staff construct "truths" or racialised discourses about service users who are of different cultural backgrounds to the perceived norm. These discourses or ways of talking about service users further perpetuate and reinforce racialised stereotypes and established assumptions surrounding those very same groups. Historically, these discourses have sustained colonial practices and more recently are manifested through language in the form of racial microaggressions. The use of microagression uses language to assert power, intimidate and portray that particular groups are unwelcome by restating discourses and stereotypes in a way that puts down an individual.

Mainstream Australian society struggles to unpack issues concerning race and socio-cultural differences. The current political climate allows overt racism to occupy powerful platforms in the media (Bond, 2016; Noonan, 2019) and parliament (Worthington & Doran, 2019). It is important to note that reforms in policy have attempted to address racism by adopting a human rights informed cultural competence framework. This is evidenced in the

Victorian Government's Aboriginal Health, Wellbeing and Cultural Safety initiatives (Victorian Government, 2012, 2017, 2019) and more so in the recent edition of accreditation standards for mainstream health services where cultural safety and a culturally secure environment specifically for First Nations peoples is prioritised in the Clinical Governance Standard (Australian Commission on Safety and Quality in Health Care, 2017). However, these reforms can often take time to be implemented within services and some initiatives, such as the Australian Government's Closing the Gap framework, are failing to meet targets (Commonwealth of Australia, 2020; Bond & Singh, 2020). Such top-down approaches perpetuate the deficit discourse about First Nations Australians as failing, and contribute to racial microaggressions, and to them not being addressed or challenged within health services and more broadly in society.

Derrida has observed that 'all racisms have their basis in culture and in institutions' (1985, p. 294). In other words, racism in its many forms is created and perpetuated within the culture and the institutions that we live and participate in. As a result, racialised language evolves within these settings. Rather than self-reflecting on how they practise inclusive care, health professionals often place the problem with service users (Durey & Thompson, 2012b). The challenge to self-reflect on their exclusive practices within a powerful organisation, such as a health service, is a product of institutional racism (Durey, 2010). By highlighting the ways in which racial microaggressions manifest in everyday healthcare discourse, we may better understand how systemic racism is continually maintained and reproduced in broader society. While this is generally acknowledged, few papers have demonstrated how language is used to exclude certain individuals and groups in health services. This paper will identify examples of everyday racial microaggressions within these settings and how they work to exclude service users in healthcare practice.

Because this study specifically examines how health professionals speak about First Nations peoples, immigrants and refugees, it is important to note that the authors of this paper, one of whom is a First Nations Australian researcher, does not condone the views of the participants. At times, the paper will refer to First Nations peoples, immigrants and refugees as marginalised but only within the context that the marginalisation is purposefully caused – and continues today – through systemic socio-structural inequities (Anderson et al., 2009; Arabena, 2016; Bond et al., 2019; Malatzky et al., 2018; Sherwod & Edwards, 2006). As researchers from diverse cultural and social backgrounds that intentionally work in the pursuit of social justice, the authors acknowledge that the term 'marginalised' can be jarring.

However, this paper is about highlighting how health professionals – many of whom are white Anglo-Saxons – construct racialised "truths" and further perpetuate myths and stereotypes which maintains that oppressive position of marginality. This paper uses the term "white" as a racially constructed category in which power relations are instilled based on privilege (Moreton-Robinson, 2000). The authors also note the complexities and fluid nature of cultural and social identities and that these markers of identities overlap and move according to context, time and space (Evans, 2019).

Methods

The present study analyses 21 interviews with staff from two small, rural Government-funded health services. Data were gathered as part of a larger Australian Research Council funded project which explores increasing inclusion in rural, generalist health services in the state of Victoria, Australia (Malatzky et al., 2018; Mitchell et al., 2018). Importantly, the team comprises diverse sociocultural backgrounds, including a woman of colour born in Asia, a Barkindji woman and two white researchers raised in privileged families in rural areas. The study was approved by The University of Melbourne Human Research Ethics Committee.

The health services differ in the type of health care provided, their responsiveness to diverse client groups and in their governance and funding structures. These services were selected based upon their rural location, the significant cultural diversity of the local population, the relationships each service have with service users, and that each service had self-initiated a process to improve their inclusivity. Additionally, the team has been gathering the perspectives of service users from the same rural town as the health services to understand their experiences accessing health services; this data will be submitted for publication separately. One service was an age-specific 'walk-in' service while the other was available for all in a specific life-stage. Both had teams of 10-20 health professionals who provided both in-service and outreach support. They include clinicians (nurses, social workers, psychologists and others), reception staff and community engagement officers with the majority of staff from white Anglo backgrounds. Participants had worked in these services between four months to nine years. Data from both services have been de-identified and pooled to protect the confidentiality of staff.

Initially, researchers met with all staff from the two services to introduce the research project. Following, managers from the services disseminated the Plain Language Statement and Consent Form to all staff which included contact details of researchers. Staff were then

invited to an interview via email from researchers and those who wished to participate contacted researchers. Recruitment and interviewing of staff occurred in the period between November 2017 to April 2018.

A semi-structured interview protocol was used to capture health professionals' perspectives on working in rural mainstream health services, ways to improve inclusion in health care broadly, challenges of providing inclusive care, and issues surrounding engaging groups of service users which the specific service struggles to engage. Three researchers, one of whom is First Nation Australian, conducted the interviews separately as participants' availability was prioritised. Researchers took notes during the interviews and all consented to being audio-recorded with the exception of one participant. Recorded interviews were transcribed verbatim. Handwritten notes of the non-recorded interview were typed and added to the pool of data.

Researchers read all interview transcripts and discussed the common themes identified throughout project meetings. It was agreed that language in the transcripts reflected prejudice, microaggressions and power relations. Drawing on Derrida's approach to deconstruction, the first author then coded each interview to identify microaggressions, the context of the use of these microaggressions and how this language creates power imbalances (Whitehead, 2011). From these codes, three types of microaggressions were identified. The team, made up of researchers from different training and disciplines, discussed the types of microaggressions over multiple meetings and challenged the specific examples of each type. Following this iterative process, the three microaggressions were agreed to and are presented here (Braun & Clarke, 2013; Finlay, 2006; Liamputtong, 2013).

Findings

During interviews discussing inclusive care with 21 health professionals, it was noted that participants asserted their power through using language that reflected three types of microaggressions, namely problematising the culture(s) of service users, expression of superiority and inaction.

Problematising the Culture(s) of Service Users

When asked about factors that shaped the service users' access to services, thirteen health professionals across the two services dismissed and assumed that it is 'the culture(s)' of First Nations, immigrants and refugees that prevent them from coming into their service. Here, "culture" is used as a racial microaggression implying its association with a set of different

and undesirable behaviours as perceived by the health professionals. Some stated that 'culturally they do prefer home visits' and that 'some of the cultural views within the CALD [Culturally and Linguistically Diverse] background could prevent people from coming in.' There were other ways that racial microaggressions were utilised where excuses of "culture" manifested in phrases such as 'it's cultural…', 'these cultures' and 'it's a cultural thing' to dismiss the problem of accessing services for some clients. Another participant spoke with strong racial overtone assuming that, 'a lot of our CALD families that refuse to come to the service, have perfectly good access to transport but demand home visits.' Here racial microaggressions are used subtly as well as overtly with "culture" being problematised and framed as dictating behaviours that differ from the perceived norm. It was clear from the transcripts that genuine engagement with service users had not occurred and an attempt to understand the service user's perspective of what prevents them from engaging or accessing the service had not been established.

One participant reflected on the need to recruit a First Nations worker but implicitly added without finishing their sentence that the cultural background is also part of the problem:

> we literally need to have an Indigenous worker… working amongst the team that [clients]
> can come and see. I feel like we're making steps towards that direction *but there's still*
> *the whole culture that needs to be a bit, well*…. (emphasis added)

These comments indicate how some health professionals perceive and problematise the culture of their clients while also suggesting it is not their responsibility. When asked whether First Nations users ever disengage from the service, another participant said that 'yes they do disengage, I think because a lot of that, it's that shame-shy thing that gets in the way.' Rather than the service genuinely engaging with the perceived 'shame-shy thing', health professionals problematised the culture(s) of service users by excusing the disengagement as culturally and by default racially-contingent. It may be that there is an element of the service user's disengagement that is culturally related, yet health professionals labelled it as the only reason. One participant found it difficult and uncomfortable to articulate the reason for the disengagement of First Nations, immigrant and refugee service users from health services and explored how their culture(s) can be an impediment to them accessing the service: 'their concept of mental illness is quite different, it's a very different culture.'

Problematising culture and dismissing it as a barrier to a user's access to a service places blame, lack of utilisation of service and ultimately poor health outcomes on the user and their "culture". The term "culture", as used by health professionals, replaces the term

"race" to evade the negative historical and political connotations attached (Bond & Brough 2007). This further contradicts notions of client-centred care widely propagated in policies and frameworks and detracts health professionals from meaningfully engaging and adapting their model of care to be inclusive and accessible to all. When models of care are implemented, they are often formed without evidence or the input or perspectives of service users (Fraser et al., 2018). Language that repeatedly labels the culture(s) of service users as 'Other' (Bhabha, 1983) through phrases such as 'it's cultural', reinforces the difficulties of working with such groups and individuals and dismisses the professional's responsibility to provide care to everyone in the community.

Expression of cultural superiority

When talking about service users, health professionals continued speaking with strong racial overtones by expressing the cultural inferiority of certain groups. One of the ways this microaggression occurred was through assumptions about the lack of or non-existence of specialist health services and the barrier this creates for overseas-born users and their understanding of what Australian health services provide. One health professional commented that 'they haven't had this service in their own country' and assumed that 'they don't understand a 'well' model of healthcare.' Another assumed 'sometimes culturally they haven't experienced a [certain type of] health service before because in their culture there isn't anything like that.' It was clear throughout the interview transcripts that these statements were not based on discussions they have had with their clients, but on assumptions made about the limitations of many non-Australian health care systems. In doing so, health professionals deny how their own practice is itself culturally constructed and privileged (Malatzky et al., 2020). This microaggression reinforces an assumption of a user's lack of knowledge of the service by blaming the lack of services in a client's country of origin. Further, there is a perceived superiority implied in these statements that suggest groups of users who were born overseas are a homogenous group who 'don't understand' and need health professionals 'to get to them (to understand) what we do.' There is a lack of negotiation, adaptability and input in discussions of practice with service users.

In one service, a health professional emphasised how the stigma of a particular health issue for First Nations, immigrants and refugees 'is massively ingrained' and that this stigma experienced by the above-mentioned groups was assumed to be 'more entrenched than what European stigma might be.' Another commented how particular health conditions 'are a weakness in some cultures.' These perceptions potentially conceal the stigma of this

particular health issue (and others) that exists in dominant white culture in Australia and thus inherently reinforce the inferior nature of "other" cultures. By conceptualising the approach to health within a Western paradigm (Brown et al., 2016a), health professionals inadvertently used language of superiority that privileges biomedical approaches (Durey & Thompson, 2012b). Similarly, previous studies have also demonstrated racialised discourse through expressions of cultural superiority (Anderson et al., 2009; Essed, 1991, p. 45; Mapedzahama et al., 2012).

The notion of cultural superiority was further demonstrated in language used by health professionals regarding the disempowerment of women from immigrant and refugee backgrounds with some stating that there is a need 'to empower these women'. Dismissing gender relations in their white culture, one participant commented that 'there's a lot of gender bias, not necessarily within our culture, but definitely within some of our CALD families, it's very patriarchal.' Similarly, another participant commented that 'one of the big issues we're finding in people from the CALD community is the tension around particularly women being more empowered…which is not a traditional role.' This highlights the assumption by health professionals about the lack of agency that immigrant and refugee women have and a perceived inferiority of women's status in other cultures but not their own culture. It reinforces and perpetuates the victim discourse about immigrant and refugee women among health professionals and implies a role to intervene. These microaggressions from health professionals not only reinforce white cultural superiority but also undermine, or in this case, deny the misogyny that exists in white culture (Volpp, 2001). The focus here is on culture and how those who do not reflect nor belong to the dominant white culture are perceived as inherently inferior.

The inaction, discomfort and relegating of responsibility

When discussing engagement with clients of First Nations, immigrant and refugee backgrounds, the health professionals shared stories that suggest inaction, discomfort and at times relegating the 'difficult' client to a culturally-specific specialist service. Using phrases such as 'we don't have expertise in that (a client's culture),' they dismiss the service user's needs by suggesting that the generalist service could not assist those identified from a non-dominant cultural background. Health professionals also shared instances in training where they felt they were being blamed for past historical injustices, thus excusing themselves for the lack of engagement with First Nations service users: 'there was still lots of blame put on me for past (Australian) history and there was no sort of helpful hints on how to engage that

population.' Another spoke dismissively by framing certain user groups as complex with severe issues, 'I mean some of the things like family violence and stuff like that within *those communities* are quite severe and it's got a lot of complexity about that (emphasis added)', while another expressed their frustration and difficulty in working with specialist service providers from First Nations, immigrant and refugee backgrounds: 'we try so hard to engage all families and work with, you know, these groups that need it, but we're not getting that back from their providers as well too, so it is quite frustrating.'

These racialised statements or 'excuses' suggest that staff find engaging and working with such clients as "difficult". There is a reluctance of health professionals to self-reflect on the way they talk about particular service users as shaping these interactions, responses and models of care. In expressing these microaggressions, deficit discourses are reproduced about these groups that lead to inaction and inadvertently 'maintains status quo' and exclusive organisational practice (Durey & Thompson, 2012b, p. 9). Essed also noted that 'a main problem today is inaction among the dominant group and, more specifically, passive tolerance for racism' (1991, p. 42).

Furthermore, there were multiple examples of stories about actions that were trialled with specific groups of people and, when not fully successful, were abandoned. Embedded in these stories is an expectation of service users to willingly participate in Western frameworks regardless of prior experiences. Further, when not well attended, activities were withdrawn rather than improved, evaluated or redeveloped through a consultation process. For example, at one service, a mobile unit was developed to take the service to a targeted group. When it was not well attended by both genders, the service was ceased. In another service, sessions for those speaking a specific language were developed but when the first few sessions were not well attended, it was disbanded. In these stories, health professionals conveyed a sense of 'we've tried and given up' rather than we consulted, we engaged, we reviewed, and we persisted. There was little discussion of the development of relationships or service user need; rather the focus was on the efforts of the practitioners and their language of program development using Western healthcare language. In clinging to their service delivery frameworks, their language pushes the interests, voices and needs of service users who have differing cultural perspectives to the periphery. The blame on the under-utilisation of a supposedly tailored program clearly sat with the users of the service.

Another health professional recalled a time where they sought a service assumed to be available from a specialist community organisation for a service user from an immigrant/refugee background:

> So I did call the… cultural [specialist service] and a worker there and she basically just threw her hand up and said I don't know what to do. And I thought *it's not really our job to do it* when there's already a service there that could come and do some sort of groups or something like that… coming from a cultural like community development model, I think it would need the ethnic community or the Muslim or spiritual leader or an Indigenous spiritual leader to come into our service. (emphasis added)

This example of relegating practice is problematic in rural areas where specialist services are lacking. The language of relegating a service user to culturally specific services place a greater burden on an already-stretched and under-resourced community organisation and denies the user the choice of a mainstream service. These examples illustrate how health professionals make assumptions about who provides services rather than working together with the specialist service to achieve genuine and meaningful engagement with First Nations, immigrant and refugee users. This language negates the responsibility that mainstream health services must provide care for everyone.

Discussion

This paper identified that when discussing cross-cultural health practice, three types of racial microaggressions were commonly expressed by staff from two small rural mainstream health services. Adopting a Derridean deconstruction lens, the health professionals' perception that the culture of service users can be a barrier to their access to health services reveals the everyday interpersonal racism. This then maintains structural racism as this perspective becomes embedded within organisations, health practitioner training and practices as well as the broader Australian society. This perception stems from a racist history whereby the approach to First Nations research, policies and programs often attributed culture with problematic behaviours (Bond & Brough, 2007). Through their language, the health professionals positioned culture in the form of the 'other' and as a result takes the attention away from the Western-centric culture of health services (Downing & Kowal, 2011). The language used by health professionals laid bare the dominant attitudes about particular groups of clients that are held, reproduced and sustained within the cultures of the health services (Bond & Brough, 2007; Durey, 2010; Grant & Luxford, 2011; Levesque & Li, 2014; Mitchell et al., 2018). The excuse of cultural difference by health professionals further perpetuates the

lack of accountability on the part of services to provide appropriate and inclusive client-centred care to service users, thus perpetuating a culturally unsafe environment for accessing care. By turning the focus on the exclusive language and racialised assumptions used by health professionals, this study shifts the attention to those in power (Durey & Thompson, 2012b; Fredericks, 2010) and how they contribute to the barriers that service users face when accessing health services.

Like institutional racism, everyday racism or racial microaggression is subtle and less overt. It reinforces cultural practices, language and understandings. In using racial microaggressions, health professionals are consequently practising and delivering care that excludes and disempowers their clients. Grant has argued that there are relations of 'power within language and culture, taking language to be constitutive of culture and of culture as shaping discourses expressed through language' (2011, p. 20). The cultural practices of mainstream health services have historically been exclusive to those who occupy the dominant cultural and social position – that is white, heterosexual, able-bodied, middle class population. This is because policies, procedures, service delivery frameworks, practitioner training and other forms of structural processes were produced by the very same dominant group (Anderson et al., 2012; Brown et al., 2016b; Malatzky et al., 2018; Mitchell et al., 2018; Sherwod & Edwards, 2006). While current policies call for all health services to be culturally safe, competent and accountable (Australian Commission on Safety and Quality in Health Care, 2017; NSW Health, 2017; Victorian Government, 2019), health services reflect the values and attitudes of a perceived "dominant" culture in health care and these are normalised and reinforced through a subtle form of racism — everyday language — as well as through policies, management and organisational culture. In applying Derrida's approach to deconstruction, this study brings to the surface the way microaggressions function to construct "truths" about clients that then justify the actions and inactions of health professionals during service delivery.

The voices of the health professionals included in this analysis are used as examples of potentially unconscious racial microaggressions (Essed, 1991; Levchak, 2018; Sue, 2019). Many of the professionals indicated they were trying to meet the needs of service users known to be marginalised by the health care system, but in doing so actively excluded their voices, engagement and culture in representing them. The dominant cultural blinkers of health professionals appeared to stereotype the "other" rather than racialised language being reflected on (Jennings, Bond, & Hill, 2018). This highlights the cultural nature of health care

and the position of power held by health professionals (Malatzky & Bourke, 2017). Furthermore, mainstream health services are still yet to address other institutional barriers that prevent access to their services including achieving First Nations workforce targets and lack of accountability to policy frameworks (Arabena, 2016; Bond et al., 2019; Kendall & Marshall, 2004; McGough et al., 2018; Mitchell et al., 2020).

This study presents findings that explored how racial microaggressions manifest in healthcare discourse through 21 interviews conducted with health professionals working in only two small rural mainstream health services. While small, the qualitative constructivist approach enables detailed analysis for learnings around the use of language in healthcare. Consistency with the literature adds credibility to these findings. While the findings are not directly transferable to other mainstream health services in other regions, the types of microaggressions identified are likely to occur in other settings that comprise a majority of white professionals working with non-dominant service users, as found in other studies (Almond, 2019; Ballinas, 2017; Grant, 2018; Nadal, 2014; Sue, 2013). Another limitation was that all coding was undertaken by one author, a non-First Nations woman of colour with a particular settler and privilege lens. To broaden the perspective of this analysis, all authors read the transcripts and engaged in a critical process reflecting on the types of microaggressions and the meanings expressed by participants including a First Nations researcher and interviewer. A further limitation was the lack of inclusion of service user perspectives. Understanding how racial microaggressions operate and their impact from the perspectives of service users accessing health services would add greater evidence to the study's findings. It is important to note that the authors' intention is not to be critical of individual practitioners and those who willingly participated in the interviews, but to highlight how Western language and discourses work to marginalise and exclude those who do not identify with the dominant culture. The need for training and continuous self-reflection in cross-cultural practice in healthcare and meaningful change in models of cross-cultural healthcare is overdue (Sjoberg & McDermott, 2016).

Conclusion

To genuinely engage and change the health outcomes of service users who have historically and continue to be marginalised, health services and practitioners must redirect the cultural gaze towards themselves (Durey & Thompson, 2012b, p. 9). 'Given the everyday, automatic nature of racial microaggressions, they can easily occur within cross-racial patient-provider

interactions' (Almond, 2019, p. 590). Although difficult and to a certain extent confronting, challenging racism and racial microaggressions with staff and changing structural processes with an inclusive lens can improve health outcomes but also create a fairer, more equitable health system. Furthermore, the ambiguity of everyday racism means that more research is needed to name how it manifests in interpersonal experiences and operate within organisations. By making everyday racism visible to what has historically been invisible in organisational, institutional and social structures, we can generate solutions that are inclusive and safe for everyone in the community.

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