



# Healthcare staff's racialized talk: The perpetuation of racism in healthcare

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## ABSTRACT

Research points to the existence of racial bias and beliefs among healthcare staff but does not explicate accounts of racialization in healthcare and the day-to-day utterances that have racializing effects excluding minoritized users' right to care. This study understands racism as structural and embedded in societies and institutions, including healthcare, as well as in interactions and talk. Through excavating accounts of healthcare staff's talk that devalues minoritized users, this study posits talk as reflective and constitutive of the dominant structure of racism within which it is situated. Drawing on qualitative interviews with 58 staff in Sweden, the study delineates three categories through which racialized talk differentiates between minoritized and majoritized users. These are: Characterizing minoritized users as 'bad' users, Characterizing minoritized users' health complaints as unworthy and finally, Devaluing minoritized users as justification for suboptimal and differential care. Healthcare staff accounts show that continuous racialization of minoritized users maintains existing power-relations representing Western users as civilized and non-Western users as uncivilized and problematic. Through reiteration, these practices of exclusion become invisible, normalized, and assume the status quo. It is imperative to address racialization as it has implications for the core ethics of healthcare.

## 1. Introduction

The effects of racism on health outcomes and healthcare are pervasive (Elias and Paradies, 2021). Research demonstrates that ethnic minorities (hereafter referred to as minoritized) receive inadequate healthcare compared to ethnic majorities (hereafter referred to as majoritized), even after controlling for socioeconomic status and health insurance (Williams et al., 2019; Williams and Wyatt, 2015). The experience of racism is independently associated with an increased risk for cardiovascular diseases, hypertension, diabetes, and increased body mass index, as well as mental ill health including increased risk for depression and anxiety (Paradies et al., 2015). Death by racism is a well-documented health penalty (Williams et al., 2019), particularly during the COVID-19 pandemic (Barber, 2020). Minoritized groups such as African Americans, Blacks, and Indigenous populations in Canada, New Zealand, and Australia have higher maternal and perinatal mortality, and lower life expectancy (Paradies et al., 2015). In Canada, for instance, settler colonialism has had a lasting impact on health inequalities and mortality rates among Indigenous populations (Browne et al., 2022).

Racism in healthcare in the form of healthcare staff's racial bias in favor of White healthcare users, is described in quantitative evidence, particularly from the USA and is associated with inequalities across treatment choices (Maina et al., 2018), including pain management (Tucker Edmonds et al., 2017), HIV prophylaxis (Calabrese et al., 2014), and cardiovascular disease treatment (Eberly et al., 2019). Although staff's racial bias has largely been documented through Implicit Association Tests (IAT), studies only point to its existence rather than illuminating *how* racial bias occurs within healthcare interactions.

Healthcare staff's Othering tendencies i.e., the ways in which staff relate to users who are considered marginal and different has been explored qualitatively (Hamed et al., 2022), with studies from the USA, showing that minoritized groups are viewed as unreliable compared to Whites (e.g. Tucker Edmonds et al., 2017). Studies from Canada show that First Nations are treated with disrespect by staff (e.g. Browne and Fiske, 2001; Johnson et al., 2004) and viewed as presenting inappropriate symptoms in emergency care (McLane et al., 2022). Studies from the UK (e.g. Vydelingum, 2006) and Ireland (e.g. Lyons et al., 2008) describe staff's views of Asian minorities as irrational. In other contexts such as Spain, Belgium, and France (Briones-Vozmediano et al., 2018);

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Claeys et al., 2020; Morel, 2019), minoritized groups such as Roma and Muslims are viewed as problematic healthcare users.

Racism's association with ill health, as well as the association between staff's racial bias and suboptimal care, is well documented. Yet most studies do not examine staff's views in depth, as demonstrated in our scoping review (Hamed et al., 2022). There is a dearth of studies uncovering healthcare staff's day-to-day utterances that may have racializing effects that exclude and reduce people's entitlement and/or access to healthcare (Nazroo et al., 2020). This study understands racialization as a sociohistorical process rooted in colonial domination, wherein people are stratified somatically and culturally within groups of subordination and supraordination (Bonilla-Silva, 2009). Racialization is understood to be the process through which racism is produced and given meaning. As argued by Winant (1998) and Bonilla-Silva (2009), the importance of studying talk lies in the reproduction of racialization, including racial bias: talk legitimizes and reproduces existing structures of racism by assigning and signifying meaning to racial categories. This study posits racism as a structural organizing system of social stratification that is embedded within a network of social, economic, and political entities (Goldberg, 2016). A qualitative study is thus necessary to explore healthcare staff's racialized talk, which, refers to any talk that homogenizes and devalues minoritized healthcare users based on their racial categorization. Through an exploration of accounts of healthcare staff's racialized talk, this study contributes to understanding how racism is perpetuated in healthcare settings.

The term healthcare staff encompasses healthcare providers such as nurses, dentists, midwives, physicians, and other stakeholders, such as public health and community health staff. Healthcare user is used for those using healthcare, including medical, dental, and pharmaceutical services. Minoritized people refers to groups who are racialized as inferior in contrast to the dominant group and subjected to unequal power-relations in different institutions. Finally, majoritized people refers to the dominant majority group who are also racialized as superior and who have cultural and economic power over minoritized groups.

### 1.1. Theoretical framework

Racialized talk, also 'race' talk (Augoustinos and Every, 2016) or racialized discourse (Tator and Henry, 2000), refers to a myriad of talk related to 'race', racism and multiculturalism in contemporary societies. The most consistent finding on racialized talk is the discursive attempts people make to distance themselves from being viewed as racists (Goodman, 2014). Billig (1988) discusses this finding in the UK as "the cultural norm against 'prejudice'" (p. 94), where speakers would attempt to frame prejudicial statements about minoritized groups while simultaneously denying being racist. Wetherell and Potter (1992) and others developed this further, arguing that a denial of racism is a current characteristic of Western societies. Wetherell and Potter (1992), in their analysis of White New Zealanders, discuss how the ambiguous nature of racialized talk entails particular patterns used by majoritized groups to rationalize existing inequalities as caused by minorities' shortcomings rather than racism.

Researchers examining racialized talk point to the contested nature of racism, such that while racialized talk may be explicit, this is not necessarily so (Dunn and Nelson, 2011; Lentin, 2018). Similar results in healthcare point to the prevalence of *implicit* rather than explicit racial bias. Racial categories are rarely defined in explicit biological terms as these definitions are widely viewed unacceptable (Omi and Winant, 2014). Speakers often remove overt expressions of racism when discussing minoritized groups to evade accusations of racism (Bonilla-Silva, 2002), with contemporary racialized talk described as "slippery, apparently contradictory, and often subtle" (Bonilla-Silva, 2002, p. 42), characteristic of a colorblind racism – the dominant racial ideology in today's Western societies.

Bonilla-Silva (2002, 2009) and others show that specific essentialist cultural constructions, as opposed to biological explanations, justify

existing uneven power-relations between racial categories. Essentialism refers to the belief in underlying innate characteristics that differentiate social categories (Grillo, 2003), and categorizes individual people into groups viewed as representing distinct human types (Verkuyten, 2003). Cultural essentialism can be defined as the notion that "people are ... more or less passive carriers of their culture, whereby their attitudes, beliefs, and achievements are supposed to reflect typical cultural patterns" (Verkuyten, 2003, p. 385). Racial categories can be seen as a form of cultural essentialism (Braun and Saunders, 2017), whereby rather than applying purely biological or genetic ideas to racial categories, essentialist ideas of culture underpin racialized talk (Bonilla-Silva, 2009). Racialized talk resting on cultural essentialism entails believing that racial categories are associated with stable and fixed cultural patterns, including values and practices (ibid).

Examining racialized talk is essential to understanding racism, especially when explicit forms of racism are uncommon, since racialized talk is linked to power and the preservation of dominant structures (Goodman, 2014). Analysis of racialized talk exposes the function of talk in creating inequality in social settings and offers an understanding of how people aid, consciously or unconsciously, the continuation of racialization through the legitimization and reproduction of racial structures (Bonilla-Silva, 2002, 2009).

Consistent with research in other institutions, racism in healthcare is often subtle (Hamed et al., 2022). Research addressing the Othering of minoritized users has not examined healthcare staff's racialized talk in-depth and lacks a theoretical understanding that situates day-to-day racialized talk within existing power dynamics (Nazroo et al., 2020). This study addresses this gap by examining how healthcare staff's racialized talk contributes to devaluing minoritized users in Swedish healthcare. The study also contributes to how racism is enacted in healthcare.

### 1.2. The Swedish context

Racism has long been part of the Swedish nation state through external and internal colonial processes. Sweden's colonial complicity (Keskinen et al., 2016) in the racialization of non-European populations, for instance, Africans, Muslims, and Indigenous people as savages was part of Sweden's public and official state discourse (McEachrane, 2018). Swedish scholars such as Carl Von Linnaeus contributed to the rise of 19th century scientific racism, enforcing the notion of humans as immutably divided into four distinct 'races' with fixed moral and intelligence characteristics and skull shapes. Further, "internal or proximate colonial processes" saw the racialization of the Sami Indigenous groups, Jews, and Roma (Mulinari and Neergaard, 2017, p. 91), which facilitated the statutory limitation of Sami people's access to education, housing, and other resources in the 19th century. During the 20th century, Roma people were not allowed to register in schools, access healthcare, and stay in municipalities for more than two weeks (Teodorescu and Molina, 2021). The Swedish Society for Race Hygiene, established in 1909 (McEachrane, 2018) was supported by the medical community and later developed into the State Institute for Racial Biology that forcibly sterilised Roma and Sami people (McEachrane, 2018).

Contemporary racialization is associated with non-Western migrants, primarily Muslims, and people of African descent (also subject to historic racialization), in which racialized colonial discourse is invoked (Mulinari and Neergaard, 2017). From the 1960s, migration in Sweden has been increasingly politicised with initial discussions revolving around whether migration implies economic gain or loss (ibid). From the 1990s an increase in the numbers of arrivals meant that by 2022 about 20% of the population in Sweden were foreign-born (people born outside of Sweden), and about 30% have a foreign background (people with one or two parents born outside of Sweden, including immigrants and their children, adopted and multi-ethnic Swedes). Syria and Iraq, are the two most common countries of birth

**Table 1**  
Types of interviews.

Focus group interviews (n = 4)	Number of participants	Occupations
1	3	Nurse, Policy Maker, Physician
2	7	Nurses, Physicians, Psychologist, Policy Makers, Public Health Staff
3	6	Nurses, Public Health Staff, Physician, Psychiatrist, Social Worker
4	8	Nurses
Paired interviews (n=2)	Number of participants	Occupations
1	2	Dentists
2	2	Physicians
Individual interviews (n=29)		
	30	Nurses, Midwives, Physicians, Dental Hygienist, Pharmacist, Nurse Aid, and others

for foreign-born people in Sweden (Statistiska centralbyrån, 2022). The number of migrants from African countries has increased, primarily from Somalia, Eritria, and Ethiopia (ibid). A public discourse focusing on the assimilation of non-Western migrants by adopting ‘Swedish values’, which are considered superior, prevails. The notion of the superiority of ‘Swedish values’ is not new, having been part of historic racialization wherein the Nordic ‘race’ is constructed as of supreme value. The current racialization of the non-Western migrant is a prolongation and maintenance of past colonial and racialization processes ingrained in the Swedish imagination. Sweden is seen as disintegrated due to exploitation by lazy non-Western migrants who are unsuitable to live alongside the civilized ‘White’ European Swede (Dahlstedt and Neergaard, 2019). The migrant is often imagined as “A non-privileged, non-white, non-western (...) and as such is portrayed as ‘a contemporary problem’” (Lundström, 2017, p.1), with Sweden considering itself as a ‘White’ nation devoid of colonial history (ibid). In Sweden, the word ‘migrant’, refers to non-Whites from non-Western countries rather than all people migrating into Sweden and is thus connected to racialization.

The dominant racial ideology across Swedish institutions is post-racialism or colorblindness, whereby a colonial racialized discourse that achieves cultural Othering of immigrants also constructs a racial innocence, although explicit racial terms continue to be used. The argument is that Sweden has moved past the racial ideology that existed before World War II (Alinia, 2020), making discussions around racism challenging since they go against Sweden’s core self-image.

**2. Methods**

**2.1. Study design**

This qualitative study consisted of thirty-five semi-structured individual and focus group interviews with 58 healthcare staff of diverse ethnic and occupational backgrounds conducted in different regions of Sweden. As the research topic is sensitive, individual interviews were considered most appropriate (Green and Thorogood, 2013). Focus group discussions (n = 4) were conducted when staff had time constraints, where individual interviews were not possible, or when staff in the same workplace requested to be interviewed together. Two paired interviews were also conducted as per the request of the participants (see Table 1). Although individual interviews allowed participants to speak more freely, focus group discussions provided a more interactive dialogue between participants and researchers (Green and Thorogood, 2013).

**2.2. Recruitment**

Recruitment started at the end of 2017 and ended in 2020. To investigate staff’s racialized talk, we aimed to capture differential views

on and aspects of racism in healthcare. Thus, a maximum diversity sample was chosen regarding ethnicity, occupation, and workplace, with recruitment from large hospitals, teaching hospitals, and small clinics to capture a range of views. Staff were also recruited from larger cities and small towns, with most from urban areas. Initially, healthcare institutions were emailed and visited to distribute the project’s information leaflets. Since racism is challenging to discuss, this method proved ineffective and other methods were needed, particularly to recruit minoritized staff who were often too anxious to discuss racism due to fear of repercussions, even with assurances of confidentiality and anonymity. We used prior contacts from previous projects, where we had already established trusting relations. These contacts acted as key informants and enabled us to access healthcare staff, particularly minoritized staff. Additionally, three of the authors are minoritized researchers, and one has experience as a clinician. Such ‘insider’ status provided a sense of shared racialized (and occupational) belonging. This advantage not only helped in recruitment but also in gaining trust and establishing rapport during the interview. We conducted several presentations on the project around Sweden in various healthcare settings, which increased the project’s visibility, facilitating recruitment in certain settings. The majority of those interviewed were majoritized staff (n = 36/58) which we discuss as a potential study limitation in section 4.1.

Table 2 includes participant characteristics, including their occupational and racialized category and gender. The locations where staff were employed are not shown to avoid the risk of individuals being identified, especially those recruited from small towns. All participants were Swedish citizens and spoke fluent Swedish.

**2.3. Data collection**

Participants received an information leaflet describing the project before the interview. Verbal and written consent was obtained. Most interviews were conducted by the first and fourth authors (32 out of 35 interviews), both minoritized researchers. Most interviews were conducted in Swedish, but other languages, such as English, Arabic, and Hindi, were also used according to staff’s preferences. The various language possibilities were described in the information sheet and verbally before interviews were undertaken.

An interview guide was formulated by the authors to facilitate but not determine discussions (Kallio et al., 2016). The interviews started with non-threatening context-setting questions before moving to racism-specific questions (Seidman, 2005). Staff were initially asked about their occupation and their typical workday. A question about how

**Table 2**  
Participants’ characteristics (n = 58).

	n (%)
<b>Occupation</b>	
Nurse	20 (34%)
Physician	11 (19%)
Dental professional	8 (14%)
Midwife	4 (7%)
Psychologist	3 (5%)
Others: Pharmacist, Social Worker, Nurse Aid, lab Analyst, Public Health Staff and Policy maker	12 (21%)
<b>Racialized category</b>	
Minoritized	22 (38%)
Majoritized	36 (62%)
<b>Gender</b>	
Female	46 (79%)
Male	12 (21%)

the so-called ‘migration crisis’ may have affected the dynamic in their workplace was posed. Migration in Sweden is often racialized, and we hoped this question would generate discussion of racism.

The interview guide and interviews were constantly discussed within the research team. After initial interviews, discussions pertaining to our interview guide concluded that more direct questions on how staff reasoned around racism were warranted. Hence, we added a question on what the word racism invoked. Discussions also resulted in the use of vignettes based on accounts of racism in healthcare, generated through initial interviews to facilitate further discussions on racism, especially when participants were apprehensive. Vignettes have been used in health research to explore sensitive issues such as mental illness (Medina et al., 2011) and racism (Haider et al., 2014). Our vignettes encompassed a range of stories reflecting different dimensions of racism, including racism towards users and staff (see supplementary material 1).

All interviews were recorded except five, where written notes were taken, at the participants’ request. The interviews lasted between 23 and 110 min. All recorded interviews were transcribed verbatim, stored, and coded in AtlasTi 8.

#### 2.4. Data analysis

Data analysis is an iterative process that starts with the interview (Kallio et al., 2016). An initial coding scheme was constructed based on our reading of the interviews. This coding scheme was applied to a couple of interviews by all authors and the results were compared to inform modifications to the scheme. The first and second authors tested the modified coding scheme on two further interviews. After another round of discussion, the coding scheme was again modified. The first author coded all the interviews with the final coding scheme which included the following broad codes: reasoning around racism, incidents of racism, the effect of racism, response to racism, and miscellaneous. This initial coding was the first coding stage and highlighted contradictions in how healthcare staff talked about racism, and the stories they experienced and witnessed.

Coding revealed that the way healthcare staff discussed racism was at times contradictory and ambiguous. To make it easier to analyse these contradictions, we used a data display and visualization method as guided by Miles et al. (2019) (see Supplementary Material 2). The “organized, condensed assembly of information that allows analytic reflection and action” (Miles et al., 2019, p. 16) by systematically displaying data in a table such that connections between different codes could be visualised, generated new coding categories and a re-coding of existing categories. It also informed the ongoing analysis aiding in drawing conclusions and making visible contradictions in talk. Using the table made it easier to see that staff accounts included ways through which minoritized users were discussed in healthcare (see supplementary material 2 for an excerpt of the data visualization table).

Core categories, including subcategories, were defined and redefined with all authors engaged in a continuous discussion throughout the analytical process to ensure trustworthiness. The interviews were reread by the first author, and the analytical process was further scrutinized after discussion with all authors. The analysis was conducted in the interviews’ original language to stay close to the data. Quotes were only translated into English after the article was drafted.

#### 2.5. Ethical considerations

Ethical clearance was obtained from the Ethical Review Board in Sweden. Participants were informed that participation was voluntary. The study’s aim and methods were explained. All participants received verbal and written information about the study. All data were handled with confidentiality and stored according to the University’s and the General Data Protection Regulation of the European Union.

As racism is a difficult issue and could entail emotional labor for those who encounter racism, all participants were provided with the

contact details of the project members if they had additional inquiries or questions. Participants’ detailed background information has been withheld to protect their identity and ensure confidentiality.

It is noteworthy that our interest does not lie in labelling healthcare staff as racists or antiracists given our understanding of racism as structural (Bonilla-Silva, 2009). Our emphasis is not on individual actors per se but on analyzing racialized talk and its effect in devaluing minoritized users to uncover structures of racism.

### 3. Findings

#### 3.1. Western sensibilities and non-western irrationalities

The representation of the Western as sensible and the non-Western as irrational and its evocation in different ways was the dominant theme in the data. Healthcare staff accounts revealed an assumption of an inherent incompatibility between minoritized and majoritized healthcare users. The minoritized user was represented as the ‘bad’ user compared to the ‘good’ majoritized user. This representation was used to portray minorities’ health conditions as unworthy and to justify sub-optimal and differential care. The analysis resulted in three categories: Characterizing minoritized healthcare users as ‘bad’ users, Characterizing minoritized users’ health complaints as unworthy, and Devaluation of minoritized users as justification for suboptimal and differential care.

Consistent with findings on racialized talk (Goodman, 2014), most healthcare staff distanced themselves from racism, constructing themselves as antiracist. In general, staff were cautious when discussing minoritized users and sought to evade accusations of racism. When giving accounts of how minoritized users are discussed in healthcare, most staff, except three, gave accounts of how other staff talk about minorities, offering little or no reflection on their own possible bias. The three staff who engaged in racialized talk were exceptions. Why this was the case is not clear in the context of this study, although we note that two of them occupied senior academic and clinical positions. While their talk was exceptional, it will be analyzed as part of the data as it offers a window into the complexity of racialized talk, since exceptions to the rule offer a mean to reflect on the ambiguities in data (Phoenix and Orr, 2017). Further, these examples validate the descriptions offered by other staff on racialized talk in healthcare as a form of triangulation.

#### 3.2. Characterizing minoritized healthcare users as ‘bad’ users

Healthcare staff accounts of how minoritized users were discussed in healthcare implied a hierarchal stratification of the ‘bad’ minoritized user and, by contrast, the ‘good’ majoritized user. The ‘good’ healthcare user listens to staff and complies with medical instructions (Sointu, 2017). In contrast, and through racialized talk, minoritized users were characterized as challenging, frustrating, illiterate, and non-compliant users who require excessive work.

Participants’ accounts showed that explicit racial slurs were used to demarcate difference. Words such as the n-word, *svartskalle* (a Swedish racial slur that translates to black skull), and camel f\*\*\*r were reported as insults for minoritized users. Racial slurs were, for the most part, not used in the presence of minoritized users but when speaking about these users with other staff (including minoritized staff). Racial slurs provided a toxic and direct way to dehumanize minoritized users by proclaiming a negative attitude towards the entire racialized group.

A minoritized pharmacist who worked in private pharmacies and a hospital setting discussed the use of racial slurs by majoritized staff. She had worked for more than five years both as a pharmacist and with research when we interviewed her and recalled how she happened to hear two senior majoritized male doctors discussing Africans while sitting in the hospital’s common area:

“Baboons, these Africans are baboons. I would never go to Africa, they are uncivilized” and then I sort of panicked and just completely froze (...) This was such a clear case, and I felt I should have reported him.

(Minoritized pharmacist, female)

The participant explained that one of these doctors specialized in treating specific disorders more prevalent among Africans, and so had many African patients. According to the participant, the other doctor nodded in agreement when Africans were described as baboons, while other people in the common area did not react. The participant, who is of African origin, discussed how horrified she was but did not report the use of an explicit racial slur.

While racial slurs were used by staff, the most common racialized talk characterizing minoritized users as ‘bad’ users was the use of essentialist claims about ‘their’ culture in contrast to ‘our’ culture. Staff explained that this was articulated for the most part by alluding to inherent cultural differences rather than biological ideas of racial stratification. Racialized talk was used to label minoritized users as being loud and having too many visitors, unlike majoritized users who were viewed as self-contained.

A minoritized midwife who worked for more than 20 years in different levels of healthcare, as a nurse assistant, a nurse, and finally as a midwife, discussed the ‘us’ and ‘them’ dichotomy. The participant explained how she witnessed her majoritized colleagues often complaining about minoritized users, especially Africans and Arabs. She spoke an African language and was sometimes asked to interpret for her colleagues when healthcare users could not speak Swedish. Thus, she witnessed how her colleagues treated users from African countries differently. The participant stated:

They do it indirectly ... but I sometimes notice, my colleagues, always when there are patients from other backgrounds, they usually say like this: “Well, how many visitors do they have then?” That tone, like, they expect migrants to have more visits, they think it is unpleasant that there are a lot of people who come and visit. It is discussed: “Yes, it is their culture” ... it becomes us and them and they differentiate between patient groups.

(Minoritized midwife, female)

This ‘us’ and ‘them’ dichotomy articulated by this participant and discussed by other staff was validated by three majoritized staff who engaged in racialized talk depicting minoritized users as ‘bad’ users. Their racialized talk reflected a paternalistic view, representing themselves and Western culture as the holder of knowledge. Two dental care staff with more than 20 years of experience in dental care discussed how African men are lazy and drink too much alcohol. They talked about how it is their duty to teach minoritized users how to live in the modern age, by stating that minorities still live in the 19th century. These sentiments were iterated by another majoritized staff, who worked as a nurse in a hospital setting. She stated:

I think this is the difference between Northern European culture and Arabic culture: we raise our children very strictly when they are little (...). In that kind of culture, they have all the freedom when they are little. They can do whatever they want. They can sleep [and] eat whenever they want. They can ... yeah, if they want to turn everything over in healthcare: they say, “It’s just children.” And I think this is a problem.

(Majoritized nurse, female)

Minoritized users were clumped together as one group irrespective of education, class, or other social aspects. Additionally, minoritized users were infantilized and conceived as backward and unable to raise their children who were also perceived as difficult to control, as iterated by the same nurse in another part of the interview.

Staff also described minoritized users as conniving, and taking

advantage of healthcare provision. This was discussed by a majoritized dentist with more than 30 years of clinical experience, who, in naming the increasingly anti-immigrant political climate in Sweden suggested that this may have given some healthcare staff space to speak negatively about minoritized users. He described how staff state that:

“Many who come, only come to take advantage of the system and things like that.”

(Majoritized dentist, male)

The participant clarified that it was not only majoritized staff who spoke negatively of minoritized users but also minoritized staff. This was echoed by another majoritized staff, who was a newly graduated physician at the time of the interview:

I don’t remember which country the doctor was from, but ... he meant that those people from his country ... that these patients from this country behave differently towards doctors and nurses respectively. Unfortunately, this is generally commonplace in healthcare ... that they also are a bit whiny and angry.

(Majoritized physician, female)

The participant explained that this characterization of minoritized users was “commonplace” in healthcare. This talk distinguished between groups of healthcare users along racial lines, characterizing minoritized people as out of control and dangerous with inherently different behavior than majoritized users. This aids in creating a climate of suspicion towards minoritized users.

Staff explained that racialized talk would be provoked by a name that was perceived as ‘foreign’ or ‘non-Swedish.’ Preconceived ideas about minoritized users’ behavior justified how staff spoke about these users before any healthcare interaction even occurred. A ‘foreign’ name in a patient’s list could result in staff engaging in racialized talk that involved an expectation that the healthcare interaction would be frustrating, based on the user’s presumed racial belonging. The quote below by a newly graduated minoritized dentist illustrates this:

Even at the clinic, people can express themselves a little bit like ... let’s say you have patient A who happens to have a ‘foreign’ name, then they immediately start talking, they immediately assume that it will be difficult, that they won’t be able to speak Swedish (...). Then I feel a bit concerned because I have a ‘foreign’ name, maybe people think the same about me when I sit in the waiting room, ah oh it’s a ‘foreign’ name, let’s see if they can speak Swedish, things like that.

(Minoritized dentist, female)

This participant discussed how she heard majoritized staff in her clinic react when they saw a booked healthcare user with a ‘foreign’ name assigning minoritized users to a general category, which became cues provoking racialized talk.

### 3.3. Characterizing minoritized users’ health complaints as unworthy

Staff accounts also indicated that racialized talk assigned demeaning racial characteristics to health complaints about ‘bad’ users. Staff described how minoritized users’ complaints, particularly pain, were less worthy of attention, with some discussions representing minoritized users as weak users who cannot tolerate pain, and others representing them as resistant to pain. Both representations of pain resulted in the creation of *difference* along racial lines.

In a focus group discussion, there was conversation about how minoritized users’ complaints were differently expressed. A majoritized physician, with many years of experience, stated:

There is this thing on how some people express pain (...) this classic way of speaking about them “Yes, but they scream too much, or they are so weak,” or something like that.

*(Majoritized physician, female)*

Staff in this group discussed how pain and other complaints were racialized, so their expression by minoritized users became related to their racial identity, which was conceived as frustrating. As such, the ‘classic way’ of speaking about minoritized users’ complaints, was to characterize them as culturally weak; hence, their complaints became a result of that weakness. Referring to minoritized users as weak implied that complaints were less worthy with these users “screaming too much” because “they do not understand” rather than expressing pain related to plausible diagnosed or diagnosable conditions.

Accounts of racializing health complaints included prescribing specific words to these complaints, such as ‘ethnic’, ‘cultural’ and ‘functional’. Staff explained that users from the “Middle East,” Africa, and Roma were discussed in a negative manner: “as if they have some kind of ethnic pain.” The term ‘functional’ in Swedish (*funktionell*) was used to dismiss health complaints as stemming from perceived fussiness. Describing pain through these terms was discussed by participants in another focus group, which included different occupational categories, years of experience, and ethnic belongings. The participants in this group discussed how this representation was more prevalent in maternal care:

1: Some people’s pain is not valued as highly as others for instance, Black people are expected to be pain-resistant. There are a lot of such perceptions. I think it may be something that comes into play ...

*(Majoritized physician, female)*

2: Yes exactly ... Cultural pain, which was mainly linked, I remember, to maternal care, that it was categorized so ... “how do we assess pain based on the background of people”? There was such a pretty clear aspect of it, that healthcare workers would say: “Here is a person from Somalia or the Horn of Africa.” And then maybe there was a notion that people who come from those places describe pain in this way and so their pain is not taken seriously ...

*(Majoritized public health officer, male)*

Two medical majoritized students, in their last year of medical training who were interviewed together, discussed how majoritized physicians and nurses spoke of minoritized users’ complaints as different, especially Arabs, who were seen as exaggerating their pain and hence should not be taken seriously:

There is this myth that people experience pain differently depending on where they come from, and that Arabs just exaggerate their pain. I’ve met many sensible people, good senior doctors who think this way. It’s like partly ingrained in them, that some people’s pain is different and then it’s like you ignore entirely all medical research that one knows about how pain arises ...

*(Majoritized medical student, female)*

The above-mentioned participants contemplate on a critical issue: that racialized talk about pain goes against scientific knowledge. They described witnessing “intelligent physicians” who would “throw their scientific knowledge out the window” when interacting with minoritized users, as one participant stated in another part of the interview. This reflects the power that preconceived racialized ideas have on how minoritized users’ complaints are characterized.

### 3.4. Devaluation of minoritized users as justification for suboptimal and differential care

Accounts by staff show that at the heart of racialized talk is the use of these characterizations to justify suboptimal and differential care. In interviews with staff revealed that because minoritized users were discussed as frustrating users, this was used as an excuse to treat them more harshly and with less affection than majoritized users. An experienced

minoritized midwife of African origin said:

I discovered that when it was Swedish patients, women giving birth, my colleague was more ... caring, giving more support. And even after giving birth, she hugged the woman when the woman was leaving the hospital. When it was a foreign patient, you could see the difference, .... in her face, in her expressions, she did not want to come close to this patient.

*(Minoritized midwife, female)*

That differential suboptimal care was given due to preconceived ideas of minoritized users as culturally different and requiring more work than others was iterated by other staff. In a focus group with majoritized nurses, one woman described how culture was used to justify suboptimal care:

One tries to find an excuse to give different care in a way that is a bit hidden. I think people talk about that ... yes, that it is culturally conditioned. That maybe one does not express pain in the same way if someone comes from a different culture (...) and then one tries to justify, you know ... not seeing it the way it is supposed to be seen ... but that it is more acceptable to use culture as an excuse to why one does not give optimal .... well painkillers (...) I absolutely believe that there are cultural differences but that one might use it as an excuse to behave as a racist.

*(Majoritized nurse, female)*

In this focus group discussion, majoritized nurses extensively discussed ‘cultural’ and ‘ethnic’ pain. Within this context, presumed cultural traits of patients were used to justify inadequate prescription of drugs, such as painkillers. Characterizing minoritized users as ‘bad’ users and their pain as unworthy of care offered a ground for staff to justify not prescribing painkillers in the absence of a medical justification.

As delineated in the previous category, talk that characterized minoritized users as ‘bad’ users did not necessarily involve an actual meeting with a healthcare user. This meant that this talk could also be used to justify suboptimal care based on this characterization without referring to particular people and, at times, without a proper medical assessment of a particular condition, as discussed by a minoritized nurse. This participant, who worked as a nurse assistant and later as a nurse, explained that minoritized users were discussed as noisy and having too many visitors. She also noted that when she worked at a psychiatric ward, Somali healthcare users were routinely subjected to differential care:

Many times, as soon as we got a patient from Somalia, my colleagues would immediately say “yes, it must be a drug induced psychosis (...)”. They have this prejudice directly, that: “But he must have taken drugs, and so it has induced a psychosis.” The first thing they do is conduct drug tests and so on (...), and then it’s like, that this ... but do we have to have such a picture, must there really be drugs involved?

*(Minoritized nurse, female)*

The participant maintained that her colleagues would immediately assume that Somali users who presented at the psychiatric department must have taken illegal drugs. This perception was reinforced through talk that differentiated Somali users from majoritized users, where the latter even though psychotic would not be automatically presumed to have taken drugs. According to the participant, Somali users were routinely characterized as drug-users, and hence subjected to a regular requirement to take drug tests and prove themselves ‘clean’, despite the absence of a medical justification for testing.

A minoritized female physician also discussed how minoritized users were “systematically” left out of the healthcare decision-making process in a way that she “has not experienced with White patients.” This was

usually justified by stating that these challenging users would not comply with treatments, including pain prescriptions and other medications. The physician discussed a case where a minoritized user presented with a previously fractured elbow that did not heal properly affecting the arm's mobility severely. She stated that the orthopedic consultant who looked at the patient's notes prior to the consultation with the patient, reacted when seeing the user's 'foreign' name by saying:

"This will never work. We cannot do this; these patients are difficult." I tried to discuss with him because it seemed that this patient, who came from another country, would not be able to take part in the decision-making process (...); once the patient came in, the doctor did not listen at all. He just said: "We will not be able to operate on this."

(Majoritized physician, female)

According to the physician, proper medical procedures were not followed because the consultant had already racially categorized the user as difficult, concluding that the arm would not be operated on, excluding the user from the subsequent decision-making process, which, according to the participant, would not have happened had the user been White.

Staff's accounts demonstrated that talk about minoritized users' pain as 'ethnic' and 'cultural' and their presumed exaggerating tendencies concerning their health conditions justified not taking this pain seriously in the context of maternal care. An African midwife described her own experience when she gave birth at a hospital without appropriate support because the majoritized midwife did not believe she was in labor. As African women are discussed as resistant to pain, she was not perceived as being ready to give birth even when she explained to the midwife that the baby was coming. Another example was given by a newly graduated minoritized physician, who discussed a case where a newly arrived Arab migrant woman was not taken seriously in maternity care, resulting in her death:

She told them: "This is not my first child. I had a child before, and the doctor told me, "Because you had a very tough delivery, so next time when you are pregnant, you should go through a C-section." And she told the doctors, but no one listened to her. And they were like: "You're going to be fine." She told them: "I have a problem with my pelvic area" but no one listens to these patients (...) so, they ended up after, I don't know, 16 hours of trying a vaginal delivery, they decided in the end, to go for a C-section, but it was too late because, after a few days, she passed away.

(Minoritized physician, female)

According to the physician, the Arab woman had explained that when she gave birth in her home country, the physician had told her that her delivery was complicated and advised her to have a C-section for any future births. But "no one actually listens to these patients," since talk that characterizes minoritized users as exaggerating their symptoms and pain justifies them being ignored.

#### 4. Concluding discussion

Our findings echo the way that minoritized groups have been historically dominated, and violated (Mills, 1999). The continuous racialization of minoritized users maintains power-relations that represent Western users as progressive and non-Western users as uncivilized. Studies have shown that minoritized healthcare users experience disrespect, dismissal of symptoms, lack of negotiation in decision-making, loss of trust, and higher unmet needs, which results in delays in seeking care (Hamed et al., 2022). Studies also show that implicit racial bias of staff influences diagnosis and treatment (Maina et al., 2018). The study's strength lies in its examining racialized talk that devalues minoritized users along a continuum of racial domination

that underlies their experience. The assumption that staff possess objective medical knowledge, contributes to the perception that the 'good' healthcare user upholds staff's authority. The 'good' healthcare user is seen to uphold the authority of the staff. In contrast, the 'bad' user is viewed as non-compliant and failing to accept staff's unbiased knowledge. Scholars such as Bonilla-Silva (2009) show that people often avoid explicit racist discourse, mostly framing their 'race' talk through tacit cultural racism. While we found evidence that racialization might be masked within cultural essentialism, most of our informants described overt racialized talk hidden behind medical objectivity and hierarchical authority, which risks becoming routinized. Recent studies on colorblindness in healthcare have shown that physicians who deny racism, tend to use 'race' more in medical education (Okah et al., 2022). Hence, our findings warrant further investigation of how racialization and racialized talk are produced in healthcare, especially pertaining to how medical discourse could be used to obfuscate racism.

We have shown how racialized talk entails racialization of minoritized users' health conditions. Healthcare staff maintain a tacit understanding that when conditions are described as 'ethnic' and 'cultural', then no treatment is required. Minorities' own knowledge of their illness and body is disregarded, as they are likely to be viewed as incompetent, and excluded from decision-making processes, which is consistent with studies on minoritized users' experiences (Hamed et al., 2022).

The construction of pain and other conditions as 'ethnic' becomes established and justifies differential care. In Sweden and in other national contexts in the Global North, minoritized women have a significantly higher maternal mortality rate than majoritized women (Esscher et al., 2014). The main reason for this mortality penalty is suboptimal care. Racism is related to adverse health outcomes including increased risk for death (Paradies et al., 2015) and differential diagnosis and treatment outcomes including differential pain prescription to minoritized users, as well as differential diabetes, hypertension, and heart disease medication prescription (Hamed et al., 2022). Based on the accounts provided by staff, talk that helps to differentially evaluate users' symptoms and pain can explain how minoritized users are routinely ignored, resulting in inadequate treatment for minoritized groups and adverse health outcomes.

While this study contributes to exploring how racism is perpetuated in healthcare, difficulties encountered in recruiting minoritized staff may have limited the type of accounts and stories that were shared. Due to our recruitment strategy of working with previous contacts, a certain recruitment bias may have limited the type of racialized talk that we have captured, although we aimed for a diversity sample. As we have not focused on specific healthcare professional groups, we have limited insight into the specificities of inter-professional racialized talk in specific healthcare settings. That the interviewed staff were cautious when discussing minoritized users and tended to construct themselves as antiracist could be attributed to the fact that most interviews were conducted by minoritized researchers. However, this could also be attributed to what Bonilla-Silva (2009) refers to as "racism without racists" - a key characteristic of contemporary societies where people try to evade accusations of racism. When asked about racism, staff discussed racialized talk as commonplace in healthcare but maintained their position as antiracist by arguing that 1) yes, racism may exist, 2) and here are some examples where racism is perpetuated, 3) not by us, but by other healthcare staff, often elsewhere.

The processes whereby minoritized users are vulnerable to exclusion from healthcare, that perpetuate "racism without racists", need to be scrutinized. There is a need to implement policies that would minimize racism in healthcare interactions, diagnosis, and treatment. First, anti-racism must be part of healthcare institutions' mission, and goals, acknowledging racism's interrelated dimensions and how they contribute to a context of fear among minoritized staff and users. It is paramount to ensure that minoritized staff and users are able to discuss racism without fear and repercussions. To do this, we suggest establishing co-production groups of users and staff to work for policy leading

to material change within care institutions. Second, we propose that racism should be recognized as a social determinant of health and studied in medical education as such. Third, healthcare institutions should conduct case reviews and audits to determine how racism and racialization may have influenced decision making.

### CRedit authorship contribution statement

**Sarah Hamed:** Writing – review & editing, Writing – original draft, Visualization, Validation, Project administration, Methodology, Investigation, Formal analysis, Conceptualization. **Hannah Bradby:** Writing – review & editing, Validation, Supervision, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Suruchi Thapar-Björkert:** Writing – review & editing, Validation, Methodology, Conceptualization. **Beth Maina Ahlberg:** Writing – review & editing, Validation, Methodology, Conceptualization.

### Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

### Data availability

The data that has been used is confidential.

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The study was approved by the Uppsala Regional Ethical Review Board (Dnr 2018/201).

### Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.socscimed.2024.117085>.

### References

- Alinia, M., 2020. White ignorance, race, and feminist politics in Sweden. *Ethn. Racial Stud.* 43 (16), 249–267. <https://doi.org/10.1080/01419870.2020.1775861>.
- Augoustinos, M., Every, D., 2016. The Language of “race” and prejudice: a discourse of denial, reason, and liberal-practical politics. *J. Lang. Soc. Psychol.* <https://doi.org/10.1177/0261927X07300075>.
- Barber, S., 2020. Death by racism. *Lancet Infect. Dis.* 20 (8), 903. [https://doi.org/10.1016/S1473-3099\(20\)30567-3](https://doi.org/10.1016/S1473-3099(20)30567-3).
- Billig, M., 1988. The notion of ‘prejudice’: some rhetorical and ideological aspects. *Text - Interdisciplinary Journal for the Study of Discourse* 8 (1–2), 91–110. <https://doi.org/10.1515/text.1.1988.8.1-2.91>.
- Bonilla-Silva, E., 2002. The linguistics of color blind racism: how to talk nasty about blacks without sounding “racist.”. *Crit. Sociol.* 28 (1–2), 41–64. <https://doi.org/10.1177/0896920502080010501>.
- Bonilla-Silva, E., 2009. *Racism without Racists: Color-Blind Racism and the Persistence of Racial Inequality in America*, 3 edition. Rowman & Littlefield Publishers.
- Braun, L., Saunders, B., 2017. Avoiding racial essentialism in medical science curricula. *AMA J. Ethics* 19 (6), 518–527. <https://doi.org/10.1001/journalofethics.2017.19.6.peer1-1706>.
- Briónes-Vozmediano, E., La Parra-Casado, D., Vives-Cases, C., 2018. Health providers’ narratives on intimate partner violence against Roma women in Spain. *Am. J. Community Psychol.* 61 (3–4), 411–420. <https://doi.org/10.1002/ajcp.12235> psych.
- Browne, A.J., Fiske, J.-A., 2001. First Nations women’s encounters with mainstream health care services. *West. J. Nurs. Res.* 23 (2), 126–147. <https://doi.org/10.1177/019394590102300203> psych.
- Browne, A.J., Lavoie, J.G., McCallum, M.J.L., Canoe, C.B., 2022. Addressing anti-Indigenous racism in Canadian health systems: multi-tiered approaches are required. *Can. J. Public Health* 113 (2), 222–226. <https://doi.org/10.17269/s41997-021-00598-1>.
- Calabrese, S.K., Earnshaw, V.A., Underhill, K., Hansen, N.B., Dovidio, J.F., 2014. The impact of patient race on clinical decisions related to prescribing HIV pre-exposure prophylaxis (PREP): assumptions about sexual risk compensation and implications for access. *AIDS Behav.* 18 (2), 226–240. <https://doi.org/10.1007/s10461-013-0675-x> psych.
- Clayes, A., Berdai-Chaoui, S., Tricas-Sauras, S., De Donder, L., 2020. Culturally sensitive care: definitions, perceptions, and practices of health care professionals. *J. Transcult. Nurs.* 1043659620970625 <https://doi.org/10.1177/1043659620970625>.
- Dahlstedt, M., Neergaard, A., 2019. Crisis of solidarity? Changing welfare and migration regimes in Sweden. *Crit. Sociol.* 45 (1), 121–135. <https://doi.org/10.1177/0896920516675204>.
- Dunn, K., Nelson, J.K., 2011. Challenging the public denial of racism for a deeper multiculturalism. *J. Intercult. Stud.* 32 (6), 587–602. <https://doi.org/10.1080/07256868.2011.618105>.
- Eberly, L.A., Richterman, A., Beckett, A.G., Wispelwey, B., Marsh, R.H., Cleveland Manchanda, E.C., Chang, C.Y., Glynn, R.J., Brooks, K.C., Boxer, R., Kakoza, R., Goldsmith, J., Loscalzo, J., Morse, M., Lewis, E.F., Abel, S., Adams, A., Anaya, J., Andrews, E.H., et al., 2019. Identification of racial inequities in access to specialized inpatient heart failure care at an academic medical center. *Circulation. Heart Failure* 12 (11), e006214. <https://doi.org/10.1161/CIRCHEARTFAILURE.119.006214>.
- Elias, A., Paradis, Y., 2021. The costs of institutional racism and its ethical implications for healthcare. *J. bioeth. Inq.* 18 (1), 45–58. <https://doi.org/10.1007/s11673-020-10073-0>.
- Esscher, A., Binder-Finnema, P., Bødker, B., Högborg, U., Mulic-Lutvica, A., Essén, B., 2014. Suboptimal care and maternal mortality among foreign-born women in Sweden: maternal death audit with application of the ‘migration three delays’ model. *BMC Pregnancy Childbirth* 14, 141. <https://doi.org/10.1186/1471-2393-14-141>.
- Goldberg, D.T., 2016. David theo goldberg’s are we all postracial yet? *Ethn. Racial Stud.* 39 (13) <https://doi.org/10.1080/01419870.2016.1202439>, 2226–2226.
- Goodman, S., 2014. Developing an understanding of race talk. *Social and Personality Psychology Compass* 8 (4), 147–155. <https://doi.org/10.1111/spc3.12095>.
- Green, J., Thorogood, N., 2013. *Qualitative Methods for Health Research*. SAGE.
- Grillo, R.D., 2003. Cultural essentialism and cultural anxiety. *Anthropol. Theor.* 3 (2), 157–173. <https://doi.org/10.1177/1463499603003002002>.
- Haider, A.H., Schneider, E.B., Sriram, N., Dossick, D.S., Scott, V.K., Swoboda, S.M., Losonczy, L., Haut, E.R., Efron, D.T., Pronovost, P.J., Freischlag, J.A., Lipsitt, P.A., Cornwell, E.E., MacKenzie, E.J., Cooper, L.A., 2014. Unconscious race and class bias: its association with decision making by trauma and acute care surgeons. *J. Trauma Acute Care Surg.* 77 (3), 409–416. <https://doi.org/10.1097/TA.0000000000000392>.
- Hamed, S., Bradby, H., Ahlberg, B.M., Thapar-Björkert, S., 2022. Racism in healthcare: a scoping review. *BMC Public Health* 22 (1), 988. <https://doi.org/10.1186/s12889-022-13122-y>.
- Johnson, J.L., Bottorff, J.L., Browne, A.J., Grewal, S., Hilton, B.A., Clarke, H., 2004. Othering and being othered in the context of health care services. *Health Commun.* 16 (2), 255–271. [https://doi.org/10.1207/S15327027HC1602\\_7](https://doi.org/10.1207/S15327027HC1602_7).
- Kallio, H., Pietilä, A.-M., Johnson, M., Kangasniemi, M., 2016. Systematic methodological review: developing a framework for a qualitative semi-structured interview guide. *J. Adv. Nurs.* 72 (12), 2954–2965. <https://doi.org/10.1111/jan.13031>.
- Keskinen, S., Tuori, S., Irni, S., Mulinari, D., 2016. Complying with Colonialism: Gender, Race and Ethnicity in the Nordic Region. Routledge Ltd. <https://doi.org/10.4324/9781315573212>.
- Lentin, A., 2018. Beyond denial: ‘Not racism’ as racist violence. *Continuum J. Media Cult. Stud.* 32 (4), 400–414. <https://doi.org/10.1080/10304312.2018.1480309>.
- Lundström, C., 2017. The White Side of Migration: reflections on race, citizenship and belonging in Sweden. *Nordic J. Migrat. Res.* 7 (2). <https://doi.org/10.1515/njmr-2017-0014>. Article 2.
- Lyons, S.M., O’Keeffe, F.M., Clarke, A.T., Staines, A., 2008. Cultural diversity in the Dublin maternity services: the experiences of maternity service providers when caring for ethnic minority women. *Ethn. Health* 13 (3), 261–276. <https://doi.org/10.1080/13557850801903020> psych.
- Maina, I.W., Belton, T.D., Ginzberg, S., Singh, A., Johnson, T.J., 2018. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. *Soc. Sci. Med.* 199, 219–229. <https://doi.org/10.1016/j.socscimed.2017.05.009>.
- McEachrane, M., 2018. Universal human rights and the coloniality of race in Sweden. *Hum. Right Rev.* 1–23. <https://doi.org/10.1007/s12142-018-0510-x>.
- McLane, P., Mackey, L., Holroyd, B.R., Fitzpatrick, K., Healy, C., Rittenbach, K., Plume, T.B., Bill, L., Bird, A., Healy, B., Janvier, K., Louis, E., Barnabe, C., 2022. Impacts of racism on First Nations patients’ emergency care: results of a thematic analysis of healthcare provider interviews in Alberta, Canada. *BMC Health Serv. Res.* 22 (1), 804. <https://doi.org/10.1186/s12913-022-08129-5>.
- Medina, C., Salvador, X., Teresa Faixedas, M., Gallo, P., 2011. [Health services’ utilization patterns in Catalonia, Spain]. *Med. Clínica* 137 (Suppl. 2), 42–48. [https://doi.org/10.1016/S0025-7753\(11\)70028-8](https://doi.org/10.1016/S0025-7753(11)70028-8). Scopis.
- Miles, M.B., Huberman, A.M., Saldana, J., 2019. *Qualitative Data Analysis: A Methods Sourcebook*, fourth ed. SAGE Publications, Inc.
- Mills, C.W., 1999. *The Racial Contract*, first ed. Cornell University Press.

- Morel, S., 2019. Inequality and discrimination in access to urgent care in France ethnographies of three healthcare structures and their audiences. *Soc. Sci. Med.* 232, 25–32. <https://doi.org/10.1016/j.socscimed.2019.04.028>. APA PsycInfo.
- Mulinari, D., Neergaard, A., 2017. Theorising racism: exploring the Swedish racial regime. *Nordic J. Migration Res.* 7 (2) <https://doi.org/10.1515/njmr-2017-0016>.
- Nazroo, J.Y., Bhui, K.S., Rhodes, J., 2020. Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism. *Sociol. Health Illness* 42 (2), 262–276. <https://doi.org/10.1111/1467-9566.13001>.
- Okah, E., Thomas, J., Westby, A., Cunningham, B., 2022. Colorblind racial ideology and physician use of race in medical decision-making. *J. Racial and Ethnic Health Disparities* 9 (5), 2019–2026. <https://doi.org/10.1007/s40615-021-01141-1>.
- Omi, M., Winant, H., 2014. *Racial Formation in the United States*, third ed. Routledge. <https://doi.org/10.4324/9780203076804>.
- Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., Gee, G., 2015. Racism as a determinant of health: a systematic review and meta-analysis. *PLoS One* 10 (9). <https://doi.org/10.1371/journal.pone.0138511>.
- Phoenix, C., Orr, N., 2017. Analysing exceptions within qualitative data: promoting analytical diversity to advance knowledge of ageing and physical activity. *Qualitative Research in Sport, Exercise and Health* 9 (3), 271–284. <https://doi.org/10.1080/2159676X.2017.1282539>.
- Seidman, I., 2005. *Interviewing as Qualitative Research: A Guide for Researchers in Education and the Social Sciences*, third ed. Teachers College Press.
- Sointu, E., 2017. ‘Good’ patient/‘bad’ patient: clinical learning and the entrenching of inequality. *Sociol. Health Illness* 39 (1), 63–77. <https://doi.org/10.1111/1467-9566.12487>.
- Statistiska centralbyrån, 2022. Utrikes Födda I Sverige. SCB. <https://www.scb.se/hi-tta-statistik/sverige-i-siffror/manniskorna-i-sverige/utrikes-fodda/>.
- Tator, C., Henry, F., 2000. The role and practice of racialized discourse in culture and cultural production. *J. Can. Stud.* 35 (3), 120–137. <https://doi.org/10.3138/jcs.35.3.120>.
- Teodorescu, D., Molina, I., 2021. Roma street-workers in Uppsala: racialised poverty and super precarious housing conditions in Romania and Sweden. *Int. J. Housing Pol.* 21 (3), 401–422. <https://doi.org/10.1080/19491247.2020.1854950>.
- Tucker Edmonds, B., McKenzie, F., Austgen, M.B., Ashburn-Nardo, L., Matthias, M.S., Hirsh, A.T., 2017. Obstetrical providers' management of chronic pain in pregnancy: a vignette study. *Pain Med.* 18 (5), 832–841. <https://doi.org/10.1093/pm/pnw195>.
- Verkuyten, M., 2003. Discourses about ethnic group (de-)essentialism: oppressive and progressive aspects. *Br. J. Soc. Psychol.* 42 (Pt 3), 371–391. <https://doi.org/10.1348/014466603322438215>.
- Vydelingum, V., 2006. Nurses' Experiences of Caring for South Asian Minority Ethnic Patients in a General Hospital in England. *Nursing Inquiry*, Oxford, pp. 23–32. <https://doi.org/10.1111/j.1440-1800.2006.00304.x>.
- Wetherell, M., Potter, J., 1992. *Mapping the Language of Racism: Discourse and the Legitimation of Exploitation*. Harvester Wheatsheaf and Columbia University Press. [http://catalogue.pearsoned.co.uk/educator/main\\_content/index.page](http://catalogue.pearsoned.co.uk/educator/main_content/index.page).
- Williams, D.R., Wyatt, R., 2015. Racial bias in health care and health: challenges and opportunities. *JAMA, J. Am. Med. Assoc.* 314 (6), 555–556. <https://doi.org/10.1001/jama.2015.9260> psych.
- Williams, D.R., Lawrence, J.A., Davis, B.A., 2019. Racism and health: evidence and needed research. *Annu. Rev. Publ. Health* 40 (1), 105–125. <https://doi.org/10.1146/annurev-publhealth-040218-043750>.
- Winant, H., 1998. Racism today: continuity and change in the post-civil rights era. *Ethn. Racial Stud.* 21 (4), 755–766. <https://doi.org/10.1080/014198798329856>.