

Implicit bias against the Romas in Hungarian healthcare: taboos or unrevealed areas for health promotion?

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Summary

The Roma or Gipsy population is the largest ethnic minority both in Europe and Hungary with a 10–15 years lower life expectancy and significantly worse health indicators than majority populations. The purpose of this exploratory study was to investigate a sensitive and controversial topic: the perspectives of healthcare staff about the presence and impacts of implicit bias in the Hungarian healthcare system towards Roma patients. Therefore, between June 2017 and May 2018 semi-structured interviews were conducted involving 13 healthcare professionals. Interview transcripts were coded and thematically analysed. The presence and occasional manifestation of prejudices against the Romas were noted by the interviewees, most commonly in the form of longer waiting time, comments or other meta-communicative tools. Study participants appeared to exclude a direct relationship between health providers' implicit bias and the lower quality of health services or the worse health status of Roma patients. However, as reported, indirect negative effects may occur in cases where a patient refrains from seeking care due to previous perceived or experienced discrimination. As barriers to effective patient–provider communication and cooperation, differences in culture, health-seeking behaviour and gaps between health literacy levels were emphasized. In terms of prevention, enhancing anti-discriminatory attitudes from early childhood within the families, the role of media in conveying unbiased information, increasing health awareness of the Roma people as well as educating healthcare providers on culture-related issues may be beneficial. Stress and burnout of healthcare professionals also need to be addressed as these may impact on the enactment of unconscious biases.

Key words: implicit bias, Roma ethnic minority, healthcare professionals

INTRODUCTION

The Roma/Gipsy population is the largest European ethnic minority with ~10–12 million people (Kalaydjieva *et al.*, 2001). As the term 'Gipsy' is often considered derogatory,

the first Roma World Congress (London, 1971) decided to use the identification name 'Roma' (Romani) for this population (ROMEDIA Foundation, 2012). Linguistic and genetic studies have located the Roma people's origins in the

Indian subcontinent and following a gradual migration the Romani people reached the Balkans as early as the 12th century and finally spreading throughout Europe (Mendizabal *et al.*, 2012).

According to the 2011 census, 315 583 people declared themselves Roma, which was 3.2% of the total Hungarian population of 9 937 628 inhabitants (CSO, 2011). It is not easy to define who belongs to the Roma ethnic minority, and the Act LXXVII of 1993 on the Rights of National and Ethnic Minorities prohibits forcing anyone to reveal his/her ethnicity. Based on a series of special sociological estimations, the number of Roma people in Hungary was estimated as 640 000 in 2009 (6–7% of the total population), and this major discrepancy between the declared and estimated data has been attributed to the numerous prejudices concerning this ethnic minority (Hablicsek, 2007). Demographic characteristics of Roma people significantly differ from those of the majority population, their natural demographic indicators (age distribution, high fertility and mortality rate, low life expectancy at birth) are similar to populations in the stage of demographic transition (Hablicsek, 2007; CSO, 2011).

While the Roma groups do not form one single population, all the published results show a uniform and significant difference between the health indicators of the Roma and the non-Roma people. The recently published Roma Health Report (EC, 2014) reveals that in the European Union (EU) the longevity rate—the proportion of people who can expect to reach the age of 75 and over—is 51% regarding the non-Roma population, whereas the rate for the Roma population is only half of this (26%). More than 20 years ago, a book entitled ‘The Health Situation of the Gypsies’ was published and its author indicated that Roma in Hungary live ~10–15 years less than the national average (Szirtesi, 1998). Demographic data available suggest that this gap has not narrowed since then (CSO, 2011). In addition, morbidity rates among the Roma are significantly worse throughout Europe suggesting that they are more commonly and more seriously ill during their shorter lives (EC, 2014). Studies show higher rates of infectious diseases (particularly in segregated communities) as well as chronic, non-communicable diseases (Szirtesi, 1999; Kósa *et al.*, 2007). Some studies highlight Roma peoples’ worse socio-economic status, lower level of education and employment, poorer living conditions, unhealthy lifestyle (e.g. poor nutrition, higher frequency of smoking), as well as reduced access to quality healthcare and limited inclusion in prevention (vaccination) programmes (Szirtesi, 1999, Kósa *et al.*, 2007, EC, 2014). There is also evidence that Roma communities are less

well informed about health issues and may face discrimination in access to healthcare (Babusik, 2007).

In a comparative Hungarian study, some kind of discrimination related to health service use was reported by 35% of the Roma people and 4.4% of the general population (Kósa, *et al.*, 2007). Out of the Roma people who reported discrimination, 69% attributed it to their ethnicity or skin colour and 18% attributed it to their social status. Data from the ‘Equality, health and the Roma/Gypsy community’ internet publication (2007) refer to the results of a survey supported by the Hungarian Ministry of Health (2001–2002), according to which 11% (145) of the 1200 Roma interviewed claimed that they had already been discriminated because of their ethnic origin during healthcare (Khetanipe Association, 2007). ‘Inadequate treatment or care’ (29%), ‘verbal humiliation’ (26%), and ‘intentional longer waiting time’ (9%) were cited mainly. Another study from 2007 points out that in primary care, most physicians do not take into account the financial capacity when treating Roma patients (e.g. when prescribing medications), and many of them are unaware of the higher morbidity and mortality rates of the Roma and also of the causes of these indicators (Babusik, 2007). The issue that is even more serious is the occurrence of direct discrimination. According to this study, one-fifth of the Roma people report on the refusal of out-of-hours home visits, and this is believed to be associated with the Roma’s housing deprivation, segregation, and overcrowding. Segregation also occurs as an openly discriminatory practice during inpatient care, as indicated by the so-called ‘gypsywards’, that is, the intentional placement of Roma and non-Roma patients in separate wards (Babusik, 2007).

When analyzing the causes of their higher morbidity and mortality rates, in addition to assessing the role of genetic, socio-economic and lifestyle factors, exploring the presence and effects of prejudice in healthcare may be reasonable. This study aimed to explore how healthcare professionals see the position of the Roma people in terms of equal opportunities in the Hungarian healthcare system, as well as to learn about their views about the presence, effects and prevention of prejudices.

METHODS

The national interviews are part of an international study

A small-scale international study was launched in the spring of 2017 as the initiative of the ‘Amsterdam Medical Center’. As a Central European partner, the Department of Operational Medicine, University of

Pécs, Medical School (UPMS), represented by the first author, was invited to join the research project. The study aimed to explore the presence of ‘unconscious prejudice’ and its effects on healthcare and the health condition of certain vulnerable populations. In the study, the focus of the Dutch partners’ interviews was on prejudice against the so-called ‘irregular migrants’ (unregistered by the authorities) and on the elderly. Investigations in Hungary focused on prejudices regarding the healthcare of the Roma ethnic minority. In this article, we present the national results exclusively with the consent of the principal investigator of the international project. The research was approved by the Research Ethics Committee of the University of Amsterdam (Ethics Approval Number: 566-7389).

The studied population

An important consideration in selecting subjects for the study was the involvement of practising doctors and nurses. The participants were selected and involved in the research first through personal contacts and by snowball sampling. This method is a non-probability sampling technique where existing study participants recruit additional subjects from among their acquaintances. Participants were approached by telephone, and were informed orally about the aims of the research and were guaranteed anonymity. Participation in the research was voluntary and unpaid. The demographic data (gender, age, occupation, professional experience) and the recorded interviews were numbered, names and additional personal data were never included in any research documentation. Participants were from the Hungarian capital, Budapest and from Baranya and

Fejér counties, totalling 13 people (Table 1). All clinicians that were approached agreed to participate.

Mixed-type (semi-structured) interview method

Between June 2017 and May 2018, semi-structured interviews were conducted by the first author. In this method, interviews are conducted along with specific questions, but there is also the opportunity for informal discussion and asking additional questions. The duration of the interviews was between 30 and 45 min per person. The interview took place at interviewee’s workplace, and only the interviewer and the interviewee were present. The interview topic guide was prepared in English by members of the international research group based on their professional interest and goals and was translated into Hungarian by the first author for the national studies.

Processing the results: structuring the answers, qualitative data analysis

The answers to the questions formulated in the interview draft were structured and analyzed along six main questions:

1. Do you think that unconscious stereotypes and prejudices are present in healthcare (in general)? How?
2. Are there any differences between patient groups? If yes, from what perspective? Do healthcare staff have more prejudices with certain groups of patients (e.g. the Romas)? Could you give an example?
3. If yes, do you think that prejudices against the Romas may lead to worse quality (suboptimal) of healthcare provided? How/why not? Could you give an example?

Table 1: Healthcare staff interviewed

	Profession	Specialty	Gender	Age	Professional experience (years)
1.	Nurse	Infectology	Female	53	28
2.	Doctor	Infectology	Female	37	12
3.	Doctor	Pulmonology	Male	28	4
4.	Doctor	Radiology	Male	29	4
5.	Nurse	Emergency medicine	Female	58	25
6.	Dentist	Dentistry	Male	26	3
7.	Dentist	Dentistry	Male	39	17
8.	Doctor	Infectology	Female	41	13
9.	Nurse	Nephrology	Female	61	40
10.	Doctor	Family medicine	Male	57	33
11.	Nurse	Surgery	Female	51	30
12.	Doctor	Orthopaedics	Male	60	35
13.	Doctor	Paediatrics	Female	27	2

4. If yes, do you think that unconscious stereotypes and prejudices may lead to health status differences or worse health status for the Roma people? How/why not?
5. Have you ever observed any prejudice or any manifestation of unconscious stereotypes between healthcare providers and the Roma patients? How (not)? Could you give an example?
6. Can unconscious stereotypes and prejudices be prevented? If yes, how? If not, why not?

Several hours of recorded audio were transcribed, and then keywords and key messages were highlighted with bold letters according to each of the six main topics. This allowed coding and the thematic analysis of the answers for the first author, an independent, non-Roma researcher. In sections 'Results' and 'Discussion' the numbers in brackets refer to interviewees who are associated with the answer.

RESULTS

Prejudices in healthcare in general and particularly towards the Romas

When study participants were first asked whether prejudices (in general) are present in the healthcare system, most of them (12/13) answered almost automatically 'yes', and as one interviewee expressed 'similarly to all domains of society and all walks of life, prejudice is present in healthcare, too' (8). A female respondent (2) drew attention to gender biases, pointing out that there are specific 'female' and 'male' medical professions, such as surgery, traumatology, or gynaecology. Another (also female) respondent (11) confirmed the 'stone-engraved' presence of gender biases in society, putting it simply: 'the driver is a man, the nurse is a woman'.

Many of the interviewees (10/13), even after the first general question about prejudices, automatically associated it with prejudice against the Romas and began to reflect accordingly. Although, this may have been also due to their prior information about the main focus of the investigation. Respondents who work in workplaces, where in the course of their daily work, they meet certain vulnerable, disadvantaged or segregated patients more often (e.g. homeless people, HIV positive, alcohol or drug user patients at infectology wards), felt they were 'more accustomed' to these populations and believed that they do not have prejudices against them (1, 2, 8). However, they also reported that during the placement of patients on the wards, 'in the interest of peace and quiet and that of other patients', they often take

into account not only the condition of the patients (e.g. separation of terminal patients) but also their ethnic origin. As reported, 'when and where it is possible, a non-Roma patient will not be placed among Roma patients' (8). Some interviewees (1, 2, 4, 6) pointed out that during healthcare, staff make earnest efforts to 'avoid potential conflicts' and scrupulously take care that 'there should be no problem.' As an explanation for this, along with 'political correctness', they have brought in 'sensationalist media' that try to highlight any 'issues' and even make a big deal of it to generate news (views, clicks or even political advantage). In this context (i.e. 'avoiding conflicts'), and complemented by the Roma population's 'strong ability for advocacy' (e.g. 'arriving in large groups', 'being too loud', 'claiming their rights violently') some of the respondents (1, 2, 3, 12) referred to the phenomenon of 'positive discrimination', presuming that generally the Roma people are not disadvantaged but are rather favoured during care. However, the motivation behind this benefit, in addition to those characteristics listed above, may occasionally be rather discriminatory, i.e. 'to call in a Roma patient first may imply to get rid of him/her first' (7). According to our interviewees, some Roma patients arrive to the healthcare system with the presumption that 'they will be discriminated anyway' (1, 6, 10). Some interviewees felt that some Romas appear to be dissatisfied and feel discriminated even if they have to wait reasonably because care is not always provided on a 'first come, first served' basis (1, 11). One interviewee claimed that some patients complain about having to wait a lot or receiving poorer care (e.g. 'getting fewer tubes than others') because of their Roma origin (11). Other participants alleged that sometimes providers are even called 'racist' because of Roma patients' perceived discrimination (10, 12). In the background of 'avoiding conflicts', study respondents drew our attention to another, unfortunate phenomenon, namely their fear of 'the other', 'the one different from the majority' (3), 'the unknown', when they 'do not know what to expect' (1), and moreover, they 'fear the revenge of the relatives, for example, when the resuscitation of a Roma patient is unsuccessful' (4, 11).

Manifestations of prejudice and discrimination from the practice

It is undeniable that prejudices and negative discrimination are sometimes manifested during care against the Romas, and our interviewees mentioned some examples of discrimination, both their own experiences or from

their work environment. These experiences include the 'longer waiting time' but 'only when it does not endanger the patient's condition' as it was emphasized by study respondents (3, 4, 5). Comments that 'patients do not or only partially perceive' (6) are also common, as well as the use of unnoticeable meta-communicative tools, such as 'frowning and making faces or grimaces' (3, 6, 7, 9). Additionally, increased precautions during care may occur, such as the unjustified use of rubber gloves or masks specifically in case of the Roma patients (13).

Some interviewees appeared to express their own discriminatory views (4, 5, 11, 12) justified by their past negative experiences, or referring to the following: 'similarly to the presence of the (extreme) right-wing political views' in the entire society, they are also present in the medical society'. They also noted that healthcare professionals, typically, 'do not express their prejudices towards the actual patient, but rather they express their generally negative feelings towards the Romas' (6), and not in the presence of the patients, but 'behind their back'. According to another interviewee, expressions of displeasure or prejudice may occur not particularly towards Roma patients, but rather when they think that the certain patient is greatly responsible for his or her actual health problem (e.g. 'you stupid junkie' or 'why did you drink so much?') (9). Occasionally, these comments may be expressed in the presence of the patients, especially 'when they are not fully conscious' (9). A male respondent condemned the obvious discriminatory manifestations he experienced (e.g. it is 'insulting and offensive to make jokes about the name of a Roma girl under anaesthesia') (3).

A taboo: assessing patients' socio-economic background

In the course of this study another important topic was raised. In some cases, our respondents appeared to consider it important to 'be aware of the patients' origin and financial background' as well as to map their social background at the time of taking medical history and designing the therapeutic plan (3, 6, 7). They argued that it was important for the physician to get an idea of whether the patient would be able to buy expensive medications over a long period of treatment (3), or which drug to prescribe (considering the more expensive, but better medication, or the cheaper one, which is slower in effect or may have more side effects) (7). Others highlighted that it is important for the doctor to assess the patient's compliance for the treatment plan (3, 6, 8, 9, 13). As participants claimed,

physicians have to know whether it is worthwhile to commence a long-term, costly therapeutic procedure that requires more patient cooperation, or if it is likely that the patient will not follow medical advice (e.g. in case of a patient with lower health literacy) (9), or he may even leave the hospital arbitrarily during an initiated costly treatment (13). According to one of the interviewees (7), information about the patient's socioeconomic, social or financial situation may also be important 'to avoid situations that are embarrassing for both of them'.

Effects of prejudices on the quality of care for the Roma patients

Concerning the question whether prejudices may lead to lower quality of care for the Romas, most (10/13) of our respondents agreed that based on their personal experiences, regardless of the presence and occasional manifestations of prejudices (i.e. longer waiting time, negative comments), the Roma patients may not receive lower quality of care than the non-Roma patients due to their ethnic background. As reported, even prescribing less advanced medications may not lead to lower level of care overall, and while considering the financial conditions of patients our respondents strive to prescribe the best quality drugs or medical devices (3). Study participants strongly confirmed that in their practice patients may not be moved back on waiting lists or their surgical appointments may not be postponed because of their ethnic background and interventions that are more painful may never be applied intentionally (5, 6, 7). Interviewees clearly stand by their medical profession and oath to treat their patients to the best of their knowledge regardless of their origin. However, as reported, patients subjectively may feel it differently, or their behaviour may trigger a less positive attitude or impatience of their care providers, but in most cases this is an (often individual) reaction to the patient's actual behaviour and not a consequence of the prejudices or discrimination of the healthcare staff (2, 3, 4, 6, 11, 13). This may be due to, for example, the patient's self-harming behaviour (2, 4, 6), unaccountability (e.g. leaving the hospital on his/her own free will before completing treatment) (1, 13), or because of certain behavioural patterns (e.g. a lot of loud relatives) originating from his/her culture (2, 7). These may impact the patience, attitude and reactions of the doctors and other healthcare staff, especially when they are overburdened (2, 3, 4, 6, 9).

Effects of prejudices on the health status of the Roma patients and the role of culture and communication

A further, perhaps even more important question of this study sought to explore the views of healthcare professionals whether prejudices could lead to worse health status for Roma patients. The majority of our respondents (12/13) appeared to exclude this relationship and tend to refer to complex influences, such as ‘more common risky health behaviours’ (3, 5, 12), ‘financial difficulties’ and ‘being undemanding’ (12, 13), ‘poor compliance’ (8, 9, 12, 13), ‘not following medical instructions’, ‘interrupting treatment’ (1, 13), ‘denying to undergo necessary surgeries’ (12). One of the respondents noted that some Roma patients may have a different perception of disease and healing, and therefore treating their chronic illnesses seems a much greater challenge. As he said, ‘for Roma patients, rapid and spectacular improvement is more important, than the long-term improvement’ (3). It was also commonly mentioned by the study participants that Roma people tend to turn to the healthcare system too late when their illness is at an advanced stage or when some potentially irreversible complications have already occurred (2, 5, 6, 10, 11, 12). On the other hand, though less often, the opposite may also be true, as one male interviewee noted, that some Roma patients tend to seek medical attention for every negligible symptom or call the physician on-duty or the paramedics for minor complaints, which—if it happens frequently—may result in ‘not being taken seriously’ (4). He also concluded that some cultural differences (e.g. exaggerated complaints, dramatized, theatrical behaviours) may lead to misunderstandings in communication, health professionals ‘may not take the symptoms seriously’, or ‘may lose their patience or distort their attitudes’ and, ‘in extreme cases, they may lead to misdiagnosis’ (4). The importance of proper communication for a better doctor–patient cooperation was also emphasized by study respondents: ‘explaining everything several times, more loudly, more slowly, more clearly, in short sentences’ (5), or ‘it is important to take the time to discuss with them what will happen and explain things over and over again’ (1). In the background of communicative misunderstandings, one interviewee (5) presumed the differences in the education level, health knowledge and health literacy between the physicians and the Roma patients. Nevertheless, according to our respondents, stereotypes may indirectly contribute to the poorer health of the Roma, for example, if someone fails to seek timely medical care because of his past negative experience of being

humiliated or the belief of being discriminated during treatment (6, 10).

Roots and prevention of prejudices

Although respondents mostly recognize their own and their colleagues’ prejudices and discriminatory behaviours, they could not explain the reasons behind them. They presume that these may be rooted in their family, their upbringing and may also be due to the social and media influences they have been exposed to over their lifetimes (2, 3, 5, 6, 8, 9, 11). Participants expressed controversial views on how unconscious or conscious these prejudices are, and claimed that in many cases, their boundaries are blurred (2, 4). As they said, the changed tone and style of speech are presumably unconscious and unintentional, sometimes may be a reflex-like, automatic reaction to the patient’s actual behaviour and may originate from a previously negative experience of a doctor or a nurse (2). At the same time, ‘joking’ over an anaesthetized patient’s head and intentionally making the patient wait are conscious discriminatory behaviours (4).

The final question of this study focused on the prevention of prejudices. Our interviewees’ opinion of it is strongly divided on whether ‘prejudices’ can be prevented or not, particularly when they are not intentional, but unconscious. According to the respondents, prejudices cannot be completely prevented (as the influence of family, environment and media is virtually unavoidable), still, they may be influenced by conscious and consequent education started by the family during early childhood (2, 3, 5, 8, 9, 11). If this does not happen within the family, then prejudices may also be (self-)controlled consciously later on, for example, during work special attention should be paid to ensure that our prejudices do not influence our decisions and behaviour (1, 2, 4, 8). As reported, self-reflection is crucial, i.e. to ask ourselves why we have prejudices and recognizing the reasons may bring us closer to the solution (13).

Communication trainings are also considered important for prevention (1), and as media may have a key role in shaping public opinion; therefore, it would be necessary to convey information that does not lead to generalization (2, 6). Some study participants expressed that along with the conscious self-education, the education of the Romas about tolerance, cooperation and acceptance of the values and norms represented by the majority populations would also be important to achieve conflict-free cohabitation and mutual respect (3, 8, 10, 12). Interviewees’ recommendations include, running integrated classes at schools (5), catching up with

disadvantaged Roma children (9), and highlighting 'good examples' from the Roma community who may serve as motivation for the others (9). Overall, as claimed, this would require complex social responsibility and actions and should not be the sole responsibility of the families, communities and schools (8).

DISCUSSION

The aim of our research as part of an international study, was to explore health professionals' views on the presence, effects and prevention of prejudices towards the Roma patients in the Hungarian healthcare system.

The presence and occasional manifestation of prejudice against the Romas in the Hungarian healthcare system was noted by the study participants, most commonly in the forms of longer waiting time, comments and other meta-communicative tools (facial expressions, such as grimaces, etc.) that are generally unnoticeable by the patients. The use of the so-called 'Gypsy-wards' was also mentioned, a practice, that is considered by Roma patients as open discrimination (Babusik, 2007), whereas, according to our healthcare staff interviewees, this may serve the interest of both the Roma and the non-Roma patients, due to cultural differences (e.g. the regular visits of a large number of loud relatives in case of the Roma patients).

Although our study has not demonstrated a direct causal relationship between unconscious biases and health outcomes, several other studies (Feeley and Torres, 2020; Hall *et al.*, 2015; Periyakoil, 2019) have demonstrated links between prejudice, the quality of caring and the quality of care. For example, a recent publication from the 'Institute for Healthcare Improvement' highlighted the contribution of racism to increased maternal mortality rates of American black women (Feeley and Torres, 2020). Our findings resonate with a recent review, which demonstrated that racial/ethnic bias in health professionals' attitudes, whether conscious or not, may lead to prejudicial behaviour, as providers may spend more time with people that look as sound like them, and therefore may learn more about the needs and concerns of majority ethnic rather than minority ethnic patients (Hall *et al.*, 2015). Our findings of implicit and explicit biases are important because of the links that Hall found to patient-provider interactions (Hall *et al.*, 2015), treatment decisions, treatment adherence, as well as to patient outcomes. Furthermore studies suggest that our finding of biases against Roma patients is likely to impact on the engagement of this community with healthcare (Babusik, 2007), resulting in reduced preventative measures such as vaccination and

screening (Babusik, 2007), as well as relatively late presentation of time-sensitive issues such as stroke, myocardial infarction and sepsis (Baráth *et al.*, 2007). There are also the direct impacts of enduring mistreatment, including societal and media prejudice, on mental health and well-being (Baráth *et al.*, 2007), and a comprehensive, much-quoted meta-analysis demonstrated that even perceived discrimination may have significant negative effects on both physical and mental health (Pascoe and Smart Richman, 2009).

'Seeking medical attention too late' as well as 'neglecting and leaving diseases untreated' are healthcare-related behaviours that have been commonly indicated by study participants as characteristic for Roma patients (8/13). The background of this phenomenon may be worth investigating further in future studies in order to initiate effective prevention interventions. It would be important to know whether the fear of illness, pain, or death might be dominant or distrust towards doctors, as it was highlighted in a study published by the International Organization for Migration (Baráth *et al.*, 2007). Alternatively, could there be financial reasons, or previous negative experiences of discrimination, or perhaps the underestimation of the value of their health, negative vision of their future or acquired helplessness? A better understanding of the causes may provide an opportunity to improve the situation, as an apparently minor health policy intervention has achieved tremendous results since 2009 in Hungary, namely the extension of performing cervical screening to trained local nurses. The programme resulted in a much higher participation of Roma women at cervical screenings, who previously had not attended screening due to financial or distance reasons, or who were not willing (or not supported or allowed by their husbands) to participate for cultural reasons, as screenings had been mostly performed by male gynaecologists (9) (Pakai *et al.*, 2018).

Cooperation between the Roma population and the healthcare system is further hampered by deficiencies in the knowledge of healthcare professionals about the characteristics of traditional Roma culture, such as the importance of social support for the Romas, the reason why the whole family arrives together to see the doctor (collectivist vs. individualist culture) (Hofstede, 2011). Culturally, the Romas may have different perception of health and disease (e.g. value of health), different health beliefs, attitudes and due to generally lower level of education, they may have lower health literacy (Babusik, 2007; Khetanipe Association, 2007). They tend to have different perceptions of death, and express emotions and pain differently. Some of them are afraid of the dead, and some cry aloud and mourn their still alive but dying

relative, while others are afraid of invasive interventions, needles or syringes, and express physical pain intensely, loudly, often theatrically (4). To avoid conflicts arising from cultural differences (e.g. culturally different forms of grief for the Roma and the non-Roma relatives), a Hungarian study recommends the creation of the so-called ‘grace’ or ‘mourning rooms’ in hospitals (Babusik, 2007).

When it comes to health promotion interventions for Roma communities, it would be worth considering certain specific elements of Roma culture as a positive resource and taking advantage of them, such as building on the well-known social cohesion and mutual support of the Romas, which are currently only considered as a burden in care (Baráth *et al.*, 2007). For this reason, it might be favourable to find those key figures and opinion leaders, or heads of the families, who have a voice in the community, and engage them for certain important purposes (such as attending screenings or educations), and with their support and mediation try to reach the wider community (Smith *et al.*, 2019).

In addition to increasing the health awareness and health literacy of the Roma population, sensitization of the healthcare system may also be of crucial importance. This may include targeted training programmes in undergraduate and postgraduate education of healthcare professionals focusing on proper medical and healthcare communication with ethnic minorities and other diverse populations. On the other hand, increasing the number of Roma students in the education of health professionals (i.e. by supporting the studies of disadvantaged Roma students with special scholarships and mentor programmes), as well as the more pronounced inclusion of Roma representatives in multicultural healthcare teams and providing Roma-friendly health services (i.e. employing Roma cultural mediators) might also be beneficial, as suggested by a current Hungarian study (Kósa *et al.*, 2020).

Finally, our findings are in line with studies which found a link between physician burnout and stress on the enactment of unconscious biases (Hall *et al.*, 2015; Dehon *et al.*, 2017; Vogel, 2019) suggesting that it is also important to address physician well-being and workload.

Nevertheless, this study has some limitations that need to be considered. The first is the use of snowball sampling method that may have introduced selection bias. Although snowball sampling may promote approaching participants who meet the criteria for inclusion, still, it may lead to the underrepresentation or overrepresentation of particular groups within a sample, therefore it is unlikely that snowball samples are

representative of the population of interest. A further methodological limitation is the study design that may not follow rigorously the classical qualitative research methodology. Imperfections include the lack of piloting of the interview draft and returning the transcripts for participants’ correction, and these may have some effect on interpreting study outcomes. Despite those limitations, strengths of this study include the investigation of a highly sensitive and understudied area of research. Our findings may provide a better understanding of Hungarian health professionals’ views on the presence and effects of implicit racial bias towards the Roma patients in healthcare, as well as about the need and strategies of the prevention of prejudices.

In conclusion, the results presented in this study offer a novel insight into a sensitive and under researched area: the presence of health professionals’ prejudice towards the Roma ethnic minority in Hungary and its presumed effects on the quality of care and the health status of the patients. Although the healthcare providers interviewed in this study did not feel that provider prejudice was directly responsible for poorer health outcomes amongst the Roma population, they could see the indirect impacts of discrimination on engagement, late presentation, preventive care and mental health. In terms of prevention, enhancing equity, tolerance and anti-discriminatory attitudes started by the family during early childhood are of primary importance. Additionally, as media has a huge responsibility in shaping public opinion, therefore, it would be crucial to focus on providing factual, unbiased information, without misleading or ‘blurry lines’. The ‘front-page stories’ may have a negative impact on the judgement of the entire Roma population, and thereby may strongly contribute to prejudice towards them. Education of both parties on culture-related issues in healthcare, and the prevention of stress and burnout of care providers are also essential tasks for the future. In future studies, it would be interesting to explore the views of Roma healthcare providers about prejudice existing in healthcare, and also to investigate the short and long-term effects of focused behavioural educational interventions—targeting both healthcare staff and Roma communities—on the quality of care and on patient outcomes, as well as on the level of burnout of healthcare professionals.

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ETHICAL APPROVAL

The research was approved by the Research Ethics Committee of the University of Amsterdam (Ethics Approval Number: 566-7389).

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