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Why don't health care frontline professionals do more for segregated Roma? Exploring mechanisms supporting unequal care practices

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ABSTRACT

Rationale: Unequal provision of health care contributes to the poor health status of segregated Roma in Central and Eastern Europe. Studies on the drivers and mechanisms behind this are lacking.
Objective: We explored what kinds of substandard practices health care frontline professionals engage in regarding segregated Roma and what mechanisms support such practices during the professionals' careers in care services.
Methods: Over a three-month period at five different locations in Slovakia we interviewed and observed 43 frontline professionals serving segregated Roma. Next, through qualitative content analysis we identified in the data three themes regarding kinds of substandard practices and 22 themes regarding supporting mechanisms. We organized these themes into an explanatory framework, drawing on psychological models of discrimination and intergroup contact.
Results: The frontline staff's substandard practices mostly involved substandard communication and commitment to care, but also some overt ethnic discrimination. These practices were supported by five mechanisms: the staff's negative experiences with people labelled "problematic Roma patients"; the staff's negative attitudes regarding segregated Roma; adverse organizational aspects; adverse residential-segregation aspects; and poor state governance regarding racism. In the course of their careers, many professionals first felt obliged and diligent regarding segregated Roma patients, then failing, unequipped and abandoned, and ultimately frustrated and resigned regarding the equal standard of care towards the group.
Conclusions: Health care frontline staff's practices towards segregated Roma are frequently substandard. The psychological processes underlying this substandard care are supported by specific personal, organizational and governance features. These mechanisms cause many frontline professionals gradually to become cynical regarding segregated Roma over the course of their careers. Health care staff should be supported with skills and tools for effectively handling their own and others' racism, the culturebound and structural vulnerabilities of patients as well as related professional expectations regarding equity.

1. Introduction

Both the social and health statuses of segregated Roma in Central and Eastern Europe (CEE) are extremely poor. CEE Roma rank among the largest ethnically defined populations in the region (EUFRA & UNDP, 2012). In their countries of residence, large proportions of Roma live in ethnically segregated enclaves, areas in which only Roma live, under extremely poor housing conditions, and they face harsh discrimination (EUFRA, 2018; EUFRA & UNDP, 2012). Compared to respective national standards, segregated Roma everywhere suffer from much higher burdens of both infectious and non-communicable diseases and have much shorter lifespans (Cook et al., 2013; EUC, 2014).

Unequal health care systems contribute to the poor health status of CEE Roma, but evidence is still rather scarce on what drives and

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supports such unequal care. In general, poorer health care services for Roma, both in terms of access to and quality of services, have been shown to be common across the region based on large-scale European survey data (Arora et al., 2016; Duval et al., 2016; Kühlbrandt et al., 2014). Differences between patients in their socioeconomic and other circumstances usually related to standard access to health care fail to explain all of these care inequalities (Arora et al., 2016; Kühlbrandt et al., 2014). Rigorous regional qualitative (Colombini et al., 2011; George et al., 2018; Janevic et al., 2011; Rechel et al., 2009) and quantitative academic studies (Janevic et al., 2017; Kolarcik et al., 2015), as well as non-governmental research (EUC, 2014; EUFRA, 2013; EUFRA & UNDP, 2012) have started to question if and how discrimination against Roma within health care systems is involved in these inequalities. These studies have identified incidences of multiple discrimination towards Roma, including racial discrimination on ethnic grounds, at both the personally mediated and the institutional level. However, evidence on what drives and supports such unequal care remains scarce.

Slovakia presents a well-suited setting for exploring the mechanisms underlying poorer health care services for segregated Roma in the region. With approximately 450,000 Roma residents, the country has one of the largest population shares of Roma (8%) in all of Europe. Similar to other countries in CEE, the majority of Slovakia's Roma (over 50%) reside in segregated enclaves, where the socioeconomic and health status of inhabitants are typically extremely poor (Filadelfiova and Gerbery, 2012; HepaMeta, 2014). Likewise, worse access to health care and its generally poorer quality, as well as discrimination in health care facilities, have also been found to be common for segregated Roma in Slovakia (CRR, 2017; Jarcuska et al., 2013; Kolarcik et al., 2015). Compared to other CEE countries with similarly significant and marginalized Roma populations (e.g., Bulgaria, Serbia, Macedonia), marginalization in Slovakia has persisted despite the EU-standard health care and anti-discrimination legislation, and a relatively well-performing economy. In turn, it might be easier here to identify what drives such unequal care practices under relatively favorable formal and socioeconomic circumstances. Additionally, previous studies in Slovakia have assessed the approach of local segregated Roma themselves to health and health care services comprehensively compared to elsewhere in CEE (Belak et al., 2017a; Belak et al., 2018; Filadelfiova and Gerbery, 2012; see Durst, 2011).

The current study based in Slovakia focused on the micro- and meso-level drivers of inter-personal discrimination against Roma in health care services. Personal, psychological, and organizational influences that support such practices among individual care professionals were observed. More specifically, we assessed: 1) the kinds of such substandard practices of health care frontline staff (health care professionals dealing with Roma patients directly); and 2) any mechanisms directly supporting such substandard practices among these professionals during their careers in care services.

2. Method

2.1. Theory and design

A qualitative study of the involved actors' practices and perspectives presents a potentially productive initial strategy for exploring *specific* unequal care. Previous research has shown unequal care practices to vary greatly across both sociopolitical and situational contexts (Mullings, 2005; Pettigrew, 2016) and to be very prone to reporting biases (Lewis et al., 2015; Quillian, 2006; Schnittker and McLeod, 2005). For assessment of specific discriminatory practices, the involved authors therefore recommend also assessing real-life situations over longer-term periods and qualitative study of the perspectives of both the supposed victims and the supposed perpetrators.

Drawing on the above recommendations and following-up on our previous exploratory research on the related perspectives and practices of segregated Roma (Belak et al., 2017a, 2018), we designed an exploratory study focusing on the practices and perspectives of health care frontline staff serving such Roma. More specifically, we aimed at exploring: 1) the kinds of substandard everyday practices of health care frontline staff regarding segregated Roma, 2) the mechanisms supporting such substandard practices among these professionals during their careers in care services. We defined mechanisms as specific circumstances that systematically generate certain effects (Hedström and Ylikoski, 2010). As our research was intended to be exploratory rather than confirmatory, in other words, seeking new hypotheses rather than testing available ones (Gravlee, 2011), we focused in particular on identifying as many kinds of practices and mechanisms of interests as possible – regardless of their individual significances in terms of frequency or representativeness. To ensure the indiscriminate inclusion of whatever the frontline staff would themselves find relevant, we employed a classic mini-cycle of grounded-theory approach (Glaser and Strauss, 2017). We started our data acquisition with an opportunistic and open-ended fieldwork phase, continued with preliminary qualitative content analysis of the acquired preliminary data and finished with a more structured follow-up fieldwork phase drawing on the preliminary analysis.

2.2. Samples

In total, we observed and interviewed 43 health care frontline professionals across six different health care facilities in five different geographical locations, split between the two counties with the highest proportion of segregated Roma communities in Slovakia. The respondents included hospital nurses and physicians working in gynecology and obstetrics, pediatrics and internal medicine wards (31); emergency rescue (ER) assistants and physicians (10); and a nurse and a physician from a pediatric clinic (2). A summary of the samples appears in Table 1.

Table 1
Samples of respondents across field sites.

Field sites	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6
Type	ER Station	ER Station	Hospital	Hospital	Hospital	Clinic
County	Kosice	Presov	Kosice	Presov	Presov	Presov
Geographic location	Area 1	Area 2	Town 1	City 1	Town 2	
Ownership	State	Private	Private	Private	State	Private
Respondents						
ER assistants/physicians	4/2	2/2	N/A	N/A	N/A	N/A
Hospital nurses/physicians	N/A	N/A	2/6	5/9	3/6	N/A
Clinic nurse/physician	N/A	N/A	N/A	N/A	N/A	1/1
Male/Female	4/2	3/1	5/2	7/7	3/6	1/1
Length of practice span	7–22 yrs.	12–25 yrs.	17–31 yrs.	4–38 yrs.	1–31 yrs.	10–26 yrs.
Also in a managerial role	2	1	2	3	3	1
Respondents in total	43					

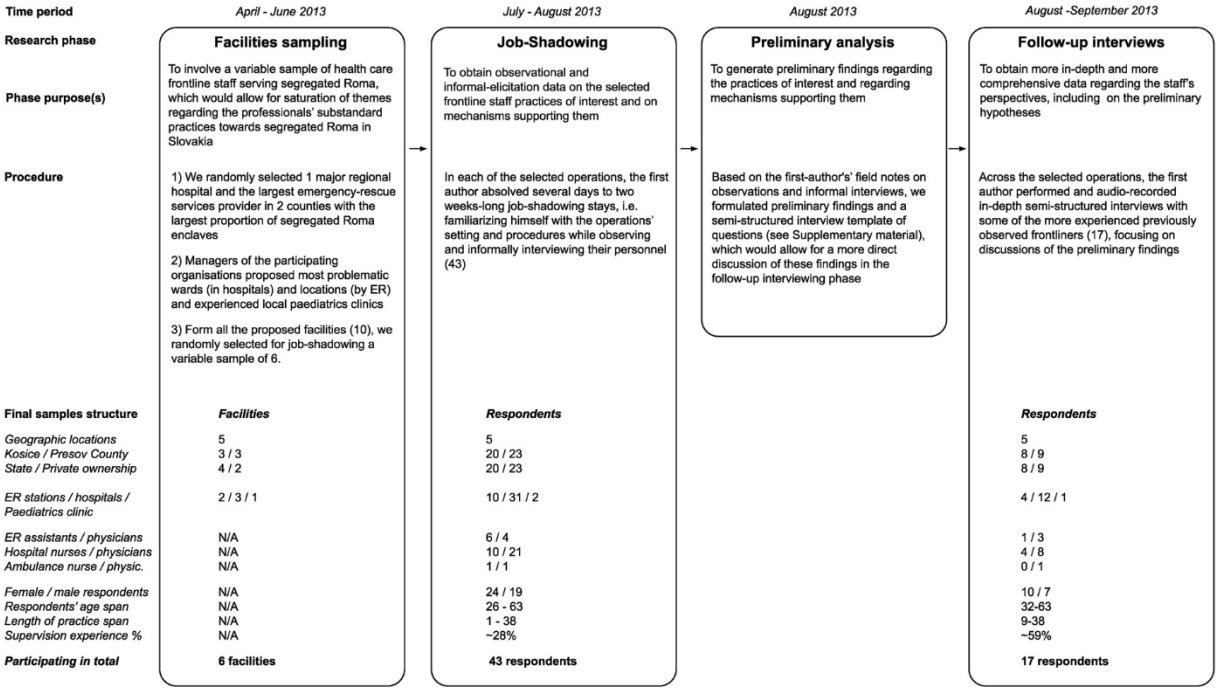

Fig. 1. Samples, sampling and procedures.

2.3. Procedure

The study took place between April and September 2013 in four stages: sampling of facilities, job-shadowing and informal interviewing, preliminary qualitative content analysis, and follow-up structured interviews (see also Fig. 1). For data collection, we combined the methods most often used by ethnographers in organizational research: job-shadowing with informal interviewing and semi-structured follow-up interviews (Czarniawska, 2018; McDonald, 2005). The fieldwork was performed by the first author. Originally, we only aimed at exploring the kinds of substandard practices and the mechanisms that support such practices. However, in the preliminary analysis phase we noticed that we had also acquired a considerable amount of data on how some of the studied professionals had experienced their gradual adoption of substandard practices during their careers. We therefore included an exploration of these aspects into the study, too. To enable identification of as many different kinds of practices and mechanisms as possible, our sampling of respondents aimed at ensuring samples as varied as possible according to the different characteristics of the facilities (e.g., geographic locations, service types, and owners of these services) as well as of personal characteristics and roles of the frontline staff themselves (e.g., gender, length of practice, profession, and participation in the facility management or not); see Table 1 and Fig. 1. Within the participating facilities, no professionals refused to participate. Saturation was reached for all topics brought up by the study.

In the job-shadowing phase, our observations and interviews addressed two primary questions regarding the study aims: 'What substandard practices are there regarding segregated Roma in this practice? What supports them?' This fieldwork phase aimed at obtaining initial data regarding the aims, as little influenced by our own theoretical assumptions as possible. In the follow-up semi-structured interviews, the focus on the study's aims was applied more explicitly and in-depth, according to an interview structure incorporating direct questions regarding the aims as well as regarding the preliminary findings (see also Supplementary file 1).

2.4. Analysis and reporting

After the follow-up interviewing phase, the fieldnotes on direct observations and informal elicitation were merged with transcripts of the follow-up interviews into a single MAXQDA© database. Using this database, the first author then performed, separately for each aim, a conventional qualitative content analysis (Hsieh and Shannon, 2005). He identified parts of the text dealing with similar aspects of the professionals' substandard practices and of circumstances supporting them throughout their careers. Next, he coded the identified sequences as distinct practices- and mechanisms-related themes, respectively. He then created thematic summaries for all texts coded with identical codes, focusing on capturing both the eventual variability and dominant patterns in whatever the themes described, especially in relation to the stratification variables used in the sampling (places, roles, demographic characteristics).

As our sample of respondents was not representative for the frontline staff positions in general, we cannot report general relationships between work roles or personal characteristics of the respondents and specific observations regarding their practices or perspectives. However, we do provide rough estimates of the proportion of respondents that the specific findings applied to within our sample (all, most, half, some, none) and emphasize the eventual discrepancies in the respondents' perspectives. In addition, we confront controversial views of the respondents with the first author's direct observations wherever these were available.

The analysis provided us with 25 thematic summaries, split according to the study's aims, which we present organized into a tentative explanatory framework. The summaries describe different aspects of the frontline staff's substandard practices and the mechanisms identified that support such practices, with one summary describing how the frontline professionals faced and experienced the mechanisms during their careers in care services. We report all the summaries organized into a tentative explanatory framework loosely based on socio-psychological models of discrimination and inter-group contact (Kauff et al., 2017; Pettigrew, 2016). The framework presents the identified substandard practices as the outcomes of five supporting mechanisms. Given the primary micro- and meso-level focuses of our study, our

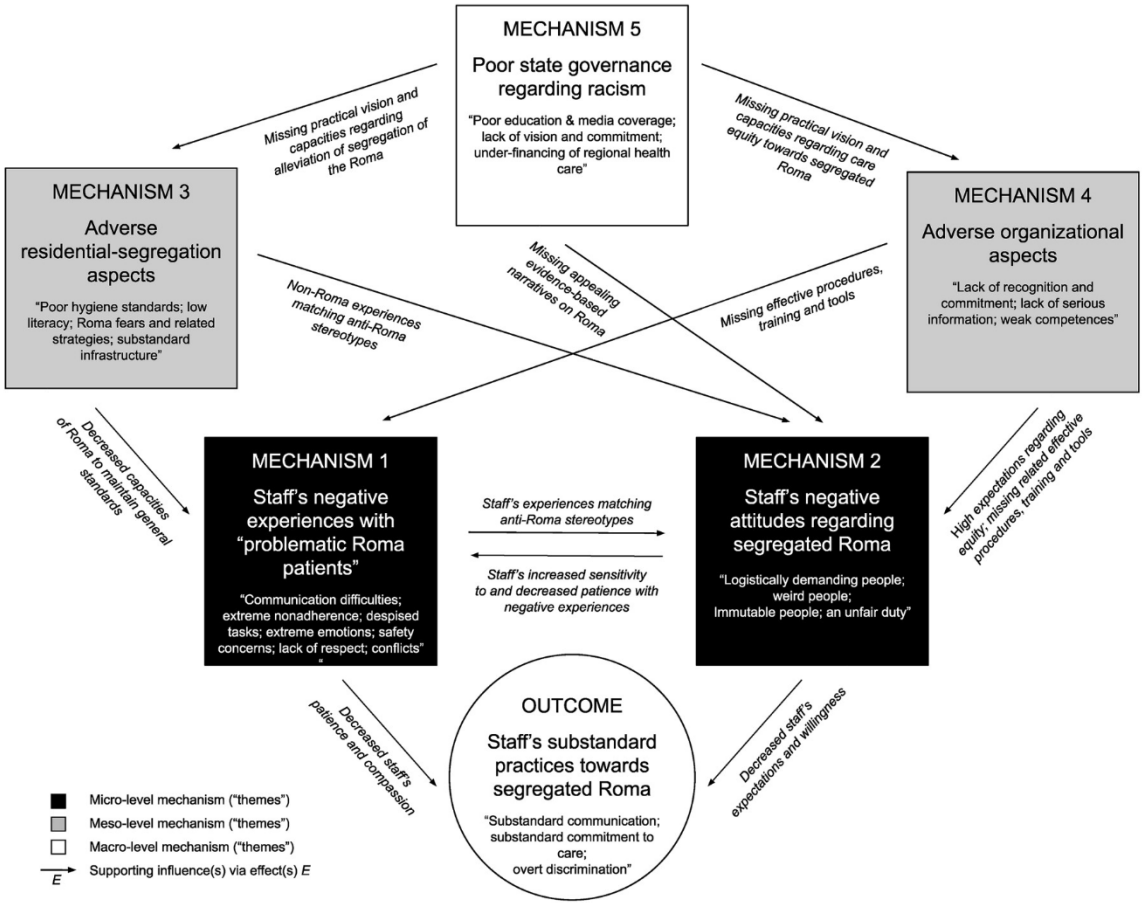

Fig. 2. Explanatory framework on health care frontline professional's substandard practices towards segregated Roma (Slovakia 2019).

findings regarding the last mechanism, labelled "poor state governance regarding racism", were based on less data. Therefore, throughout the main text we present our findings regarding this mechanism only briefly and as only providing cues for interpretation.

3. Results

Our tentative explanatory framework provides a schematic overview of all our findings and appears in Fig. 2. The framework presents three kinds of identified frequent substandard practices towards the Roma as an outcome of five mechanisms supporting such practices. The kinds of substandard practices involve substandard communication, substandard commitment to care and overt ethnic discrimination. The supporting mechanisms regard the staff's negative experiences with people labelled as "problematic Roma patients"; the staff's negative attitudes regarding segregated Roma; adverse organizational aspects; adverse residential-segregation aspects; and poor state governance regarding racism.

In the following main text, we first dedicate a section to each of the study's two aims. In the first, we review and explain the identified kinds of frontline staff's substandard practices. In the second, we review and explain the mechanisms that supported such practices. In the thrid section, we explain how the staff faced and experienced these mechanisms during their careers. In Table 2, we list, describe and illustrate in more detail all the identified specific themes, based on which we formulated the primarily sought micro- and meso-level kinds of practices and mechanisms (in the main text, we emphasize references to these underlying themes with italics). In Supplementary file 2, we present and discuss additional information that we obtained regarding the macro-level mechanism labelled "poor state governance regarding racism". In addition, in Supplementary file 3 we provide verbatim excerpts from four semi-structured interviews that illustrate exceptionally well the frontline professionals' perspectives on various themes.

3.1. Frontline Staff's substandard practices towards segregated Roma

All consulted frontline professionals shared the view that any of their own or their colleagues' substandard practices towards the Roma mostly concerned "only" *substandard communication* and *substandard commitment to care* towards "only some" segregated Roma with whom cooperation was considered to be very problematic; that is, they did not discriminate against Roma on an ethnic basis. However, most of the professionals admitted struggling at least occasionally with maintaining standard communication and commitment towards all segregated Roma. In addition, we observed that communication with Roma patients included substandard features that almost never occurred towards non-Roma patients. These included derogatory references to the patients' ethnic origin or a complete lack of the frontline staff's effort to elicit the patients' own views.

Moreover, several respondents admitted they knew or heard about colleagues who would also *overtly discriminate* against Roma patients, especially those assumed to come from segregated enclaves; thus, they treated such patients worse "because they were (such and such) Roma". Most respondents declared that they considered such practices as inappropriate and unacceptable, and several suggested they mostly happened in working collectives that included powerful individuals with generally unpleasant personalities:

> "It's individual, it's some people's personalities […], they may have had a bad personal experience; perhaps, they were raised to become like that in the past; surely some of them were. […] The problem is

Table 2
Summaries of identified themes with examples.

Theme	Description	Examples
Outcome: Frontline staff's substandard practices towards segregated Roma		
Substandard communication	Use of more directive and less compassionate communication styles towards and about selected patients	- General rudeness; frequent micro-aggressions such as: irony ("Dearest madame"), provocation ("Don't you feel anything for your own children?"), belittling ("I know it's hard for you to understand"), use of offensive labels ("our dear Roma co-citizens", "Gypsies"); strict and loud tone of speech; ignoring patients' questions
Substandard commitment to care	Poorer planning and follow-up on clinical cases of selected patients	- Less effort put into planning and supervision of follow-up treatment (e.g., organizing of surgeries in remote specialist centers or prescribing and following up on complex medication regimens)
Overt discrimination	Avoiding or taking more paternalist, invasive, laxer or offensive approaches to treatment of selected patients explicitly due to their origin	- An emergency rescue assistant refusing to help his colleague outside the vehicle in a Roma settlement because he "would not consider Roma settlements to be places any decent people should be required to visit" - Obstetricians preferring caesarean section in the case of segregated Roma women so as "not to have to deal with them personally" - Direct verbal abuse, including racist slurs
Supporting mechanism I: Frontline staff's negative experiences with "problematic Roma patients"		
Communication difficulties	Difficulties understanding what the patients mean and instructing them	- Failures in elicitation of "even the most basic information" (parents' lack of knowledge on approximate location and basic functions of bodily organs or exact ages of their children) - Inconsistencies in information elicited from patients (e.g., not matching clinical records or patients nodding in agreement to contradictory statements)
Extreme nonadherence	Lasting consequences for patients' health or death due to apparently deliberate nonadherence to related clinical recommendations	- Withdrawals from pre-agreed life-saving surgeries followed by death of the patient - Leaving of children behind alone in the hospitals after birth or emergency treatment - Relatives' failure to maintain basic hygienic status of their children (e.g., parasitosis recurring after being previously cured)
Despised tasks	Tasks experienced as disgusting	- Bathing and removal of parasites (mostly lice) from "hygienically neglected" patients - Handling of the patients' "dirty and smelly" clothes - Examination of patients in poor personal hygienic state - Visits to the "filthy" quarters or households in segregated Roma enclaves
Extreme emotions	Patients or their relatives becoming emotionally extremely aggravated	- Patients' relatives' "loud weeping", "violent arguments" - Self-harm (e.g., hair tearing, banging heads on walls) - Direct personal accusations of clinical failure or racism, verbal abuse, spitting attacks
Safety concerns	Experiences of feelings of risk to one's own health	- Fear of attacks from patients' relatives, where extreme emotions are present (e.g., in the cases of death of patients, especially children) - Fear of contagion during visits to segregated Roma enclaves
Lack of respect	Patients' communication styles experienced as impolite by the staff (more frequent with patients considered well-off segregated Roma)	- Patients not using common polite expressions (e.g., greetings) - Patients not expressing gratitude for help and stressing clinicians' duties - Patients evoking supposed racism of the staff ("You don't want to help us because we are Gypsies!")
Conflicts	Patients' and their relatives' conflicts with other patients and their relatives and related claims towards staff	- Both non-Roma and Roma patients' refusals to share hospital rooms with segregated Roma and related conflicts and claims - Loud communication and arguments between segregated Roma and related conflicts and claims from patients
Supporting mechanism II: Frontline staff's negative attitudes regarding segregated Roma		
Logistically demanding people	Segregated Roma viewed as requiring special personal assistance upon any service provision	- Viewed as typically requiring postponements or remission of fees and supplementary fees - Viewed as typically requiring more extensive and repeated instructions - Viewed as often missing required documentation (e.g., insurance cards, IDs, referral notes) - Viewed as sometimes requiring language translations
Weird people	Segregated Roma viewed as reacting in incomprehensible ways and making irrational decisions	- Viewed by some staff as often responding with inappropriate emotions ("They would start shouting like crazy.", "They tend to set up a theater here.") - Viewed as rarely considering long-term consequences (e.g., "They only care about the present.")
Immutable people	Segregated Roma viewed as incapable of adopting different kind of practices than they exhibit in the present	- Viewed by some staff as inert to both standard and tailored activities aimed at their behavioral change ("The Gypsies will always remain Gypsies, no matter what you do for them!" "It's genetic!")
An unfair duty	Having to work with and for segregated Roma viewed as an unfair obligation in the societal context	- Negative experiences from work for segregated Roma experienced as upsetting because of the view that Roma fail taking care of themselves ("Why should we take care of their newborns, when they themselves leave them here behind just like that?!")

(*continued on next page*)

Table 2 (*continued*)

Theme	Description	Examples
		- Negative experiences from work for segregated Roma experienced as upsetting because of the view that other actors in the society fail to take care of them ("Is this really my job – to explain the most basic things over and over to them? Aren't they supposed to learn all these things at school? Nobody else is offered such extras here!")
Supporting mechanism III: Adverse organizational aspects		
Lack of recognition and commitment	Staff's superiors and management in facilities not reflecting on the existing staff's negative experiences with the work for segregated Roma in practical and effective ways	- Lack of interest, guidance and commitment from supervisors when staff voice related discontent ("At best, they [hospital superiors] will just nod in understanding and tell you they are sorry, but that there is nothing they can do about it.") - Lack of tools and clear procedures in place for prevention and management of the care-provision aspects experienced as negative (e.g., guidelines regarding patients' demands for segregation in hospital rooms) - Lack of compensation for related extra work ("You see, it's [difficult communication] constant extra time that nobody will pay us for. We are being punished financially for serving here.")
Lack of serious information	Staff are not being offered and the facilities' standard operating procedures do not reflect on any serious information regarding history, living conditions and perspectives of segregated Roma	- Some staff expressed interest in non-racist explanations of some of the segregated Roma patients' seemingly irrational behaviors and extreme emotions, of various aspects of their everyday life and living conditions - Some staff expressed dissatisfaction with not being provided practical training specifically regarding care provision for segregated Roma
Lack of legal authority	Staff feel unable to solve care-related problems or to achieve better care outcomes due to lack of legal authority	- Some staff claimed diminishing success in achieving segregated Roma patients' cooperation due to decreasing availability of legal disciplining tools ("Before [during the Communist era], the Roma knew they could end up in jail or their kids could be taken away from them, if they didn't cooperate. Now, they have no obligations anymore, only rights!")
Supporting mechanism IV: Adverse residential-segregation aspects		
Poor hygiene standards	Low frequency and thoroughness of personal hygiene practices in the segregated Roma enclaves	- Poor personal hygiene of some segregated Roma patients understood by some staff as caused by standard lack of effort in the segregated communities ("It's normal not to wash there, apparently.") - High prevalence of hair, skin and gut parasitosis (lice, fleas, helminths) among segregated Roma patients understood by some staff as caused by standard lack of effort in the Roma settlements
Low literacy	Poor literacy standard in segregated Roma enclaves including health literacy	- Patients' and their relatives' lack of knowledge of basic biomedical concepts about the human body understood as part of general illiteracy normal in the settlements ("People coming from there sometimes cannot sign their names – how could they know anything about physiology?") - Patients' and their relatives' lack of services-user knowledge viewed as part of general illiteracy normal in the settlements ("Most people there don't know how to make a polite phone call, what to ask for, etc. And this concerns whomever they need to call, not just to make an appointment.")
Roma fears and related strategies	Patients and their relatives prevented from effective use of care services due to varied insecurities they share regarding people and processes outside segregated enclaves	- Patients' and their relatives' nonadherence and emotions experienced as extreme or weird understood by some staff as consequences of Roma fear ("Imagine how hard must it be to come here, into such an unfamiliar environment.") - Patients' avoidance of services understood as a consequence of lack of trust towards the non-Roma ("Of course, they don't trust us, the non-Roma, why should they? No wonder they only come here when they absolutely have to.")
Substandard infrastructure	Unavailability of standard household amenities and community infrastructure in most segregated Roma enclaves	- High prevalence of hair, skin and gut parasitosis (lice, fleas, helminths) among segregated Roma patients and in their residential enclaves understood by some staff as caused by lack of infrastructural means - Patients' difficulties with maintaining care-related documentation understood by some staff as caused by unavailability of safe means for storage in their households

when such a person becomes the head of a department – I know departments like that – it then somehow attracts similar people, and it [overt discrimination] just becomes normal there." (male gynecologist-obstetrician (42), 17 years of practice).

3.2. Mechanisms supporting substandard practices

Mechanism I: Frontline staff's negative experiences with "problematic Roma patients." Seven themes emerged that all described distinct and difficult aspects of the frontline professionals' negative experiences from clinical encounters with some segregated Roma patients: *communication difficulties*, *extreme nonadherence*, *despised tasks*, *extreme emotions*, *safety concerns*, *lack of respect* and *conflicts* (see Table 2 for details regarding these themes). The professionals labelled patients with whom they had such experiences as "problematic Roma (patients)". According to all respondents, these patients made up only a relatively small proportion of all their segregated Roma patients, and

most of the staff admitted also experiencing the same kinds of problems with some non-Roma patients (most often quoting examples of people without homes and intoxicated persons). Implying Roma ethnicity in the labelling was nevertheless considered appropriate by all respondents, because such problematic behavior was, in their opinion, more common among Roma than among non-Roma. Moreover, all respondents concurred that some aspects of the negative experiences were "Roma features" in the sense that they never occurred in non-Roma patients (e.g., the style and extremity of *extreme emotions*). The frontline professionals' impressions that such kinds of problems were much more frequent or happened exclusively with patients identified as Roma matched the first author's experience of the same from his direct observations of the professionals' interactions with patients.

These negative experiences directly supported the staff's substandard practices, at least with respect to the "problematic Roma patients" and in situations when such experiences occurred, as they instantly decreased the staff's patience and compassion (see Fig. 2). Moreover, according to some respondents and the first author's direct observations, such experiences matched and thus further supported some of the professionals' negative general attitudes regarding segregated Roma and their effects, as further discussed below.

Mechanism II: Frontline staff's negative attitudes regarding segregated Roma. Four themes emerged that all described the distinct negative attitudes that frontline professionals had towards segregated ("poor", "settlement", "dirtier", etc.) Roma, rendering them as people *logistically demanding, weird, immutable* and presenting *an unfair duty* (see Table 2). The respondents in our sample varied greatly regarding how far and for what reasons they considered these characteristics to apply to all segregated Roma. For instance, most of the respondents considered providing their services to segregated Roma to be *an unfair duty* for different, even contradictory reasons. On the one hand, staff less prone to have negative attitudes towards segregated Roma, i.e. staff making up approximately half of all our respondents and varied in other characteristics, believed that the provision of care involved tasks that were appropriate but beyond their job description. On the other hand, staff more prone to have negative attitudes believed that these Roma didn't deserve engaged care due to their own failing self-care.

According to the consulted frontline professionals, these negative attitudes directly supported the staff's substandard practices towards segregated Roma patients, as they decreased the staff's expectations from such patients and their willingness to treat them with standard levels of compassion and commitment (see Fig. 2). Next, expecting the worse from (such and such) Roma was also viewed as simultaneously supporting the professionals' readiness to experience more and to tolerate less the above-described negative aspects of clinical encounters with Roma, especially with the "problematic Roma patients":

> "The boys [ER assistants] see this more directly. They look at it as if from above. […] They see that this is a drunk and Gipsy, so it's assumed that he just can't handle his wine, that he's drunk because he wants to be drunk and it's his own fault and that's how they approach it." ER physician, female (42), 17 years of practice.

Mechanism III: Adverse organizational aspects. Three themes emerged that all described distinct adverse aspects of the organizational setups of the frontline professionals' facilities and operations with respect to segregated Roma: *a lack of recognition and commitment* from superiors, *a lack of serious information* regarding segregated Roma and *lack of legal authority* (see Table 2). The *lack of legal authority* on the part of the staff was spontaneously brought up and emphasized mostly by respondents (approximately half of the respondents who varied in their other characteristics) who considered segregated Roma patients to be immutable and highly problematic people. The *lack of serious information regarding segregated Roma*, in the sense of both insufficient previous education and follow-up training on the job, was brought up mostly by respondents with less negative attitudes regarding Roma.

According to the involved respondents, these organizational aspects supported the frontline professionals' substandard practices towards segregated Roma in two ways: via supporting their negative experiences with "problematic Roma patients" and supporting their negative attitudes regarding segregated Roma patients (see Fig. 2). Both of these ways included a lack of effective procedures, training and tools as mediating effects of poor organization. For example, most respondents felt that their managers showed poor recognition of and commitment regarding the recurring organizational difficulties by not seeking or providing clear, effective procedures for preventing or handling the negative experiences that staff constantly experienced with "problematic Roma patients". Some respondents said that the managers themselves operated in a similarly unfavorable organizational situation: while facing increasing pressure to meet raising expectations regarding equal care (e.g., from legislation, services owners, patients, activists) no one provided them with effective practical instructions and tools to do so. Their experience with such an organizational setup fed the frontline staff's views that working for segregated Roma presented an *unfair duty* in the societal context:

> "Dr X, one of the best doctors I have, did whatever he could, of course, but the fetus was already born dead. They [a Health Care Surveillance Authority's investigation commission] later found it must have already been dead for 10 or so hours before the woman started to give birth here. […] But back then, the Gypsies [parents] insisted that the physician had been drunk, and they started to threaten me and called this television station. […] I was going to meet the parents, and the television crew assaulted me here in front of the director's office. I was very disappointed that the television company acted on this kind of stimulus and about the kind of questions they were posing: "Which one of your doctors failed?" […] These kinds of scenarios are now common, but nobody up there [at the Ministry of Health] cares – they wash their hands with harassing doctors by the Health Care Surveillance Authority. Why would any doctor not try to avoid treating such [Roma] people then?" (male internal medicine specialist and hospital director (57), 34 years of practice).

Mechanism IV: Adverse residential-segregation aspects. Four themes emerged that all described distinct adverse aspects of the segregated Roma's residential situation*: poor hygiene standards*, *low literacy*, *Roma fears and related strategies* and *substandard infrastructure* (see Table 2). Most respondents acknowledged all these aspects as important but greatly varied regarding their causes and relative importance.

The adverse residential-segregation aspects were assumed by the respondents to support the substandard practices of frontline professionals in two ways: supporting the staff's negative experiences with "problematic Roma patients", and supporting their negative attitudes regarding Roma. The living situation of segregated Roma constrained their capacities to maintain various personal standards which, in turn, contributed to the professionals' disproportionately frequent or even specific negative experiences with patients from this group. For example, most frontline staff understood the generally low literacy standard in segregated settlements to be the primary cause of their communication difficulties with Roma. According to some respondents and the first author's observations, the negative attitudes of many frontline professionals regarding segregated Roma were in general supported by the professionals' frequent experiences of Roma behavior intimately connected with their residential segregation, which matched existing anti-Roma stereotypes. For example, some professionals interpreted the frequent strategic Roma behavior driven by fear (see Table 2) as an example and proof of Roma weirdness and indifference towards their own health or future in general.

3.3. The frontline Staff's experiences of the mechanisms throughout their careers

One theme emerged describing how the frontline professionals'

experiences of the above-presented mechanisms often developed over the course of their careers in care services and how this related to their eventual (non)adoption of substandard practices. In general, the professionals greatly differed regarding which of the above-described mechanisms would apply to them and how. One pattern became clear, however. Frontline staff who started their careers with negative attitudes about segregated Roma – approximately half of those consulted regardless of their other characteristics – retained such attitudes throughout their careers. Those who started their careers without such attitudes usually adopted them gradually.

More specifically, the latter group described their career experience as feeling first obliged and diligent, then failing, unequipped and abandoned, ultimately frustrated and resigned from the ambition of an equal standard of care towards segregated Roma. These frontline professionals described, and the first author directly observed, many sophisticated strategies they improvised to compensate for specific disadvantages of segregated Roma patients and the related extra work, which often went beyond their job duties:

> "For example, we have created this small lending fund for Roma who wouldn't have the money to pay the supplementary fees for their medications […] – we basically just gave these mothers our own personal money, and they were supposed to return it to us after receiving their social welfare payments. Something they then, of course, often just didn't do." (female pediatrician and head of department (33), 9 years of practice).

These frontline professionals' feelings of being unequipped and abandoned were based in their views on the above-described adverse organizational but also governance influences: they felt that they faced high expectations from both their superiors and society, but they were provided with no practical support (see also Supplementary file 2). In addition, some of these professionals mentioned that their proactivity was viewed by some colleagues as weird.

As reasons for their ultimate resignation, the involved staff mentioned that their extra efforts did not lead to any significant long-term changes for segregated Roma patients or for their own difficult work situation. In the words of one gynecologist (male (42), 17 years of practice) "sooner or later you will realize you can only choose between useless burnout and joining your cynical colleagues." The initial motivation and consequent frustration upon their eventual resignation seemed to be rooted ideologically on a personally deep, identity-related level – most such respondents said that they felt that taking part in such discriminatory double-standard practices was psychologically damaging (e.g., during the interviews, two respondents cried upon discussing this issue). Also, these professionals spontaneously stressed that positive personal experiences with a Roma significantly helped them to resist the above-described negative experiences, feelings and attitudes.

4. Discussion

We assessed substandard practices of health care frontline professionals regarding segregated Roma and mechanisms supporting such practices over the professionals' careers in care services. We found that the frontline staff's substandard practices mostly regarded substandard communication and commitment to care, but also overt ethnic discrimination (see Table 2). This outcome was supported by five mechanisms: frontline staff's negative experiences with people labelled "problematic Roma patients", the staff's negative attitudes regarding segregated Roma, adverse organizational aspects, adverse residential-segregation aspects and poor state governance regarding racism (see Fig. 2). Over the course of their careers, numerous frontline professionals who started without negative attitudes towards segregated Roma patients first felt obliged and diligent, then failing, unequipped and abandoned, and ultimately frustratingly resigned regarding the equal standard of care for segregated Roma.

We found that the frontline staff's substandard practices towards segregated Roma mostly involved substandard communication and commitment to care, but also overt ethnic discrimination (see Table 2). This matches previous research on discrimination towards the Roma within CEE health care services in two respects: in similar prominent forms of discrimination, including the persistence of racist concepts and labelling, and in the perpetrators' unwillingness to be identified as practicing discrimination (Andreassen et al., 2017; Colombini et al., 2011; EUFRA, 2013; 2018; George et al., 2018; Janevic et al., 2017). The finding of health care staff trying to justify their ethnically biased discrimination practices as experience-driven and rational is in line with studies showing the historical mutation of explicit racism within health care settings and beyond into less explicit, more indirect forms (Mistry and Latoo, 2009; Mullings, 2005; Sue et al., 2007). Our findings thus strongly corroborate the idea that CEE segregated Roma do face both overt and less direct forms of ethnic discrimination in health care while adding that the forms of indirect discrimination are often not understood as racism by their perpetrators.

We found two mutually supportive mechanisms driving the identified substandard practices psychologically: the frontline staffs' negative experiences with and their negative attitudes regarding segregated Roma (see Fig. 2). Some previous studies on discrimination against CEE Roma have also identified the negative experiences of health care personnel with segregated Roma and their negative stereotypes towards them (e.g., Andreassen et al., 2017; Janevic et al., 2017). Our study adds an example of how these phenomena might drive substandard practices via negative emotions on the part of the perpetrators, and how these mechanisms mutually support one another. These accounts match contemporary socio-psychological models of discrimination and inter-group relations in their emphasis on the crucial role of the perpetrators' negative inter-group emotions and the close relations of these emotions to context-specific inter-group cognitive contents (Kauff et al., 2017; Pettigrew, 2016). Our findings thus suggest that, as elsewhere, the emotional capacities of frontline staff may also play a crucial mediating role in the practice of discrimination against segregated Roma.

Among the identified negative attitudes, we found that most consulted frontline professionals considered their work for segregated Roma to be an unfair duty within the societal context (see Table 2 and Supplementary file 2). We also found that the rationale for adopting such an attitude varied between frontline staff showing more and frontline staff showing fewer negative attitudes towards segregated Roma, regardless of their other personal characteristics. While the first-mentioned of these professionals (about half our sample) complained about having to provide services to people who didn't deserve them, the latter half complained about being confronted with the outcomes of other professionals not fulfilling their duties. These findings resemble those of the only other study we found on a similar topic regarding CEE segregated Roma, that of Wamsiedel (2018), which also provides a concise overview of how "deservingness" has been found to influence clinical encounters with patients in general. According to the study, hospital triage frontline staff in Romania also incorporated their personal views regarding both their facilities' capacities and the served minorities' moral eligibility into their clinical decision-making. Our study thus underlines the crucial importance of how health care professionals understand their competences vis-à-vis varied structural forces, including structural constraints of both their organizations and patients, for the psychology of their involvement in substandard practices.

We found two mechanisms driving the identified substandard practices indirectly at the meso-level: adverse organizational aspects and adverse residential-segregation aspects (see Fig. 2). Previous studies have identified the extremely poor living conditions of segregated Roma and health care organizations' failure to accommodate the consequences of this as important structural drivers behind unequal care provision to this group (Andreassen et al., 2017; Colombini et al., 2011; George et al., 2018; Janevic et al., 2017). Our findings add a novel dimension to this picture regarding how and which personal and

organizational features negatively affect the psychological capacities of health care staff to treat segregated Roma adequately. Further, our findings indicate that these capacities might be significantly affected by varying professional cultures and governance features (see Supplementary file 2). This pattern is in line with ecological models that understand ethnic discrimination in health care as practices simultaneously rooted across all levels of society (e.g., Ford and Airhihenbuwa, 2010; Phelan and Link, 2015; Singer et al., 2016). Our findings thus suggest that to improve the care for segregated CEE Roma, along with addressing their segregation both outside and within the health care systems, attention also needs to be given to the psychological capacities of the services personnel.

Finally, we found that about half of the consulted frontline staff, regardless of their other roles and personal characteristics, showed some resistance to adopting substandard practices: they began their careers lacking negative attitudes towards segregated Roma, proactively experimented with minimizing negative experiences, cherished positive experiences with Roma and found their own ultimate resignation frustrating. We found no other studies on such processes. Yet, our findings match two promising propositions in current applied socio-psychological research on discrimination, the already mentioned crucial role of recurrent negative inter-group emotions in the formation and maintenance of negative inter-group attitudes, and the positive effects of positive inter-group emotions by most people (Kauff et al., 2017; Pettigrew, 2016). Our findings indicate that a substantial proportion of CEE health care professionals may be ideologically and emotionally prone to resist negative attitudes and discriminatory practices towards Roma throughout their careers but mostly end up unable to maintain this resistance over time. Further, our findings show that being involved in the standardized practice of ethnic discrimination may also take a psychological toll on at least some of the involved perpetrators (see Shellae Versey et al., 2019).

4.1. Strengths and limitations

The main strengths of our study regard our use of ethnographic methods. Our preceding long-term ethnographic research on related Roma practices and perspectives supported a well-informed sampling strategy. Our careful rapport-building with and open-ended, non-judgmental attitude towards the alleged perpetrators of discrimination in the initial fieldwork phase built personal trust and enabled a sincere openness among many of the visited professionals, even regarding their own double-standard practices and related feelings. The main limitation of our study was it did not include segregated Roma patients as the supposed victim group. In theory, this could have caused an underestimating of the extent and harshness of the healthcare staff's discrimination practices due to the perpetrators' social-desirability reporting bias. However, given the study's above-discussed relatively critical acknowledgements of our respondents regarding their own practices, we believe we have dealt with this issue appropriately via the inclusion of careful rapport-building, direct observations and critical follow-up phases.

4.2. Implications

For health care practice, in line with the critical-race theory (Ford and Airhihenbuwa, 2010; Came and Griffith, 2018) and recent recommendations specifically regarding Roma inclusion (EUFRA, 2018), our findings imply that health care professionals at all levels need to be supported with skills and tools to better understand, monitor and manage both their own and others' direct and indirect racism, as well as any culture-bound and structural vulnerabilities of their patients (Bourgois et al., 2017; Kleinman and Benson, 2006). Also, given that employment of community health workers and of clinical professionals from the targeted minorities rank among the most effective interventions regarding ethnic health inequalities in general (Lehmann and Sanders, 2007; Phillips, 2011), we advise more extensive use of existing health-mediation programs for segregated Roma communities and ensuring more Roma in the clinical professions, wherever possible (Belak et al., 2017b; Thornton, 2017).

For future research, our findings imply that we need studies on how the competence and capacities of CEE health care professionals could be increased to curb racism (Bailey et al., 2017; Came and Griffith, 2018) and for more effective management of patients' culture-bound and structural vulnerabilities (Bourgois et al., 2017; Kleinman and Benson, 2006). Our study provides an innovative example of how the use of ethnographic methods may enrich such evidence.

5. Conclusions

We identified an explanatory framework regarding the substandard practices of health care frontline staff towards segregated Roma. The framework shows that psychological processes underlying such substandard care are supported by specific personal, organizational, and governance features; why many frontline professionals become cynical regarding segregated Roma over the course of their careers; and why expecting health care frontline professionals to achieve care equity alone might turn counter-productive. Related pro-equity governance frameworks, such as the National Roma Integration Strategies (EUC, 2018), might benefit from endorsing better monitoring and support of the professionals' capacities to curb both direct and indirect racism, to accommodate the culture-bound and structural vulnerabilities of their patients, to psychologically manage related professional expectations, and to employ and respectfully work alongside more Roma care professionals.

Author Contributions

Andrej Belak Conceptualization, Methodology, Investigation, Formal analysis, Writing - Original draft preparation. **Daniela Filakovska Bobakova** Writing - Review & Editing. **Andrea Madarasova Geckova** Funding acquisition, Writing - Review & Editing. **Jitse P van Dijk** Writing - Review & Editing. **Sijmen A Reijneveld** - Writing - Review & Editing

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Appendix A. Supplementary data

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