Cultivating trust: ethical imperatives to dismantle institutional racism in health care

To the Editor: Recent condemnation of hate speech exposes a profound ethical crisis embedded deeply within Australian health care.[1] These events demand an honest reckoning with systemic racism and settler–colonial legacies and structures that continue to marginalise Indigenous, migrant, racialised and minoritised communities. Ethical health care demands more than isolated condemnations; it requires radical structural transformation grounded in dignity, justice and accountability if the already precarious trust of racialised communities is to be meaningfully addressed.

As inquiries continue into the video showing two racialised nurses at Bankstown Hospital allegedly boasting about denying care to Israeli patients and making violent remarks,[1] the incident has sparked intense public outrage and debate over the ethical responsibilities of health care providers.[2] To date, no verified evidence has shown that Jewish patients at the hospital experienced harm or neglect as implied. Yet, when health care workers engage in, or are perceived to engage in, discriminatory or degrading speech, the effects can resonate far beyond the moment, especially within systems where institutional racism is already well documented, thereby intensifying longstanding concerns about care and dignity in health care.

Crucially, the swift condemnation of this incident did not emerge in a vacuum.[1] It unfolds alongside the ongoing genocide of the Palestinian people,[3] where hospitals, schools and basic infrastructure have been systematically destroyed — all met with overwhelming institutional silence. That silence is never neutral; it reveals whose lives are lamentable, whose suffering is acknowledged, and whose is rendered invisible.

Within Australia, systemic racism is deeply entrenched in health care and public health institutions.[4] For those marginalised — Indigenous, Black, migrant, refugee and minoritised communities — these spaces often become sites of othering rather than care, both for patients and health care workers.[5,6] The harm is not limited to overt acts but persists quietly in everyday practices.[7] This ongoing normalisation erodes whatever fragile trust racialised communities may place in institutions, highlighting institutional complicity in sustaining structural racism.

Public outrage, although justified, reinforces institutional complicity when it selectively condemns some violations while silencing others. As I have discussed elsewhere, the racial and political economy of outrage demands closer scrutiny.[8] Calls for accountability must move beyond isolated acts and address the historical and structural forces that continually erode precarious trust. Trust for the racialised is not a given; it is a ghost, hovering where histories of harm refuse to let it settle. Given that it is already fractured, it must be cultivated through substantive accountability and structural transformation that confronts both past and ongoing violence.

Thus, ethical health care is not reducible to technical skill — it requires a profound commitment to recognising persons with dignity, and addressing institutional racism means confronting the very oppressive conditions. Learning from this incident, Australian health care must move beyond reactive outrage. It must engage in radical, sustained transformation — rejecting settler–colonial entanglements and dismantling structural racism — so that dignity and justice are not aspirational but foundational.

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